Title: What matters most to people in musculoskeletal physiotherapy consultations? A qualitative study.

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ABSTRACT

**Title:** What matters most to people in musculoskeletal physiotherapy consultations? A qualitative study.

**Background:** Person-centred approaches to care require clinicians to engage in trying to understand the full range of problems and concerns, treatment and investigation requests, and emotional and social issues that people bring to the consultation. If, however, the main issues of importance are not openly declared and discussed they cannot be addressed. This is likely to result in people receiving the care that clinicians think they need, rather than care based on individual needs and preferences.

**Objective:** To understand people’s abilities to express the issues of importance to them within a consultation and clinicians’ abilities to acknowledge and address those issues.

**Design:** A qualitative study using an interpretive phenomenological approach.

**Methods:** Fifteen people and their physiotherapists were interviewed and their consultations recorded. The resulting data sets were analysed to identify and report themes within the data.

**Findings:** The findings revealed that people present with what are often simple issues, but which are sometimes expressed in an unstructured way in clinical encounters and are often difficult for clinicians to establish. Three linked themes emerged: (1) clear versus unstructured agendas; (2) people need information and understanding; and (3) developing a sense of collaboration.

**Conclusions:** The issues of importance that people bring to a consultation are varied and often vague. This research highlights the importance of communication to elicit, identify and address the issues of importance to people in clinical encounters to ensure a positive experience and outcome for both the individual person and clinician.
**Tweetable Abstract:** Achieving desirable health outcomes is more likely when people are supported to think about their priorities and ‘what matters to them’.

**Key Words:**

Communication

Qualitative Research

Physical Therapy Modalities

Referral and Consultation
What matters most to people in musculoskeletal physiotherapy consultations? A qualitative study.

Introduction

Traditionally the practice of many physiotherapists has been characterised by a strongly biomedical paradigm, involving a process of reasoning or problem solving that leads to the formulation of a diagnosis and/or ‘problem list’ and often a clinician-centred symptom-focused treatment plan.

In recent years the ‘biopsychosocial’ model of care has acquired popularity in response to mounting research evidence that the appreciation of health and illness requires clinicians to try to understand the full range of problems and concerns, treatment and investigation requests, and emotional and social issues that people bring to the consultation (Foster and Delitto, 2011). A person-centred approach involves sharing control of the consultation, and some models have introduced the concept of ‘agendas’ as the key to understanding people (Levenstein et al., 1986).

Encouraging individuals to voice their agendas or what matters most to them allows the clinician to develop an understanding of them as a person in terms of their individual needs and problems, and is dependent on the style of communication adopted by the clinician. However developing a true partnership in a health care consultation can prove challenging as the dominant culture of ‘clinician knows best’ means that people are often reluctant to declare their views and opinions (Frosch et al., 2012).

Health professionals need complex interpersonal and communication skills, as well as technical expertise. Communication is a skill which is seen as a key professional
competence. The culture of current physiotherapy practice has called for collaboration and a sharing of power and responsibility so that clinicians are more responsive in terms of understanding people’s agendas and what matters most to them (CSP, 2005).

Evidence suggests that this does not always happen, with clinicians often overestimating a person’s treatment expectations and underestimating the worries they have about their symptoms and their need for information and explanation. Previous studies have identified that physiotherapists often display a strong desire to either treat the person (Jones et al., 2014), or to make decisions that they believe are in their best interests (Dierckx et al., 2013; Stenner et al., 2016). If the main issues of importance to people are not openly declared and discussed this can lead to significant problems in health care delivery in terms of poor outcomes and potentially increased costs. This is because people are more likely to receive the care clinicians think they need, rather than care based on individual needs and preferences.

The aim of this study therefore was to understand people’s abilities to express the issues of importance to them within a consultation and clinicians’ abilities to acknowledge and address those issues.

Method

Research into communication typically focuses on data collected from observations or interviews. In a person/clinician encounter the interactions are interdependent and are likely to influence each other. The use of interviews alone can lead to potential biases such as socially desirable responses or obtaining generalised views. Therefore to achieve a complete picture of the physiotherapy consultation both clinicians and people were interviewed, along with the consultation being digitally recorded (Barry et al., 2001).
Phenomenological approaches are particularly effective at bringing to the fore an individual’s contextually-grounded experiences of events and difficulties expressed from their own perspective or ‘lifeworld’ (Mishler, 1984). Acknowledging that no consultation can proceed without relying in part on the ‘voice of medicine’ or the perspective of the clinician, the tendency for clinicians to dominate consultations can lead to a fragmentation of communication and a failure to understand the lived situation and topics that matter most to people (Judson et al., 2013).

