

**THE NATURE OF THE FEMALE
PATIENT–PHYSIOTHERAPIST
RELATIONSHIP IN SAUDI
ARABIAN MUSCULOSKELETAL
OUTPATIENT SETTINGS: A
CONSTRUCTIVIST GROUNDED
THEORY**

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Abstract

The relationship between the physiotherapist and the patient is fundamental to the delivery of musculoskeletal healthcare. In order to deliver high quality patient care it is vital that an effective therapeutic relationship is established. To date, there has been very little research into the nature of the patient–physiotherapist relationship and none has been conducted in Saudi Arabia. This study explored the nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings.

A total of ten female musculoskeletal physiotherapists and nine female patients participated in this qualitative study, situated in the interpretive research paradigm. Purposive sampling was used to initially select participants. Subsequent theoretical sampling, informed by data analysis, allowed specific participants to be sampled. Data was initially collected from nineteen semi-structured interviews with ten female musculoskeletal physiotherapists and nine female patients participants, which were audio-recorded and transcribed. As the study approached theoretical sufficiency, three of the physiotherapists and three patient participants were theoretically sampled for a second interview. A constructivist grounded theory approach involving the constant comparative method of analysis was used to code and analyse data to construct a substantive theory of the nature of the therapeutic relationship between female patients and physiotherapists.

Patients' and physiotherapists' embraced three types of therapeutic relationships: clinical, professional and personal. These relationships were influenced by the different physiotherapist professional roles and patient personas that have been adopted during their interaction. The different characteristics of the three physiotherapist professional roles, along with the two patient personas, led physiotherapists and patients to have different expectations of the relationship, which, in turn, had an impact upon the experience of the relationship. This ultimately shaped the relationship outcomes between the physiotherapists and patients.

Participants' negotiation was identified as the key factor which contributed to the experience of the relationship between them. Physiotherapists and patients experienced different types of negotiations. The two types of physiotherapist-patient experience of negotiation were trust, partnership negotiation and decision-making negotiation. Within each type, there have been existed variations in the level of negotiation that were related to and influenced by the physiotherapist's professional role and patient's persona, as expressed during the interaction. A number of influencing factors were identified to contribute to participants' negotiation and helped to explain the nature of the therapeutic relationship between physiotherapist and patient: time availability, sociocultural factors, participants' self-efficacy, and professional self-esteem. These findings provide the first explanation for the nature of the patient–physiotherapist relationship within the Saudi Arabian musculoskeletal outpatient setting. The substantive theory developed through this study has implications for physiotherapy practice, education and research, and may inform physiotherapy curricula development, continuing education, and professional development activities in Saudi Arabia.

Contents

ABSTRACT	I
CONTENTS	II
LIST OF TABLES.....	VII
LIST OF FIGURES	IX
ACKNOWLEDGMENTS	XI
DECLARATION	XII
CHAPTER 1: THESIS RATIONALE AND OVERVIEW.....	1
1.1 Introduction	1
1.2 Thesis Rationale	1
1.2.1 Professional Motivation	1
1.2.2 Personal Motivation.....	2
1.2.3 Theoretical Motivation.....	3
1.3 Structure of Thesis.....	5
Chapter 1- Thesis Rationale and Overview	5
Chapter 2- Saudi Arabia-Historical, Religion and Cultural Context.....	5
Chapter 3- The Therapeutic Relationships.....	5
Chapter 4- Methodology.....	5
Chapter 5- Methods.....	6
Chapter 6- Findings.....	6
Chapter 7- Discussion, Clinical Implications and Conclusion.....	6
CHAPTER 2: SAUDI ARABIA- HISTORICAL, RELIGION AND CULTURAL CONTEXT ...	8
2.1 Introduction	8
2.2 Chronology.....	8
2.2.1 Historical Background	8
2.2.2 The Saudi Arabian Economy	9
2.2.3 Women Education	10
2.2.4 Women and Higher Education	11
2.3 Religion, Political and Geographical Backgrounds.....	11
2.4 Social Classification	15
2.5 Gender in the Saudi Culture	17
2.6 Gender in Social Context.....	19
2.7 Gender Mixing in Healthcare Sector.....	20

2.8 Women’s Education in Saudi Arabia	24
2.8.1 Development of Women’s Education in Saudi Arabia	25
2.8.2 Princess Noura bint Abdul Rahman University for Women	27
2.9 Physiotherapy Education and Regulations in Saudi Arabia	28
2.10 Healthcare System in Saudi Arabia	29
2.11 Health Workforce Plan and Saudisation	33
2.12 Cultural and Religious Contexts of Saudi Arabian Women	35
2.13 Women’s Health in the Islamic Culture of Saudi Arabia.....	39
2.14 Physiotherapy Management of Female Patients in Musculoskeletal Outpatient Settings in Saudi Arabia	42
2.15 Chapter Summary	46
CHAPTER 3: THERAPEUTIC RELATIONSHIPS	48
3.1 Introduction	48
3.2 Use of the Literature in the Study.....	48
3.3 Historical Development of the Doctor–Patient Therapeutic Relationship	54
3.4 Defining the Therapeutic Relationship.....	58
3.5 Healthcare Professional–Patient Therapeutic Relationship Models	60
3.6 Healthcare Professionals’ Beliefs.....	64
3.7 Patients’ Beliefs.....	67
3.8 Ways of Experiencing the Patient Encounter.....	70
3.9 Motivation Factor on Outcomes	72
3.10 Patient Expectations	75
3.11 Therapeutic Relationship—Influencing Factors.....	75
3.12 Research Question and Aims	77
3.12.1 Research Question	77
3.12.2 Research Aims	77
3.13 Chapter Summary	77
CHAPTER 4: METHODOLOGY	79
4.1 Introduction:.....	79
4.2 A Qualitative Approach	79
4.3 Epistemological Positions of Qualitative Research	80

4.4 Locating this Research within the Interpretive Paradigm.....	82
4.5 Grounded Theory: The Methodology.....	83
4.6 Schools of Grounded Theory.....	85
4.6.1 Theoretical/Philosophical Underpinning of Grounded Theory.....	87
4.6.2 Constructing Grounded Theory.....	89
4.7 The Grounded Theory Debate and its Relation to this Research.....	90
4.8 Rationale for Selecting Constructivist Grounded Theory.....	92
4.9 Insider Research.....	94
4.10 Ethical Considerations of this Research.....	96
4.10.1 Ethical approval.....	98
4.10.2 Confidentiality and Anonymity.....	98
4.11 Trustworthiness of the Study.....	99
4.11.1 Credibility.....	100
4.11.2 Transferability.....	103
4.11.3 Dependability and Confirmability.....	104
4.12 Data Analysis.....	104
4.12.1 Open Coding.....	105
4.12.1.1 Focussed Coding.....	106
4.12.1.2 Axial Coding.....	107
4.12.1.3 Selective Coding.....	108
4.12.2 Constant Comparative Analysis.....	108
4.12.3 Memo Writing.....	109
4.13 Chapter Summary.....	112
CHAPTER 5: METHODS.....	113
5.1 Introduction.....	113
5.2 Research Focus.....	113
5.3 Research Context and Procedures.....	114
5.3.1 Selecting the Setting.....	114
5.3.2 Selecting the Sample.....	114
5.3.2.1 Purposive sampling.....	114
5.3.2.2 Theoretical sampling.....	115
5.4 Physiotherapist Recruitment.....	115
5.5 Patient Recruitment.....	117
5.6 Data Collection.....	118
5.7 The Researcher-Participant Relationship.....	122
5.8 Data Management and Storage.....	125
5.9 Data Collection and Analysis.....	126
5.9.1 Data Collection Interviews 1-10.....	126
5.9.2 Data Analysis Interviews 1-10.....	127

5.9.3 Data Collection Interviews 11-19	131
5.9.4 Data Analysis Interviews 11-19	134
5.9.5 Data Collection Interviews 20-25	138
5.9.6 Data Analysis Interviews 20-25	139
5.10 Theoretical Sorting and Integration	144
5.11 Chapter Summary	150
CHAPTER 6: FINDINGS	151
6.1 Introduction	151
6.2 Participants' Backgrounds.....	151
6.3 Work Situations in the Musculoskeletal Outpatient Settings	153
6.4 Antecedent Conditions	156
6.4.1 Physiotherapist Professional Roles	156
6.4.1.1 The Teacher	156
6.4.1.2 The Treater	160
6.4.1.3 The Person-Centred	162
6.4.2 Patient Personas.....	164
6.4.2.1 The Active Patient	164
6.4.2.2 The Passive/Dependent Patient	167
6.5 Expectations of the Relationship	169
6.5.1 Physiotherapist Expectations of the Therapeutic Relationship	170
6.5.1.1 Expectations of Partnership	170
6.5.1.2 Expectations of Trust.....	173
6.5.2 Patient Expectations of the Therapeutic Relationship	178
6.5.2.1 Active Patient Expectations of Professionalism	179
6.5.2.1.1 Respect Patient Autonomy	179
6.5.2.1.2 Empathy and Partnership.....	180
6.5.2.1.3 Knowledge and Expertise	182
6.5.2.1.4 Trust and Rapport.....	183
6.5.2.2 Passive/ Dependent Patient Expectations of Personable relationships	185
6.5.2.2.1 Caring, Helping and Loving Attitude	185
6.5.2.2.2 Openness and Good Communication Skills	186
6.6 Experience of Relationship.....	188
6.6.1 Physiotherapists' Trust and Partnership Negotiation.....	189
6.6.1.1 The Teacher	189
6.6.1.2 The Treater	190
6.6.1.3 The Person-centred.....	191
6.6.2 Patients' Trust and Partnership Negotiation.....	194
6.6.2.1 The Active Patient	194
6.6.2.2 The Passive/Dependent Patient	195
6.6.3 Physiotherapists' Decision-making Negotiation	199
6.6.3.1 The Teacher	199
6.6.3.2 The Treater	200
6.6.3.3 The Person-centred.....	200
6.6.4 Patients' Decision-making Negotiation.....	201
6.7 Types of Relationship	203
6.7.1 The Professional Relationship	204
6.7.2 The Clinical Relationship	207
6.7.3 The Personal Relationship	212

6.8 Influencing Factors	218
6.8.1 Time Availability	218
6.8.2 Socio-Cultural Influences.....	220
6.8.2.1 Gender Identities	220
6.8.2.2 Language Barriers.....	224
6.8.2.3 Patients' Education	226
6.8.3 Self-efficacy.....	228
6.8.4 Professional Self-esteem.....	230
6.9 Chapter Summary	232
CHAPTER 7: DISCUSSION	234
7.1 Introduction	234
7.1.1 Summary Point 1	234
7.1.2 Summary Point 2.....	236
7.1.3 Summary Point 3.....	239
7.1.4 Summary Point 4.....	244
7.1.5 Summary Point 5.....	255
7.1.6 Summary Point 6.....	259
7.2 Final Reflections on the Research Journey	269
7.3 Implications for Education	273
7.4 Implications for Clinical Education	276
7.5 Implications for Practice	281
7.6 Suggestions for Further Research Work.....	286
7.7 Thesis Limitations.....	288
7.8 Contribution to Knowledge	290
7.9 Conclusions.....	292
REFERENCES.....	294
APPENDICES.....	323
Appendix 1- Faculty of Health and Social Science Research Ethics and Governance Committee, University of Brighton Ethics Committee Approval	324
Appendix 2- Institutional Review Board (IRB) Study Approval.....	325
Appendix 3- Participant Information Sheet for Physiotherapists	326
Appendix 4- Patients Invitation Letter in Arabic Version	331
Appendix 5- Participant Information Sheet for Patients.....	332
Appendix 6- Physiotherapist Interview Transcript Sample.....	337
Appendix 7- The Interview Schedule, Consent Form and Participant Information Sheet for Patients (Arabic Version)	348

List of Tables

Table 2.1 Population, number of hospitals, and available beds in the Kingdom of Saudi Arabia.....	32
Table 3.1 Place of the literature in this study.....	50
Table 3.2 Published papers related to the Patient-Physiotherapist relationship.....	52
Table 4.1 Major differences between constructivist and objectivist grounded theory.....	93
Table 5.1 Interview guide physiotherapist interviews 1-5.....	127
Table 5.2 Interview guide patient interviews 1-5.....	127
Table 5.3 Examples of initial line-by-line coding employed during physiotherapist interviews 1-5.....	128
Table 5.4 Examples of initial line-by-line coding employed during patient interviews 1-5.....	128
Table 5.5 Data collection and analysis physiotherapist interviews 1-5.....	130
Table 5.6 Data collection and analysis patient interviews 1-5.....	130
Table 5.7 Interview guide used during theoretical focussing of physiotherapist and patient interviews 11-19.....	133
Table 5.8 Examples of physiotherapist focussed coding.....	135
Table 5.9 Examples of patient focussed coding.....	135
Table 5.10 Data collection and analysis interviews 11-19.....	137

Table 5.11 Analytical memo written for interviews 20-25.....	139
Table 5.12 Relationship between the categories therapeutic professional roles, their expectations of the relationship and type of relationships, developed after interviews Pt1, 7, and 9.....	141
Table 5.13 Relationship between the categories patient personas, their expectations of the relationship and type of relationships, developed after interviews Pa3, 5, and 7.....	142
Table 5.14 Analytical memo used to interrogate the data.....	143
Table 6.1 Physiotherapists' characteristics.....	152
Table 6.2 Patients' characteristics.....	153
Table 6.3 Participants' therapeutic professional roles.....	163
Table 6.4 Summary of professional roles with practical applications.....	164
Table 6.5 Patient participants' personas.....	164
Table 6.6 Summary of patient personas with practical applications.....	169
Table 6.7 Patient expectations of the relationship.....	187

List of Figures

Figure 2.1 Map of the Kingdom of Saudi Arabia.....	13
Figure 2.2 Structure of the healthcare sectors in Saudi Arabia.....	31
Figure 2.3.A Saudi Arabian women wear an ‘Abaya’.....	38
Figure 2.3.B A black, cloak-like long dress and a ‘Tarha and Niqab’.....	38
Figure 4.1 Grounded Theory tree of knowledge.....	83
Figure 4.2: Constructivist grounded theory.....	89
Figure 4.3: Coding analyses at each phase level.....	110
Figure 5.1 Explanatory matrix with negotiation as the central organising category. This forms the basis of the storyline presented in Chapter 6.....	147
Figure 5.2 Summary and timeline of the data collection and analytical processes.....	149
Figure 6.1 Antecedent conditions of physiotherapists and patients.....	169
Figure 6.2 Treater, teacher and person-centred partnership expectations of the relationship.....	173
Figure 6.3 Teacher, treater and person-centred trust expectations of the relationship.....	177
Figure 6.4 Physiotherapists’ professional roles and each role expectation of the relationship.....	178
Figure 6.5 Patients’ personas and each persona expectation of the relationship...	188

Figure 6.6 The physiotherapist–patient experience of relationship (negotiation) and the level of their negotiation.....	203
Figure 6.7 Types of relationship outcomes.....	217
Figure 6.8 The explanatory matrix of the nature of the patient–physiotherapist therapeutic relationship.....	231

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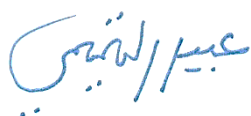
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Declaration

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

Signed

A handwritten signature in blue ink, written in Arabic script, which appears to be 'عبدالله بن محمد' (Abdullah bin Muhammad).

Dated 23rd April 2015

Chapter 1: Thesis Rationale and Overview

1.1 Introduction

The purpose of this study was to obtain a theoretical insight into the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings. In this chapter, the professional and personal driving factors of this research study are introduced and the rationale of the thesis is provided. An overview of the structure and content of the thesis by way of a summary of each chapter is then been given.

1.2 Thesis Rationale

1.2.1 Professional Motivation

I came to this study through personal, academic and professional experiences, having fifteen years of experience as a senior physiotherapist working in a musculoskeletal outpatient setting. I was always interested in the therapeutic relationship between physiotherapists and patients. Attached to one of the biggest multi-entity tertiary care hospitals and one of the leading healthcare institutions in Saudi Arabia (King Faisal Specialist Hospital and Research Centre/KFSH&RC), my work has involved frequent interactions with patients and physiotherapists from different cultural backgrounds.

After my graduation in 1998, with a Bachelor of Science (BSc) in physiotherapy, I worked for four years at King Faisal Specialist Hospital and Research Centre as a staff physiotherapist before receiving a promotion to a senior physiotherapist in 2002. Since then, my research interest has been in women’s health. In 2007, I received a scholarship award to pursue my Master’s degree in women’s health in the United Kingdom at the University of Brighton. Within this speciality, my greatest interest has been the treatment of urinary incontinence. The sensitive nature of the subject requires that patients receive treatment with compassion and empathy. Urinary incontinence is a very isolating condition and women do not talk about it openly. Therefore, it is critical for me to spend time with my patients, to gain a deep

understanding of how their problem affects them, and to give them the support and help patients feel they need. I deeply believe that the relationship between the patient and the physiotherapist is important and must be included when evaluating the outcome of treatment.

As a doctoral student, I have accessed various theoretical perspectives and conceptual models. I have made myself more cognisant of how our perspectives and expectations colour our views of our social realities and ourselves. For this study, I decided that my aim was to illuminate, rather than challenge, the participants' views about reality. I saw my work as a construction of meanings rather than a discovery of the objective truth (Charmaz, 2006). My major task was to construct a theory from the multiple stories of people involved in the study and to acknowledge my role as an interpreter.

The motivation for this thesis was a desire to explore the nature of the female patient–physiotherapist therapeutic relationship. Such information would inform physiotherapists to assist them in making recommendations for physiotherapeutic services in Saudi Arabia. This issue launched me into the field of the patient–physiotherapist relationship, and my exploration of it in the context of musculoskeletal physiotherapy outpatient clinics, from where my research question was developed. In Saudi Arabia, there is a growing need to understand how social restraints imposed upon Saudi women affect women's health and their response to current treatment approaches. The cultural uniqueness of Saudi women warrants special attention. The degree to which patients and physiotherapists interact and the nature of the relationship between them, especially women, in developing countries remains unknown. Accordingly, more research is needed regarding the nature of this relationship, particularly within Saudi Arabia, a geographic region that has remained outside of the scope of mainstream academia until recently.

1.2.2 Personal Motivation

The therapeutic relationship in musculoskeletal physiotherapy outpatient clinics in my work place and other hospital settings can pose some difficult, but rewarding,

challenges. The therapeutic relationship is a challenge for those who seek the means to help patients, and it is a challenge to the patient trying to find relief of his/her unpleasant symptoms. Considering that women do not always openly discuss problems related to musculoskeletal disorders in women's health issues such as urinary incontinence, and despite the fact that the religious teachings of Islam lead many to feel thankful for their circumstances in spite of feeling great pain, the relationship between patients and physiotherapists can become extremely challenging. While the patient/physiotherapist relationship is, ideally, a bio-psychosocial process relying on engagement by both the patient and the physiotherapist to ensure that the primary objectives of treatment are achieved, what I witnessed challenged my assumptions.

One day was pivotal for me. I joined one of the junior therapists in a treatment session that I was supervising. The junior therapist asked the patient at the beginning of the session about the physical pain she was enduring and how she felt about it. The patient answered her with '*Thanks God I am fine*', without looking her in the eyes. I knew from her facial expression that she was in pain. Her expression reminded me of how, as Muslims practising Islam, we believe that we should thank God in all life situations even if we are passing through difficulties and pain. Although the doctrines of Islam teach us to give thanks for everything, it made me think of why this patient felt thankful, even though it was clear that she was enduring acute pain. I felt compelled to look into the nature of the female patient–physiotherapist therapeutic relationship. The fact that I am a Saudi Arabian female coupled with my familiarity with the culture has played an important role in the development of this study. My experiences have influenced the research choices and content presented in this thesis.

1.2.3 Theoretical Motivation

The patient–physiotherapist relationship can be seen as a specialized form of a human relationship. Work in other disciplines has differentiated the dynamics of relationships between people who are in a relationship, which are 'historically derived representations of experience' (Duck, 1998). In the absence of a conceptual

framework that can be applied to patient–physiotherapist therapeutic relationships, the significance of the different factors in the patient-physiotherapist relationship and how they affect patient care and treatment outcome are unlikely to be established.

Although the patient-physiotherapist relationship is discussed frequently in academia, particularly through research, the foundations of such research are restricted by standard theoretical platforms, failing to address the variability that comes from modern research. In other words, the data is insufficient in its explanation of the variance, complexity, and subjectivity that arises in the treatment of socio-culturally diverse patients. In Saudi Arabia, the diversity of the community has implications for modern practice, as professionals endeavour to interpret patient expectations and interactions according to their appropriateness or effectiveness. The relationship between patient and physiotherapist is increasingly diverse and highly fluid, due in large part to the complexities and diversity of patients.

My previous experience in research is limited to two systematic review studies in areas related to health professions as part of my bachelor’s degree in physiotherapy and my master’s degree in women’s health. As such, this is my first experience in a qualitative research project and in the use of participant interviews as a data collection method. Nonetheless, my clinical and professional experience of women’s health physiotherapy undoubtedly helped to sensitise me to this research area. Likewise, my familiarity with the research setting and its members was helpful in gaining access to the research setting. This was especially helpful in building a researcher-participant rapport, which is considered beneficial in facilitating the process of constructing knowledge about a selected research area in collaboration with persons who are directly involved in it (Mruck & Mey, 2007).

Nevertheless, it was also important to ensure that my personal experiences and views did not foreclose the generation of rich data from the participants (Charmaz, 2009), making it essential to manage reflexively any preconceived ideas. In this regard, this introductory chapter opened by expounding my own views about the social process being investigated and proceeded by giving information about my clinical and professional background. Furthermore, throughout data collection and analysis, reflexive reactions to the data were documented distinctly from the actual

data, while self-scrutiny of research decisions took place throughout the research project.

1.3 Structure of Thesis

The thesis consists of seven chapters. A brief overview of the content and structure of this thesis, and a synopsis for each chapter is presented overleaf.

Chapter 1- Thesis Rationale and Overview

In this chapter, the area of research and the context in which it is set, is introduced. The professional and personal rationales for the study are described, an overview of the contents of the thesis is provided.

Chapter 2- Saudi Arabia-Historical, Religion and Cultural Context

In this chapter, introductory information about Saudi Arabia, reviews of the healthcare system, services, facilities and the development of women's education, are presented. The physiotherapy community in Saudi Arabia is described. The specific socio-cultural background of Saudi Arabia with a focus on Saudi Arabian female culture and its influence on the relationship between patients and physiotherapists is presented. The Saudi Arabia religion and culture are thus discussed together because of the close link between these two concepts.

Chapter 3- The Therapeutic Relationships

In this chapter, a journey through the historical developments of the therapeutic relationship, and critical reviews of the theory and research associated with the nature of the patient–physiotherapist relationship and other healthcare professions are detailed. A discussion of the main concepts and ideas based on the literature relating to the nature of patient–physiotherapist relationship is contained.

Chapter 4- Methodology

In this chapter, the methodological approach adopted in this research is described and justified. The choice of methodology in light of the research question and the field of therapeutic relationship are examined. The chapter continues by positioning

the study in the interpretive research paradigm and explains how my epistemological and ontological decisions have influenced my choice to use constructivist grounded theory. It continues by discussing the ethical considerations relevant to this research study and how such issues were managed. Finally, in this chapter, the measures taken to ensure the trustworthiness of this research study are discussed.

Chapter 5- Methods

In this chapter, the methods used in this study to gather data and derive meaning from these data through analysis, in line with the iterative nature grounded theory are discussed. The chapter begins by outlining the strategies used to access, recruit and sample participants for this study. Finally, this chapter presents an explicit and detailed account of the methods of data collection and analysis which were employed to construct an explanatory model of the patient-physiotherapist therapeutic relationship, serving as an audit trail, thereby increasing the dependability and confirmability of the study.

Chapter 6- Findings

In this chapter, the findings of the study are presented. The chapter begins by presenting the backgrounds of the study participants to provide context for the findings. Along the way, each aspect of the theory is supported by quotations from participant interviews and serves as supportive evidence for the theoretical claims made. The data is organised to illustrate the key conceptual relationships which form the constructed theory. The full theory of the nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings in this study is presented and concludes this chapter.

Chapter 7- Discussion, Clinical Implications and Conclusion

In this chapter, the findings in the context of the extant literature are discussed. The chapter begins by re-visiting the research question and outlining how the findings have addressed it. Outline of the six key summary points which are considered to be theoretical insights of the nature of the patient-physiotherapist therapeutic relationship is then preceded. The study and the constructed theory are examined and critiqued, so that the reader can judge the quality of the thesis. The chapter continues by considering the rigour of the study, and my final reflection on the

research journey and the impact I personally had on the study. Finally, I discuss the study's contribution to the knowledge base of physiotherapy and the implications the findings have for practice, education and further research.

Chapter 2: Saudi Arabia- Historical, Religion and Cultural Context

2.1 Introduction

In this chapter, the relevant literature in support of conducting a study in the Kingdom of Saudi Arabia is presented and reviewed. The chapter begins by giving an overview of Saudi Arabia and background information on its healthcare system and organization. It describes the development of women's education in Saudi Arabia and introduces the physiotherapy professional education and regulations. It is intended as an aid, particularly for those who are unfamiliar with Saudi Arabia's history, land, people, and social welfare, health and education system. In this chapter, the socio-cultural context of Saudi Arabia underpinning the relationship between patients and physiotherapists is then discussed. The chapter follows by giving an overview of the religious and cultural context as well as the context of women in Saudi Arabia. The physiotherapy management of female patients in musculoskeletal outpatient settings in Saudi Arabia is described. The importance of this chapter is to provide the reader with background knowledge about the social and culture issues that may influence the nature of the female patient–physiotherapist relationship.

In the coming section below, an explicit time frame for the Saudi Arabian context and background including historical, economy, women education and higher education development, using time bands, in chronological order, with contemporary (most recent) references is presented.

2.2 Chronology

2.2.1 Historical Background

When the Ottoman Emperor Salim I occupied Egypt in 1517, he inherited Hijaz, Jeddah and Medina (Al-Rasheed, 2013). However, while the easternmost territories of Saudi Arabia were incorporated into the Ottoman sphere of influence, the vast yet arid centre of the country (Najd) remained outside of Turkish control (Askan, 2013). Between the sixteenth and the eighteenth centuries, local emirs and tribal leaders

exerted control over the Najd region (Al-Rasheed, 2013). During the late eighteenth century, the religious leader Abd Al-Wahhab joined forces with the powerful Al-Saud family forming the first Saudi emirate (1744-1818) (Askan, 2013). Fuelled by the strict monotheistic doctrine of Al-Wahhab, the Wahhabi-Saudi forces sought to rid Hijaz, Iraq and Syria from the jahilyya (religious ignorance and paganism) associated with the Ottoman regime (Al-Rasheed, 2013; Jordan, 2011). While they were defeated in 1818, by 1824 Najd was back under the control of Al-Saud-Wahhabi forces (Jordan, 2011). The demise of the power, authority and legitimacy of the Ottoman Empire during the closing decades of the nineteenth century provided fertile grounds for the expansion of the House of Saud beyond the Najd region (Askan, 2013). Under the leadership of ibn Saud, Riyadh was captured in 1901, Hijaz was reclaimed in 1925 and Najd was formally incorporated into the modern Saudi state under the auspices of the Royal Decree in September 1932 (Elliot House, 2013).

2.2.2 The Saudi Arabian Economy

The economy of modern day Saudi Arabia is rooted in the discovery of oil in Jabal Dhahran 1933 (Jordan, 2011). In 1948, the Ghawar oil fields (the largest oil fields in the world) were first discovered in the eastern province of Al-Hasa (Ulrichsen, 2011). In the aftermath, the Arabian-American Oil Company (Aramco) was established to exploit the resources located at Ghawar and elsewhere in the country (Jones, 2010). Oil revenues to the monarchy rose sharply from \$10 million in 1946 to \$110 million in 1951 (Bowen, 2008). By the early 1970s, demand for oil from the West was growing at approximately 10% per year (Ramady, 2005). The incumbent 'oil boom' drastically increased the foreign workforce (both Arab and western nationals) of KSA with the proportion of foreign workers rising from 59% at the end of the 1970s to a peak of 65% in 1985 (United Nations, 2003). Oil thus represented a dual process of change incorporating: (1) a socioeconomic transformation from an agrarian economy to an industrialised economy; and (2) a demographic transformation which challenged the legitimacy of historical political networks based upon "family ties, personal loyalty and patronage" (Zagorski, 2009:441). In response, since 2003 the Saudi government has implemented a policy of

'Saudisation' in a bid to increase the number of Saudi workers in the national economy (Ramady, 2005).

2.2.3 Women Education

A crude and rudimentary form of primary education formally commenced prior to the official creation of the Saudi state with the General Directorate of Education for Boys established in 1926 (Al-Rawaf and Simons, 1991). In 1951, King Abdul Aziz established a secondary education system funded by the rapidly increasing revenues accrued from oil (Al-Rasheed, 2002). In 1953, the education system was institutionalised in the guise of the Ministry of Education, which was led by King Fahad (Al-Rawaf and Simons, 1991). During the same year, the first public schools for boys were opened (Al-Rawaf and Simons, 1991). Before 1959, the only education available for girls was private tutoring (*katatib*) in which girls could "retain all aspects of their Muslim identity" (Jamjoom and Kelly, 2011:119). By the early 1960s, an agenda for female education had begun to emerge backed by the Crown Prince Faisal and his wife (Weston, 2008). When the prince became King in 1964 the reform of public education was accelerated with the first government school for girls established in the same year (Weston, 2008).

By the mid-1970s it is estimated that approximately 50% of Saudi girls attended public schools (Al-Rasheed, 2002). The number of women's institutions increased from fifteen in the 1960s to 155 during the 1970s (Hamdan, 2005). By 1981 the number of girls enrolled in public schools in KSA was almost equal to the number of boys (Ulrichsen, 2012). At the dawn of the twenty first century, female literacy was 50% (in comparison to approximately 72% for males) (Hamdan, 2005). While this is the lowest literacy rate in the Persian Gulf, it is a huge increase on the 2% female literacy recorded during the early 1970s (Hamdan, 2005). However, although public schooling for girls has improved outcomes, it was not until 2002 that women's schooling at all levels (elementary, secondary and university) was moved from the Department of Religious Guidance to the Ministry of Education on a par with education provision for males (Hamdan, 2005).

2.2.4 Women and Higher Education

The first university in KSA (the King Saud University) was founded in Riyadh in 1957 (Al-Rawaf and Simons, 1991). Six other higher educational institutions followed incorporating Islamic University (1961), King Fahd University for Petroleum and Minerals (1963), King Abdul-Aziz University (1967), Um Al-Qura University (1967), Imam Muhammad bin Saud Islamic University (1974) and King Faisal University (1975) (Alamri, 2011). This necessitated the creation of the Ministry of Higher Education in 1977 - a centralised institution responsible for implementing the state's higher educational policies (Alamri, 2011). At this time, increasing numbers of women were enrolled in KSA's universities. By 1980, there were more female graduates in the humanities than males (Hamdan, 2005).

From 1991 to 2004, female enrolments in KSA universities increased by 512% (Jamjoom and Kelly, 2011). At the graduate studies level, the female enrolment rate is one of the highest in the world (48%) (Jamjoom and Kelly, 2011). Between 1990 and 2009, increased spending on higher education resulted in the number of female faculty members rising by 242% (Jamjoom and Kelly, 2011). As a result, women presently represent 60% of the total number of university students in Saudi Arabia (Jamjoom and Kelly, 2011). However, while remarkable progress has been made over the last twenty years, three barriers remain prevalent. Firstly, higher education remains formally segregated according to gender (Al-Rasheed, 2015). Secondly, women's choice of diploma degrees is limited to the humanities and natural sciences with vocational subjects such as engineering, Islamic studies, law, education and agricultural science reserved for men (Jamjoom and Kelly, 2011). Thirdly, there is an imbalance in the staff-student ratio in women's universities with almost twice as many male academics (27, 488) than female academics (14, 401) (Jamjoom and Kelly, 2011).

2.3 Religion, Political and Geographical Backgrounds

The Kingdom of Saudi Arabia means different things to different people around the world. For example, to some it means a land of oil, a land of wealth and a land of money; to others it is a land of the desert and extreme heat. It could also mean the birthplace of Islam, a blessed and sacred land that is the Land of the Two Holy

Mosques at Mecca and Medina, the two holiest places in Islam for all Muslims around the world. Nowadays, the Kingdom of Saudi Arabia has become well known as the world's single largest oil exporter, having about one third of the world's reserves of oil and it has the world's largest reserve pumping capacity for oil. The majority of the income generated in Saudi Arabia (approximately 85%) comes from the oil industry (Jones, 2010). In the past, the Saudi Arabian economy was heavily dependent on simple agriculture, selling sheep, goats or camels and fishing. The discovery of oil in 1936 helped to create wealth, which allowed Saudi Arabia to develop into a modern country, to provide free healthcare and education, and a tax-free society for its residents (Jordan, 2011).

Saudi Arabia is located in the middle of a desert, surrounded by seawater at its southern and eastern borders (Royal Embassy of Saudi Arabia Washington, DC, 2013). The size of Saudi Arabia is around 1.96 million square kilometers, the 14th largest country in the world (Royal Embassy of Saudi Arabia Washington, DC, 2013). Saudi Arabia is the largest state in the Middle East and, due to its oil wealth, the country is a major force in the Arabic world (Walston, Al-Harbi and Al-Omar, 2008). Occupying about four-fifths of the Arabian Peninsula, Saudi Arabia shares borders with: Jordan, Kuwait and Iraq in the north; Bahrain, Qatar and the United Arab Emirates (UAE) and the Gulf on the eastern frontiers; the Sultanate of Oman on the southeast frontier; Yemen in the south; and the Red Sea and the Gulf in the west and northeast respectively (Royal Embassy of Saudi Arabia Washington, DC, 2013).

The population of Saudi Arabia is 27 million including 8.4 million foreign residents (Royal Embassy of Saudi Arabia Washington, DC, 2013). The capital city is Riyadh, located in the centre of the country. Saudi Arabia is divided into 13 provinces, each with its capital (Royal Embassy of Saudi Arabia Washington, DC, 2013). Al-Wosttah in the centre; the Hijaz region, also called "Algharbiah", located along the Red Sea, contains the holy cities of Makkah (Mecca) and Madinah (Medina), the port city of Jeddah and the summer capital of Taif; the Al-Sharghiyah region in the East; Al-Janoob in the South; and the Al-Shamal region in the Northern part of the Kingdom (See Figure 2.1).

The Kingdom of Saudi Arabia's climate varies from one region to another due to its varying terrain and the influence of high tropical air. However, in general the Kingdom of Saudi Arabia has a very hot summer with the highest average maximum daily temperature of 43 degrees Centigrade in July, a cold winter with the lowest average minimum daily temperature of 9 degrees Centigrade in December (Elliot House, 2013). Overall, the country typically has a dry, desert climate; however, the northern and southern regions of Saudi Arabia have small amounts of rain during the winter (Elliot House, 2013).



Figure 2.1 Map of the Kingdom of Saudi Arabia

Islam is the only religion practiced in Saudi Arabia. Official spoken languages are Arabic and English (Royal Embassy of Saudi Arabia Washington, DC, 2013). The latter is mostly spoken in urban areas (Royal Embassy of Saudi Arabia Washington, DC, 2013).

Saudi Arabia was recognized as a kingdom in 1932. Saudi Arabia is “the most theocratic state in the contemporary Sunni Muslim world” (Jordan, 2011). It is based on the Wahhabi interpretation of Islam (Jordan, 2011). The Wahhabi religion of Islam was introduced to Saudi Arabia by Mohammad bin Abdulwahab, a native scholar from Najad (Riyadh today) (Jordan, 2011). In 1740, Mohammad bin Abdulwahab bonded with Saud bin Abduaziz, the founder of Saudi Arabia, to establish a religious state based on the Wahhabi interpretations of Islam (Jordan,

2011).

The followers of Wahabbi Islam call themselves Salafis. Based on the Salafi doctrine, Muslims should strictly follow the Qur'an and Sunnah (Prophet Mohammad and his followers) (Elliot House, 2013). The Salafi doctrine considers the period lived by Prophet Mohammad and his followers the golden era of Islam (Elliot House, 2013). According to the Salafis, Muslims today are required to follow the lifestyle of Prophet Mohammad and his followers. Moreover, an Islamic state has to be socially and politically structured similarly to the socio-political system during the golden era of Islam (Elliot House, 2013). Anything that came after that golden era of Islam is considered an insulting to Islam (bida'a) (Elliot House, 2013). The Salafi doctrine as such forbids modern lifestyles, including western norms and customs (Elliot House, 2013).

Under the Salafi doctrine in Saudi Arabia, religious authorities intervene in every aspect of public social life. This is instituted to prevent people getting diverted from the Islamic behaviours of the golden era of Islam (Elliot House, 2013). In Saudi Arabia, one's social behaviours are expected to conform to his/her affiliated group and Islamic behaviours (Jordan, 2011). Social behaviours in public are observed and regulated by the religious police, the Committee of Encouraging Virtue and Preventing Vice (Jordan, 2011).

The political system in Saudi Arabia is authoritarian and based on a monarchy, consistent with the law of governance during the golden era of Islam. Authority is shared among the Saudi Arabian King and his royalty and religious leaders (Ulama) (Ulrichsen, 2011).

The Council of Ministers, also called the Cabinet, advises the King and facilitates the country's development. It represents 22 different government ministries and is presided over each week by the King or his deputy. The Cabinet is responsible for drafting and overseeing the implementation of the internal, external, financial, economic, education and defence policies, as well as the general affairs of the State (Council of Ministers of Saudi Arabia, 2013).

The “The Consultative Assembly of Saudi Arabia” represents one of the ruling methods in the country. It is the formal advisory body of Saudi Arabia, and it cannot pass or enforce laws, a power reserved for the King. The Consultative Assembly has limited powers in government, including the power to propose laws to the King (Consultative Assembly of Saudi Arabia, 2013). The Consultative Assembly is permitted to propose draft laws and forward them to the King, but only the King has the power to pass or enforce them. The Assembly does, however, have the power to interpret laws, as well as examine annual reports referred to it by state ministries and agencies. The Assembly is also authorized to review the country's annual budget, and call in ministers for questioning (Consultative Assembly of Saudi Arabia, 2013). Influence of the Assembly in its present form comes from its responsibility for the Kingdom's five-year development plans, from which the annual budgets are derived, its ability to summon government officials for questioning, and its role as a policy debate forum (Consultative Assembly of Saudi Arabia, 2013).

The Council is situated in Riyadh and consists of 150 members, all of whom are appointed by the King for a four-year term of office. In January 2013, King Abdullah issued two royal decrees, granting women thirty seats on the council, and stating that women must always hold at least a fifth of the seats on the council. According to the decrees, the female council members must be "committed to Islamic Shariah disciplines without any violations" and be "restrained by the religious veil." The decrees also state that female council members would be entering the council building via special gates, sit in seats reserved for women and pray in special worshipping places. Earlier, officials said that a screen will separate genders and an internal communications network will allow men and women to communicate. Therefore, women first joined the council in 2013, occupying thirty seats. Furthermore, that year three women were named as deputy chairpersons of three committees, including the human rights and petitions committee, the information and cultural committee, and the health affairs and environment committee (Consultative Assembly of Saudi Arabia, 2013).

2.4 Social Classification

Before the discovery of oil, Saudi Arabia was a poor country. The national income

relied mostly on the revenues paid by pilgrims to Mecca and Medina, the two holiest cities for Muslims (Jones, 2010). Oil for the first time was discovered in 1938, which led to the economic development of the country (Jones, 2010). With the establishment of the Arabian-American Oil Company (Aramco) in 1949, foreigners including Americans and other westerners migrated to Saudi Arabia for skilled jobs in that company (Jones, 2010). With the upward economy in the 1970s, Saudi Arabia continued to receive immigrants from around the world (Jordan, 2011). These immigrants have limited access to citizenship or integration into the native culture of Saudi Arabia. Saudi employees after the discovery of oil were mostly unskilled workers (Jordan, 2011). As time went by, Saudis acquired more education, which qualified them to attain highly skilled jobs (Jordan, 2011).

A major social division is that between guest workers (i.e. those from abroad) and local citizens. The upper class in Saudi Arabia includes the royal family, top Ulama, and wealthy merchants (Jordan, 2011). The Lower class includes nomads and unskilled workers (Jordan, 2011). Upper middle class includes educated professionals such as medical doctors, engineers, and professors (Jordan, 2011). Lower middle class includes skilled workers such as clerics and those working in administration (Jordan, 2011).

Traditionally, extended family members live in the same household. With the emergence of the middle class, extended families gave way to family households (Jordan, 2011). Polygamy means marrying more than one wife. Muslim scholars argue that, before Islam, men were able to marry more than one wife, and as there was no adherence to how many wives a man could have in any other religion, the number of wives was unlimited (Philips & Jones, 2005). They argue that Islam made it clear that this practice should be limited to four and be controlled and allowed only for a reasonable reason and with ability to perform justice between wives.

The growing economy and political openness have brought a massive influx of an international workforce with diverse social and cultural backgrounds. An emerging foreign (non-Saudi Arabian) social group made of professionals, technical experts, students and a vast corps of workers was formed within the traditional societies of urban cities (Ulrichsen, 2011). Despite efforts to insulate the Saudi Arabian

population from the influence of the increasing foreign community, the inevitable interaction at school, work and neighbourhood introduced a gradual and visible social change. Cross-marriages among the different social subgroups produced a new generation of mixed blood Saudi Arabians with modified socio-cultural values, a great degree of tolerance and more flexible attitude toward the inherited traditions.

In addition to recruiting non-Saudi Arabian professionals like doctors and nurses, visas were issued to non-professional labourers needed to do the unskilled manual work. These labourers included maids, drivers and guards. Perceived as a sign of wealth and social prestige, most Saudi Arabian families imported labourers from Asia, India and other Arab countries to do the domestic chores previously expected of the different members of the family. The Gulf News⁷ reported that of the nine million foreign labour-force working in the Kingdom, three million were domestic helpers (5 April 2012). Even people in rural areas were gradually getting used to foreign labourers doing the farming and herding work for them.

2.5 Gender in the Saudi Culture

In Saudi Arabian culture, gender-based segregation is sanctioned by the society and enforced through government structures. In public areas, for example, there is no mixing of the sexes and there are different physical areas assigned for males, females and families. Traditionally, all hospital settings in Saudi Arabia are designed to have separated waiting areas assigned for males and females. Women are not allowed to interact and work with unrelated men in most settings, unless out of necessity. Usually (though not exclusively), Saudi Arabian women work in universities, social work and development programs for women, banks, and in the healthcare sector. However, driving and riding bicycles in public places are forbidden for women. Saudi Arabian women depend on their close male relatives such as fathers, brothers and husbands to drive them around (Al-Rasheed, 2015). The men are responsible for bearing the family's financial burdens even if their wives are working, unless joint decisions are made on alternatives and the wives make concessions (Ulrichsen, 2012). In any case, Saudi Arabian women are allowed to build their own businesses, invest their money, and own property (Al-Rasheed, 2015).

In Saudi Arabia, Islam is not just a religious ideology; rather, it is a social system embracing detailed prescriptions regarding every aspect of people's life. Saudi Arabians, however, may vary in their understanding, interpretation and practice of Islam. It has been observed that the intensity with which men and women of the social subgroups adhere to the traditional regulatory system and comply with the overall inherited religious understanding varies enormously. A western author, Parssinen (1980: p.166), argued that the socio-cultural diversity that characterises the Saudi Arabian population includes: urban and nomadic, tribal and non-tribal, city-dwellers and villagers, literate and illiterate, open-minded and conservative.

The veiling of women and gender segregation are cultural mechanisms to ensure modesty and to keep women's behaviour under low profile (Parssinen, 1980). In practice, some families may adopt more conservative standards in defining the extent of veiling and segregation. Saudi Arabians, like many Arabs and Muslims, believe that the conduct of women represents a serious source of potential jeopardy to the honour and reputation of the family (Ulrichsen, 2012). Possibly as a way to protect these social values, certain laws and regulations have the effect of restricting women's roles and mobility outside the household boundary.

Huge oil revenues have brought an influx of wealth to the Kingdom. However, in addition to gained benefits, affluence has created problems. On one hand, Saudi Arabians were determined to preserve their cultural and religious heritage and on the other, they aimed at realising all advantages wealth might bring. As a Saudi Arabian born and brought up in the country, I perceive that the dichotomy between tribal and non-tribal groups and between conservatives and modernizers has always been at the heart of the country's social, economical and political affairs. The expansion of educational and economical opportunities may have succeeded in bringing these groups into a common ground concerning highly contentious issues such as women's rights for education. On other issues, education and economy seem to have further polarized these groups. For example, there has been a conflict in the views of these groups regarding women's participation in the labour market, particularly in relation to women's work within mixed-gendered settings (See Al-Bar 1984, Chapter 2: p.33).

2.6 Gender in Social Context

Saudi Arabia has a patriarchal social system that maintains the power of men over women and respect for age and seniority (Long, 2003). The traditional extended family forms the basic unit of the society with prevailing gendered-roles whereby men are providers and protectors and women are housewives. Members of the extended families live in close proximity whenever possible; if not, they socialise on a regular basis. Each family member shares a sense of collective obligation and responsibility for the welfare of the family. Long (2003) argued that it is to the extended family not the government that a person first goes to seek help and support. The family is the most important social institution; for Saudi Arabians, family means identity and status. Family members share a sense of corporate identity and each is expected to live up to socially prescribed ideals of honour, pride and dignity. Families may form alliances with other families who share common interests and life-styles.

Strict gender segregation is sanctioned by the state and society. Males and females who are not barred from marriage by incest rules should not interact in individual or group settings. Women may work outside the home in settings where they do not have contact with unrelated men. Women are employed in girls' schools and the women's sections of universities, social work and development programs for women, banks that cater to female clients, medicine and nursing for women, television and radio programming, and computer and library work. Sections of markets are set aside for women sellers. However, despite the increased amount of employment opportunities, unemployment for women in Saudi Arabia in 2008 was as high as 24.9% (Al-Rasheed, 2013).

Men have more rights than women. Women are not allowed to drive; cannot travel abroad without the permission or presence of a male guardian (*mahram*); are dependent on fathers, brothers, or husbands to conduct almost all their private and public business; and have to wear a veil and remain out of public view. However, women can own property in their own names and invest their own money in business deals. Women's status is high in the family, especially in the roles of mothers and sisters. Significant numbers of women have had high levels of success

in academia, literary production, business, and other fields, yet their achievements are not celebrated publicly and they are barred from most aspects of public life (Al-Rasheed, 2013).

Since women are not permitted to drive in Saudi Arabia, most families are increasingly applying for visas to recruit male drivers from Asian countries. The selection and preference of non-Arab and non-Saudi Arabian family drivers might be attributed to the great degree of freedom experienced, particularly by women, in the presence of these drivers. Freedom, in this context, refers to being able to take the veil off while in the car and to carry out a private conversation without worrying about being understood by the driver.

2.7 Gender Mixing in Healthcare Sector

Due to limited work opportunities (MoP, 2005b), an increasing number of Saudi Arabian women started to venture into demanding education and challenging careers such as nursing. El-Sanabary (1993) suggested that, for these women, having a secured job would justify the sacrifice. This shift might be linked to an increasing awareness that nursing is one of few academic specialties known for its job security (Hamdi & Al-Hyder, 1995). The challenge is Saudi Arabian women applying for a job in non-traditional mixed work settings may require their mahram's (male guardian's) written approval (Article 4, Labour Law, Royal Decree No. M/51). A male guardian is a close family member such as a husband, a father, a brother or even a son over the age of 22 years. This approval tends to leave women at the mercy of their guardians. Alawi and Mujahid (1982) and Hamdi and Al-Hyder (1995) reported that Saudi Arabian female nurses often experience family conflicts associated with night shifts, caring for male patients, the 12-hour shifts and weekend duties.

Describing the career choice experience of four Saudi Arabian female nurse leaders, Lovering (1996) found that Saudi Arabian nurses respond to being part of a minority in a number of ways. They may work harder to get the same recognition given to the dominant group or they may seek to be invisible and hide their accomplishments. As an expatriate Director of Nursing, Lovering suggested that non-Saudi Arabian

nurses tend to view Saudi Arabian nurses as irresponsible because they tend to request day shifts, flexible working hours, paid or unpaid leave in order to meet family commitments. She also described discriminatory hiring practices against Saudi Arabian nursing graduates particularly in hospitals where such decisions are made primarily by non-Saudi Arabian staff (Loving, 1996).

For socio-cultural reasons, the participation of Saudi Arabian women in nursing has been restricted because of mixed-gender work settings (Alawi & Mujahid, 1982; Al-Johari, 2001; El-Sanabary, 1993; Hamdi & Al-Hyder, 1995; Jackson & Gary, 1991; Meleis & Hasan, 1980). Unlike teaching, which is strictly gender-segregated, nursing implies working with doctors, patients and other health professionals of the opposite sex. This has contributed to a perception of nursing as an unacceptable occupational choice among many Saudi Arabian families who tend to direct their children to socially and professionally recognised career options such as teaching and medicine. Al-Johari (2001), Hamdi and Al-Hyder (1995) and Mansour (1992) argued that school students (females), who may be interested in the humanitarian aspect of nursing and may acknowledge the need to replace the non-Saudi Arabian nurses, are most likely unwilling to risk their reputation and jeopardise the family name by choosing a career in nursing. Investigating Saudi Arabian people's attitudes toward Saudi Arabian women working with men in hospitals, Al-Rashidi (2000) conducted a survey in three main cities. Results showed that respondents held the least favourable attitudes toward Saudi Arabian women working in hospitals, particularly as administrative staff and nurses.

Gender mixing is further aggravated with published written opinions of religious scholars and modern Muslim writers. Al-Bar (1984), a Saudi Arabian conservative writer and an internist who received his specialised medical training in England, claimed that the role of women is primarily that of mothers and wives taking care of their families and homes. In his book, he argued that the breakdown of family values is linked to women's employment and to their paid work outside the home. He warned against the collapse of the family unit as a result of women's employment. He also voiced his concern about the moral corruption that may result from the mixing and intermingling of men and women at work places. Despite referring to the important role played by the early Muslim women in the battlefields, the author

believes that nursing for women is permitted only in highly segregated settings and during a time of war or crises.

The long hours and rotating shifts which characterise a career in nursing were frequently cited as major deterrents to the uptake of nursing by Saudi Arabian female school students (Al-Johari, 2001; Hamdi & Al-Hyder, 1995; Mansour, 1992; Meleis & Hasan, 1980). Gender mixing and rotating shifts are work-related conditions which conflict with deep rooted traditions particularly in relation to women.

Strongly associated with the socially unacceptable long rotating shift work expected of nurses is a prevailing social belief that a career in nursing would reduce women's chances of getting married. This issue was investigated in the Saudi Arabian literature showing that Saudi Arabian female nurses are perceived as unsuitable marriage partners and prospective mothers. More than half the sample of male high-school and university students involved in the study by Jackson and Gary (1991) was against marrying a nurse. Ten years later, Al-Johari (2001) reported that more than half the Saudi Arabian male university students would look for a working wife but tend to avoid nurses. Compared to the sample in the former study, those involved in the latter study appear to have acknowledged the need for a working wife to support a satisfactory standard of living. However, they (males) would not choose a nurse (female).

Bearing in mind that Saudi Arabian women are not permitted to drive, transportation to and from their work place was reported as problematic for Saudi Arabian female nurses (Al-Rabiah, 1994; El-Gilany & Al-Wehady, 2001; El-Sanabary, 2003). Even in Arab and Muslim countries where women can drive, means and cost of transportation were found to influence nurses' satisfaction (Amarsi, 2003; Demir, 2003; Zuraikat & McClosky, 1986). Furthermore, as working mothers, nurses struggle to find safe, accessible and affordable child-care facilities for their young children (Al-Rabiah, 1994; El-Gilany & Al-Wehady, 2001). This is not unique to Saudi Arabia; nurses from other Arab (Egypt and Jordan), Muslim (Turkey) and western countries (Canada and United Kingdom) have cited similar concerns (Demir, 2003; Ghazi et al., 1994; Moores et al., 1983; Stewart & Arklie, 1994; Whittock et al., 2002; Zuraikat & McClosky, 1986). Problems with transportation

and child care further stir family conflicts placing Saudi Arabian female nurses under heavy family-work pressure.

Subject to family and work pressures, Saudi Arabian female nurses often request day-shift areas that can easily integrate with their family responsibilities (Alawi & Mujahid, 1982; Tumulty, 2001). Their male guardians may demand such a request as a condition to continue a career in nursing. Alawi and Mujahid (1982) suggested that many qualified Saudi Arabian female nurses prefer either to stay at home or take administrative jobs that are more convenient, family friendly and rewarding in their own right. Similarly, Al-Rabiah (1994) highlighted that the Ministry of health is constantly losing married Saudi Arabian female nurses for the same social and work-related reasons that cause low enrolment to nursing programmes. This was consistent with the finding reported by Al-Kandari and Ajao (1998) which highlighted that, despite the exemptions made for the female nurses with special social needs or family problems, Kuwaiti nurses continued to prefer outpatient clinics. This trend tends to leave the in-patient units highly dependent on non-Saudi Arabian nurses.

Evaluating the nursing service at the Ministry of Health, Tumulty (2001) reported that Saudi Arabian female nurses find working in primary healthcare or ambulatory clinics more compatible with their families' expectations than the 24-hour responsibility at the hospitals. She argued that reducing the weekly 48 working hours should maintain the highly valued child-bearing and family-relation norms and would promote nursing as an attractive career option for women. The above suggest that retention of Saudi Arabian female nurses within the highly un-Saudised in-patient units continues to be a challenge for policy makers and poses an important and relatively un-explored topic for future nursing research.

It can be concluded that to date there have been some changes in women's position in Saudi Arabia due to changes in the lifestyle of the Saudi Arabia community, the efforts of the present government under the guidance of King Abdullah, and the international human rights movement. In general the position of women in Saudi Arabia is a cause of great debate and much remains to be done, however, hopefully, we may (and eventually will) be moving towards a much brighter future and position for women.

2.8 Women's Education in Saudi Arabia

Before 1960, female education in Saudi Arabia was completely rejected by Saudi Arabian scholars and the community, and it was necessary to convince and assure them that the purpose of educating a girl was to teach her Islamic teaching and to be a good mother (Al-Rasheed, 2013). Yet, as AbuKhalil (2004) noted, higher education was not open for men until 1957. Since 1960, education has been under the administration of the Ministry of Higher Education, an agency that has controlled male education from the start. It is only since 2005 that women's education has changed from control by members of the conservative religious scholars to slightly less strict oversight (Hamdan, 2005).

In recent years, however, formal education has expanded in order to encourage female study at the secondary and tertiary education levels. Before 2009, there were no state educational facilities available to women similar to those available to men in subjects such as engineering, law, and many other specialties that women might wish to study. In fact, the Ministry of Higher Education agreed to consider sending women abroad to finish their studies in high-demand subjects, which probably would have been impossible if women's education was still under religious control. Despite improved educational standards for women in Saudi Arabia, Tjomsland (2009) reported concerns regarding the number of women who use education as a means of social transition from youth to marriage, failing to enter the workforce upon completion.

Given the principles of Wahhabism, a conservative religious revival movement primarily advanced by Sunni Muslims that led to the creation of the Kingdom of Saudi Arabia, the role of women within the community of medicinal practice is conflicted at best, and it continues to linger under the constraints of a male-dominated regime (Doumate, 2003). Tjomsland (2009) reports that the *ulama*, the educated class of Muslim legal scholars trained in *sharia* law, remain deeply integrated in local politics affecting the character and design of the national educational system.

2.8.1 Development of Women's Education in Saudi Arabia

Interest in education in Saudi Arabia grew along with the development of the economy after the discovery of oil in 1935. The Ministry of Education was established in 1953 and public schools for boys opened the same year. Girls, however, remained confined to their homes by the traditional norms of gender segregation. Their education was restricted to the home, where a *sheikh* (an honorific term meaning 'elder' that carries the meaning of 'leader' or 'governor') would teach them how to read the *Qur'an* and the basics of writing in Arabic. It was only in the late 1950s and early 1960s that important steps to open the first schools for girls in Saudi Arabia were taken by the future King Faisal and his wife, despite intense resistance from Muslim clerics (Jamjoom and Kelly, 2011). In 1964, King Faisal, once he assumed the throne, undertook a series of reforms that would allow women's education to fall under supervision by a committee composed of senior clerics and their representatives (Jamjoom and Kelly, 2011). By the mid-1970s, about half of all Saudi Arabian girls attended school. In the early 1980s, education was available to all Saudi Arabian girls, and young women were already enrolled in and graduating from the universities. In the late 1980s and early 1990s, more female students graduated from secondary schools than male students did. Nonetheless, the public system of women's education in Saudi Arabia is segregated and is supported by the Saudi Arabian government.

Education in Saudi Arabia is an area where women have experienced significant progress. The Saudi Arabian government has gone to considerable effort to increase girls' access to education and reduce the gender gap at different educational levels. Women's education has brought about a number of social developments in the country, such as a reduction in birth and mortality rates (Shawky and Milaat, 2000). Some of the reasons for the reduction in birth and mortality rates, cited by Shawky and Milaat (2000), were related to increased educational levels obtained by women; in other words, there is a correlation between higher levels of education and the knowledge of reproductive health and family planning information. Some added reasons for reduced birth and mortality rates in Saudi Arabia include improvements in knowledge about health and nutrition, as well as increased female participation in the labour force. However, lingering social norms, local traditions, and the structure

of the public education system often place constraints on women realizing their opportunities in society and their participation in the labour market (Al-Munajjed, 1997). Today, reforming the educational system for girls has become a priority as well as a great challenge for the Saudi Arabian government. A mixture of local norms and traditions, social beliefs, and principles emanating from the patriarchal system exert a considerable influence on women's lives, limiting their opportunity to acquire or complete their education. Marriage and the low level of awareness of the social and cultural value of girls' education are major factors that hamper girls' education (Shawky and Milaat, 2000).

The constraints posed by the Ministry of Education can prevent many women students from obtaining opportunities for obtaining scholarships to study abroad; most often, these opportunities are appointed to men. The Ministry of Higher Education requires that every female student have a male accompanying her; this person, known as a *mahram*, is a male relative acting as a personal escort for women when travelling (if she travels alone she needs to obtain consent from the *mahram* to travel). Women also need to obtain consent from the *mahram* to receive scholarships for studying abroad (Al-Rasheed, 2015). At the university level, the fields of education and training for women are limited, as the specializations do not correspond to the needs of the labour market. Women's degrees are concentrated in education and teaching, human sciences, natural sciences, and Islamic studies (Al-Rasheed, 2015). Due to cultural restrictions and biases in relation to the expected role of women in society, the education system has reinforced gender-segregated cultural norms. This explains the high concentration of women in education, as teaching is generally perceived as a female job, as well as a social extension of a woman's cultural role as mother and homemaker (Al-Rasheed, 2015). Data indicate the lack of women's enrolment in scientific fields. This limits Saudi Arabian women's potential for progress in an age that is increasingly orientated toward scientific and technological advancements.

The Saudi Arabian government provides new opportunities for young Saudi Arabian women to enrol at all levels of higher education, with incentives in the form of stipends throughout their years of study. More than 38 educational institutes for women in the country and 8 universities for women are directly under the patronage

of the Ministry of Education. Women represent more than 58% of the total population of Saudi Arabian university students. Government statistics indicate that the total number of female students enrolled at the university level who were seeking a bachelor's degree almost quadrupled from 93,486 in 1995–96 to 340,857 in 2005–06 (Gender and Citizenship, 2008).

The government has also afforded vocational training for women. The number of vocational institutes for women reached 27 in 2004–05, enrolling more than 3,408 female students to study home economics. The number of vocational institutes for training in sewing reached 51 in 2004-2005, where more than 2,218 students are enrolled (Al Hamed et al., 2007). At the same time, the private sector launched a number of private schools and universities for girls and women, based on the efforts of individuals or private institutions. Private schools and universities are under the supervision of the Ministry of Education. There are approximately ten private colleges and universities for women spread throughout major cities including Riyadh, Al Khobar, Jeddah, and Al Baha.

A strong teaching and scientific research approach is therefore necessary in the field of women's public education; opportunities for cross-disciplinary education and research with other international universities, as well as the use of international expertise, are not broadly available (Hamdan, 2005).

2.8.2 Princess Noura bint Abdul Rahman University for Women

King Abdullah bin Abdul Aziz Al Saud laid the foundation stone for the new infrastructure of Princess Noura bint Abdul Rahman University for Women in October 2008. The university is one of the largest centres of higher education for Saudi Arabian women, presenting them with new educational opportunities to enter the labour market. The university includes an academic area of 15 colleges, such as the College of Medicine, College of Nursing, College of Pharmacology, College of Physiotherapy, College of Dentistry, and a number of other colleges such as the College of Administrative Sciences, the Computer and Technology College, The Kindergarten College, The College of Science, and The College of Languages and

Translation. The university also includes a housing area and public facilities for staff and students, such as mosques, schools, and other recreational installations. By the end of 2014, the university is projected to have 50,000 female students (Al Riyadh Newspaper, 2/11/2008).

2.9 Physiotherapy Education and Regulations in Saudi Arabia

The Ministry of Higher Education established the College of Applied Medical Sciences section of rehabilitation science department in 1979 to meet the need in the Kingdom of Saudi Arabia for skilled healthcare professionals. Until very recently, the College of Applied Medical Sciences at King Saud University was the only physiotherapy college in the kingdom of Saudi Arabia (Rehabilitation Science Department, 2009). Currently, Saudi Arabia has 19 schools of physiotherapy, which offer physiotherapy programs at a Bachelor degree level. There is one school that offers a master's level, and two of them offer Doctor of Physical Therapy Programs (DPT). The length of the Bachelor level program is typically 5 years including one internship year.

Like most other countries, all physiotherapists must receive a graduate degree from an accredited physiotherapy program before taking the national licensure examination that allows them to practice. The Saudi Commission for Health Specialities (SCHS) is the corporate body of the scientific commission, which is licensed to provide evaluation for all holders of health certificates prior to professional classification and practice within the Kingdom of Saudi Arabia (Saudi Commission for Health Specialities, 2014).

According to the SCHS, physiotherapists who obtain a Bachelor degree are classified as a specialist, while physiotherapists with a Master of Science and 2 years of experience are classified as senior specialists. A physiotherapist with a PhD and 3 years of clinical experience is recognized as a consultant physiotherapist (Saudi Commission for Health Specialities, 2009).

Although the SCHS is the accrediting body for the physiotherapy profession, each hospital in Saudi Arabia has its own accreditation criteria, for example King Fahad Medical city (where the study has been conducted) credentialed physiotherapists as physiotherapist II for a new graduate physiotherapist, physiotherapist I for a physiotherapist with 5 years' experience including 2 years of specialist experience or having a Master's degree with 2 years of experience, and senior physiotherapist for a physiotherapist with 7 years of experience including 2 years of specialist experience or having a Master's degree with 4 years of experience.

The Saudi Arabian Physical Therapy Association (SPTA) is the official non-profit association created to develop the profession of physical therapy in Saudi Arabia and for skill development of physical therapy professionals. The agreement to establish the Saudi Arabian Society for Physiotherapy was issued by the King Saud University's council in 1981; however, the actual activity of the association did not start until 2001 by forming a preparatory committee whose task was to establish the foundation for the association. The association seeks to achieve many objectives through its various activities, most importantly to upgrade the physiotherapy services in the Kingdom of Saudi Arabia, promote scientific research in the various physiotherapy areas, upgrade the scientific and practical efficiency of the physiotherapists, collaborate between workers in the local, Arab and International levels, and to spread awareness and concern to maintain health in the community (Saudi Physical Therapy Association, 2012).

2.10 Healthcare System in Saudi Arabia

The healthcare system in Saudi Arabia is classified as a national health care system in which the government provides healthcare services through a number of government agencies. Health services in Saudi Arabia are provided through three main sectors: the Ministry of Health (MOH) network of hospitals and primary healthcare centres that are distributed throughout the country, other governmental institutions, and the private sector (Albejaidi, 2010).

The MOH is the largest provider of healthcare services in the Kingdom, providing 59.5% of the total health services in Saudi Arabia (Almalki et al., 2011). Although the MOH is charged with the healthcare of the entire population, other governmental and private facilities are also important healthcare providers and represent 19.3% and 21.2% of the health services, respectively (Almalki et al., 2011; Walston et al., 2008).

The MOH also provides 2,037 Primary Health Care (PHC) services through a network of healthcare centres. The referral system provides care for all members of society from the level of general practitioners at health centres to advanced technology specialist services through 220 general and specialist hospitals (Almalki et al., 2011). The MOH is considered to be the leading government agency responsible for the management, planning, financing and regulation of the healthcare sector.

Other governmental sector healthcare providers include facilities that are highly respected, and generally, considered better quality. These include facilities funded by the Ministry of Defence and Aviation Medical Services, Ministry of Interior Medical Services, National Guard Medical Health Affairs, University hospitals, King Faisal Specialist Hospital and Research Centre (KFSH&RC), and The Royal Commission for Jubail and Yanbu provides health facilities for employees and residents at the two industrial cities (Jubail and Yanbu). The second largest healthcare provider, other than the MOH, is the Medical Services Department of the Ministry of Defence (Figure 2.2) (Almalki et al., 2011; Walston et al., 2008).

The private healthcare sector, including hospitals and clinics, continues to grow due to the increase in demand for health services where individuals can purchase quick and high quality care (Barrage et al., 2007). The private sector has grown rapidly over the past several years and expanded its services, especially in the large cities of Saudi Arabia, such as Riyadh and Jeddah.

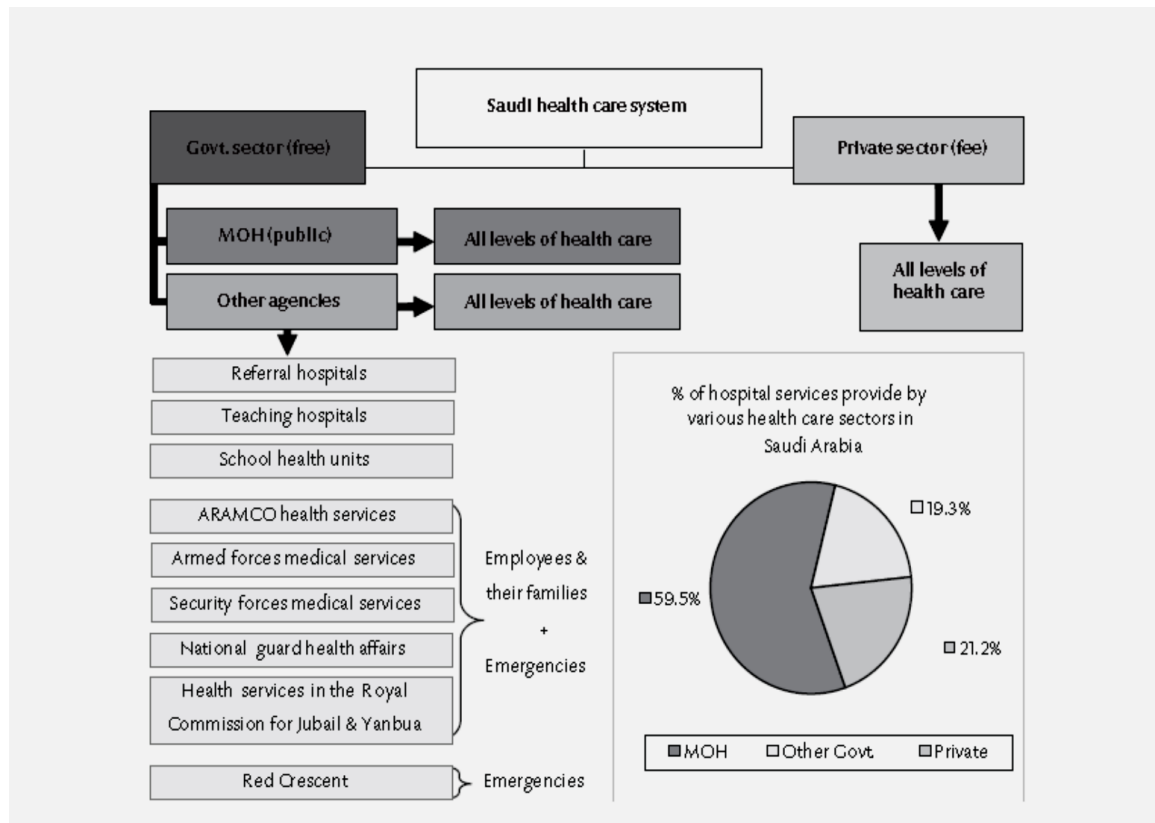


Figure 2.2 Structure of the healthcare sectors in Saudi Arabia (Almalki et al., 2011)

In 1971 there were only 18 private hospitals; however, by 1996 this number had grown to 75 and by 2005 to 113. This accounts for approximately 21% of all hospital beds. The private sector has been the primary provision for foreign workers until very recently. However, the MOH has devised a plan to alleviate pressure on public hospitals and to ensure that all workers in companies have access to health provision. Therefore, in the 1980s, the MOH ordered all companies to provide compulsory health insurance for all their expatriate workers, which resulted in the companies having to pay for an extensive package of services according to their choice of private hospitals (Barrage et al., 2007).