This study was therefore informed by the interpretive paradigm of enquiry, and based on a phenomenological approach. The specific ‘interpretive’ orientation applied was grounded in the philosophical hermeneutics approach of German philosopher Gadamer (1996). Data in the form of consultations and more formal semi-structured interviews was placed alongside and fused in context with the author’s experiences or pre-understandings as a physiotherapist to facilitate interpretation, allowing for a more complete understanding (Stenner et al., 2017).

**Sample and data collection**

Fifteen data sets were generated within a musculoskeletal service within one trust in South West England. We purposively sampled 15 of 28 (54%) clinicians who responded positively to an e-mail outlining the research and inviting them to participate. This purposive sample was chosen to represent different genders, clinic locations and grading of staff.

We then recruited 15 people referred for physiotherapy over the age of 18 years through the administration staff in the booking office when they booked appointments with clinicians who had already been recruited (one per clinician). Clinicians were not involved in any way in the recruitment of participants. The principal recruitment criteria were people presenting with musculoskeletal pain who were able to communicate in the English language. Individuals who expressed an interest were provided with a participant information sheet and gave
informed written consent. Their characteristics are displayed in Table 1. Only two of the people approached declined to take part in the study, citing a lack of time as the main reason. This total sample size was chosen based on views of Creswell (1998) that in phenomenological studies a sample size of between 5 and 25 was sufficient.

**INSERT TABLE 1 HERE**

The sequence of data collection is given in Table 2, which consisted of person interviews in the clinic immediately before and after the consultation with the clinicians. Consultations ranged from 20 to 45 minutes. Clinician interviews about these consultations were undertaken at a convenient time later on the same day. Interviews and consultations were digitally recorded and transcribed. The first author (RS), a male physiotherapist with extensive musculoskeletal experience and seven years’ experience as a qualitative researcher, conducted the interviews. Topic guides were used to guide the interviews and adapted in light of emerging findings in line with an inductive approach. The topic guides addressed issues of importance concerning factors such as presenting problem and symptoms; diagnosis theories and understanding; individuals’ reactions to their referral; clinicians’ behaviours; wanted and unwanted activities or treatments; and emotional or social issues such as fears and concerns.

**INSERT TABLE 2 HERE**

**Analysis**

Data was analysed manually by the first author (RS) based on a thematic analysis (Braun and Clarke, 2006), guided by the principles of Gadamerian hermeneutics; linking the
different data sources, before looking for common themes across the data. The specific process for interpretation of the data is set out in Table 3. A tentative analysis of each data set was undertaken as the hermeneutic texts were assembled, but a more detailed analysis was performed once all the data had been collected. To ensure dependability, a second author (SP) facilitated refinement of the thematic analysis through peer review and auditing (Seale, 1999). In some qualitative methodologies data saturation is required to recognise the end of new insights, but by using an interpretive phenomenological approach they are replaced, thus no data saturation can exist (Koch, 1999).

**INSERT TABLE 3 HERE**

**Findings**

Of the people referred for physiotherapy recruited for this study, no one had only one issue of importance, presenting with a range of two to five topics that they wished to discuss. Sixteen different items of importance were identified. The top five items and the percentage that were voiced and addressed by the clinicians are shown in Table 4. Others have not been reported due to the very small numbers and often individual nature of the remaining issues.

**INSERT TABLE 4 HERE**

Three main themes relating to the issues of importance that people bring to a consultation and how they were elicited and addressed were formed.

*Theme: 1 Clear versus unstructured agendas*
Some of the issues were very open and well-defined and had clearly been identified by people before the pre-consultation interviews, whereas for others they only surfaced during the pre-consultation interviews as they started to talk, suggesting some people had difficulty formulating questions and considering the topics of importance to them prior to their initial consultation. At one end of the spectrum was a well-informed person who expressed their preference clearly and directly, for example Participant 7, who presented with a single concern, requesting surgical treatment for a previously diagnosed problem.

“What I am expecting is to finish up with surgery. I want my right hand to be as good as my left”. (Participant 7: Pre-consultation interview)

At the other end of the spectrum were consultations where the issues of importance were less clearly defined, suggesting that some people may have needed support and preparation to take part in a different type of consultation. Improving activation and preparation is likely to result in more meaningful conversations between people and clinicians.

“I wasn’t sure if he knew exactly why he was here and I did try and pin him down a little bit on that and said what would make this a good outcome for you today or you know what are you hoping to get and he didn’t really have an answer” (Participant 12: Post-consultation interview with clinician).

For some people their apparent lack of understanding as to why they had been referred or what service they had been referred to may have inhibited their ability to engage. As a consequence some appeared quite ‘passive’ or disengaged in the pre-consultation interviews, with a third of the participants initially stating that they had no real expectations of their visit.

“I have no expectations I have got an open mind about it you know.”(Participant 4: Pre-consultation interview)
“Not an awful lot to be honest I thought I was going to see a physiotherapist, and I just wondered what that was going to do” (Participant 9: Pre-consultation interview)

“I don’t know what to expect, because they’re the medical expertise [sic] I’m not” (Participant 5: Pre-consultation interview)

This cultural norm of peoples’ deference to the perceived knowledge of the experts can be difficult to overcome. However in the case of Participant 5, although they initially appeared very ‘passive’, the approach of the clinician inviting interaction and participation in the consultation led to the person expressing satisfaction with the clinician’s approach.

“I felt comfortable and I wasn’t being rushed” (Participant 5: Post-consultation interview)

For this person, despite some initial uncertainty, the potential development of trust and confidence in the relationship ultimately resulted in issues of importance ‘surfacing’.

“What is actually causing this muscle pain, if it is muscle pain, or if it’s anything else?”(Participant 5: Consultation with clinician)

“What can I do to make things a bit easier for myself basically?” (Participant 5: Consultation with clinician)

Theme 2: People need information and understanding

A lack of understanding may be the reason why some people feel restricted in their role and have trouble formulating their thoughts or requests and identifying clear issues of importance. In this study the people frequently reported lack of understanding, such that information and an explanation of their condition and a diagnosis was one of the main issues of importance that emerged for all but one participant.
“Firstly I’m hoping from her experience that she may be able to give me a better evaluation of what it could be, narrowing it down a bit instead of the doctors saying ‘It could be this, it could be that’” (Participant 6: Pre-consultation interview).

“Well I’ve just been hoping to present my symptoms, perhaps get a firmer diagnosis” (Participant 13: Pre-consultation interview).

Overall the findings further underline the importance people place on provision of information about their condition. A ‘crash course’ in explaining the diagnosis, its treatment options, outcomes and evidence takes time and energy from the health system, and a number of people in this study voiced disappointment at the lack of information given to them by the various health care professionals they had consulted.

“I’m hoping you might know a little bit more than the GPs would, hopefully with your experience and knowledge, as they don’t seem to have a clue.” (Participant 6: Consultation with clinician)

“I’ve been to see three different doctors I’ve never seen the same one and they’ve all sort of brushed it aside. I don’t think they are taking me seriously………….” (Participant 9: Pre-consultation interview)

They also expressed satisfaction when this need was effectively addressed.

“It was great; she (clinician) examined me for a start, which hasn’t really happened. Um……. yeah she examined me, she explained a lot whilst she was doing it as well and um sort of gave me more of an understanding of the mechanics of the back.”(Participant 10: Post-consultation interview)

For some people it was clear that the value of this information was perhaps to provide reassurance and allay fears or uncertainties about the cause of their problem which was arguably greater for some than their desire to receive a therapeutic intervention.
“You know I am quite scared when I have one of these attacks because it is quite severe. Um... and I want to know I suppose that it’s nothing more serious” (Participant 1: Pre-consultation interview)

“Um, I’d like my mind put at rest that there’s nothing sinister going on to be honest and that only really stems from the fact that as soon as you get past the 50 stage you become high risk for all these things……” (Participant 10: Pre-consultation interview)

People need evidence-based information just as much as clinicians do, which might help to avoid the problem of poor quality care. It could also help to counter misplaced perceptions about treatment and investigation needs, management options and likely outcomes. Participants presented with an array of information needs which included: diagnosis (including reassurance that it was not due to a sinister cause, likely recurrence and prognosis), exercise and activity (including the likelihood of exacerbating the problem), and the impact of the problem (on current or future work and hobbies).