Another unique aspect of healthcare in Saudi Arabia is that, every year, the country serves more than 5 million pilgrims and visitors to the Holy Mosque in Makkah. The government provides free health services to pilgrims through the Ministry of Health facilities. In 2005, in the month of Ramadan, nearly 3.4 million pilgrims came to

Makkah to perform Omrah (religious activities). According to the Saudi Arabian authorities, more than 250,000 cases of pilgrims were treated in the MOH facilities that year. MOH assigned 22 hospitals and 165 primary care centres to serve pilgrims during the Hajj pilgrimage activities with more than 9,600 personnel, including physicians, nurses and allied health personnel, engaged to work in these health centres (Walston et al., 2008).

Saudi Arabia	Numbers
Population	28,376,355
Number of hospitals	415
Number of beds	58,696
Hospitals affiliated to MOH	251
Number of beds in hospitals affiliated to MOH	34,450*
MOH - Ministry of Health, *10,948 beds in other governmental sectors	

Table 2.1 Population, number of hospitals, and available beds in the Kingdom of Saudi Arabia (Al-Jadid, 2013).

Healthcare is currently free of charge in Saudi Arabia to all Saudi Arabian citizens and expatriates working in the public sector. It is funded primarily through the Ministry of Health and augmented by other governmental health facilities. The government also requires that expatriates working in the private sectors have some level of healthcare coverage paid by their employers (Walston et al., 2008).

This part of the chapter has discussed the healthcare system in Saudi Arabia and principally focused on its level of development, its services, facilities and healthcare organisation. It is practically impossible to discuss women's education in Saudi Arabia without introducing the social and tradition forces that have shaped women's status not only in education, but also in society in general. It is clear that the Saudi Arabian government is serious about improving the quality of girls' education and has started to implement a new restructuring strategy. A high-level committee, consisting of academics and experts as well as members of the Shura Council, supervises the educational restructuring process. This restructuring is still at an

initial and exploratory stage and it may take a few years before their impact is evident.

2. 11 Health Workforce Plan and Saudisation

As with all other sectors of the economy, most healthcare workers, including physiotherapists, physicians, nurses and pharmacists, are expatriates from Egypt, the Philippines, Pakistan, India, Bangladesh and many other countries. A significant number of Europeans, Australians, Canadians and Americans are also among the vast array of healthcare providers. According to the most recent data (Central Department of Statistics and Information, 2012), there were 55,284 physicians and 110,858 nurses in the country in 2012, of which 70% and 79% respectively worked in the public sector. In the same year, only 23.1% of physicians and 32.3% of nurses in the country were Saudi nationals. The total number of physicians employed by the Ministry of Health (MOH) was 25,832, and of those only 22.6% were Saudi nationals, whereas 63,297 nurses were employed by the MOH, and of those, 50.3% were Saudi nationals. Interestingly, of the 17,148 physicians and 23,308 nurses in the private sector, only 4.9% and 4.8%, respectively, were Saudi nationals (Central Department of Statistics and Information, 2012).

In order to have an understanding of the development of physiotherapy in Saudi Arabia, it is necessary to understand also the development of other areas of healthcare in the country. Continuing efforts have been achieved since the late 1950s to provide training opportunities locally and abroad for Saudi nationals to become healthcare professionals. Training for male nurses aides began at the first Health Institute in 1958. Currently there are many Health Institutes and Junior Colleges operated by the MOH for high school graduates to receive a diploma in nursing. Concurrently, the Ministry of Higher Education operates a number of Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) programs. Recent data indicate that 67% of Saudi nurses were trained at a Health Institute and 30% graduated from a Junior College. Only 3% of Saudi nurses graduated from BSN programs (Central Department of Statistics and Information, 2012). A number of private schools of nursing have emerged in the last 10 to 15 years.

Additionally, hundreds of Saudi men and women are enrolled on government scholarships in medical schools in more than a dozen countries in Europe, Asia and North America. A number of programs in Saudi universities and vocational institutions also offer training and education in health-related professions, including a Master's degree in Health Administration (Central Department of Statistics and Information, 2012).

The prospects and implications of the "Saudisation" policy must also be carefully examined in the context of demand and supply of health workers. This refers to the requirement in the Kingdom of Saudi Arabia under the Ministry of Labour for the workforces of Saudi companies and business organizations to be made up of Saudi nationals to a certain level. With the projected growth of the population to 30 million by 2016 and an increase in the number of retirement age people from 1 million to 2.5 million by 2020 (Booz & Company Inc. 2007), the country will need an additional 15,000 to 20,000 hospital beds and nearly 15,000 more physicians. It is also expected that there will be the need for a dramatic increase for physiotherapists as well. At the projected production levels of Saudi doctors and nurses, the prospects of meeting that demand without importing foreign workers is virtually zero.

It is important to note that most Saudi health workers are currently employed in the public sector. As part of a three-stage policy, publicly owned healthcare facilities will become part of the private sector, which will cause the Saudis presently employed in the public sector to have to compete with non-Saudis in the rapidly growing private sector. In a competitive market place, it seems likely that many of the new jobs in the private sector will be filled by non-Saudi health workers who are willing to work at lower salaries (Central Department of Statistics and Information, 2012).

Given that until about the middle of the twentieth century, little existed in the way of an organized healthcare system, it must be acknowledged that Saudi Arabia has achieved significant strides in developing the healthcare infrastructure. In the span of half a century, a number of universities and research institutions, hundreds of hospitals, and thousands of primary care centres have been established. Dozens of training programs are in place to train various cadres of healthcare workers,

including allied health professionals. The Saudi experience as well as that of other Gulf States such as Kuwait, Qatar, Oman and UAE demonstrates that, with generous financial support, it is not difficult to erect modern facilities and fill them with internationally recruited personnel capable of providing first-rate clinical care (Central Department of Statistics and Information, 2012). The challenge, however, is to make the system efficient and sustainable.

Despite the availability of a number of public and private training programs, self-sufficiency in the supply of physicians, nurses and allied health professionals will not occur in the foreseeable future. Given the projected reliance on foreign workers to meet the healthcare needs of its citizens, the country will need to reconsider the policy of "Saudisation". To successfully make the transition to a twenty-first century meritocratic society, it is important to offer the promise of assimilation into the private sector and a long-term future in careers. Finally, the challenges Saudi Arabia faces are not insurmountable. With careful planning, implementation and adjustment of policies, there is plenty of reason for optimism and hope for the future.

In the following section, the specific socio-cultural background of Saudi Arabia with a focus on Saudi Arabian female culture and its influence on the relationship between patients and physiotherapists is presented.

2.12 Cultural and Religious Contexts of Saudi Arabian Women

Hahn (1995: p.66) defined culture as ‘a coherent set of values, concepts, beliefs and rules that guide and rationalise people’s behaviour in society’. Helman (2002: p.2) defined culture as ‘that complex whole which includes knowledge, beliefs, art, morals, law, customs and habits acquired by man as a member of society’. Andrews and Boyle (2003: p.33) added that culture is ‘an integrated pattern of human behaviour that includes thoughts, communication, actions, customs, beliefs, values, racial, religious or social issues’. In addition, culture facilitates the development of harmonious attitudes and behaviour among a group. According to Tjale and De Villiers (2004: p.31), culture comprises a ‘system of shared ideas, concepts, rules and meaning that shapes people’s way of life’. Furthermore, culture stipulates

guidelines to the members of a society on how they should experience and view the world and how to behave in relation to other people.

It is important to note that cultural practices may change from one generation to the next, as time and the environment influence the individuals' lives and the people with whom they interact. According to Helman (2002), individual, educational, socio-economic and environmental factors influence the culture, health beliefs and behaviours of individuals. Saudi Arabia is a country that, despite modernisation and industrialisation, remains strongly rooted in its religious and cultural traditions. The population reflects a socioeconomic diversity varying from the desert-dwelling Bedouins to the members of the royal family (Jordan, 2011). The Saudi Arabian government encourages young people to continue their studies in the western world. Some of these youngsters may return to their country with different perceptions of the world and their cultural values might be influenced by western society. However, in Saudi Arabia there are still those who are currently deeply rooted, like the Bedouins, whose traditional and cultural needs should be considered and accommodated by healthcare providers. Culture is a complex and dynamic process (Tjale and De Villiers, 2004) and therefore single dimensions should not be viewed in isolation.

Saudi Arabian law, called Shariah, is based on the Salafi interpretations of Islam (Baki, 2004; Mobaraki & Söderfeldt, 2010). These interpretations contribute to placing women in a subordinate position (Mobaraki & Söderfeldt, 2010). Women, for example, are required to get the consent of a man related to her if she wants to pursue education, work, travel, or even undergo invasive medical surgery. (Mobaraki & Söderfeldt, 2010). In the tribal system of Saudi Arabia, women are treated as properties of men. Unmarried, women are properties of their fathers. Divorced and widowed women are properties of their sons (Mobaraki & Söderfeldt, 2010).

Historically, before the emergence of Islam, Arab elite women veiled their faces to represent their prestigious status (Baki, 2004). The Salafi Islam has adopted the veiling practice for women and sometimes has forbidden women from showing their faces in some regions of Saudi Arabia (Mobaraki & Söderfeldt, 2010). Only

recently, the Saudi Arabian women been allowed to have official government identification, show her face in the photo of her identification, and not require the consent of a male relative to attain such identification (Mobaraki & Söderfeldt, 2010).

Saudi Arabia, the birthplace of Islam, is one of the few Muslim countries where women are forced by custom to cover their hair with headscarves and their bodies with cloaks called “*abayas*” in most parts of the country. It is also common to see Saudi Arabian women wearing full-face veils “*niqab*”. For a traditional woman, keeping her body covered is essential. Privacy, being cared for by a female healthcare provider and covering the body and head and face is a very important way of demonstrating modesty (Leininger and McFarland, 2002) (See Figure 2.3.A & Figure 2.3.B overleaf).

Figure 2.3.A



Figure 2.3.B



Saudi Arabian women wear an ‘Abaya’ (Figure 2.3.A), a black, cloak-like long dress and a ‘Tarha and Niqab’, a head and face cover (Figure 2.3.B) (Al-Shahri, 2002: p.135).

Saudi Arabian women are not required by law to wear the niqab. However, in cities such as Dammam, Riyadh, Mecca, Medina and Abha many women observe niqab as tradition. According to Saudi Arabia's Sahriah law, women's clothing should meet the following conditions:

- Women must cover their entire body, but they are allowed to expose one or both eyes in necessity.
- Women should wear an abaya and niqab thick enough to conceal what is underneath, and the abaya should be loose-fitting.
- Women should not wear brightly coloured clothes or clothes that are adorned which may attract men’s attention (Islam Q&A, 2008).

The Saudi Arabian culture is structured by fundamental Islamic teachings. As mentioned earlier, these teachings include the belief that women should remain inside their homes and be excluded from public physical activities such as riding a bike or running in public. Women’s activities in Saudi Arabia are thus centred at their homes (Abahussain & El- Zubier, 2005). Whether cultural factors contribute to the findings that Saudi Arabian women have poorer diet adherence than men is not known (Al-Khalidi & Khan, 2000). Saudi Arabian women’s health beliefs and behaviours are framed by the Saudi Arabian culture and the Islamic faith. In a study that describes Saudi Arabian women’s knowledge and beliefs about illnesses, for example, women reported causes of illness as God-related, in addition to contact

with an ill person, the weather, and germs (Ide & Sanli, 1992).

As the Saudi Arabian socio-cultural context is structured in line with the Salafi interpretations of Islam. These could impose limitations on Saudi Arabian women's adaptabilities to adopt a healthy lifestyle. Saudi Arabian women thus may require special health needs that may be distinct from the needs of Muslim women living in other Islamic countries.

2.13 Women's Health in the Islamic Culture of Saudi Arabia

A patient suffering from a musculoskeletal disorder may endure psychological and social stressors due to changes in physical function and social roles. These stressors cause emotions that need to receive attention from physiotherapists to aid in the development of proper treatment programmes (Ruini et al., 2003). Patients suffering from musculoskeletal disorders are susceptible to varying influences both at a physiological and at a psychological level. Changes in physical function and social roles or responsibilities can have a significant impact on an individual's emotional state; practitioners must have the ability to recognise and help manage a patient's emotional state during treatment phases (Gard and Gyllensten, 2004; Ruini et al., 2003). The ability to identify and express emotions is a prerequisite for having emotional intelligence, an ability needed in physiotherapy treatment situations (Gard and Gyllensten, 2004). Outside of academic circles, emotional intelligence concepts have blossomed into entrepreneurial enterprises. In 1995, a psychologist and journalist Daniel Goleman wrote his widely known book, *Emotional Intelligence: Why It Can Matter More than IQ*. The book became an instant best seller. Consequently, the concept of emotional intelligence was adopted by big businesses that espoused it as a leadership mantra. Goleman (1995) defined emotional intelligence as the cognitive skills required to monitor and regulate emotions. Emotional intelligence contain abilities in five domains: (1) self-awareness; (2) self-regulation; (3) social skill; (4) empathy; and (5) motivation (Goleman, 1998).

A central component of culturally sensitive care is the consideration of the views and values of the patient (Hunt, 2007). Accordingly, physiotherapy care should account for the particular cultural perspectives of an individual patient. When the

role of culture is ignored in a clinical encounter, communication, understanding and collaboration patients and hospital staff may be impeded. In turn, the goals of physiotherapy care are likely to seem less relevant to the patient (Hunt, 2007). Physiotherapists' perceptions and understanding of different cultures affect their delivery of treatment and the expectations held by their patients (Black and Purnell, 2002). Personal cultural experiences, values, and biases influence a physiotherapist's ability to adapt and respond appropriately in interactions with patients (Krefting, 1991; Meadows, 1991). The establishment of treatment goals as an essential element of physiotherapy practice is susceptible to culturally related factors (Hunt, 2007; Lee, Sullivan, and Lansbury, 2006).

In the increasingly multicultural context within which the global community continues to operate, physiotherapists must have the ability to discern the patient's susceptibility to cultural values and social expectations (Hunt, 2007; Lee, Sullivan, and Lansbury, 2006). Accordingly, expert practitioners are not only skilled in academic theory and practical treatment strategies; they are also skilled observers of the conditions prescribing cognitive and behavioural functions. In few countries is this diverse perspective more prevalent than in Saudi Arabia wherein a dichotomy of value systems requires that practitioners not only embrace the Muslim-dominant local culture, but also that they embrace an emergent population of members from Western society. Accordingly, the effective Saudi Arabian physiotherapist is responsible for maintaining an effective toolbox of skills sets and an ability to recognise diverse cultural factors that can influence interactions with patients. When commonalities in cultural values or language are not overtly present, then physiotherapists must engage other faculties (e.g., emotional, intuitive, cognitive, psychomotor) in order to meet patient expectations and support their preferences for relational interactions (Mutha, Allen, and Welch, 2002).

Expectations of gender roles and female socialization are major obstacles to women's entry into the workforce in Saudi Arabia. The prevailing view is that a woman's place is in the home and that outside employment is justified only when necessary. Women in Saudi Arabian culture play a vital role in most families as providers of healthcare. Looking after the children and providing first aid constitutes the main tasks of women in the home. The role assigned to women is probably the

source of different social attitudes between men and women. These important differences in attitude seem difficult to eliminate through medical training or through the structure of health organization. The pressures to get married to care for the family at home compel many young women either to forget employment completely or to choose an occupation such as teaching, one that seems easy to integrate with family responsibilities (Altorki, 1986). Very few are willing take on a demanding education and career, unless it has the prestige that justifies the sacrifice, such as medicine. Saudi Arabian society has not fully accepted the idea of women's work outside the home, despite the thousands of employed Saudi Arabian women, most of who are in the education sector.

The public and members of the health team, particularly physicians, appear to lack an understanding of the nature of the physiotherapy profession. Medical educators consider physiotherapy students less intelligent and less capable. Physicians have a 'superiority complex' and consider anyone else in the medical team inferior to them (Altorki, 1986). Ironically, while sharing the same working conditions, medicine is not as stigmatized as physiotherapy, nursing and other healthcare professions, and yet medicine enjoys high prestige and status, making it the most coveted and prestigious educational and vocational option for Saudi Arabian and Muslim women in general.

Socioeconomic status is a related problem. As with women in most economically developing countries, the opportunities available for them have a major influence on their educational and career choices. The wealthy and more advantaged groups are more likely to enter prestigious occupations and professions than the socially and economically disadvantaged who are less likely to pursue higher education (Altorki, 1986). In wealthy Saudi Arabia, despite efforts towards democratization such as free education, the majority of women who graduate from high schools and enter colleges come from middle- and upper-class backgrounds.

Physiotherapist competency, meanwhile, has roots in particular assumptions of ability, awareness, and commitment. Diagnosis and treatment requires an astute understanding of anatomy and physiology; however, the health services provided in musculoskeletal disorders are frequently much more dynamic and multi-faceted.

Health problems do not receive effective treatment solutions from those who do not understand the cultural expectations of one country, particularly regarding healthcare professionals who are also expatriates (Almalki, Fitzgerald, and Clark, 2011). Health problems of those native to specific cultural contexts, including cultural contexts in Saudi Arabia, require that health professionals develop awareness of local conditions, particularly regarding the needs and concerns of Saudi Arabian women. Continued dependence on foreign healthcare providers interferes with the proper delivery of healthcare to Saudi Arabians, especially women, because of the communication problems resulting from differences in language and culture between healthcare providers and patients. In the absence of high education levels and, possibly, a good interpreter, patients face significant language barriers in trying to communicate with healthcare providers. Because of the misunderstanding that eventually develops, patients do not receive effective treatment and, therefore, they are completely dissatisfied with the relationship between them and their physiotherapists. As one report noted, “The effectiveness of non-Saudi Arabian, often non-Arabic-speaking health personnel [is] limited by their inadequate understanding of the Saudi Arabian environment and culture. Patient communication has suffered because of the cultural gulf, therefore, healthcare clients have to continuously adjust to new workers ignorant of the culture and system” (Nyrop, 1984: p.130).

Hence, an important goal to consider is the achievement of a balance between the numbers of Saudi Arabian and foreign healthcare providers.

2.14 Physiotherapy Management of Female Patients in Musculoskeletal Outpatient Settings in Saudi Arabia

Physiotherapy is a health profession concerned with restoration, maintenance, and promotion of optimal physical function by using clinical reasoning to select and apply appropriate treatment (The Chartered Society of Physiotherapy, 2013). Physiotherapists specialize in specific areas such as, orthopaedics, aged care,

neurological rehabilitation, lymphedema management, pelvic floor rehabilitation, sports medicine and paediatric physiotherapy.

A physiotherapy department is available in each hospital. The nature of the department, its facilities and provision will vary according to the hospitals resources. Unlike the United Kingdom (UK) and other western countries, patients/clients need a referral from a physician to access a physiotherapy clinic. By law outpatient physiotherapy treatment approaches and decisions are the physiotherapist's decision and physiotherapists evaluate the condition and commence physiotherapy management as appropriate. It represents an autonomous practice.

Physiotherapy goals in most hospital settings in Saudi Arabia include:

- Providing optimal patient care.
- Contributing to the development of the highest standards for the practice of physiotherapy in Saudi Arabia.
- Interacting with healthcare professionals in many disciplines.
- Providing prevention services.
- Providing clinical education and training to King Saud and Prince Noura bint Abdul Rahman Universities internship students and engaging in consultation, and research.

The physiotherapist roles are to assess physical and functional abilities (measuring flexibility and strength or analysing gait), identify potential and existing problems, perform condition-specific tests and measurements, consult with other health care professionals, determine a prognosis and treatment plan, provide education and additional information to patients (such as giving them instructions for home exercise programs), maintain clinical and statistical records and research areas of special clinical interest.

Changing health policies and directions within the healthcare system have had a large impact on how physiotherapists practice and how they focus their work. The implementation of early discharge from acute care facilities of musculoskeletal outpatients and expansion and development of new programs, require

physiotherapists to develop workload planning. A more sophisticated approach to team work has also added greater complexity and responsibility to many physiotherapist positions. In particular, communication with patients, other health professionals, families, carers and external service organizations have become far more complex.

The role of the physiotherapist within the multidisciplinary team has also changed. There is increased responsibility for interpreting information and advising other health professionals on appropriate patient management. Physiotherapists in many areas of clinical practice have adopted a more advanced consultant type role where their input is highly valued and their contributions are directing medical clinical decision-making.

There is strong evidence for the cost-effectiveness of many physiotherapy interventions: interventions that are underpinned by solid evidence and that provide realistic alternatives to patient management. These include the management of incontinence and osteoarthritis of the knee, and involvement in a consultative role, in medical and orthopaedic outpatient clinics (The Chartered Society of Physiotherapy, 2013).

Female physiotherapists in a musculoskeletal outpatient setting in Saudi Arabia see common musculoskeletal conditions of women, including:

- Acute back pain including sciatica and disc problems
- Chronic back pain
- Neck pain, including whiplash
- Headaches
- Shoulder, elbow, wrist, hip, knee and ankle pain
- Injuries post trauma, including fractures
- Post orthopaedic operations (spinal, shoulder and knee surgery, joint replacements)
- Sport injuries
- Work related injuries
- Sprains and strains/soft tissue injuries

Outpatient physiotherapy settings in Saudi Arabia play an important role in Woman's Health conditions e.g.: incontinence management, pelvic floor rehabilitation, osteoporosis and pre post natal exercise programmes. This service is a growing service offered to the female client in the Saudi Arabian community as well as to the professional staff at the hospital. Patient numbers are continuously on the rise and for the year 2013, 1500 new referrals have been made for evaluation & treatment.

A comprehensive evaluation and individualized treatment program has been designed to address patient's symptoms and their underlying causes. This program may include: flexibility and strength training, postural awareness training, therapeutic modalities, patient education, manual therapy techniques (joint mobilisations, manipulations), soft tissue techniques (myofascial release, stretches, PNF, trigger point techniques), tapping, bladder management and pelvic floor exercise training.

Physiotherapy staffing in outpatient departments is managed by the head of department with input from the supervisors, based on the demand for services through monitoring monthly statistics and identifying the need to open new services to reflect congruency with hospital goals and objectives. Priorities may be necessary in some circumstances and outpatient supervisors may act as additional clinicians or increase their caseload to cover the demand for services.

The physiotherapy staff communicate with other health professionals through written documentation and through attendance at team meetings and medical rounds. Communication also occurs with patients and family members. Externally the physiotherapy department communicates with King Saud University and the Saudi Physiotherapy Association. The physiotherapy department is also involved in offering ergonomic advice and in service training on safe patient handling and back care to other disciplines, such as nursing and medical records departments.

Outpatient physiotherapy is facing a continuous increase in new referrals. A screening physiotherapist is assigned to screen all patients referred to the outpatient clinic and to determine the urgency of treatment. Patients with acute or severe pain

are scheduled for treatment within the same day, and non-urgent patients are given appointments as appropriate, within 2-3 weeks. Re-referrals for the same condition within 3 months that are not in severe pain are re-assessed and given a limited course of treatment according to the therapist's findings and chronic re-referrals for the same condition, i.e. more than 4 times in 12 months are to be reviewed for one session and discharged with a home program, the referring physician being notified. The referral will be accepted only if the patient has a clear definite diagnosis by the referring physician. Outpatient physiotherapy treatment approach decisions are the physiotherapist's responsibility and therapists evaluate the condition and commence physiotherapy management as appropriate.

2.15 Chapter Summary

Knowing the structure of Saudi Arabian society and understanding the role of tradition and religion is vital to understanding social change in the country, especially as it relates to women. These strong cultural and religious factors create a number of issues that influence the nature of the patient-physiotherapist therapeutic relationship and are important to recognise. Female patients have recognised the signs of musculoskeletal disorders, and for this reason, they have pursued treatment. Their knowledge cannot be discarded by the physiotherapist because of their education level, or intellectual ability. By providing explanations of the physiotherapy process e.g. the treatment plan, physiotherapist's expectations, a diagnosis, a timeframe for recovery, and by use of visual aids to assist explanations to non-educated female patients, the bridge through catharsis and open communication will ensure that both parties are attentive to future relational connectivity and committed to overcoming the primary causes that initiated the visitation in the first place.

In this chapter, the socio-cultural background of Saudi Arabia and its influences on the relationship between patients and physiotherapists have been discussed. Although there is no statistical information regarding the female patient's difficulties in maintaining attendance for physiotherapy appointments, it is evident from the information provided in this chapter that particular challenges in the number of

physiotherapists and the inflexibility of scheduling is not helpful to consistent and regular visitation. As a direct result, there are challenges for physiotherapists who seek to honour 'Shariah' whilst simultaneously performing the duties of their subscribed profession. Accordingly, it is evident that over the following sections in this research, the complexity of the Islamic expectations for female social members will have implications for the provision of treatment to Saudi Arabian women.

Changing the attitudes toward women and their role in society is already underway, and is bound to accelerate with increased female education and workforce participation. A change in public attitudes of physicians and other healthcare providers towards physiotherapists is needed to improve the image of the latter. Having discussed all issues in the socio-cultural background of Saudi Arabia and its influences on the relationship between patients and physiotherapists, it is essential to look at the nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings.

In the next chapter, the main concepts and ideas based on the literature relating to the nature of the patient-physiotherapist therapeutic relationship is outlined.

Chapter 3: Therapeutic Relationships

3.1 Introduction

This chapter begins by discussing the role that the literature played in this research, in light of the grounded theory methods employed in this study. In this chapter, a journey through the historical developments of the doctor-patient therapeutic relationship is detailed. The chapter contains a discussion of the main concepts and ideas based on the literature relating to the nature of the patient–physiotherapist relationship, patient–physician relationship models, and explores the underlying theory and models which are associated with the patient–physiotherapist relationship. Finally, the literature reviewed in this chapter and the previous chapter, led to the development of the research question and aims, which conclude this chapter.

3.2 Use of the Literature in the Study

Grounded theorists resist the temptation to perform an exhaustive literature review prior to the commencement of a research study. The original grounded theory texts (Glaser and Strauss, 1967), and later works by Glaser (1978) advocate being ‘theoretically sensitive’, by entering the field with limited a priori knowledge, and the researcher not committing themselves to specific preconceived theories (Glaser and Strauss, 1967). However, other grounded theorists recommend superficially consulting the literature prior to data collection as it can serve to provide insights into the studied phenomenon, giving context and clarity to the research questions (Birks and Mills, 2011). As I possessed an awareness of some of the existing theories of therapeutic relationships prior to conducting the research, attempting to discard this a priori knowledge would constitute a positivistic “evasion of cognition” (Bryant 2002b: p.7). Furthermore, as part of the PhD process, I was required to develop a ‘Research Plan Approval’ document which needed to be approved academically and ethically before commencing with the research project. A superficial review of the literature pertaining to therapeutic relationships and the common research methods used in the field was necessary to prepare the proposal

document and to develop and justify the research question. The balance between having extensive a priori knowledge which can stifle the construction of new theory, and possessing enough substantive knowledge to provide what Glaser would describe as “a partial framework of local concepts” (Glaser and Strauss, 1967: p.45), is difficult to judge. I recognised this fine balance, and I attempted to take a reflexive, critical and questioning approach throughout the initial superficial literature review.

During the later phases of data collection the extant literature played a more active role in the research study, so as to ‘sharpen my nose’ during analysis and data collection (Urquhart, 2002). As categories developed and a substantive theory began to be constructed, the literature was used as a tool to ask questions of the data, develop theoretical sensitivity and acted as a source of ‘secondary data’ which was able to link concepts and help develop categories (Charmaz, 2006). Using the literature in this way, at this stage of the research process enhanced my theoretical sensitivity, enabling me to develop a heightened awareness of meaning and analytical insight with regard to the developing theory (Tan, 2010). The literature which helped to inform the later stages of data analysis and led to the development of the substantive theory is reviewed in the context of this study’s findings, in Chapter 7. Finally, an overall summary of the use of the literature during this research study is provided in Table 3.1 overleaf.

Study Stage	Body of Literature (Selection)	Aims
Stage 1	<p>Preliminary literature review</p> <ul style="list-style-type: none"> • Patient–physiotherapist relationship • Patient-healthcare provider relationship • Saudi Arabia settings, culture and health services • Women in Saudi Arabia, health, education and clinical education 	<ul style="list-style-type: none"> • Identifying gaps in the literature • Developing and refining research question and aims • Exploring significance of research area • Building theoretical sensitivity
	<p>Methodological literature review</p> <ul style="list-style-type: none"> • Qualitative research methods • Grounded theory methodology and its different approaches • Symbolic interactionism • Social constructionism 	<ul style="list-style-type: none"> • Reflecting on ontological, epistemological and theoretical assumptions • Situating the study within the interpretive research paradigm • Selecting the methodological approach • Designing the study • Preparing for data collection and analysis
Stage 2	<p>Ongoing literature review</p> <ul style="list-style-type: none"> • Healthcare professionals’ beliefs • Patients’ beliefs • Expectations of the therapeutic relationship • Motivation factors on outcome 	<ul style="list-style-type: none"> • Viewing data with increasing levels of abstraction • Conceptual leverage from the literature • Enhancing theoretical sensitivity
	<p>Literature engagement and review guided by data analysis and developing theory</p> <ul style="list-style-type: none"> • Physiotherapist’s professional role • Patient personas • Patient autonomy • Personal, clinical and professional relationships 	<ul style="list-style-type: none"> • Updating the preliminary literature review • Situating the present study in the context of the therapeutic relationship literature • Providing contextual comparisons of the findings with similar empirical work
	<p>Integrative literature review</p> <ul style="list-style-type: none"> • Epistemology of negotiation • Self-efficacy • Professional self-esteem • Learning styles theory • Self-motivation • Locus of control • Learned helplessness 	<ul style="list-style-type: none"> • Engaging the present theory with empirical research and with formal theories • Scaling up the emergent theory • Testing and developing core category • Citing original contributions

Table 3.1 Place of the literature in this study

The literature was accessed in a variety of ways throughout the research study. Only literature in English that could be obtained from online or hand searching was identified. Online databases included: Allied and Complementary Medicine (AMED), Cumulative Index to Nursing and Allied Health Literature (CINHAL), Emerald, PubMed, MEDLINE, Science Direct and Web of Science.

The search was restricted to articles in the English language, but no limits were imposed in terms of year of publication; indeed, this review includes studies published both before and after the present study's various stages of data collection. Most of the retrieved studies were carried out in the United Kingdom, the United States, Australia, Canada and the Scandinavian countries. One area that is under-explored in research is the nature of the therapeutic relationship between physiotherapists and patients. The Table 3.2 overleaf illustrates the characteristics and details of the reviewed patient–physiotherapist therapeutic relationship studies that were found, which includes sixteen studies. The review presented in this section is mostly based on findings emerging indirectly from studies focusing on therapeutic relationships between patients and healthcare professionals, including physiotherapists. No published studies have explored any aspect of therapeutic relationships in Saudi Arabia.

The inclusion criteria in the search for resources and their refinement included qualitative, quantitative and mixed research; no restrictions were placed on the study design. Furthermore, the inclusion criteria were research articles that had patients, physiotherapists and healthcare professionals as their population subjects.

Study	Study Design	Perspective	Aim/Purpose
Bassett & Tango (2002)	Qualitative: phenomenological study	Patient	Interpret/understand Māori people's experiences of being physiotherapy patients
Bellner (1999)	Theoretical discussion	Physiotherapist Expert opinion	Delineate different senses of responsibility in the TR between OTs and PTs and their patients
Gyllensten et al. (1999)	Qualitative case study with cross-case analysis	Therapist	Investigate expert PT's perception of important factors influencing the quality of the interaction in physiotherapeutic treatment
Gyllensten et al. (2000)	Qualitative case study with cross-case analysis	Therapist	Investigate what factors PT experts in psychiatric physiotherapy perceived to be important in the interaction between patient and PT
Gyllensten et al. (2003)	Qualitative case study with cross-case analysis	Patient	Explore experiences of patients undergoing BBT in psychiatric physiotherapy and to study the concept of the working alliance in a physiotherapy context
Hargreaves (1982)	Discussion paper	Physiotherapist expert opinion	Discuss the relevance of non-verbal skills and the importance of their use in the physiotherapy setting
Hills & Kitchen (2007)	Qualitative study (multi-method approach)	Patient	Explore the factors that affect patients' satisfaction with musculoskeletal outpatient physiotherapy
May (2001)	Qualitative	Patient	To generate the range of dimensions of care that patients believe are important in their satisfaction with an episode of physiotherapy
Payton & Nelson (1996)	Descriptive study with some qualitative elements	Patient	Discover how physiotherapy patients understand their role in therapy, particularly their role or involvement in goal-setting, treatment planning and evaluation of outcomes
Potter et al. (2003b)	Qualitative	Therapist	Gain an understanding of PT's perceptions of the difficult patient in private practice and determine what strategies PT's use and would like to improve when dealing with difficult patients

Potter et al. (2003a)	Qualitative	Patient	Identify the qualities of a 'good' PT and ascertain the characteristics of good and bad experiences in private practice from the patient's perspective
Syzbek et al. (2000)	Theoretical discussion	Physiotherapist expert opinion	Elaborate the concept of the PT–patient relationship, taking counselling and psychotherapeutic encounters as the model
Talvitie & Reunanen (2002)	Qualitative (using discourse analysis)	Observational	Investigate dominant forms of the interaction that takes place between PTs and patients in stroke physiotherapy
Thornquist (1992)	Qualitative	Observational and therapist perception	To ascertain what occurs in first encounters between patients and PT
Westman Kumlin & Kroksmark (1992)	Qualitative	Therapist	Delineate PT's conceptions of establishing therapeutic relationships with patients and conceptions of activating the resources of the patients
Williams & Harrison (1999)	Systematic review (discussion)	Physiotherapist expert opinion	Explore the power dynamic in PT interactions

Table 3.2 Published papers related to the Patient-Physiotherapist relationship

I have critically analysed the literature that was selected; I followed through a set of concepts and questions and compared items to each other. Instead of just listing and summarizing items, I assessed them, and I discussed strengths and weaknesses. A number of guides were available which described approaches to evaluating different types of research in the clinical and social sciences (See for example Greenhalgh, 1997; NHS CRD, 2001).

The key questions for assessing the quality of studies in a literature review are summarised as follows:

1. Conceptual framework:
 - Are the aims clearly stated and research questions clearly identified?
 - Does the author link the work to an existing body of knowledge?
2. Study design:
 - Are the methods appropriate and clearly described?
 - Is the context of the study well set out? Did the research design account for possible bias?
 - Are the limitations of research explicitly identified?
3. Research analysis:
 - Are the results clearly described, valid and reliable?
 - Are the results clearly described in terms of trustworthiness including credibility, transferability, dependability and confirmability?
 - Is the analysis clearly described?
4. Conclusions:
 - Are all possible influences on the observed outcomes considered?
 - Are conclusions linked to the aims of the study?
 - Are conclusions linked to analysis and interpretation of data?

3.3 Historical Development of the Doctor–Patient Therapeutic Relationship

The concept of a relationship between a healthcare professional and the patient is not new. The ancient Greek physician, Hippocrates, is known to have talked about the relationship between a doctor and patient as essential, and that in many cases it has a ‘curative effect’ (Svenaesus, 2001). More recently, the concept has been the focus of psychoanalytic theory, and can be viewed to have emerged from the psychoanalytic tradition. Freud was one of the first ones to talk about it and argue that the client and therapist must form an ‘analytic pact’ from which the client’s symptoms are explored and understood (Safran and Muran, 2000b).

The relationship between patient and doctor has been described as “...one of the most unique, but also problematic, forms of human relationship” (Helman, 2003: p.1). In 2003 a study of the views of 2,506 patients and 1,201 doctors in six countries (the United States of America, the United Kingdom, Canada, Germany, South Africa and Japan) concluded that “The patient-physician relationship is a

crucial underpinning of stable societies, second only in importance to family relationships in all countries studied” (Magee, 2003: p.13).

In the next section, the socio-cultural context of the doctor-patient relationship, by which I mean the general characteristics, roles and responsibilities of doctors and patients that influence the nature of the relationship between them is explored. The rationale for choosing to review this relationship in specific amongst all healthcare professions is due to the common atmosphere and similarities possess to the physiotherapist-patient relationship. The historical development of the doctor-patient therapeutic relationship in the *United Kingdom* is provided, outlining the changing power relations between doctors and patients.

The way that society has viewed the roles of doctors and patients has changed through history. From the fifteenth to the nineteenth century, medicine operated more like a trade than a profession, with a range of practitioners available, including physicians, herbalists, wise-women, apothecaries and midwives (Pelling and Webster, 1979; Porter, 1997; Saks, 1994). Moneyed patients shopped around and, in a social regime dominated by patronage, physicians often deferred to powerful patients’ self-diagnosis and preferred treatments (Porter, 1997; Porter, 2002; Rivett, 1997). Patients from higher social classes might treat the doctor as a superior type of servant; for example, admitting doctors only by the tradesman’s entrance (Porter, 1997; Rivett, 1997).

The nineteenth century was marked by advances in science, leading to reforms in medical policies and institutions (Porter, 1997). Medicine became more objective and analytic as the invention of the stethoscope, microscope and discovery of the power of x-rays enabled a more systematic and scientific approach to diagnosis which was less reliant on the patient’s subjective account (Lupton, 2003; Porter, 1997). Advances in knowledge, grounded upon experimental anatomical and physiological investigation, elevated the societal position of doctors, and medical institutions such as the College of Physicians developed under royal patronage (Porter, 1997). To obtain legitimacy by the state and by patients, a number of textbooks were published, full of praise and admiration for the work of medical doctors emphasising their social importance and professional status (Baldini, 1996).

In the early twentieth century, physicians had access to a range of technological aids, including thermometers, sphygmometers and diagnostic laboratories, whilst penicillin and other antibiotics brought enormous new therapeutic power (Porter, 1997). As diagnosis and treatment improved, doctors were accorded admiration and respect (Duffin, 1999; Porter, 1997). The 1911 National Insurance Act and the later establishment of the NHS provided free access to healthcare and consultation rates rose (Rivett, 1997).

In the early 1950s sociologist Talcot Parsons examined the social structure of the doctor–patient relationship (Parsons, 1951). He described the doctor’s role as professional and specialised, based on high technical competence. Doctors were expected to apply scientific knowledge to the best of their ability to forward the recovery of their patients. In return, doctors maintained professional authority and certain privileges. In contrast, patients occupied a passive ‘sick role’ unable to improve their own health without the expertise of the doctor. This view of the power relations between doctor and patient, with the doctor in a dominant and autonomous position and the patient occupying a more passive role, continued into the 1960s and 1970s, with medical power seen as an entrenched feature of modern health care (Elston, 1991). In this period, medicine infiltrated many spheres of life, for example, involvement in normal pregnancy and childbirth and the introduction of screening for babies and children (Porter, 1997; Rivett, 1997). Doctors controlled not only decisions about their patients’ treatment, but also the amount of information disclosed about the prognosis. For example, a study by Glaser and Strauss in 1966 found that American physicians were reluctant to disclose impending death to their patients, and nurses were expected not to disclose it without the consent of the responsible physician “American physicians very infrequently make such announcements. Much more frequently they drop gentle, oblique references, relying on the patient’s willingness to read those references correctly” (Glaser and Strauss, 1966: p.22).

A number of works by sociologists in the 1970s explored the doctor–patient relationship. Freidson (1971) proposed the conception of illness as a social action arguing that medicine controlled the definition of what counted as illness in the society “In the course of obtaining a monopoly over its work, medicine has also

obtained well-nigh exclusive jurisdiction over determining what illness is and therefore how people must act in order to be treated as ill” (Freidson, 1971: p.205).

He argued that the medical profession had a “bias toward illness” (Freidson, 1971: p.259), an inclination to see illness and the need for treatment rather than health or normality. This assertion was echoed in Illich’s (1975) description of over-medicalisation, which he argued led to a requirement for medical processing through every stage of life, creating life-long patients. Illich was highly critical of the medical profession, suggesting that medicine produced clinical and social damages which outweighed its potential benefits, to the extent that “The medical establishment has become a major threat to health” (Illich, 1975: p.11).

His portrayal of the doctor–patient relationship emphasised the power relations at work: doctors had a great deal of power while patients lacked any autonomy, remaining “defenceless” (Illich, 1975: p.25). Foucault (1973) suggested that classificatory medicine, in which treatment followed diagnosis, based on deduction from the evident symptoms, focussed on clinical signs rather than the patient’s experience of illness “In order to know the truth of the pathological fact, the doctor must abstract the patient... Paradoxically, in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses” (Foucault, 1973: p.8).

The doctor therefore maintained a professional distance from the individual patient to correctly interpret the signs of disease, an act in which the patient played no part other than as the site of that disease.

In the 1980s public opinion shifted away from passive acceptance of the doctor’s advice. Patients’ rights, such as informed consent, were stressed. Ian Kennedy’s Reith lectures in 1980 called for a new relationship between doctor and patient, with people taking greater responsibility for their lives, challenging the power that doctors exercised over their lives and arguing that “doctors must be made accountable to us” (Kennedy, 1981: p.167). Growing dissatisfaction with the medical profession was reflected in an increase in patients seeking health advice from ‘alternative’ practitioners, such as acupuncturists (Porter, 1997; Rivett, 1997).

The socio-cultural context of the doctor–patient relationship in contemporary Britain is markedly different from the paternalistic relationship of the past, which is still characterise the present socio-cultural context of the healthcare professional-patient relationship in Saudi Arabia. While there is more recognition for a patient’s autonomy amongst physicians in Saudi Arabia, most patients still favour a family centred model of care (Mobeireek et al., 2008). Greenhalgh and Wessely (2004) described the modern phenomenon of ‘healthism’, particularly among middle-class patients in the United Kingdom, characterised by high health awareness and expectations, information-seeking and distrust of doctors. Many claim that medical authority is in decline and, although some sectors of society continue to venerate the medical profession, it is no longer a given (Duffin, 1999; Gray, 2002). Patients are increasingly willing to question doctors, with increased access to health information, evidence of medical incompetence or negligence and a rise in consumerism (Gray, 2002).

In the next sections, the main concepts and ideas based on the literature relating to the nature of the patient–physiotherapist therapeutic relationship is outlined.

3.4 Defining the Therapeutic Relationship

In physiotherapy, a growing body of research continues to demonstrate that the therapeutic relationship is a strong predictor of patient outcomes (Gyllensten, Gard, Hansson, and Ekdahl, 2000; Horvath and Greenberg, 1994; Talvitie and Reunanen, 2002). Consistent with the findings of Pedersen (2009), the majority of research in this field is quantitative, and it fails to address many of the phenomenological variables underlying the constructs and conditions of this relationship. Research conducted by Szybek, Gard, and Linden (2000) reminds us that the therapeutic process involves a two-way relationship between the physiotherapist and the patient. A central element of this relationship is an active, cognitive evaluation of interactions and communication that results in adjusted perceptions and behaviours in patients. Underlying this interaction is a wide range of emotive and cognitive functions that must be addressed in detail in order to establish the basis for this particular study and the relevance of its contribution to academia.

Dosamantes (1992: p.361) described what is recognised as “projective identification”, or a psychological process that is simultaneously both defence and communication wherein an inter-subjective exchange between the therapist and the patient transpires. The complexity of this relationship is manifest in the exchange of expectations by the two parties. Psychologically, the physiotherapist is a willing recipient of the patient’s expulsion and projection of unwanted grievances, whilst the patient is equally willing to receive feedback and explore alternatives recommended by the therapist (Dosamantes, 1992). Thus, as Dosamantes described, the relationship between physiotherapists and patients is one of mutual empathy. Here, the patient–physiotherapist relationship is, still according to Dosamantes, most effective when both participants engage in an open and goal-oriented communicative practice that works towards the treatment of musculoskeletal disorder. The challenge for therapists, however, is in recognising how their own biases, emotions, and attitudes influence the clinical treatment scenario and incidentally affect a patient’s acceptance and engagement within the treatment cycle.

Although the importance of communication in patient–clinician interactions is undisputed, its influence on treatment outcomes is less clear as reported by Roberts and Bucksey (2007). They concluded that only by learning more about the context of communication can clinicians establish ways to optimise the patient–clinician relationship, maximise the non-specific treatment effects and enhance the patient’s experience. It is known that communication does not rely only on what is said but also on the manner or style in which it is expressed, incorporating interplay between verbal and non-verbal factors. An investigation into the association between communication factors and constructs of the therapeutic relationship in the patient–clinician relationship conducted by Pinto et al. (2012) reviewed 12 papers. The constructs of therapeutic relationship in the included studies were rapport, trust, communicative success and agreement. Interaction styles that showed positive large correlations with therapeutic relationship were those factors that help clinicians to engage more with patients by listening to what they have to say, asking questions and showing sensitivity to their emotional concerns.

Mead and Bower (2000) described the patient-centred care approach as involving the following dimensions: a bio-psychosocial perspective understanding the

individual's experience of illness, sharing power and responsibility, developing a relationship based on care, sensitivity and empathy, and self-awareness and attention to emotional cues. The factors identified in the report by Pinto et al. (2012) are more related to the provision of emotional support than to the shared decision-making approach. Another study that focusses on the importance of emotional support was conducted by Bredin in 1999 and explored the experience of undergoing a mastectomy and having a "changed body" in the words of the patient. It discussed the anxiety that can be caused by a diagnosis of breast cancer and its progression and the threat of a mastectomy creating a distressing disturbance of body image, partly because of the breast's symbolic and physical association with being a woman. The study concluded that patient satisfaction and psychological well-being are enhanced when clinicians perform caring behaviour and when they attend to the emotional needs of patients. As acknowledged by Leach (2005) another essential ingredient in the development of the therapeutic relationship is time. Leach showed that the development of a strong therapeutic relationship and the subsequent production of positive client outcomes are dependent on effective communication skills, practitioner behaviour, collaboration, time and trust.

3.5 Healthcare Professional–Patient Therapeutic Relationship

Models

Research has attempted to conceptualize the nature of the relationship between healthcare professionals and their patients, resulting in the development of various models (Emanuel and Emanuel, 1992; Jensen et al., 2002). Emanuel and Emanuel (1992) examined four models of physician–patient relationships based on different viewpoints regarding the goals of the physician–patient interaction, the physician's obligations, the patient's values, and the concept of patient autonomy. The first model is called the *paternalistic model*, in which the physician functions as if he or she is the parent of the patient. The physician makes clinical decisions for the patient and the patient does not participate in decision making at all. However, because patient autonomy is valued within the medical field, this model is only seen as acceptable in emergency cases where the patient is deemed unable to make decisions. The second model is known as the *information model*. It implies that the

physician's role is as an information provider, while the patient makes all decisions according to the information received. This model does not satisfy the physician's needs because, in this case, his or her role is limited to that of a technician. The third model is called the *interpretive model*, which implies the physician's ability to interpret the patient's values and needs in order to match these to the best course of action available. The decision still lies in the hands of the physician, and in extreme cases, he or she may become paternalistic. The final model—and the one that appears most promising—is called the *deliberative model*. In this model, the physician attempts moral persuasion without coercion so that the patient's values are directed toward the best course of action and the patient is empowered by the deliberation process.

In order for physicians to be effective in utilizing either the interpretive model or the deliberative model, they must demonstrate the ability to elicit the expression of the patients' feelings and needs. In 2000, Levinson et al. published a study regarding how patients provide clues, and how physicians respond to these clues, in primary care and surgical settings. The authors defined a *clue* as a "direct or indirect comment that provides information about any aspect of a patient's life, circumstances, or feelings" (Levinson et al., 2000: p.1021). The authors' study of these clues was conducted as a descriptive, qualitative study within a larger study focusing on malpractice issues, where they examined a total of 116 randomly-selected routine office visits to 54 primary care physicians and 62 surgeons in community-based practices in Oregon and Colorado. Each session was audiotaped, transcribed, and analysed with regard to the following measures: 1) frequency of the presentation of clues by patient per visit, 2) the nature and content of the clues, either emotional or social, and 3) the nature of physician's responses to the clues, either positive or missed. One or more clues were recorded in 52% of primary care visits and 53% of surgeon's office visits. Patients initiated the offering of these clues 70% of the time, while in the remaining 30% of cases, the physicians encouraged and elicited the clues. The nature of the clues were classified as emotional in 76% of primary care visits and 60% of surgeon's office visits. In terms of responses, physicians positively responded 21% of the time in primary care and 38% in a surgeon's office, although they often missed opportunities to acknowledge the patients' feelings. Visits with missed opportunities tended to be longer than visits

with positive responses. These results indicate that the physician's ability to recognize a patient's clues and respond positively will improve the quality of care, and decrease the time required for care. Thus, this ability is potentially cost effective. Levinson et al.'s study offers a unique contribution to how quality of care can be improved through the subtle ability of healthcare professionals to pick up patient clues and respond positively. However, there were several methodological limitations in the study. Firstly, all the physicians studied were male, due to the sampling framework of the malpractice study. In addition, the data collected were limited to audiotaped recordings; therefore, nonverbal responses, such as posture, facial expressions, nodding, touching, and handing a tissue, were not analysed. Although the authors mentioned inter-rater consistency, they did not report the inter-rater reliability measures such as percentage agreement among raters or kappa statistics.

Another framework thought to affect patient-practitioner interactions is the concept of human needs. In their paper, Darby and Walsh (2000) used a theoretical approach to update the Human Needs Conceptual Model based on its application in the practice of dental hygiene. The model itself was based on Maslow's Human Need theory, which places self-actualization as the highest motive that can be attained only when other needs are fulfilled (Maslow, 1970). Darby and Walsh viewed the functions of dental hygiene practitioners as fulfilling three levels of purpose: 1) to identify their patients' need deficits and the causes of these, 2) to support them with signs and symptoms as evidence, and 3) to provide interventions that included referring patients to dentists. When Emanuel's practitioner-patient models are applied to their conclusions, Darby and Walsh seem to take the position of the interpretive model.

The importance of the therapeutic relationship has also been recognized in other medical disciplines such clinical psychology, where it has been known to affect the outcome of the treatment (Plakum, 2001; Zuroff et al., 2000). Zuroff et al. (2000) conducted a randomized controlled trial of seriously depressed individuals who underwent brief outpatient treatment, in order to determine the effects on treatment outcome of 1) the building of a therapeutic alliance with the patient, and 2) the trait of perfectionism in the patient. Twelve treatment sessions were completed and 149

were analysed. One group received two forms of psychotherapy and the other group received a medication and clinical management. The measures analysed included dysfunctional attitude scale, clinical improvement, perceived quality of the therapeutic relationship, and therapeutic alliance. The results indicated that the trait of perfectionism in patients was negatively correlated with patient contribution to the therapeutic alliance, as well as with clinical improvement. Therapeutic alliance was positively correlated with clinical improvement across various treatments for depression. The reliability and validity of each measure was not clearly stated except for citing previous studies for sample inclusion, exclusion, and assessment procedures.

In physiotherapy, the physical contact that occurs between the patient and therapist is one of the fundamental elements of the practice. Depending on the specific intent of the touch, this physiotherapist-patient contact can be perceived and classified differently. Touch can be an expression of humanistic care, conveying emotional aspects such as empathy or caring. In 2002, Roger et al. published the first observational study—a naturalistic case study design with a cross-case analysis—on how physiotherapists use touch in inpatient acute and rehabilitation settings. A total of 8 mutually exclusive types of touch were identified. These were 1) therapeutic intervention, 2) assistive touch, 3) perceiving information, 4) providing information, 5) caring touch, 6) building rapport, 7) security, and 8) preparation. Various combinations of these types of touch were also observed. The majority of the practitioners believed that their clinical experience was the most influential factor in acquiring a particular touch style and adapting it to the need of the patient. Helm et al. (1997) reported that the culture, education, and clinical experience were all important in the acquisition of touch style. In addition, in terms of frequency of touch, caring touch dominated in Helm et al.'s study, whereas assistive touch dominated in the study of Roger et al.

In the field of physiotherapy, the patient–practitioner collaborative model was developed by Jensen, Lorish, and Shepard (2000), and Barr and Threlkeld (2002) later published a therapeutic intervention case study applying this model to the treatment of a 50-year-old man suffering from subacute back pain. Following the four stages of the patient–practitioner collaborative model, the therapist and the

patient first established the therapeutic relationship. During this stage, the therapist determined the patient's main concerns, which included a strong desire for independence. The therapist then diagnosed the patient's condition through manual inquiry. This stage revealed not only the patient's physical status but also the patient's belief about his condition. Next, the therapist and the patient attempted to find a common ground through negotiation. Using the patient's interest in biomechanical information regarding his gait, mutual goals were set. The long-term goal reflected the patient's concern and desire to be independent. Finally, the intervention was applied and the follow up for further refinement toward better outcomes was planned.

Different models have been utilized to explain the health professional–patient relationship (Emanuel and Emanuel, 1992; Jensen et al., 2000). However, the patient–practitioner collaborative model provides more specific guidance in terms of the process of collaboration (Barr and Threlkeld, 2002; Jensen et al., 2000). Empirical evidence exists regarding the positive effect of therapeutic relationships on the outcomes in clinical psychology (Plakum, 2001; Zuroff, 2000). Although the importance of the therapeutic relationship in physiotherapy practice is also documented, no empirical studies have been performed and none has been conducted in Saudi Arabia.

3.6 Healthcare Professionals' Beliefs

Sweden's Stenmar and Nordholm (1994) published a survey of physiotherapists' beliefs about what makes therapy work. The pilot study for this research, which involved in-depth interviews of 6 physiotherapists followed by a literature review, revealed that the attributes of a successful practice can be placed into the following categories: 1) therapists' knowledge and techniques, 2) patients' own resources, such as capacity for healing and motivation to change, and 3) the interaction between physiotherapists and patients. The result of the study indicated that Swedish physiotherapists perceived the therapist–patient interaction and the patient's personal resources as more important for treatment success than the therapists' own knowledge and techniques. With respect to gender, female therapists valued a

holistic approach more than male therapists. In terms of specialties, orthopaedic physiotherapists placed significantly greater weight on their own knowledge and techniques than those who worked in psychiatric departments. The authors admitted, however, that the limitation of the study lay in the validity of the survey instrument. The low reliability of the subscales they implemented could be improved by increasing the number of subscales and thus, the authors recommended further improvement of the survey instrument before attempting to replicate this study elsewhere.

In addition to Sweden, other research has explored the practice of physiotherapy in other countries. Stiller (2000), for example, explored the ethos of the physiotherapy profession in the United States. In this work, the author defined the ethos of a profession as a composition of the distinguishing characteristics, sentiments, and beliefs of that profession that guide the behaviour of practitioners. In order to reach this conclusion, the author performed a descriptive, qualitative study utilizing data from: 1) interviews with three American Physical Therapy Association Fellows, and 2) focus group interviews with 11 Prime Timers, whom are at least 50 years of age senior physiotherapists and not working full time but continued to be active in the profession. All data were transcribed and coded in order to formulate themes. The results indicated that the main traits of physiotherapists in the US were caring, helping, hard work, dedication, warmth, openness, and positive attitude. This ethos was determined to be influenced by external factors such as social and cultural attitudes. In addition, there were internal factors that were found to affect ethos, e.g. the increased number of males in the profession after World War II and increased educational requirements. In terms of the methodology of the study, although not mentioned explicitly, data triangulation (Merriam, 2002; Patton, 2002) was performed in order to improve the dependability of the study. The author mentioned the use of a contrast-comparative method for coding the data but the inter-rater reliability was not documented. Furthermore, the trustworthiness of the study could have been improved by providing an audit trail as well as a member check (Merriam, 2002). An audit trail is a tool for the reader to authenticate the study findings by following the document trail of the research process. A member check is a verification method often used by the researcher to seek the subject's confirmation of the accuracy of the interview transcript.

While the definition of the ethos given by Stiller assumes that beliefs guide the behaviour of practitioners, another theory from the realm of social science is worth mentioning. Ajzen and Fishbein's (1980) theory of Reasoned Action contends that actual social behaviour is formed by a person's attitude toward the behaviour, intention, and the subjective norm in place, all of which are all based on underlying beliefs. Dunkle and Hyde (1995) applied this theory to predict the interest selection of physiotherapy and nursing students in the specialty of care of elderly. A total of 176 subjects responded to a survey regarding their attitudes toward the elderly, their intention to work with the elderly population, and other factors that might influence speciality selection. After discovering their beliefs, actual speciality selection was examined through follow-up phone calls. The results indicated that the intention to work with the elderly was influenced by the students' attitudes toward the elderly, as well as students' perceptions of their familial expectations for working with elderly people. In addition, there was a statistically significant but minimally positive correlation between the intention to work with the elderly and actual job selection ($r = .26$ for PT, $r = .31$ for RN; $p = .01$). One of the implications of this research to physiotherapy educators is that it is beneficial to implement care of elderly courses that aim to form positive attitudes toward elderly people. Although the exact return rate was not reported, the internal consistency of the survey was acceptable. Ajzen and Fishbein's theory on the relationship between an individual's intention and subsequent behaviour was cited as the intention-behaviour model by Merrill (1994) in her clinical commentary article regarding compliance and motivation in rehabilitation. Merrill combined this theory with a health needs model, indicating that perceived need can determine an individual's intent to behave in certain ways. Therefore, helping the patient understand the need for certain behaviour is a useful motivation-enhancing step of which physical therapists should be aware.

Mail surveys are most commonly used to study healthcare related beliefs (Cousins, 2000; Stenmar and Nordholm, 1994) while other methods, including interviews and grounded theory, are utilized in a few studies (Corrie and Callanan, 2001; Ostlund, 2001; Stiller, 2000). Descriptive survey studies are useful in examining the beliefs of a large number of subjects, especially if the surveys are carefully constructed with an in-depth literature search, pilot studies, or pre-study interviews (Cherkin et al., 1988). Studies indicate that healthcare professionals, such as physicians,

chiropractors, and physiotherapists, each possess their own unique beliefs about their patient management (Stenmar and Nordholm 1994; Stiller, 2000;). Attempts have been made to explain the relationships among physiotherapists' beliefs, intentions, and behaviours through the use of explanatory theories such as Ajzen and Fishbein's Theory of Reasoned Action (1980) and by investigating the ethos of the profession (Stiller, 2000). Although these studies imply that the acquisition of knowledge through professional education and clinical practice may influence belief formation, the directions of causes and effects are still unclear.

3.7 Patients' Beliefs

In addition to the studies on healthcare professionals' beliefs, there is literature on patients' perspectives on the rehabilitation process (Alori, 2002; Cousins, 2000; Ostlund et al., 2001). In 2000, Cousins published a survey study on older women's beliefs and values with respect to exercise. The author concluded that older women tend to avoid exercise due to 'nocebo' (false assumption of risk). She postulated there are various reasons underlying this belief. For example, older women may be too fragile to perform certain forms of exercise. In addition, they lack experience with fitness activities, which may place them at psychological risk, such as the risk of feeling foolish. Finally, the internalization of the older female stereotype imposed by society, and the persistent public warnings of risk related to exercise, are both negatively affecting older women's beliefs regarding exercise. One of the implications of this study for physiotherapy practice is that physiotherapists must provide accurate health risks for exercises they instruct. The author clearly stated the study's limitations, which were mainly survey instrument issues such as the form being too long, resulting in poor participation in the open-ended answer section. The response rate was an undesirable 59.4%. Non-respondents were not followed up for determination of non-respondent bias. Thus, the validity of the survey is reduced. Although this was not a study of therapists' beliefs, it demonstrated the potential relationships between the subjects' beliefs about exercise and their biological and psychological states, as well as the societal impact of these beliefs. Furthermore, although the author implied—or rather assumed—that there was a relationship between beliefs and actual behaviour, the actual behaviour was not examined.

Additionally, since the study was performed in Australia, the applicability of this study to the Saudi Arabia might be limited.

Alori (2002) described the formula for successful rehabilitation through his experience as a patient after becoming quadriplegic following an accident. He contended that the following three factors are crucial for successful rehabilitation: 1) trust between therapist and patient, 2) communication or feedback from both sides about what is going on, and 3) motivation of both the patient and therapist working together in the therapy process. He gave his own story as an example of both successful and unsuccessful rehabilitation with various physiotherapists. Although his story should be taken as an anecdote with minimal strength of evidence, his suggestions are valuable to physiotherapists who have a strong desire to improve their practice in terms of patient outcomes. It would be fascinating to find out whether his therapists had similar or diverse beliefs about what they considered the ingredients for a successful outcome. Due to the study's location in Pennsylvania (US), generalizability of this study's results to the rehabilitation environment in the other countries may be limited.

Qualitative research methods can be employed for exploring patients' perspectives on the rehabilitation process. In 2001, Swedish researchers, Ostlund et al. published a study utilizing interviews of patients regarding what factors promoted or hindered their rehabilitation processes. Twenty subjects who experienced musculoskeletal injury and rehabilitation were recruited for a semi-structured interview. The contents of interview surrounded their life prior to injury, their life at present, their family, work and rehabilitation experiences, and their future plans. Transcribed interviews were analysed to discover overall themes. The main theme that emerged from the subjects' rehabilitation experiences was that it was most beneficial for them to have a therapist who was supportive. From the analysis of the data, the author constructed a socio-emotional model of rehabilitation agents, a matrix consisting of two factors: support and rehabilitation type, either individualized or standardized. In this model, the supportive therapist who provides an individualized program is labelled as a professional mentor, and that is the ideal model for a physiotherapist. A practitioner who is supportive but who uses a standardized program is termed an empathic administrator. A therapist who is not supportive yet provides individual

rehabilitation is labelled as a distant technician, and the non-supportive therapist who provides standardized rehabilitation is classified as a routine bureaucrat. Although this study is unique in that it both focuses on the patients' perspectives and utilizes qualitative methods, the methodology lacks some credibility and trustworthiness because the author did not provide any mechanism to trace back to the original data, such as an audit trail, or give evidence of triangulation.

Other research has shown that culture not only contributes to the individual's understanding of a particular disease, but it also influences what individuals consider desirable treatment approaches (Klienman, 1988). For example, Hmong people believe that epilepsy is caused by spiritual reasons and that epileptics have a supernatural power that allows them to detect the existence of the spirit. Thus the Hmong culture dictates that a shaman who has supernatural powers must treat the disease, rather than biomedical practitioners. In addition, healthcare professionals are known to, as a group, possess their own culture. In 2002, Cromie et al. published qualitative research about physiotherapists who themselves had experienced work-related injuries. The culture of physiotherapy was characterized by two specific beliefs: 1) physiotherapists would not experience work-related injuries due to proper knowledge and skills, and 2) they are caring and hardworking. Another study found that when both the patient and the physiotherapist fail to negotiate their mutual ground in order to work as a team, some physiotherapists may label their patients as 'problem' patients in order for them to cope with their own helplessness and inability to be effective in the episode of care (Thompson, 2000).

Although limited in quantity and quality, the literature on patients' perspectives regarding exercise and the rehabilitation process revealed the potential impact of patients' values and beliefs on rehabilitation outcomes (Alori, 2002; Cousins, 2000; Ostlund et al., 2001). These values and beliefs can be closely associated with both patients' and physiotherapists' own cultural backgrounds (Bohmert, 2002; Cromie et al., 2002; Fadiman, 1997; Kleinman, 1988). It has been suggested that the physiotherapist's inability to gather or incorporate the patient's values into a treatment approach may be perceived as suboptimal care (Alori, 2002; Ostlund et al., 2001). These findings are consistent with the theory of physiotherapy practice,

particularly regarding the source of knowledge and how the knowledge is used in practice, addressed by both Jensen and colleagues (1999) and Thornquist (1994).

3.8 Ways of Experiencing the Patient Encounter

The interaction between the physiotherapist and patient is an important part of the physiotherapy treatment and, thus, also an important part of the physiotherapist's professional competence. Tyni-Lenne (1987) suggested that the physiotherapy process could be described as the integration between the processes of problem solving, decision-making and interaction.

Studies of physiotherapy praxis according to an *expert-novice* paradigm comprise descriptive studies of the variations between expert (or master) clinicians and novice physiotherapists with regards to their work within different clinical settings, and how the development of expertise in physiotherapy is constituted (Jensen, Shepard, & Hack, 1990; Jensen, Shepard, Gwyer, & Hack, 1992; Martin, Thornberg, & Shepard, 1993; Shepard & Jensen, 1990; Shepard, 1993). These studies find, for example, that expert physiotherapists focus on the patients' verbal as well as non-verbal communication during the patient encounter, while novices use a medley of approaches for gathering data and maintaining rapport (Jensen et al., 1992).

Patient-physiotherapist interaction has also been the focus of several empirical recent studies pertaining to what can be labelled a *communicative perspective* of physiotherapy praxis. This research perspective aims at articulating the socially and professionally constructed basis upon which therapies are chosen and co-operation is built (Engelsrud, 1990; Thornquist, 1992; Thornquist, 1994a; Thornquist, 1994b). The focus of communicative research is, thus, different from studies performed from what can be described as a *cognitive perspective*, where the target of inquiry is the physiotherapists' diagnostic thinking or clinical reasoning. It has been suggested that physiotherapists adopt clinical reasoning processes similar to those of their medical counterparts (Dennis & May, 1987; Payton, 1985; Thomas-Edding, 1987), but it has also been argued that physiotherapy actually places greater emphasis on treatment and subsequent evaluation than the medical models, which emphasise diagnosis

(Higgs and Titchen, 1995). Thornquist (1994) proposed that attention should not be restricted to either clinical reasoning or communication but, instead, should be directed towards the relationship between communication and clinical reasoning, in order to understand how a health problem is defined.

Based on an empirical study on physiotherapist/patient encounters, Thornquist suggested the existence of different frames of reference for physiotherapy interventions. A *dualistic* frame of reference was identified from a case where the diagnostic interest was mobility of the patient's joints from a biomechanical perspective. Characteristic of the interactive process was that the physiotherapist imposed his/her perspective on the patient, neglecting non-verbal body language, and thereby restricting the course of interaction. A *phenomenological* perspective of the patient as an embodied subject, with the body as an expression of the person's life and history, was also discerned as a frame of reference. The initiative taken during the encounter shifted between the physiotherapist and the patient. The physiotherapist had an accepting attitude towards the patient's body language and this was integrated into the process, thus opening and expanding the course of interaction (Thornquist, 1994a: 1994b).

A field study of physiotherapists working in primary healthcare showed similar frameworks (Abrandt, 1996). In this study, two physiotherapists' encounters with a total of 15 patients were observed. Two perspectives of the physiotherapists' relationships to patients were discerned: a dualistic, medical, organ-oriented perspective, and a dialectic, interaction-orientated perspective. Similar results were also obtained by Westman-Kumlien & Kroksmark (1992), who showed, in a study of first encounters between 10 physiotherapists and their patients, that two main perspectives regarding the therapeutic relationship dominated among the physiotherapists: 1) The relationship was based on a dialogue aimed at discovering the patient's own conceptions of his/her problems and strategies to solve them or 2) the relationship was not based on a dialogue, but rather, the physiotherapist perceived him/herself as the authority. Studies by Engelsrud (1990) and Ek (1990) also point out the authoritative role taken by some physiotherapists during treatment sessions.

The importance of developing communicative skills has been recognised within several physiotherapy training programmes in Sweden. At the Faculty of Health Sciences in Linköping, interaction has achieved a status as an overarching concept, central and instrumental to other core concepts within physiotherapy. Problem-based learning (PBL) is the common pedagogical approach for all programmes of study there (Kjellgren et al 1993), and its implementation has consequences for the organisation of the physiotherapy curriculum in particular. In PBL, real-life situations are taken as a point of departure for learning. This requires an alternative organisation of the curriculum, since what appears as a problem, an event or a phenomenon in real life is seldom disciplinary but rather thematically organised.

The principle of thematic organisation is therefore a characteristic feature of the curricula at the Faculty of Health Sciences. The structure and content of the physiotherapy curriculum are based on the concepts of *Movement*, *Health* and *Interaction*, all considered central to physiotherapy. The intended curriculum is one way of describing what is meant to be conveyed by means of the formal education. At the same time, it is insufficient to provide an understanding of the attained curriculum, or the impact of the education in terms of how the basic concepts of physiotherapy are actually conceived of by the students. In this respect, we know little about how the provided emphasis on communication skills actually impacts the newly graduated physiotherapists' professional work or conceptions regarding the core concepts within the profession.

3.9 Motivation Factor on Outcomes

Motivation is perceived to be one of the essential ingredients for successful rehabilitation from the patient's perspective (Alori, 2002), and is effective in achieving short-term improvement during the rehabilitation process (Friedrich et al., 1998). There is an abundance of literature available on motivation as an ingredient for rehabilitation (Alori, 2002; Friedrich et al., 1998; Grahn et al., 1999; Merrill, 1994; Talvitie, 1992), and most studies imply the need for both the therapist's and the patient's involvement in the process. Merrill (1994) reviewed the concepts surrounding patient compliance and illustrated the relationships among needs, motivation, intention, and behaviour. She stated that healthcare practitioners must

influence patients in order to secure compliance. Furthermore, to be influential, it is necessary to gain a patient's trust in addition to using persuasion. Merrill described the four characteristics of a persuasive message as 1) expertness or appearance of being knowledgeable, 2) nonverbal as well as verbal communication with warmth, genuineness, and empathy, 3) confidence and enthusiasm, and 4) trustworthiness encompassing technical competence, altruism, and freedom from value judgment.

Friedrich et al. (1998) performed a double blind prospective study to assess the effect of a combined exercise and a motivation program on the compliance and level of disability of patients with chronic and recurrent low back pain. This randomized controlled trial recruited 93 patients with low back pain and assigned them to either physiotherapy alone or physiotherapy plus a motivation program, for a total of 10 sessions. The motivation program included five compliance-enhancing interventions: 1) extensive counselling and information that included clear instructions, aims, and expectations, 2) reinforcement techniques such as providing positive rewards, 3) writing a "treatment contract" based on the oral agreement between the physical therapist and the patient, 4) requesting the patient post the contract at home or at work, and 5) giving responsibility to the patient to report his or her compliance with respect to his or her home program. One of the results was that the people who received physiotherapy plus the motivation program were significantly more likely to participate in their exercise appointments. The disability and pain intensity scores were significantly lower in the physiotherapy plus motivation group at the 4- and 12-month follow-ups. At the 4-month follow up, the finger-to-toe test and abdominal strength were significantly better in the physiotherapy plus motivation group than in the physiotherapy only group. Motivation scores, self-reported compliance, and the modified Waddell score did not show statistically significant differences between the groups. The researchers concluded that there was a short-term benefit of a motivation program on patient outcomes, but no long-term (12-month) exercise compliance benefit. The authors clearly stated the study's limitations, including the lack of validation of both motivation and compliance measures. In addition, the control (physiotherapy only) group was not instructed to keep an exercise log, so the report of compliance may not have been as accurate as in the experimental group. The authors suspect that the external validity limitation may be due to the use of identical physiotherapists as

therapy providers for both groups, i.e., the referring physicians might have positively influenced the participants. In addition, comprehensive psychological testing was not performed at the beginning of the study. Additionally, since the study was performed in Vienna, Austria, the applicability of this study to the Saudi Arabia might be limited.

In contrast to the positivistic research method used by Friedrich et al., descriptive qualitative research was used by Grahn et al. (1999), who conducted a prospective study spanning two years that looked at the process of motivation towards change in patients with prolonged musculoskeletal disorders to determine which factors resulted in increased independence. Written and face-to-face interviews were conducted for twenty patients, three times each, for two years, the transcriptions were coded, and then themes were developed. The authors concluded that the process of developing the motivation to change is strongly related to subjects' perceived human support. Therefore, they recommended that healthcare professionals perform a simple motivation analysis during their evaluation in order to better serve patients with prolonged musculoskeletal disorders. In addition, questions about patients' emotional network and social support at work must be included in the assessment of motivation to change. This study attained credibility, trustworthiness, and dependability by implementing triangulation, an audit trail, and a member check. However, the code development description did not include inter-rater reliability, such as the percent agreement or kappa statistics. Due to the study's location in Sweden, generalizability of this study's results to the rehabilitation environment in the other countries may be limited.

Conceptual studies by Merrill (1994) and Talvitie (1992), as well as empirical studies by Freidrich (1998) and Grahn (1999), have addressed the positive effect of promoting patient motivation on outcomes. Specific strategies were presented to optimize the patient's compliance and motivation. However, it is not clear whether physiotherapists believe that promoting patient motivation is one of the key elements for successful patient outcomes. Utilizing an emic approach may reveal whether a belief comes from the self and one's own experience, or from knowledge provided by an authoritative source, such as education and scientific research.

3.10 Patient Expectations

Patient expectations entail both physiotherapy itself and the outcomes of physiotherapy (Bassett and Tango, 2002; Gyllensten et al., 2000; Hills and Kitchen, 2007; May, 2001; Potter et al., 2003a). Bassett and Tango (2002) and Hills and Kitchen (2007) explored Maori people's experiences of physiotherapy and the factors which affect the patient's satisfaction with musculoskeletal physiotherapy, respectively. They both found that expectations were dependent on whether clients had received previous physiotherapy. Those without previous experiences had either low expectations or no preconceived notions about therapy. On the other hand, people with past experience had definite expectations about physiotherapy in general and what they would achieve from their course of treatment. Some examples of expectations were: to be assessed, diagnosed; given an explanation of the problem and treatment; learning self-management strategies and learning symptom relief or resolution.

A number of both physiotherapist and patient perception papers implied that expectations may influence the therapeutic relationship. Gyllensten et al. (2000) suggested patient expectations and hopes, along with other factors, may underlie what was to take place in the actual interaction between the patient and the therapist. Hills and Kitchen (2007) found that if a patient was expecting a specific treatment that had been beneficial previously, but did not receive this treatment; disappointment resulted, particularly if the patient was not given the opportunity to discuss possible treatment options. Similarly, in Potter et al. (2003a) study, the therapists identified unrealistic patient expectations of the physiotherapist and/or physiotherapy treatment as being problematic: patients wanted "quick fixes in one session when that is not possible" or to have "all their physical problems treated today" which the therapist stated is an "unrealistic expectation" (Potter et al., 2003a: p.56).

3.11 Therapeutic Relationship—Influencing Factors

The subject regarding patient–physiotherapist therapeutic relationship- influencing

factors comprises three categories: external factors, physiotherapist prerequisites, and patient prerequisites. Firstly, several studies have identified external factors such as structure, processes, and the environment as factors which may contribute to the therapeutic relationship (Gyllensten et al., 2000; Gyllensten et al., 1999; Hills and Kitchen, 2007; May, 2001; Potter et al., 2003b; Williams and Harrison, 1999). For example, the participants in Hills and Kitchen's (2007) study identified the structure of provision of physiotherapy as an important aspect of their care. This included factors such as waiting time, open access, and having enough time with their therapist. Patients appreciated a flexible appointment system, with quick and local access to a therapist, and not being kept waiting for more than ten minutes. Similarly, the studies of Potter et al. (2003b) and Gyllensten et al. (2000) identified a pleasant and welcoming environment in the physiotherapy practice as important to help put the patient at ease and to establish a good basis for treatment.

Secondly, prerequisites of the physiotherapist were identified by most of the patient perception papers and half of the therapist perception papers as factors which may contribute to the therapeutic relationship (Gyllensten et al., 2000; Gyllensten et al., 1999; Gyllensten et al., 2003; Hills and Kitchen 2007; May 2001; Potter et al., 2003b). In particular, the skills and competence of the therapist was a commonly mentioned prerequisite. Hills and Kitchen (2007) commented that patients valued a therapist who was knowledgeable and provided a good explanation of their problem, while participants were dissatisfied when this was lacking. Similarly, May (2001) reported that physiotherapists with a good knowledge base and good skills inspired confidence in their patients, and therefore enhanced satisfaction with physiotherapy. One therapist commented that a particular course she completed improved her knowledge, strengthened her credibility as a physiotherapist, and improved her interaction with patients (Gyllensten et al., 1999). Other subcategories in this subject include the life experiences and personal characteristics of the physiotherapist.

Thirdly, some studies have identified prerequisites of the patient, as factors which may contribute to the therapist–client relationship. This included the patient's personal characteristics, existing resources, life experiences, and willingness to engage (Bellner, 1999; Gyllensten et al., 2000; May, 2001; Szybek et al., 2000; Westman, Kumlin and Kroksmark, 1992).

3.12 Research Question and Aims

The theories and research reviewed in this chapter show that the relationship between the physiotherapist and the patient is fundamental to the delivery of musculoskeletal healthcare. In order to deliver high quality patient care it is vital that an effective therapeutic relationship is established. To date, there has been very little research into the nature of the patient–physiotherapist relationship and none has been conducted in Saudi Arabia. Research, as highlighted by this chapter, exposes the large gap in the knowledge base of the patient-physiotherapist therapeutic relationships, which this thesis aims to address, and forms the basis for the research question and aims presented in the following sections.

3.12.1 Research Question

- What is the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings?

3.12.2 Research Aims

The research question had the following aims:

- To explore the nature of the female patient–physiotherapist therapeutic relationship in Saudi Arabian musculoskeletal outpatient settings.
- To explore the expectations, attitudes and perceptions of physiotherapists and patients within the therapeutic relationship.
- To develop an explanatory model of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings.

3.13 Chapter Summary

The literature reviewed in this chapter provides a valuable conceptual and theoretical framework for this thesis. Literature on healthcare providers/physiotherapist–patient relationships helped to develop the research question, and theoretically sensitise me to guide in initial data collection and analysis. The literature which guided the advanced stages of data collection and analysis is

presented in Chapter 7. Using the literature in this way enabled me to ask questions of the developing substantive theory, and therefore helped to broaden its explanatory power and theoretical sufficiency.

In the next chapter, the methodology adopted in this research is discussed in details, and the decisions made in regard to the choice of the methods employed to address the research question and aims of this study are justified.

Chapter 4: Methodology

4.1 Introduction:

In this chapter, the methodological decisions taken in this research are described and justified. The choice of methodology in light of the research question and field of therapeutic relationships is examined. The chapter continues by positioning the study in the interpretive research paradigm and discusses how the researcher's epistemological and ontological decisions have influenced the choice of the research methods used to collect and analyse data. The chapter goes on to explore grounded theory and the issues around the insider research approach adopted in this study. It continues by presenting the ethical considerations relevant to this research and explains how such issues were managed. Finally, it discusses the measures taken to ensure the trustworthiness of this research.

4.2 A Qualitative Approach

This study aimed to explore the nature of the female patient–physiotherapist therapeutic relationship in Saudi Arabian musculoskeletal outpatient settings. By exploring the expectations, attitudes and perceptions of physiotherapists and patients within the therapeutic relationship, an ‘insider’ or ‘emic’ perspective could be obtained (Holloway and Wheeler, 2010). A qualitative approach to the research study was adopted because it facilitated understanding of socially interactive processes in the natural setting. Qualitative research looks for answers to questions that emphasise how social experience is created and given meaning (Denzin and Lincoln, 2008). As a process of research, qualitative methods have been developed to allow a systematic investigation of how individual participants ‘make sense’ of the world and how they interpret and experience events and social interactions (Bryman, 2008b).

The views and perceptions of patients and physiotherapists about their therapeutic relationship are subjective. These views are likely to be influenced by numerous factors, both professional and personal, as is the interpretation of these perceptions. A qualitative research approach made explicit the interaction between the participant

and researcher, and acknowledges that there are multiple realities and that every person's experience is unique (Nicholls, 2009). In particular, the interpretivist theoretical approach taken in this research emphasises the processes and actions of these multiple realities and aims to conceptualise them in order to understand the phenomena and processes under study (Charmaz, 2006). Therefore a qualitative research approach was seen as appropriate to address the research question of this study (Section 3.12).

Whilst this research is qualitative in nature; the term qualitative alone is insufficient to describe the specific knowledge, assumptions, methodology and data collection methods that underpinned the study. Qualitative research is considered an umbrella term for a collection of general approaches (methodologies) which include a number of ontological and epistemological perspectives that guide the collection and analysis of data (Carpenter, 1997; Lincoln and Guba, 2000). As the 'goal' of research is to generate knowledge, researchers need to be explicit when stating the paradigm in which their work is located in. It is argued that "three fundamental facets of research: epistemology, methodology, and method, should provide the framework for planning, implementing, and evaluating the quality of qualitative research" (Carter and Little, 2007: p.1316). The choices regarding epistemology, methodology and methods in relation to this research study are discussed below.

4.3 Epistemological Positions of Qualitative Research

The paradigm of qualitative research is made up of different theoretical assumptions and methods which can be used to this form of qualitative research. Willis defines a paradigm as "A comprehensive belief system, world view, or framework that guides research and practice in a field" (Willis, 2007: p.8).

The basic assumptions that define a research paradigm can be drawn from the response to three fundamental questions:

- Ontological questions- What is the form and nature of reality, and therefore what is there that can be known about it?
- Epistemological questions- What is the nature of the relationship between the knower and what can be known?

- Methodological questions-How can the inquirer go about finding out what they believe can be known?

(Guba and Lincoln 1994, p.108)

This research study assumed a relativist ontology and a subjectivist epistemology. Adopting a relativist ontology meant that the researcher acknowledged the existence of multiple realities and perspectives (Guba and Lincoln, 1994; Lincoln et al., 2011). By adopting a subjectivist epistemology, this research would develop an understanding of the social worlds of participants (Guba and Lincoln, 1994) through a socially interactive process which would co-construct knowledge and meaning (Crotty, 1998).

Working within the interpretive paradigm I carried throughout the research process certain beliefs, meanings and assumptions about the nature of therapeutic relationship and how it could be 'known'. In addition, operating within a certain paradigm influenced my choice of methodology and decisions regarding the methods of data collection. My own personal experiences also contributed to the unique perspective of my research. However, by adopting a subjectivist epistemological and relativist ontological position I and consequently my research were tied to the interpretive paradigm to which these rules and assumptions belong. The next section outlines these assumptions in the context of this research.

Numerous classification systems have been put forward to categorise, conceptualise and make explicit the differences (and similarities) between the various research paradigms (for example, Creswell, 2003; Denzin and Lincoln, 2000; Guba and Lincoln, 1994; Willis, 2007). Relevant to this study, Higgs and Titchen (2000) discuss the three most often used paradigms in healthcare research. These are: 1) the empirico-analytical paradigm, to which the scientific method belongs. It adheres to the positivist philosophy, which holds the belief of a single, objective quantifiable reality; 2) the interpretive paradigm, which takes into account the context of the situation, timings and subjective meanings of the phenomena under investigation and accepts that there are multiple perspectives and multiple truths; and 3) the critical paradigm, which produces emancipatory knowledge, emphasising alternative ways of thinking and how thinking is socially and historically constructed. The empirico-analytical paradigm is often considered to be a quantitative research

paradigm, while the interpretive and critical paradigms are thought of as qualitative research paradigms. This research aimed to explore the nature of the therapeutic relationship from the perspectives of the participants, and as such it was conducted in the interpretive paradigm. The section below further explores why and how this decision was made.

4.4 Locating this Research within the Interpretive Paradigm

The interpretive research paradigm seeks an understanding of a particular phenomenon, and recognises that the context in which any form of research is conducted is essential to the interpretation of the data gathered (Willis, 2007). The essence of interpretive qualitative research is to develop a contextual understanding of social processes, therefore the interpretative paradigm was considered appropriate for this exploration of the nature of therapeutic relationship processes of study participants. Situating this research within the interpretive paradigm meant that the research aims were to construct a theoretical model that would help understand and thereby explain the processes involved in the nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings.

The interpretive paradigm has been advocated as well suited to the generation of knowledge in the social sciences, in both the philosophical stance it assumes and the methods utilised to collect and analyse data (Higgs and Titchen, 2000). The resulting theory generated in the interpretive paradigm assumes “multiple realities; indeterminacy; facts and values as linked; truth as provisional; and social life as processual” (Charmaz 2006, p.126). By acknowledging a relativist ontology, and a subjectivist epistemology this research assumes that there are multiple realities and that meaning and understanding are co-constructed between the researcher and the participants (Denzin and Lincoln, 2008).

A constructivist grounded theory method set within an interpretivist paradigm would enable the research question and aims set out in Section 3.12 to be addressed, which were to develop an explanatory model of the nature of the female patient-physiotherapist therapeutic relationship. In this study, I have taken a relativist ontological and subjectivist epistemological stance reflecting my position that

realities are multiple and constructed and that the data of the research are co-created by me and the research participants. Grounded theory was chosen as it would allow me to construct a theoretical, explanatory model to systematically understand the social and interactive process of therapeutic relationship. The following sections provide an overview of grounded theory and explain the decision to adopt it in this research study.

Figure 4.1 below is a diagrammatic representation (Grounded theory tree of knowledge) of the theoretical position that supports the Constructivist Grounded Theory approach and how Constructivist Grounded Theory has further developed from the original grounded theory approach.

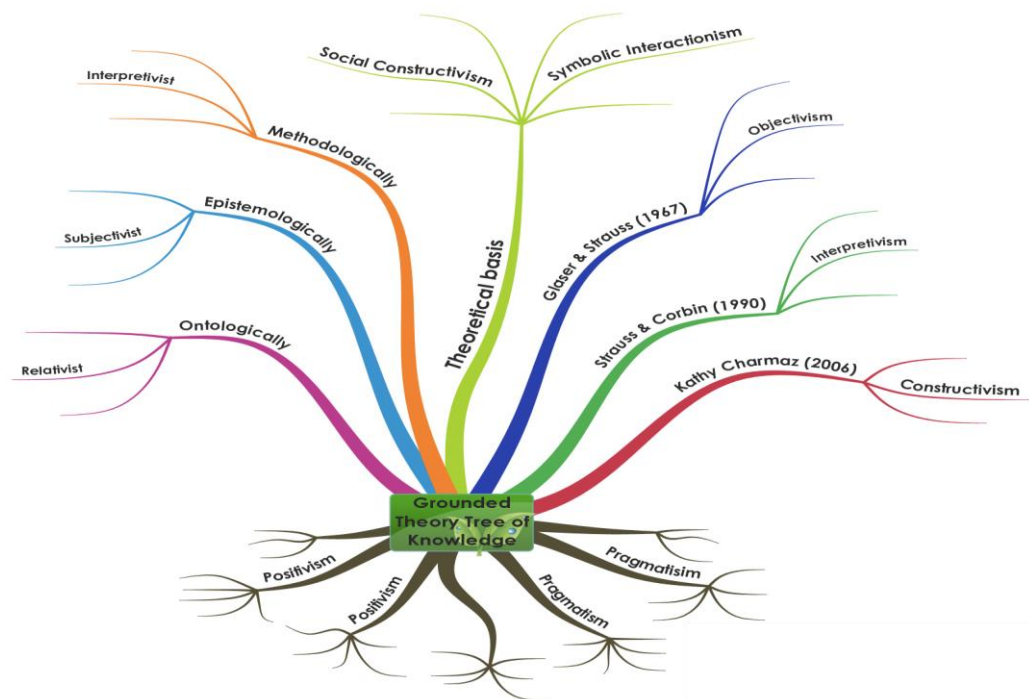


Figure 4.1: Grounded Theory Tree of Knowledge (Gardner et al., 2010)

4.5 Grounded Theory: The Methodology

Grounded theory methodology was originally described by Barney Glaser, a quantitative researcher, and Anselm Strauss, a qualitative researcher, in the mid

1960s. In their pioneering book, *The Discovery of Grounded Theory* (Glaser & Strauss, 1967) these two sociologists articulated the strategies they had adopted for a collaborative research project on dying (Glaser & Strauss, 1965: 1968). First described as “a process that articulated the discovery of theory from qualitative data” (Robrecht, 1995: p.170), the method arose from the combined research histories of Glaser and Strauss (Charmaz, 2000; Clarke, 2005; Dey, 1999; Stern & Covan, 2001). Grounded theory methodology stems from, and is fundamentally linked with, Symbolic Interactionism (Charmaz, 2000; Clarke 2005; Ezzy, 2002; Milliken & Schreiber, 2001; Smith & Biley, 1997). The link between the theoretical underpinning of Symbolic Interactionism and the methods of conducting grounded theory research is represented by grounded theory methodology (Milliken & Schreiber, 2001).

According to Bryant and Charmaz (2007b), grounded theory is the most widely used—or more accurately, the most—qualitative research methodology. Since its original conception, there has been much debate and confusion regarding the theoretical perspectives taken and the methods employed in its use (Allan, 2003; Charmaz, 2000; Locke, 1996; Walker and Myrick, 2006). Addressing the ambiguity of the term ‘grounded theory’, Bryant makes the distinction between the phrases ‘grounded theory method’ and ‘grounded theory’ (Bryant, 2002a). He argues that while many researchers claim to use grounded theory methods of data analysis, their intention may not be to produce an actual grounded theory—something he views as a possible outcome of the method (Bryant, 2002a). Bryant’s contentions make some sense, in that the early writings of Glaser and Strauss omitted any discussions regarding the philosophical and methodological underpinnings of grounded theory, and instead focused only on the different methods of analysis (Birks and Mills, 2011). However, contemporary permutations of grounded theory that are explicit in their epistemological foundations, such as the constructivist grounded theory used in this thesis, move grounded theory to a methodology-methods ‘package’ (Birks and Mills, 2011). In this study, grounded theory will be considered as a methodology-methods package, with the ‘contents’ of the package being the methods used to collect, handle and analyse the data (such as coding, memo-writing and the constant comparative method of analysis), underpinned by the theoretical perspective of constructivism (Charmaz, 2006).

4.6 Schools of Grounded Theory

Although grounded theory was originally described by Glaser and Strauss in the mid 1960s, a review of the literature identified a change in the original authors' views and the development of new grounded theory since their classic 1967 and 1968 statements (Glaser & Strauss, 1967; Glaser 1978). Since this time, the two authors have taken grounded theory in somewhat different directions (Charmaz, 2000), Glaser in his own research, and Strauss in his treatise with colleague Juliet Corbin. This divergence from the 'original' grounded theory led to the creation of two 'schools' of grounded theory: the Glaserian version, based on the original work and the subsequent writings of Glaser; and the Straussian version, based on refinements Strauss made to the original version in association with Juliet Corbin (Charmaz, 2006; Heath & Cowley, 2003; McCallin, 2003). There is however a third 'school,' in which scholars have moved—and continue to move—grounded theory away from the positivism associated with both Glaser's and Strauss and Corbin's versions of grounded theory (Bryant, 2002: 2003; Charmaz, 2000: 2005; Clarke, 2003: 2005; Seale, 1999).

McCallin (2003) suggests that the Glaserian version of grounded theory has further developed and been reframed into a second school of Glaserian thought. A similar issue occurs in the Straussian version, where in his later works in association with Corbin, the method has been distanced from its roots of Symbolic Interactionism (Clarke, 2005). However, there is no indication in the literature that this should lead to consideration of a second school of Straussian thought.

When designing a study, it is essential that consideration be given to the methodological issues in grounded theory (McCallin, 2003). In light of this, wide and extensive readings in the area of grounded theory methodology were undertaken, providing the opportunity to identify and understand the differences between the three 'schools'. The review of grounded theory literature highlighted the differences, which encompassed both theoretical and methodological issues. And in fact, the underlying ontological and epistemological assumptions of the original authors of grounded theory were found to be at the centre of the methodological differences.

Annells (1996) suggests that the Glaserian version of grounded theory has its ontological roots in critical realism. Critical realism assumes that an objective world exists independently of our knowledge and beliefs, and as such, the researcher is considered to be independent of the research (Annells, 1996). This stance is in contrast to the Straussian version of grounded theory, which has its ontological roots in relativism, where it is argued that reality is interpreted. In light of this, Strauss and Corbin's (1998) text encourages the researcher to be involved in the method. The constructivist version of grounded theory (Charmaz, 1990: 2000: 2003; Charmaz & Mitchell, 2001), like the Straussian version, has its ontological roots in relativism. However, the constructivist grounded theorist takes a reflexive stance on the modes of knowing and representing studied life, in that they give close attention to the empirical realities and people's collected renderings of them, and locate themselves within these realities (Charmaz, 2005).

Glaser remained consistent with his explanation of the grounded theory method for many years following his divergence from Strauss regarding the direction of the method. Glaser defined grounded theory as a method of discovery; the categories were emergent from the data, and the method relied on empiricism, which was often direct, narrow, and analysed a basic social process (Charmaz, 2006). Strauss (1987) redirected the method into a more verifiable position in his treatise with Juliet Corbin (Strauss & Corbin, 1990: 1998). Strauss and Corbin's version focuses on the use of new technical procedures rather than the comparative methods of the earlier grounded theory approaches. Glaser's version is described as a more patient, relaxed approach that waits for the theory to emerge from the data. One of Glaser's criticisms of the Straussian approach is that Strauss and Corbin's procedures force data and analysis into preconceived categories (Charmaz, 2006).

Constructivist grounded theory adopts traditional grounded theory guidelines; however, it does not subscribe to the positivist assumptions postulated in earlier formulations of the methodology (Charmaz, 1990: 2000: 2003; Charmaz & Mitchell, 2001). In accordance with the apparent paradigm, constructivist grounded theorists take a reflexive stance on the modes of knowing and representing studied life. Therefore, the constructivist approach to grounded theory assumes a flexible approach, and is in part a response to Glaser and Strauss's invitation in their original

statement of the grounded theory method for researchers to use strategies flexibly and in their own way. Charmaz (2005: 2006) provides the researcher with a way of ‘doing’ grounded theory whilst taking into account the theoretical and methodological developments of the last four decades.

4.6.1 Theoretical/Philosophical Underpinning of Grounded Theory

The theoretical position of pragmatism propounds that by acting and interacting (often during a problematic situation), people can creatively develop knowledge of the world that may be useful in practice (Corbin and Strauss, 2008). Charmaz adds that pragmatism considers reality as “fluid” and open to multiple interpretations, and therefore pragmatists see truth as “relativistic and provisional” (Charmaz, 2006: p.187). Symbolic interactionism refers to the premise that the process of human interaction provides the meaning for an individual’s experiences (Blumer, 1986). The theory holds that human behaviour is based upon the meaning that individuals place on symbols (people and things), and how such meaning is interpreted and communicated through language. Also central to the theory is that meaning is constructed through the interaction between people, rather than being assumed or ‘intrinsically emanating’ from the symbol (Blumer, 1986).

Together, the two philosophical perspectives of pragmatism and symbolic interactionism emphasise the key notion of grounded theory research, which is to develop new theory by exploring social process and interaction. In relation to the current study, the emphasis that symbolic interactionism places on the shared construction of meaning is particularly relevant in facilitating an understanding of the nature of the therapeutic relationship from the study participants’ perspective. In practice, this meant that during the interviews, I was able to learn about the perspectives and experiences that underpinned the patients’ meanings, rather than making my own assumptions about what they meant. This contributed to a rich and deep account of what participants were (or were not) saying, which could then be compared to what other participants had said in previous and subsequent interviews.

Constructivist grounded theory views grounded theory methods as a set of principles and practices, not as prescriptions (Charmaz, 2006). Flexible guidelines are

emphasised, rather than methodological rules and requirements. Glaser (2002), in his response to Charmaz and her version of constructivist grounded theory, argued that constructivist data, if it exists at all, is a small part of the data that grounded theory uses. However, Charmaz (2006) contends that it is possible to use the basic grounded theory guidelines that were originally developed almost four decades ago, and combine them with the methodological assumptions and approaches of the twenty-first century. This approach is supported by Bryant (2002) and Clarke (2003: 2005).

Consequently, I determined that there was no requirement to mix the different schools of grounded theory, since the use of constructivist grounded theory allows the researcher to use the structure of the Straussian version, whilst maintaining the additional flexibility of a constructivist approach. Strauss and Corbin (1998) have specifically warned the researcher against rigidly following set procedures, and this warning added to my resolution to use constructivist grounded theory as the basis for my research. The structured approach proposed by Strauss and Corbin (1998) also allows for flexibility and creativity; thus, the Strauss and Corbin's structure was used to frame the analysis phase of this study whilst maintaining a constructivist mindset for theory development.

The ontological and epistemological assumptions discussed earlier in this chapter, and how these assumptions assisted in selecting constructivist grounded theory as the methodology utilised in this study, have been described above. Consideration of such assumptions led to the determination that the nature of the patient–physiotherapist therapeutic relationship could be best explored through the use of a constructivist approach. To explore the basis of the therapeutic relationship, I believed that it was necessary to understand how the participants constructed their own understandings and perceptions of the nature of the therapeutic relationship between patient and physiotherapist.

Figure 4.2 represents this interpretation of the Constructivist Grounded Theory position as conceptualised for this research. Focusing on discovering the underlying basic social process, developing understanding of mutual realities, and emphasis on inter-relationships.

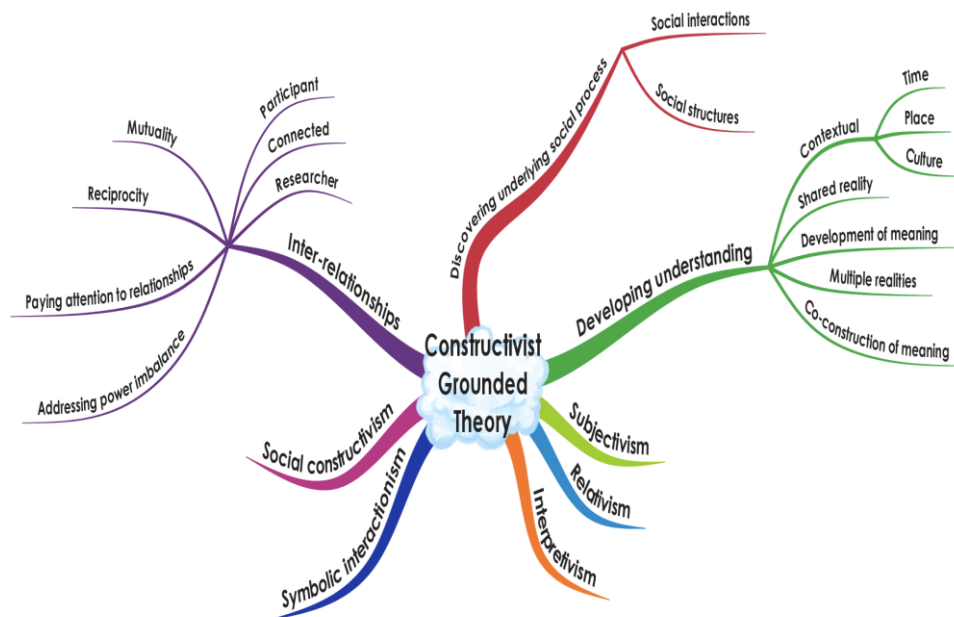


Figure 4.2: Constructivist Grounded Theory (Gardner et al., 2010)

4.6.2 Constructing Grounded Theory

While Glaser, Strauss and Charmaz vary in their underlying philosophical approaches to grounded theory and the actual methods used to develop the theory, they do agree on the purpose of the approach. In using grounded theory, the researcher inductively develops theory from interpreting the data generated by a study of the phenomena that the theory represents (Glaser & Strauss, 1967); hence, the theory is ‘grounded’ in data. The resultant theory is usually substantive, in that it has relevance to the substantive area from which the data was collected. A substantive theory is modifiable, whereas more formal theories are less specific to a group and place, and therefore have wider application for disciplinary concerns and problems (Strauss & Corbin, 1998). The purpose of substantive theory is to “predict, explain and interpret [a] phenomenon” (Baker, Norton, Young & Ward, 1998: p.548). This study was aimed at developing a substantive theory that is relevant to the contextual boundaries of the research question.

The researcher moves between generating categories from the data (induction) and

considering how these categories fit with other data (deduction). The importance of induction and deduction in the development of a grounded theory is explicated by Glaser and Strauss (1967), Glaser (1978: 1998), Strauss (1987), Strauss and Corbin (1998) and Charmaz (2006); however, the role of abduction is not addressed by these authors in any significant detail. In discussing the work of Pierce, a pragmatist sociologist, one researcher explains abduction as “the philosophical background to the processes that are involved in grounded theory.” And unlike induction, abduction “makes imaginative leaps ... to general theory without having completely empirically demonstrated all the required steps” (Ezzy, 2002: p.14).

The induction, deduction and abduction processes are structured through the execution of the core elements of the grounded theory method. Texts written by the grounded theory method’s originators, Glaser and Strauss—both separately and as co-authors—describe the core elements of grounded theory to be: coding, memoing, constant comparative method of analysis, theoretical sampling, and theoretical sensitivity (Glaser & Strauss, 1967; Glaser, 1978: 1992: 1998; Strauss, 1987; Strauss & Corbin, 1990: 1998). These core elements are discussed in detail in Chapter Five.

4.7 The Grounded Theory Debate and its Relation to this Research

As much as the value of grounded theory has been recognised, so have its limitations. Methodological and philosophical aspects of grounded theory have come up against harsh criticism. Much of the criticism levelled at grounded theory centres on the role of the researcher and the assumptions grounded theory makes regarding cognition and knowledge. Numerous authors have pointed to the positivist leanings suggested in the early works of Glaser and Strauss (Charmaz, 2000; Bryant, 2002a; Bryant, 2003; Charmaz, 2006). Bryant in particular (Bryant, 2002a: 2002b: 2003), has been strongly critical of the early grounded theory writings of Glaser and Strauss (Glaser and Strauss, 1967) and the later works of Corbin and Strauss (Corbin and Strauss, 1990; Strauss and Corbin, 1994). One issue which is frequently seen as problematic by researchers using grounded theory is the treatment of the literature. The original grounded theory (Glaser and Strauss, 1967), and later works by Glaser (1978: 1992), advocated being ‘theoretically sensitive’, by not entering the field with a priori knowledge, and not committing oneself exclusively to a specific

preconceived theory (Glaser and Strauss, 1967). Bryant strongly argues against the notion that the researcher's previous ideas and knowledge can be "turned on and off like a tap" (Bryant, 2003: p.3). Assuming that the theories, knowledge and experiences of the observer can be put aside to maintain theoretical sensitivity, this would place the researcher in a "totally neutral position" as a "dispassionate, passive observer" (Bryant, 2003: p.3). However, I agree with other authors that the literature review at the beginning of the research needs to be minimal so as to enable the researcher to orientate themselves in the research field and identify and justify the research questions and aims (Birks and Mills, 2011). I also concur with the notion that during the later stages of data analysis and theory development, steeping oneself in the literature and associated ideas may "sharpen' the researcher's nose" so that they will understand what the theory is about (Urquhart, 2002: p.49) without forcing the literature on the developing theory (Glaser, 2008).

My decision as to when and how to consult the extant literature was based on the regulations and expectations of the PhD programme on which I was enrolled, together with my own personal view. I was required to consult the literature early on in the research process, and during the development of a 'Research Plan Approval' document I had to outline the nature of the research area and justify the necessity for the study and its potential contribution to the therapeutic relationship. This involved finding out what research had been carried out in physiotherapy and other healthcare professions. Later on in the study, during the data analysis phase, specific literature was selected and consulted, in order to theoretically sensitise myself to concepts developing from the analysis.

An additional feature of grounded theory which is debated throughout the literature is the notion of theoretical saturation (Glaser and Strauss, 1967). Glaser and Strauss used this term to describe the point in the research process where no additional data are being found which provides new theoretical insights. Considering the constructivist approach to grounded theory taken in this research, the term theoretical sufficiency, as offered by Dey (1999) and Charmaz (2006), fits better with the subjectivist epistemological position that this study assumes, as data serves to suggest categories rather than saturate them. Consistent with a subjectivist epistemology, aiming for theoretically sufficient categories meant I remained open

to the multiple interpretations and meanings of data, and was less likely to prematurely close “analytical possibilities” (Charmaz, 2006: p.115).

In summary, at the commencement of the research study, I familiarised myself with the three major schools of grounded theory (Glaserian, Pragmatist and Constructivist), and the merits and criticisms of each. As a result, I found Glaser’s positivist interpretation of grounded theory (Glaser, 1978: 1992) to be untenable given my interpretivist philosophical perspective (Section 4.4). Glaser’s notion of theory emerging from data analysis (by way of a detached researcher/observer) was inconsistent with my view, that there were multiple truths and that realities were constructed and interpreted through and active an interactive process (Crotty, 1998). The strong pragmatist and symbolic interactionist leanings of Strauss and Corbin’s grounded theory approach (Strauss and Corbin, 1990; Strauss and Corbin, 1994), in particular their later writings (Corbin and Strauss, 2008), appeared to have congruency with my relativist and subjectivist positions. However, I found Strauss and Corbin’s approach to be overly focused on the methods of analysis and coding, and that their version of grounded theory was complicated, prescriptive and disengaging, although I did find some limited use in employing aspects of Strauss and Corbin’s (1990) ‘coding paradigm’ as an analytical tool during data analysis (discussed later in Section 5.9.4). Finally, I considered that Charmaz’s constructivist interpretation of grounded theory (Charmaz, 2000: 2006) was congruent with both my personal and the theoretical perspectives. This approach to grounded theory enables me to acknowledge the active role I played in constructing data and subsequently the substantive theory. The next section further details the rationale for selecting constructivist grounded theory research for this study.

4.8 Rationale for Selecting Constructivist Grounded Theory

Kathy Charmaz’s constructivist approach to grounded theory has been a major redefining of grounded theory, occurring as a consequence of the philosophical issues directed at the earlier versions. Charmaz’s contemporary approach to grounded theory aims to be more congruent with epistemological methodological developments over the past two decades (Charmaz, 2000: 2006), and is the grounded theory approach taken in this research. Charmaz distinguishes between two different

approaches to grounded theory; ‘constructivist’ and ‘objectivist’ (Charmaz, 2000: 2006), and argues that the ‘traditional’ approaches, labelled ‘Glaserian’ or ‘Classic’ grounded theory, fall into the objectivist grounded theory category.

The major differences between constructivist and objectivist versions of grounded theory are summarised in Table 4.1 below.

Version of grounded theory	Constructivist grounded theory (Annells 1996; Charmaz 2000; Clarke 2005; Charmaz 2006; Mills et al. 2006; Bryant and Charmaz 2007; Mills et al. 2007; Birks and Mills 2011)	Objectivist grounded theory (Glaser and Strauss 1967; Glaser 1978, 1992)
Research paradigm	Interpretive	Positivist/post positivist
Role of the researcher	Interactive, participatory and Reflexive	Passive, objective and Detached
Analysis	Theory is there to be discovered and represents the facts of a real and external reality	Codes, categories and patterns passively emerge from the data
View of theory	Theory is constructed and represents a re-construction of multiple realities	Theory is there to be discovered and represents the facts of a real and external reality

Table 4.1 Major differences between constructivist and objectivist grounded theory

According to Charmaz, objectivist grounded theory “accepts the positivistic assumption of an external world that can be described, analysed, explained and predicted” (Charmaz, 2000: p.254). To take this objectivist approach to grounded theory would mean I would need to ‘get inside the heads of my participants and attempt to be as accurate, unobtrusive and detached as possible in order to know the truth of what the study participants meant during interviews’. Taking an objectivist

approach to grounded theory would be inadequate given my own subjectivist epistemology and personal view that therapeutic relationship is complex and involves multiple socially interactive processes.

In contrast, constructivist grounded theory recognises that the researcher co-creates the data and ensuing analysis through an interactive process, resulting in an “interpretative portrayal” (Charmaz, 2006: p.10). In adopting a constructivist approach to grounded theory, I could explore different meanings and views of therapeutic relationship raised by participants, and I took the view that data did not provide a “window on reality” (Charmaz, 2000: p.523).

In relation to this study, constructivist grounded theory offered a flexible research approach that would facilitate the development of a substantive theory concerning the nature of the patient-physiotherapist therapeutic relationship, which would account for the multiple views, perceptions and understandings of the research participants. Furthermore, in taking a constructivist approach to grounded theory it is acknowledged that the theory generated from this research cannot be taken to be a ‘once-and-for-all’ explanatory model of patient-physiotherapist therapeutic relationship, but rather the findings are situated in time and culture (Burr, 2003), meaning that alternate theories could be created from my data.

In summary, constructivist grounded theory, situated in the interpretive research paradigm, has been discussed in this section. Recognising the core assumptions, operating principles and the major developments of the method through time, allowed me to appreciate the strengths and limitations of grounded theory. Moreover, understanding the key differences and similarities between different interpretations of the grounded theory method enabled me to make an informed choice as to the most suitable variation to utilise in my research study.

4.9 Insider Research

As a clinical physiotherapist investigating the patient-physiotherapist therapeutic relationship, I can be said to be an ‘insider’ engaging and relating to information within a community of which I am a member (Brannick and Coghlan, 2007). While

I am an insider to my own knowledge of therapeutic relationships that I use with my own patients, I am at the same time an outsider to the truths and perceptions of other participants of the therapeutic relationships, with the majority of whom I have never met, and have no prior relationship. The insider-outsider position or practitioner-researcher position has both advantages and disadvantages (Brannick and Coghlan, 2007; Jarvis, 1999; Morse, 2010; Robson, 2002; Shah, 2004) and these are discussed below in relation to this research study.

As an insider I entered the field lacking naivety, and the familiarity of aspects of the topic challenged me to 'step outside' so that I could explore the meaning of what was said and not take for granted routines, terminology and practices which needed to be questioned and explored. My position as an insider and my very limited experience in qualitative research meant I initially found it difficult to 'make the familiar strange', to be able to view the data with 'fresh eyes'. This was especially apparent during my first interview with a physiotherapist participant, who was a senior clinical physiotherapist and very experienced practitioner. During the interview I thought I was too agreeable and failed to chase up her terms and phrases, and I assumed meaning of what was said. Soon after this interview, I met with one of my supervisors (Dr Nikki Petty) who had attended this interview with me during her visit to Saudi Arabia as part of the data collection observation and had her feedback. Then, I further practised my interviewing approach and gained valuable feedback from other researchers. As a result, I was more confident in myself as a researcher, and felt more able to ask seemingly obvious questions, and not worry how trivial they might appear to the participant. This process helped to take me further down the 'road of researcher' and away from the 'path of practitioner'.

My changing sense of who I was, was further facilitated by keeping a reflexive journal, which allowed me to question my assumptions and explore my values, and any aspects of the data that appeared 'obvious'. Furthermore, the fact that data collection and analysis were occurring in tandem, and the use of the constant comparative method of analysis, meant that I actively questioned the data and compared stories and incidents which were both similar and different (Labaree, 2002). This process moved me on analytically, and further facilitated the shift from practitioner to researcher.

The reflexive journal allowed me to be introspective and reflexive on my underlying assumptions and ‘preunderstanding’, and facilitated a level of self-ignorance and ‘defamiliarisation’. In addition, during supervisory meetings my supervisors, questioned and probed at my developing concepts and categories, and their outsider perspectives helped draw me over and above the data. This process of reflexive awareness (Brannick and Coghlan, 2007) enabled me to take on new perspectives, and kept me focussed on eliciting what participants meant during their interview. In taking a constructivist approach to interviewing, I recognised that the data generated during the interview was a co-constructed report which was both situational and contextual rather than a ‘truth’ that I was able to know (Mills et al., 2006). Exploring participants’ words, situations and events, allowed me to have a ‘textured’ and rich understanding of what was said (Charmaz, 2006). Furthermore, inviting participants for a second interview enabled me to follow up concepts which were discussed during the first interview, and further explore the meaning of what participants said. In addition, practising my interview technique and interview schedule with physiotherapist friends who were not involved in the study, allowed me to reflect on my interview style to ensure that I took an inquiring but not challenging approach to interviewing participants.

4.10 Ethical Considerations of this Research

This study was guided by five ethical principles: (1) respect for human dignity, (2) respect for free and informed consent, (3) respect for privacy and confidentiality, (4) respect for justice and inclusiveness, and (5) balancing harm and benefits (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, 1998, with 2000, 2002, and 2005 amendments). The ongoing process of free and informed consent ensured that prospective subjects were given adequate opportunity to discuss and contemplate their participation and assurance that they were free not to participate and had the right to withdraw at any time without penalty (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada, *Tri-*

Council Policy Statement: Ethical Conduct for Research Involving Humans, 1998, with 2000, 2002, and 2005 amendments). Participants were informed of their rights as a study participant, including potential harm and benefits of participating in the study. Participants were informed that they could decline to answer any of the questions during the interview, and that they were free to ask questions about the study at any time. Written informed consent was obtained from all study participants.

Due to the depth of discussion, qualitative interviews can provoke distressing memories (Holloway and Wheeler, 2002) and, although I did not expect that participants would become upset or distressed during interviews, it remained a possibility. I was especially aware that the interview questions had the potential to cause some embarrassment and emotional distress, especially if physiotherapist participants recalled past incidents, which may be distressing to them and perceived that their views, beliefs of the therapeutic relationships between them and patients and their approaches to practice were being critically judged. Before each interview, it was emphasized to all participants that they were the experts of their own practice, practical applications and focus of interaction, and that my role as a researcher was to 'explore and capture' rather than 'criticize and evaluate' their practice and therapeutic practical application (Unsworth, 2008). **In the case of unprofessional or safety issues, disclosure of poor practice, negligence or harm emerge from the interview, I (the researcher) would then be required to break confidentiality and would have to discuss how to address the issue with my supervisors before passing the information to the appropriate authority. This has not been recorded, since none of the physiotherapist participants showed any sign for the need for disclosure of poor practice.**

Furthermore, all participants were informed that if, for any reason, they became upset, anxious or distressed during the interviews, the interview would be paused, and they would be asked if they wanted to continue. In order to ensure that I placed the participants' welfare ahead of my aim of generating research data, I had to make appropriate preparations should such situations arise, and this included being prepared to do follow-up interviews with a 'well-being' phone call to participants or directing them to counselling services via their general practitioner. However, none

of the participants showed any signs of distress during the interview process and no follow-up phone calls were necessary.

A variety of strategies, as defined in the Research Ethics Application, were applied to the research process, so as to ensure that all necessary ethical considerations were considered and incorporated into the research design. This section describes the actions taken to ensure that ethical requirements for this study were met in relation to: ethics approval from the University of Brighton, informed consent and confidentiality/anonymity and dissemination of results.

4.10.1 Ethical approval

Ethical approval was first obtained from the Joint Sub-Committee of the University of Brighton and the Faculty of Health & Social Science Research Ethics and Governance Committee (FREGC) (See Appendix 1). Approval was then obtained from the Institutional review board (IRB) of the King Fahad Medical City (KFMC) and King Faisal Specialist Hospital and Research Centre (KFSH&RC) in which the study was conducted (See Appendix 2).

4.10.2 Confidentiality and Anonymity

Confidentiality of the potential participants, their unique identifying information, and their data was maintained by incorporating the following steps:

- 1) Assigning a research pseudonym to each of the participants. Participants were referred to with arbitrary variables e.g. Pt1, Pt2, for physiotherapists and Pa1, Pa2, for patients.
- 2) Ensuring all hand-written consent forms were secured in a private and locked location.
- 3) Interviews were conducted in a mutually agreed upon location, thus ensuring privacy protection for the participant.
- 4) Audio-taped recordings and hard-copy documents requiring participant

identification reflected only the participant's research pseudonym and were stored in the password protected electronic data-base and locked file drawer, accessible only to me as the principal investigator.

5) Upon completion of the research, audiotapes and back-up discs will be destroyed and paper data will be shredded. Only the electronic data will be maintained and accessible by unique authentication through password protection using the principal investigator's laptop device. This data store will be accessed for the purposes of future submissions of this study for publication.

4.11 Trustworthiness of the Study

The application of the term 'rigour' in qualitative research is much debated (Morse et al., 2002; Sandelowski, 1986: 1993; Rolfe, 2006). Some consider that 'rigorous' qualitative research simply means that the research is reliable and valid, and that therefore the criteria should apply to all types of research regardless of methodology (Davies and Dodd, 2002). In support of this view, Morse and colleagues argue in favour of reliable and valid qualitative research, and that while the notion of rigour has a quantitative bias, they consider the concepts of reliability and validity as "overarching constructs" which can be appropriately used in "all scientific paradigms" (Morse et al., 2002: p.19). Others contend that strongly implementing criteria for rigour will stifle the creativity of qualitative research. For example, Whittemore et al. (2001) argues that while there is tension between rigour and creativity, "some kind of validity criteria and some methodological or technical procedures are essential to guard against the investigator's conjuring up concepts and theories that do not authentically represent the phenomenon of concern" (Whittemore et al., 2001: p.526). These views illustrate the fine balance between rigour and creativity.

With regard to this research, the originators of grounded theory developed their own criteria to assess the quality of a grounded theory study (Glaser and Strauss, 1967). However, the positivistic assumptions of the traditional grounded theory mean that these criteria do not lend themselves to the constructivist approach taken in this study. More suitable to this interpretive research is the concept of 'trustworthiness',

which Rolfe (2006) argues moves the responsibility for judging the quality of the research from the producer to the reader. Trustworthiness encompasses ‘credibility’, ‘transferability’, ‘dependability’ and ‘confirmability’ which are used to replace the criteria of rigour in the positivist paradigm of internal and external validity, reliability and objectivity (Lincoln and Guba, 1985). Each of the criteria of trustworthiness are discussed in relation to this research below.

4.11.1 Credibility

The criterion of credibility aims to provide confidence that the research has obtained an appropriate interpretation of the meaning of the data which reflects the experience and views of participants (Whittemore et al., 2001). In this study several efforts were made to ensure the credibility of the research data. A prolonged engagement with the data and repeated interactions and interviews with participants contribute to the credibility of this research (Lincoln and Guba, 1985). A prolonged engagement is the investment of adequate time to achieve the research purposes of learning about the phenomena of interest. It includes building rapport, learning the culture, and testing for misinformation. Throughout the research process I practiced as a physiotherapist working in a musculoskeletal outpatient setting and immersed myself within the field of patient-physiotherapist relationships. This insider position provided opportunities for me to informally verify, test and check my theoretical insights as they developed during data analysis. During data collection, I actively sought to develop a trustful researcher-participant relationship, which facilitated the sharing of participants’ rich details of the nature of the patient-physiotherapist therapeutic relationship, which I could explore further through questioning.

The generated theoretical construction should be checked against the participants’ meanings of the phenomenon (Chiovitti & Piran, 2003). Some authors have questioned the value of this type of verification in grounded theory research, arguing that checking the emerging theory is an integral part of a constant comparative method (Elliot & Lazenbatt, 2005), with Glaser & Strauss (1967) insisting that the grounded theorist should focus on generating, rather than verifying, theory. However, verifying my theory with the participants themselves was considered particularly important in view of the constructivist approach to grounded theory

adopted in this study (Mills et al., 2006). Thus, since I wanted to ensure that participants are involved in the different stages of the present research project, I considered it crucial to seek consensual validity by taking the findings of the study and their interpretation back to the participants to enable them to confirm and refute the emerging theory, as recommended by Benton (1996). Dick (2007) partly contests the involvement of participants in the interpretation of data due to their views being mostly local (emic) rather than generalized (etic); however, since this study aimed at generating a substantive (rather than a formal) theory, I perceived that such (admittedly 'local') views were important to gauge. The adopted approach also concurs with the notion of "phenomenon recognition" as a means of enhancing the credibility of the emerging theory (Schatzman & Strauss, 1973, p. 135).

To ensure that the substantive theory emerging from the study actually reflected the participants' views and experiences (rather than my own) the participants were involved in member checking, thereby ascertaining that they "recognized" the main concepts presented in the substantive theory and their relevance to their therapeutic relationship with patients (Schatzman & Strauss, 1973, p. 135). A process of member-checking was done once the interviews had been fully transcribed.

The purpose of member check interviews was to obtain feedback on my analysis thus far in terms of accuracy of interpretation and to seek physiotherapist participants' reactions to the findings. Additionally, it was to address the theory by determining how well the findings (abstract interpretations) resonated with physiotherapists' perceptions, expectations and experiences of therapeutic relationships between them and patients.

The member check provided the opportunity to clarify concepts, refine categories and to begin to develop tentative relationships among categories. For example, following up on a conceptual lead, physiotherapists were asked to clarify professional roles that were reconstructed from their views and beliefs of the therapeutic relationships between them and patients as treaters, teachers or person-centred and their expectations for the relationship.

Two physiotherapist participants (participant 7 and 9) were asked to read through the interview transcript to confirm that it represented an accurate account of what

was said, and they took the opportunity to add further comments that they perceived necessary.

I was fascinated by the idea that patients sometimes do not know why they were visiting a physiotherapist. To visit a physiotherapist and not know why you were attending seems unthinkable. A later interview with Pt 7 clarified this for me as she shared her experiences of trying to understand the patient's expectations, ***“It’s difficult to know because you often do get people who have things that the medical professions given up on completely”***, reflecting unexplained symptoms. Therefore, the whole physiotherapy process of a relationship with the patient (communicating) and of exploring their symptoms is a process that is designed for understanding the sometimes hidden nature of the underlying root cause of the patient's physical symptoms. Having assessed a patient's expectations, the physiotherapists may then have to proceed to managing those expectations.

As Pt 9 described, some patients attend with very high or unrealistic expectations ***“their expectations are too big to fulfil”, “I think a lot of people have too much expectation”***. Managing these expectations involves educating the patient in the physiotherapy process. She said, ***“I manage their expectation by going through the process and explaining to them...”*** There is an expectation of service provision within this relational model whereby female patients place physiotherapists on a similar level to providers offering more minor services (e.g., masseur, fitness instructor, etc.).

The diversity of the physiotherapists yielded the articulation of three specific types of identity that were derived from the physiotherapists' beliefs about: (1) the transference of professional/expert knowledge; (2) the clinical management of the musculoskeletal condition; and (3) the interpersonal nature of physiotherapy practice. The teacher, the treater and the person-centred practitioner were the professional identities that developed from the declaration of these views. The analysis also revealed that professional identities greatly influenced the physiotherapists' expectations with teachers expecting a professional relationship, treaters expecting a clinical relationship and person-centred practitioners expecting a personal relationship.

Physiotherapists were asked how well the study findings resonated or reflected their experiences of therapeutic relationships, and whether anything seemed inconsistent with their experiences. The two interviews were audio-recorded with physiotherapists' consent. These interviews ranged in length from 30-40 minutes.

During supervisory meetings, critical feedback on my interpretations of selected passages provided guidance and searching questions to help refine the analysis and developing theory. While it has been argued that research supervisors do not provide a dispassionate examination of the study (Holloway, 1997), their knowledge of qualitative research, combined with their substantial clinical experience added to the credibility of the research.

Qualitative researchers should disclose their assumptions, biases and beliefs, and how they may have shaped the research findings (Creswell and Miller, 2000). From the time of commencing the PhD study, and throughout the data collection and analysis period, I maintained a reflexive diary, and wrote field notes and memos. These methods of reflexivity enabled me to put in writing any feelings or thoughts that arose and to document any occurrences during the course of the study. Making my presuppositions explicit in this way, meant I could test out and check any assumptions and analytical thoughts I had, with the data (Cutcliffe, 2003).

To improve the depth of the evidence, I sought to underpin a grounded theory, so different healthcare provision environments were included in the study. The use of multiple data collection sites increased the researcher's exposure to different physiotherapists and patients.

4.11.2 Transferability

Transferability is the extent to which the ideas generated may be applied to other populations or situations, and may be considered the theoretical generalisability of the findings (Bryman, 2008b). During interviews, one of my objectives was to obtain what are known as "thick descriptions"; that is, data which is "deep, dense and detailed" (Denzin, 1989: p.83). Furthermore, in Chapter 6, the findings are presented as rich, detailed and contextualised accounts of participants' views and perceptions of the nature of therapeutic relationship between them. Providing such

rich descriptions will allow the reader to judge whether theoretical concepts of the research findings might be transferable to other people in other settings, while also evaluating the quality of the research. For example, the extent to which the findings of this research study are transferable to Middle Eastern female patients and physiotherapists can be judged by the reader.

4.11.3 Dependability and Confirmability

Dependability refers to the extent to which the reader can evaluate how the findings of the study were achieved and the degree of consistency of the researcher's data analysis and decision-making processes (Holloway and Wheeler, 2010). Confirmability refers to the degree to which the findings relate to the data and offer a faithful interpretation of the view held by the participants, and are not a reproduction of the views, assumptions and beliefs of the researcher (Lincoln and Guba, 1985). An audit trail (Lincoln and Guba, 1985) increased the dependability and confirmability of the study, so that readers can follow and judge the research process. In this study, the audit trail consisted of records from all phases of the research processes and documented how the theory was constructed from the data. By detailing the methods used to collect, handle and analyse data, and the process used to construct the explanatory theory, it serves as an audit trail to enhance the dependability and confirmability of this study. The writing of memos, interview transcripts, interview notes, interview guides and regular logs into a research diary all provided a 'trail of evidence', documenting each stage of the inquiry process. Moreover, interview techniques, critical self-reflection and feedback from supervisors, in conjunction with a reflexive research diary have attempted to increase my proficiency in data collection and analysis, and in doing so have contributed to the quality of this research. In the chapter descriptions of examples of data collection and analysis are provided, which serve as part of the audit trail of the procedures and processes carried out in this research.

4.12 Data Analysis

Data analysis is reliant on the researcher's analytical skills and creativity so that the

meaning and the interconnections in the data can be interpreted in order to develop a theory (Strauss & Corbin, 1998). While this study generally utilised the procedure described by Strauss & Corbin (1998) for analysis of the data, the procedural steps were not rigidly adhered to. Charmaz's (2006) explication of the procedures of data analysis provided valuable guidance in the data analysis. The Conditional Relationship Guide and the Reflective Coding Matrix proposed by Scott (2004) provided a useful analytical tool, which also provided further advancement to the conditional/consequential matrix proposed by Strauss & Corbin (1998).

An overview of the analytical steps taken in this study is explained below. Specific examples of these steps and processes are provided in methods chapter Section 5.9. The major analytical processes used in this study were:

- Coding
 - Line-by-line coding, in-vivo codes, action codes, focussed coding, axial coding, selective coding
- The constant comparative method of analysis
- Memo-writing

4.12.1 Open Coding

Open coding is the analytic process through which labels are assigned to data for the purpose of identifying categories, their properties and dimensions. Initial coding remained close to the data (Charmaz, 2006) and where possible in vivo codes were used. Open coding was used as transcripts were re-read whilst listening to the audio recording of the interviews. This fractured data into sections for closer scrutiny and subsequently, the assignment of a label (Charmaz, 2005: 2006; Strauss & Corbin, 1998). The labelling of data is synonymous with the creation of a code. These labels often consisted of a participant's actual words (in vivo code). On other occasions however, the labels consisted of alternative words which reflected understanding of the data, for example, covert approach. As such, in the initial coding, the labels were generally descriptive with some being the actual words used by the participants.

Whilst keeping the research question in mind, as many interpretations as possible

were made of the data (Charmaz, 2005: 2006; Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990: 1998). Initially, this was done by asking, what does this mean? or what is going on here? This sometimes meant that the same section of text was assigned more than one code. At times, a question was asked regarding the participant's entire response whilst at other times the focus was only on two or three words within a response. Impressions and questions about codes were documented in memos throughout the analysis process.

The transcripts were initially coded manually. These codes were then transferred to a computer file using Microsoft Word 2003®. Coding the transcripts by hand was advantageous as it facilitated microanalysis and allowed more of the data to be seen and codes to be assigned simultaneously. This resulted in a more consistent assignment of codes. Line by line analysis allowed for careful comparison of new data with what was already coded (Glaser, 1978). A code label was assigned to incidents, events, actions, or objects in the data, which were understood as indicators of a particular phenomenon (Strauss & Corbin, 1998). These concepts were analysed for common themes. They were then grouped together according to these themes and assigned a higher order label (Corbin & Strauss, 1990). Grouping concepts together under a higher order label marked the commencement of category development (Strauss & Corbin, 1998). Through a comparison of the code labels, it was also possible to identify the properties and their dimensions. Properties were "attributes of a category" and "dimensions represent the location of a property along a continuum" (Strauss & Corbin, 1998: p.117).

4.12.1.1 Focussed Coding

Charmaz (2006) identifies focussed coding as being the second major phase in the coding process. Focussed codes are more directed, selective and conceptual than the initial word by word and line by line coding (Glaser, 1978). Focussed coding was used to capture, synthesise and understand the main themes in a participant statement. The assigned codes remained active and close to the data, thus allowing for movement across interviews and comparison of the experiences, actions and interpretations of the participants.

4.12.1.2 Axial Coding

Axial coding, the process of “reassembling data that were fractured [and labelled] during open coding” (Strauss & Corbin, 1998: p.124), was performed alternately with open coding (Glaser, 1978; Strauss & Corbin, 1990; 1998). Axial coding was commenced after analysis of the first ten participant interviews (five physiotherapists and five patients) proposed certain categories. The identification of these through the open coding process is essential for the process of axial coding to begin, because the development of categories and relational statements revolves “around the axis of a category” (Strauss & Corbin, 1998: p.125). In this study, axial coding involved the use of Scott’s (2004) Conditional Relationship Guide to assist in the development of the subcategories, thus answering Strauss & Corbin’s (1998: p.125) “when, where, why, who, how and with what consequences” questions regarding a category.

A major point of departure between Glaser, and Strauss and Corbin in their understanding of axial coding relates to its exact nature. Glaser (1978) calls this activity theoretical coding, and like Strauss & Corbin (1990: 1998), recommends that this activity be undertaken alternately with open coding. Glaser (1992) argues that theoretical codes precluded the need for axial coding because theoretical codes “weave the fractured story back together” (Glaser, 1978: p.72). As such, Glaser did not agree with the coding paradigm proposed by Strauss & Corbin (1990: 1998). Strauss & Corbin’s (1990: 1998) coding paradigm is a guiding framework which allows processes, as well as structures, to be considered in relation to the context of the social phenomenon being studied. Identifying structures and processes in turn allows for an exploration of why certain events happen and how they happen (Strauss & Corbin, 1998).

Using the Conditional Relationship Guide as an aid to locate the scope of the study, only those conditions which emerged from the data were identified. Strauss & Corbin (1998) warned against using the proposed axial coding matrix as a prescription for the conditions and consequences to be identified. Using the coding paradigm amounts to preconception in Glaser’s (1992) view, in that it predetermines the theoretical codes to be used. Glaser’s preference is for the theoretical codes to emerge.

Axial coding provides a framework which can be applied by the researcher (Charmaz, 2006), and this framework may extend or limit the researcher's vision. The framework was used in this study to brighten the clarity of the links between the categories and their subcategories. Strauss and Corbin's approach to axial coding also facilitated an exploration of particular actions or strategies which were used by participants. Axial coding located the properties and dimensions on a continuum and, through this process, it became apparent that the participants were using strategies to form a therapeutic relationship between them.

4.12.1.3 Selective Coding

Selective coding is the "process of integrating and refining the theory" (Strauss & Corbin, 1998: p.143). It involves the identification of the core category or the major theme of the research from which the theory emerged (Strauss & Corbin, 1998). The core category is central, with all other categories subsequently becoming subcategories and frequently appearing in the data. In the case of this study, the core category appeared, to some extent, in all of the interviews. This allowed for a logical and consistent explanation of what was occurring. Indeed, it gave an insight into the nature of the patient-physiotherapist relationship in musculoskeletal outpatient settings by relating the sub-categories to the core category. Through the use of this approach, the basic theoretical scheme became apparent from the data.

4.12.2 Constant Comparative Analysis

Comparative analysis has been identified as an essential feature of the grounded theory methodology (Charmaz, 2006; Glazer, 1978; Strauss & Corbin, 1998). Throughout the analytic process, the constant comparative method was used to compare incidents with one another and to identify the similarities and differences in order to facilitate the development of concepts (Ezzy, 2002; Strauss & Corbin, 1998). Constant comparative analysis assisted in grouping concepts under higher order categories (Strauss & Corbin, 1998).

Through the use of constant comparative analysis, data earned its way into the study when the process revealed repeated patterns in the data (Chiovitti & Piran, 2003).

This technique allowed for a comparison of data against itself, against other data and also against conceptualisations (Duchscher & Morgan, 2004).

4.12.3 Memo Writing

Memo writing, as proposed by Charmaz (2006), is the pivotal intermediate step between data collection and the drafting of the theory. Memo writing in grounded theory is a crucial method as it prompts the researcher to analyse data and codes early in the research process (Charmaz, 2006; Glaser, 1978; Strauss & Corbin, 1990: 1998). Memos contain “products of analysis or directions for the analyst” (Strauss & Corbin, 1998: p.217). Writing of the memos began at the commencement of the study and continued until the completion of the chapters related to the findings. Memos were kept as notes to self and these notes provided a means of documenting thoughts related to the codes, the emergent categories, and the interaction of the categories as the study progressed. These notes were recorded when they occurred and took the form of both hand written and typed notes, depending on when these ideas surfaced.

The memos were useful as they allowed the researcher to identify leads to follow through theoretical sampling (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990: 1998). They were also useful in supervision meetings.

Strauss and Corbin (1998) expanded the original notion of grounded theory memoing by identifying various types of memo. Code notes, theoretical notes, operational notes and logical and integrative diagrams were all proposed in Strauss and Corbin’s expansion, with an expectation that these memos would be at the conceptual level, corresponding to the coding stage that they relate to. Charmaz (2006) indicated that the memos may be free and flowing, with Charmaz encouraging the researcher to write freely regarding the analysis that they are undertaking. This was the approach adopted in the present study as the researcher viewed the Strauss & Corbin (1998) approach to memoing as being too procedural and somewhat restrictive.

Coding analysis at each phase level is highlighted in Figure 4.3 overleaf.

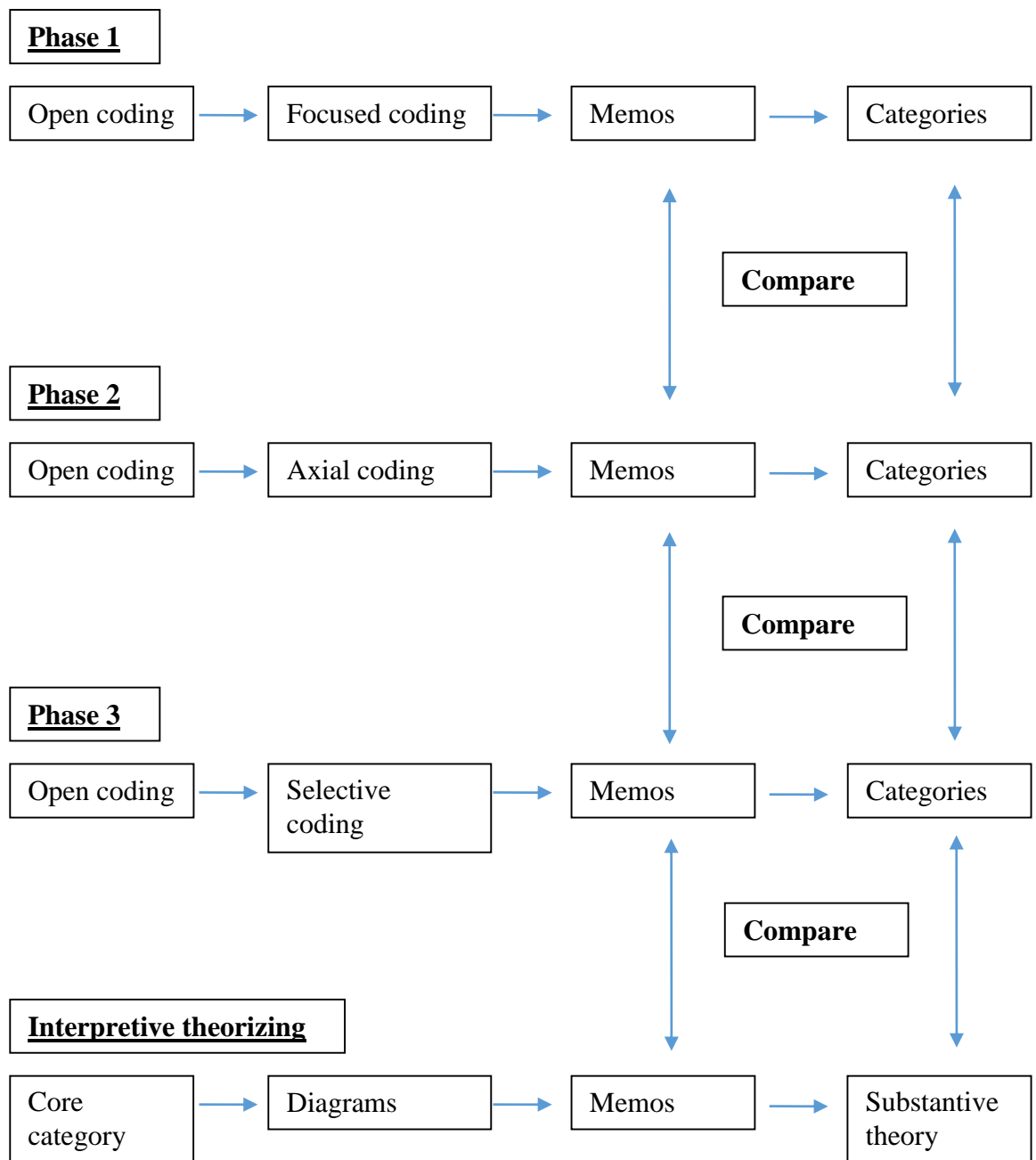


Figure 4.3 Coding analyses at each phase level

Open coding associated with a manual approach was done throughout and carried on in each phase of the study, which entailed line-by-line analysis, then

applying meaning units and in vivo codes to sections of text relevant to each transcript. After 10 interviews (five physiotherapists and five patients) **800 open codes emerged. The 800 codes were further reduced into 400 focussed codes**, which moved across all data within each phase and this condensed data provided an explanation of data. **Examples of open coding were: Trusting; respecting; listening; caring; understanding; openness; honesty; humanity; expectation; knowledge; culture; scheduling; responsibility; clarification, etc. Examples of focussed coding were: Educating; treating; personalising; engaging; participating; motivating; partnership; passivity; dependency; demanding, etc.**

Central to this was asking myself the reflexive questions cited by Charmaz (2006) (See section 5.9.4). This was to aid in reflexivity and brought to the surface any preconceptions I may have been applying or forcing on to the codes. Cluster and advanced memos were central to the constant comparative method. This was also enhanced through research supervision and self-reflection via my reflexivity journal. After this process, within each transcript, the literature was reviewed in relation to codes, which emerged to aid in constructing the categories developed in phase 1.