Although some of these information needs were only partly voiced by the participants, they were still often addressed by the clinicians almost as a matter of routine. This particularly applied to issues of concern regarding the cause of the presenting problem. For example Participant 5 in the pre-consultation interview said:

“I want to know that there's nothing, I don't know what you call it.......serious.”(Participant 5: Pre-consultation interview)

However despite the person failing to voice these concerns in the consultation, the clinician offered reassurance by saying:

“It is definitely nothing unusual or anything worrying going on.” (Participant 5: Consultation with clinician)

All of the participants were able to impart their symptoms, but in two cases the clinicians, having elicited information on the main symptoms of concern, then failed to acknowledge or
pay selective attention to this information when management decisions were being made. In the case of Participant 2, he was particularly concerned about some persistent pins and needles and not the pain which was resolving.

“I’m still getting the pins and needles; it’s numb on the thumb and the finger but it’s the pins and needles that bother me, the pain is only a very dull ache now.” (Participant 2: Consultation with clinician)

Interestingly the clinician, despite clearly picking up on this, still focused their treatment on addressing the pain aspect of the person’s complaint.

“The main problem was, mainly kind of pins and needles in his fingers, but also some of the pain that was going down his arm which kind of has resolved. But I suppose more so now the pins and needles in his fingers I guess.” (Participant 2: Post-consultation interview with clinician)

**Theme 3: Developing a sense of collaboration**

As can be seen from Table 4 the clinicians addressed a majority of the issues that people brought to the consultations, including on occasions issues that people failed to voice in that consultation. The attitudes, skills and behaviours of healthcare providers can have a significant impact on the extent to which people feel engaged and supported to manage the social, emotional and physical impacts of their condition.

The clinicians in this study used a range of open-ended questions to try and engage the person as an active partner and establish their focus for the consultation, for example:

“So what are your thoughts on today in terms of what you wanted to talk about or ask about?” (Participant 7: Consultation with clinician)
“What are your thoughts about being here and what I can do for you?” (Participant 10: Consultation with clinician)

“What are you hoping to gain from coming to physiotherapy?” (Participant 1: Consultation with clinician)

A number of people also talked about positive, ‘person-centred’ behaviours and approaches that they had experienced, which helped to develop trust and confidence in their relationship with the clinician.

“Um, it felt like a collaborative process, it didn’t feel like she was not listening to what I felt or needed and she had her own agenda, it definitely wasn’t like that.” (Participant 1: Post-consultation interview)

“He did explain, talked to me like a human being, like a person not you know, some stupid female, kind of thing, he made me feel at ease”(Participant 8: Post-consultation interview)

“Yes I told her that I had these just worries about things like ovarian cancer, sometimes you feel silly saying that to people and it’s nice if somebody doesn’t make you feel silly when you say it” (Participant 10: Post-consultation interview)

This sense of partnership working where both parties feel safe in communicating with each other is key to achieving a positive clinical outcome, and should be regarded as a core element of professional expertise.

**Discussion**

Consultation skills within the physiotherapy profession are underexplored and still overlooked when compared to development and evaluation of technical treatment skills. Effective communication is vital in ensuring a positive experience and outcome for both
people and clinician. Healthcare increasingly emphasises the need to empower and engage people, and for consultations to be conducted in partnership (Bodenheimer et al., 2002). One of the most important tasks in the clinical encounter is for the clinician to accurately identify a person’s agenda or “issues of importance”, as this allows the clinician to engage with the person’s perspective, develop trust and to work in a person-centred manner.

Participation in clinical encounters depends on a complex interplay of personal, clinical and contextual factors. The strongest predictors of a person’s participation are the clinical setting and the clinician's communicative style (Street et al., 2005), whose origins lie in the person-centred approach where the clinical agenda is located firmly in the person’s experience thereby making it meaningful and relevant to them.

In this study a comprehensive understanding of the issues that mattered most to people was only achieved through adopting a methodology that invited people to portray their full selves. By using a qualitative research method that was person-centred and structured closer to the lifeworld a deeper more complex situated view of people’s ideas, concerns, expectations, relationship with clinicians and lived experience of their problems prior to and during the physiotherapy encounter was gained.

By accessing experiences of the physiotherapists and people, in hermeneutic terms the author was able to use their experiences to discuss key factors relating to what really mattered to the patients. This allowed for the Hermeneutic Circle to be experienced and through such feedback and subsequent dialogue shared understandings reached.