In phase 2, the same process was undertaken to obtain the open and axial coding, which informed the categories. Once again, memos were central to this process. Reflexivity was further incorporated within data collection in this phase by employing the process and action questions, as cited in Section 5.9.3 (Table 5.7) the interview guide for the next nine interviews (five physiotherapists and four patients). The follow-up interview aided in participant verification of meaning attached to the data.

Personal reflection was also incorporated into each of the interview transcripts. This was further challenged through discussion with my research supervisors. The categories and focussed coding from phase 1 were then compared with the **50 axial codes in phase 2, these were, for example: communicating through education; communicating through treatment; communicating through personalisation; role of patient; and focus of interaction**, which developed the main categories at the end of phase 2 with the aid of memos. Once again, the literature was utilized during the formation of the open and axial coding in phase 2.

All focussed and axial coding were also compared with each other until theoretical sufficiency was reached with advanced memos aiding in reaching this stage. This led to the development of categories in phase 2.

In the last phase, the process for coding was similar to ascertain the open and selective coding for phase 3. These were then compared with the main categories, focussed and axial coding from phase 1 and 2, which also incorporated the sorting of all memos over the course of my study, **such as: therapeutic professional roles; patient personas; expectations of the relationship; types of relationship and influencing factors. The selective coding and core category “negotiation”** were then verified through the theoretical sampling of three physiotherapist and three patient participants, who concurred with the categories, focussed and axial coding. If participants had not concurred with the categories and focussed coding, this would have indicated that data was not saturated and further sampling would have been undertaken. At this point, a further integrated selective literature review took place and a draft of initial findings was written.

Participants’ verbatim quotes were utilized and this is interwoven within the emerging theory and outlined in the findings chapters, as it was key that this was not rewritten, thus leading to the misrepresentation of the participants’ words.

4.13 Chapter Summary

The methodological decisions taken in this study have been discussed in this chapter. It discusses the choice of qualitative research in light of the research question and the field of therapeutic relationships. The chapter aims to explain and justify the decision to locate this research in the interpretivist paradigm, adopting a relativist ontology and subjectivist epistemology. The research methodology used is theory-generating constructivist grounded theory, of which the researcher is considered an insider to the phenomena under exploration. The measures taken to ensure that this study is trustworthy were also discussed. In the next chapter, the methods used to collect and analyse data and how these analytical processes led to the findings of this research study are detailed.

Chapter 5: Methods

5.1 Introduction

In this chapter, the methods used in this study to gather data and derive meaning from these data through analysis, in line with iterative nature of grounded theory research are discussed. By providing an explicit account of the methods employed in this study, to construct the substantive theory, this chapter serves as an audit trail, thereby increasing the dependability and confirmability of the study. The chapter begins by detailing the strategies used to access, recruit and sample participants for this research. Finally, the processes of data collection and analysis are presented in details.

5.2 Research Focus

Crotty (1998) pointed out that our research is normally driven by interest in a topic or area rather than the choice of methodology and theoretical assumptions. He also suggested that after choosing the research area we consider the method and then explore the methodology behind the method. The study was based on my interest in the nature of the therapeutic relationships, an account of my interest background was provided in the introductory chapter of the thesis. The overall aim of this study was: To explore the nature of the female patient-physiotherapist therapeutic relationship in Saudi Arabian musculoskeletal outpatient settings and to explore the expectations, attitudes and perceptions of physiotherapists and patients within the therapeutic relationship.

This study focussed on female patients and physiotherapists within musculoskeletal outpatient clinics in Saudi Arabia. The culture of the study setting requires that only female physiotherapists or researchers may have contact with female patients due to the unique cultural and religious framework in Saudi Arabia.

5.3 Research Context and Procedures

5.3.1 Selecting the Setting

King Faisal Specialist Hospital and Research Centre (KFSH&RC), and King Fahad Medical City (KFMC) were chosen as the sites for this study. These two organisations were deemed appropriate because they are large organisations which employ many physiotherapists, and have patients with differing educational and socioeconomic backgrounds. KFSH&RC is the biggest multi-entity tertiary care hospitals and one of the leading healthcare institutions in Saudi Arabia. It is located in Riyadh and has patients and physiotherapists from different cultural backgrounds. A high percentage of patients are either from the royal family, or from a high to middle socioeconomic class, with wealthy and highly educated backgrounds (<http://www.kfshrc.edu.sa>). KFMC is the largest medical complex in Saudi Arabia, and is located in Riyadh with mainly Saudis and Arabs employees. A high percentage of patients are Bedouins and from rural areas with varied educational backgrounds (<http://www.kfmc.med.sa>).

5.3.2 Selecting the Sample

This study employed two sampling approaches, which are considered as fundamental features of grounded theory research, namely purposive sampling and theoretical sampling (Charmaz, 2006). The nature of these sampling approaches and how they were used in this research is described in the following sections.

5.3.2.1 Purposive sampling

Purposive sampling may be defined as the “intentional selection of information-rich cases whose study will illuminate the central questions of the research” (Patton, 2002: p.230).

Purposive sampling was initially used to select physiotherapists who had satisfied the following criteria to be included in this study:

1) Were female, located in Riyadh, 2) Had maintained a minimum of two months working experience in musculoskeletal outpatient clinics, and 3) Spoke Arabic and/

or English.

Patients must have met the following criteria to be included in the study:

1) Were Arabic adult females located in Riyadh, 2) Had attended musculoskeletal therapy for at least one treatment session, and 3) Were able to give informed consent.

The main data collection phase took place between mid-February 2011 and the end of January 2012. A total of ten female musculoskeletal physiotherapists and nine female patients had expressed willingness to participate in the study and would be a starting point to explore their perspectives, experiences and understandings of the nature of the patient-physiotherapist therapeutic relationship.

5.3.2.2 Theoretical sampling

Theoretical sampling is the process of data collection whereby the researcher collects pertinent data to develop the evolving theory, and is considered as a key component of grounded theory research (Charmaz, 2006). After one interview with each of the ten physiotherapist and nine patient participants, theoretical sampling involved returning to three physiotherapist participants (Pt 1, 7, and 9), and three patient participants (Pa 3, 5, and 7). The purpose of this was to highlight key aspects of their perceptions of the nature of the patient-physiotherapist therapeutic relationship, to provide an opportunity to share with them and validate my developing interpretation of their experiences, and to explore specific areas that had been highlighted as significant during the interview discussions. In addition, I theoretically sampled these participants for a second interview to confirm and explore the core category whilst broadening the scope the developing theory (Cutcliffe, 2000).

5.4 Physiotherapist Recruitment

Because of my current position as a senior physiotherapist working in a musculoskeletal outpatient clinic at a referral hospital (KFSH&RC), my role required me to lead and manage interns and junior physiotherapists in their clinical

practice, and to report their performance to the outpatient supervisor. In order to reduce the risk of coercion in the research data gathered from physiotherapists, I recognised that some physiotherapists might possibly have felt compelled to volunteer for the study or participate so as to validate their roles at the hospital in relation to my own professional role. To alleviate this risk, I used education coordinators acting as research assistants at both institutional sites and at any time that I needed to recruit additional participants.

The recruiters in each of the two hospitals agreed to participate voluntarily and without monetary compensation. The recruiters I used for this study occupied the role of education coordinators and acted as research assistants; they both possessed extensive knowledge and skills associated with research ethics, and participant recruitment as a result of the position they had in their workplace. Musculoskeletal physiotherapists in both departments were informed about the study during an outpatient meeting during which the recruiter education coordinator in each hospital introduced the study and the purpose of participation. The recruiters in each hospital also communicated with the head of the physiotherapy department to inform them that, if there was a need for further information regarding this study, they were available to provide that information upon request. No further information sessions were required and potential participants self-identified via telephone, face-to-face or e-mail to the recruiters as directed.

An information sheet, a consent form and a stamped addressed envelope were delivered to a workplace mailbox belonging to female physiotherapists by the recruiters (See Appendix 3). The recruiter's contact information was also included in the information pack. When the potential participant read the information and determined that they were interested in participating in the study, they personally contacted the recruiter.

Physiotherapists who confirmed their interest in participating after the meeting, were recruited on signing a consent form. The recruiters then obtained their contact information and read to them the content of the letter of information about the study. A meeting was then mutually arranged between the recruiter and the physiotherapist participant to facilitate the consent process. This meeting enabled the potential

participants to ask any outstanding questions and exercise their option to sign the study consent form.

In all of the instances when the recruiters met with the potential physiotherapist participants face-to-face to review the letter of information, the participants expressed their willingness to participate and signed the consent form at that time. Once the consent was obtained from the participant, the recruiter notified me and provided their name and contact information. I contacted all participants who had given their consent using their preferred mode of contact (e-mail, face-to-face or by telephone) to schedule an interview.

All interviews were arranged between me personally and the participant; mutually agreed upon times and locations were confirmed with attention paid to the need to maintain confidentiality throughout the interview experience. When compiling the interview plan, consideration was also given to the physiotherapist participants' work schedule, location and time. In all instances, participants preferred to have interviews take place either before or after their workday when they would not have to confront patient care demands. All interviews occurred in a meeting room away from their clinical area location. Only the participant and I were present at the interviews. A total of ten female musculoskeletal physiotherapists, in which five physiotherapists from each hospital participated in the study.

5.5 Patient Recruitment

Patient recruitment for the study was dependent on support from the front desk receptionists in each hospital. A flyer was posted on the message board in the outpatient physiotherapy departmental waiting area in each hospital. There was visible information regarding the research study on the posters, with the principal investigator's name also stated (See Appendix 4). All current female patients with a musculoskeletal disorder who had at least one treatment session with a physiotherapist received an information pack containing an information sheet, consent form and a stamped addressed envelope (See Appendix 5). The poster and the information pack also contained the receptionist's contact information. This information facilitated the ability for potential participants to self-identify and

communicate directly with the receptionist. When the potential participant read the information and determined that they were interested in participating in the study, they would then personally contact the receptionist by referencing the contact information from the poster or the information pack.

As soon as five female patients from King Faisal Specialist Hospital and four female patients from King Fahad Medical City confirmed their interest to participate, the recruitment posters were removed from the message board locations. Once the potential participants identified themselves to the receptionist, she conducted a brief review of their criteria as outlined on the recruitment poster, in order to assess participants' suitability for the study. Patients who confirmed their interest to participate, were recruited on signing a consent form. The recruiters then obtained their contact information and read to them the content of the letter of information about the study. In all of the instances when the recruiters met with the potential patient participants face-to-face to review the letter of information, the participants expressed their willingness to participate and signed the consent form at that time. Once the consent was obtained from the participant, the recruiter notified me and provided their name and contact information. I personally contacted all patient participants who had given their consent using their preferred mode of contact (e-mail, face-to-face or by telephone) to schedule an interview.

All interviews were arranged between me personally and the patient participant; mutually agreed upon times and locations were confirmed with attention paid to the need to maintain confidentiality throughout the interview experience. Location and time were also incorporated into the interview plan. In all instances, patient participants preferred to have their interviews take place after their treatment session. All interviews occurred in a meeting room away from the clinical area locations. Only the participant and I were present during each interview.

5.6 Data Collection

Using grounded theory situated within the interpretive paradigm meant I had to enter the research participant's world and explore their personal meaning (Charmaz, 2006). Semi-structured interviews would seek to obtain detailed descriptions of the

experiences and perceptions of participants with “respect to interpreting the meaning of the described phenomenon” (Kvale, 2007: p.51). This style of interviewing would maintain an ‘openness’ and ‘flexibility’ to the interview, while still allowing to focus on the topic areas to be covered and the lines of inquiry to be pursued (Holloway and Wheeler, 2002). Charmaz considers that this type of “intensive” interviewing to fit especially well with a grounded theory approach, as it is “open-ended yet directed, shaped yet emergent, and paced yet flexible” (Charmaz 2006: p.28). During data collection, this form of interviewing facilitated me to further pursue and explore ideas and concepts that developed during the interview, meaning that the interview guide varied between participants and interviews. Examples of Interview guides are presented later in Section 5.9.

Interview Procedure

In accordance with Kvale (2007), each interview began with a briefing, in which I defined the topic under discussion and re-iterated to the participant the purpose of the interview and why they had been invited to participate. During the briefing I reminded the participant that the interview would be audio recorded, and that at any time they were free to stop the interview, without providing a reason. At the end of each interview, a period of approximately ten minutes was put aside so that participants could be debriefed (Kvale, 2007). The debriefing period provided an added moment of reflection for both the participant and the researcher, and it involved the participant being asked if they had anything more to say, and how they found the interview experience. The participants were further reminded that their interview recording would be fully transcribed, and that they were would be invited to add any further comments if they so wished.

During the debriefing period, participants’ were reminded that only I and the supervisory team would have access to the interview data. At the conclusion of the interview, participants were also asked of their wish and permission to be contacted via telephone, for further interviews (if necessary), and they were informed that the decision was entirely up to them and that they were under no obligation. Before commencing each subsequent interview, participants were again provided with an information sheet to read, and it was at this point that they gave written consent if they were happy to participate.

The interview questions needed to get behind and underneath the therapeutic relationship of participants, and explore the assumed meanings of what was said (Charmaz, 2006). During my transition from practitioner to researcher, exploring issues in this way during interviews was challenging, particularly during the first two interviews, when I was in the midst of this transition. I learnt not to take anything at face value, and as a researcher, adopt a default position of ignorance and unfamiliarity during interviews. For example, from my own clinical experience, I was familiar with specific aspects of physiotherapist professional roles, such as evaluating, treating and educating. I learnt that by exploring physiotherapist participants' perceptions and understandings on these issues during interviews, I could begin to 'see' the variation in physiotherapist professional roles, and I used probing questions to delve into these issues more deeply. Constantly writing analytical memos and regularly logging into my reflexive journal, pushed me to persistently ask questions of the professional role and meanings, such as 'treating' or 'teaching', helping me through the transition from practitioner to researcher.

An interview guide, rather than a script or schedule, was used to direct the discussion towards areas pertaining to the research question and aims. Although the nature of the patient-physiotherapist therapeutic relationship was the focus of all the interviews, the interview guide varied between interviews, and was driven by the data analysis and the concepts that developed from previous interviews. Using a constructivist grounded theorist approach meant I paid close attention to participants' definitions of terms and the context in which the terms were expressed (Mills et al., 2006). In therapeutic relationship terms, this involved exploring the meaning of often implicit statements or descriptions of relationship meanings, which participants took-for-granted as every day experience of therapeutic relationship. When participants were sharing their experiences and perspectives of the nature of therapeutic relationship between them, I would re-use their own language and terminology, which I would then further explore through deeper questioning. Using an open-ended questioning approach helped guard against the 'forcing of data' into predetermined categories, and helped to ensure that I asked questions which were focused and significant, yet allowed the participant to freely express their views (Charmaz, 2006).

My own knowledge of therapeutic relationships, review of the existing literature, and discussions from my supervisors informed the initial and ongoing interview guide. During the course of the interview I explored participants' answers further, not only to clarify meanings of the terms they used, but also to explicate more fully the often-hidden aspects and details of the nature of therapeutic relationships between them. As suggested by Kvale (2007), follow-up questions were employed, and body language strategies such as a nod or an 'mm' were implemented to encourage the participant to further elaborate on their answers. Probing questions were used to gain specific examples and to add context and richness to the interview.

In my role as researcher, when conducting interviews it was necessary to make the participants (interviewees) feel as comfortable as possible. Conscious attempts were made to stick to a number of measures. These measures included, conducting the interview in a convenient place, ensuring privacy, maintaining informality and establishing a rapport. To ensure informality and generate a rapport, the seating arrangement was formulated in such a way that there were no desks or high tables between the participants and myself during the course of the interview. I offered food and refreshments to the participants to help put them at ease. Eating food together tends to promote conversation, relax participants and aid communication within the interview session (Krueger & Casey, 2009). Participants were welcomed and thanked for agreeing to meet with me; all physiotherapist and patient participants seemed animated during the interviews and showed a keen interest in the topics under discussion, and were generally cooperative and informative.

At the beginning of each interview, time was spent reiterating the nature of the study, participants' rights, and what the interview was going to cover. Participants were encouraged to ask any questions at this point. Time was also spent chatting informally and building a rapport. An attempt was also made throughout the interviews to create and maintain an informal atmosphere and to encourage participants to talk at length.

Interviews were tape-recorded using a digital recorder. The information sheet made it clear that the interviews would be audio recorded. None of the participants expressed any concern about the recording equipment. Non-verbal cues, such as

glancing at the recorder, or a reluctance to speak freely were looked for but not noted. The only reported disadvantage of using a tape-recorder is that it might inhibit the participants' ability to talk comfortably; however, I did not feel that the participants were put off by the use of a tape recorder.

Each interview lasted approximately an hour and a half. Participants were initially informed that interviews would take approximately 1 hour, but were encouraged to talk for as long as they liked. The data from all interviews were transcribed verbatim. The first two interviews were transcribed by the researcher as it had the benefit of facilitating full data immersion as highlighted by Charmaz (Charmaz, 2006). It was felt that due to the number of interviews and my own limitations in typing proficiency; the help of a professional transcriber was sought for the remaining interviews. The turnaround time from interview to transcription was one week, at which point I read and re-read the transcripts whilst listening to the interview recording (See Appendix 6, sample of one physiotherapist interview transcript). Due to religious orientation and/or as a social habit, participants tended to often use phrases such as “thank God”, “God almighty”, “glory to God”, “praises to God” or “God willing”. These phrases were not transcribed. Repeated statements and speech habits such as “you know”, “well”, or “told you” were also not transcribed. Interview tapes were retrieved from the transcriptionist once the transcripts were completed and I requested that he delete electronic copies of them from his computer system. In order to ensure transcription accuracy as well as to re-engage with the data, I reviewed each transcript for completeness and accuracy by simultaneously listening to the original audio-recording while reading an electronic version of the transcript.

5.7 The Researcher-Participant Relationship

When I first initiated the research process, I fostered a sense of trust with all potential participants by discussing mechanisms built into the study design to protect their anonymity. I established my credibility by offering some details from my background, including my ongoing practice as a senior physiotherapist as well as a researcher and my genuine desire to understand their experiences and perceptions of the patient–physiotherapist relationship in musculoskeletal outpatient settings. I tried

to adopt a stance of neutrality which I understood as being non-judgemental. I balanced this with empathy, that I believed communicated an interest and caring for the participants. For an interview to be effective the two parties must establish rapport, and I felt that for this to occur I had to be fully present in the situation, and attentive and responsive to the verbal and non-verbal communication of the participants and myself as the interviewer. Facilitating rapport and empathy with the participants helped build a relationship that enabled disclosure, but it was also important to balance this with neutrality (Patton, 2002). This involved transcending the interview process and reflexively observing myself as the physiotherapist and the interview dynamics (Hutchinson et al., 1994).

Data collection from the participants consisted of open-ended, semi-structured interview questions, which were used as a reference and to initiate discussion about the research aim. During the interviews I sought clarification from the participants when I was unclear about their meaning, and would restate what I thought I had heard using their own words. Open-ended interview questions were asked of the participants to ensure that they continually guided the process. Consequently, in all of the interview experiences I would begin the interview by asking the first open-ended question and found myself not having to ask the next three questions. This provided credibility with respect to the construction of the interview questions, because they were consistent with the participants' thinking. The last three questions of the interview guide were more focused questions and provided more clarification from the participants if their initial responses necessitated more specificity.

The dual role that I had as both a physiotherapist practitioner and researcher had inherent tensions, and these tensions were most noticeable when I was in conversation with other physiotherapists. I was therefore aware of feeling apprehensive about how I would present myself for the interviews. Was I a physiotherapist practitioner doing research, or was I a researcher who also practiced? The difference between these two different stances was subtle, but one of the biggest issues facing practitioner researchers is the way in which their knowledge and identity affect the collection of data (Reed, 1995). My clinical experience could not be ignored, and I decided to be completely open with the participants about my experience as a senior physiotherapist. Moreover, many of the

physiotherapists that I contacted to interview would be aware of me as a physiotherapist.

For participants which I had existing, previous and potentially future relationships with (such as work colleagues) it was important to clearly establish and develop a new and separate researcher-participant relationship. This relationship would sit within the context of the research study and was bounded by my ethical responsibilities to participants. It needed to facilitate my primary aim as a researcher, which was to generate ethical research data which could be analysed. For example, for participants that I had ongoing relationships with during the study (and also potential future relationships), it was important to ensure that discussions regarding the research, which occurred outside of the formal interviews sessions, were 'on their terms', and only took place if they chose to raise and discuss the study further.

As I shifted from practitioner to researcher, I also perceived a shift in how participants' related to me, during the periods of data collection. As the researcher-participant relationship developed, I sensed that they became more trusting of my role as a researcher and more assured in their role as a participant. This was especially evident during follow-up interviews, whereby it appeared that participants displayed a greater degree of openness and trust and they seemed more comfortable sharing personal and detailed information of the nature of therapeutic relationship between them. I considered this shift in participants to be a positive one, and it contributed to the credibility of the research data generated.

Finally, during data collection, I was conscious of becoming over-involved in the interview, and the discussion became a two-way conversational 'chat', rather than an exploratory process aimed to generate research data. The three practice interviews with friends provided an opportunity to reflect on my interview style, and rein in my enthusiasm, so that it was more focused and directed towards specific related to the nature of the patient-physiotherapist relationship.

5.8 Data Management and Storage

The confidentiality of the research data and its sources were maintained throughout the study. Prior to, and immediately following each interview, I checked the equipment to ensure proper functioning. All sources of data including signed consent forms, demographic information, interview audiotapes, written transcripts and their translations and data analysis notes were stored in a locked cabinet in the researcher's work place. In addition, Electronic data were in password protected files accessible only to the researcher. Furthermore, anonymity of the research participants was maintained by substituting anonymous codes for names, with only myself having knowledge of the original names of participants. All data will be destroyed once the research is completed and publications have occurred.

Translation

The interview schedule, consent forms and participant patient information were originally written in English and, thus, had to be translated to Arabic (See Appendix 7). To ensure that the Arabic version was close to the English version, a back-translation technique was used. To test the translation equivalence, the original forms were first translated from English to Arabic by a bilingual translator and then back-translated from Arabic to English by a bilingual translator. The two versions of each form were then compared to confirm translation equivalence. This was done by employing professional translators in Saudi Arabia to ensure quality and accuracy. However, the forms were adequately translated to Arabic without losing any meaning.

Six interviews were conducted in English (four Western physiotherapists with two follow up interviews with two of the four physiotherapists). In contrast, the task of translating Arabic interviews was not straightforward. Arabic is a rich language; it has different words or terms referring to one English equivalent. With translation, there is a risk of losing what the participant was saying by not using her own words. The main challenge was to overcome the major differences between the Arabic and English languages. The Arabic language uses a style which is long-winded (as opposed to English, which is much more succinct), does not rely on vowels, and uses a structure which does not resemble the English language in any way. The use of professional translators, however, helped to overcome these challenges.

5.9 Data Collection and Analysis

As grounded theory is iterative, the methods of data collection and data analysis occurred in unison. The next section details how the data collection and analysis processes ‘played out’ and how they led to the generation of the substantive theory. Figure 5.2, toward the end of this chapter, illustrates the processes of data collection and analysis used in the study.

5.9.1 Data Collection Interviews 1-10

The aim of the first interviews (five physiotherapists and five patients) was to explore the nature of the therapeutic relationship between them. This was achieved by asking questions which would allow the participants to reflect on and describe their perception, experience and expectation of the therapeutic relationship. Initially, the interview themes were quite broad, and the developing issues were pursued in more detail with probing follow-up questions. An interview guide used during interviews 1-10 is shown in Table 5.1 for physiotherapists and in Table 5.2 for patients overleaf.

Interview Guide

Prompt Questions for Physiotherapists

1. *How would you describe your therapeutic relationship with the patient? In what ways does it differ from your relationship in other contexts?*
2. *What are your expectations of the patient within this relationship?*
3. *Can you think of a time when you developed a very good relationship with a patient?*
4. *What was it about the relationship that made it so good?*
5. *Can you think of a time when your relationship with a patient was difficult? What was it that made it difficult?*
6. *How does the relationship you have with your patient influence your overall management of the patient?*

Table 5.1 Interview guide physiotherapist interviews 1-5

Prompt Questions for Patients

1. *How would you describe your relationship with the physiotherapist?*
2. *What are your expectations of the physiotherapist within this relationship?*
3. *To what extent does the relationship with the physiotherapist influence your engagement within the treatment session?*
4. *What factors might influence your interaction with the physiotherapist? What issues do you feel like discussing with a physiotherapist?*
5. *What factors are of importance for a good relationship with a physiotherapist?*
6. *Are there factors which may disturb a good relationship with a physiotherapist?*

Table 5.2 Interview guide patient interviews 1-5

5.9.2 Data Analysis Interviews 1-10

The transcriptions were read and re-read at least three times before coding began. During this process, I listened to the recording of the interview in order to immerse myself in the data. Data analysis of the first ten interviews took the form of initial line-by-line coding (Charmaz, 2006). Table 5.3 and Table 5.4 overleaf, provides an example of how line-by-line coding was used during physiotherapists and patients interviews 1-10.

Quote	Line-by-line code
<i>I expect them [the patient] to trust me ... I've worked in this field for years, I know how the body works ... (Pt2).</i>	<ul style="list-style-type: none"> • Trusting vital • Acknowledging professional expertise
<i>They need to see you as a person not just as a therapist. So it's important to talk (Pt5).</i>	<ul style="list-style-type: none"> • Addressing the human piece • Self-disclosure

Table 5.3 Examples of initial line-by-line coding employed during physiotherapist interviews 1-5

Quote	Line-by-line code
<i>I feel that we're working together on my treatment journey, that's what I would say about that. I would say I bring things to her in ways that, like, I'm a partner in what we're doing because she listens to my instincts... So, I am a participant, I'm not just a passive player (Pa5).</i>	<ul style="list-style-type: none"> • Working in dynamic and reciprocal relationship • An egalitarian partnership
<i>It's up to her. She decides what we do and when we do it ... she decides what we talk about. I just go along with her (Pa3).</i>	<ul style="list-style-type: none"> • Lack of autonomy • An inability to voice opinions in a clinical setting

Table 5.4 Examples of initial line-by-line coding employed during patient interviews 1-5

From the very moment the analysis commenced, memos were written, thus helping to link data gathering with data analysis. At this stage, memos were also written about each participant, acting as a form of an analytical 'case study'. These memos analysed each participant's perception and expectation of the therapeutic relationship between patient and physiotherapist, thus meaning that similarities and differences in expectation of the relationship could be compared. For example, I noted how some physiotherapist participants expected only to address the technical aspects of the profession, compared to others who appeared to expect that they would be talking and listening to patients. I noted that, in addition to the differences in patient participants' expectations, certain patients expected to only receive treatment, compared to others who appeared to expect that they would share

responsibilities in treatment decisions.

The amount of interview data and the number of initial codes generated, combined with my inexperience in grounded theory, meant that it was difficult to ‘see’ differences or familiarities in the data. In order to facilitate the constant comparative method of analysis, participants were logged onto a spreadsheet, which had their participant number running longitudinally down, and the characteristics of their expectations, together with any ‘key points’ which appeared to differentiate them from other participants. For example, the spreadsheet enabled me to compare expectations between individual physiotherapists as well as later between physiotherapists and patients had of each other within the therapeutic relationship (such as trusting, collaborating, talking, listening, educating and treating), as well as the consequences and conditions associated with these processes. This sizable table allowed me to stand back and ‘see’ what different participants were saying and also provided an element of ‘distance’ from the data so that patterns could be identified. Table 5.5 and Table 5.6 overleaf, show some of the line-by-line codes developed from the physiotherapists and patients ten interviews.

Codes	Quote
Teaching the patient about their musculoskeletal condition	<i>I teach you how to do your exercise. I bring you to the point of understanding while you know a little bit about your body. I'm teaching you to treat and fix yourself and then to keep checking to make sure that everything is going okay (Pt1).</i>
Addressing the problems that are afflicting patient's body	<i>Get the information out from the history, to get the information from an examination, to allow us to formulate a diagnostic tree of what we think is going on, that will allow us to treat it, or to advise them that there is nothing wrong with them, to reassure them from that point of view. I think that's what our role is (Pt3).</i>
Blurring the boundaries between the physiological needs of the patient and the emotional needs of the person	<i>I'm interested in them as a person not just their medical piece (Pt9).</i>

Table 5.5 Data collection and analysis physiotherapist interviews 1-5

Codes	Quote
Implementing exercise routines in patient's own time	<i>We [the physiotherapist and I] will work together... we will continue to persevere so that we can get to a point where I can move on (Pa1).</i>
Reacting to circumstances as they occur	<i>The physiotherapist can decide how best to fix me (Pa8).</i>
Underlying patient's fragile emotional and psychological condition	<i>I can't do the things she tells me to do; I just don't have it in me. I'm not nearly as strong or as capable as she thinks (Pa4).</i>

Table 5.6 Data collection and analysis patient interviews 1-5

From the first ten interviews, key concepts such as 'partnership', 'trusting', 'educating', 'focusing on body treatment' and 'listening' were developed. It appeared that certain physiotherapist participants were very focussed on understanding their approaches to patients in developing a therapeutic relationship with them through partnership and education, whereas other physiotherapist

participants were not. However, the potential relationship between these processes and proceeding outcomes and actions needed further exploration. In addition, there was also uncertainty regarding why some physiotherapist participants found educating and patients' collaboration with them during treatment sessions to be essential in the development of a professional relationship, while others perceived listening and talking to be the focus of the development when it came to their therapeutic relationship with patients. This was also the case with patient participants, whereby it appeared that patients were focussed on what they need from the "experts", e.g., information and education, answers to questions, do the things they are expected to do. The needs they articulated were instrumental (physical in nature) and required the skill of physiotherapist vs. expressive (emotional in nature). They wanted their help, they wanted to be heard, they wanted their views considered. However, some patients did speak about their relationships in ways which reflected intimacy or closeness.

This stage was very concrete and descriptive not abstracted. Following the first ten interviews, it was felt that a substantial amount of data had been collected, and that a pause in data collection was necessary in order to get a handle on the analysis, thus meaning that differences and similarities between the data and participants could be deeply compared and explored. This reflexive pause proved to be very useful, and allowed the interview guide to be theoretically focussed so that these major concepts and categories could be more deeply explored through interviews 11-19 with five new physiotherapist participants and four new patient participants, as discussed below.

5.9.3 Data Collection Interviews 11-19

As stated above, following the first ten interviews, data collection was paused for two months in order to theoretically focus the interview guide for the next nine interviews (five physiotherapists and four patients). Table 5.7, shows a revised interview schedule with examples of theoretically focussed questions for physiotherapist and patient interviews 11-19. Through focussing the interview guide, it was possible to get behind the meaning of the developing concepts in order to explain the similarities and differences between categories. As I continued to shift

from practitioner to researcher, I became more analytical during these interviews, and not taking for granted participants' words, meanings and experiences became my 'default mode'.

Focussed Interview Guide

Physiotherapist Interview Guide

1. Physiotherapist-patient relationship

- a. *What do you think would be the ideal relationship between physiotherapists and patients? How often do you think you manage to achieve that? What are the things that prevent it?*
- b. *What were your initial aims with your patient? Why? How did you intend to meet those aims?*
- c. *How do you go about establishing a relationship with a patient? How have you learned how to do this? Do you think it's something you are good at doing?*
- d. *What sort of relationship do you want to build with your patient? How do you relate to the patient and with what aim?*
- e. *Is the relationship between physiotherapist and patient the same all the time, or does it change? Over time? With different patients? With different conditions?*

2. Professional roles

- a. *How do you relate to patients in a therapeutic process?*
- b. *How would you describe your role as a physiotherapist? What is it that you aim to give your patients?*
- c. *How do you perceive your role with patients? Why? Exceptions?*
- d. *Is that role the same for all your patients, or does it vary?*
- e. *Is there anything that restricts your ability to carry out that role?*

3. Experience of the interaction

- a. *How do you like to work with patients? How do you want patients to behave towards you? How do you want patients to view you?*
- b. *What things facilitate a good therapeutic relationship with patients?*
- c. *What are the barriers to developing and sustaining a good therapeutic relationship with patients?*

Patients Interview Guide

1. Patient-physiotherapist relationship

- a. *What expectations do you have of the therapeutic relationship between yourself and your physiotherapist?*
- b. *How would you describe your therapeutic relationship with your physiotherapist?*
- c. *How does it differ from your therapeutic relationship with other healthcare practitioners? Can you provide some specific examples about how it is the same or different?*

2. Patient personas

- a. *How do you relate to your physiotherapist during the treatment process?*
- b. *What role do you think the therapeutic relationship has when it comes to the outcome of your care?*

3. Experience of the interaction

- a. *What will improve the therapeutic relationship you have with your physiotherapist?*
- b. *What do you think creates difficulty in forming and sustaining a therapeutic relationship with your physiotherapist?*
- c. *How do you want your physiotherapist to behave towards you?*
- d. *How do you want your physiotherapist to view you?*

Table 5.7 Interview guide used during theoretical focussing of physiotherapist and patient interviews 11-19

5.9.4 Data Analysis Interviews 11-19

Having employed line-by-line coding in the first ten interviews, the number of codes became cumbersome, and fracturing the data into such small and numerous pieces became challenging as constant comparison was necessary. For interviews 11-19, coding took the form of ‘focussed coding’ (Charmaz, 2006), which allowed larger segments of data to be coded according to the significance perceived by earlier codes developed line-by-line. This facilitated a more conceptual approach to coding,

through which I was able to develop categories and sub-categories. I also returned to the data generated from earlier interviews (interviews 1-10) and analysed and re-coded these data based on the focussed codes. Table 5.8 and Table 5.9 below, provides an example of focussed coding used for the analysis of data from physiotherapist interviews 1, 9 and 10 and patient interviews 6 and 9.

Quote	Focussed code
<i>It's your responsibility to do it, to demonstrate exercises and educate patients and it's the patient's right to know and learn. So I think it [teaching] is not something you should avoid (Pt1).</i>	Communicating through education
<i>The physiotherapist-patient relationship is almost like a business-type relationship, where, you know, they come in, they tell me the facts, and I provide the information and the treatment plan (Pt10).</i>	Communicating through effective treatment
<i>How can you treat the patient if you don't know the person? You need to find out as much as you can about them... not as patients, as people... so that you can help them (Pt9).</i>	Communicating through personalisation

Table 5.8 Examples of physiotherapist focussed coding

Quote	Focussed code
<i>She [the physiotherapist] was trying to tell me what to do, how to do it and, you know, she just thought she was the boss ... I had to tell her what I wanted, the things I wanted to do to help me (Pa9).</i>	Engaging through participation
<i>I don't want to participate in the treatment session, I just want to receive the treatment and feel good...the physiotherapist should decide and do the job required (Pa6).</i>	Engaging through passivity and dependency

Table 5.9 Examples of patient focussed coding

Categories were made conceptually denser by constantly questioning the data in the form of 'when, where, why, who, how and with what consequences' (Corbin & Strauss, 1990). While I did not strictly follow the coding paradigm of Corbin &

Strauss (1990), it was a useful analytical tool with which to begin sorting, ordering and linking categories and subcategories. This meant that coherence was given to the theoretical processes developed from the data analysis.

During the analysis of data from interviews 11-19, diagramming was employed to overcome the issues I was having with NVivo and to focus my analysis on the substantive area of enquiry rather than losing sight of the research questions. Diagramming helped force me to organise my analysis and begin to construct theoretical links between categories. It also facilitated the process of constant comparison by ‘actually seeing’ a visual image of the categories and the developing theory (Charmaz, 2006). The construction of the diagrams proved to be very helpful in providing a visual representation of categories, and how they potentially fitted together. Constructing and re-constructing different versions of the diagrammatic model pushed me to look further for connections within the data. At this point I was beginning to feel overwhelmed with the large amount of data and felt I began to suffer from what Clarke (2005) describes as ‘analytical paralysis’. Diagramming helped me to organise categories and their relationships into a process-based model which was focussed on the substantive area of the nature of the patient-physiotherapist therapeutic relationship.

The process of diagramming helped to move the analysis on by exploring the concepts of ‘educating’, ‘treating’ and ‘personalising’, as well as the relationships between these and other concepts, such as the ‘role of the physiotherapist’. The major categories and subcategories which were constructed following the analysis of interviews 11-19 are shown in Table 5.10 overleaf.

Category	Property
Communication	Non-verbal (evaluating, assessing, moving) Verbal (listening and talking)
Relationship developing goals	Support and guidance Evaluate and implement Empathy and rapport
Communicating through education	Teaching Partnership
Communicating through treatment	Body focussed Determine the problem
Communicating through personalisation	Understand the person Listening Personal touch and human touch
Role of patient	Active player Passive recipient
Interaction	Honesty Openness Trust

Table 5.10 Data collection and analysis interviews 11-19

At this stage of data analysis, it appeared there were distinct variations in terms of how participants communicated relationship development when interacting with each other and also the intended goals of their relationship during treatment and management. The constant comparative method of data analysis had forced me to ask questions such as:

- What are the factors behind the different ways in which physiotherapist participants interact with patients?
- What is the relationship between the physiotherapist participants' professional therapeutic roles and patients' different personas and the influence of these personas on patients' perception of the physiotherapy profession?
- What are the different roles that physiotherapists adopt with their patients?
- How might these different physiotherapists' professional roles and different patient personas influence the nature of participants' therapeutic relationship?

It was at this point during the study that my thinking began to shift from ‘just’ exploring the nature of the patient-physiotherapist relationship, to also investigating the different therapeutic professional roles which physiotherapists occupied in their relationship with patients, as well as the different patient personas they adopted in the treatment session. I hypothesised that these different physiotherapists and patients roles and personas may ultimately influence the nature of the therapeutic relationship between them. After maintaining a close connection with the data during the early periods of analysis, I returned to the data to follow-up and explore the differences in styles of physiotherapist-patient interaction, communication and variations in the approaches to the relationship between them, which I termed ‘therapeutic professional roles’ and ‘patient personas’.

At this point I consulted the existing literature on professional roles and identities (Bartlett et al., 2009; Lindquist et al., 2006; Öhman & Hägg, 1998; Richardson et al., 2002). This enhanced my theoretical sensitivity and led to the development of three different therapeutic professional roles which physiotherapist participants adopted with their patients. These were provisionally termed ‘Teacher’, ‘Treater’ and ‘Person-centred’ respectively. At the same time, I consulted the existing literature on different patient identities (Harris et al., 2003; Kenny, 2004; Norman & Conner, 1995; Ogden, 2007). This enhanced my theoretical sensitivity and led to the development of two different patient personas which patient participants adopted with their physiotherapists during the therapeutic relationship. These were provisionally termed ‘Active’ and ‘Passive/dependent’ respectively.

5.9.5 Data Collection Interviews 20-25

From the analysis of data obtained from interviews 1-19, it appeared that the different professional therapeutic roles adopted by physiotherapist participants influenced the nature of their therapeutic relationship with patients, and specifically the personas adopted by the patient participants in the relationship process. The decision was made to theoretically re-sample three physiotherapists who represented each of the three therapeutic professional roles in order to further explore and test the potential effect of these roles on relationships. Participants 1, 7, and 9 exhibited strong characteristics of the three therapeutic professional roles. Three patient

participants, namely Pa3, 5 and 7 were theoretically re-sampled in order to further explore and test the characteristics of the patients' active and passive/dependent personas as well as the influence of these personas on the nature of the therapeutic relationship between them and physiotherapists.

An analytical memo is provided in Table 5.11 below, and summarises the major ideas to be followed up during the interviews from the theoretically sampled physiotherapist participants 1, 7 and 9 and patient participants 3, 5, and 7.

<p style="text-align: center;">Analytical Memo</p> <p>Physiotherapist Participants</p> <ul style="list-style-type: none">• <i>Physiotherapist participants appear to play different roles in their relationships with patients. Some physiotherapists control, some guide and some help the patient to guide. What are the factors behind this variation?</i>• <i>Are these 'preferred' therapeutic professional roles which characterise different physiotherapists' relationships with patients during a treatment session? If so, how does this preference develop?</i>• <i>How do physiotherapist participants move between these different professional roles, and what are the 'triggering factors'?</i>• <i>What are the differences and similarities between the different therapeutic professional roles identified?</i> <p>Patient Participants</p> <ul style="list-style-type: none">• <i>What are the differences and similarities between the different patient personas identified? Are they really that distinct, and if so how and why?</i>• <i>What influence do these patient personas have on the relationship between them and the physiotherapist?</i>• <i>What are the 'triggering factors' that enhance the development of different patient personas?</i>

Table 5.11 Analytical memo written for interviews 20-25

5.9.6 Data Analysis Interviews 20-25

The data analysis from these interviews followed a similar method to the previous two interviews. However, as these participants were theoretically sampled, I had a good idea regarding which aspects of data were required to fill gaps in categories for further theory development. My increasing theoretical sensitivity helped make the

constant comparative method of analysis an easier and more fluent process, and by this point I had become extremely immersed in the data.

As with previous interviews, following the completion of each interview I made lengthy memos, and recorded my initial thoughts, feelings and hunches about the interview. The data analysis from these interviews further developed the three different therapeutic professional roles, and the variations of expectations in each of these three professional roles. This in turn helped them to develop a relationship with their patients and to identify the type of relationship resulting, which I termed 'expectations of the relationship' and 'type of relationship outcomes'. At this point I used the extant literature on therapeutic relationship expectations (Barron et al., 2007; Richardson et al., 2002; Szybek et al., 2000) and type of therapeutic relationships (Bartlett, 2009; Bright et al., 2012) to help make sense of how participants would employ aspects of their expectations to engage with the patient and influence the nature of their relationship. I used the language and abstracted from these extant theories to help push me to be more creative and imaginative in my labelling of the data. Indeed, Table 5.12 overleaf illustrates the theoretical connections, established at this point, between therapeutic professional roles and their expectations regarding the nature of the relationship and its development with patients.

Therapeutic professional roles	Expectations of the relationship	Type of relationships	Example
Teacher	Partnership expectation	Professional relationship	Teaching and constructing knowledge and sharing responsibilities
Treater	Professional competence expectation	Clinical relationship	Patient's body treatment and trust in Pt professional skills
Person-centred	Interpersonal competence expectation	Personal relationship	Personal characteristics, self disclosure, honesty and respect

Table 5.12 Relationship between the categories therapeutic professional roles, their expectations of the relationship and type of relationships, developed after interviews Pt1, 7, and 9

The data analysis from theoretically sampled patient interviews (Pa3, 5, and 7) followed a similar method to the physiotherapist interviews illustrated above. The data analysis from these interviews further developed the two different patient personas, and the variations of expectations in each of these two personas. This helped to develop a relationship with their physiotherapists and identify the type of relationship outcomes. As I intended to develop the theory through a cycle of data immersion, constant comparative analysis and engaging with the extant literature, I regularly tested my ideas and hypotheses by informally talking to physiotherapy colleagues and with my own patients whilst at work. By diagramming and re-diagramming, I was able to view the data in different ways, trialling different orders, and trying different concepts as core categories. Table 5.13 overleaf illustrates the theoretical connections established at this point, between patient personas, and their expectations regarding the nature of the relationship and its development with their physiotherapists.

Patient personas	Expectations of the relationship	Type of relationships	Example
Active	Expectations to play an active, participatory role in the rehabilitation process	Professional relationship	Make choices that suit their own unique needs
Passive/ Dependent	Expectations to shunt clinical responsibility onto the physiotherapists	Clinical/ Personal relationship	Withdrawal, passive behaviour and resistance to physiotherapist discourse if not adequately supported on a psychological and emotional level

Table 5.13 Relationship between the categories patient personas, their expectations of the relationship and type of relationships, developed after interviews Pa3, 5, and 7

In addition, by comparing the data from physiotherapist and patient participants in this round of data collection with the previous data, it was possible to develop and refine the major properties of the different therapeutic professional roles and patient personas. This resulted in the development of two additional categories; ‘experience of the relationship, and ‘reaction to the relationship’. These new categories were then integrated into the advanced diagrammatic model. I then revisited the data collected from interviews with previous participants, and with these two categories in mind, further developed the relationships between them. This resulted in the differences between the therapeutic professional roles and patient personas becoming clearer. It became apparent that the particular therapeutic professional role of physiotherapist participants influenced how they interacted with the patient, the experience of the relationship and their reaction to the relationship. This also made it possible to gauge the patients’ personas, the influence that each persona had on the perception of the physiotherapy profession, the experience of the relationship and their reaction to the relationship.

Indeed, the theory was becoming more process based, with the relationships and linkages between categories developing. However, there was a need to identify the factors behind physiotherapist participants' therapeutic professional roles and patient personas and the factors which would help clarify the variation in these roles and personas. This was crucial for the theory to have real explanatory power. Through writing advanced analytical memos I 'interrogated' the key categories whilst scrutinising the relationships between them, and by constantly referring back to my data, I ensured that my findings were truly grounded in the data (Charmaz, 2006). An example of an analytical memo used to interrogate the data at this stage is illustrated in Table 5.14 below.

Analytical Memo
<p style="text-align: center;">Physiotherapist Participants</p> <ul style="list-style-type: none"> • <i>Can physiotherapist participants change their professional role? If so what are the triggers and what are the consequences? Can others not change their role? Why?</i> • <i>Are the therapeutic professional roles favoured and preferred by physiotherapist participants, or are there a range of therapeutic 'options' which all physiotherapist participants can take, depending on the individual patient and their situation?</i> • <i>What are the influencing factors which might result in a physiotherapist participant favouring a particular therapeutic professional role? How has this developed and what are the conditions?</i> <p style="text-align: center;">Patient Participants</p> <ul style="list-style-type: none"> • <i>What are the attitudes that the particular patient takes in a treatment session? In terms of the role that the patient takes in the encounter, for example, is the patient actively engaging or taking a more passive persona?</i> • <i>What are patient participants 'doing' and what is 'going on' when they adopt a particular persona? What are the consequences of this process?</i> • <i>What are the influencing factors which might result in a patient participant favouring a particular persona? How has this developed and what are the conditions?</i>

Table 5.14 Analytical memo used to interrogate the data

Writing analytical memos further developed the theory, thus meaning that categories, sub-categories and their relationships were defined and refined. New categories which were formed at this point included physiotherapist participants' perception of the nature of the therapeutic relationship between them and patients, which was strongly related to their therapeutic professional roles. How physiotherapist participants viewed the nature of the therapeutic relationship was based on a number of factors which were hypothesised and examined by referring back to the data. For example, from my own experience as a physiotherapist I hypothesised that one factor which could be related to how physiotherapist participants viewed the nature of the therapeutic relationship, was through their professional identity. Indeed, this was deductively 'tested' by returning to the data to look for evidence to support or refute said hypothesis. Charmaz considered that using one's own experiences to generate ideas and hypotheses which are then examined in the data enables the researcher to make "logical inferences" regarding the theoretical relationships between categories and cases (Charmaz, 2006: p.104). By forming hypotheses which could explain the different perceptions of the nature of the therapeutic relationship which physiotherapist and patient participants held, and moving back into the data to check them empirically. Abduction or abductive reasoning involves examining the data and then forming multiple hypotheses which might explain what is 'observed' in the data. These hypotheses are then proved or disproved by re-examining the data and arriving at the post credible interpretation (Birks & Mills, 2011).

I was inadvertently taking an 'abductive' approach to reasoning which is thought to be one of the major characteristics of grounded theory analysis (Charmaz, 2006).

5.10 Theoretical Sorting and Integration

At this stage I was still to select a core category, or develop a new one to help explain the variations in the data, particularly the variation in physiotherapist participants' therapeutic professional roles, how these developed, as well as the variation in patient participants' personas and how they developed. My hunch was that getting behind these variations was central to developing a theory with real explanatory power. Whilst I had an idea about what my theory was 'all about', it

was difficult to clearly articulate precisely what it was trying to explain, thus resulting in a significant period of frustration. I repeatedly asked myself ‘what are participants doing, and to what end’? When asking this question I was conscious of the criticism frequently levelled at grounded theory studies, and especially at those researchers who do not follow a ‘Classic’ or ‘Glaserian’ approach to grounded theory. Indeed, critics feel that these researchers risk developing a descriptive account rather than a conceptual theory (Cutcliffe, 2005). I considered that arriving at a core category, which would help organise my data to form a conceptual theory, was vital when it came to ensuring it had explanatory power and avoiding pure description.

This process of writing and re-writing the storyline enabled me to apply my theoretical sensitivity so that the extant literature which I had engaged with during data analysis helped to reinforce and increase the explanatory power of the developing theory (Birks & Mills, 2011). The storyline (and accompanying conceptual diagram) was written and re-written several times and involved grouping major categories with their representative memos and providing interview data from participants in which to ground my theoretical claims. This period spanned more than ten months, and it was during this process of moving back and forth between writing the storyline and engaging with the data (and literature) that I developed the category of ‘negotiation’ which was ultimately selected as the core category. By engaging with the literature around epistemology of negotiation and decision-making (Bird, 1994; Hill & Kitchen, 2007; Hush et al., 2012; Oien et al., 2011; Strauss, 1978), I began to view the data and theory through this conceptual lens. This lens began to pull the theory together, and provided an order to all categories, thereby helping to get behind and explain the differences between the variations in therapeutic and clinical decision-making negotiation.

I explored the reasons behind participants’ perceptions of negotiation and how these related to the physiotherapists’ therapeutic professional roles, their expectations of the relationship, and to patients’ personas and their expectations of the relationship and the affect of the reaction to the type of relationship outcomes between them. This, in turn, generated new codes related to the factors which influenced participants’ negotiation and their reaction to the relationship, such as the time

availability and the socio-cultural factors. This process helped move the core category towards theoretical sufficiency, meaning I could effectively explain all aspects of the theory and account for variations in the data.

After engaging with the literature, holding discussions with supervisors, peers and colleagues who provided critical feedback, further re-organising of the theory was deemed necessary so that, in the words of Glaser (1978), it had ‘fit and workability’. In other words, this re-organising was carried out in order to ensure that the substantive theory fitted the data and had explanatory power, and therefore relevance. This is presented fully in the next chapter.

In the process, “negotiation” appeared increasingly central in the emerging theoretical explanation and presented the central category of ‘the experience of the relationship’. Other important categories were determined as being antecedent conditions (e.g. physiotherapist professional roles; patient personas), expectations (e.g. partnership; patient-focussed; body-focussed; person-focussed; autonomy; trust; empathy; emotional support), type of relationship outcomes (e.g. clinical relationship; professional relationship; personal relationship) and influencing factors (e.g. time availability; socio-cultural factors).

Figure 5.1, overleaf, depicts an explanatory matrix incorporating several of these categories. The latter theoretical memo and explanatory matrix were subsequently populated with data and this formed the basis of the early drafts of the storyline of the findings presented in Chapter 6. Thus, writing proceeded from drafting increasingly theoretical memos (as exemplified in this section) to supplementing those memos with evidence from the data (as presented in the next chapter) and eventually writing about the resultant theory in the context of relevant literature (Chapter 7), whereby progression is encouraged by Charmaz (2006) and Strauss & Corbin (1998) among other grounded theory authors.

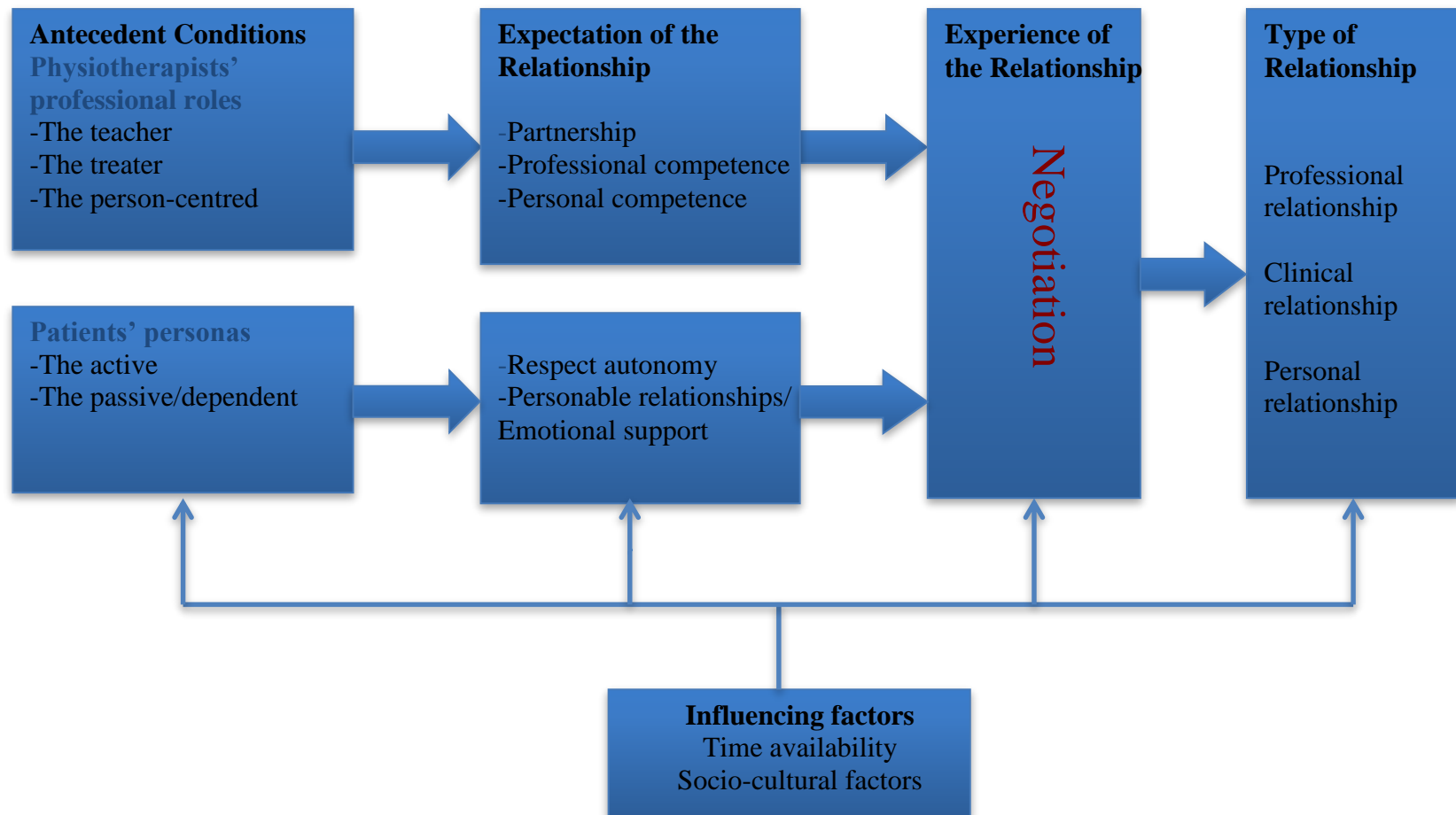


Figure 5.1 Explanatory matrix with ‘negotiation’ as the central organising category. This forms the basis of the storyline presented in chapter 6.

Due to the iterative and non-linear nature of grounded theory, the processes and procedures of grounded theory can be difficult to illustrate. Figure 5.2, overleaf, attempts to capture the iterative analytical processes used in this study, and provides a timeline and summary of how data collection, analysis and engaging in the literature, were tied together in this research study.

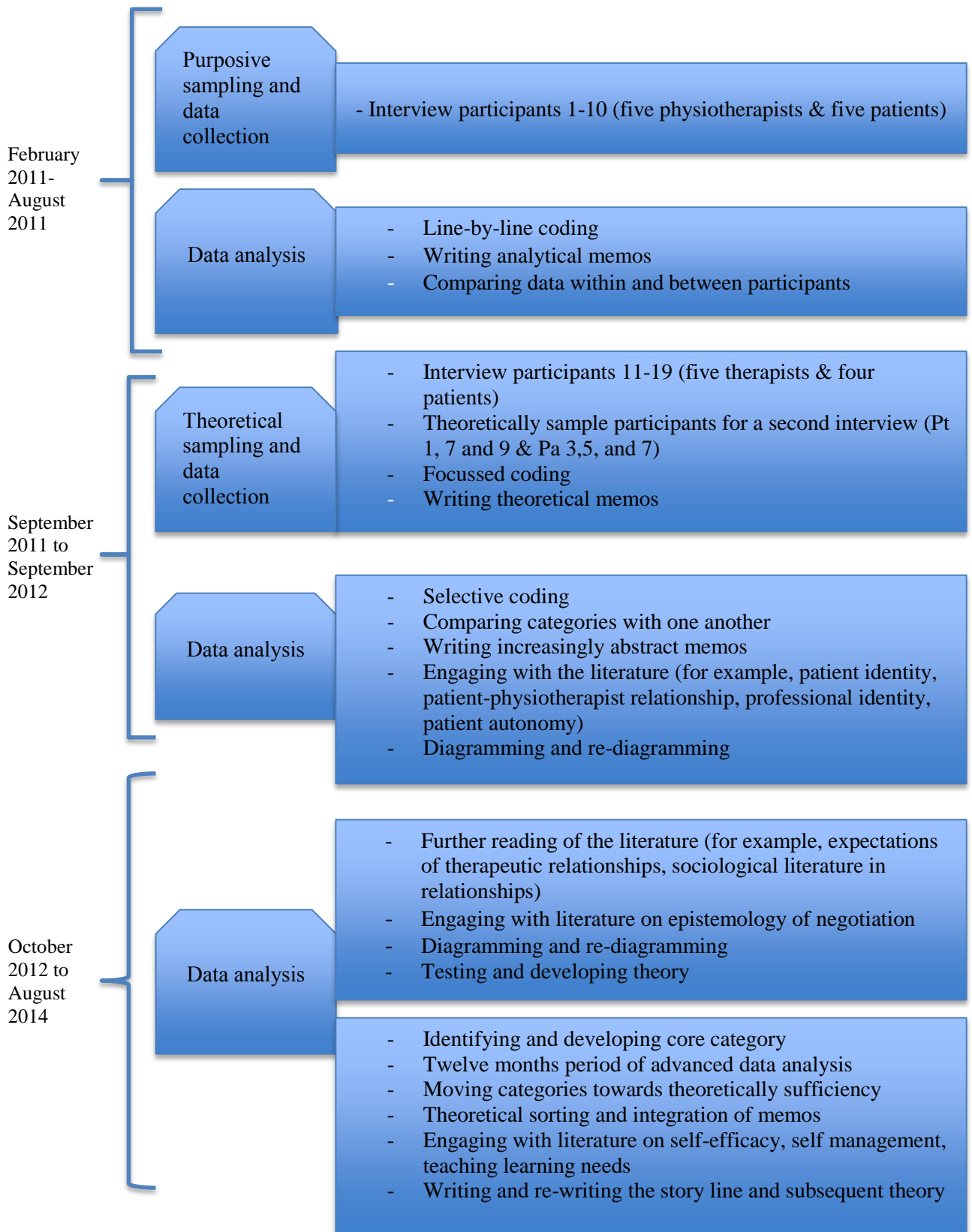


Figure 5.2 Summary and timeline of the data collection and analytical processes

5.11 Chapter Summary

In this chapter, the rationale behind the methods used in the data collection and analysis procedures used in this study has been justified and documented. In this chapter I have presented the characteristics of the participants and the process of their recruitment. Indeed, the chapter has detailed my methods of data collection, sample selection, interview structure, questions and interview techniques. An overview has also been provided of any decisions which I have made in this process and the challenges which I have encountered; all of which is representative of the data collection methods. The data was analysed using grounded theory coding, the constant comparative method of analysis and memo-writing throughout the process of analysis, theoretical sorting, as well as theoretical sampling in order to explicate the codes to categories.

This chapter, together with the previous chapter, provides the reader with an audit trail, thus demonstrating how a theoretical model regarding the nature of the patient-physiotherapist relationship in musculoskeletal outpatient settings in this study has been constructed. The next chapter uses the explanatory matrix introduced in the present chapter to propose a substantive theory grounded in evidence from interview data.

Chapter 6: Findings

6.1 Introduction

This chapter presents the principal factors related to the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings, and concurrently proposes a substantive theoretical explanation derived from the analysis of these findings. To ensure that the latter is “grounded” in the data (See Chapter 4), excerpts from interview transcripts are interspersed throughout the presentation of the findings. Most data segments included in this chapter were selected on the basis of their representativeness; quotations were selected to ensure that there was variation across study participants. At times, quotations were selected to offer an extreme or contrasting view, in order to provide breadth to the findings. When extreme or less typical quotations are used, this is made clear.

To provide context to the findings of this research, the chapter begins by introducing the background of the study participants and the work situations in Saudi Arabian musculoskeletal outpatient settings. The nature of the relationship between the physiotherapists and the patients will then be discussed. The substantive theory of the patient–physiotherapist relationship will be examined focussing on the antecedent conditions of both patients and physiotherapists, their expectations from the therapeutic relationship, and their interaction to the relationship. Of particular interest in this chapter is the primary core category of ‘negotiation’ in the relationship between physiotherapists and patients by focussing on the social and cultural factors affecting this relationship. A specific evaluation of the Saudi Arabian patient-physiotherapist relationship is also provided as a summary application of these empirical findings in practise.

6.2 Participants’ Backgrounds

This study focussed on female patients and physiotherapists within musculoskeletal outpatient clinics in Saudi Arabia. The culture of the study setting requires that only female physiotherapists or researchers may have contact with female patients due to the unique cultural and religious framework in Saudi Arabia.

Ten physiotherapists participated in this study; six were Saudi Arabian female physiotherapists and four were Western female physiotherapists. A total of six physiotherapists were recruited from King Faisal Specialist Hospital; four of these were Western physiotherapists and two were Saudi Arabian physiotherapists. A total of four Saudi Arabian physiotherapists were recruited from King Fahad Medical City; all of these physiotherapists were Saudi nationals. The key characteristics (primarily age and professional experience) of the physiotherapist participants are presented in Table 6.1 below. When citing the comments of the physiotherapist participants, reference to the participants will indicate physiotherapists as Pt, and each will be referred to as Pt1, Pt2, Pt3, *etc.*

Name	Age	Education level (Speciality)	Years of experience since graduating	Years of experience in musculoskeletal outpatient clinic
Pt1 (Western)	40	Master's degree Musculoskeletal (Belgium)	16	14
Pt2 (Saudi)	28	Master's degree Women's Health (UK)	5	4
Pt3 (Saudi)	37	Bachelor's Degree Physiotherapy (SA)	13	9
Pt4 (Saudi)	31	Bachelor's Degree Physiotherapy (SA)	9	8
Pt5 (Saudi)	26	Bachelor's Degree Physiotherapy (SA)	2	1
Pt6 (Western)	55	Master's Degree Neuro-Musculoskeletal (Australia)	25	12
Pt7 (Western)	38	Bachelor's Degree Physiotherapy (Holland)	13	10
Pt8 (Western)	34	Bachelor's Degree Physiotherapy (UK)	10	8
Pt9 (Saudi)	45	Master's Degree Healthcare Management (UK)	22	16
Pt10 (Saudi)	44	Master's Degree Quality Assurance (UK)	21	20

Table 6.1 Physiotherapists' characteristics

The nine patients who participated in this study were all Arabic-speaking Saudi Arabian adult females. Five patients were recruited from King Faisal Specialist Hospital; four patients were recruited from the King Fahad Medical City. The key characteristics (including age, marital status and education) of the patient participants are presented in Table 6.2 overleaf. When citing the comments of the

patient participants, reference to the participants will indicate patients as Pa, they will be referred to as Pa1, Pa2, Pa3, etc.

Name	Age	Education level	Marital status	Length of treatment time under PT prior to interview
Pa1	27	Bachelor's Degree	Single	1 month
Pa2	38	Bachelor's Degree	Married	3 weeks
Pa3	48	High School	Married	3 months
Pa4	40	High School	Single (divorced)	2 months
Pa5	25	Bachelor's Degree	Single	3 weeks
Pa6	65	Elementary School	Widow	8 weeks
Pa7	48	Master's Degree	Single (divorced)	1 month
Pa8	55	High School	Married	10 weeks
Pa9	31	Bachelor's Degree	Single	1 month

Table 6.2 Patients' characteristics

During the interview, five out of the nine patients had their heads and body covered with only their face being revealed (Tarha and Abaya); The remaining four were younger patients who were educated to a higher level and were wearing normal dresses and revealed their faces and hair. From the ten physiotherapists, five Saudi Arabian physiotherapists were wearing a lab coat and a head cover (Tarha). The remaining four Western physiotherapists were wearing a uniform which included blue scrubs and a lab coat. Interviews were carried out in Arabic with Saudi Arabian physiotherapist and patient participants and in English with Western physiotherapist participants.

6.3 Work Situations in the Musculoskeletal Outpatient Settings

The musculoskeletal outpatient physiotherapy service is predominately a physician or consultant referral service. Any patient whose condition affects his or her ability to perform functional activities can be referred to an outpatient physiotherapy

service by a physician, by nursing staff through the high risk screening process, by orthotists and prosthetists, or cross referral from physiotherapy/occupational therapists. Services are available for patients with arthritis, osteoarthritis, rheumatoid arthritis, traumatic injuries, musculoskeletal, women's health and orthopaedic disorders. According to the physiotherapy records of the King Faisal Specialist hospital, more than 80 female patients are seen daily in the musculoskeletal outpatient setting. In the King Fahad Medical City, 70-80 female patients are seen daily.

The ratio of female to male physiotherapists in the outpatient physiotherapy department at King Faisal Hospital is 8:5, 50% of the physiotherapists are Western senior physiotherapists due to hospital standards and VIPs requirement expand. The percentages of Western physiotherapists in other hospitals – including King Fahad Medical City, where the study was conducted – are much lower, with 90% of Saudi Arabian physiotherapists and the ratio of female to male physiotherapists is 8:8. On average, in each of the two hospitals a patient would have 10-12 treatment sessions over 4-6 weeks with an average length of 30-45 minutes for each treatment session.

Women visiting a physiotherapist in Saudi Arabia have usually been referred by a general practitioner or a specialist as a result of reported ailments and difficulties. By law, the outpatient physiotherapy treatment approaches are the physiotherapist's decision and physiotherapists evaluate the condition and commence physiotherapy management as appropriate. There are still on rare occasions a few doctors who set out the plan of treatment in patients' referrals, considering that there are still some medical doctors that have the perception of physiotherapists as technicians who follow instructions.

Patients are highly restricted in their mobility, and therefore, their attendance at therapy sessions is likely to be made with great difficulty. As mentioned earlier, Saudi females are prohibited by law from driving and require a guardian escort for their commuting. From tasks such as driving to even the use of public transport, women are limited in their ability to access transportation. Due to guardianship restrictions, any outside travel will require the coordination of schedules with a male family member (brother, husband, father, etc.), which has an impact on the

flexibility in scheduling regular appointments with the physiotherapist; for example, one physiotherapist commented:

In the Saudi culture, family obligations supersede the women's need to take care of themselves, suggesting that the hassles associated with attending treatment such as securing transportation, play a major role in adherence among Saudi females (Pt2).

As introduced earlier, by law, treatment of Saudi Arabian women is performed entirely by women. There is an expectation that once within the cubicle, the “niqab” may be removed for therapy. Local women in Saudi Arabia are almost universally veiled. It's rare to see an unveiled Saudi woman, and usually it's only in places of work like the hospital, where a veil inhibits sight for medical work. But there are also some female health professionals that don't remove their “niqab” in the workplace, where they conform to their society and cultural expectations. They would feel uncomfortable, as the “niqab” is used to remove temptation from men, who tend to stare at unveiled women due to the novelty. There is a small percentage of female patients, especially those who come from rural areas, that refuse to remove their “niqab” during treatment sessions as a cultural norm. This would impact on the interaction between the patient and the therapist and lead to lack of non-verbal communication between them. This was reflected in the following statement:

I don't like to treat a female patient who refuses to remove her 'niqab' while we are in the treatment session alone. How can I communicate with her if I can't see her facial expressions? I feel tense and uncomfortable (Pt5).

Wealthy families hire female helpers from the developing countries and most women are dependent on them. Female patients arrive accompanied with their housemaid, they remain with them in the treatment session and take the responsibility to demonstrate home exercise program to them at home. Physiotherapists face a significant language barrier in trying to communicate with the patient's housemaids:

I find it difficult to illustrate and demonstrate the exercises to my elderly patient's helper. A Pilipino or an Indonesian helper who doesn't speak the language and whom I am supposed to deal with instead of the patient herself (Pt7).

6.4 Antecedent Conditions

The analysis of antecedent conditions is focussed on the key factors influencing beliefs and attitudes of the physiotherapist and patient participants prior to the commencement of treatment that influence the nature of the relationship between them.

6.4.1 Physiotherapist Professional Roles

The physiotherapists constructed a range of professional roles in relation to their relationship with a patient. However, the roles that appeared were not fixed; rather, roles were fluid, with physiotherapists expressing a myriad of different ideas and beliefs focussed on physiotherapists' approaches to patients and the role-based definition of professional responsibility in physiotherapy. Professional roles that were reconstructed from the views and beliefs of the participant physiotherapists on the nature, purpose and function of the relationship between them and patients were the teacher, the treater and the person-centred.

The following sections will define each professional role.

6.4.1.1 The Teacher

The main role of the physiotherapist is, from this perspective, to teach the patient about their musculoskeletal condition so that they are better able to manage the condition. They focus on teaching and motivating patients to enable them to manage their own pain and dysfunction based on the physiotherapist feedback; the role of 'teacher' was obvious in five of the physiotherapist participants (Pt1, Pt3, Pt6, Pt7, and Pt8).

Teacher physiotherapists endeavoured to instruct patients how to complete exercises so as to 'fix' the physical problems that they are experiencing:

I think you have to go at it from the perspective that it's your responsibility to do it... Demonstrate exercises and educate patients and it's the patient's right to know and learn. So I think it's not something you should refrain from (Pt7).

Teacher physiotherapists believed that teaching patients and disseminating information to them should occur in a timely fashion and, moreover, these physiotherapists thought that patients have the right to know and learn everything that relates to their musculoskeletal disorder. Throughout the physiotherapist feedback, the role of 'teacher' was manifest, as highlighted in this response:

I am a teacher. That's how I see it. I teach you how to do your exercise. I bring you to the point of understanding while you know a little bit about your body. That your body is what heals you up... And I show you that this exercise and that exercise will do the job. I'm teaching you to treat and fix yourself and then to keep checking to make sure that everything is going ok (Pt1).

There was a general assumption that knowledge created an authoritative state for assisting the patient:

I become a resource for them. And they know that they can come to me and consult for anything. So I'm a resource... I am a teacher (Pt6).

Yet such authoritative positioning can also result in complex relational outcomes, as responsibility for knowledge requires that physiotherapists are competent in their recommendations and instructions. This burden of 'knowing' was summarily expressed:

I think it's a good thing to say, "I don't know, I can't supply that information because I don't have enough knowledge about that. ... I can ask my senior physiotherapist colleague and she will come around and talk to you". ... I think, generally speaking, that saying 'I don't know' is most often positive because you just don't leave it hanging ... I've never been uncomfortable saying that. ... I don't recall being challenged on that ... And I think it's a very honest thing to say (Pt3).

Physiotherapists who adopted the teacher role sought to inspire confidence in patients, whereby information is disseminated in order to affect change or direct

interventions:

After I've examined the patient I usually speak with the patient about what I think is going on. This is what I think we should do and I think that helps establish the confidence. I think it's the communication and education that ensues sort of the interaction that starts, helps establish the trust (Pt8).

The importance of physiotherapist-patient dialogue was broadly emphasised across teacher physiotherapists, both as a confidence-building mechanism and a teaching-based dynamic. This was expressed as follows:

If one could be more specific and say is there anything that a physiotherapist does specifically that could erode the confidence between a patient and a physiotherapist probably the biggest thing might be ... The perception of avoiding education (Pt7).

Teacher physiotherapists used education as a means of encouraging patients to take an active role in the treatment process. In this way, the physiotherapist was able to facilitate a collaborative approach to decision-making rather than taking decisions on the patient's behalf, a point that the following participant underlined:

You can't make the decision for the patient; I think you've just got to be able to give them enough information and understanding that they can decide (Pt3).

They were also aware of the pitfalls of partnership, that teaching the patient about their musculoskeletal condition does not necessarily equate to a sharing working relationship as the following excerpt revealed. The ability for patients to manage their disorders and, thus, care for themselves involves individual responsibility during and after each step of the treatment process:

Of course, you can teach them and teach them and they can sit there and nod and say "yes, I understand" but if they then go home and don't do any exercises and do all the bad things that has got them in this state then you'll get nowhere (Pt7).

There were many different ways in which the teacher physiotherapists wanted to

support their patients. They viewed themselves as facilitators recognizing that it is up to the patient as to whether they are to be educated or not. Therefore, the teacher physiotherapists attempted to facilitate the patients' teaching by helping them to understand themselves and helping them to make decisions about themselves:

I speak a lot more than she does, so you know in spite of that it helps me cause when I can hear myself as well, it helps me to sort myself... one thing is to have something going on inside you but once you speak it out loud, you get a certain clarity (Pt8).

The findings suggested that learning is a symbiotic process where physiotherapists can learn from their patients in the same way that patients can learn from them and, moreover, where the patients' unwillingness to practice what the physiotherapist teaches renders the treatment process null and void.

Because physiotherapists believe that patients have the right to know what they must do to manage their musculoskeletal disorder, the knowledge gained by patients is a means towards giving them more physical mobility. Individual responsibility for patients to manage and, thus, treat their musculoskeletal disorders is an expected outcome of the relationships they have with their teacher physiotherapists.

The roles and responsibilities of a teacher appeared from within the pedagogical process that was mostly implemented by Western physiotherapists. Subsequent responses from teacher physiotherapists revealed a belief that patients should know and learn everything that relates to their musculoskeletal disorder so that they can manage it on their own as needed. Moreover, the ability for patients to manage their disorders and, thus, care for themselves involves a requirement of individual responsibility during and after each step of the treatment process. Individual responsibility for managing one's musculoskeletal disorder ensures less dependence on hospitals for providing services to patients. Individual responsibility for managing one's disorder indicates an added assurance that patients will cooperate because physiotherapists have enough years of professional experience to demonstrate their practical knowledge of caring for the body. This way of imparting knowledge can be considered a practical mechanism for the teacher's professional role.

6.4.1.2 The Treater

For treater physiotherapists, the primary function of the role is to locate ways of effectively diagnosing and subsequently treating the patients' musculoskeletal conditions. The role of 'treater' was evident in four of the physiotherapist participants (Pt1, Pt3, Pt6, and Pt10). Adopting the treater role influenced the physiotherapist's focus of interaction with the patient. In particular, the physical response of the body became paramount for the treater physiotherapists. To achieve such outcomes, treater physiotherapists looked to attain a scientific, rational understanding of the condition as a theoretical starting point of any subsequent intervention, as underlined in the following view of a treater physiotherapist:

Get the information from the history, to get the information from an examination, to allow us to formulate a diagnostic tree of what we think is going on, that will allow us to treat it, or to advise them that there is nothing wrong with them, to reassure them from that point of view. I think that's what our role is (Pt10).

This framework drew on the biomedical model, focussing on the diagnosis and treatment of the condition.

One of the most important things that physiotherapists do is understanding bodies of anatomy and having some techniques or at least some information and ... you can see things about people that they can't see themselves about their wellness or illness (Pt3).

Treaters emphasized their technical expertise in obtaining body-focussed knowledge through skilful physiotherapeutic techniques and procedures. Their confidence in a body-focussed approach meant they tended not to actively seek the patient's input into treatment and management decisions.

Treater physiotherapists sought to direct and decide for the patient, in accordance with what they had discovered during their body-focussed examination:

The patients do come to you or to me because they need some help with whatever their problem is. And I think my main role should be treating them to make them better if they do have a problem, or to reassure them if they don't have a problem (Pt10).

The clinical nature of the treater persona was represented as a ‘business-like’ relationship:

The physiotherapist-patient relationship is almost like a business-type relationship, where, you know, they come in, they tell me the facts, and I provide the treatment plan (Pt10).

Physiotherapists who adopted the treater role are similar to teacher physiotherapists in that they are keen to educate patients so they can learn more about their condition. For this reason, three participants (physiotherapists 1, 3 and 6) adopted both a teacher and a treater professional role. The need to teach patients about their condition had an effect upon the approach that some treater-teacher role physiotherapists take with their patients. For them, it was imperative to create an environment where their patients feel comfortable so that patients are able to express themselves fully and take an active part in the treatment process, a point that the following two excerpts appeared to underline:

It’s very important that they have the treatment, education and information that they need to feel comfortable at whatever stage they’re at (Pt6).

If they [the patients] don’t talk about their problems then they’re not going to learn how to fix them ... you’ve got to get them to work with you (Pt1).

Supplementing such feedback and highlighting the role of the physiotherapist in treating and encouraging self-treatment was expressed as the following:

Patient compliance has incredible impact on outcome so I typically say to patients, “you have to do your part”, which is, you know, doing your exercises ... watching for the symptoms... (Pt3).

Physiotherapists who sought to effectively treat the musculoskeletal condition consequently promote a relationship that is predominantly rooted in the management of the patient’s dysfunction. While it is imperative for treater physiotherapists to listen to their patients and for the patients to learn about their condition, it is the body’s response to physical distress coupled with the medical insights afforded by expert knowledge that seems to guide the interaction.

Expanding upon this concept of a treater responsibility to intervene, help, and treat, senior physiotherapists described their role as an expert in the physiotherapy field focussing on the differentiation in knowledge and skills between physiotherapist and in relation to diagnostic indicators of musculoskeletal disorders. The skills and competencies of the physiotherapist are viewed as an inhibitor or catalyser for actualising the desired patient outcomes.

6.4.1.3 The Person-Centred

The third professional role identified was the person-centred role. Half of the physiotherapists (Pt2, Pt4, Pt5, Pt8 and Pt9) indicated their commitment to person- or patient-centred practises, prioritising the interests, values, and expectations of the patient in their practical interventions:

Physiotherapists explained how adopting a person-centred role influenced their degree of empathy and person-centred professional commitments:

I try to hold love and empathy for the person, unconditional love that is not judgmental. I also try not to have any preconceived ideas (Pt8).

The person-centred role created an emotional support between the physiotherapist and the patient that was expressed as follows:

It is the deep empathy for patient suffering and the need for my support to assist with alleviation (Pt8).

The connection operated beyond the bounds of the symptoms, the intervention, or the outcome; instead, it is a social bridge which allows for more personalised behaviours:

I think it's the way I approach people ... in general and patients, I'm very friendly and I'm generally smiling and I enjoy my work and I enjoy meeting people (Pt4).

And it's more the people ... the people connection that ... I enjoy because the rest of it is just a routine duty (Pt9).

Person-centred physiotherapists also referred to the need to treat patients with respect:

Other physiotherapists ... they address patients like you come here and you do that and I don't like those words ... I'm professional and human, you know, you have to address them by their names (Pt5).

To establish empathy, person-centred physiotherapists committed to providing patients with a level of support, emotional connection, and collaboration that was designed to meet or exceed expectations, which incorporated self-disclosure, the discovery of commonalities, and the expression of emotions:

The sharing ... with any patient, you know, sharing some little aspect of yourself with them and sharing common interests (Pt2).

Sometimes I get very emotional too and I will show it ... if I'm sad I'll show it to them. So when I'm happy I do too and I think people appreciate that and I think they feel it, that shows you care (Pt5).

Person-centred physiotherapists saw patients as individual people, and they were committed to getting to know the person behind the patient and their body, and to consider the social and emotional impact of their problem. For them, understanding the person from this perspective was important to build and maintain an effective relationship and to understand the patients' personal meanings and how they experience their dysfunction.

Some junior physiotherapists (Pt2 and Pt5), those with less experience, may prioritise patient caregiving and the person-centred responsibilities underlying their professional behaviour by amending their role to meet the unique needs of each patient as they are not confident enough with their level of expertise and skills.

Table 6.3 below shows the distribution of physiotherapist participants amongst the three therapeutic professional roles.

	Teacher	Treater	Person-centred
Physiotherapist Participants	1, 3, 6, 7, and 8	1, 3, 6 and 10	2, 4, 5, 8 and 9

Table 6.3 Participants' therapeutic professional roles

Table 6.4 below provides a summary overview of each of these professional roles and the three practical applications that were identified as unique priorities for the application of each role.

Characteristic	Teacher	Treater	Person Centred
Relationship Therapeutic Goal	Teaching and constructing knowledge/ Sharing responsibilities	Patient's body treatment/ Confidence in own expertise	Personal characteristics/ Empathy and Rapport
Focus of Interaction	Patient-focussed	Body-focussed	Person-Focussed

Table 6.4 Summary of professional roles with practical applications

6.4.2 Patient Personas

The findings revealed the prevalence of two major personas amongst patient participants: the active patient and the passive/dependent patient. In particular, the dichotomy between patients who adopted an active persona and patients who adopted a passive/dependent persona was constructed to be a key influence on the patients' responses to the relationship development between them and the physiotherapist. Table 6.5 below shows the distribution of patient participants amongst the two personas.

	Active	Passive/ Dependent
Patient Participants	1, 2, 5, 7, and 9	3, 4, 6 and 8

Table 6.5 Patient participants' personas

6.4.2.1 The Active Patient

The active patient is one who is willing to take a firm stance so as to ensure that they receive the treatment that they desire. Thus, rather than reacting to circumstances, the active patient looked to take control of the situation. The majority of the patients who perceived themselves to be active were aware that a successful therapeutic

relationship could only occur through a willingness to cooperate with the physiotherapist and to function within the structure of the agreed treatment plan. Thus, the active patient is one who assumes that the physiotherapist will realise that treatment is a two-way process:

We [the physiotherapist and I] will work together... we will continue to persevere so that we can get to a point where I can move on (Pa1).

Active patients sought to participate in the treatment of their musculoskeletal condition, which had a significant effect upon the type of relationship that developed between themselves and their physiotherapists. The participation can take a number of forms. For instance, some patients adopted a coercive approach to working with their physiotherapists:

The physiotherapist's behaviour was very unreliable and not consistent and I was demanding to get the treatment modality I wanted ... I played the same game with some of the other physiotherapists. I tried to communicate with her by saying, you know, "you be frank with me, I'll be frank with you" ...It was the only way I could get the treatment and felt respected (Pa9).

Here, then, the patient articulated the relationship between themselves and the physiotherapist in terms of a game, one where the patient (i.e. the consumer) holds the upper hand. In this instance, the patient actively strove to address what she perceived to be deep-rooted power imbalances between themselves and the physiotherapist by asserting herself. This was a sentiment that was corroborated by another patient who recalled how she challenged what she perceived to be over-zealous behaviour on the part of the physiotherapist:

She [the physiotherapist] was trying to tell me what to do, how to do it and, you know, she just thought she was the boss ... I had to tell her what I wanted, the things I wanted to do to help me (Pa7).

The above response indicated that the active patient is one who believed that the relationship between themselves and the physiotherapist would be defined by partnership, a point that the following participant was keen to underscore:

I feel that we're working together on my treatment journey, that's what I

would say about that. I would say I bring things to her in ways that, like, I'm a partner in what we're doing because she listens to my instincts... So, I am a participant, I'm not just a passive player (Pa5).

From the above response, two points were apparent. On the one hand, the active patients' are underpinned by the ideal of an egalitarian partnership. Therefore, as the following participant revealed, for the active patient power was deemed to be a detriment to the development of an effective therapeutic relationship between the physiotherapist and the patient:

Sometimes, the physiotherapist ... she acts like she has the power ... but she can't have any power [over me] ... she needs me to believe in what she is saying otherwise her words, they are empty (Pa2).

On the other hand, the majority of the patients who identified themselves as active were keen to develop some semblance of a personal relationship with their physiotherapists. For instance, the following participant recalled her sense of frustration when working with a physiotherapist who adopted an overly clinical approach to practice:

She [the physiotherapist] prepared a package of exercises and she just wanted me to apply them regardless of me as a person ... she didn't see me as a whole person ... I didn't like that relationship at all (Pa5).

The active patient was the one who did not distinguish her needs as a patient and her needs as a person. If the physiotherapist does not treat them in a personal way, the active patients will not simply bow to the will of the physiotherapist. Rather, the active patient will seek to influence the situation so as to bring about the outcome that they desire:

There is no use in just sitting there and being unhappy. If it isn't working, I'll tell her (Pa7).

I respect what she [the physiotherapist] says, of course, and I listen to her ... but if it doesn't feel right, then I will tell her so. I will look to change [the treatment] (Pa2).

The active patient sought to facilitate a dynamic and reciprocal relationship with the physiotherapist. Advocating an active persona was, therefore, a choice on the part of the patient: a conscious decision to engage in partnership with the physiotherapist. The active patients' persona is consequently influenced by a belief in partnership.

6.4.2.2 The Passive/Dependent Patient

The passive/dependent patient persona did not demonstrate a will to take control of the treatment; they simply reacted to circumstances as they occurred. Where active patients looked to affect the situation, passive/dependent patients allowed the situation to dictate their thoughts and behaviour. They offered little by way of any attempt to take part in the treatment of their musculoskeletal condition and to engage in partnership with the physiotherapist. Rather, the passive/dependent persona assumed that the physiotherapist would be able (and willing) to dictate the pattern of treatment, thereby 'fixing' the body's dysfunction:

She [the physiotherapist] says that this is what I should do and I then try to do it (Pa3).

She [the physiotherapist] knows what is best for me ... she has the knowledge ... I do not question what she says (Pa8).

Passive/dependent patients placed a great deal of emphasis upon the interpersonal communication between themselves and the physiotherapist:

You have to find out if she [the physiotherapist] is a nice lady or if she is not a nice lady ... that's something you learn in life (Pa3).

I need the physiotherapist to be a nice person ... I need her to be caring and compassionate (Pa6).

The underlying emotional and psychological issues influenced the development of the relationship between the passive/dependent patient persona and the physiotherapist. As the following two patients underlined, there was an association between passivity/dependency and the patient's fragile emotional and psychological condition:

My physiotherapist was very tough. She kept telling me that I was depending on her and that I was not trying to help myself, she didn't understand my situation and my psychological conditions (Pa4).

I don't feel confident enough to tell her that she is pushing me too hard ... she doesn't understand how I feel (Pa6).

Passivity/dependency seemed to be an identity that the patient felt the need to adopt in every aspect of their life. These patients were not, then, dependent upon the physiotherapist solely for their treatment; they were also dependent upon them as people to provide them with the emotional and psychological support that they felt they needed. This was a point that was made by the following patient:

I don't feel comfortable when she [the physiotherapist] pushes me too hard ... I want her to understand that it is not easy for me ... I want her to support me ... to take it slow. I am not a confident person (Pa8).

Passive/dependent patients' lack of confidence and self-esteem was a recurrent term that was mentioned by these participants. They tended to embrace pessimistic beliefs with regards to their ability to positively influence health outcomes:

I can't do the things she tells me to do; I just don't have it in me. I'm not nearly as strong or as capable as she thinks (Pa4).

The passive/dependent patient identity was characterised by an inability to voice opinions in a clinical setting. They simply conform to what they perceive to be the predominant social and cultural standards and norms. It was, therefore, the passivity and dependency of the patient that influenced the way in which they were treated by their physiotherapists.

The most notable views, beliefs and opinions of the physiotherapist and patient participants were crucial to the participants' understanding of the nature, purpose and function of the relationship and goals to be accomplished during the session, which led to the development of three different therapeutic professional roles that physiotherapist participants adopted with their patients and two different personas that patient participants adopted with their physiotherapists.

Table 6.6 below provides a summary overview of each of these patient personas and the two practical applications that were identified as unique priorities for the application of each persona.

Characteristics	Active	Passive/ Dependent
Relationship Therapeutic Goal	Participation in clinical-decision making	Shunt clinical responsibility onto the physiotherapist
Focus of Interaction	Assertive behaviour	Passive and withdrawn behaviour

Table 6.6 Summary of patient personas with practical applications

Physiotherapists' and patients' antecedent conditions are summarized in Figure 6.1 below

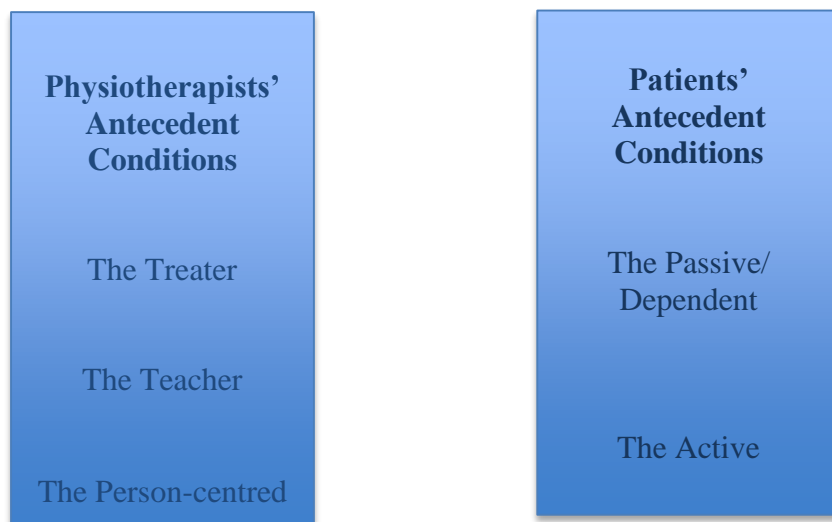


Figure 6.1 Antecedent conditions of physiotherapists and patients

6.5 Expectations of the Relationship

There are specific relational expectations that have an effect upon individual responses during the development of the patient–physiotherapist relationship. The following sections will explore these variations and similarities, drawing distinction between physiotherapist and patient expectations.

6.5.1 Physiotherapist Expectations of the Therapeutic Relationship

Partnership and trust were the two major expectations physiotherapists embraced in their relationships with patients. As was the case with the therapeutic professional roles, physiotherapists' expectations were not rigid or fixed according to the specific type of role that they adopted, the teacher, the treater and the person-centred role. However, the findings suggested that there were theoretical connections, between physiotherapists therapeutic professional roles and their expectations regarding the nature of the relationship and its development with patients.

6.5.1.1 Expectations of Partnership

Teacher, treater and person-centred physiotherapists recognised the important role that patients play in the management of their musculoskeletal dysfunction. The expectation of a partnership relationship was particularly strong in teacher physiotherapists. ***Teacher*** physiotherapists ***expected the relationship between themselves and their patients to be forged by participation and partnership*** with the physiotherapist teaching the patient about their musculoskeletal condition and the patient responding in kind by implementing exercise routines in their own time:

What makes a good relationship with anybody is collaboration ... and a partnership between the patient and the health care provider. The partnership is the single most important thing and then both sides of that partnership, much like a marriage, have to know what their responsibilities are and you have to have an understanding of what their commitment is to living up to their part of that responsibility. And we need good mutual participation so that you can know when things are changing (Pt1).

Teacher physiotherapists shifted the clinical decision-making responsibility towards the patient, and actively encouraged them to be involved in making treatment and management decisions:

They have opportunities to share with me their ability to function in activities that are important in their life, and then I take that information, we establish goals for that, and then we design a treatment to try to reach those goals (Pt6).

The more you engage the patient in their treatment, the better your results are. (Pt3).

While the teacher physiotherapists use their professional knowledge and expertise to help inform decision-making, the patients maintain overall responsibility for decisions about their own treatment. For example, there was an underlying expectation reported in which the patient must take action and facilitate their own treatment according to the collaborative protocol:

You can't make the decision for the patient; I think you've just got to be able to give them enough information and understanding that they can decide (Pt7).

Partnership and collaboration in the physiotherapist–patient relationship are established in various forms from active, purposeful intervention to passive, support-oriented commitment by patients:

There were a lot of things and there was fear. And having to get her to really think about her choices ... I could make suggestions, give her the options that seemed to be right now. But it was difficult... clearly all she wanted was to get rid of the stress of pain. It was essential for her to realize where certain choices might move her (Pt7).

This indicated a necessary partnership between the teacher physiotherapist and patient, which ultimately defined and influenced the nature of the therapeutic relationship. Furthering such insights, Pt8, a person-centred physiotherapist, highlighted the extent to which decision-making involves persistence on the part of the physiotherapist:

We work together...continue to persevere to get to a point where that person can move on (Pt8).

Person-centred physiotherapists *emphasized that the patient should be encouraged to take the lead in decision-making*, and it appeared that they endeavoured to give whatever treatment and management the patient requested. As illustrated by the comment above, they felt that through helping to educate patients about their condition and the possible treatment options, they could make informed decisions about their own care, implying a patient-led approach to clinical decision-making.

However, while all of the physiotherapists who took part in the research study referred to the primacy of partnership as a prerequisite of informed decision-making, *treater* physiotherapists were compelled to ***adopt a more authoritarian role in order to dictate the pattern of treatment***. They assumed responsibility for treatment and management decisions, encouraging the patient to be passive, so that they could direct their treatment to the patient's body. Their goal was to improve patients' health through improving function of muscles and bones, using specific treatment techniques, as illustrated by the following comments:

Although we all as physiotherapists like to have a two-way exchange of ideas there are some instances where you have to be a little bit more paternalistic in your approach to fulfil patient expectations (Pt3).

All what matters to me is to treat my patients and manage them properly, it is my duty...I don't expect them to participate and I don't wait for partnership... I just expect them to receive therapy (Pt10).

They seem to endorse the notion of giving treatment to the patient-as-a recipient, implying a paternalistic approach to care. They considered that they possessed the knowledge and skills to achieve their goal and improve the patient's health with minimal active involvement of the patient.

Whilst this responsibility to intervention superseded the general domain of 'partnership' in physiotherapist expectations, there were other contributory factors that the participants revealed as essential in establishing effective therapeutic relationship. Saudi Arabian and Western physiotherapists Pt3, Pt6, Pt7 and Pt10 all indicated that female patients in Saudi Arabia typically attend sessions accompanied by a maid, husband or family member. This, in turn, has a profound effect upon the concept of partnership and, somewhat inevitably, upon the physiotherapists' expectations of the relationship between themselves and the patient:

You head into the session anticipating a one-to-one relationship, but then find a third party intervening on your patient's behalf. This fracture of the self-care ideal undermines your dialogue regarding personal accountability and responsible behaviour (Pt3).

It's the ones that don't help themselves, the ones who seem helpless ... they're the ones who are most difficult [to work with] ... no matter what you say or what you do they won't do anything to help themselves (Pt6).

Such a lack of individual motivation and commitment to personal responsibility is viewed as a significant rift between the physiotherapist expectations and the actual patient outcomes, a gap that will be discussed in later sections in relation to patient expectations and relational force; these are summarised below in Figure 6.2 below.

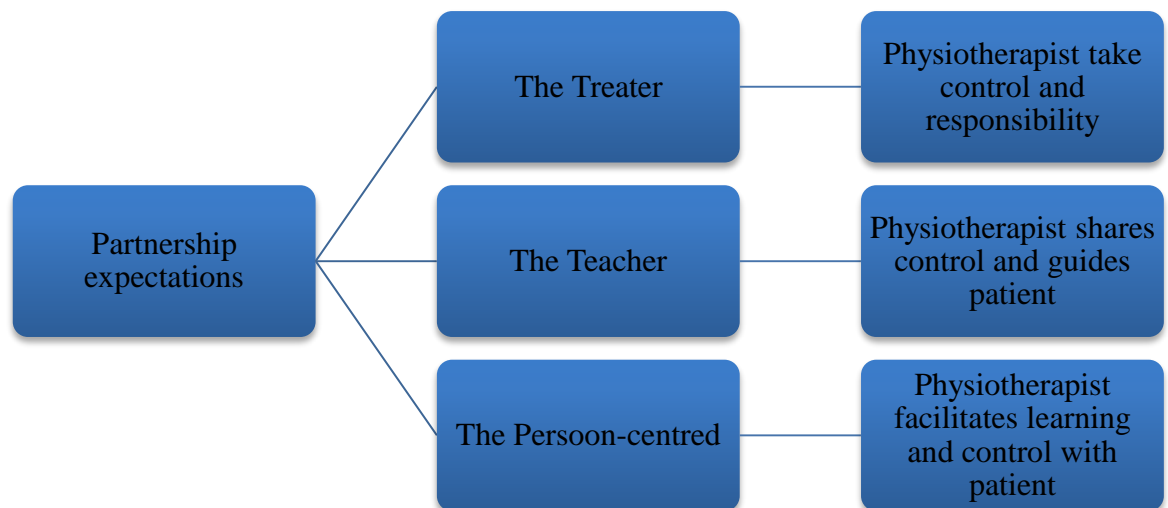


Figure 6.2 Treater, teacher and person-centred partnership expectations of the relationship

6.5.1.2 Expectations of Trust

Teacher and treater physiotherapists were seek to ***focus on trust building through establishing professionalism and a robust background of experience and competence***, whilst *person-centred* physiotherapists simultaneously were ***prioritising personal characteristics and a compelling the engagement of the patient in the therapeutic process***.

Physiotherapists' expectations of trust involved the trust of the patient in the physiotherapist's competence and the trust of the physiotherapist in the patient participation's. While there are other underlying dimensions of trust, they are related to either of these two practical outcomes, creating predictability in the patient response. For this reason, physiotherapists feel themselves compelled to focus on building trust by establishing professional roles (e.g., disclosure of a rich educational

and professional background) while emphasising the need for patients to engage willingly in the therapeutic process. For example, if, as recognised by Pt3, a Saudi Arabian teacher and treater physiotherapist, and Pt8, a western teacher physiotherapist:

Saudi Arabian patients do not respect Saudi physiotherapists authority and/or knowledge, then, their willingness to share personal medical history and physiological information will likely be reduced.

Treater physiotherapists offered various impressions of trust and trust building, for example:

The patient's ability to trust my judgement is essential to influencing behavioural change and pursuing mutual goals (Pt3).

The ability for patients to trust physiotherapists, according to the treater physiotherapist above, is a factor that can facilitate the behaviours necessary for a treatment process to work. Highlighting the complexity of the trust-building process, a teacher physiotherapist expressed the following:

When you're first assessing your patient, we ask patients questions, we get, we obtain a history... it gives the patient the opportunity to let you know that all things that are bothering them, all their physical health complaints, sometimes they bring in some of the other issues that may be going on in their lives. And then once you've had the opportunity to speak with them, ask them other important questions that pertain to their health and other things, examine them ... it's still a fairly private event and I think that helps establish the trust. After I've examined the patient, I usually speak with the patient about what I think is going on. This is what I think we should do. It is the way of negotiation. I think that helps establish the trust (Pt1).

Such feedback reflected relational expectations maintained by physiotherapists, whereby the physiotherapist pursued an in-depth history of the patient's musculoskeletal dysfunction, and expected professionalism and knowledge that are keys to the treater and teacher physiotherapist's role. Treater physiotherapist Pt10 suggested that there was an underlying 'assumption of trust', which may not actualise as a direct result of patient perceptions or unwillingness to embrace this relationship. There were concerns raised regarding trust and the capacity for treaters

to build trust with unwilling or resistant patients:

Although we as physiotherapists meet patients with the assumption that they already trust us, we do acknowledge that there are situations when trust is not immediately evident, such as when patients have had negative past experiences with physiotherapists or have been influenced by what others have told them about physiotherapists in general (Pt10).

One of the limitations was the degree to which past experiences influence the perceptions that the patients have of their physiotherapists. Physiotherapists highlighted this concern, suggesting it was both experiences and preceding feedback (e.g. doctor recommendations) that influence the physiotherapist assessment:

They'll say, you know I heard very good things about you from my doctor or I have a friend who was looked after by you. So they already have ... some information about you in the absence of having first met you ... I think that's a very fortunate thing...that may have already helped establish the trust (Pt2).

While trust was an important expectation of all of the physiotherapist participants, it was more pivotal for those physiotherapists who perceived themselves to be person-centred practitioners. For these physiotherapists, a personal relationship between them and the patient could only come about once trust had been firmly established. However, trust, in this instance, does not develop independent of the physiotherapist; rather, trust develops organically as an environment of mutually agreed openness is fostered by person-centred physiotherapists:

Patients will tell you things even when they hardly know you, which they would never probably disclose to anyone else. There's this kind of... relationship that is possible, if you don't mess it up somehow, that is very intimate and ... is very trusting, at least on the patient part and the physiotherapist part (Pt9).

I create an atmosphere where they can be really relaxed, and they can speak and feel that it's non-judgmental, and they don't have to hide and many of them will tell me that they hide things from their doctors. And then they tell me things...it is that kind of trusted relationship (Pt5).

Person-centred physiotherapists thus looked beyond the clinical management of the musculoskeletal disorder. These physiotherapists saw themselves as helping patients move forward and achieving mutually set goals. Thus, as the following quote detailed, there was an expectation of positive outcomes that was directly tied to the establishment and maintenance of trust between physiotherapist and patient:

I hope that my patients are able to trust me enough so that I can make a meaningful difference in their life. It is the bond built on trust that allows us to progress to a new level of interaction (Pt8).

Whilst the trust condition for physiotherapists revolved around an anticipation of patient trust and engagement in the therapeutic relationship, physiotherapists also made assumptions regarding the influence of trust on patient behaviour:

It was hard because you want to help people but when you get... responses like that "I don't want to do anything by myself", "I am not showing any improvement", you really feel like you're doing nothing and that you are increasing the burden on them. I mean your job is caring. You're to relieve burden. You are to help people. You are to move them forward. You know you're there... you're a physiotherapist (Pt9).

Such a response was indicative of a variance between physiotherapist and patient perceptions of what trust equated to in the therapeutic relationship. Whilst person-centred physiotherapists such as Pt9 and Pt3 prioritised 'making a difference' over other outcomes, the behaviour of their patients had consequences for the actualisation of such therapeutic relationship. There was an implied expectation of participation that was tied to the physiotherapist–patient trust and was imposed by physiotherapists on the therapeutic relationship. Catalysing working behaviours, person-centred physiotherapist described this initiative as follows:

It's very important to me to feel like I'm making a difference ... that they have the treatment, education and information that they need to feel comfortable at whatever stage they're at (Pt2).

Furthering this expectation of active participation in the therapeutic process, a person centred physiotherapist expressed the following:

I want to be able to know that I can help them to get better, especially when you've seen a patient who's been there for so long (Pt5).

A comfortable physiotherapist-patient relationship included mutual respect and understanding and had to promote the development of trust and leads to setting realistic expectations together. Two person-centred physiotherapists expressed this as follows:

I like to have open communication with respect and honesty. I like patients to trust me and feel like they can tell me whatever is going on (Pt9).

Patients are looking for trust, they are looking for an educated answer. I think as long as you can provide that to them and show them that you are open to them and that you are listening to their complaints, I think that goes a long way to developing that relationship (Pt5).

Trust expectations of teacher, treater and person-centred physiotherapists are summarised in Figure 6.3 below.

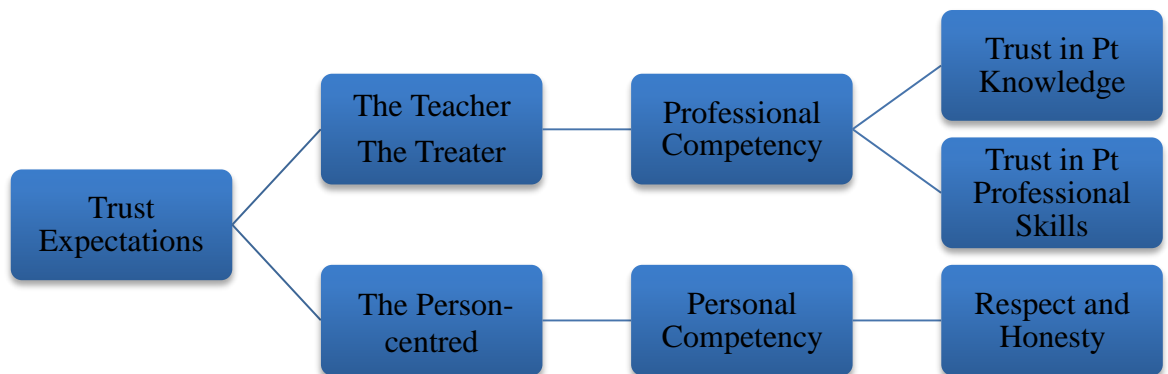


Figure 6.3 Teacher, treater and person-centred trust expectations of the relationship

Physiotherapist professional roles and each role expectation of the relationship are summarised in Figure 6.4 below.

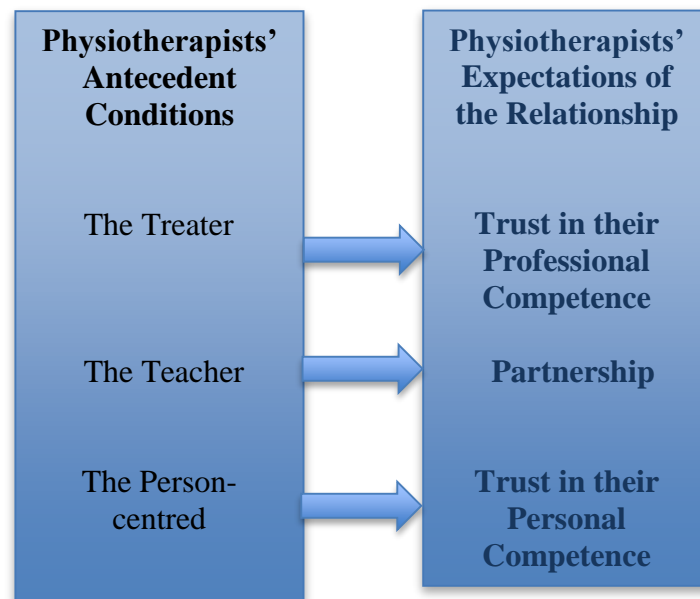


Figure 6.4 Physiotherapists' professional roles and each role expectation of the relationship

6.5.2 Patient Expectations of the Therapeutic Relationship

The expectations of patient participants are considered under two headings:

- Active patient expectations of professionalism, including respect of their autonomy, empathy, partnership, knowledge and expertise, trust and rapport.
- Passive/dependent patient expectations of personalisation, including care, helpfulness, a loving attitude, openness and good communication skills.

As was the case with the patient personas, patients' expectations were not rigid or fixed according to the active or the passive/dependent patient persona that they adopted. However, the findings suggest that there was a distinct correlation between patient personas and expectation.

6.5.2.1 Active Patient Expectations of Professionalism

6.5.2.1. Respect Patient Autonomy

For active patients, the respect of patient autonomy was recognised as an important contribution of the treatment process. Throughout the patients response, there were two primary options available in respect of autonomy, including (a) imposing consumer (patient) choice on selection of health services and (b) behavioural adjustments and control taking. Accordingly, these adjustments were designed to establish autonomy and control, which may influence the treatment outcome, as illustrated by an active patient:

When she stopped listening then there's no point in talking to her, it doesn't matter who I talk to . . . I don't talk then either if she doesn't listen. It's like pointless. Why should I sit there and say things only to be misunderstood (Pa1).

Patients expected respect through the recognition of inherent dignity, worth and uniqueness of every individual, regardless of the patients' socio-economic status, personal attributes and the nature of the physical dysfunction:

Through repeated letters to my doctor, I tried to get him to take action on my behalf, namely, write desired referrals to a specific physiotherapist (Pa7).

A patient who adopted an active persona confessed to not taking part in the physical exercise regimen given to her by her physiotherapist so as to facilitate a move to a different physiotherapist:

I have been given enormous amounts [exercises & instructions] that I have not been following. Because I don't think you should perform exercises as long as you don't know what it's about ... in this case I just receive the treatment and for next referral I ask for another physiotherapist (Pa1).

Another active patient persona reported utilising a blended strategy that included aligning their objectives with their physiotherapists through open discussion and negotiation:

I think I felt the control in the beginning was only to say no to the treatment. And then when I asked that question and she was able to respond to me, I discovered that the control could be to accept some of the treatment that I felt comfortable and safe with (Pa8).

Active patients prioritised the evolution of mind-sets and perspectives towards a more complementary standard of therapeutic partnership:

I've made a decision about the treatment modality that my physiotherapist absolutely hated. And, I think, the best thing she did was actually to express that... She said, 'Today you are saying no. Can we agree to talk about it next session?' And I said... 'Well, we can agree to talk about it an hour from now but it's not going to change my mind'. Well, surprisingly, I changed my mind (Pa9).

The expression of autonomy through intra-relational behaviour manifested as either passive or active strategies on the part of the patient. Whilst physiotherapists played a direct role in such processes, it was the lack of control or autonomy that ultimately inspired deviant or amended behavioural outcomes. The response from these patients indicated that they want to remain an active part of the decision-making process, or else they will likely take charge of their own wellbeing. Such strategies were dependent upon the characteristics of the patients (active or passive/dependent) and their behavioural proclivities regarding deviance from physiotherapist direction.

6.5.2.2 Empathy and Partnership

Although physiotherapists must be cognizant of the patient expectations and needs during the treatment process, there was a need to establish authority and take control over the treatment that was obvious throughout the patient feedback. From a perspective of personalisation and empathy, Pa2 and Pa7, who both adopted an active persona, noted that empathy was rendered more straightforward when the physiotherapist took an interest in the patient:

She is sort of interested in you ... she gets to know you ... what's wrong with you and that sort of thing ... it gives you confidence (Pa2).

She knew what I was going through (Pa7).

Empathy as defined by this group of patients was the expression of understanding, validating and resonating with the meaning that the healthcare experience holds for the patient. For this reason, some of the patients talked about preferring to see a single physiotherapist with whom they were able to develop an empathetic relationship rather than seeing several physiotherapists:

It helps having an open and honest dialogue and relationship so that pretty much anything can be discussed...If you have the trust, then you find that you are...more willing to put those things out on the table (Pa2).

Extending such observations, active patients suggested that physiotherapists who listened to what they are saying empower the patient, and facilitate the pursuit of self-help treatment outcomes:

I think she went beyond listening and really she was inquiring. And, I think, by doing that she sort of empowered me and she empowered herself in her eyes because that inquiry signals some equality between us, and I think it made our communication so successful (Pa1).

In the description of therapeutic relationship scenarios, partnership between the physiotherapist and the patient was largely straightforward with the patient willing to accept the expert advice administered by the physiotherapist. For instance, several active patients described decision-making as a dynamic process in which control was at times shared and yet at other times shifted to one or another person. Either the physiotherapist or the patient may assume, defer or share control in decision-making:

We sort of realized that there a meta-process that has to occur first, which is the physiotherapist and the patient have to agree about how the decision is going to get made (Pa7).

The foundations of partnership reported by the patient participants were based upon the effective management of the gap between expected personable relationship and empathy and the actualised outcomes from the physiotherapists. For some patients, the degree of partnership required to be engage in treatment was much lower than for others, reflecting a degree of passivity and dependence that revealed a preference

for direction:

I have never professed to be an expert in this field. My physiotherapist was the guide and I just had to follow her direction. This made me feel more confident and I was able to make changes in the right way (Pa6).

Such a response reflected one of two dominant paradigms: the passive/dependent patient. These individuals require a more individualised, personalised service that is focussed on their unique needs. The active, control-demanding patients expressed a different view:

This is my problem; all I require is the identification of solutions (Pa2).

They may understand what issues I am having, but I don't expect to be treated like a child (Pa9).

The variation between patient personas is an important factor when expecting partnership and a trusted patient–physiotherapist relationship, one that ultimately requires a commitment to awareness and information-seeking behaviour.

6.5.2.3 Knowledge and Expertise

Patients expressed a willingness to learn about their musculoskeletal condition in an attempt to gain greater relationship outcome. For some patients, this proved to be a relatively simple exercise with physiotherapists very willing to teach their patients:

You can ask her anything, anything under the sun. And she will answer your questions (Pa1).

She explained to me what the problem is, and what could be done (Pa5).

They really clarify everything they're going to do (Pa6).

Patients also acknowledged that they need to understand why the treatment has been established the way it is:

I needed to have an explanation for why a particular modality was being delayed when I thought it was so crucial ...My physiotherapist explained to me: "You know, your age is a factor" (Pa7).

As expressed in this feedback, many active patients count on the physiotherapist who is treating their musculoskeletal disorder to answer their questions, explain the condition and, moreover, to help them to manage the symptoms in the future:

Like with [the physiotherapist], she shares herself. She's very open. And I think that's a very curative modality that's not used in mainstream medicine (Pa2).

However, it should be noted that there was a narrow boundary dividing patients who wished to educate themselves (i.e. active patients) and patients who simply wished to be told what to do (i.e. passive/dependent patients). Passive/dependent Patients like Pa8 expressed a desire to have the physiotherapist lead them through every part of the treatment process:

The physiotherapist would express 'here is what you should do and how you should do it' and I was okay with that. It was about getting results, not about trying to change the strategies (Pa8).

Focussing on the persona-based biases of the physiotherapists and the patients, the relationship process has revealed a link between autonomy, trust, partnership, empathy and education, whereby the patient preferences will ultimately impact upon the outcomes of the relational cooperation. The strength of such relationship ultimately provides patients with either a compelling reason to engage in the treatment protocol or one to reject the guidance of the physiotherapist. For this reason, empathy, knowledge, autonomy, and effective communication all catalyse more effective outcomes from the relationship building process.

6.5.2.4 Trust and Rapport

Patients who expected a relationship that is characterised by trust assumed that trust would occur naturally. Similarly, some patients also expressed an expectation of a relationship where the rapport between them and the physiotherapist would come naturally:

What I need to do is I need to like them [the physiotherapist] ... when we like

each other ... we can trust one another ... so I expect to get on with her, to trust and be open (Pa2).

There's got to be that connection ... it has to be like that (Pa3).

The expectation of rapport was underpinned by an assumption that the patient and the physiotherapist will strike up a bond that transcends the treatment of their musculoskeletal condition. This was a difficult outcome to bring about with rapport being dependent not solely upon the expectations of the patients but also upon the teacher/treater/person-centred role of the physiotherapists. Patients did not deliberate upon the subtle yet clear differences between trust and rapport. Where trust is a belief that can be embraced by one or both of the parties, rapport is a relationship when two people are in tune with each other's needs. Thus, while trust is a reasonable expectation to embrace, rapport is an ideal that, in reality, few patients are fortunate to experience with their physiotherapists. This was a point that was expanded upon by the following patients:

I have had a number of them [physiotherapists]... with none of them have I felt a comfortable relationship ... there was no rapport (Pa5).

I expected us to click but we just didn't connect in that way ... it was very frustrating (Pa4).

Viewed from this perspective, expectations of rapport can lead to disappointment as the reality of working with teacher and/or treater physiotherapists is far removed from their idealistic vision of a harmonious therapeutic relationship. Not all of the patients expressed an expectation of rapport when embarking upon a relationship with their physiotherapists. This was especially true of patients who adopted an active persona:

I don't care whether or not I like them or we get on or not. I don't care whether they like me ... I want to get better, to be free from pain ... if they can help me ... then that is all [that matters] (Pa1).

The findings consequently suggest that there was a distinction to be made between those patients who expected trust and rapport on an interpersonal level and those

patients who looked only to trust the medical expertise of the physiotherapists with whom they are working. Where the former involves an assumption that a certain type of interpersonal relationship will emerge, the latter involves a realisation that the physiotherapist–patient relationship is one where the patient must play an important part in the dynamics that unfold between the two parties. This was a view expressed by several of the participants with an active persona:

You cannot expect her [the physiotherapist] to do all the work ... it has to be from the two of us (Pa2).

[Trust] is a complex thing ... how can I expect her to trust me if I do not trust her (Pa9).

She cannot do it alone ... I need to work on them [my exercises] ... I need to show her that she can trust me as well (Pa7).

There were subtle variations to patients' expectations of trust and rapport. While integral to all of the patient participants, for some trust and rapport were expressed as end products of the therapeutic relationship whereas for other patients trust and rapport were articulated primarily as ideals derived from distorted perceptions of the physiotherapy profession. For certain patients, then, trust and rapport were grounded primarily in professional conceptions of the physiotherapist–patient relationship.

6.5.2.2 Passive/ Dependent Patient Expectations of Personable relationships

6.5.2.2 Caring, Helping and Loving Attitude

Passive/dependent patients expect the therapeutic relationship to include caring, helpful, gentle, sincere, genuine, and loving attitudes:

I had a number of physiotherapists who were patient, intelligent, consistent, caring, compassionate, sincere and strong with their 'hands on' treatment (Pa4).

They expressed their engagement with the physiotherapist in the therapeutic relationship through passivity and dependency as they only felt good through receiving treatment and through personable relationship including a caring, helping and loving attitude from the physiotherapist:

My physiotherapist was very tough, she kept telling me that I was depending on her and that I was not trying to help myself, she didn't understand my situation and my psychological conditions (Pa2).

I don't want to participate in the treatment session, I just want to receive the treatment and feel good...the physiotherapist should decide and do the job required (Pa6).

Patients were aware of a sharing that was taking place between the physiotherapist and the patient. There was a sharing of time, information, and oneself:

She's also very patient. She listens. And I don't think I can express that enough. She asks questions. She shows a genuine concern...(Pa8).

6.5.2.3 Openness and Good Communication Skills

Other important expectations identified were listening and being open. Physiotherapists needed to be open to listen and to hear what the patients have to say and hear who they really are. Patients appreciated how the physiotherapists listened and responded to them:

Being treated by a physiotherapist who listened to me and gave me some relief from my pain, whom I could call and talk to about my injury (Pa6).

The physiotherapist seemed rushed when she began the appointment. I was nervous because this was my first visit. With no greeting or introduction she began the assessment immediately. When she looked up at the clock and sighed, I felt as though I shouldn't have come – like I was wasting her time (Pa3).

The passive/dependent patients needed to feel that they could be themselves. In order for this to be accomplished, they needed to feel that they were being respected and not judged by the physiotherapists:

I guess like I do not feel any judgment from her so I guess I can say whatever is on my mind like if I am really ticked off about something I can say that (laughs), if, um, whatever it is I can say it (Pa6).

When passive/dependent patients reflected on their physiotherapy visits, it was often

the emotional support and communication style that they remembered or commented on, not necessarily the technical skills of the physiotherapist. Perhaps that is why communication was so frequently cited in formal complaints from patients. It was important to not underestimate the value of having a good “bedside manner” and its impact on these patient personas outcomes.

My physiotherapist took the time to explain what she was doing during the assessment; it helped me understand why she was doing certain tests on my pelvis and how they might be related to my back pain (Pa8).

The physiotherapist was standing behind me and rolled down the waistband of my pants without any warning or explanation. To be honest, it felt inappropriate; I was so embarrassed I didn't even know what to say. Why wasn't I asked, or an explanation given? (Pa4).

Patients placed a high value on receiving careful attention from their physiotherapist and not feeling rushed through their visit. When physiotherapists take their time, patients feel they are listened to and receive thorough care.

Patients' expectations are summarised below:

Active Patient Expectations	Passive/ Dependent Patient Expectations
<p>Professionalism</p> <ul style="list-style-type: none"> • Respect Autonomy • Partnership and Empathy • Knowledge and Expertise • Trust and Rapport 	<p>Personable relationships</p> <ul style="list-style-type: none"> • Caring, Helping and Loving Attitude • Openness and Good Communication Skills

Table 6.7 Patient expectations of the therapeutic relationship

Patient personas and each persona expectation of the therapeutic relationship is summarised in Figure 6.5 overleaf.

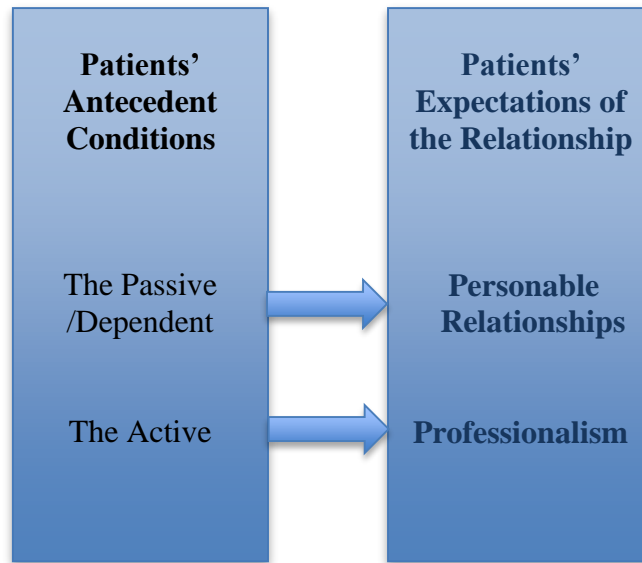


Figure 6.5 Patients' personas and each persona expectation of the therapeutic relationship

6.6 Experience of Relationship

The findings suggested that the relationship between the patient and the physiotherapist is subject to an on-going process of negotiation. Physiotherapists and patients experienced different types of negotiations, each of the physiotherapist and the patient had an expectation about the relationship and this was negotiated between them. When there was a mismatch between participant expectations and experience, there were existed variations in the level of negotiation that were related to and influenced by the physiotherapist's professional role and patient's persona, as expressed during the interaction.

The two types of negotiation are:

- Physiotherapist and patient trust and partnership negotiation
- Physiotherapist and patient decision-making negotiation

6.6.1 Physiotherapists' Trust and Partnership Negotiation

Physiotherapists' responses to trust and partnership negotiation varied according to the degree to which physiotherapists adopted their roles as teachers, treaters or person-centred.

6.6.1.1 The Teacher

For teacher physiotherapists, partnership was *mutually negotiated*, and treatment and management was aimed at guiding the patient towards their personal health goals:

When they take on board what you're saying, when they learn about the way their body responds and the limitations ... then it's really rewarding ... you can see what you're doing is good, it's right for them (Pt7).

The patient's positive response to the physiotherapist's treatment consequently emphasised the physiotherapist role as a teacher:

The more she showed a willingness to learn, the more I wanted to teach her about the condition, how it works (Pt1).

The physiotherapist professional role was also positively emphasised when patients expressed a desire to actively collaborate with the physiotherapist and her working treatment methods:

The patient thought of herself as a partner, which was great, because it made my job so much easier, and the relationship just kind of grew from there (Pt6).

The following 'teacher' physiotherapist recalled how patients' unwillingness to learn made her more inclined to impose her teacher philosophies upon the patient–physiotherapist relationship:

I have had plenty of patients who do not want to learn ... they just look at you, or through you ... it bothers me, of course, but it doesn't make me change the way that I am, in fact I think it makes me even more determined to show them what they need to do to get better; it makes me more

determined to teach them about their condition (Pt7).

The passive/dependent patient persona served to perpetuate the physiotherapist values and beliefs. In this case, the teacher physiotherapist did not question her methods; rather, they were reinforced.

The following ‘teacher’ physiotherapist confessed that patient’s passivity and dependency could result in putting her in a position of not negotiating with the patient and agree to go along with the patient and see the consequences:

Some of them [the patients], they do not want to take part in the treatment, they want you to do all the work. Sometimes, I go along with that ... I do the work ... but then sometimes I don't. I sit back and go “OK, you want to do nothing, let's do nothing.” At this point we're stuck (Pt3).

6.6.1.2 The Treater

Treater physiotherapists articulated trust negotiation based upon the patient’s willingness to engage in a relationship where the treatment of the musculoskeletal condition constituted the bedrock of the therapeutic relationship:

She [the patient] listened to what I was saying. She trusted my judgement and we had a fine [relationship] (Pt3).

The patient understood that we were there to treat the problem so she knew to trust me (Pt10).

Treaters also highlighted the primacy of the clinical management of the musculoskeletal condition as a factor impinging upon the trust negotiation:

There was nothing more to it [the relationship] ... there was no idle chitchat or time wasting. I instructed her, she listened, and we came up with a plan. The plan was how the relationship developed ... we reacted to the plan and nothing else (Pt3).

When the patient responds positively to the treatment plan, then you know you're doing the right thing ... so you just continue what you're doing ... you continue to treat them in this way (Pt6).

The following treater physiotherapist intimated that the passive/dependent patient persona encouraged her to re-emphasise her professional role:

When you come across patients who don't believe in what you're doing, you need to remember why you do it ... you do it to free people from their pain. You do it to make them better. That's what I do in any situation. I treat the problem to try to make them better (Pt1).

Treaters that took a control and responsibility to partnership negotiation **emphasised a limited level of patient involvement**. These treaters took the lead in management and they did not encourage active patient involvement and input:

Ultimately, you're the physiotherapist and they're the patients. It's up to you to say what you want to do ... if they don't want to respond, it's not your fault ... you can't control the mind just like you can't control the body (Pt10).

Treater physiotherapists seldom confessed to abandoning their professional role as a consequence of the passive/dependent persona of patients. For treaters, the relationship revolved around the core function of the physiotherapy profession as the clinical treatment of the musculoskeletal condition. Treaters were centered on their treatment techniques, skills and technical expertise, and were focussed on taking charge of the patient and their problem.

6.6.1.3 The Person-centred

Person-centred physiotherapists **facilitated high levels of patient involvement**. They encouraged the patient to take a lead in partnership negotiation. They promoted educating patients so that they could make informed decisions themselves.

The following person-centred physiotherapists revealed the extent to which partnership and trust negotiation and patient personas are intertwined:

It's important for me to get to know the patient ...you know, the person so when they're open and personable, then it's usually a great experience (Pt8).

It's just the way I like to do things. Working with patients who are there with you in the treatment... you know that they are really there...it is so important as it frees you up to be yourself (Pt4).

I invest a lot of myself [in the relationship] ... when the patient does likewise, it encourages me to continue working in this way ... I'm more open not only with that patient but also with others (Pt2).

The active patient persona had an effect to the physiotherapist's propensity to work in a particular manner (in a person-centred manner).

Physiotherapists who adopted a person-centred role also commented:

Yes, it's true, some patients do not want to know you ... but that doesn't mean you've got to retreat: on the contrary, it makes you want to make all the more effort to get to know them (Pt8).

I like to think that there's a reason why they're not responding to the treatment. Either they're shy or they're scared or maybe they're in too much pain ... regardless, I try to get them to open up to me so I can help them move on from whatever it is that's bothering them (Pt2).

The nature of our job is to treat the person, not just the patient, so if the patient doesn't want to engage with the treatment, it's up to you to get to know the person ... I never waver from this way [of working] (Pt9).

Physiotherapists' referred to a 'default setting' as a way of combating what they consider to be the frustrating responses of patients.

As the following responses attested, physiotherapists were acutely aware that, in some cases, the personal characteristics of patients served to impede the development of the patient-physiotherapist relationship, making it difficult for them to work with passive/dependent patients:

I have patients who are doubtful. Their main approach to life is disbelief. They, basically, if they don't say it out loud...they're saying to themselves, "I doubt it." No matter what you say, they snuff, they huff... they click their tongues. The extreme of this would be a patient to whom I'll have to say, "I can't help you. I really can't help you." Mostly it's the people who are not open to life, and their feelings are closed off, and it's too hard for them to face up to the truth of life (Pt9).

So this lady was unsure about treatment options. She was never real with me. She was incredibly anxious but she wouldn't share anything (Pt2).

I had a patient who was like rough... And this lady just put you off from day one and she was like 'oh why is me, why is this happening? I'm so sorry for

myself and it shouldn't be happening to me ... And at first I thought ... how am I going to stand this lady? (Pt8).

The responses from the person-centred physiotherapists revealed the important part played not solely by defensive behaviour patterns but also by the aggressive and subversive behaviour of some patients. Teacher, treater and person-centred physiotherapists described the problems they encountered with patients undergoing emotional and psychological issues:

You like the majority of your patients, but every once in a while you come across somebody who for whatever reason, because we're all human, you may not. But it doesn't mean you don't provide health care ... you still have to provide the best health care you can, but it's always nice when you like them (Pt5).

Her behaviour was very unreliable and not consistent and I think she was manipulating me to get the treatment modality she wanted and she played the same game with all the other female physiotherapists. And I tried to communicate with her by saying, you know, you be frank with me, I'll be frank with you. I want to try and help you. All the appropriate things or that I thought were appropriate things. Ultimately I don't think any of us, myself included, developed a rapport with her. I think she was so socially challenged the only way she could communicate with people was how it would meet her needs or be a gain for her (Pt6).

She was extremely aggressive the entire time, very angry, very nervous... You could clearly tell that this woman ... was verbally disinhibited and that maybe that was one of her problems. She clearly had problems with managing her anger ... she was extremely verbally offensive, extremely aggressive ... That's such an obvious example of a relationship that didn't work (Pt2).

She was never real with me. She was never genuine. She was incredibly anxious but she wouldn't share anything. ... If you even touched a chord she would look you straight in the eye and she would turn her head. She would purposely call me by the incorrect name (Pt10).

She was a difficult patient because she was particularly needy ... Just from a time point of view, I didn't have enough time to devote to her to make her happy ... She had ... on-going care from a psychiatrist... and unfortunately she had a very serious disc herniation. She was a young person, only 41 (Pt3).

6.6.2 Patients' Trust and Partnership Negotiation

The degree to which patients were involved in trust and partnership negotiation with the physiotherapist during treatment session was influenced by two factors: (1) the personas of the patients (2) the role, behaviour and attitudes of the physiotherapists.

6.6.2.1 The Active Patient

The findings implied that those patients who adopted an active persona were more likely to adopt a *proactive, participatory approach* to the treatment process, thereby facilitating an open relationship between the two parties, a point that the following participants (both of whom were active patients) underlined:

So, I am a participant, I'm not just a passive player. She respects my feelings and my intuitions (Pa9).

I'm there to learn from her ... I'm eager to work with her, to get better together (Pa7).

Active patients expressed a desire to learn about their condition so that they could take actions to improve their condition:

I would ask her, you know: "how does this work? Why do I not seem to be getting better even though I am practising the exercises at home?" (Pa2).

Person-centred physiotherapists are in a much more advantageous position when it comes to getting their patients to participate with them. A treater type role did little to facilitate an open, partnership relationship with their patients:

Um, well I don't really consider myself having a relationship with my [current] physiotherapist... although, she is an expert physiotherapist, and I'm her patient. She is very knowledgeable, but I don't feel like I have any connection with her. There's no personal...like with [the other physiotherapist] she shares herself. She is very open (Pa1).

The trust and partnership between the patient and the physiotherapist can serve to re-negotiate deeply embedded beliefs, views and assumptions.

Patients relished embarking upon a lengthy treatment and/or rehabilitation process. Even those patients who adopted an active persona testified that the interaction with healthcare professionals, be they doctors or physiotherapists made them feel uncomfortable and in many cases fearful of an uncertain future. For example, according to the following active patient, discussing treatment meant acknowledging a reality that they would prefer to ignore:

In having to talk about it [my musculoskeletal condition] I had to own up to my problems, which made me feel very mad [because] I can no longer do the things that I want to do (Pa1).

The propensity to withdraw, therefore, is interpreted as a trait that was not characteristic of any particular persona. Rather, the very process of treating a painful and in many cases emotionally and psychologically debilitating musculoskeletal condition is in itself enough to make patients more defensive than they might normally be a point that the following participant (again, an active patient) was keen to underscore:

It's not me ... I like to talk, especially to other women ... but when she [the physiotherapist] started asking me questions about my movement, my body ... private things ... and I didn't want it [the conversation] anymore (Pa5).

6.6.2.2 The Passive/Dependent Patient

Several patients mentioned a propensity to: (1) withdraw from the relationship between themselves and the physiotherapist and (2) withhold information from the physiotherapist. The likelihood of patients withdraws and passivity was influenced by the degree to which the patients adopted a passive/dependent persona. These episodes were described by passive/ dependent persona as follows:

“Clamming- up” during the treatment session and not providing any more detailed information about myself (Pa6).

I find myself not talking ... I do not answer all of her [the physiotherapist's] questions (Pa8).

I become very nervous and quite agitated. I feel very uncomfortable and I don't talk ... I just want to leave [the treatment room] (Pa4).

Passive/dependent patients were *less likely to participate* in the treatment process negotiation as the following responses attested:

I just didn't want to respond. The more she tried to get me to talk, the less I felt like doing so (Pa6).

It just didn't get any better. I wanted to listen to her, to what she had to say, but I did not want to be part of it [the relationship] (Pa3).

Patients who adopted passive/dependent persona were much less likely to seek out ways to improve their relationship with physiotherapists. They tended to respond to situations rather than seeking to control them:

I just didn't see any hope, there was nothing I could do ...we just did not click (Pa3).

She said I was dependent on her, that I wasn't doing enough for myself and perhaps she was right but she didn't realise the problems I had adjusting to things ... she didn't listen (Pa4).

Passive/dependent patients, who had hitherto expressed little inclination to participate, were inspired to adopt a more positive and proactive trust and partnership negotiated relationship when they encountered physiotherapists who bolstered their sense of self-esteem:

At first I really didn't want to get to know her but she made me feel so wanted, you know, like a human being and eventually I was much more open and honest with her (Pa6).

Physiotherapists who displayed a caring, empathetic attitude were cited as key reasons why hitherto hesitant patients are able to negotiate during the treatment process. The following responses were common for passive and active types of patients:

I guess I do not feel any judgment from her so I guess I can say whatever is on my mind like if I am really ticked off about something I can say that (laughs), if, whatever it is I can say it (Pa9).

I do believe that the good manners displayed by my physiotherapist made me

feel that I am welcomed to participate in treatment decisions, so I do accept her, accept her advice. (Pa3).

I felt empowered. I felt like we were doing this together (Pa 8).

Her whole way of dealing with it gave me permission to succeed rather than to fail and think that I couldn't do it (Pa6).

She makes me feel like I can truly be myself. I can ask as many questions as I want and still feel comfortable and having the enjoyable professional relationship (Pa5).

The patient acknowledged that her withdrawal attitude was not solely on account of the discussion of the musculoskeletal condition but also because of the way in which this involved a blurring of the boundaries between the public realm of the treatment room and the private sphere of the family and the home. For many women in Saudi Arabia, talking about their body in such an open manner is a highly uncomfortable experience. This is the case even if the physiotherapist is also a woman. The propensity to withdraw is, therefore, exacerbated when the relationship with the physiotherapist transformed from a treatment discussion to a hands-on treatment of the musculoskeletal condition as the following responses implied:

I don't want her to touch me ... I prefer she shows me how to do them [the exercises] ... not to touch (Pa4).

When she places her hands upon me I feel very uncomfortable ... I know she's only doing her job but I do not like it (Pa6).

It was those patients who adopted a passive and/or dependent persona who most commonly expressed an inclination to withdraw as a consequence of the physiotherapist treating their bodies. Few of the active patients articulated a problem with physiotherapists touching them.

Patients were directly influenced by the way that they felt their physiotherapists were treating them. Patients' who felt that their physiotherapist was overbearing and dictatorial were most likely to express a desire to withdraw. The following responses were typical of such a scenario:

The Physiotherapist says: "you do this; you do that". She had neither manners

nor kindness (Pa1).

I found her very rude ... her attitude was "I know best; you listen to me" (Pa5).

I did have a physiotherapist once who thought she knew it all and ignored what I said. She had a preconceived idea about what treatment I needed and when I told her I couldn't be able to do everything she recommended ... she was focused on my injury and not listening to me (Pa8).

When physiotherapists attempted to assert their professional knowledge as a teacher role upon the interaction so as to encourage the patient to learn about their condition, some patients interpreted this as evidence of conceited and superior behaviour on the part of the physiotherapist. While some patients withdrew as a consequence of physiotherapists adopting teacher and treater type roles, other patients withdrew when physiotherapists were too personal in their interactions with them:

I had this one physiotherapist and she was very chatty and nice but, the more I saw her, the more she wanted to know... you know, not just about my movements but about my family and my life. She was too personal ... and I began to tell her less about myself (Pa9).

Active patients were more likely than passive/dependent patients to seek out a relationship where the treatment of the musculoskeletal condition constitutes the bedrock of the therapeutic relationship. The findings suggested that all patients were likely to withdraw if they felt as though their physiotherapist was not a person that they could respect and trust on either a professional or personal level. For example, the following active patient expanded upon the need for a semblance of trust and partnership negotiation between the two parties:

It's a two-way process. I show her respect and she should show me respect. If you don't respect her, it's almost impossible [to work together] (Pa2).

Similarly, the following passive/dependent patient echoed the sentiments outlined above:

With some of them, they make it so hard because they don't treat you with

respect and dignity. The relationship cannot work like this without any respect (Pa4).

One of the patients described the problems that her daughter had coping with a physiotherapist who displayed little by way of any respect or dignity during the treatment process:

She [my daughter] would come home and she'd be furious. She said, "I hate that physiotherapist"... I thought they were minor things, but she'd be trembling she was so furious ... in fact we discussed this and that's why we booked her there, because she was such a good therapist, technically a good therapist, but socially a very harsh one (Pa7).

The professional role, behaviour and mannerisms of the physiotherapist have a profound effect upon the extent level to which patients participate during the treatment process.

6.6.3 Physiotherapists' Decision-making Negotiation

The decision-making negotiation process was inevitably bound to the partnership that developed between the physiotherapist and the patient.