In particular the findings highlight the potential difficulties some people have in fully formulating and discussing topics of importance to them at their initial consultations, as some people may be anxious, forgetful, feel inhibited from asking questions or have low levels of activation (Hibbard et al., 2004). Previous research has noted that people are reluctant to ask questions when they do not understand information related to their medical condition (Arnold et al., 2012). People in this study had a range of between two and five issues to
discuss which is in keeping with Byrne and Long (1976) who found that people come with an average of three concerns, and that the initial concern stated is seldom the most important to address. It is important therefore for clinicians to avoid hastily focusing on the first concern raised by the person.

The people in this study often presented with simple, but at times an apparent unstructured expression of issues, such that many gave an impression of being disengaged and often passive in their approach, but as can be seen from Table 4 most people in this study expected an explanation or an improved understanding of their problem.

Patient activation relates to an individual's capability in terms of their knowledge, skills and confidence to manage their health. A lack of understanding may be the reason why some people feel restricted in their role and have trouble formulating their thoughts or requests and identifying clear issues of importance. So what matters to a person may depend to some extent on what they already know about their condition. Dealing with lack of understanding of their condition and filling any knowledge gaps is often the first stage and main goal for people with low levels of activation to manage their own healthcare, followed by increasing self-awareness and the role they can play in their management.

The hidden agenda is regarded as one that is known to the person prior to the consultation but remains unvoiced (Barry et al., 2001). Some of the items that went unvoiced in this study were concerns that centred on the need for a diagnosis and for reassurance that the pain was not due to a sinister cause. This was in contrast to the findings of Barry et al (2001) who noted that people did not generally express fears about the implications of diagnoses or ideas about their symptoms. Some research has focused on how best to structure questions that prompt people to express additional concerns they may have. One approach to do this is to ask the question “anything else?” or “what else?” until the person indicates there is nothing more to discuss (Rodriguez et al., 2008). However Heritage et al (2007) suggest rephrasing this question as “is there something else you want to address in the visit today?”
to more effectively identify a person's concerns. Despite the clinicians frequently demonstrating a range of communication skills and professional experience to try and facilitate people’s involvement, there was no evidence of clinicians using such ‘screening’ approaches to elicit people’s full agendas. Clinicians need to be sensitive to the range of potential issues that people may bring to a consultation, as well as considering the way in which these items might be elicited.

**Strengths and Limitations**

This study has several strengths and limitations. One possible limitation is the potential self-selection bias by responding clinicians, meant that those responding might have been more likely to adopt a collaborative approach in consultations. Also the study population were on average older than the general population. Previous work has shown that older people ask fewer questions and often spend less time with their clinician, and on the whole tend to have passive relationships with their clinicians (Mann et al., 2001).

A potential strength of the study was that a more complete picture of communication within the consultation was only possible through a methodology in which both clinicians and people were interviewed, along with a recording of the consultation. It was hoped that by using both interviews and recording the consultation that the potential disparity between how people and clinicians present in clinical practice and how they present in interviews could be reduced. All people have histories, presentations and experiences which are individual, however it became clear early on in the interviews that participants found it challenging to talk freely about issues of importance to them, and despite some initial concerns that the pre-consultation interviews may impact on the conduct of the consultation, this didn’t appear to have any significant bearing as they didn’t seem to be any better ‘prepared’.

Although this study provides a better understanding of the issues of importance that people bring to the physiotherapy encounter, a relatively small number of participants cannot be
considered to be simply representative of a notional, homogenous ‘wider population’ of people presenting with musculoskeletal disorders.

**Conclusion**

The findings suggest that the issues of importance that people bring to a physiotherapy consultation are varied and often vague. For this group of people an understanding of their problem appeared to be more valued than other matters. People need to understand their medical conditions in order for them to take an active role in their health care. For the clinician this means it is imperative that they understand pathology and contemporary pain biology concepts as they relate to musculoskeletal pain so that they can engage in positive dialogue with people to address their reported need for an explanation and understanding.

For people, systems and approaches are needed to support them to think about ‘what matters to them’. This may help them to set their priorities for the consultation and engage in more meaningful conversations with clinicians. Achieving desirable health outcomes is more likely when people actively participate in their care. Clinicians also need to be flexible. Responding to each patient as a person is essential as no single dimension of person-centred care exists without reliance on other dimensions. At the centre of this process is effective communication (Cooper et al., 2008) to fully engage the person in the process so that the issues of importance that people bring to a consultation can be successfully identified, and addressed.