Physiotherapists' responses to decision-making negotiation varied according to the degree to which physiotherapists adopted their roles as teachers, treaters or person-centred.

6.6.3.1 The Teacher

Teacher physiotherapists shared the responsibility of clinical decision-making with their patients, resulting in treatment and management decision being *mutually negotiated* between themselves and the patient. Their high levels of emotional self-awareness and their ability to relate to people meant they were flexible in their decision-making and could respond to the individual patient's capabilities:

Decision-making is the shifting of control, too. I mean, in giving her control, then she handed it over [to me]. And it is a dynamic that as in any interaction goes back and forth (Pt6).

Any management, any decision-making, anything, whatever you are going to decide, the patient has to be included, I mean you have to discuss the whole thing with the patient. So you just don't make that decision yourself (Pt7).

While teachers embraced patient autonomy and collaboration, there was movement within the degree of autonomy which patients exercised at any particular time during treatment. At times they would actively take responsibility when performing certain clinical procedures, and at other times, they would encourage patients to take a more active role and assume more responsibility.

6.6.3.2 The Treater

Treater physiotherapists considered themselves as instrumental decision-makers, and were confident in their ability to make independent decisions based on their knowledge. Their confidence in a body-focussed treatment meant they tended not to actively seek the patient's input into treatment and management decisions. Their role leaned towards being paternalistic, authoritative and knowledgeable, and ***they sought to direct and decide for the patient***, in accordance with what they had discovered during their body-focussed examination and treatment:

My main part of the contract is to treat, to understand the body as best I can, and to obviously be guidance in the treatment plan (Pt10).

Treaters did not emphasise communicating with the patient using words and language. They considered that the patients' bodies contained intelligible facts and that the body had its own history. Treaters emphasised their technical expertise in obtaining body-focussed knowledge through skillful techniques and procedures, they took control and responsibility for restoring the patient's body function.

6.6.3.3 The Person-centred

Person-centred physiotherapists worked with patients to develop the skills to self-manage their health issue, looking to facilitate learning. They focussed on teaching and motivating patients to enable them to manage their own pain and dysfunction. The patient sets their own health goals and objectives and the person-centered physiotherapists helped them to reach them. In addition to their technical expertise, person-centered physiotherapists emphasised listening and learning from their

patients, and they were focussed on building an understanding of the patient's problem and how it could have an impact on their function in day-to-day life so that patient-specific treatment plans could be developed with the patient:

Express caring in that interaction: this is what the physiotherapist can do. And the quality of that caring is what enhances the intrinsic motivation of the patient to take the responsibility (Pt4).

They considered patients as autonomous individuals, and a **high level of patient involvement** in decision-making negotiation characterised their role, and they sought to place the decision-making in the hands of the patient.

6.6.4 Patients' Decision-making Negotiation

Some patient participants (active patient persona) had obvious preferences for particular treatments and management interventions and were reluctant to consider taking another treatment plan and strategy (See section 6.4.2.1), while others (passive/dependent patient) appeared to be more flexible and could adapt to their physiotherapist treatment plan and strategy (See section 6.4.2.2). This variation in flexibility is illustrated by the following two comments:

I am looking for a hands-on treatment type, while there are other patients that are happy to have their treatment with only exercises and machines...I go through my preferences (Pa2).

I would be guided by them [the physiotherapist] as to what they want to decide... I would accept any kind of modality they apply (Pa6).

The first patient showed a strong reliance on technical hands-on skills inherent to the physiotherapist's professional competence, expertise and knowledge. In contrast, the second patient sought the physiotherapist's views and input into treatment decisions, and appeared to be much more flexible with regard to moulding to the physiotherapist's preferences and perspectives.

Several **active patients** described decision-making as a **dynamic process in which control was at times shared and yet at other times shifted to one or another person.**

Either the physiotherapist or the patient may assume, defer or share control in decision-making.

According to the active patients, physiotherapists who were deemed to be insensitive (i.e. physiotherapists who adopted a discernibly treater professional role in their relationship to patients) did not facilitate open, trusting and respectful, shared decision-making relationships. Likewise, according to the teacher physiotherapists, *passive/dependent* patients who were not receptive to their efforts and *share limited and low level of involvement in responsibility* were seen as barriers to mutual participation in the decision-making negotiation. Thus, passive and dependent patients could compromise the development of an open and shared negotiated decision-making therapeutic relationship.

The two types of physiotherapist-patient experience of negotiation were trust, partnership negotiation and decision-making negotiation. There were variations in the level of negotiations between the physiotherapist and the patient in each type, which was related and influenced by the different physiotherapist roles and patient personas adopted during their interaction. These are summarized in figure 6.6 overleaf.

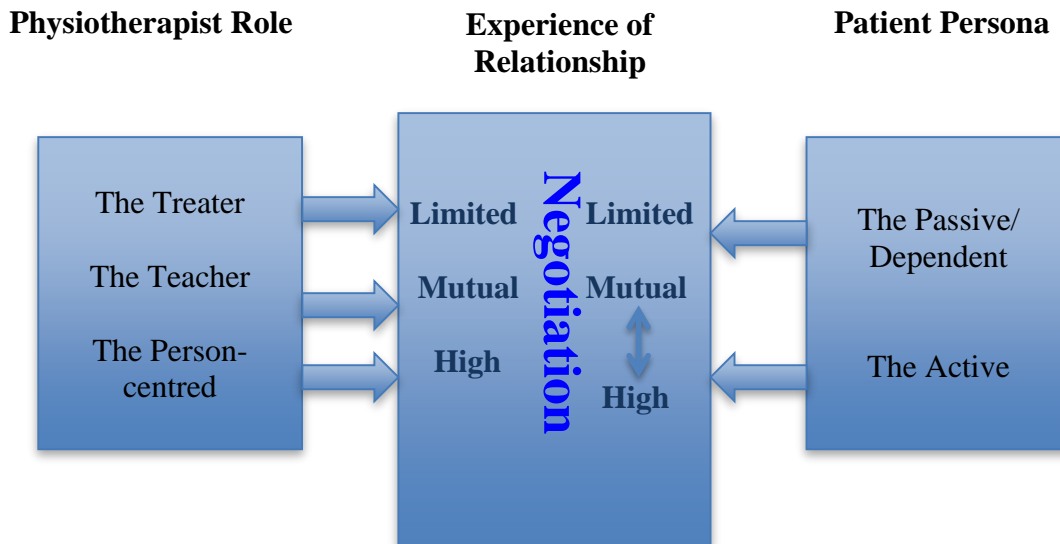


Figure 6.6 The physiotherapist–patient experience of relationship (negotiation) and the level of their negotiation

6.7 Types of Relationship

The different characteristics of the three professional roles along with the two patient personas led physiotherapists and patients to have different expectations of the relationship, which, in turn, had an impact upon the experience of the relationship, and, ultimately, the type of the relationship outcomes between the physiotherapists and patients.

There are three primary models of physiotherapist–patient relationships that were embraced by the participants in this study, namely: (1) the professional relationship, (2) the clinical relationship and (3) the personal relationship. These three physiotherapist–patient relationship models are presented overleaf with quotations to illustrate the essence of the relationship outcome. This is not to suggest that all participants fitted distinctly in each model, rather it offers a broad differentiation of participants’ therapeutic relationship to allow for theoretical comparison.

In the following sections an overview of the three types of the relationship outcomes is provided.

6.7.1 The Professional Relationship

The professional relationships are characterised by physiotherapist and patient participants as a comfortable interpersonal rapport, a trustworthy and honest mutual self-disclosure of personal information and a shared, equal-levelled negotiated decision-making and partnership. A number of teacher physiotherapists provided examples of the foundations of a professional relationship, focusing on mutual expectations of purpose and goal-orientation in the working dialogue:

I believe in being professionally related with a patient but not on a personal level. And what I mean by that I think you have to maintain a certain level of distance, i.e, a professional and appropriate behaviour. But it can still be special, based on sharing interests and discovering commonalities to develop a personal rapport with a patient (Pt3).

Some of the physiotherapists described how they placed emphasis upon the personal identity of the patient attempting to gain a sense of who they were before the onset of their musculoskeletal dysfunction. This, in turn, ensures that treating patients as people, rather than recommending treatments, becomes a patient-centred relationship. For instance, teacher physiotherapists described the importance of treating patients as people:

I understand that you're feeling horrible right now and I know this isn't the way you'd like to be. And so I do a gentle reminder of what I remember they were like and how we will try and get them back to that point and even better (Pt6).

Physiotherapist participants used conventional methods of negotiation in a bid to influence the development of the professional relationship between themselves and their patients. All of the physiotherapists felt they endeavoured to communicate with their patients. For some physiotherapists, communication was conceived of primarily as a way to explain the nature, function and purpose of the musculoskeletal treatment. This was especially true of physiotherapists who adopted the teacher professional role:

At the beginning, I tell the patient what I think is wrong with them and how we can go about fixing the problem. I make sure that they know everything

there is to know at the outset (Pt1).

There has to be an open and frank discussion during the first evaluation session. The patient needs to tell you as much as they can about their movements, their pain and so on, so that you can devise a plan to treat them (Pt6).

Treater physiotherapists interpreted negotiation as an interchange that is dominated by the professional and expert knowledge of the physiotherapist. Patients' views are used primarily to inform the development of the treatment plan at the outset of the relationship. The complexities of working with patients suffering from debilitating musculoskeletal conditions ensures that the physiotherapist is willing to modify treatments over the course of their therapeutic relationship with a patient. This was a point that was raised by the following treater physiotherapists:

Obviously, if they [the patient] come back to me and say they can't do this exercise or that they are experiencing too much pain then I have a duty to listen to them and to see if we can come up with a new treatment plan that works for them (Pt10).

Conditions are subject to change and the body is no different ... it [the musculoskeletal condition] can get better or it can get significantly worse so we [as physiotherapists] need to be flexible (Pt1).

The relationship between the patient and the physiotherapist was in a state of flux, subject to an almost constant process of re-negotiation. For example, the following teacher physiotherapist noted that the relationship changed as a consequence of the treatment of the musculoskeletal condition:

It [the relationship] is always changing because the patients are learning how to manage their body better ... they become more confident and then we have more to discuss and negotiate (Pt7).

For teacher physiotherapists, then, while negotiation was perceived to be integral to the development of the professional patient–physiotherapist relationship, it was a tool that was primarily at the whim of the underlying musculoskeletal condition. In contrast, person-centred physiotherapists who expected a personal relationship to develop between themselves and their patients articulated a much broader view of

negotiation as the following two responses suggested:

If by cooperation we mean involvement then, yes, I'd say the relationship is one that is defined by cooperation (Pt4).

I would not want a relationship where it's just me telling them what to do and the patient blindly following. Negotiating is crucial [to the relationship] because it helps to establish trust (Pt2).

Negotiation can also be used by physiotherapists to resurrect relationships that have become strained. This point was articulated by the following physiotherapist who adopted teacher and person-centred roles:

Inevitably, there are times when things are not going well, when the patient is just sick of their problems and sick of the sight of you! Some of them say they don't want to continue, that they've had enough of you teaching them ... the trick is to back off. Give them a break for a couple of weeks. Let them come back to you when they are renewed. Most of the time, this is what they do (Pt8).

This physiotherapist adopted a powerful means of negotiating with a patient who was frustrated. In relinquishing her position as a teacher and by allowing the patient time to ruminate on her condition, the physiotherapist was able to communicate effectively with the passive/dependent adopted patient persona. The patient–physiotherapist professional relationship was, therefore, one that is subject to considerable change.

If the patient had experienced a more involved relationship with a physiotherapist in the past, physiotherapists may encounter problems in their attempts at negotiating partnership:

Ok, with [the more involved physiotherapist], I feel I can truly be myself. I can ask as many questions as I want and still feel comfortable and having an enjoyable professional relationship. With the current physiotherapist, I may or may not ask questions, and there's a tension involved...there is no sharing (Pa5).

Both patients and physiotherapists trust, respect and offer empathy to one another, actively engaging in building a relationship that makes shared decision making

possible. This, then, is the essence of the professional relationship, one where a negotiated sense of decision-making can emerge from a mutually respectful therapeutic relationship. It was apparent that the most important factor influencing the development of the professional relationship is time: only over a period of time can the requisite levels of trust be established between the patient and the physiotherapist.

6.7.2 The Clinical Relationship

A strictly clinical relationship between physiotherapists and patients is characterised by an impersonal approach, which involves a minimal level of personalisation in addition to a formal and somewhat distant or disengaged manner. From a clinical perspective, then, the physiotherapist's expert knowledge dictates the pattern of the intervention. Whilst for some physiotherapists, adopting a clinical approach to practice is not considered an effective means of facilitating a partnership with the patient, for others it is sometimes the only means of addressing the technical aspects of the profession. Many of the physiotherapists who participated in this study suggested that they would prefer not to adopt a strictly clinical approach for treating musculoskeletal disorders in patients:

I don't always try ... I don't ... if it doesn't ... click right away it's not a big problem, it is only a technical body-focused relationship (Pt10).

Treater physiotherapists observed that the interchange between themselves and the patient was managerial, introducing only a limited scope of personal factors into the relationship:

There was no communication, very limited negotiation. It was strictly business-like. 'Come in and I will provide you with the treatment session. I will review your chart, any issue? Yes? No? See you later' (Pt3).

From a clinical perspective, the treater persona holds a strong presence, creating a foundation on which the physiotherapist relies on her behavioural and relational choices. For instance, one physiotherapist recalled working with a patient that made it nearly impossible to establish a professional understanding:

She was a difficult patient because she was ... particularly needy ... Just from a time point of view, I didn't have enough time to devote to her to make her happy ... She had ... on-going care from a psychiatrist... and unfortunately she had a very serious disc herniation. She was a young person, only 41 (Pt3).

Physiotherapists that adopted the treater role to clinical decision-making emphasised a low level of patient involvement in this negotiation. They took the control in clinical decision-making and they did not encourage active patient involvement and input. Treaters that controlled clinical decision-making were centred on their treatment techniques, skills and technical expertise, and were focussed on taking charge of the patient and their problem.

The foundation offered by the clinical approach allows physiotherapists to excel at their treatment-related tasks, whilst minimising the interpersonal dependency. Working relationships that involve more personal interactions may seem physically demanding and emotionally draining. As such, physiotherapists may feel the need to protect themselves from the adverse psychological consequences of working with patients they may perceive as overly needy:

The work tends to be pretty intense and it's pretty draining and if I do it for very long at any one block of time it's depressing. I certainly can have an affective depression from being in this sort of circumstance of dealing with this stuff every day (Pt3).

The quote above suggests that a clinical approach to practice is characterised by little or no social interaction discussing what patients actually experience because of their musculoskeletal disorders. This, in turn, has a profound effect on the extent to which patients feel they are part of a mutual partnership. The clinical context demands that the patient–physiotherapist relationship is characterised by little or no social interaction. This, in turn, has a profound impact upon the extent to which patients are able to feel as though they are part of a mutual collaboration relationship:

It wasn't a comfortable, satisfying relationship but it went this way...and I couldn't do anything to change it...(Pa4).

In clinical relationships, then, the patient–physiotherapist interactions are very physical and body-focussed, a point that was expanded upon by a number of patients:

[It was like] just kind of ignore them, you know, just let them do, let them do what they have to do and they'll do it (Pa8).

Um, well I don't really consider myself having a relationship with my physiotherapist... although, she is an expert physiotherapist, and I'm her patient. She is very knowledgeable, but I don't feel like I have any connection with her. There's no personal... like with [the other physiotherapist] she shares herself. She is very open (Pa1).

Patients noted distinct differences in the way in which some treater-based physiotherapists interacted with them. In particular, patients were quick to observe the extent to which aspects of clinical relationship limited the involvement in decision-making negotiation and the development of any form of beneficial interpersonal relationship.

Patients would choose to ignore the advice of their physiotherapists. The following participant noted how she decided to reject the working methods of the physiotherapist as a means of registering her dissatisfaction with the relationship that was unfurling between the two parties:

I think I felt that in the beginning the only way I could get any control was to say "No" to the treatment. I just refused to do what she asked, no discussions, I just said "No" (Pa9).

This was a particularly extreme response given by a patient who adopted an active persona. Other patients also articulated a willingness to adopt similarly obstreperous ways of negotiating with their physiotherapists. The following participant, who adopted a passive/ dependent persona, confessed that:

I just received the treatment and for next session I won't show up and I go for another physiotherapist (Pa4).

This was a particularly antagonistic and disruptive method of negotiation adopted by

the patient, one that is best understood in terms of non-compliance. Passivity in this instance was manifested as a form of withdrawal and aggression whereby the patient deliberately sought to undermine the professional capabilities of the physiotherapist.

The patient's negotiation in this case involved a third party acting on behalf of the patient in a bid to bring about the patient's preferred outcome. While this form of negotiation can bring about the change that the patient desires, it was extremely doubtful whether subversive means of negotiation such as this could have a lasting, positive effect for the patient. The same patient noted how she was consistently left dissatisfied with the level of service she received in an outpatient setting:

Nothing has changed ... the new physiotherapist thinks the same as the last one. She has to have the last say. In the future, I will look to change her [the physiotherapist] again (Pa4).

Active patients sought to negotiate with physiotherapists regardless of whether they perceived the treatment to be beneficial or not:

I just said what was on my mind; "this isn't working for me. How's about we try something different?" (Pa2)

If I don't like the way that things are going then we have to try to find a new way [of working]. It's up to us [the patient and the physiotherapist] to make things work together ... all you have to do is talk (Pa9).

The patients alluded to traditional conversation and discussion as the most viable means of negotiating with physiotherapists. They sought to address what they perceived to be imperfections in the patient–physiotherapist relationship. Yet even when the therapeutic relationship was deemed to be functioning in a satisfactory manner, active patients continued to look to negotiate the terms of the relationship. In particular, active patients articulated a desire to work in partnership with the physiotherapists and, in some cases, to collaborate in decision-making as the following responses attested:

I do want to have a say in what occurs. This is not a shock. It is, after all, my body (Pa5)

I tell her [the physiotherapist] what is needed. I have to help to decide what is best. It is the only way to make it [the relationship] work (Pa7).

The traditional method of negotiation was used not only to voice dissatisfaction; it was also used as a means of emphasising autonomy. Negotiation was a straightforward way for patients to assert their authority upon the interaction between themselves and the physiotherapist. Some patients looked to make deals with physiotherapists so as to ensure that outcomes conformed to their expectations and hopes, a point that the following active participant was keen to highlight:

It's a game you have to play. You say, "look, I'll do this for you if you do this for me." There has to be some give and some take from both or it [the relationship] will never work (Pa9).

The patient–physiotherapist relationship is referred to in terms of a game, one where the patient is able to influence outcomes via traditional and conventional methods of negotiation. While this was an avenue that was predominantly explored by active patients who were willing to take appropriate measures to influence the development of the relationship, some passive/dependent patients also alluded to efforts to negotiate through conventional means. For example, the following patient who adopted a passive/dependent persona revealed how she attempted to communicate with her physiotherapist:

It wasn't the case that I said nothing ... When I felt as though the exercises were not making a great deal of difference, I did try to talk to her but she would not listen. She was insistent: she knew what was best for me (Pa4).

The patient's attempted to negotiate via conventional means was thwarted by what she deemed to be the physiotherapist's unwillingness to listen to what she was saying. The patient's attempt to negotiate was unsuccessful because of her inability to impose her ideas, values and beliefs upon the physiotherapist.

6.7.3 The Personal Relationship

In contrast to professional and clinical relationships, personal relationships were described by proponent of a less strictly professional approach to treatment to suggest a more informal relationship characterised by openness. In particular, personal relationships involve more disclosure from physiotherapists and greater equality in decision-making. Consequently, a personal bond emerges as one physiotherapist remarked:

You just connect on a different place and it's a more personal place. They're probably people that in ordinary life you would choose to be friends with. They're people who share relatively similar thoughts and beliefs about life, about people (Pt9).

Person-centred physiotherapists encouraged the patient to take a guide in clinical decision-making. They emphasised the importance of the patient to controlling the possible directions that treatment and management could take.

While physiotherapists who engaged in a more personal relationship with patients suggest a lack of professionalism, the same physiotherapists may argue that they are strictly adhering to the confines of clinical treatment. Despite the fact that personalised relationships between physiotherapists and patients can occur in clinical settings, physiotherapists using a more personal approach may find a strictly clinical treatment relationship overly sterile. As indicated by the interview data, some physiotherapists described the mutual sharing of thoughts, feelings, cultural origins (Pt2 and Pt4), emotions (Pt5 and Pt8), hopes and stories (Pt5) as foundational features of the personal relationship:

Relationships are almost palpable. It's a tone in the voice; it's a look in the eye. It's a silence that says it's okay (Pt9).

A physiotherapist was able to communicate her empathy to the patient in a non-verbal fashion, which according to the same physiotherapist can have an impact upon the development of the personal relationship:

Showing that you care can make such a difference ... the barriers [that the patient erects] come down and she begins to listen to what you are saying.

They trust you more (Pt9).

Using eye contact or talking in a certain manner can help, therefore, to build trust.

This was a point that was raised by several person-centred physiotherapists:

As soon as the patients are used to your face, the way that you look at them, they do begin to open up to you ... at least most of them do (Pt2).

I have what I like to call my 'therapy voice' where I talk very softly and very slowly. I make sure not to raise my voice or sound as if I am becoming irritated, even when I am finding the day or the patient extremely difficult to deal with (Pt5).

Little things like eye contact are really important, especially in health care scenarios where the patient is in pain or vulnerable ... it's not enough for them to hear that you care: they need to be able to see it (Pt9).

Physiotherapists alluded to the problems that occur when patients refuse to remove their 'nigab' during treatment session. The responses of the following physiotherapists were typical of the views of the vast majority of the sample group:

I don't like to work with a patient who insists on wearing her nigab while we are in the treatment session alone with no male presence ... I mean, how can I communicate with her if I can't see her facial expressions? It makes me feel tense and very uneasy (Pt5).

Facial expressions are very important...I don't feel comfortable [when the patient wears the nigab] and therefore I cannot develop a connection with these patients, especially if they stayed covered during the whole treatment session ... it is so annoying (Pt8).

Saudi Arabian physiotherapists were equally frustrated when dealing with patients who remained fully covered during treatment session. For example, the following Saudi Arabian physiotherapist was keen to underline her exasperation at some patients' unwillingness to show their faces to female health care professionals:

Why a woman would insist in covering her face where there are only both of us in the room I do not know. It has a very bad effect on communication and it completely ruins any attempt to build trust (Pt10).

In addition to revealing the importance of tones of voice and facial expressions, the findings suggested that touch was also an important non-verbal method of negotiation that physiotherapists were able to use in a bid to communicate with their patients. For instance, the following Western physiotherapists emphasised the intrinsic value of touch to the development of the patient–physiotherapist relationship:

It goes without saying that when you are working with the body, you can communicate more with a healing touch than you can with a thousand words (Pt8).

Ours is a 'hands-on' job so the better you are with your hands, the more likely you will be to communicate with the patient (Pt6).

In addition to acknowledging the hands-on nature of the physiotherapy profession, participants also revealed that touch was an important way of establishing trust with patients. The following person-centred physiotherapist recalled how she used touch to help a nervous patient become more relaxed during treatment session:

Just a hand on the shoulder is sometimes all it takes to let them know that you care ... that they are safe with you (Pt9).

As was the case with facial expressions, the value of touch was compromised by prevailing social and cultural norms in the Kingdom of Saudi Arabia. For many patients, the very idea of allowing a physiotherapist even a female physiotherapist to touch them was out of the question:

When they are so defensive that they won't even let you touch them then you have serious problems (Pt2).

Some of them are so tense and uptight that you cannot touch them, not even to let them know you care or that you are aware what they are going through. Sometimes, it's like treating a statue (Pt7).

Through the application of such tactics, physiotherapists engage in both verbal and non-verbal communication to establish a rapport with their patients. Person-centred physiotherapists who embraced this form of practice used professional boundaries as

a means of segregating themselves from their patients and, thus, secure themselves from becoming too personally involved. One physiotherapist considered these boundaries instrumental in allowing her to continue working long-term with patients:

You develop good relationships with a lot of patients but I think I also put up barriers somewhat because you wouldn't survive in this job if you didn't. ... I learned that early on and, you know, I think I do ... put up barriers because you just couldn't do that every day and not fall apart, I don't think (Pt2).

Physiotherapists recognised that significant involvement with patients is exhausting and is not necessarily helpful in treating musculoskeletal disorders. They suggested why too much personal involvement is detrimental to their own wellbeing:

I get too involved ... I worry about them (Pt4).

I think that you don't want to get too much into their [the patients'] lives, at least I don't. It's protective (Pt3).

Imposing barriers was deemed a form of self-protection. Physiotherapists must strike a balance between, on the one hand, disclosing information about themselves and, on the other hand, becoming intimately involved in the patient's personal life.

Patients gave an example of physiotherapists who refined just such a personal relationship with them during their time together:

She was the best physiotherapist I ever had. This lady was amazing; we got to know each other. She was interested in me as a person (Pa8).

It was like she made me feel sort of uplifted (Pa5).

Patients consistently referred to conversation as a way to break down the barriers that impinge upon the development of an open effective therapeutic relationship between physiotherapists and their patients:

We talked, sure, back and forth. I asked her where she came from and she told me how many kids she had and that kind of thing. And we commented on

things that were on television (Pa2).

In some instances, patients even felt that they might be able to develop a friendship-type relationship with their physiotherapists:

Maybe you could get a friendship with a physiotherapist rather than a physician, we see them frequently and spend more time interacting and communicating (Pa9).

Comparatively, each of these three relationships described above represents a different point of reference for professional, behavioural, and relational outputs in practise. The challenge of managing an on-going relationship with patients, however, can result in situations that require the physiotherapist to amend their professional role and persona in order to meet the requirements of the patient.

To highlight the tripartite framework of the physiotherapist's role in a relationship, Figure 6.7 overleaf highlights the three types of relationship outcome. Importantly, this model describes the practical flow-through of relational decision making whereby *treater* physiotherapists begin with a clinical foundation and pursue clinical outcomes of the physiotherapist–patient relationship with *controlled decision making negotiation*. As *teacher* physiotherapists build rapport and develop confidence with their patients, the foundations for a robust, more *mutually shared decision-making negotiated relationship* are created. *Person-centred* physiotherapists choose to progress to the personal relationship, embracing additional dialogue and discussion during the course of the treatment and a *greater level of decision-making negotiation*. As a protection mechanism and a form of retrenchment, physiotherapists default downwards on this model, until finally focussing on a purely clinical relationship in order to prevent any violations of personal boundaries.

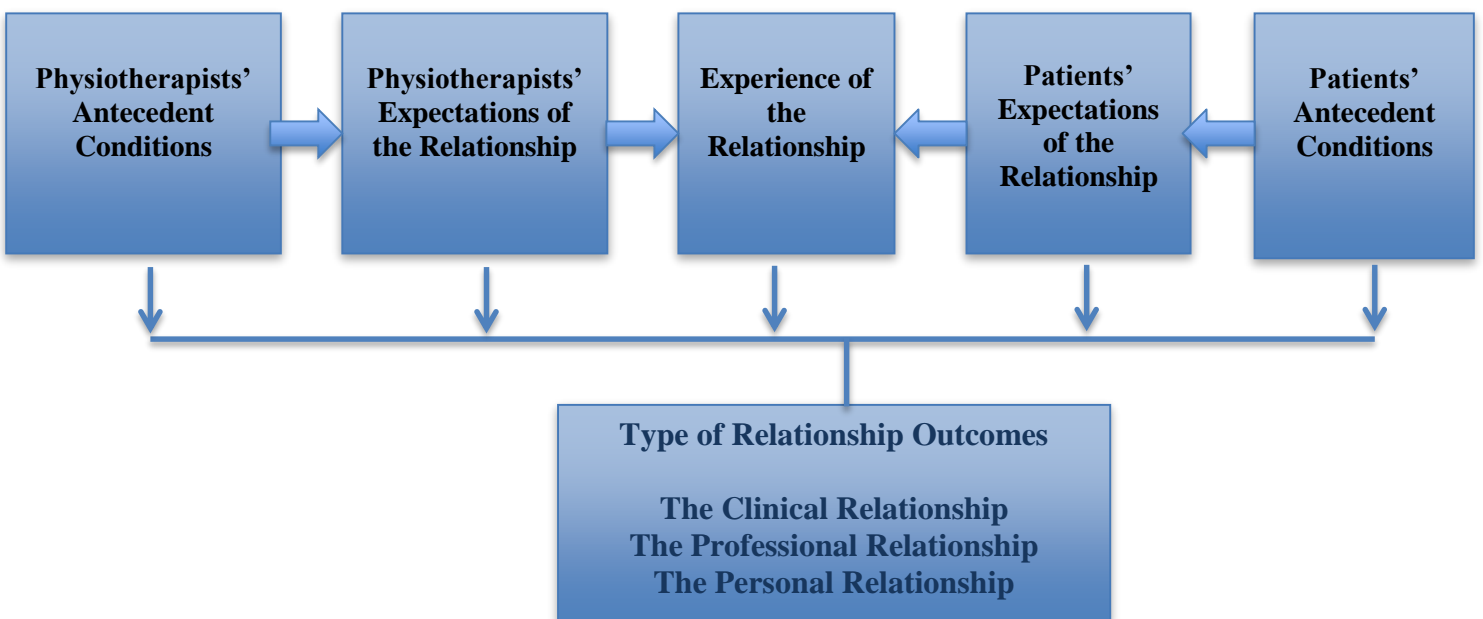
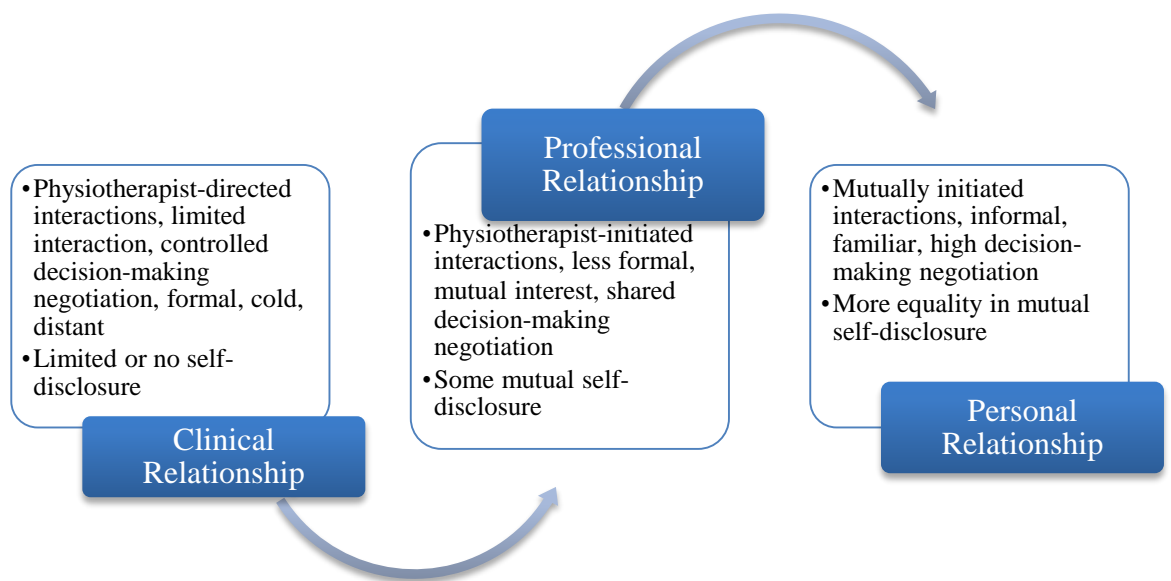


Figure 6.7 Types of relationship outcomes

6.8 Influencing Factors

A number of factors were identified which influenced participants' negotiation, such as time availability, sociocultural factors, participants' self-efficacy and professional self-esteem.

6.8.1 Time Availability

For participants in this study, time was recognised as a critical force in the therapeutic relationship, one that not only affects the depth of the relationship, but also allows physiotherapists to amend their professional role from a treater to a more person-centred role. Physiotherapists and Patients discussed the influence that time availability has on their perceived type of relationships with each other. For instance, one physiotherapist explained:

There's currently a patient that I have known for more than 8 years and she [has] had recurrent referrals ... I've been treating her since that time...so you develop special relationships with these patients (Pt4).

Physiotherapists recognised that seeing patients regularly (i.e. twice a week as an outpatient) allowed them to develop a personal relationship. Person-centred physiotherapists expanded upon the value that time had in the improvement of a personal relationship:

It isn't one appointment and that's it... you do build on that rapport with time and frequent visits (Pt2).

I think probably the most important is being able to listen, and give them time. That's probably the most common complaint that I hear through the patients themselves about other specialists or even their family doctors that they just aren't given the time to explain what their concerns are. And so I try and provide that opportunity to the patients, to have the time, so I book patients in long time slots, rather than every 30 minutes, or so. Well, actually I book 40 minutes for every patient... even if they are chronic [repeat] patients (Pt9).

From the patient's perspective, time was a vulnerability and frequently resulted in loss of control over the treatment process. Citing a range of common reasons for not attending appointments (e.g. transportation, illness, childcare), it was clear that

lifecycle effects play a role in moderating the commitment of patients to the therapy:

But that is assuming that we have had the chance and time to get to know these patients, but sometimes with patients who attended late or are being seen on a very busy day and under a busy work load... and we have no prior knowledge ... then you just ... provide the treatment and instructions required (Pt10).

The majority of the physiotherapists interviewed spoke of the pressure of time as it related to the treatment session with many identifying this as the main barrier to the establishment of a negotiated professional relationship with their patients. Time and availability, according to the physiotherapist quoted above, played a role in the type of persona used to work with patients. When physiotherapists have patients showing up late for an appointment or if they have overload patients to help in one day, the physiotherapists must adjust their treatment roles accordingly. This is the case despite some patients not receiving the treatment expected from physiotherapists:

Time is a big thing, it's terrible, it's terrible, trying to make some sort of relationship and have some sort of meaningful treatment in fifteen to twenty minutes, it's just bad (Pt8).

Sometimes you have to just, you know, for speed you have to just say, "right, you're going to have this" and that's it (Pt5).

The accelerated rate of conversation was recognised by these physiotherapists as detrimental to the treatment process, particularly in areas where knowledge itself was sacrificed due to time constraints.

Patients suggested that the greater the amount of time they had to spend with the physiotherapist, the more at ease they felt in their company:

I guess time would be a factor, time spent with that person (the physiotherapist)...I know her quite well now, I mean obviously over a period of time ... I have been going there for a long time (Pa9).

Other patients were acutely aware of the time constraints that were placed upon physiotherapists:

She [physiotherapist] was busy ... everything was on the fly. She ... had a lot of people to look after and she was just going, going, going, the whole time (Pa4).

Such feedback reflected an understanding that physiotherapists are busy and committed to other patients; however, it also highlighted a patient's need for greater personal attention in order to resolve specific issues influencing treatment plans and protocol.

6.8.2 Socio-Cultural Influences

6.8.2.1 Gender Identities

Given the core demographics of the participant population and the unique socio-cultural background of these participants, it was observed that socio-cultural forces and gender differences play a critical role in the patient–physiotherapist relationship. The characteristic male-female dynamic of the Saudi Arabian population that was explained in the introductory chapters was recognised to have a direct influence on the patient–physiotherapist relationship. Within the context of Saudi Arabia, some physiotherapists expressed grievances with the cultural expectations associated with strict theocratic rule and how that influences the ways in which women are allowed to interact with men. This is particularly the case when, as is stipulated by the legal protocol in Saudi Arabia, women are not allowed to attend appointment with physiotherapists without the assistance of her husband or a *mahram* (close male relative), or another close family relative. Women are not necessarily allowed to make their own treatment decisions; they must defer treatment decisions to their husband or *mahram*. Further complications occur when women in Saudi Arabia are legally obliged to wear the *abaya*, and *niqab* to make themselves appropriately presentable within social and cultural contexts and when some of them insist on keeping the *niqab* on the treatment session where only a female physiotherapist is present:

I don't like it when my patient's husband joins her in the treatment session and takes her role in explaining her case ...I don't feel comfortable and she can't as well discuss some sensitive issues related to her complaints in front

of him ... I usually ask him to wait in the waiting area until we finish the session (Pt5).

The physiotherapist's reaction was influenced not by the patient but, rather, by her husband, who took it upon himself to act as a conduit between the physiotherapist and the patient. For the physiotherapist, this represented a breach of the relationship between the two parties. She was no longer dealing with the patient and her musculoskeletal condition; she was reacting to the patient's husband and his views, which existed outside of the bounds of the patient–physiotherapist relationship:

Every time I asked her a question, she would talk about her husband and what he thought about the treatment ... never did she say what she thought, how she felt ... in the end, I came to realise: I wasn't having a relationship with her, I was having a relationship with her husband (Pt5).

The patients' reliance upon male relatives acted as an obstacle standing in the way of the relationship development. This was an issue raised by several of the physiotherapist participants:

At home they're not encouraged. They're lazy and idle not because they want to but because they're told to ... it's very disheartening (Pt2).

They [the Saudi patients] have a poor lifestyle, they need a change...to move more, to exercise... this would definitely improve their physical and psychological condition and their active participation in treatment plan ... the problem is nobody tells them to change, they're just told to put their feet up and rest, you know, to be a good woman (Pt9).

The subjugated role assigned to women in Saudi Arabian society has directly contributed to the promulgation of passive/dependent female stereotypes. The problem of working with passive/dependent patients was exacerbated by the age of the patient and their educational attainment. Elderly patients with a limited education were described as the most challenging for physiotherapists:

Some of the older patients are very trying ... they don't want to help themselves ... some of them, they don't even know where to start (Pt4).

In contrast, the younger patients and those patients who had attained a higher level of education were often cited as being more proactive and collaborative in their relationship with physiotherapists. From an external perspective, the socio-cultural dynamics within Saudi Arabia are complex and influential, resulting in experiences, which non-resident Western physiotherapists found to be frustrating or confusing. In fact, this may lead Western physiotherapists to make personal judgments about their experiences with patients they see on a regular basis:

Ten years ago, when I first got here...the body awareness was very low among ladies. It's getting better these days because of the media. I think people are more aware and educated about the importance of physical fitness, especially the young generation but the old ladies the really traditional ones are very modest. A lot of really traditional women, sometimes, when I say, "look up in the mirror" a woman says, "why should I look up?" They are very shy. Later on, they really know what's going on. Getting to the "aha" time when they say "Ah! I get it. And I can do the exercise properly; I show them this can happen (Pt6).

The importance of the age and level of educational attainment of the patient was consistently deemed to be critical to the nature of the female patient–physiotherapist relationship, regardless of whether the physiotherapist adopted a teacher, treator or person-centred role:

There's no question: there's a huge difference ... things are changing in the country and women know more now than they ever did before (Pt4).

It is of added importance to observe the ways in which prevailing socio-cultural constrictions placed upon women in Saudi Arabia work to limit the ways in which healthcare professionals instil confidence in female Saudi Arabian patients. However, as indicated by the Western physiotherapist quoted earlier, Western influences (e.g., the media) lead to more opportunities for women to make their own health decisions. Simultaneously, because there are strict gender expectations of women in the country, regulations on media to protect women from Western ideals can cause problems in a country with a strong theocratic hold on its citizens. The above case can demonstrate the problems associated with cultural differences between physiotherapists and patients, and these differences depend on factors such as age, education, access to technology, and upbringing in either a rural or an urban

environment.

Some of these factors may lead to degrees of trust and mistrust by patients regarding the physiotherapists who treat them for musculoskeletal disorders. One physiotherapist commented on the cultural differences between Saudi Arabian and Western physiotherapists while addressing how patients see the educational attainment by physiotherapists as influencing the degrees of trust patients have in terms of how the treatment process will work for them:

There are still some VIP [very important person] patients, especially the elderly female patients, that don't trust Saudi Arabian physiotherapists. They believe in Western physiotherapists, they are in doubt about Saudi Arabian physiotherapists' level of education and quality of performance and expertise (Pt1).

The physiotherapist indicated how some patients might consider themselves more important. However, the same physiotherapist indicated how elderly Saudi Arabian women might wish to receive treatment from Western physiotherapists because of perceptions that they are more trained to treat patients as humans. Elderly Saudi Arabian women seeking treatment for musculoskeletal disorders may see Western physiotherapists as more person-centred and, thus, open to various treatment options for patients regardless of cultural affiliation.

A number of patients articulated the problems that prevailing socio-cultural issues had upon their experiences with physiotherapists:

I am an educated woman and I can understand the instructions and demonstrate the exercises easily, but what about my mother who is non-educated...We can't send her to physiotherapy without her helper so she can apply the exercises to her at home. I know that this would ma[k]e her [a] passive patient and not willing to participate in her own rehabilitation, but we are used to this, particularly with [the] elderly non-educated women in our society (Pa5).

Although our Prophet Mohammad was proud of his wives and daughters, and he was giving them the right to everything in life...women here are extremely withdrawn and neglected...Men keep telling them 'You are a woman, you know nothing...How would you know' ...This is not Islam. This is tradition and culture" (Pa7).

While one patient indicated a link between inter-generational differences and cultural shifts in the expectations of women, the other patient indicated how the use of Islam (and even the application of *sharia* law) influenced the ways women receive treatment. The second patient quoted above indicated how the way in which women are treated departs from the traditional religious expectations rooted in Islam. As a result, limitations placed upon Saudi Arabian female patients are reflective of the constraints placed upon Saudi Arabian healthcare professionals regarding the treatment decisions physiotherapist must make when treating musculoskeletal disorders. In both cases, the inferior socio-cultural position of women in Saudi Arabia negatively influences attempts at attaining equity in a working professional relationship. While Western women are, to a degree, free from these cultural restrictions, it is apparent that understanding the nature of the patient–physiotherapist relationship in Saudi Arabia demands a critical evaluation of the integral role that gender plays in contemporary Saudi Arabian society.

6.8.2.2 Language Barriers

Language barriers, particularly between Saudi Arabian patients and Western physiotherapists, are closely linked to the challenges resulting from socio-cultural influences. In Saudi Arabia, this is a common problem. For instance, according to research undertaken by Walston, al-Harbi, and al-Omar (2008), Saudi Arabian nationals make up a mere 17% of the physicians and nurses presently working in the country. However, while, for patients, the influence of foreign nationals is a regular feature of healthcare provision in the country, language problems for Western healthcare professionals represent a new and significant challenge.

My biggest frustration initially, was the loss of direct communication with my patients. My lack of spoken Arabic was a definite disadvantage. The language barrier often complicated the simplest task, making it time-consuming (Pt1).

Furthermore, Arabic bears little resemblance to the oral and written traditions of the English language. Therefore, although they sometimes learn a few words, Western physiotherapists are unable to communicate effectively with their Saudi Arabian patients:

We as Western physiotherapists do experience feelings of helplessness, frustration and stupidity (Pt8).

In contrast to the above, an experienced Western physiotherapist who had lived in Saudi Arabia for more than 10 years illustrated:

There used to be when I first came to Saudi Arabia a significant language barrier in trying to communicate with patients to establish that initial rapport. Now, you don't need many words to make someone feel comfortable (Pt6).

When the same physiotherapist was asked about her view on having a patient's son, brother or husband with her acting as a translator in the treatment session, she stated:

Yes. They are not bad. And I can tell you sometimes you have to settle them down. Any of the family members should translate only what I am saying because if you're teaching an exercise and I see the results are quite different, I say no; they didn't say what I said (Pt6).

As indicated by the physiotherapist, while some physiotherapists may have issues with speaking a patient's native language, the fact that Saudi Arabian women have others with them who are able to translate can play a significant role in the development of a therapeutic professional relationship. However, when there is a husband or male relative present during treatment sessions, the accuracy of translating information stated by physiotherapists to patients is a critical factor in how well the treatment process works for patients. Accuracy of translating information made by physiotherapists may depend on socio-cultural factors such as educational attainment, as that is more likely available to Saudi Arabian men. Nonetheless, regardless of the conditions in treating musculoskeletal disorders, patients must have the ability to care for themselves in an organised manner; they must also believe they are capable of taking the necessary steps of a treatment programme without depending entirely on physiotherapists.

6.8.2.3 Patients' Education

A perceptual distinction was observed between educated and non-educated patients' interpretations of the physiotherapist role and their approaches to patients in the scope of the health-related intervention. This distinction has its basis in social status (e.g., educational background, socioeconomic status, and gender) and likely has significant impacts on the role of physiotherapists within the caregiving environment, particularly in Saudi Arabian hospitals offering physiotherapeutic services. Those with more education have a much firmer understanding of the professional roles held by people working in the medical industry while those with less education seem to have contempt for professionals with roles other than doctors. The lack of respect for the status of physiotherapists is an important revelation offered by these participants that is related to past experiences, personal biases, and interpretations of the physiotherapist process.

Across the participant populations, there were two distinctions drawn between non-educated patients and educated patients that segmented the opinions about physiotherapists and their professional roles:

Physiotherapy practice involves massaging and exercising; it is not a honourable job (Pa8).

I have an image that they (physiotherapists) don't know as much as doctors, they are helpers... who have to follow doctors instructions only... and the physiotherapist applies some exercises and massage (Pa6).

Alternatively, educated patients indicated that:

Competent physiotherapists offer superior interventions; but you have to know that your physiotherapist is experienced (Pa1).

My physiotherapist was a lifesaver. Before I met her, all that was offered was test after test. Afterwards, there was someone actually working with me, advocating my issues and figuring out how to fix me (Pa9).

From a more general purpose-based perspective, there was a consensus across the patients that the physiotherapist role was multi-functional, ambiguous, and often situationally defined. Specifically, Pa2 described this position as 'a catch all for your aches and pains'.

Some non-educated patients assumed that the physiotherapist would be able (and willing) to dictate the pattern of treatment, thereby ‘fixing’ their body’s dysfunction:

I come with the perception that physiotherapy is to fix it all (Pa6).

I think that physiotherapists do have that magic stick that can fix everything in one time (Pa3).

The physiotherapist can decide how best to fix me (Pa8).

Further, the following insight demonstrates the conflict between the physiotherapist’s self-perceptions and the patient’s interpretations in the early phases of the physiotherapy process:

You have a doctor who recommends that you see the physiotherapist. Then you explain everything to her that you explained to your doctor. She recommends some exercises and treatments, and then shows you how it is supposed to work. After that, you are pretty much on your own until you go back to the doctor (Pa8).

When treated by experienced physiotherapists, educated patients demonstrated a realisation of value and purpose in the activities performed by the physiotherapist, as well as the responsibilities related to providing care for patients:

God bless her for being a great Saudi Arabian physiotherapist caring for us at a very critical time (Pa7).

I was hopelessly in pain before I met my physiotherapist. Her knowledge and skill has made such a difference for me. There were issues that I didn’t even understand before walking in her; now I am putting the lessons into practice at home (Pa5).

Such responses revealed a benefit-based interpretation of value in the physiotherapist role as perceived by patients. This differentiation between early stage interpretation of the value and status of physiotherapists and the post-intervention understanding of their skills and responsibilities has implications for practitioners.

6.8.3 Self-efficacy

The interpersonal skills of both the patients and the physiotherapists are indicators of the development of the three types of relationship outcomes. One important factor influencing the response of physiotherapists to the behaviours of patients is self-efficacy. Self-efficacy consequently referred to “beliefs in one’s capabilities to organise and execute the courses of action required to manage prospective situations” (Bandura, 1997: p.2). As the following physiotherapists revealed, this represents a special challenge for physiotherapists working with patients who lack confidence and self-esteem.

Self-efficacy is all about how you estimate yourself. And the fact is that if you don't rate yourself very highly, others won't either (Pt2).

Self-efficacy is one of those elusive things that I have found hard to find over the years. It comes with practice through and through being true to oneself, i.e. when we have the integrity to live by our values. Maybe it's something that just happens as we get older, that's kind of been my experience too, although that could be simply because as we get older we become less 'chameleon' (Pt7).

Regardless of the extent to which physiotherapists conceive of themselves as teacher, treater or person-centred physiotherapists, the fact that some physiotherapists perceived self-efficacy as elusive (and, thus, hard to recognise immediately) renders it a difficult phenomenon to encourage in patients. As the following physiotherapist detailed, while some physiotherapists have expert knowledge, they are not masters of their patients’ outcomes:

Mostly, it's that I, that we develop a relationship where we figure out together, where we have to go through the human journey together. I don't know, I am not a master of these people, they come here, and adapt, and I have nothing, other than I have some knowledge that they don't have. And so, my job, the way that I relate to the people that come to me, is to listen, treat and to try to provide them with education and instructions. And it just so happens that that is the main modality I use sensing professional self-worth (Pt5).

As the physiotherapist indicated, self-efficacy does not strictly apply to patients. Here, the physiotherapist admitted limitations of technical and professional expertise

and that, therefore, a strictly clinical approach to treatment cannot apply to patients. Self-efficacy, in the case stated above, involves the need for physiotherapists to express humility when they are unable to meet the patients' expectations. However, the physiotherapist quoted above uses a person-centred approach by listening to what patients have to say about their musculoskeletal disorders.

Self-efficacy, moreover, plays a critical role where there are major differences in socio-cultural expectations between Saudi Arabian and Western physiotherapists and the patients they treat. As the following testimony from a patient underscored, many Saudi Arabian women are imbued with a sense of hopelessness that severely limits their worldview and, thus, limits the ability for physiotherapists to promote self-efficacy on behalf of the patient:

I am not at peace with myself. I mean that I don't appreciate myself and my personal worth, I don't have a positive attitude about myself and my abilities, I don't see myself as competent and in control of my own life, and being able to do what I want (Pa4).

Extremely low self-esteem such as the type recounted above represents a serious barrier to the edification of a productive therapeutic relationship. In such circumstances, the role of the physiotherapist can involve assessing the patient's psychological state before thinking about effectively treating their musculoskeletal condition. As the following responses revealed, it is essential for physiotherapists to make themselves aware not only of the vulnerable psychological state of their patients but also of their responses to difficult personal and professional challenges:

If you have an emotional reaction of anger or frustration, you notice many of the thoughts and small triggers that build up towards those emotions. You also notice moments when you can change the interpretations in your mind, or not believe what we are thinking. In this heightened awareness you instinctively make better choices in your thought process long before an emotional reaction or destructive behaviour (Pt6).

And I will also often ask questions so I don't start saying things that they couldn't relate to. I'd like to be sure that I don't say anything that they can't relate to. I don't mind expanding their view a bit, but I always go very gently and go from the place that they are (Pt7).

Physiotherapists who are aware of the relationships that they have forged with patients are in a better position to understand the patients' expectations, wishes and fears. This, in turn, establishes a platform upon which health care professionals are able to address problems of self-esteem and, as a result, to inspire a sense of self-efficacy in patients who lack confidence. In the final analysis, though, it is only through the mastering of experiences that patients are able to acquire such self-belief.

6.8.4 Professional Self-esteem

The professional self-worth as a physiotherapist was considered to be a continuum between high and low (Funnel, 1999). Professional self-esteem was associated with self-efficacy in clinical practice; high perceived self-efficacy was associated with high self-esteem and vice versa. The impact of professional self-esteem on the nature of therapeutic relationships has been discussed within self-efficacy.

The full explanatory matrix of the nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings in this study is illustrated fully in Figure 6.8 overleaf.

Nature of the Relationship

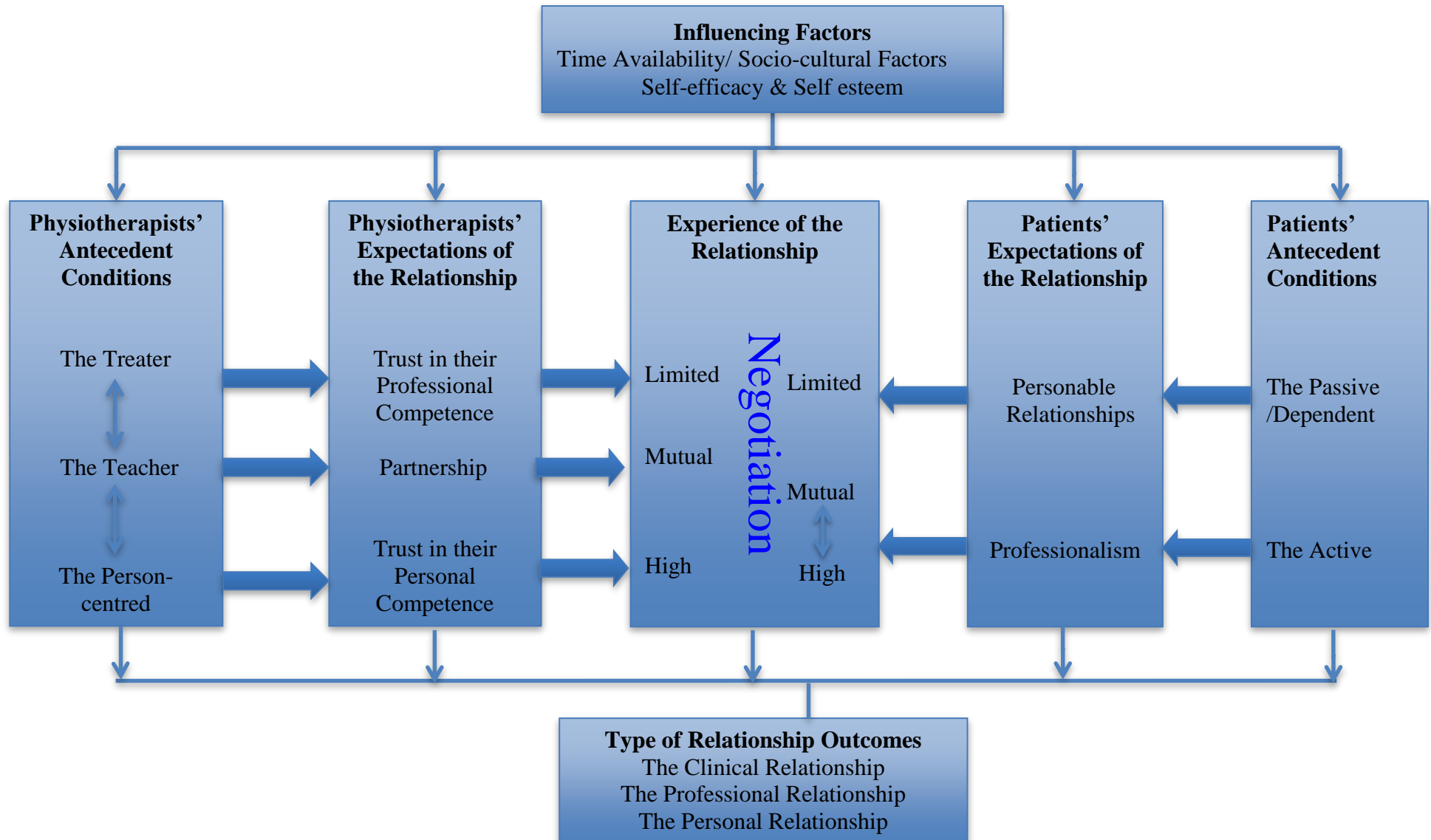


Figure 6.8 The explanatory matrix of the nature of the patient-physiotherapist therapeutic relationship

6.9 Chapter Summary

The findings have led to the development of a substantive theory of the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings. In this chapter, the participants’ background, and their work situations in musculoskeletal outpatient settings have been presented. The nature of the patient–physiotherapist relationship was influenced by the different physiotherapist professional roles and patient personas that have been adopted during their interaction. The different characteristics of the three physiotherapist professional roles, along with the two patient personas, led physiotherapists and patients to have different expectations of the relationship, which, in turn, had an impact upon the experience of the relationship. This ultimately shaped the relationship outcomes between the physiotherapists and patients.

Participants’ negotiation was identified as the key factor which contributed to the experience of the relationship between them. Physiotherapists and patients experienced different types of negotiations. The two types of physiotherapist-patient experience of negotiation were trust, partnership negotiation and decision-making negotiation. Within each type, there have been existed variations in the level of negotiation that were related to and influenced by the physiotherapist’s professional role and patient’s persona, as expressed during the interaction.

Three primary models of physiotherapist–patient relationships were embraced by the participants: the professional relationship, the clinical relationship, and the personal relationship. While clinical relationships left little room for disclosure and pursue clinical outcomes of the physiotherapist–patient relationship with limited level of decision making negotiation, professional relationships allowed rapport, trust and honesty to develop from a shared negotiation between the physiotherapist and the patient, personal relationships, embracing additional dialogue and discussion during the course of the treatment and a greater level of decision-making negotiation. A number of influencing factors were identified to contribute to participants’ negotiation and helped to explain the nature of the therapeutic relationship between physiotherapist and patient: time availability, sociocultural factors, participants’ self-efficacy, and professional self-esteem.

In the next chapter, the findings in the relation to the existing literature are discussed and evaluated. The implications of the substantive theory to physiotherapy practice, education and research are discussed.

Chapter 7: Discussion

7.1 Introduction

This chapter discusses the substantive theory of this study in the context of the existing literature. It begins by presenting six key summary points which are considered to be theoretical insights into the nature of the patient–physiotherapist relationship in musculoskeletal outpatient settings – developed as a consequence of the constructed theory. The chapter continues by considering my final critical reflection and reflexivity on the research journey and the impact I had on the study. Finally, the study's original contribution to the knowledge-base of physiotherapy is discussed, and the implications of the findings for practice, education and further research are outlined.

This study aimed to explore the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings. The substantive theory is illustrated fully in Figure 6.5, in the previous chapter. This is the first study that has been undertaken into the nature of the female patient–physiotherapist relationship in the Kingdom of Saudi Arabia. This section summarises the major findings that developed from the study, situating them in the context of the relevant literature.

7.1.1 Summary Point 1

Physiotherapists tended to adopt one of three professional roles: the teacher, the treater and the person-centred.

The findings from this study suggested that physiotherapist's professional roles that appeared were not fixed; rather, roles were fluid with physiotherapists. Professional roles that were reconstructed from the views and beliefs of the participant physiotherapists on the nature, purpose and function of the relationship between them and patients were the teacher, the treater and the person-centred.

The findings that there is diversity in how physiotherapists identify with their professional role is consistent with research investigating graduating

physiotherapists professional identities and expectations of professional life (Lindquist et al., 2006; Öhman and Hägg, 1998; Richardson et al., 2002). In this study, physiotherapists were characterised as treaters, teachers or person-centered according to their professional roles. *Treaters* viewed the nature of their relationship with patients as *body-centred*, whereby they considered themselves as the central, authoritative figure that *possessed the knowledge and technical skills to discover and treat the patients' problems*. *Teachers* viewed the therapeutic relationship as a collaboration, whereby the therapeutic relationship was *patient-centred* and involved the *sharing of knowledge and decision making with the patient*. *Person-centred* physiotherapists considered their relationship with patients as *facilitating empowerment*, and they *focussed on informing patients, eliciting their personal preferences and needs and providing choice*. The finding that physiotherapists' views and beliefs of their professional and therapeutic role, influences their clinical practice and behaviour, is consistent with research in physiotherapy professions (Evans, 2007; Thornquist, 2006). During professional education, practitioners begin to develop their own values, beliefs and philosophy of professional practice, which are considered to be some of the most important and influential forms of professional socialisation (Richardson, 1999a: 1999b; Richardson et al., 2002). Undergraduate training would have enabled groups of individual practitioners to develop shared perspectives, common values and assumptions (Richardson, 1999b). Practitioners may also have refined and developed new perspectives and values based on the day-to-day social interaction in the workplace with other colleagues (Richardson, 1999b).

This reflected research undertaken by Lindquist et al. (2010) who deduced that learning to become a physiotherapist involves the adoption of three pathways: learning to cure the body structure, learning to educate about movement problems, and learning to manage people's health. Moreover, as Ohman and Hagg (1998) observed in a qualitative analysis of gendered perspectives of physiotherapy practice, female physiotherapists can be segregated into two distinct character types: the 'supervisor' (i.e. the teacher) and the 'treater'. Although physiotherapist participants expressed that they had an open mind with regards to future professional roles, these character types were choice-decided; as a consequence, they informed participants' views on a long-term basis, acting as a mosaic work-based philosophy

(Ohman and Hagg, 1998). It was observed from the findings in this study that female physiotherapists have been mostly separated into three distinct character types: the 'Western senior' (i.e the teacher) in which they trust their clinical knowledge, the 'senior' (i.e the treater) in which they have confidence in their own technical expertise and the 'junior' (i.e the person-centred) where they do sometimes compensate their limited technical and practice skill experience with interpersonal communication skills.

However, while the person-centred role was potent, and consciously adopted by the majority of the physiotherapists, the findings in this research study also revealed a distinction between the idealistic and realistic views of the physiotherapist participants which, in turn, influenced the extent to which person-centred philosophies were deemed to be the most important roles for physiotherapists. While some physiotherapists' roles were constructed upon idealistic views (for instance, that the physiotherapist is able to consistently work in an unbiased fashion regardless of circumstance), other participants were aware of the thin, barely perceptible dividing line between person-centred role and patient attachment. Thus, as has been intimated in previous studies, the findings of this research study suggested that while person- and patient-centred views represent integral features of contemporary therapeutic relationships, these are tempered by the realisation that physiotherapy is primarily a medical service that is underwritten by practitioners' expert clinical knowledge (Bartlett et al., 2009; Ohman et al., 2001; Trede, 2012).

7.1.2 Summary Point 2

Patients tended to express one of two personas: the active patient persona and the passive/dependent patient persona.

The findings revealed the prevalence of two major personas amongst patient participants: the active patient and the passive/dependent patient. In particular, the dichotomy between patients who adopted an active persona and patients who adopted a passive/dependent persona was constructed to be factors of patients' responses to the relationship between them and physiotherapists: where *active patients sought to participate in clinical decision-making, passive/dependent*

patients tended to shunt clinical responsibility onto the health care professionals.

These insights mirrored research undertaken by (Aldwin, 2009; Norman and Conner, 1995; Ogden, 2007). Individuals who identify themselves as passive or submissive are more likely to perceive problems during medical treatment which, in turn, has a detrimental effect upon coping (Aldwin, 2009; Norman and Conner, 1995; Ogden, 2007). Similarly, extensive research undertaken by Doyal (1995: 2000: 2001) revealed that socially constructed gender characteristics and identities are crucial in shaping the capacity of women to realise their potential for health outcomes. The findings from this research study suggested that while gender characteristics and identities in the Kingdom of Saudi Arabia are deeply embedded they are subject to considerable variation. Passive/dependent patients in this study placed a great deal of emphasis upon the interpersonal communication between themselves and the physiotherapist. The underlying emotional and psychological issues influenced the development of the relationship between the passive/dependent patient persona and the physiotherapist.

This finding was congruent with the empirical findings presented by Harris, Morton and Barley (2003) and by Kenny (2004) which suggested that the psychological burden involved with resistance from patients to achieve the necessary positive outcomes of treatment can seem overwhelming. Therefore, patients inhibit their willingness to embrace the physiotherapist as an ally in the treatment process. As described by several of the physiotherapists interviewed for this study, an initial wariness or uncertainty influences patient behaviour during the first meeting when physiotherapists collect information to determine the first steps of a treatment programme. Physiotherapists are challenged to overcome particular hurdles (e.g. communication, psychological, behavioural) in order to identify the root of the problem. Whenever these challenges occur, complications with both the clinical and the professional relationship standards become apparent, and they prevent the possibility of a much-needed open exchange between physiotherapists and patients. In particular, the findings suggested that there was a considerable distinction between patients who adopted an active persona and patients who adopted a passive/dependent persona. Where active patients look to influence the situation, passive/dependent patients allow the situation to dictate their thoughts and behaviour.

One interesting theoretical feature to consider is how patients may perceive a loss of identity in physiotherapy; patients may feel this loss of identity when physiotherapists refer to them only as patients (Eccleston, Williams and Rogers, 1997). As a result, the patient is reduced to the composite of their symptoms, and patients eventually embody the characteristics of musculoskeletal disorders. This notion is especially important for patients with chronic pain accompanying musculoskeletal disorders. Eccleston, Williams and Rogers (1997) recognised that for individuals without a specific and demonstrated pathology for their pain, the default response of physiotherapists is to scrutinise or invalidate their claims related to their overall well-being by compartmentalising their patients' physiological burdens into a psychological domain. Yet this psychological association is critical to the realisation that therapy itself is procedural and involves alleviation of pain through purposeful actions and behaviours. This echoes with the finding in this study, in that those patient's who adopted passive/dependent persona, it seemed to be an identity that the patient felt the need to adopt in every aspect of their life. The patient was not, then, dependent upon the physiotherapist solely for their treatment; they were also dependent upon them as people to provide them with the emotional and psychological support that they felt they needed. As a result, it helps to consider past research conducted by Harding and Williams (1995) which argues that physiotherapists must strive for cognitive restructuring in patients by focussing on experiences of depression and anxiety as linked with resistance to, and misunderstanding of, treatment protocols in order to gradually affect thinking habits that may prevent physiotherapeutic interventions in the future.

The findings also suggested that female patients' responses to treatment were directly related to the extent to which patients believed that they had the power to influence situations. Thus, the findings of this study revealed that patients' responses to musculoskeletal treatment are largely determined by the self-efficacy of the individual with a clear and identifiable link between, on the one hand, the thoughts and feelings of the patients and, on the other hand, their behaviour during the treatment process. Patients' participation in clinical decision making were, therefore, intrinsically related to the way they thought. This corroborated research undertaken by Klaber Moffett and Richardson (1997) who highlighted the integral role that patients' responses play in the development of the patient-physiotherapist-

relationship. In particular, the authors of this study observed the primacy of patients' perception of control, their ability to cope with pain and the fundamental principles of operant conditioning.

7.1.3 Summary Point 3

Physiotherapists and patients embraced different expectations of the therapeutic relationship.

Partnership and trust were the two major expectations physiotherapists embraced in their relationships with patients. The findings suggested that there was a distinct correlation between professional role and expectation. As Richardson et al. (2002) noted, the expectations of the physiotherapy profession that students form during their training have a profound effect upon the attitudes and opinions of the physiotherapists. Moreover, as Trede (2012) observed, dominant modes of working continue to focus upon a subjective professional perspective which, in turn, emphasizes the links between personal identity and clinical practice. *Teacher and treater* physiotherapists in this study were compelled to *focus on trust building through establishing professionalism and a robust background of experience and competence*, whilst *person-centred* physiotherapists simultaneously were *prioritising personal characteristics and a compelling the engagement of the patient in the therapeutic process*.

Partnership and trust between the physiotherapist and patient has been widely referred to in the physiotherapy literature as a parameter which may be core to the therapeutic relationship (Bassett and Tango, 2002; Bellner, 1999; Gyllensten et al., 1999; Gyllensten et al., 2000; Gyllensten et al., 2003; May, 2001; Payton and Nelson, 1996; Potter et al., 2003a; Potter et al., 2003b; Talvitie and Reunanen, 2002; Thornquist, 1992; Westman Kumlin and Kroksmark, 1992; Williams and Harrison, 1999). The partnership theme comprises several subcategories which seemed to be evident in the literature: trust, mutual respect, knowledge exchange, power balance, and active involvement and collaboration with the patient. In this study, the expectation of a partnership relationship was particularly in teacher physiotherapists. *Teacher* physiotherapists expected the relationship between themselves and their

patients to be forged by *participation and partnership* with the physiotherapist teaching the patient about their musculoskeletal condition and the patient responding in kind by implementing exercise routines in their own time. *Person-centred* physiotherapists emphasised that the *patient should be encouraged to take the lead in decision-making*, and it appeared that they endeavoured to give whatever treatment and management, the patient requested. *Treater* physiotherapists were compelled to *adopt a more authoritarian role in order to dictate the pattern of treatment*. They assumed responsibility for treatment and management decisions, encouraging the patient to be passive, so that they could direct their treatment to the patient's body. Their goal was to improve patients' health through improving function of muscles and bones, using specific treatment techniques.

These insights mirrored the physiotherapist perception and almost the patient perception research paper that identified active involvement or collaboration as a component which may contribute to the therapeutic relationship. This may include active involvement in managing the condition as well as involvement in the treatment process (May, 2001). This concept is linked to the holistic attitude to healthcare, in which patients are seen as active participants (Gyllensten et al., 1999). In many ways, active participation is also linked to the 'power balance', a concept which was alluded to in a number of papers (Bellner, 1999; Potter et al., 2003b; Talvitie and Reunanen, 2002; Thornquist, 1992; Westman Kumlin and Kroksmark, 1992; Williams and Harrison, 1999). In a theoretical discussion paper, Bellner (1999) examined various relationship models as tools with which therapists can better understand their relationships. The guild model places the therapist in a power position in which they are the 'expert'. In this model, the therapist expects cooperation from the patient but does not seek active participation. Conversely, the interactive model was identified as preferable regarding the development of a good therapeutic relationship. This model considers the relationship between the therapist and the patient in terms of a collaboration of equals making differing contributions, and active participation is emphasised. This notion of the importance of equality is supported by Williams and Harrison (1999) who suggested that the result of a power imbalance is often conflict, dissatisfaction and an overall non-therapeutic effect.

The expectations of patient participants in this study are considered as *active patient* expectations of *professionalism*, including *respect of their autonomy, empathy, partnership, knowledge and expertise, trust and rapport* and *passive/dependent* patient expectations of *personable relationship*, including *care, helpfulness, a loving attitude, openness and good communication skills*. As was the case with the patient personas, patients' expectations were not rigid or fixed according to the active or the passive/dependent patient persona that they adopted. However, the findings suggested that there was a distinct correlation between patient personas and expectation. Focussing on the impact of expectations on the outcomes of physiotherapy, Metcalfe and Moffett (2002) recognised that the promotion of active engagement and effective communication by physiotherapists can have significant and positive effects on the outcomes for patients with musculoskeletal conditions.

Moreover, the findings are also indicative of research undertaken by Hill and Kitchen (2007) into patients with chronic musculoskeletal conditions, in which the authors noted that patients tend to adopt one of three identities: positive patient, negative patient or ambivalent patient. Where positive patients expect a high degree of healthcare and are willing to act in order to bring about the outcomes they desire, negative and ambivalent patients harbour few expectations with regards to the standard of the healthcare they receive or, more importantly, the nature of their relationship with healthcare professionals (Hill and Kitchen, 2007). Not only do negative and ambivalent (i.e. passive and dependent) patients experience negative interactions, they also impede the development of an open partnership in which decisions are negotiated rather than imposed. This was a common feature of the findings in this research study. Partnership and information sharing is an expectation and preference of patients seeking complementary therapy (Richardson, 2004) and primary musculoskeletal care (Parsons et al., 2012), and the finding that some physiotherapists adopt one-sided approaches to decision making is of concern.

Related to both treatment and intervention (e.g. surgery) outcomes, there is a positive correlation between expectations and outcomes, highlighting the significance of active patient engagement and effective communication as important to the treatment process (Metcalfe and Moffett, 2002). Yet, when the expectations of active engagement and effective communication from patients are not required, the

current study has demonstrated that an inability of patients to engage and communicate effectively can severely hinder the development of positive treatment outcomes. As observed by several of the patients in this study, the inability to communicate effectively with the physiotherapist or a lack of acknowledgment of symptoms and treatment solutions can lead to resistance from patients during the treatment process. As a result, patients may seek help elsewhere to have their musculoskeletal disorders treated. Physiotherapists, therefore, must acquire awareness of the specific psychological needs of their patients, particularly during the initial fact-finding and educational stages of the treatment processes.

One of primary differences observed in the interview data from patients and physiotherapists concerned the expectations relating to the treatment process, its idealised outcomes, and the role of each party in this process. As physiotherapists are introduced to their patients and to their varying symptoms, experience and past patient characteristics emerge as antecedent factors eliciting responses from physiotherapists specific to each case (Thomson and Love, 2013). As a result, patients may feel a more generic effect during the early stages of the therapeutic relationship, increasing their resistance to particular emotional or psychological revelations. On the other hand, patients often expect physiotherapists to emulate a 'treater' persona by anticipating empathy and in spite of receiving a more clinical approach to treatment. Differences between physiotherapist and patient expectations create tensions in the relationship making treatment interventions extremely difficult by placing the burden of resolution squarely upon the physiotherapist (Thomson and Love, 2013). In this way, the physiotherapist is not only a professional therapist, but also a skilled student challenged to identify opportunities for connecting with patients without sacrificing the quality of care.

The study findings assert that the complex nature of physiotherapy involves both musculoskeletal disorders and physical influences that must be navigated by the modern professional. A consequence of this complex relationship, the distinct personal characteristics of professionals may impact their ability to provide adequate services to their patients. Researchers such as Gard (2007) caution that in cases where the psychological impact of the physiological phenomena is sufficiently overwhelming, psychological treatment must be pursued early in the process in

order to enhance treatment possibilities. Further, where cross-cultural barriers prevent physiotherapists from navigating barriers to communication or interacting professionally with their patients, it is essential that intrinsic skill sets in communication and empathy are accessible (Gard, 2007). It is this distinctive, intuitive interfacing that ultimately challenges both patient and physiotherapist to accept the treatment relationship and the depth at which it impacts on an emotional plane. From planning to dialogue to education, the range of options available to the physiotherapist continue to expand; the challenge in physiotherapy is recognising which option is best fit for the client's unique needs and scenario (Gard, 2007).

Snyder and Snyder (1961) also emphasized the importance of counselor warmth for the relationship and identifying three types of warmth, including commitment to therapy, effort to understand, and spontaneity. Although Snyder and Snyder differentiated between these three types of warmth, they are likely related to one another, in that putting forth effort to understand a client is related to the therapist's commitment to therapy and willingness and ability to spontaneously offer feedback and support. From the current study, findings demonstrate that knowing each patient as a person related to spending time with the patient, giving the patient an opportunity to talk, and helping the patient understand the meaning of her experiences. The physiotherapist–patient relationship provided a safe environment for the patient to talk.

Physiotherapists' described treatment sessions with patients as taking on a social context. The physiotherapist and the patient shared experiences. It was important during the physiotherapist/patient interaction for physiotherapist to talk about themselves, being open and using self-disclosure to help patients be at ease. It was found that knowing the patient with respect to their autonomy and variation in their personas was key in facilitating transitions, guiding when and how to disclose information, and assisting patients to move toward their goals and beyond their limitations. It was suggested from patient's expectations that these relational factors help to create a positive sentimental climate in the clinical environment and therefore may enhance the therapeutic relationship (Gyllensten et al., 1999, May, 2001). For example, friendliness helps patients to feel at ease, while empathy allows patients to feel they are being treated in a sympathetic and respectful way (May,

2001).

7.1.4 Summary Point 4

The patient–physiotherapist experience of the relationship is subject to an on-going process of negotiation.

The findings from this research study identifiably suggested that the patient–physiotherapist relationship is not static; rather, the findings suggested that the relationship between the patient and the physiotherapist is subject to an on-going process of negotiation, which renders physiotherapist professional roles and patient personas, their expectations of the relationship and reactions to the experience of relationship negotiation fluid. Several models of patient involvement in clinical decision-making and partnership negotiation have been discussed in the literature, some of which resonate with the findings from this study; these are discussed below.

Participants characterised as *treaters* adopted a body-focussed interaction to clinical decision negotiation. This type of negotiation was associated with *limited patient involvement*, and it is consistent with ‘paternalistic’ models of decision making described in the literature (Emanuel and Emanuel, 1992; Deber, 1994; Parsons, 1951). The determination of these participants to obtain information from the patient’s body through skilled analysis and examination placed little priority on exchanging or sharing information with the patient, implying an ‘all-knowing’ practitioner (Emanuel and Emanuel, 1992). Even though the paternalistic model of care and decision making has been heavily criticised in the literature (Ballard-Reisch, 1990; Beisecker and Beisecker, 1993; Thompson, 2007), the finding that such a one-sided negotiation is consistent with research in physiotherapy (Cruz et al., 2012a; Cruz et al., 2012b; Thornquist, 2001b). A negotiation to decision making which fails to explore and consider a patient’s perceptions and expectations may hinder the development of a patient’s sense of control over their problem (Klaber Moffett and Richardson, 1997) and miss a valuable opportunity to enhance their self-efficacy (Bandura, 1982). When participants characterised as treaters did attempt to ‘educate’ patients, its nature was predominantly transferring the anatomical, biomechanical and clinical facts from their clinical examination and the risks associated with their intended treatment strategies.

The findings from this study indicate that participants characterised as *teachers* adopted a negotiation to clinical decision making which was shared with the patient and embraced an *mutual level of patient involvement*, as is consistent with shared models of decision making in the literature (Ballard-Reisch, 1990; Charles et al., 1997; Charles et al., 1999b). A shared negotiation to clinical decision making emphasises the patient as an active partner, and involves both the patient and physiotherapist sharing knowledge and information, so that decisions can be mutually negotiated and agreed together (Charles et al., 1997; Charles et al., 1999b). At times, these physiotherapist participants would take the lead such as in providing the patient with knowledge and information. While at other times, they encouraged the patient to lead the way, as they recognised they were ‘experts’ on issues such as their personal experiences and preferences. The finding that some participants shared clinical decision making with patients is consistent with other research (Edwards et al., 2004a; Edwards et al., 2004b; Jensen et al., 2000).

This study found that physiotherapists who were characterised as *person-centred* adopted a patient-guide to clinical decision-making negotiation and advocated *high levels of patient involvement* that were analogous to the ‘informed choice’ (Gafni et al., 1998) and ‘consumerism’ models of decision making (Emanuel and Emanuel, 1992) in the literature. These physiotherapist participants would share information such as the nature of their diagnosis and possible treatment and management options. They would also encourage patients to express their own views and preferences regarding their problem and possible treatment and management options, thereby providing a channel for patients to exercise control, and thus facilitating empowerment (Emanuel and Emanuel, 1992) and enhancing patient self-efficacy (Bandura, 1982). These participants felt strongly that the patient’s autonomy should be valued, and they emphasised patients’ responsibility in making their own decisions, which is consistent with the ‘informed choice’ models of decision making (Gafni et al., 1998).

In contrast to physiotherapists, the findings revealed that patients attempted to negotiate with physiotherapists by identifying their autonomy. The findings suggested that the former is entirely dependent upon the persona that patients adopted. Where *active patients* will change physiotherapists in an attempt to

facilitate a sense of autonomy, passive/dependent patients will exercise little or no authority upon the developing partnership with their physiotherapist. The findings derived from the experience of the interaction corroborate research undertaken by Asbring and Narvanen (2004) who underscored the way in which female patients diagnosed with chronic fatigue syndrome attempted to gain increased control over their situation by acquiring knowledge about their illness.

Emphasising the value of patient partnership negotiation in the therapeutic process, researchers such as Watson (1996) and Nordin et al. (2014) described a variety of relational forces which encourage physiotherapist–patient interactions, and thereby encourage patient accountability in the therapeutic process. Partnership, according to Nordin et al. (2014: p.1), is recognised as the ‘action of taking part in something’ or ‘being involved in a life situation’; yet such definitions fail to qualify the dimensionality of such processes during therapy. In the current study, partnership and participation were recognised by both physiotherapists and patients as important and complementary elements in the therapeutic relationship. Yet there are gaps between effective and non-effective participation which reflect patient agendas, patient knowledge, and patient expectations during therapy (Nordin et al., 2014). As a consequence, patients who feel that they are participating in the process may actually be undermining the physiotherapist’s agenda, particularly if they misunderstand or misinterpret the treatment protocol.

Similar to the participants in the current study, Nordin et al. (2014) offer a qualitative snapshot of dualistic experiences during the therapeutic process, whereby patients are either satisfied with their physiotherapist’s interpretation of their symptoms or feel undermined, slighted, and disconnected with the physiotherapist’s findings. Deficiencies in physiotherapist–patient communication, such as assumptive inferences or associations, can lead to critical gaps in the relational framework, as expectations are unfulfilled. Given the feedback from both physiotherapists and patients in the current study, it is suggested that within the passive/dependent and active patient personas, there is an underlying distinction in which self-confidence and self-efficacy are primary catalysts for change. Whilst there is a broad range of forces operating upon such outcomes, research presented by Watson (1996) and Nordin et al. (2014), and further validated in the current study,

suggest that open communication and participative dialogue can encourage more active participation, whilst prescriptive, clinical communication and one-sided exchanges are more likely to lead to passive participation.

For physiotherapists, the burden of navigating such responses is important; however, experiential and antecedent conditions (e.g. education, cultural values, time constraints, etc.) may ultimately restrict the ability to identify and internalise such pathways. Describing the continuing professional development (CPD) protocol for this industry, French and Dowds (2008, p.193) highlighted the ‘personal and professional growth’ and development of ‘skills needed for new roles and responsibilities’ that emerge out of the CPD process. As CPD continues to emerge as an industry standard (rather than aberration), it is evident that physiotherapists are being challenged to critically evaluate their own skill sets, pursuing additional education and knowledge through formal channels to improve their in-practice behaviours and relationships (French and Dowds, 2008). Whilst most of the participants in the current study have acknowledged that they evolve their perceptions and abilities through experiences and patient relationships, the need for more formal, in-depth training is becoming a precursor to improvements and successes in this field.

As stated in the proverb above, to find the best approach to training and supporting the professional development of physiotherapists, one must actively seek a deeper understanding. The theoretical perspectives presented in the next section have underpinned this process.

Education/ Learning and Related Theoretical Framework

First, professional development as understood in physiotherapy will be described. Since professional development is centrally concerned with learning, and is affected by both personal and contextual factors, adult learning theories which cover these have been employed. The transformative perspective on learning has been used in the exploration of how to understand learning on the individual level, has been used to consider contextual factors.

Professional Development in Physiotherapy

Physiotherapists' professional development is considered an important part of working as a responsible healthcare and rehabilitation professional, and it refers to a life-long process of learning and refining practice and skills to ensure the best possible care for patients (Aslop, 2000; Swisher & Page, 2005). Physiotherapists, as autonomous professional practitioners, are obliged to keep abreast of changes of a dynamic work field and profession, and monitor and develop their skills and behaviour accordingly (Higgs et al., 2001). The process of physiotherapists' professional development starts in physiotherapy undergraduate training, as physiotherapy students are socialized into their roles as professionals and members of a professional community (Richardson, 1999a). As such, professional education plays a vital role in laying the base for a professional identity, after which the professional development process becomes a lifelong endeavour of striving towards professional goals, and professional competence and expertise: physiotherapists' "professional development is dependent upon their ability to be situationally responsive and continually to review and evaluate their work through critical thinking, clinical reasoning and processes of reflection" (Richardson, 1999b: p.467).

As a life-long process of learning, professional development is commonly discussed in terms of Continuing Professional Development (CPD) (CSP, 2003; French & Dowds, 2008). Key principles of CPD include individual responsibility in learning, and a continuous and systematic learning process with clear learning objectives that is planned and based on outcomes of learning (CSP, 2003). The professional development process requires skills of reflection, and conscious effort through a structured approach which can help practitioners develop a reflective practice (CSP, 2005; Donaghy & Morss, 2000). CPD includes work-based and informal learning as well as institutional, formal learning (Eraut, 1994). The work-based or situated learning is of great value for physiotherapists' learning and professional development (Richardson, 1999b). As physiotherapists engage in the context of their working lives, their professional knowledge is tested and further developed through reflection on, and evaluation of, practice (CSP, 2005). Learning thus occurs as knowledge learned in courses is tested and applied in practice, and valuable learning also occurs in the workplace itself.

Just as physiotherapists' professional development is affected by their workplace and culture, the manner in which physiotherapists approach professional development also feeds back into how the profession is shaped in that particular culture (Richardson, 1999b). Furthermore, the workplace, such as the clinical setting, is part of a larger context, which is constantly changing. The context is thus of considerable importance for physiotherapists professional development.

Finally, there are the personal, intrinsic factors of each physiotherapist that will affect how he or she develops professionally. Professional development is each individual physiotherapists' responsibility: "learning must be planned and negotiated personally rather than be structured and assessed by others" (Aslop, 2000; p.4). This is a challenge, when work and personal life put many other demands on both time and energy. Important personal skills needed are reflection and critical thinking (Donaghy & Morss 2000; Richardson, 1999b), a will and desire to learn (Illeris, 2006), as well as a well-rooted professional identity (Richardson, 1999b).

Professional development is thus impacted by both personal and contextual factors. These factors are interlinked and to understand how Saudi Arabian and Western physiotherapists can encourage and work with professional development of physiotherapists in Saudi Arabia, a different context than their own, these factors will be important to explore. They will here be considered from the perspective of relevant adult learning theories.

Adult Learning

The term adult learning is broad and encompasses a diverse field of different clientele, contents and delivery systems (Merriam, 1993). It is complex, and there are a range of different theories and approaches to understanding how adults learn (Illeris, 2009). From this broad expanse of theory and knowledge about learning, two approaches have been chosen. But before describing these, there are a few general conceptions about adult learning that are useful to consider.

Much of adult learning theory stems from the first half of the 20th century, developed by educational and developmental psychologists (Merriam, 1993). Early

focus was on measuring learning capacity through the aging process, as well as the measurement of intelligence, how aging affects memory, and abilities to problem solve and process information. More recent developments take a broader approach, where the social and cultural context of the learners, as well as their experience and personal histories are considered in relation to how adults learn (Merriam, 1993). Thus adult learning includes two different but integrated processes, one which is concerned with social interaction and the external environment, and one which focusses on internal processes (Illeris, 2006). Adult learning also includes formal and informal processes, which can occur in every-day life, in institutionalized settings and in the workplace. A basic concept of adult learning as opposed to child learning is that this is a life-long endeavour where adults take control over and responsibility for their learning. The basic concept is that adults' learning is bound by what they are interested in, and what they see as meaningful to learn: teaching or "outside influence ... will always be received in the light of the individual's own experience and perspectives" (Illeris, 2006: p.17).

As stated, there are both internal and external factors that impact professional development processes. The added dimension of Western physiotherapists working cross- culturally and in a development context makes this even more important. The perspective they stem from is developed within their own particular contexts, and when they engage in new contexts with people from a different culture, this will impact how they interact, how they communicate, and how they understand each other. Thus, in terms of professional development of Saudi Arabian physiotherapists in a development context, the internal and external processes will be considered based on transformative learning and situated learning, respectively. The overarching aim with using these theories is to facilitate a comprehensive perspective on what it means to work with and experience professional development with physiotherapists from different backgrounds and cultures.

Transformative Learning

All learning entails change, and this is particularly true in transformative learning in that it "shapes people" (Clark, 1993: p.47). Transformative learning is part of both personal and professional development processes, it can be both educationally

structured and part of every-day life (Clark, 1993). Transformative theory is related to contextual theories of adult learning and stems from a humanistic understanding of the person (Clark, 1993; Mezirow, 1991). Transformative learning holds that prior experiences shape who we are, and who we are directs our intentions and our interpretations of experiences. As such, learning is described as “the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one's experiences in order to guide future action” (Mezirow, 1991: p.12).

In childhood, learning occurs formatively through both socialization – informal learning of social norms through interaction with parents, friends and mentors – and through formal schooling. We are socialized into particular roles, and into particular ways of seeing the world. Even though as adults we are more self-directed in our learning, our understanding is invariably shaped by these ways of seeing, and we are continually influenced by our culture, language and experiences. “Culture can encourage or discourage transformative thought” (Mezirow, 1991: p.3), so where, what, and how we learn is directly related to the culture in which we have grown up, as well as in which we continue to learn. Beyond recognizing the importance of context in shaping meaning perspectives, transformative learning in general gives less attention to the matter of context. It is aspects of the individual processes of learning that will be explored from the transformative perspective.

Reflection in transformative learning

In defining reflection Mezirow refers to John Dewey, describing it as “the process of rationally examining the assumptions by which we have been justifying our convictions” (Mezirow, 1990b: p.5), and “the central dynamic in intentional learning, problem solving, and validity testing through rational discourse” (Mezirow, 1991: p.99). Reflection enables us to see through the way we normally interpret experiences: we reassess the validity claims that were made by meaning perspectives formerly unchallenged (Mezirow, 1991). Importantly, this is done through discourse with others. This communicative, reflective process is a “critical-dialectical discourse” (Mezirow, 2003: p.60) where the dialogue stems from each person's meaning perspective and involves their beliefs and feelings. Carr and

Kemmis (1986) described dialectical thinking as the process by which the opposition of two poles leads to a reconstruction of thinking and acting.

A critical reflection on assumptions and a full participation in dialectical discourse are thus two main elements of the transformative learning process. Communicative with others, where we all stem from our own meaning perspectives, which may be contradictory, it is a critical reflection over the differences that can lead to learning, and potentially to transformation. This is the essence of communicative learning, which will be described below.

Instrumental & communicative learning

Following Jürgen Habermas, a German philosopher and sociologist who stems from the tradition of critical theory and pragmatism, Mezirow (1991) makes a distinction between instrumental and communicative learning. Instrumental learning is concerned with controlling and manipulating the environment and other people, and learning ‘how to do’ things. It often takes a cause-and-effect approach where instrumental action is empirically based and follows technical rules – “it centrally involves assessing truth claims – that something is as it is purported to be” (Mezirow, 2003: p.59). Instrumental learning is based on a hypothetico-deductive developmental logic (Mezirow, 2009), in other words, knowledge is constructed or confirmed based on the testing of hypothesis; this is a common approach in scientific research.

Communicative learning is concerned with understanding others, and what they mean, as well as making ourselves understood: “the process of understanding involves claims to rightness, sincerity, authenticity, and appropriateness rather than assessing a truth claim” (Mezirow, 2003: p.59). Communicative learning is thus analogical-abductive (Mezirow, 2009), which means that the validity of knowledge, beliefs and ideas are tested through informed discussion leading to a consensual best explanation. In the process of transformative learning, it is through communication and dialogue with others that we can validate our experiences. We attempt to understand others through validating their assertions, and harmonizing these with

our own (Mezirow, 1990a). Transformative learning can occur in both instrumental and communicative learning, and reflection is required for both (Mezirow, 2003).

Instrumental learning is a traditional educational approach in physiotherapy through the teaching of established approaches, techniques and treatments, as well as in the approach to research in evidence-based practice that is common in physiotherapy. Herbert et al. (2001), which largely involves processes which follow along the lines of the hypothetico-deductive model. Physiotherapy is also a social practice, and there is an increasing focus on the relationship between the patient/client and the professional, which requires communication skills in the professional and an understanding of patients' ideas, beliefs and expectations for treatment (Atkins & Ersser, 2008). Narrative reasoning, for example, is not concerned with validating hypotheses by testing as in instrumental learning, but rather by mutual agreement between the patient and therapist (Edwards et al., 2004). Both instrumental and communicative learning are required in the process of learning to be a physiotherapist and in subsequent professional development. Instrumental learning has been the main focus in teaching of physiotherapists in Saudi Arabia, but what is being discussed in this thesis is a more communicative learning approach for both Saudi Arabian and Western physiotherapists.

Communicative learning is inherently a social interaction that is impacted by each person's meaning perspective. Since these meaning perspectives are contextually formed, it is of relevance to consider the contextual factors of learning.

Contextual learning & knowledge transfer

The contextual nature of knowledge is another factor that must be considered in terms of promoting the professional development of a Western-developed profession into a developing country with a different cultural context, using professional theories and teaching practices that are based on Western concepts of clinical practice and learning. Situated learning critiques the idea of generalizability of knowledge, that knowledge gained from one context is directly applicable in a different one, including between work-place and educational settings (Billett, 1996: 2004). All learning and knowledge is proposed to be socially and culturally

influenced, since the contexts in which learning occurs and knowledge is developed is socially constructed (Eraut, 2004). This is of import when introducing, promoting and teaching a profession cross- culturally, when the knowledge being taught, and the manner of teaching, has roots in a different cultural context. It is essential to consider when seeking understanding of how this can be done in the best way.

Thus the idea of knowledge transfer, transferability of knowledge can be described as near or far transfer (Billett, 1996). In near transfer, knowledge is applied between contexts or communities of practice that are closely related. Far transfer involves the opposite: the greater the difference and distance between communities of practice, the lesser the likelihood for the knowledge to be directly applicable. Transfer of knowledge also relates to the type of knowledge (Eraut, 2004): some forms of knowledge will be more transferable than others, and some are easier learnt in an educational setting than in the workplace. For example, in physiotherapy the body of professional knowledge is broad, it is practical and theoretical, social and academic, and it is under constant development. Certain things are less dependent on cultural factors, such as particular treatment techniques, anatomy and biomechanics. Certain things can be learned theoretically in more formal educational settings, such as physiology. Other aspects of physiotherapy, such as clinical reasoning, skills of communication, collaboration, patient education etc., need to be developed in relevant contexts. It is these aspects of the profession that are harder to both research and teach, without an understanding of the local context. Thus these aspects are a challenge for expatriate physiotherapists teaching or researching the practice of Saudi physiotherapists.

van der Velden (2004) has discussed the use – and abuse – of knowledge in development work: “what is knowledge? Who decided what knowledge is? Whose knowledge matters?” (van der Velden, 2004: p.75). She advocated “knowledge sharing (and learning) [which] is more than knowledge transfer – bringing knowledge from where it is available to where it is needed. Sharing takes place within a dialogue of knowledges in which knowers exchange experiences, values and ideas” (van der Velden, 2004: p.78). This links back to communicative learning, and part of the process of successful knowledge transfer requires an understanding of the new situation or context into which one enters (Eraut, 2004).

Finally, there are concerns with the idea of knowledge transfer in terms of development work, where Western norms form the framework for the practice.

7.1.5 Summary Point 5

Three primary models of physiotherapist–patient relationships were embraced by participants: the professional relationship, the clinical relationship, and the personal relationship.

The different characteristics of the three professional roles along with the two patient personas led physiotherapists and patients to have different expectations of the relationship, which, in turn, had an impact upon the experience of the relationship, and, ultimately, the type of the relationship outcomes between the physiotherapists and patients. Three primary models of physiotherapist–patient relationships were embraced by the participants in this study; (1) the professional relationship; (2) the clinical relationship; (3) the personal relationship. While clinical relationships left little room for disclosure, professional relationships allowed rapport, trust and honesty to develop from a shared negotiation between the physiotherapist and the patient. Meanwhile, personal relationships blurred the boundaries between professional roles and emotional relationships which ultimately, exacted a debilitating psychological toll upon physiotherapists. Physiotherapists who favoured a personal approach to practice had to establish professional boundaries as a means of safeguarding their own psychological and emotional wellbeing.

This finding has resonance with the literature. Facilitating patient empowerment so that they can be involved in decision making about their treatment involves situating the patient at the centre of their care (Lawn et al., 2011). The literature argues that in practice, enabling patient empowerment requires placing the patient as professionals in their own right and experts of their own care, bodies, symptoms and situations (Holmström and Röing, 2010). This echoes with the finding in this study, in that those physiotherapists characterised as teachers focussed their interaction on the patient in order to generate meaningful, pertaining to the impact that their pain and dysfunction has on their daily life and activity. The literature suggests that interacting and communicating in this way facilitates a *professional relationship*

and *patient-centred approach to education and self-management of patients*, particularly those with chronic conditions (Anderson and Funnell, 2010; Holmström and Röing, 2010; Klaber Moffett and Richardson, 1997).

Physiotherapists who were characterised as person-centred emphasised engaging the patient and interacting with them as a person. This finding has some resonance with the literature on *personal relationship* in '*person-centred*' care (Ekman et al., 2011), which recognises more fully, the significance of *knowing the person behind the patient*. In this study, participants characterised as person-centered went beyond just understanding the patient's diagnosis and functional problem, but also sought to develop and interact with the patient as a human being, and considered them as a person with "feelings, and needs – in order to engage them as an active partner in their care and treatment" (Ekman et al., 2011: p.249). Physiotherapist-patient *clinical relationship* interaction which *emphasises patients' bodies* limits treater physiotherapists' understanding to that of the objective reality of patients' anatomical, physiological and biomechanical dysfunctions (Nicholls and Gibson, 2010). This view fails to connect the physical impairment with patients' social world and lived experiences, which is necessary for a deeper understanding which is embodied and relational (Todres, 2008; 2011).

There is a thin, barely perceptible dividing line between professional relationships – constructed from the premise of mutual respect, advocacy and trust – and personal relationships in which the physiotherapist becomes too involved with the patient. Thus, as Gard and Gyllesten (2004), highlighted that, while it is important to acknowledge the significance of emotions as a predictor of good interactions in treatment situations, it is also prudent to observe the distinction between professionalism and personalisation in healthcare. Viewed from this perspective, there can be little doubt that positive effectiveness of the relationship between physiotherapists and patients is indeed pivotal to the delivery of successful healthcare provision.

The findings of this study suggested that, while it is important to acknowledge the importance of the professional role as a predictor of relationship outcomes, it is also important to exercise caution when attempting to conceive of the physiotherapist–

patient relationship as one that is defined according to preconceived types. Most notably, the three professional roles highlighted by the physiotherapists who took part in the research study cannot be viewed in isolation. For instance, while physiotherapists who adopted teacher roles alluded to the importance of educating patients so as to inspire the confidence needed to activate change, the teacher-based perspective also incorporates effective treatment of the patient and their condition in addition to adopting a person-centred role so as to build trust and rapport. Likewise, while physiotherapists who adopted treader roles underscored the primacy of the treatment of the condition (body-focussed interaction), they also intimated that professional/technical expertise played an important part as a conduit through which to teach patients about the limitations that had been placed upon their physical movement. Moreover, although physiotherapists who adopted person-centred roles highlighted the centrality of looking beyond the patients' incapacities – so as to build personal relationships – these participants also alluded to the primacy of professional and clinical models of practice, with a desire to improve the quality of life of the patient, acting as the chief motivating factor for person-centred practitioners.

This resonates with the finding that whether physiotherapists conceive their roles to be teachers, treader or person-centred, effectively managing the condition continues to represent the core function of the role (Lindquist, 2006). Moreover, as became apparent during the findings, when trust develops, patients tend to see physiotherapists not as teachers, treader or person-centred, but, rather, as an incorporation of all three professional roles. Therefore, it is important to highlight the essential fluidity of professional roles in a musculoskeletal outpatient setting. Rather than considering themselves to be either professional, clinical or personal physiotherapists, it is perhaps more vital to understand these identifications as traits that while more prominent in some practitioners than others, are present in all physiotherapists working at top-tier healthcare organisations. This was indicative of research undertaken by Lingard et al. (2002) in which the authors concluded that professional roles in healthcare organisations are, in essence, discursive constructions, which reflect professional competitions. Only through learning and shifting their perspective can healthcare professionals hope to move themselves and assist others to move along the continuum towards expertise (Scholes, 1996: 2006).

This study's findings revealed that patients' willingness to negotiate with physiotherapists was directly related to the personas that they adopted. Active patients were more likely to negotiate with physiotherapists while passive and/or dependent patients were more likely to allow the physiotherapists to dictate the terms of the treatment, thereby dominating the relationship between the two. However, in this research study the findings also revealed the importance of conventional and unconventional means of negotiation as pathways to change. This was the case both for patients and physiotherapists. For some patients, conventional methods of communication were used to address perceived imbalances in the patient–physiotherapists relationship. Most notably, the findings revealed that discussing treatment plans with physiotherapists could serve to address the problem of withdrawal and passivity during consultation and treatment sessions. This was indicative of research undertaken by Oien et al. (2011) who deduced that the demanding nature of the treatment process generates significant potential for communication as a negotiation process in long-term physiotherapy relationships.

Like patients, physiotherapists reported that they attempted to negotiate in both traditional and non-traditional fashions. For example, the findings suggested that physiotherapists resort to conventional methods of communication with their patients. This is resonant with research undertaken by Klaber Moffett and Richardson (1997) and Dean et al. (2005) who outlined the major underpinning of physiotherapists' bargaining processes, which incorporate listening, exploring patients' beliefs and modifying patients' expectations based upon their own views of treatment. The patient–physiotherapist relationship is a partnership in which both treatments and outcomes are constantly renegotiated (Dean et al., 2005; Klaber Moffett and Richardson, 1997; Strauss, 1978).

The current research study also alluded to the importance that physiotherapists assigned to non-verbal means of communication. There is a long and rich tradition of academic literature that has been published on the ties that bind physiotherapy to non-verbal communication. Building upon the insights first afforded by Hargreaves (1984) and Dockrell (1988), research has highlighted the organic relationship between 'hands on' caring professions and non-verbal skills. Most notably, the literature has outlined the way in which physiotherapists need to rely upon

alternative methods of communication so as to instil trust in patients who are experiencing physical distress (Hush et al., 2012; Klaber Moffett and Richardson, 1997; Shaw, 2008). Yet the findings from this current research study also alluded to the deep-seated obstacles impeding physiotherapists' attempts to engage in non-verbal means of negotiation. In particular, the responses of the physiotherapist participants revealed that social and cultural barriers influence the bargaining potential of physiotherapists, with some Saudi women's insistence upon wearing the *niqab* during treatment sessions cited as the most important obstacle to non-verbal means of negotiation. Thus, while this research study clearly suggested that patients' personas and physiotherapists' professional roles, along with their expectations of the relationship and reactions to the experience of the relationship, are fluid, the impact of prevailing social and cultural customs remains a powerful determinant of the development of the female patient–physiotherapist relationship in the Kingdom of Saudi Arabia.

7.1.6 Summary Point 6

Nature of the female patient-physiotherapist relationship is influenced by a number of factors.

This study identified a number of factors which influenced, or were associated with, the nature of the therapeutic relationship between physiotherapists and patients. The literature has outlined the significance of patients' perceptions of the physiotherapy profession (Hills and Kitchen, 2007; Payton et al., 1998). In particular, the literature alluded to the problems of patients perceiving physiotherapy to be a lesser medical profession than doctors or physicians (Hills and Kitchen, 2007; Payton et al., 1998). With regards to the patients' perceptions of the physiotherapy profession, the participants who took part in this research study contradicted a lack of faith in the competency of physiotherapists as independent healthcare professionals. In particular, the differences in patient participants educational level suggested that there was a perceptual distinction between higher echelon medical professionals (i.e. doctors and physicians) and technicians such as physiotherapists.

Physiotherapists were consequently deemed to be working according to the instructions of doctors, rather than working autonomously according to the insights bestowed via their own professional expertise. Thus, as Miles and Leinster (2010) observed, there are hierarchical ladders that impact upon the construction of the ideal medical professional, which, in turn, exerts a profound influence upon doctor–patient relationships. Moreover, as Kleinman and Van Der Geest (2009) observed, there is a considerable difference between patients’ views of medical experts who predominantly offer biomedical expertise (i.e. doctors, general practitioners and physicians) and patients’ views of care-giving healthcare professionals (i.e. those practitioners that engage in direct, ‘hands-on’ interventions). Where patients tend to infrequently question the decisions of biomedical experts, patients are much more likely to challenge the professional opinions of care-giving healthcare practitioners (Kleinman and Swain, 2004; Van Der Geest, 2009). For this reason, the patient–physiotherapist relationship is often fraught with friction and dissonance.

This was an assumption that was regularly expressed by the patients who took part in this research study. However, patients acknowledged that their perceptions of the physiotherapy profession changed as a result of their experiences with physiotherapists. Most notably, the findings revealed that the hard work and persistence of physiotherapists, coupled with their interpersonal skills, were able to positively influence the expectations of patients receiving musculoskeletal treatment. The findings suggest that, while patient expectations exert a considerable influence upon health outcomes, the development of the patient–physiotherapist relationship is defined both by expectation and experience.

There is an underlying expectation that patients have an inherent need to communicate, whereby the catharsis experienced through discussion and expression of their symptoms and experiences can be therapeutic in itself (Nordin et al., 2014). Yet, within a culture that limits the socialisation of its female population and imposes specific expectations regarding interactions, help-seeking behaviour, autonomy, and the communication process itself are all extremely complex. Across the participant feedback in this study, a range of culturally specific examples highlighted several conditions for Saudi Arabian women which make open discussion and communication with the physiotherapist difficult including the

paternalistic oversight of husbands during the treatment session visit, cultural traits which minimise social speech and interaction, and time constraints which limit the ability to attend sessions. Key codes identified by the physiotherapists include dependency, subjugation, restraint, silencing, and resistance – all of which affect the communication domain of the physiotherapist–patient relationship.

There are few studies in this field which focus explicitly on Saudi Arabian women during the physiotherapy process. One empirical evaluation conducted by Al-Eisa (2010) focussed on the behavioural characteristics of Saudi women, assessing whether appointment attendance could be correlated with specific symptomatic or behavioural dimensions. Through a retrospective evaluation of adherence records, it was determined that a prevalence of high non-adherence for Saudi women could be observed, whereby early withdrawal from treatment was viewed as a direct inhibitor to the therapeutic process (Al-Eisa, 2010). Within the current study, both physiotherapists and patients observed that time constraints were particularly influential for a patient's continuation of treatment, and in many cases, the inaccessibility of transportation or appropriate escorts was identified as a negative precursor to cessation. Al-Eisa (2010: p.5) confirmed such time and transportation burdens, further supplementing that, 'in Saudi culture, family obligations supersede the women's need to take care of themselves'. The consequences of such personal constraints include a resistance to help-seeking behaviour, marginalisation of physiological pain or ailments, or even a personal aversion to self-treatment and concern.

For Saudi Arabian women, the sociocultural pressures may result in particular behaviours that are inconsistent with their own desires or help-seeking needs. On the other side of this relationship, moreover, the distinct sociocultural values of Saudi Arabian women were demonstrated in the current study to influence patient behaviour, and subsequently influence the perspectives, values, and assumptions by physiotherapists regarding Saudi Arabian women. Focussing on the three professional roles adopted by the physiotherapists in this study – the treater, the teacher, and the person-centred physiotherapist – it is evident that time limitations and treatment constraints would be likely to negatively affect the values and behaviours of each of these physiotherapists (Al-Eisa, 2010). Furthermore, as the

relationship develops, investment in personal, real relationships becomes more burdensome if patients are non-receptive or unavailable. Therefore, the default relational outcomes include clinical or professional practices, constraining the personalised influence which Saudi Arabian women have self-reported to be seeking in such settings.

Shame, self-doubt, and victimisation in physiotherapy settings can be powerful catalysts for both positive and negative behaviours. Many of the patients in this study identified their own burdens as shameful and/or constrictive, resulting in vulnerabilities that mitigated their willingness to participate in this process. This finding is reinforced by Werner et al. (2004) study, in which he presented a range of stories and examples of ‘shamed’ women and their help-seeking behaviour. Due to intense sociocultural pressures and a personal unwillingness to accept the ‘weakness’ which is perceived as underlying chronic pain, many of the women in the Werner et al.’s (2004) study resist treatment, instead attempting to remain stoical in the face of persistent and chronic symptoms. Such findings are similar to Kut et al. (2007), and, surprisingly, both Werner et al. (2004) and Kut et al. (2007) championed a similar empowerment model of intervention, whereby individuals are encouraged to counteract feelings of pain and weakness through validation of their concerns and strengthening of their knowledge in regards to interventions and treatments. Ultimately, even in those societies like Saudi Arabia – where women may resist communicating their burdens of pain – recognition and validation of symptoms can assist greatly in self-efficacy and, therefore, in active participation within the treatment process.

Characteristic of the patient learned helplessness behaviour is what Harris et al. (2003) described as a role loss phenomenon, whereby pain and mobility issues affect normalcy and the patient’s prototypical lifestyle. As a result, the vulnerabilities and need for legitimation described by Kenny (2004) are magnified. This can be seen when physiotherapists are confronted with particular traits and/or characteristics in patients. When this occurs, there is an internal mechanism, defined by experience, which compartmentalizes feedback according to past experiences and specialized knowledge. This mechanism impacts patients in various areas including their self-concept, their living roles and responsibilities, and their personal aspirations and

agendas; therefore, any failure to acknowledge such effects may ultimately result in internal conflict (Harris et al., 2003). Whilst physiotherapists may see therapy as a modality for recovering lost abilities and roles, amongst the participants in the current study, there was a clear association between deficiencies in self-worth and self-esteem and the therapeutic process. In fact, both the patients and the physiotherapists indicated that patient resistance was largely a result of an unwillingness to accept and embrace the therapeutic process, regardless of the displayed behaviours.

The loss of identity in physiotherapy is an important phenomenon, which results in individuals being assigned an informal and generic title of 'patient' (Eccleston et al., 1997: p. 700). As a result, the patient is reduced to the agglomeration of their symptoms, a dilution of identity with particular consequences for chronic pain sufferers. Eccleston et al. (1997) recognised that for individuals without a specific and demonstrated pathology for their pain, the default response of physiotherapists is to scrutinise or invalidate their claims, attempting to compartmentalise their physiological burdens into a psychological domain. Yet it is this psychological association, which is critical to the realisation that therapy itself is procedural in nature and involves alleviation of pain through purposeful actions and behaviours. As a result, Harding and Williams (1995) proposed that physiotherapists must strive for cognitive restructuring by focusing on patient anxiety, depression, resistance, and misunderstanding in order to gradually affect thinking habits that may prevent physiological interventions in the future.

Rotter developed the locus of control construct as one component of Social Learning Theory (SLT) (Rotter, 1966; 1982: Rotter & Hochreich, 1975). According to SLT, the likelihood of a given behaviour occurring, i.e., the behaviour potential, varies according to (a) the expectancy that a particular reinforcement will occur as a result of the behaviour, (b) the value of the expected reinforcement, and (c) the psychological situation, i.e., the components of a given situation, including meaning attached by the individual to various components of the situation (Rotter, 1982). Within this theory, reinforcement is "any action, condition, or event which affects the individual's movement toward a goal" (Rotter, 1982; p.94). According to SLT, positive reinforcement refers to any consequence that increases the likelihood that a

behaviour will occur (Rotter, 1982). Patients' movements were, therefore, intrinsically related to the way that they thought.

This corroborated research was undertaken by Klaber, Moffett and Richardson (1997) who underlined the integral role that patients' responses play in the development of the patient-physiotherapist relationship. In particular, the findings of the current research study observed the primacy of patients' perception of control, their ability to cope with pain and the fundamental principles of operant conditioning. Likewise, Martin et al. (2005), Kirsten et al. (2010) and McLean et al. (2010) also alluded to the importance of the thoughts and feelings of the patients as determinants of their responses to treatment and, more importantly, their adherence to exercise programmes. Most notably, these studies suggested that patients who displayed signs of anxiety, low self-esteem and depression typically do not respond well to treatment and do not adhere to mutually established exercise regimens (Kirsten et al., 2010; McLean et al., 2010).

Numerous variables affect the expectancy of a reinforcement occurring as the result of a particular behaviour. Expectancy is influenced by an individual's previous experiences in a particular situation, as well as generalized expectancies for behaviours and resulting reinforcements in similar situations. One type of generalized expectancy concerns whether an individual views a causal relationship between one's own behaviour and the reinforcements that follow. That is, individuals develop generalized expectancies that either (a) a particular reinforcement results directly from the individual's behaviour or attributes, or (b) reinforcement results from other factors, such as luck, fate, chance, powerful others or factors that are "unpredictable because of the great complexity of forces surrounding them" (Rotter, 1982; p.171). In the former circumstance, when reinforcement is viewed because of one's own behaviour, *internal* expectancies for reinforcement exist. Alternatively, when reinforcement is viewed because of other factors, *external* expectancies for reinforcement exist (Rotter, 1982).

Emphasising the multi-dimensional character of physiotherapist-patients relationships, Szybek et al. (2000) described three primary components of the psychoanalytic view of the physiotherapy relationship including the working alliance, a transference configuration, and a real relationship. The working alliance

is defined as the 'patient's motivation to overcome illness', representing as a balance between the 'patient's reasonable ego and the analyst's analysing ego' (Szybek et al., 2000: p.182). Transference is a form of experiential intuition, whereby physiotherapists and patients rely upon past experiences to describe and influence existing relationships, oftentimes resulting in gaps and barriers to affiliation, partnering, and agreement (Szybek et al., 2000). Importantly, Szybek et al. (2000) differentiated between patient and physiotherapist transference, describing the physiotherapists approach as countertransference representing either an unconscious displacement of patient feelings, attitudes, and behaviours or compliance with patient expectations based upon past experiences. Finally, the real relationship represents 'the realistic and genuine relationship between the analyst and the patient' and is inversely correlated with transference mechanisms (Szybek et al., 2000: p. 183).

The distinction among these three dimensions of the relationship between physiotherapists and patients was patent throughout the participant feedback, describing particular biases and interactive forces that either supported or inhibited the relationship building process. For example, where physiotherapists reflected the degree to which past experiences with demanding patients influenced their ability to respond positively and openly to new patient behaviours, it is evident that a form of counter-transference was interfering with the development of a real, complementary therapeutic relationship. Yet patients, as described by Szybek et al. (2000) and more recently by Kidd et al. (2011) clear transference through a variety of psychological forces, oftentimes impacting upon satisfaction and valuation as a result of deficiencies in personal awareness and scrutiny. The 'helpless' persona, for example, cited by Szybek et al. (2000), manifests in spite of treatment interventions and physiotherapist support, reflecting psychological burdens that may be unresolved as patients continue to experience pain and discomfort.

The present study revealed that cultural awareness can be developed through recognition of cultural differences and similarities and in maintaining sensitivity to the needs of patients from other cultures. Western physiotherapists can draw on their own understanding of other cultures to recognise cultural differences, and they can use their background to recognise similarities. This recognition is not limited to the

differences between cultures; it is also extended to the recognition of differences within the same cultural group. This understanding is relatively similar to Campinha-Bacote's (2002) work, as she argued, when explaining the concept of cultural desire, that accepting other differences and building upon similarities are important processes in relation to culturally responsive care. This study, as well as the previous research, highlighted the importance of developing cultural awareness when looking after patients from different cultures (Campinha-Bacote, 1999; Flowers, 2004; Jirwe et al., 2009; Taylor, 2005).

Assessing personal attitudes prior to interacting with patients from other cultures is important; it is about recognising personal prejudice, bias and stereotyping of other people. This process helps Western physiotherapists adapt to new cultural contexts and to develop respect for patients' cultures and religious heritages. This finding supports the work of Campinha-Bacote (1999: 2002: 2003) and Jirwe, Gerrish and Emami (2006) in that cultural awareness implies awareness of oneself that requires the self-reflection and understanding of one's own attitudes towards patients from other cultural backgrounds. Without such reflection on one's own attitudes, healthcare providers may impose their own culture on patient care (Campinha-Bacote, 2003). Significantly, the study's findings also indicated that the Western physiotherapists' ethnocentric viewpoints impeded the process of cultural competence and negatively affected upon their interaction with the patients and the nature of the therapeutic relationship between them. The participants used their cultural lens to view, evaluate and judge the behaviours and practices of people from other cultures (Dayer-Berenson, 2011). The Western physiotherapists in this study lacked knowledge about their patients' culture and language, which created many struggles and challenges for them when applying treatment and performing care. Specifically, the participants demonstrated a limited knowledge of the beliefs related to the patient passive/dependent persona in the Saudi culture.

The participants characterised their disempowerment as a lack of confidence, the inability to challenge intimidation by the local and dominant patient, as well as passive patient personas. Negative attitudes, and cultural and linguistic differences, were also identified in the literature as causing feelings of disempowerment (Deegan and Simkin, 2010). This was similar to the Western physiotherapists' experience in

this multicultural environment indicated that, without sufficient education and support, cultural diversity is risky and can influence the therapeutic relationship. This issue is compounded when a language barrier exists. This study suggests there is a need for continuous education to increase the expatriate physiotherapists' cultural competence in terms of cultural awareness, knowledge and skills, as the Western physiotherapists in this study were inadequately prepared in this respect. Feelings of culture shock and disempowerment can influence the physiotherapists' emotional and psychological well-being; this, in turn, can affect therapeutic relationships with their patients.

In summary, this part of the chapter has presented a critical discussion of the empirical findings collected from a study of physiotherapists and patients within the Saudi Arabian physiotherapeutic settings. This is the first study that has been undertaken into the nature of the patient–physiotherapist relationship in the Kingdom of Saudi Arabia, and it is the first to do so from the perspective of female patient–physiotherapist relationships.

Focussing on the forces contributing to the relationships manifested during these treatment processes, several different systems have been shown to operate to varying degrees, influencing the openness and purpose-orientated nature of the physiotherapist–patient exchange. Specifically, key antecedents, including the physiotherapist professional roles, patient personas, physiotherapist/patient value systems, and physiotherapist/patient past experiences, have been shown to either support or detract from the therapeutic relationship. In addition, this research has observed that gaps in relational expectations for both parties can result in a deterioration of working communication and, subsequently, the treatment outcomes.

Good listening and communication skills during the treatment session are essential qualities for a physiotherapist using a holistic approach. A holistic approach encourages patient participation in the physiotherapist-patient relationship and patient empowerment. Physiotherapists are also seen as being important in the process of achieving a holistic view of the patients, their social circumstances and their individual conditions.

As a 'hands on', caring profession, physiotherapy has historically been influenced by interpersonal issues, particularly the development of the relationship between patients and practitioners. There can be negligible doubt that relationships that are characterised by positive associations such as trust, openness, respect and rapport tend to have a greater impact upon health outcomes than relationships that are defined by mistrust, apathy and disassociation. For this reason, the holistic approach and the person-centred conceptions of practice have become increasingly influential to physiotherapy as expert knowledge is fused with the requisite interpersonal and communication skills that are needed to forge productive working partnerships in complex situations. Physiotherapists are thus charged not only with clinically treating the musculoskeletal condition but also with motivating the patient to engage in exercise regimens and, in many cases, to change self-defeating behavioural patterns.

This research study has demonstrated that person-centred practices perform an integral role in health care delivery in the Kingdom of Saudi Arabia. Moreover, this research study has also suggested that the relationship between female physiotherapists and patients in the Kingdom of Saudi Arabia is influenced by prevailing social and cultural customs, which, in turn, conspire to shape the identities, expectations and reactions of both the patients and the physiotherapists. The development of the patient-physiotherapist relationship is thus influenced by the extent to which both parties are willing and able to negotiate their partnership. Patients and physiotherapists who are flexible tend to experience a relationship that is open while patients and physiotherapists who are rigid typically experience relationships that fail to deliver results beyond basic clinical functions. As a result, the development of the female patient-physiotherapist relationship is primarily influenced by individual responses to treatment and the extent to which patients and physiotherapists are willing to negotiate with one another.

Finally, relationally distinctive elements, including experiences, reactions, and the purpose and focus of the relationship itself, have effects on the functionality of this partnership and negotiation and its ultimate objectives. For physiotherapists, these findings reveal the critical nature of self-awareness, introspection, and self-observation during the dialogue with patients, focussing on developing a more

person-centred foundation and avoiding the base-level pitfalls of clinical exchanges. For patients, internal vulnerabilities and a need for personal validation can have significant effects on willingness to open up, resulting in withdrawal and resistance to physiotherapist discourse if not adequately supported on a psychological and emotional level. For Saudi Arabian women, sociocultural and lifestyle burdens magnify these effects, resulting in a need for practical interventions that are capable of circumventing many of the relational pitfalls observed during this study.

The next section presents a final reflection on the research journey with the acknowledgement and discussion of how I influenced the research process, and the ways in which I may have had an impact upon its findings.

7.2 Final Reflections on the Research Journey

This dissertation represents a personal journey for me. This journey took me back to a place that was involved in my development, both from a personal and a professional point of view. There were multiple influences that motivated me to undertake this research, including my experiences as a senior physiotherapist working in a musculoskeletal outpatient setting, events that I witnessed and experienced, and the exposure to ‘real life’, which I had the privilege of being exposed to there.

As I shared personal knowledge in the form of therapeutic relationships throughout this work, I realised how much my personal knowledge – the lens through which I interpreted the data – was directly shaped by the research experience (and data) itself. My interpretive lens was made up of knowledge and assumptions from multiple lenses including relevant literature and my experiences. Yet, this lens was immersed in a symbiotic relationship with the research process and the data itself. The multi-directional push–pull relationship of my practice, research, and personal life is undeniable, and the constructivist methodology that I worked within not only allowed me to fully engage this multi-directional relationship, but, I believe, required me to do so.

I have faced many challenges throughout the PhD journey. Before beginning this study, my knowledge in the field of the nature of patient–physiotherapist relationships was limited. I did not have any experience in researching human relationships. However, on reading the literature related to psychology, sociology and qualitative approaches, I became aware of the field and felt comfortable in carrying out the research.

Additionally, reading the healthcare professional–patient relationship studies contributed to my thinking – particularly about professional roles and cultural influences. It has challenged my assumptions and led me to consider ways in which the study could be emancipatory rather than pathologising. However, it is clear from the relative absence of recent and in-depth literature about the nature of the patient–physiotherapist relationship that the main focus in this arena is still very much on physiotherapists’ perspectives. By carrying out this study, I was in a fortunate position to develop a unique and in-depth perspective on the female patient/physiotherapist research field.

Another challenge was in choosing the methodology approach and my position as a researcher. Prior to the study, I was not familiar with qualitative research terminology and philosophy such as ontology, epistemology and grounded theory. Although choosing the constructivist grounded theory approach was very direct, choosing the data analysis approach took me time. After several meetings and discussions with my supervisors, I chose the methods of Strauss and Corbin (1989) and Charmaz (2006) as an approach for the analysis. I have learned a lot about data analysis by carrying out this research. As a PhD student, I have been exposed to various theoretical perspectives and conceptual models and became more aware of how our perspectives and expectations colour our views of ourselves and our social realities. In fact, undertaking this research has had a consequent improvement in my awareness, my skills in research methodology and my confidence, and it has shed light on my potential role as a contributor to literature in the field of patient–physiotherapist therapeutic relationships.

When I initiated participant recruitment, it was encouraging that the study was well received and of interest, especially to the female physiotherapists. I had anticipated

encountering challenges in gaining access to staff physiotherapists and was not sure how they would perceive the study. I was concerned they might not see their participation worthy of the time commitment. However, this was not the case.

This study served as my introduction to conducting qualitative research. Upon beginning the constructivist grounded theory research process, I felt confident that I understood the various methods and components of grounded theory. However, I could not envision how the process would actually unfold. Specifically, I wondered how I would really move from codes through to memos and then the developed theory. I also wondered if I would have enough data to generate insights.

Once reflective writing analysis was underway, I began to understand that the coding process occurs very naturally, because it begins so closely and literally tied to the data. As I realised that codes were repeated within and across data sources, the more abstract coding also seemed to happen easily. It was at this point that I noted, in my reflexive journalling: “I can see why some grounded theorists, especially those in the Glaserian school of thought, would posit that the ‘data speak for themselves’ and that the theory *emerges* rather than is developed by the researcher.” Certainly, it ‘felt’ as though the theory emerged on its own, without my interpretation. However, in my constructivist reflexive journalling, I regularly noted the way my lens may be impacting the way I ‘saw’ the data. This experience runs in parallel to Schön’s (1983: 1987) notion of different professionals framing situations differently, thus finding different problems within the same scenario.

In the writing process, interestingly, the findings section seemed to ‘write itself’. Charmaz (2006) suggested that if the memo-writing process is conducted carefully, the memos serve as the step prior to writing the theory. This observation proved to be true for me; the memo writing, in combination with diagramming and sorting, ultimately created the framework for Chapter 6.

I was also convinced of the iterative process described in the grounded theory texts. Again, in preparing to conduct the research, I read across schools of grounded theory, and found that grounded theory is an iterative process. The constant comparative method is often cited in qualitative literature; however, until I experienced it, I did not fully understand it. I was able to make use of theoretical

sampling based on existing data, and was also able to return to the previous data after further data was collected. In this way, I feel that I strongly followed the grounded theory core method of constant comparative analysis, moving between data collection, analysis, writing, and theoretical sampling in a constantly iterative way.

I return to three important goals for constructivist grounded theory, as previously mentioned in Chapter 4. A constructivist grounded theorist should strive for: (1) a researcher's reciprocal relationship with a participant – who constructs meaning with the researcher and ultimately develops a theory grounded in the experiences of both; (2) establishment of a balanced relationship between researcher and participant, with explicit attempts to mediate inherent power imbalances; (3) clear positioning of the author's role in the text, and the influence of the literature review and how participants' stories grew into theory through the writing process (Mills et al., 2006). In this chapter, and in Chapter 3, I have attempted to demonstrate my explicit attempts to achieve the three goals stated above.

Having experienced the data-collection and data-analysis process, and having listened to the female physiotherapists' and patients' perceptions and experiences, I realised the impact of the culture and religion on the nature of patient–physiotherapist relationship. The main thing that will stay with me is the enjoyment of talking to the participants, with their vibrancy and energy. Meeting participants and talking to them gave me an incentive to complete the study because they felt so strongly that they wanted their perceptions to be heard. They wanted to eliminate the barriers from society that constantly reinforced their therapeutic relationship. Finally, conducting this research has given me the opportunity to gain experiences in the field of healthcare professional–patient relationship studies, to learn from the physiotherapists and patients and to build good relations with them. Patients come to visit me in the hospital whenever they have an appointment; they even ask me questions about how my data collection is going and ask about the study's progress. Throughout the PhD journey, my confidence has increased, which has had a positive impact on my research skills.

The following section will offer comprehensive conclusions on the basis of this research and recommend an operative platform for supporting physiotherapists in career development and competency building in order to navigate such relational burdens. The implications that these findings have for education, clinical education, practice and research are discussed in the following sections.

7.3 Implications for Education

The finding that there is variation in physiotherapist professional roles may be taken into account in undergraduate training. Physiotherapists' educators need to consider how they can identify, monitor and guide the development of students' therapeutic relationships with patients, and how these aspects relate to the expectations of stakeholders and the values and mores of the profession. Students holding different views of knowledge and practice may require different approaches to learning (Lindquist et al., 2010).

Undergraduate curricula may be developed so that there is an equal emphasis on the development of human relationship skills other than technical skills. Learning should also be focussed on developing emotional self-awareness, communication, interpersonal skills and the therapeutic use of self (Taylor, 2008).

Learning Styles

Learning is described as the process whereby knowledge is created through the transformation of experience. Individuals use learning to adapt to and manage everyday situations, giving rise to different styles of learning. The concept of learning styles has received considerable attention in the empirical literature, and many theories have been proposed in order to better understand the dynamic process of learning (Arthurs, 2007; Coffield, Moseley, Hall & Ecclestone, 2004). A variety of learning style theories and frameworks have been developed, along with accompanying instruments that operationalize their learning style constructs (Dunn & Griggs, 2003; Loo, 2004). Hickcox (1995) categorises learning style instruments as falling into three groups: 1) instructional and environmental learning preferences;

2) information processing learning preferences; and 3) personality-related learning preferences.

Evaluating students' learning styles provides knowledge about their particular preferences. This awareness can be used to develop, design, format, and deliver educational programmes and resources that will motivate and stimulate students' acquisition, integration, and application of information and professional knowledge, through individualising instruction. Furthermore, "understanding styles can improve the planning, producing, and implementing of educational experiences, so they are more appropriately compatible with students' desires, in order to enhance their learning, retention and retrieval" (Federico, 2000: p. 367).

The most common learning theory in allied health research is the theory of information processing, which considers personality and suggests four sequential stages for the learning process. The information processing theories are based on Lewin's *Cycle of Adult Learning* (Kolb, 1984). Lewin's cycle describes four sequential stages during the learning process. The first stage is concrete experience, followed by personal reflection on that experience. This is then combined with previous knowledge (abstract conceptualisation), and finally, new ways of adjusting to experiences are explored (active experimentation) (Kolb, 1984). Kolb's based his *Experiential Learning Cycle* on Lewin's work, and it is now the most commonly applied theory for health professionals (Titiloye & Scott, 2001). Kolb supports the concept of learning style being influenced by personality traits.

In Kolb's *Experiential Learning Cycle*, an individual would ideally cycle through all four stages (Kolb, 1984). In reality, some stages may be skipped, or one stage may become the primary focus of the learning experience. As described by Kolb, a preference for the concrete experience stage results in the person learning from specific experiences or through relating to people. When the reflective observation stage is preferred by the learner, careful observation and searching for meaning is likely to be evident (Kolb, 1984). A preference for the abstract conceptualisation stage will produce logical analysis and systematic planning. The final stage of the cycle involves taking risks and pursuing activities or tasks—behaviours that are observed in an individual with a preference for active experimentation. Kolb takes Lewin's original cycle a step further, proposing a specific learning style preference

based on an individual's utilisation of the four learning phases (Kolb, 1984). The resulting learning styles are '*accommodator*', '*diverger*', '*converger*' and '*assimilator*'.

Another notable learning style model was developed by Felder and Spurlin (2005), who proposed four learning style dimensions: *active/reflective*, *sensing/intuitive*, *visual/verbal*, and *sequential/global*. According to this model, 'active learners' tend to retain and understand information best by doing something active with it, such as discussing, applying, or explaining it to others, while 'reflective learners' prefer to first think about the information quietly. Active learners prefer group work to a greater degree than reflective learners, who prefer working alone (Felder & Silverman, 1988). Sitting in lectures without any physical activity (other than taking notes) is difficult for both learning types, but particularly so for active learners.

'Sensing learners' tend to enjoy learning facts, while 'intuitive learners' often prefer discovering possibilities and relationships. Sensors often prefer to solve problems using well-established methods and dislike complications and surprises; intuitors like innovation and dislike repetition. Intuitors are less likely than sensors to resent being tested on material that has not been explicitly covered in class (Felder, 1993). Sensors tend to be patient with details, good at memorising facts, and doing hands-on (laboratory) work; intuitors may be better at grasping new concepts and are often more comfortable than sensors with abstractions and mathematical formulations. Intuitors tend to work faster and be more innovative than sensors, while sensors tend to be more practical and careful than their intutor counterparts. Intuitors do not enjoy educational activities that involve a great deal of memorisation and routine calculations, while sensors dislike courses that have no apparent connection to the real world (Felder & Silverman, 1988).

'Visual learners' remember best what they see—for example, pictures, diagrams, flow charts, time lines, films, and demonstrations (Felder & Silverman, 1988), while 'verbal learners' get more out of words (written and spoken explanations) (Felder, 1993). Both types learn more when information is presented both visually and verbally. Traditionally, in most university lectures, little visual information is presented other than *PowerPoint* slides or plastic overhead projector sheets. Students primarily listen to lectures and read material written on boards and in

textbooks and hand-outs. This is unfortunate given that most people are visual learners, meaning that most students do not learn nearly as much as they would if more visual presentation aids were used in classroom contexts (Sims & Sims, 2006). Adaptable learners are capable of processing information presented either visually or verbally.

‘Sequential learners’ tend to gain understanding in linear steps, with each step following logically from the previous one. ‘Global learners’ tend to learn in large jumps, absorbing material almost randomly without seeing connections, and then suddenly "getting it." Sequential learners prefer to follow logical stepwise paths in finding solutions; global learners may be able to solve complex problems quickly or put things together in novel ways once they have grasped the big picture, but they may have difficulty explaining how they did it.

One key in addressing the quality of physiotherapy education may lie in exploring how students are managed, and more importantly, how they are guided in obtaining the knowledge and skills to deliver high quality healthcare:

- To facilitate learning, the preferred learning style of each physiotherapy student should be determined, and instructors should employ teaching strategies that cater to those preferred learning styles.
- In order to understand learning style theory, instructors should determine their own preferred learning style. This may make it easier for teachers to understand how to use learning and teaching strategies that facilitate learning in students with different learning styles.

7.4 Implications for Clinical Education

As a key component of professional physiotherapy practice, clinical reasoning was a buzz-word in trainings for the Saudi Arabian physiotherapists, where expatriate teachers returned to the importance of Saudi Arabian physiotherapists developing skills of clinical reasoning. Clinical reasoning is anticipated as a central skill for modern, professional physiotherapy practice (Jones et al., 2008). It is “a context-dependent way of thinking and decision-making in professional practice to guide

practice actions” (Higgs & Jones, 2008: p.4). Clinical reasoning develops through interaction with others – peers and patients – and it is affected by each individual’s frame of reference (Edwards et al., 2004; Higgs & Jones, 2008).

Higgs and Jones state that “one of the greatest challenges of clinical reasoning is to harmonize generally accepted healthcare practices and evidence for practice with patient-centred practice” (Higgs and Jones, 2008: p.11). Thus there are a few things to consider in terms of teaching clinical reasoning for Saudi Arabian physiotherapists. Firstly, clinical reasoning is a Western concept of professional practice that has been developed in line with developments in Western countries, and this must be considered when promoting it in a different context. For example, in teaching clinical reasoning one must consider the roles of the patient and the physiotherapist. In the modern concept of clinical reasoning, the role of the patient or client is a critical aspect. Instead of being a passive recipient in the treatment encounter, the patient is expected to play an active role in maintaining health, and participate in decisions made regarding their health (Higgs & Jones, 2008). This view issues from Western informed society where medical- and health-related information is readily available via media (Internet, television, magazines etc). Saudi Arabia presents a different situation. Although technology is making a breakthrough and information is becoming more easily available, its use is limited; even if the information is available in local languages, illiteracy is a major factor. The concept of informed consent of patients must be mirrored in the communitarian context of Saudi Arabia. Furthermore, the patients generally have a more submissive role to the physiotherapists, which impacts how they collaborate in the treatment situation. This does not mean that patient responsibility is less valid for Saudi Arabian patients, but it must be viewed in light of local cultural practices and the roles of the patients and physiotherapists.

Secondly, as obvious as it may seem, clinical reasoning should not be confused with reflection. Clinical reasoning skills have been perceived as basic, but this does not mean that skills of reflection are basic. The physiotherapists reflected over aspects of their practice, and reflection was particularly stimulated, and perceived as important, when discussing clinical cases and ethical dilemmas in practice. Here the matter of cross-cultural communication becomes of great import. What Western–

physiotherapists and researchers – perceive is affected by their understanding of the way things are, and limited by both language barriers and differences in interpretation of what the other person means with what they are saying. It is impacted by their cultural competency and the extent to which they are able to participate in the field. This raises concerns regarding how Western physiotherapists teach clinical reasoning. How clinical reasoning should be manifested and taught for Saudi Arabian physiotherapists must be more collaboratively explored.

Finally, clinical reasoning cannot be learned from books or lectures. It is a social and contextual process that needs to be understood and explored within the specific context (Higgs & Jones, 2008). The manner in which clinical reasoning is taught must stem from the Saudi Arabian physiotherapists approaches to learning, and this is not something that can be learned within the short span of a development project. Perhaps there should be less talk about clinical reasoning, which can easily become too abstract, and more emphasis on encouraging reflection as part of a collaborative, communicative approach between Saudi Arabian physiotherapists, and between Western- and Saudi Arabian physiotherapists. Discussing experiences with others aids the process of reflection, where expressing ones thoughts and ideas to others in a comprehensible manner helps clarify these (Rodgers, 2002).

Communicative learning in the Saudi Arabian Context

The Saudi Arabian physiotherapists exhibited an instrumental approach to learning and practice. Much of Western physiotherapy teaching and research also stems from instrumental learning and action, where techniques are developed, tested and taught on a basis of easing pain, increasing mobility and improving function. This is an important part of practice and of research. However, there is also the social side of physiotherapy practice: with the increasing appreciation for the impact of ideas and beliefs of the patient in the treatment situation, communicative learning becomes highly relevant. In their study of reasoning of expert physiotherapists, Edwards et al. (2004) found that cause and effect reasoning (instrumental learning) was accompanied by narrative reasoning (communicative learning) and that the capacity to utilize both forms of learning was a feature of professional expertise. Thus, both instrumental and communicative learning are needed, and in both reasoning and

reflection are important components (Mezirow, 1991: 2009). Here, however, the focus will be on communicative learning.

As described earlier in this section, communicative learning means striving to comprehend what the other person means, and making ourselves understood. This is valid for the interaction between Saudi Arabian physiotherapists, between them and their patients, and between Saudi Arabian and Western physiotherapists. Communicative learning can enable insight for all involved, through the sharing of different perspectives that challenge beliefs and pre-supposed ideas. Here the roles of Saudi Arabian and Western physiotherapists will be more obscure: both will be learners and teachers within the hierarchical Saudi Arabian- and development context. Taking a practical approach to this, peer learning is a well- documented approach in physiotherapy education that can be explored.

Peer learning

Through participation in learning groups and discussion with peers, greater emancipatory learning can be promoted. Peer learning is described as “an education procedure in which peers coach one another through clinical experiences using demonstration, observation, collaborative practice, feedback/discussion and problem solving” (Ladyshefsky & Jones, 2008: p.433). It is suggested as a tool for encouraging clinical reasoning skills in novice practitioners: often physiotherapy students or novice practitioners do not learn as much as they could through their clinical practice of working with patients, and this can be enhanced through discussion with other physiotherapists – either fellow students or colleagues, or supervisors and teachers (Ladyshefsky & Jones, 2008). Peer learning has been seen to improve skills of physical examination, communication and clinical reasoning to a greater extent compared with individual learning (Ladyshefsky, 2002).

Meeting in small groups to discuss and learn together is not a foreign concept. According to Saudi Arabian tradition, problems are discussed and solved together; (male) leaders meet together to make decisions in traditional councils:

The successful resolution of problems does not come from confrontation but from negotiation, from a recognition that no-one must lose face, from the

crafting of a solution designed to appear as if everyone has 'won'. A change of position is not acknowledged, because that would be to admit fault (Johnson & Leslie 2008: p.93).

The suggested approach necessitates that the physiotherapists bring difficult cases to the group, or are able to share problems that challenged them in their practice. Learning from mistakes, or being able to critically look at ones practice without losing foothold or risk losing face, is considered paramount to developing as professionals. Brookfield (2008) states the importance of teachers, educators, or leaders being able to make mistakes and show them in order to lower the bar and encourage students, or novice practitioners, to learn from their own mistakes, and to question what has been their norm in terms of clinical practice. Yet this is easier said than done. There are several issues with peer learning which will hamper its effectiveness in promoting skills of reasoning and reflection, such as lack of skills for reviewing and a reluctance to be honest in appraisals in case this compromises working relationships (Swisher & Page, 2005). Such cases were also discussed with me, when I brought up the subject. In terms of Saudi Arabian and Western physiotherapists working together, cultural differences in approaches to giving and handling critique must be remembered; there are issues of communication, power and how culturally competent the expatriates are. These are important to consider, as they will directly affect both communicative learning and collaboration.