**Word Count 4177**
References:


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<thead>
<tr>
<th>Characteristics of people referred for physiotherapy</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6 (40%)</td>
</tr>
<tr>
<td>Female</td>
<td>9 (60%)</td>
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<tr>
<td><strong>Age (years)</strong></td>
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<td>18-34</td>
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<td>4 (27%)</td>
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<td>55-74</td>
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<td>Over 75</td>
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<tr>
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<tr>
<td>Employed (Part Time)</td>
<td>4 (27%)</td>
</tr>
<tr>
<td>Retired</td>
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<tr>
<td><strong>Presenting problem (body area)</strong></td>
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</tr>
<tr>
<td>Low Back</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Knee</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Shoulder</td>
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</tr>
<tr>
<td>Elbow</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Hand</td>
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<tr>
<td><strong>Clinician Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6 (40%)</td>
</tr>
<tr>
<td>Female</td>
<td>9 (60%)</td>
</tr>
<tr>
<td><strong>Grading of Staff</strong></td>
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<td>5 (most junior)</td>
<td>3 (20%)</td>
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<tr>
<td>6</td>
<td>3 (20%)</td>
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<td>7</td>
<td>4 (27%)</td>
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<tr>
<td>8 (most senior)</td>
<td>5 (33%)</td>
</tr>
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Table 1. Characteristics of people referred for physiotherapy and the clinician participants
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-consultation interview with person referred for physiotherapy</td>
</tr>
<tr>
<td>2</td>
<td>Consultation audio-taped</td>
</tr>
<tr>
<td>3</td>
<td>Post-consultation interview with person referred for physiotherapy</td>
</tr>
<tr>
<td>4</td>
<td>Post-consultation interview with clinician</td>
</tr>
</tbody>
</table>

Table 2. The sequence of interviews with clinicians and people referred for physiotherapy
<table>
<thead>
<tr>
<th>Steps in the analysis</th>
<th>Description of each step in the analytic process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Creating the texts:</td>
<td>Listening, reading and being immersed in each participant’s text.</td>
</tr>
<tr>
<td>2. Identifying interesting features:</td>
<td>Making notes of initial ideas and interesting features in the texts.</td>
</tr>
<tr>
<td>3. Initial coding:</td>
<td>A hermeneutic view resists the idea that there can be one single reading of a text. To increase the rigour of analysis a three stage iterative process was undertaken: Firstly an analysis of the type and range of issues of importance voiced by the participants in the pre-consultation interviews and choosing codes to capture the meaning in the texts was conducted. This was then compared to what was voiced in the consultations and finally compared to which issues of importance voiced (and unvoiced) in the consultations were addressed by the clinicians. A final coding based on a conclusive interpretation was written. Coding tables for each of the participants were then constructed with the corresponding data extracts.</td>
</tr>
<tr>
<td>4. Development of themes:</td>
<td>A manual approach was used to identify the</td>
</tr>
</tbody>
</table>
common patterns in the texts to form potential themes.

5. Refining the themes:
   Reading and interpreting texts as a whole in a process of deepening understanding; refining the specifics of each theme, and the overall story the analysis tells.

6. Producing the report:
   Relating the analysis back to the research aims and literature, and producing a report.

Table 3. The process for interpretation of the data.
<table>
<thead>
<tr>
<th>Main issues of importance identified in pre-consultation interviews</th>
<th>Issue voiced in pre-consultation interviews n (%)</th>
<th>Issue voiced in consultations n (%)</th>
<th>Issue addressed by clinician in consultations n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To find out what is wrong/diagnosis</td>
<td>14/15 (93%)</td>
<td>9/14 (64%)</td>
<td>12/14 (86%)</td>
</tr>
<tr>
<td>To find out what can be done to reduce symptoms/resolve the problem</td>
<td>10/15 (67%)</td>
<td>5/10 (50%)</td>
<td>8/10 (80%)</td>
</tr>
<tr>
<td>To get reassurance or allay concerns, fears or worries (in relation to diagnosis, work or exercise)</td>
<td>8/15 (53%)</td>
<td>5/8 (63%)</td>
<td>8/8 (100%)</td>
</tr>
<tr>
<td>To receive advice about self-help or self-management</td>
<td>6/15 (40%)</td>
<td>6/6 (100%)</td>
<td>6/6 (100%)</td>
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<tr>
<td>To improve fitness or general health</td>
<td>3/15 (20%)</td>
<td>3/3 (100%)</td>
<td>3/3 (100%)</td>
</tr>
</tbody>
</table>

Table 4. The five most common categories of voiced and addressed issues of importance in the consultation