In a country like Saudi Arabia, where the perception of professionalism is highly dependent on educational qualifications, attainment of power and control, a formally recognised physiotherapy council empowered by legitimate authority is perceived necessary to change the professional image of physiotherapy. Mannix and Stein (2002) suggested that achievements of professional organisations in the UK, particularly in areas of education and policy development, played an important role in furthering the development of nursing within the healthcare system and wider community. However, approving the formation of a formal organisation representing a professional pressure group made of women majority would pose a challenge particularly during a time of socio-economic change. In my opinion, the missing role of a physiotherapy union or council representing Saudi physiotherapists had discouraged many physiotherapists from lobbying, forming pressure groups or

involving the media to demand the institution of equitable and family friendly physiotherapy policies.

Undergraduate, postgraduate and continuing education programs of all physiotherapists may explore the role of developing relationships with patients in decision making negotiation in the context of sharing information and communication. Each program may include the development of clinical competencies related to developing rapport and informal and formal communication skills with patients. Communication competencies should include sharing of information and the facilitation of involvement in decision making with patients who have varying abilities to participate.

Physiotherapists can be encouraged in their professional development to undertake reflective practices in relation to the relationships they develop with patients. Reflective practice, with the aid of professional supervision would enhance self-awareness regarding the influence that the healthcare professional has over patients and their involvement in care decisions.

The education of members of the community about developing decision making relationships with physiotherapists and about the communication strategies used to maintain involvement will assist in reducing the barriers to information patients experience when confronted with musculoskeletal disorder. Community education strategies may include community forums, audiovisual materials such as discussion vignettes, brochures and facilitated web-based discussion groups.

This section has discussed a few of the challenges involved in, and suggestions for, promoting professional development for Saudi Arabian physiotherapists, as related to the Saudi Arabia context.

7.5 Implications for Practice

This study provides knowledge of how physiotherapists view the nature of the therapeutic relationship with their patients, and should help contribute to an epistemology of physiotherapy. Developing a well-rounded understanding of the epistemology of practice of the physiotherapy profession may allow for the

exploration of the tacit or non-propositional knowledge used by physiotherapy professional roles as they work through the problems of daily practice (Raelin, 2007).

Billett (1993) has investigated the forms of knowledge required for people to work effectively. Billett's (1993) taxonomy of workplace knowledge requirements for people is particularly valuable. Propositional knowledge is *knowing about things* (for example, facts, theories etc.); procedural knowledge is *knowing how to do things*; and dispositional knowledge is about *attitudes and how to interact and behave* in a workplace. Another valuable concept is strategic knowledge (Gott, 1989), which involves the ability to make judgements; knowing when to apply which knowledge to which problem is also a useful concept. An influential five-stage model of expertise development was proposed by Dreyfus (1982). It is presented in the box 1 below.

Stage 1: novice – characterised by limited, inflexible, rule-governed behaviour.
Stage 2: advanced beginner – where, in addition to the set of rules, the learner begins to learn some of the important situational aspects of the task, but may not be able to differentiate the importance of these features.
Stage 3: competent – where the learner sees actions in terms of goals and plans, based on the selection of important features of the situation, which are used to guide action.
Stage 4: proficient – where the best plan of action is selected (apparently unconsciously) and where situations are summed up quickly and plans are selected.
Stage 5: expert – where the performer acts intuitively from a deep understanding of the situation, appears to be unaware of the rules and features, and performance is fluid, flexible, and highly proficient.

(Dreyfus, 1982)

As learners advance from novice through to expert, they progress from a relatively passive strategy of receiving information to strategies which are increasingly reflective and intuitive. They move from being 'empty vessels' to become filled with, and constructors of, knowledge. Along with that comes a gradual withdrawal of the teacher in the form of coach or mentor, although some physiotherapists will always retain these types of people to help them improve, add to or analyse their skills.

Where people have become highly expert in a task, they may move to what is known as ‘automaticity’, whereby the task can be carried out automatically. At that level, some people may have difficulty communicating how they actually do the task. One of a physiotherapist’s most important skills is having the capacity to help others on their journey through these five stages – even if they themselves are already experts.

But how do physiotherapists facilitate the development of workplace knowledge and expertise? ‘Scaffolding’ the provision to learners of supportive contexts, and guidance that enables them to engage with a learning task and receive advice and assistance while they learn it, is one strategy. The scaffolding is progressively withdrawn, or changed, as expertise develops. Looking at Box 1, it is possible to see the increasing role of the learner in problem identification and problem solving. Exercising judgment in the way that a task is carried out has also assumed a greater importance for the learner. They are learning to learn instead of merely following learned rules.

A list of strategies for facilitating workplace learning is shown in Box 2. Basically, they are concerned with providing opportunities for physiotherapists to learn in authentic situations but, at the same time, enabling access to guidance to assist their move from more formal learning and knowledge contexts to less formal workplace learning. In this way, learners are more likely to be able to integrate the different forms of knowledge and make sense of them. Part of the ‘making sense’ process is providing opportunities to talk about issues and problems with others, to think about them, and to repeat the learning cycle as the level of expertise increases. It is important that learners not only develop the skills, but also an abstract understanding of the specific piece of knowledge – so that they can reflect upon it, have conversations with others about it, and use the knowledge in a range of contexts. They need to learn how to learn.

Collins (1997) has suggested a number of effective ways for teachers and trainers to facilitate workplace learning as presented in the Box 2 below.

Authenticity: material to be learned is embedded in tasks and settings that reflect the uses of these competencies in the real world.

Interweaving: learners go back and forth between a focus of accomplishing tasks and a focus of gaining particular competencies.

Articulation: learners articulate their thinking and what they have learned.

Reflection: learners reflect and compare performance with others.

Learning cycle: learning occurs through repeated cycles of planning, doing and reflecting.

The important message for educators and trainers is the idea that movement between formal and informal learning needs to be facilitated, and that teachers have an important role in assisting learners to move between these different learning contexts. The addition of the substantive theory to the knowledge-base of physiotherapy may assist physiotherapists, and those involved in clinical education, to reflect and consider their clinical decision making and their therapeutic learning style to practice.

The findings suggested that there is diversity in how physiotherapists conceptualise patient-centred care. For treaters, patient-centred care involved doing the best to, and for, the patient, with the best of intentions. In this regard, it is possible that physiotherapist participants who were characterised as treaters considered themselves as being patient-centred. Other physiotherapist participants, who were characterised as teachers or person-centred, would have conceived patient-centred care quite differently – focussing on forming and developing a therapeutic relationship, facilitating learning, sharing knowledge and decision making. Future research should explore both physiotherapists' and patients' perceptions and conceptualisations of patient-centred care, so that it can be better incorporated into practice and education.

- Clinical practice settings may include resource allocations that allow time for the development of relationships between physiotherapists and patients, for the formal and informal communication that needs to occur for patients to be involved in negotiated decision-making.

- Assessment for the purposes of treatment plan may also determine the roles patients prefer to play in decision-making negotiation with some consideration given to the various circumstances that might change the patients' preferences, such as physical or psychological incapacity. The female patients' expectations of how their family members, husband and sons should be involved in decision-making should be included in this assessment.
- Clinical practice settings could also give consideration to how patients and their family members may gain access to information about musculoskeletal disorder, treatment, the physiotherapy team, how treatment decision making occurs and how they can influence the agenda of negotiated decision making forums. Information leaflets with photographs may explain the members of the physiotherapy team in a particular setting and the physiotherapy profession. Similar information could appear on a dedicated channel on the televisions in patients' waiting rooms in outpatient settings.
- Patients and family members could be directed to appropriate web based, textual or audiovisual material that provides general information about physiotherapy profession, physiotherapist roles and responsibilities and types of musculoskeletal disorders and treatment. However, this general information should never be substituted for face to face discussions with the physiotherapists trusted by patients during treatment sessions, about individual musculoskeletal disorder patterns and treatment options and could only be used as a part of an individually planned information strategy.
- A balance clearly has to be struck between autonomous learning and ensuring that trainees and qualified physiotherapists are competent to practice. Specialty training schemes involve a range of assessments to ensure the competence of those awarded their Certificate of Completion of Training (CCT). The inclusion of assessments of communication and relating to patients in these high stakes specialty examinations highlights to trainees the importance of this area of clinical practice. But trainees must also be encouraged to continue learning and develop these skills after their examinations and throughout their careers. To achieve this, they require support during their training to become more autonomous, able to direct their

own learning in the future.

- Time and money should also be invested in trainers, for example through ‘training the trainers’ courses, to ensure they are equipped to support trainees in this transition and encourage trainees to take more responsibility for their own learning. Trainers may also need educational support to develop their own communication skills, so that they reinforce formal elements of the training programme through role modelling in their own practice.

7.6 Suggestions for Further Research Work

This study provided a theoretical insight into the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings, which were strongly influenced by participants’ experiences of different types of negotiation between them. This is the first research of its kind in physiotherapy, and the extensive findings generated indicate that there are a number of key areas of the nature of patient–physiotherapist therapeutic relationships which warrant further exploration.

As the above summary points have demonstrated, the findings of this research study corroborate much of the research that has been undertaken into patient–physiotherapist relationships (Barron et al., 2007; Klaber Moffett and Richardson, 1997; Payton et al., 1998). In particular, the research study herein has demonstrated that the development of the patient–physiotherapist relationship is predominantly defined by antecedent conditions and expectations which, in turn, influence the physiotherapists’ professional roles and the patient personas that participants adopt. Consequently, the reaction to the relationship from both patients and physiotherapists is influenced by subtle yet profoundly potent preconceptions of the relationship. This is indicative of much of the critical research that has been undertaken into the nature of the patient–physiotherapist relationship in the contemporary era (Hills and Kitchen, 2007; Potter et al., 2003a; Potter et al., 2003b). Further research could be carried out to investigate these differences from the perspectives of physiotherapists and patients, such as their expectations of perceptions of these different forms of interaction in relation to clinical practices.

This would develop further knowledge of the complex physiotherapist-patient interaction which takes place during practice, and how this influences areas of practice such as the nature and development of the therapeutic relationship.

Further research could investigate the influence that the different physiotherapist professional roles together with the different patient personas have on the nature of the therapeutic relationships between them.

Further qualitative studies on the concept of trust in relation to collaboration with physiotherapist and decision making are warranted in order to develop strategies that enhance patient and physiotherapist trust.

In addition, the research study has also shown that the nature of the patient–physiotherapist relationship is subject to considerable variation, with the relationship between the two parties renegotiated according to the differing reactions to the negotiation between them. As a consequence, the research study underlines the importance of communication as a conduit between the patient and the physiotherapist which, in turn, implies that patients and physiotherapists who look to communicate and negotiate are much more likely to experience a productive therapeutic relationship. This resonates with qualitative research into patients’ reactions to the treatment process with several studies underlining the importance of patient and person-centred manifestations of practice as ideal vehicles to motivate patients (Roskell, 2009; Shaw, 2008; Schmitt et al., 2012). Therefore, the research study herein highlights the way in which physiotherapy practice in the contemporary era is characterised by the increasing significance of market forces and rising patient expectations (Lindquist et al., 2006; Roskell, 2009). Research could be carried out to investigate whether physiotherapists are appropriately skilled to incorporate shared decision-making and person-centred approaches in their practice.

Furthermore, the research study herein has significant implications for practitioners working in countries where gender relations and gender identities are subject to acute social and cultural constrictions. Most notably, this research study suggests that communication and negotiation are rendered obsolete in situations where non-verbal means of communication are hampered and, moreover, where prevailing social and cultural attitudes derived from stereotypical gender identities impinge

upon the perceived self-efficacy of patients. This is an area that would benefit from further analysis and research in the future. In particular, clinical practice would benefit from a greater examination of the measures that Western and non-Western female practitioners take to combat the debilitating effects of social and cultural obstacles to the development of an open and productive working partnership. Further research employing focus groups could be carried out to explore the transferability of the substantive theory to therapeutic relationships in other countries.

In summary, the research study suggests that patients need to be addressed in a holistic manner that includes identification of the patient's expectations and beliefs regarding their musculoskeletal disorder. As factors such as poor patient–physiotherapist communication, partnership roles, and self-management should be emphasised in further research in an effective model that could be applied to a physiotherapy practice where may need to focus on these factors. Other factors such as the emotional aspects of patient's needs - hope, reassurance, explanations, empathy, advice, respect and understanding, would also need addressing. An appropriate model that encompasses the concept of wellness that allows patients to be in control would also likely need to be incorporated, treating the individual according to their perceptions and wishes. As it is the patient's right to decide whether she chooses to follow through with the healthcare plan, the therapeutic relationship would be of significance in aiding and emphasising self-management. These components could be investigated in relation to the therapeutic and decision-making approaches identified in this research with the potential to enhance the effectiveness of the therapeutic relationships.

7.7 Thesis Limitations

Whilst this research has produced knowledge of the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings in this study, a number of limitations to the thesis need to be highlighted. These are discussed below.

In using individuals' narratives, one may claim that this may possibly introduce

some form of bias as participants may misreport, or under-report, their relationship perceptions and attitudes, or simply voice an opinion that they thought would be consistent with common policy and social norms. Nonetheless, this study aimed to explore the nature of the therapeutic relationship between female patients and physiotherapists in musculoskeletal outpatient settings, and is consistent with the chosen qualitative methodology which sought to understand social phenomena in the natural setting, from the perspectives of the participants (Charmaz, 1998). The aim of this qualitative study was to develop a deeper and contextual understanding of the nature of the patient–physiotherapist relationship from the perspectives of patients and physiotherapists.

Another limitation relates to the data collection methods used in this study. Interviewing was chosen as it was congruent with my subjectivist epistemological position, and it enabled participants to reflect on their perception and experience of the therapeutic relationship. However, participants may have modified their answers in order to please me and appear in a positive light (Holloway and Wheeler, 2002). Being aware of this possibility during interviews enabled me to monitor and minimise the ‘interview effect’ by further questioning and probing more deeply into participants’ responses. Holloway and Wheeler (2002) suggest to minimise this effect, the interviewer should spend time with the participant, to gain their trust and to help develop the participant-research relationship. This was facilitated by using the first quarter of the interview to have an open discussion of physiotherapy profession, such as what made physiotherapist participants decide to become a physiotherapist and their practice background. These introductory interview questions were important to help enable the physiotherapist to feel relaxed and used to the interview process. The introductory questions were also important in facilitating a trustful relationship with participants, so that they would feel comfortable in sharing specific details of their experience and perception of therapeutic relationships.

Likewise, the subjective nature of the participants’ responses rendered it difficult to locate the difference between personas and roles that were adopted. This was especially true of physiotherapists’ professional roles where work-based philosophies typically occur in a piecemeal manner, often as a consequence of

training and pre-work programmes (Lindquist et al., 2006; Lindquist et al., 2010; Richardson et al., 2002). In addition, it is also important to acknowledge the conceptual limitations of intangible concepts such as motivation and patient satisfaction, which are inherently irregular and inconsistent (Hush et al., 2012; Shaw, 2008).

My skills and expertise as a qualitative researcher using grounded theory were also a limitation of this study. While immersing myself in the grounded theory literature and attending workshops helped me to feel confident that I understood what the method was 'all about' such as its purposes, components and procedures, picturing how these processes would play out in the field was more challenging. Also, during analysis I grappled with 'seeing the bigger picture' so that codes and categories were sufficiently abstract. An extensive period of data collection and analysis in combination with consulting the literature triggered analytical insights and enabled me to view the data from alternative perspectives. Finally, a record of the specific literature search strategies employed at the start of this study for the literature review chapter was not kept. Providing a clear account of how the literature was initially sourced would provide greater assurance that the review was comprehensive.

7.8 Contribution to Knowledge

This study provides a unique contribution to knowledge by being the first constructivist grounded-theory-based study exploring the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings. The findings of this research provide a substantive theory that help to develop our knowledge of, and feed into, current debates on the impact and influence of culture, religion, norms, and values on therapeutic relationships and perceptions, attitudes and expectations among female patients and physiotherapists, which have a direct effect on the nature of the therapeutic relationship between them.

As revealed in the introductory chapters, being in the field and selecting a qualitative method is a two-fold strength as, without doubt, this adds to our knowledge at a methodological level in an area that has never been researched before. This

approach – including reading materials, interviewing participants to clarify ambiguities, and further questioning according to the participants’ responses – enabled the researcher to use a variety of approaches to make sure that the data collected represents reality in the field.

This research explored the nature of the patient–physiotherapist therapeutic relationships. This area of research enabled a deeper exploration of how patients and physiotherapists view and experience the therapeutic relationship between them. A number of models of therapeutic relationships have been developed through research by a range of healthcare professions (Edwards et al., 2004a; Emanuel and Emanuel, 1992; Jensen et al., 2000), and while the findings resonate to some degree with this literature there are some differences, which have been highlighted. The substantive theory developed from this study provides the first research-based model of the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings (illustrated earlier in Figure 6.5, Chapter 6), and therefore makes a significant and original contribution to the physiotherapy knowledge base. The findings from this study suggest that the different characteristics of the three professional roles along with the two patient personas led physiotherapists and patients to have different expectations of the relationship which, in turn, had an impact upon the experience of the relationship, and, ultimately, the type of the relationship outcomes between the physiotherapists and patients. Three primary models of physiotherapist–patient relationships were embraced by the participants in this study; (1) the professional relationship; (2) the clinical relationship; (3) the personal relationship. While clinical relationships left little room for disclosure and pursue clinical outcomes of the physiotherapist–patient relationship with limited level of decision making negotiation, professional relationships allowed rapport, trust and honesty to develop from a shared negotiation between the physiotherapist and the patient, personal relationships, embracing additional dialogue and discussion during the course of the treatment and a greater level of decision-making negotiation.

The research findings might be transferable to other people in similar situations to that of the participants, while also evaluating the quality of the research. There is however, no assumption of generalisability of the theory to other contexts and the

theory is presented here for further development in other contexts that may allow for transferability and further refinement and further enhancement.

With regard to the methodology and methods adopted in this research, this thesis provides a number of original contributions. This study was amongst the first in therapeutic relationships in physiotherapy to employ constructivist grounded theory. In providing an audit trail of how the major processes and procedures of grounded theory (Charmaz, 2006) were employed in this study, and detailing how these practices resulted in the development of the substantive theory (Chapter 5), this thesis makes an original methodological contribution to the research base in therapeutic relationships in physiotherapy.

Finally, one of the gaps identified in the literature related to therapeutic relationships is that research is overwhelmingly drawn from samples of men and women. This study significantly addresses this gap by recruiting women. Therefore, a further strength of this study has been the fact that women's voices were represented when they were previously ignored in sex-related research

7.9 Conclusions

The degree to which patients and physiotherapists interact and the nature of the relationship between them, especially women, in developing countries is unknown. There has been very little research into the nature of the patient–physiotherapist relationship and none has been conducted in Saudi Arabia. This thesis details the construction of the first substantive theory of the nature of the female patient–physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings. The findings from this grounded theory study offer a number of theoretical insights into the therapeutic relationship, and the relationship between these insights constitutes the substantive grounded theory. Suggestions have been made for physiotherapist educators need to consider how they can identify, monitor and guide the development of students' therapeutic relationships with patients, and how these aspects relate to the expectations of stakeholders and the values and mores of the profession. Physiotherapists can be encouraged in their professional development to undertake reflective practices in relation to the relationships they develop with

patients. Reflective practice, with the aid of professional supervision would enhance self-awareness regarding the influence that the healthcare professional has over patients and their involvement in care decisions.

Recommendations have been made for further research which might include: the influence that the different physiotherapist professional roles together with the different patient personas have on the nature of the therapeutic relationships between them; further qualitative studies on the concept of trust in relation to collaboration with physiotherapist and decision making in order to develop strategies that enhance patient and physiotherapist trust; further research employing focus groups to explore the transferability of the substantive theory to therapeutic relationships in other countries and investigate whether physiotherapists are appropriately skilled to incorporate shared decision-making and person-centred approaches in their practice.

Epilogue

This document does not contain a static body of knowledge. Rather, the grounded theory is contextually shaped, and the personal knowledge shared through written records is a snapshot representation of one moment in a dynamic and ever-changing sea of knowledge. Even the empirical literature explored in this document will ultimately be dated and will possibly lose relevance. The theoretical content of this document stemming from great thinkers is perhaps more timeless. But at the conclusion of this document, I can already see other ways of framing, shaping, and sharing this knowledge. As Ann Oakley (1999) states: “A way of seeing, is a way of not seeing.” The substantive data could be subjected to further re-interpretation, and this constant hermeneutic relationship with the extant theory and the substantive theory developed here could provide endless re-accounts of the ‘same’ phenomena. This, then, is merely one piece of a large puzzle. My hope is that it is one small contribution to a multitude of bigger pictures.

A way of seeing is a way of not seeing. ~ (Ann Oakley, 1999)

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Appendices

**Appendix 1- Faculty of Health and Social Science Research Ethics
and Governance Committee, University of Brighton Ethics
Committee Approval**

Date: Tue, 1 Feb 2011 13:57:25
From: J.Scholes@brighton.ac.uk
To: aaltamimi99@hotmail.com ; a.p.moore@brighton.ac.uk
Subject: Faculty of Health and Social Science Research Ethics
and Governance Committee Decision on Manuscript ID FREGC-11-
00201-Feb-2011

Dear Mrs. Altamimi:

I am pleased to inform you that your application entitled "The nature of the female patient-physiotherapist relationship in a Saudi Arabian musculoskeletal outpatient setting." has been approved by the Faculty of Health and Social Science Research Ethics and Governance Committee. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Please notify The Chair of FREGC immediately if you experience an adverse incident whilst undertaking the research or if you need to make amendments to the original application.

We shall shortly issue letters of sponsorship and insurance for appropriate external agencies as necessary.

We wish you well with your research. Please remember to send annual updates on the progress of your research or an end of study summary of your research.

Sincerely,
Prof. Julie Scholes
Chair, Faculty of Health and Social Science Research Ethics and
Governance Committee
J.Scholes@brighton.ac.uk

Appendix 2- Institutional Review Board (IRB) Study Approval

Kingdom of Saudi Arabia
Ministry of Health
King Fahd Medical City



المملكة العربية السعودية
وزارة الصحة
مدينة الملك فهد الطبية

February 6th 2011
ERRC Number: 11-005
IRB Number: 11-028

Dear Ms. Abeer ALTamimi,

It is my pleasure to inform you that the External Research Review Committee, a subcommittee of the Institutional Review Board, has approved your study titled: "**The nature of the female patient-physiotherapist relationship in a Saudi Arabian musculoskeletal outpatient setting**".

Please be informed that in conducting this study, you as the Principal Investigator are required to abide by the rules and regulations of the Government of Saudi Arabia and KFMC/ERRC. The approval of this proposal will automatically be suspended on **February 6th 2012** pending the reapplication to renew the approval. You also need to notify the ERRC as soon as possible in the case of:

1. Any amendments to the project;
2. Termination of the study.

Please observe the following:

1. Personal identifying data should only be collected when necessary for research;
2. The data collected should only be used for this proposal;
3. Data should be stored securely so that only a few authorized users are permitted access to the database;
4. Secondary disclosure of personal identifiable data is not allowed.

We wish you every success in your research endeavor.

Sincerely,

Dr. Mohamad ALTannir
Head of External Research Review Committee
Institutional Review Board
King Fahad Medical City
Riyadh, KSA

المرفقات :

الرقم :

التاريخ :

Appendix 3- Participant Information Sheet for Physiotherapists

Title of the study: The nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings.

Invitation

My name is Abeer Altamimi, and I am a musculoskeletal outpatient senior physiotherapist at King Faisal Specialist Hospital and Research Centre, Saudi Arabia. I am studying for a PhD at the University of Brighton, UK. I would like to invite you to participate in a research study. Before you decide whether you agree to take part it is important for you to 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 others if you wish. 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. If you agree to participate, you will be asked to sign an informed consent form before you participate in study.

What is this research project about?

The aim of the research project is to explore the nature of the professional patient-physiotherapist relationship in a musculoskeletal outpatient setting.

Why am I being invited to participate in the study?

You have been invited because you are a physiotherapist who is having experience in treating patients in a physiotherapy musculoskeletal outpatient setting.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide not to, your decision will entirely be respected and, of course, it will not affect your employment or legal rights. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If you agree to take part what will this involve?

If you wish to take part in this study, please return the contact information form and the consent form to me in the stamped addressed envelope provided. The study involves your participation in a series of semi-structured interviews, each no longer than one hour in duration. The number of interviews is likely to be two or perhaps three, and you will be invited to participate in each subsequent interview. Open-ended questions related to aspects of your professional therapeutic relationship with patients will be asked by me the researcher. The interview will be audio-taped, which will then be transcribed and anonymised by the researcher. I will send you a copy of the transcript so that you can check it for accuracy and remove any information you feel may threaten your anonymity. The original recording will be kept at the researcher workplace in a locked drawer until the successful completion of the research project at which point it will be erased and destroyed.

Where and when will the interviews take place and how long will they last?

The interviews will take place in the outpatient department meeting room at a time which is convenient for you, which could be in the evenings or during weekends.

Each of the interviews will last between 45 and 60 minutes. Refreshments will be available after the interview.

Will everything I say be kept private?

All the information you provide will remain anonymous and kept strictly confidential unless a disclosure is made which signifies poor or unethical practice in which case the researcher will be obliged to notify the relevant authority. All data will be available only to the researcher and her supervisors. In the transcript, your name will be changed so you will not be identifiable.

Confidentiality

You will not be named in any part of the thesis or in any publications or presentations. Quotes from the interviews might be included in articles for publication in academic and professional journals. I will ensure that you cannot be identified in any way in any publications or presentations emanating from the study.

What are the potential benefits of taking part in this study?

This research will develop into a substantive theory of the nature of patient-physiotherapist relationship. The findings will be used to inform physiotherapists and also to assist in making recommendations for physiotherapy services in Saudi Arabia.

What are the potential risks and disadvantages of taking part in this study?

There is a risk that you may become distressed as you reflect on your experiences. If this happens I will ask whether you wish to continue, pause or stop the interview. If you wish I will put you in touch with a counsellor. You are free to stop the interview any time without giving reasons. There may be a possibility that you may recall past incidents which may be distressing to you, in this case the researcher will advise you to seek help from a local counsellor.

In the case of unprofessional or dangerous behaviours, disclosure of negligence or harm emanating from the interview the researcher will then be required to break confidentiality and have to pass the information to the appropriate authority.

What will happen to the findings of this study?

The findings will be available in a written summary form to the patients and physiotherapists who participated in the study.

Dissemination of the research findings to therapists will take place at local and regional level, workshops and seminars and at national and international conferences. Publications will be disseminated in professional and peer-reviewed international journals.

Who has reviewed this study?

The study has been reviewed by The University of Brighton Faculty of Health and Social Science Research Ethics and Governance Committee, the researcher's supervisors, the hospital managers and by the clinical researcher at the researcher's workplace.

What if I change my mind about taking part?

Your participation in this study is voluntary. There is absolutely no detriment in not taking part. If you choose to take part, you can still withdraw from the study at any time without giving a reason and it will not affect your employment in any way. You may discuss, in confidence, any aspect of the study with Professor Ann Moore and/or Dr Nikki Petty, who are my supervisors of this study. Their contact details can be found below.

Professor Ann Moore PhD GradDipPhys FCSP CertED FMACP FHEA
Director Clinical Research Centre for Health Professions
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Aldro Building, 2nd Floor
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Dr Nikki Petty DPT MSc GradDipPhys FMACP FHEA
Principal Lecturer
University of Brighton
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East Sussex BN20 7UR
United Kingdom
Email N.J.Petty@bton.ac.uk
Telephone +441273641806
Fax number +441273643944

If you would like to discuss this study further, please do not hesitate to contact me.

Abeer Altamimi
Senior Physiotherapist
Email altamimiab11@gmail.com
Telephone +966505257570

Therapist Contact Details

Name _____

Address _____

Telephone number _____

Email address _____

Preferred method of communication (please circle):

Address

Telephone

Email

Other (please state): _____

Consent Form for Physiotherapists

Title of Project: The nature of the female patient-physiotherapist relationship in
Saudi Arabian musculoskeletal outpatient settings

Name of Researcher: Abeer Altamimi

Please initial box

1	I confirm that I have read and understand the information sheet dated _____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my employment or legal rights being affected.	<input type="checkbox"/>
3	I agree to provide information to the researcher under the conditions of confidentiality set out on the information sheet.	<input type="checkbox"/>
4	I agree to the interview being audio recorded.	<input type="checkbox"/>
5	I agree to the use of anonymised quotes in publications	<input type="checkbox"/>
6	I have been told that my personal information will be kept confidential.	<input type="checkbox"/>
7	I agree to take part in the above study.	<input type="checkbox"/>

Name of Therapist (Please Print)

Date

Signature

 Name of Research (Please Print)

 Date

 Signature

Appendix 4- Patients Invitation Letter in Arabic Version

مطلوب

متطلبات لدراسة بحثية
طبيعة العلاقة بين المريضة وأخصائية العلاج الطبيعي في محيط
العيادات الخارجية للمضلات والعظام في المملكة العربية السعودية .

الشروط:

- 1- أن يكون عمرك أكثر من 18 عاماً .
- 2- أن تكوني سعودية الجنسية .
- 3- أن تكوني قد أنهيتي دراستك الثانوية .

تستغرق الدراسة حوالي 45 دقيقة
(سنقدم وجبة خفيفة أثناء الدراسة)

للمشاركة أو الاستفسار نرجو التحدث إلى موظف الاستقبال في قسم
العلاج الطبيعي في مبنى الأورام .
(خلال ساعات الدوام الرسمي من 7:30 صباحاً
حتى 5:00 مساءً)

Appendix 5- Participant Information Sheet for Patients

Title of the study: The nature of the female patient-physiotherapist relationship in Saudi Arabian musculoskeletal outpatient settings.

Invitation

My name is Abeer Altamimi, and I am a musculoskeletal outpatient senior physiotherapist at King Faisal Specialist Hospital and Research Centre, Saudi Arabia. I am studying for a PhD at the University of Brighton, UK. I would like to invite you to participate in a research study. Before you decide whether you agree to take part, it is important for you to 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 others if you wish. 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. If you agree to participate, you will be asked to sign an informed consent form before you participate in study.

Study information

Title: The nature of the female patient-physiotherapist relationship Saudi Arabia musculoskeletal outpatient settings.

Why am I doing this research?

I am doing this research to explore the nature of the professional patient-physiotherapist relationship in a musculoskeletal outpatient setting.

Why am I being considered to participate in the study?

I am inviting you into the study because you are a patient who is being treated in a musculoskeletal outpatient department.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide not to, your decision will entirely be respected and, of course, it will not affect the healthcare you receive in any way. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If you agree to take part what will this involve?

If you wish to take part in this study, please return the contact information form and consent form to me in the stamped addressed envelope provided.

I would like you to join in an interview with no longer than one hour in duration. You may be requested to take part in a further two interviews. Questions related to aspects of the professional therapeutic relationship with your physiotherapist will be asked by me the researcher. I will audio-tape record the interviews so that I can listen to them and help me to remember what you have said after we have finished. Then I will transcribe the interview. I will send you a copy of the transcript so that you can check it for accuracy and remove any information you feel may threaten your anonymity. I will keep the audio record locked away at my workplace until the successful completion of the research project at which point it will be erased and destroyed.

Where and when will the interviews take place and how long will they last?

The interviews will take place in the outpatient department meeting room at a time which is convenient for you, which could be in the evenings or during weekends. Each of the interviews will last between 45 and 60 minutes. Refreshments will be available after the interview.

Will everything I say be kept private?

All the information you provide will remain anonymous and kept strictly confidential. All data will be available only to the researcher and her supervisors. In the transcript, your name will be changed so you will not be identifiable.

Confidentiality

You will not be named in any part of the thesis or in any publications or presentations. Quotes from the interviews might be included in articles for publication in academic and professional journals. I will ensure that you cannot be identified in any way in any publications or presentations emanating from this study.

What are the potential benefits of taking part in this study?

This research will provide an in-depth description and explanation of the nature of patient-physiotherapist professional therapeutic relationship. The findings will be used to inform physiotherapists and also assist in making recommendations for physiotherapy services in Saudi Arabia.

What are the potential risks and disadvantages of taking part in this study?

There is a risk that you may become distressed as you reflect on your experiences. If this happens I will ask whether you wish to continue, pause or stop the interview. I will put you in touch with a counsellor if you wish. You are free to stop the interview any time without giving reasons. In the event of you wishing to make a complaint, you will be advised to discuss the situation with the host hospital complaints department.

What will happen to the findings of this study?

The findings will be available in a written summary form to the patients and physiotherapists who participated in the study.

Dissemination of the research findings to therapists will take place at local and regional level, workshops and seminars and at national and international conferences. Publications will be disseminated in professional and peer-reviewed international journals.

Who has reviewed this study?

The study has been reviewed by The University of Brighton Faculty of Health and Social Science Research Ethics and Governance Committee, the researcher's supervisors, the hospitals managers and by the clinical researcher at the researcher's workplace.

What if I change my mind about taking part?

Your participation in this study is voluntary; there is absolutely no detriment in not taking part. If you choose to take part, you can still withdraw from the study at any time without giving a reason and it will not affect your therapy or any other treatment or care. You may discuss, in confidence, any aspect of the study with Professor Ann Moore and/or Dr Nikki Petty, who are my supervisors of this study. Their contact details can be found below.

Professor Ann Moore PhD GradDipPhys FCSP CertED FMACP FHEA
Director Clinical Research Centre for Health Professions
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Principal Lecturer
University of Brighton
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49 Darley Road, Eastbourne
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United Kingdom
Email N.J.Petty@bton.ac.uk
Telephone +441273641806
Fax number +441273643944

If you would like to discuss this study further, please do not hesitate to contact me.
Abeer Altamimi
Senior Physiotherapist
King Faisal Specialist Hospital and Research Centre
Email altamimiab11@gmail.com
Telephone +966505257570

Patient Contact Details

Name _____

Address _____

Telephone number _____

Email address _____

Preferred method of communication (please circle):

Address

Telephone

Email

Other (please state): _____

Consent Form for Patients

Title of Project: The nature of the female patient-physiotherapist relationship in
Saudi Arabian musculoskeletal outpatient settings

Name of Researcher: Abeer Altamimi

Please initial box

1	I confirm that I have read and understand the information sheet dated _____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without any effect of my therapy or any other treatment or care.	<input type="checkbox"/>
3	I agree to provide information to the researcher under the conditions of confidentiality set out on the information sheet.	<input type="checkbox"/>
4	I agree to the interview being audio recorded.	<input type="checkbox"/>
5	I agree to the use of anonymised quotes in publications	<input type="checkbox"/>
6	I have been told that my personal information will be kept confidential	<input type="checkbox"/>
7	I agree to take part in the above study.	<input type="checkbox"/>

Name of Patient (Please Print)

Date

Signature

Name of Research (Please Print)

Date

Signature

Appendix 6- Physiotherapist Interview Transcript Sample

- Abeer :** Hello.
- Pt3 :** Hello.
- Abeer :** How are you?
- Pt3 :** Fine, thank you.
- Abeer :** Thank you for accepting to participate in this study.
- Pt3 :** You are most welcome
- Abeer :** I have given you an idea about the study and you have reviewed the papers. You are free to stop at any time you want and I assure strict secrecy of this interview. To start off, I'll ask you some questions about yourself. How old are you?
- Pt3 :** 37 years old.
- Abeer :** Are you married?
- Pt3 :** Yes, and I have children.
- Abeer :** How long has it been since you graduated?
- Pt3 :** 13 years.
- Abeer :** How long have you been working?
- Pt3 :** 10 years.
- Abeer :** Have you worked in different departments?
- Pt3 :** Yes, but mainly outpatient.
- Abeer :** Have you worked in different hospitals?
- Pt3 :** Yes.
- Abeer :** Can you name them?
- Pt3 :** I've worked in the Military Hospital, King Fahad Medical City, and I worked as a volunteer in King Faisal Specialist Hospital for a short period.
- Abeer :** Let's start with the study question. How would you describe the nature of the relationship between the physiotherapist and the patient?
- Pt3 :** There is no good communication between them. Patients treat us as machines. You have to serve them in any way without any feeling that they are dealing with a person. They treat the therapist as a servant.
- Abeer :** Do you feel that?
- Pt3 :** Yes.
- Abeer :** How? Can you elaborate on this?
- Pt3 :** Of course, not all of them. But most patients do that. For example, a patient says to me "I feel pain. You came late. Who do you think you are?" The patient says this if I came late to her, because I have the right to dismiss her and I am busy. I tell her very politely that I was busy. She or her watcher says to me, "Do you think you are a doctor?"
- Abeer :** So, is there a difference between their attitudes towards doctors and physiotherapists?
- Pt3 :** Yes, they wait for the doctors for hours. But if I come half an hour late because I am busy, the patient doesn't accept it. However, if she comes two or three hours late, I have to wait for her. But she waits for doctors for five or six hours. She differentiates between doctors

and physiotherapists. There is a big difference from their point of view. They treat us as if we are machines. We should always be at their service. This makes a gap between us and patients. So, the relationship between me and the patient is formal and limited. So, I just think about doing the job and I finish it as soon as possible. I hope that my relationship with the patient is better in order to give her more. But now I give her what she needs and nothing more. When the patient enters the cubicle, she treats the therapist contemptuously. She says, "What is this? Can this be useful? This can't make any difference." And I answer, "So, why did you come to the physiotherapy unit?" Then, I begin to explain to her what physiotherapy is. In addition, she thinks that the therapist is a trainer or something like that. They have no knowledge about our job.

Abeer : This is important. But what is the reason for that view? Why do you think the physiotherapy profession is not clear for the patient?

Pt3 : I always ask myself this question. I have been working in physiotherapy for ten years and the patients are still not aware about physiotherapy. There is a problem. When I started, they were calling the physiotherapist a trainer or a masseur, and up until now, I still hear such titles. This means that we should provide some information about physiotherapy. But, I don't know if this will be useful or not.

Abeer : When you first enter the cubicle, do you tell the patient about physiotherapy?

Pt3 : I introduce myself. I tell her that I will assess her status and determine the methods that are useful to her, help her and remove the pains. But still they consider me a masseur or trainer.

Abeer : Even after the explanation you make?!

Pt3 : Yes. They are not persuaded that physiotherapy is important.

Abeer : Even though you explain to her the goal of the session and what will you do with her as a therapist?!

Pt3 : Sometimes, I explain this more than once in the same session. I tell her many times, "I'm here to assess and diagnose you and to give you the treatment that helps to relieve the pain you feel or to helps to limit the problem you are facing and prevent it being aggravated." Then she says, "You will not massage me?" So, I feel that she didn't understand anything of what I explained to her many times. So, I repeat what I said many times. They don't have awareness. Then I tell her that the massage has a short-term effect and this service is not presented here in hospital. It is in the health clubs. We have exercises, correction of certain positions and improvement of your health problem. We don't make massage because massage has temporary effects and I give her names of clubs that offer a good massage service. But, they are still not aware of physiotherapy. I give her a session that contains exercises and manual therapy. At the end she says, "Is that all?" I reply, "Yes. Practice these exercises at home and come to the next appointment." Here, I feel she is not satisfied with doing exercises at home. She wants something more. I don't know what more she wants.

Abeer : Other than equipment and exercises?!

- Pt3** : Yes. And some cases don't require equipment. So, I give her just exercises. But she is absolutely not convinced with that. She wants to use equipment. This is because she doesn't understand what physiotherapy is. She wants something tangible. So sometimes, a patient says, "That's enough. Go."
- Abeer** : Do you really feel that she treats you as a machine?
- Pt3** : Yes. But I expect that the relationship will be different. For example, I expect that when the patient enters the cubicle, she will say, "Good morning. How are you?" and she will speak with me and understand me. But what usually happens is that the patient enters the cubicle, takes off the cloak and orders me to start working. There is no human-to-human or a therapist-to-patient relationship. This is the kind of people we deal with. In rare cases, the patient will interact with me and talk to me firstly as a person and secondly as a physical therapist. We have discussion and she comprehends what I am saying. In such a case, I can listen to her better. These are rare cases and they are likely to be educated.
- Abeer** : So, is this related to education?
- Pt3** : Yes. This is clear from the way she speaks with me. But others come to me without understanding why they came. The doctor referred them to me but they don't know why.
- Abeer** : Is there no explanation by the doctor to the patient about her status?
- Pt3** : Mostly, yes. Most patients who come to me don't know what the physical therapy profession is. Just the doctor referred them to me. Of course, I explain to them, but they're still not comprehending.
- Abeer** : You said this affects you and this way doesn't enable you to give the best, but just you want to do your job. Can you elaborate on this please?.
- Pt3** : Yes, because the patients enters the cubicle and wants to fight. She disrespects the physiotherapist. She feels that we are inferior to doctors. This mostly happens when a patient comes late and I press myself and let her enter. She says, "You are not a doctor. Who do you think you are?! You will do something unimportant. It's just a massage. I tell her that I will spend an hour with her for an assessment and plan of treatment but she can't understand this. She wants me to just have a look at her and give her a raise and this way she will improve. She can't comprehend that we have our own plan and our own assessment time.
- Abeer** : When you enter, do you explain this plan to all patients or you feel that some patients need explanation and others don't?
- Pt3** : Some patients need less explanation.
- Abeer** : Why?
- Pt3** : Because, they have chronic diseases and always come to physiotherapy. But to patients who come for the first time, the introduction is longer.
- Abeer** : How do you deal with patients who have chronic diseases if this is their attitude?
- Pt3** : We try to make a rule. We tell them that we will not see them again if they don't need to. If the patient comes, I say to her, "just finish your session. Then we'll see if you improved or not and I will send you

back to the doctor.” Sometimes, when I ask a patient why she came, she replies, “I want to swim in the swimming pool.” Then, I ask her, “Do you know the benefit of using the swimming pool?” And I discover that she doesn’t know the benefit of using it. She just wants to enjoy the swimming pool without understanding, although we explain to them and tell them that the swimming pool is used for a number of sessions only. And if the patient wants to continue practicing swimming she can join a social club, but we can’t keep her all the time using the swimming pool. Another kind is the patient who becomes addicted to physiotherapy. She likes to go out of her house and feels that this is the place to feel comfort. She considers it a kind of a forum or something free of charge for socialization and that’s all.

Abeer : Does this affect your relationship with the patients?

Pt3 : Of course. I want to have a case that really needs physiotherapy and I will do it and then I will discharge her whenever she is ready. But in such a case, I don’t have anything to give her. She is already done with her program and she comes just for socialization. So, what I do is I give her one session and when I access her program, I discharge her and she will not be happy. She will complain. She will go back to the doctor. She will bring another referral. So, it is an unfinished cycle. And of course this is an unhealthy environment to work in. It is becoming like a boring cycle and what I need as physiotherapist is someone to start with who really needs physiotherapy, really respects physical therapy, understands what we are doing, practices the exercises at home, gets good results and then they can go home pain free. This is really rare.

Abeer : Respect affects you. Do you think that respect is very important in your relation to the patient?

Pt3 : Yes. A few years ago, I was thinking of continuing studying for four years to become a doctor in order to gain this respect.

Abeer : So, there is a kind of underestimation for your profession. Does this affect your relationship with the patient? Does it prevent you from doing your best with the patient?

Pt3 : Yes.

Abeer : Do you lose interest?

Pt3 : Especially with that kind of patient.

Abeer : You mean the old people?

Pt3 : No. On the contrary, most old people are friendly and follow all the instructions and they really appreciate what you are doing. But I mean the middle-aged mostly.

Abeer : The educated or the uneducated?

Pt3 : Mostly the uneducated. But I mean the middle-aged in general.

Abeer : You mentioned something that attracted my attention when you said, “I want the patient to deal with me as a human being.” I want to know what you mean. Do you want to form a personal relationship with the patient?

Pt3 : No. What I mean is that when I go to other professions, as a patient for example, I like to be treated as a human being and I like to treat him as a human being, not only a doctor. I want to feel empathy. So, I

- wish to have the same. This should be from both sides. When I start and find a wall in front of me I can't achieve this.
- Abeer :** Don't you think that it is the patient who needs this from you or you also need it?
- Pt3 :** When I go to the doctor and when he starts to deal with me in an empathetic way, I treat him in the same way.
- Abeer :** So, it is you who controls this?
- Pt 3 :** When I enter, I say "Good morning. My name is But I directly face this bad attitude. It's my role to start and to introduce myself and tell the patient about the program. Then what I find may be fighting from the patient.
- Abeer :** Really! Directly?
- Pt3 :** Yes, either because of appointment, being late. And I respect her delay. I tell her that it will be a very short session because she is late and then directly I face this problem. She starts fighting. She says, "Why are you telling me this and why do you want to give me only fifteen minutes?" Although, I'm respecting her. I will not see her for fifteen minutes and then dismiss her without telling her this.
- Abeer :** Why do you let her enter?
- Pt3 :** Because, I don't want to have problems. We have the right to dismiss the patient or to reschedule the patient but sometimes you feel the patient had difficulties to arrive here.
- Abeer :** So, you appreciate the patient's circumstances.
- Pt3 :** Yes. But my appreciation is met by this bad attitude from the patient. She doesn't appreciate that I squeeze myself to see the patient.
- Abeer :** This good understanding by you is to all patients who delay or just certain cases?
- Pt3 :** No. If she is from outside and I reschedule her, maybe it will reach the higher administration.
- Abeer :** Oh. To that extent?
- Pt3 :** Yes.
- Abeer :** Did this happen to you before?
- Pt3 :** Yes. This happens when the patient is impolite from the beginning. Fighting. And you have to see the patient. Because of this bad attitude, I refuse to see the patient. Firstly, because I have the right. Secondly, because she is not behaving. This is regarding coming late and late arrival. Otherwise, during the session itself, I used to deal with the patient as a new ... not friendship but like a smooth relationship between the therapist and the patient and some of the patients really interact and they become friendly. Others don't and they put borders. Ok. I respect this.
- Abeer :** From your point of view, how do you see friendship with the patient?
- Pt3 :** I'm spending every day or every week, like three hours, with this patient and it's really important to have a good relationship between both of us ... to understand the patient and to let the patient feel relaxed with you ... you are doing a lot with the patient herself. So, actually it's important to have a good relationship with the patient. Imagine that the patient and the therapist are having this rigid relationship. You can't really reach the maximum benefit from this session.

Abeer : This is good. Friendship, flexibility and smoothness. But how can this be achieved? Does this come by asking about personal affairs?

Pt3 : It starts with the introduction. I introduce myself and I ask her about the history of her case. How will she give me the history if the relationship is rigid?

Abeer : You want her to be open?

Pt3 : Yes. Because the history is important.

Abeer : Why are patients self-restrained when talking about history?

Pt3 : Because she doesn't know you. I am asking her about her social history.

Abeer : Is it important to ask about social history?

Pt3 : Yes. It reveals many things to me.

Abeer : Give me examples

Pt3 : For example, if she has a death case in her family, like she is a widow. Or if she has a problem coming to our hospital. All such information is important. So I try to find solutions for her to make it easier for her to come to the hospital. A lot of patients who come to us have difficulties but they don't know about social work. So I try to help the patient. I guide her. But if there is no such relationship, she will tell me that she can't come and I will close her file and it's over and she will go home without any benefit. If she has children and she wants to increase their musculoskeletal level, I can give her advice. If I don't know anything about her, I will not know about her difficulties.

Abeer : So, you mean the personal relationship that is related to her benefit?

Pt3 : Yes.

Abeer : No more than this?

Pt3 : If the person is very open, it may be more social interaction.

Abeer : You don't mind this?

Pt3 : No. I don't. She may be interested in certain things I am interested in. It could be more but still with borders.

Abeer : Borders put by you?

Pt3 : Yes. Because it's not safe to be very open.

Abeer : Why? Can you explain this to me please?

Pt3 : There may be problems. People you don't know. Suddenly you get to know them. This is good. But the relation should be limited to some extent. Nobody knows what may happen in the future. It may be unsafe to be very open with the patient. As to us as therapists, we have to put some limits. However, I should be open to some extent. Because this is a human-to-human relationship.

Abeer : This control comes from you?

Pt3 : I deal with all people the same way. They differ in their attitudes. When I find the patient reserved, I respect this. Some patients don't even uncover their faces. Those, I treat them with caution. I find difficulty speaking with them. I like eye contact and lip language. So, the relationship is very rigid.

Abeer : When you see this, don't you tell her that you are in a female space and there's no need to cover her face?

Pt3 : I say this but she doesn't respond. She may take off her cloak and pants but not her face cover.

Abeer : Why?

Pt3 : Customs and traditions of the country. But some patients are open-minded. So, I feel I'm talking to my sister.

Abeer : Does the relationship allow this kind of sisterhood?

Pt3 : In some cases only. When our environments are similar and when she is educated. The areas we belong to are similar.

Abeer : Can you explain this point more?

Pt3 : I am from a city, so I am open to some extent. I work in a closed area. So, most patients are closed and they see that I am different from them. So they do not become friendly with me although I try.

Abeer : Do they just judge you by your appearance?

Pt3 : From my appearance and my way of talking. I try to explain to them that we are like each other. But still the relationship is limited. I try to joke with her to make her open to me in order to speak freely to me but she doesn't respond. Others who are from my same environment or community, we feel that we belong to each other. So, the relationship becomes more open. She can understand me better. We both understand each other. So, the session becomes more enjoyable. Otherwise, the session is antipathetic and I feel I want to finish and go.

Abeer : To that extent?

Pt3 : Yes.

Abeer : Can this change with time?

Pt3 : If she allows this to happen. But the percentage is low.

Abeer : Is there a type of patient who responds to you as to exercises and follows what you are telling her?

Pt3 : Now, the majority do the exercises. But we can say about 30 per cent don't. They come to the session and say, "we didn't do the exercises and these exercises can't lead to any result." They request that I go to their homes to do massage and exercises for them.

Abeer : Come to my home!!

Pt3 : Yes. Recently, a patient told me this. She said, "Come to my home and anoint me." And I told her that we don't do this. This is not our job. There are other people who work in home service but not in our hospital. Some patients want home service. But they don't want a physiotherapist. They want someone to do massage and make them comfortable because they don't want to do anything themselves. So, I have to explain that I have a family and I can't do this. You think you are different from them. You don't belong to this society. You can be demanded just like any other service such as coiffeur.

Abeer : You see that their treatment with doctors are different from their treatment with a physiotherapist?

Pt3 : Yes.

Abeer : You said that most of them come to you and the doctor didn't explain anything to them. In such cases, you have to explain to them?

Pt3 : Yes, we have to explain to them. Some patients like the idea and say that they will try and others aren't convinced because they don't have sufficient information about physiotherapy. Some patients don't even know that there is something called physiotherapy.

Abeer : Most doctors don't explain the case to the patient.

Pt3 : Yes.

Abeer : Patients come to you knowing nothing about their case and about what you will do with them.

Pt3 : Yes.

Abeer : Does the patient think that physiotherapy will solve her problems?

Pt3 : Exactly. Some of them think I will solve the problem even if she is complaining from tonsillitis.

Abeer : Oh!

Pt3 : Yeah, sometimes a patient asks me to prescribe some medications. They don't know anything about physiotherapy. I think here in Saudi Arabia, we are still at the start of the way of physiotherapy. I feel we need about 50 years to have good knowledge in our society about physiotherapy. We will be grandparents at that time.

Abeer : To that extent?

Pt3 : Yes. Ten years has already passed and nothing has changed.

Abeer : You feel that the idea about physiotherapy hasn't changed?

Pt3 : Yes. And I am happy you are doing a study about this topic because we need to know the nature of relationship, humanly and professionally. I want to know how it should be. Are we wrong when we think that we should be open with patients while they are reserved. I want to know what is more professional—to be open or to have limits. We didn't study this at university. I have colleagues who enter the cubicle like a bulldozer. Here, the therapist is like a machine. The patient doesn't know what he is doing for him. Others are friendly. We want to know—How should the relation be? It's never too late for me. Am I right? Or the bulldozer?

Abeer : So, what do you prefer?

Pt3 : I prefer to have special relationship with the patient. There is a special relationship between the psychologist and the patient. But the relationship between the physiotherapist and the patient isn't clear.

Abeer : What are your expectations from the patient?

Pt3 : First, she should understand my role. When she understands my role, she will respect me. Second, to be open. Third, to respond. Some patients are like walls. They never respond. They don't know if there is a benefit or not. So, communication is very important to understand the benefit. The relationship should be deeper. The patient should know that we are not doctors. Our role is different. We have goals that we want to achieve. If these goals aren't achieved, the patient will be referred back to the doctor to know what other problem she has. There is no magic.

Abeer : Do they sometimes feel like you have a magic wand?

Pt3 : Yes. However, they are always not satisfied. When a patient comes for follow up, I ask her, "Did you improve?" She answers, "Never." But when I see her, I find that the range of movement has improved and also muscle power.

Abeer : Why do they do this?

Pt3 : They are still not convinced about physiotherapy. Maybe they want to keep coming to the physiotherapy unit. Either this or that. Or, sometimes dissatisfaction is a feature of their characters, especially females here in our society have this feature.

Abeer : Why?

Pt3 : It's their nature.

Abeer : Do you think that some of them like to attract attention?

Pt3 : Yes. They like to feel they are receiving special care.

Abeer : From you or from their homes?

Pt3 : Both.

Abeer : what problems may they have at their homes?

Pt3 : Usually they have family problems and negligence.

Abeer : You mean woman in particular?

Pt3 : Yes.

Abeer : Neglected by whom?

Pt3 : Mostly, her husband. If she is a girl, it is by her family in general.

Abeer : Why?

Pt3 : This is the general view of women in our society. Although she has a great role to play in society, this role isn't appreciated. So, she feels when she comes here that she is doing something for herself. Maybe attracting attention, getting out of the closed circle she is living in, and having some socialization. May be this is a kind of catharsis to her.

Abeer : Does this really exist here in our society?

Pt3 : Yes, very much. When they come here, they make something like an assembly in the waiting area, socialization and mobile numbers exchanging. But when she comes in to the therapist she doesn't want to make socialization. If she feels comfortable, she may do that to the extent that it becomes like an addiction to her and she never wants to be discharged.

Abeer : What is your opinion about that?

Pt3 : The physiotherapy unit is the place they frequently come to while the patient may see the doctor once in a year.

Abeer : How do you sometimes gets into the personal affairs of the patient?

Pt3 : Sometimes, a patient suddenly cries. You can't leave her leave in such a state. I try to calm her but not to ask her about the matter. If she feels comfortable with you from previous sessions, she begins to tell and I feel it's a kind of relief for them sometimes. Sometimes, I direct them to the proper institute. I had some cases like this.

Abeer : Tell me more.

Pt3 : Some have financial problems and we know some charity that can help in financing these families or those who need medical equipment. She may be struggling and doesn't know how to solve her problem. When she comes to me and tells me about that, I tell her about these entities. She goes there and her problem is solved. But this happens only if the patient is open. Others don't share anything about their problems.

Abeer : This is good. It's good to guide her to a financial or psychological resource. But, do you like that she be open to you?

Pt3 : How?

Abeer : To ask about your life details for example.

Pt3 : No. I have no problem about this. I know information about her. So, it is natural that she knows information about me. However, I know some of my colleagues never tell the patient if they are married or not or if they have children. But I am not. This builds confidence between us both. In our society, many therapists are so closed. I don't like their way of treatment with patients. The relationship is very rigid. And really, they make the patient treat them like machines.

Abeer : Do you remember good relationship you built with a patient?

Pt3 : I remember on at King Faisal Specialist Hospital. When I was there, I know a patient that I can't forget. It was a very good relationship—an honest, respectful, open relationship. When I saw her in the corridors of hospital, I realized that she also didn't forget me. I have good relationships with other patients also. Some of them have an addiction not only to physiotherapy but also to me. They refuse to be treated by another therapist. I respect this. But sometimes I feel it affects the therapy. Sometimes the addiction and attachment is higher. This is also one of the problems of the relationship between the therapist and the patient.

Abeer : How do you solve this?

Pt3 : I try to request that the patient is transferred to another therapist and I become more restricted. I put some limits but I still am friendly.

Abeer : You said you built relationships. Does the beauty of this relationship lie in that she always asks about you and wants to be with you?

Pt3 : No. The beauty lies in the open way she treats me during the sessions. So, I could exactly understand her case, her pains and the improvement she achieves without restrictions and without pretention. With others, I don't have sincere relationships.

Abeer : This may be because they are afraid of discharge?

Pt3 : Yes.

Abeer : They are afraid to lose such attention?

Pt3 : Yes.

Abeer : Do you believe it is a never-ending cycle?

Pt3 : Yes.

Abeer : On the other side, do you remember a bad relationship?

Pt3 : Yes. I saw a patient only once. She was really friendly. I introduced myself to her very well. I assessed her nicely and made a full assessment. Next week, she did not come. The week after, she asked to change the therapist. She said, "I did not like her."

Abeer : Why?

Pt3 : She didn't give any explanation. This hurt me. It was a very bad feeling.

Abeer : Didn't you notice anything during your meeting?

Pt3 : No, she was friendly and I was friendly, but she didn't like me. But I never had trouble with patients. I know things that happen to my colleagues. Sometimes the patient complains. But this is mostly because of the rudeness of the therapist.

Abeer : How?

Pt3 : This is the mistake of the therapist. Some of them don't treat the patient as a human being but just as a case of disease. The patient is

not convinced with what is achieved because she doesn't deal with the patient but just with her pain.

- Abeer :** Would you like to add anything else? Or to link something to our society, customs or traditions?
- Pt3 :** Most problems occur with female patients. I have worked with males. They were more open. More flexible. They accepted the therapist as a human being. But now, I always I face problems when dealing with females. This may be a result of the culture or jealousy.
- Abeer :** Do you really feel this? Can she be jealous of your good appearance?
- Pt3 :** Yes. As to society, there is no information about physiotherapy. Secondly, they still don't accept the woman who works.
- Abeer :** Up until now?
- Pt3 :** Yes. They think that you are Saudi. You have to stay at home and leave such work to Filipinos or any other nationalities. They have problems related to transportation. The patient has to wait for the driver or for her husband or guardian to bring her. So, they come frustrated. So, this affects their attitude to us. But some of them feel they want to speak to you.
- Abeer :** How can this social frustration affect you?
- Pt3 :** Mostly, I just listen to her, try to calm her, give her some ideas.
- Abeer :** Do you want the woman in our society to be more powerful?
- Pt3 :** Yes. I want her to be independent, to have her own personality, her own financial status and education. I like her to be healthier and more fit because we have a higher percentage of patients with musculoskeletal problems. This is because of their lifestyles. They have a poor lifestyle, to move more, to get out of their houses to study.
- Abeer :** Thank you very much, we are about to finish, do you want to add anything?
- Pt3 :** I want to thank you for this study. I wish you the best in this research. I want know what are you going to do after this research?
- Abeer :** I want to know the nature of relationship between the therapist and the patient and set a frame or theory that serves the relationship and to have a framework for orientation about dealing with the patient on one side and to improve the service presented on the other side. We hope we can reach certain models.
- Pt3 :** This is very important. I really wish you success.

Appendix 7- The Interview Schedule, Consent Form and Participant Information Sheet for Patients (Arabic Version)

عنوان الدراسة: طبيعة العلاقة بين المريضة وأخصائي العلاج الطبيعي في محيط العيادات الخارجية للعضلات والعظام في السعودية.

الدعوة

اسمي عبير التميمي وأنا كبير أخصائيي العلاج الطبيعي بمستشفى الملك فيصل التخصصي ومركز الأبحاث في السعودية. إنني أدرس لدرجة الدكتوراة بجامعة برايتون بالمملكة المتحدة. أود أن أدعوكم للمشاركة في دراسة بحثية. وقبل أن تقرر ما إذا كنت توافق على المشاركة أم لا من الهام أن تفهم سبب إجراء هذا البحث وما يتضمنه. برجاء قراءة المعلومات التالية بعناية ومناقشتها مع الآخرين إذا أردت ذلك. ويمكنك أن تسألني عن أي شيء غير واضح أو إذا أردت المزيد من المعلومات. فكر وقرر إذا كنت ترغب في المشاركة أم لا. إذا وافقت على المشاركة فعليك أن توقع على نموذج موافقة مستتيرة قبل المشاركة في الدراسة.

معلومات الدراسة

العنوان: طبيعة العلاقة بين المريضة وأخصائي العلاج الطبيعي في محيط العيادات الخارجية للعضلات والعظام في السعودية.

لماذا أقوم بهذا البحث؟

أقوم بهذا البحث لكي أستكشف طبيعة العلاقة المهنية بين المريضة وأخصائي العلاج الطبيعي في محيط العيادات الخارجية للعظام والعضلات.

لماذا تم وضعي في الاعتبار للمشاركة في الدراسة؟

إنني أدعوكم للمشاركة في الدراسة لأنك مريض يتم علاجك في قسم العيادات الخارجية للعظام والعضلات.

هل يجب أن أشارك؟

لك الحرية في أن تقرر أن تشارك أم لا. إذا قررت ألا تشارك فإن قرارك سيُحترم تماماً ولن يؤثر بالطبع على الرعاية الصحية التي تتلقاها بأي شكل من الأشكال. وإذا قررت أن تشارك فستأخذ ورقة المعلومات هذه لكي تحتفظ بها وسيطلب منك توقيع نموذج موافقة.

إذا وافقت على المشاركة فماذا يتضمن ذلك؟

إذا رغبت في المشاركة في هذه الدراسة برجاء إرجاع نموذج المعلومات ونموذج الموافقة إليّ في المظروف المعنون والمختوم المقدم إليك.

أود منك أن تتحقق بمقابلة شخصية لن تستغرق أكثر من ساعة واحدة. وقد يُطلب منك المشاركة في مقابلتين أخريين. سأقوم أنا الباحثة بتوجيه أسئلة تتعلق بجوانب العلاقة العلاجية المهنية مع أخصائي العلاج الطبيعي. سأقوم بالتسجيل الصوتي للمقابلات حتى أستطيع أن أستمع إليها وتساعدني على تذكر ما قلته بعد انتهاء المقابلة. ثم سأقوم بتدوين المقابلة. وسأرسل لك نسخة من هذا التدوين (ومظروف معنون مختوم) حتى تستطيع مراجعته للتأكد من الدقة وحذف أي معلومات قد تشعر أنها تهدد سرية هويتك. سأحتفظ بالتسجيل الصوتي في مكان مغلق في مقر عملي حتى انتهاء مشروع البحث بنجاح وعندئذ سيتم مسحه وإتلافه.

أين ومتى ستتم المقابلات وكم ستستغرق؟

ستتم المقابلات في غرفة الاجتماعات بقسم العيادات الخارجية في الوقت المناسب لك حيث ممكن أن يكون في المساء أو في عطلة نهاية الأسبوع. ستستمر كل مقابلة ما بين 45 و60 دقيقة. سيتم تقديم بعض الوجبات الخفيفة بعد المقابلة.

هل كل ما سأقوله سيظل في طي الكتمان؟

ستظل جميع المعلومات التي تقولها مجهولة الهوية وسيتم الاحتفاظ بها في سرية تامة. ستكون جمع البيانات متاحة فقط للباحثة ومشرفيها. أما في ورقة التسجيل فسيتم تغيير اسمك بحيث لا يمكن معرفة هويتك.

السرية

لن يتم ذكر اسمك في أي جزء من الرسالة أو في أي منشور أو عرض. يمكن أخذ مقتبسات من المقابلات ونشرها في مقالات في الصحف الأكاديمية والمهنية. وسأتأكد من عدم إمكانية تحديد هويتك بأي طريقة في أي منشور أو عرض منبثق من هذه الدراسة.

ما هي الفوائد المحتملة من المشاركة في هذه الدراسة؟

سيقدم هذا البحث وصف وشرح عميق لطبيعة العلاقة العلاجية المهنية بين المريض وأخصائي العلاج الطبيعي. وسيتم الاستفادة من النتائج في توعية أخصائي العلاج الطبيعي وللمساعدة أيضاً في عمل التوصيات المتعلقة بخدمة العلاج الطبيعي في السعودية.

ما هي المخاطر والمساوئ المحتملة للمشاركة في هذه الدراسة؟

من المخاطر المحتملة أنك قد تشعر بالحزن خلال تعبيرك عن خبراتك. وإذا حدث ذلك سأسألك هل تريد الاستمرار أو التوقف المؤقت أو إنهاء المقابلة. وسأجعلك على اتصال بمرشد اجتماعي إذا رغبت في ذلك. ولك حرية إيقاف المقابلة في أي وقت بدون إبداء الأسباب. وإذا رغبت في تقديم شكوى سيتم إرشادك لمناقشة الموقف مع قسم الشكاوى في المستشفى المضيفة.

ما الذي سيحدث بالنسبة لنتائج هذه الدراسة؟

سيتم توفير النتائج في نموذج ملخص كتابي للمرضى وأخصائيي العلاج الطبيعي الذين شاركوا في الدراسة. وسيتم تعميم نتائج البحث على المعالجين على المستوى المحلي وعلى مستوى المنطقة وفي ورش العمل وحلقات البحث وفي المؤتمرات الوطنية والدولية. وسيتم توزيع منشورات في الصحف الدولية المهنية والتي يتم استعراضها استعراض النظراء.

من الذي راجع الدراسة؟

تمت مراجعة الدراسة بواسطة جامعة برايتون كلية الصحة والعلوم الاجتماعية ولجنة قواعد وأسس البحث العلمي ومشرفي الباحث ومدراء المستشفيات والباحث الإكلينيكي في مقر عمل الباحث.

ماذا لو غيرت رأيي بالنسبة للمشاركة؟

إن مشاركتك في هذه الدراسة مشاركة تطوعية، ولا يوجد على الإطلاق أي ضرر من عدم مشاركتك. إذا اخترت المشاركة سيظل معك خيار الانسحاب من الدراسة في أي وقت بدون إبداء الأسباب ولن يؤثر ذلك على علاجك أو على أي علاج أو رعاية أخرى. يمكنك مناقشة أي جوانب من الدراسة سراً مع الأستاذة آن مور و/أو د. نيكي بيتي وهما المشرفين عليّ في هذه الدراسة. وفيما يلي وسائل الاتصال بهما.

أستاذة آن مور دكتورة ودبلوما دراسات عليا في العلاج الطبيعي، زميل الجمعية المعتمدة للعلاج الطبيعي (المملكة المتحدة) وزميل أكاديمية التعليم العالي (المملكة المتحدة)

مدير مركز الأبحاث الإكلينيكية للمهن الصحية

جامعة برايتون

مبنى ألدرو، الطابق الثاني

49 طريق دارلي، إيستبورن

إيست ساسكس بي.إن 20 7يو.آر

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إذا أردت مناقشة هذه الدراسة بمزيد من التفاصيل لا تتردد في الاتصال بي.

عبير التيمي

كبير أخصائي العلاج الطبيعي

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بيانات الاتصال بالمريض

الاسم

العنوان

رقم الهاتف

البريد الإلكتروني

وسيلة الاتصال المفضلة (برجاء وضع دائرة حولها):

البريد الإلكتروني

الهاتف

العنوان

أخرى (برجاء ذكرها):

نموذج الموافقة للمرضى

عنوان المشروع: طبيعة العلاقة بين المريضة وأخصائي العلاج الطبيعي في محيط العيادات الخارجية للعضلات والعظام في السعودية

اسم الباحث: عبير التميمي

<input type="checkbox"/>	أؤكد أنني قرأت وفهمت ورقة المعلومات بتاريخ _____ للدراسة المذكورة أعلاه. وكان لدي الفرصة للتفكير في المعلومات وتوجيه أسئلة والحصول على إجابات وافية لها.	1
<input type="checkbox"/>	أفهم أن مشاركتي تطوعية وأن لدي حرية الانسحاب في أي وقت بدون إبداء الأسباب وبدن أي تأثير على علاجي أو أي علاج أو رعاية أخرى.	2
<input type="checkbox"/>	أوافق على تقديم المعلومات للباحثة بموجب شروط السرية الموضحة في ورقة المعلومات.	3
<input type="checkbox"/>	أوافق على التسجيل الصوتي للمقابلة.	4
<input type="checkbox"/>	أوافق على استخدام مقتبسات من المقابلة في مواد منشورة بدون ذكر اسمي.	5
<input type="checkbox"/>	تم إخباري بأن معلوماتي الشخصية ستكون سرية.	6
<input type="checkbox"/>	أوافق على المشاركة في الدراسة المذكورة أعلاه.	7

اسم المريض (برجاء كتابته) التاريخ التوقيع

اسم الباحث (برجاء كتابته) التاريخ التوقيع
