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Searching for the 'Good' in Physiotherapist Practice: Toward an Ethic of Care

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Abstract

The qualities and practices of a ‘good’ physiotherapist have not been systematically reviewed nor have practitioners’ perspectives been empirically investigated. Understanding what constitutes a ‘good’ physiotherapist has potentially profound implications that may inform professional priorities including education curricula, professional practices, competency profiles, and patient interactions. The research purpose was to examine perceptions of what constitutes a ‘good’ physiotherapist. This dissertation includes four integrated manuscripts. The first is an integrative review to critically examine how physiotherapists and patients describe the qualities of a ‘good’ MSK physiotherapist as depicted in peer-reviewed literature. Six qualities were identified as: responsive, ethical, communicative, caring, competent, and collaborative. The second and third manuscripts are hermeneutic phenomenological investigations that draw on Joan Tronto’s ethic of care theory as a theoretical perspective. The second manuscript is an examination of twelve physiotherapists’ accounts of what constitutes a ‘good’ physiotherapist garnered from semi-structured phenomenological interviews. Seven themes were identified. Two broad themes highlighted an ethical orientation to care and the integration of person-centered care with evidence-based practice. These were underpinned by more specific themes of ‘being’ competent, responsive, reflective, communicative, and ‘using’ reasoning. The third manuscript was a secondary analysis of data arising in the hermeneutic phenomenological study focused on practitioners’ accounts of ‘responsiveness’ in the practice of a ‘good’ physiotherapist. Six identified themes included: being person-centred, being attentive, being open, being a listener, being validating, and being positive. The fourth manuscript is a reflexive account of my transformed understanding of what counts as professional knowledge in physiotherapy. These studies offer perspectives suggesting the qualities and practices of a ‘good’ physiotherapist are a balance of technical competence intertwined with a relational way of being. An ethics of care is proposed to be central to the practice of a ‘good’ physiotherapist and supported by being responsive as a moral imperative. Practicing with a relational approach within a framework of practical wisdom may facilitate integration of person-centred approaches with evidence-based practices. The findings call into question the profession’s predominant emphasis on a technical rationalist approach to practice, education,

and research, and invites conversation about balancing technical competence with relational dimensions of practice.

Keywords

Physiotherapy; professional behaviours; clinical competence; professional-patient relations; musculoskeletal; orthopaedic; patient-centred care; hermeneutic phenomenology; ethics of care; phronesis.

Summary for Lay Audience

When a person requires physiotherapy to aid in recovery from a muscle or joint injury, surgery, or painful condition, they might seek the services of a ‘good’ physiotherapist either by referral from a health professional or based on the recommendation of a friend. Scholars theorize that a physiotherapist’s qualities and behaviours may influence how well the physiotherapist interacts with patients. Beyond a physiotherapist’s knowledge and skills, the physiotherapist’s qualities and ways of interacting, may also influence how well a patient may recover.

The purpose of this research was to understand what makes a ‘good’ physiotherapist. The first project involved searching and summarizing research articles that examined how patients and physiotherapists describe the qualities of a ‘good’ physiotherapist. Qualities were categorized under the following headings: responsive, ethical communicative, caring, competent, and collaborative. A second project involved interviewing twelve physiotherapists to ask them what they thought made a ‘good’ physiotherapist. Their viewpoints were organized into seven themes: an ethical orientation to care and the integration of person-centered care with evidence-based practice. These appeared to be supported by more specific themes of ‘being’ competent, responsive, reflective, communicative, and ‘using’ reasoning. The third project examined the theme of ‘being responsive’ in more depth. A ‘responsive’ physiotherapist appeared to include being person-centred, being attentive, being open, being a listener, being validating, and being positive. Another chapter of this thesis offers critical reflections on the researcher’s experiences, and new ways of thinking about the physiotherapy profession’s emphasis on scientific experiments to understand illness and injury over peoples’ understandings and experiences, and their preferences for care.

The findings of this research suggests that a ‘good’ physiotherapist is technically competent, practically wise, and relates with people as equals. Caring appears to be at the heart of the practice of a ‘good’ physiotherapist. Being responsive with patients seems to be an important ethical aspect of a physiotherapist’s caring practice. While physiotherapists are trained to be technically competent, the findings call on educators, researchers, and physiotherapists to

also include relationship qualities and behaviours in their teaching, research, and when working with patients.

Co-Authorship Statement

I, Michelle Kleiner, acknowledge that this thesis includes four integrated manuscripts that evolved as a result of collaborative endeavors. In the four manuscripts, the primary intellectual contributions were made by the first author who: researched the methodology, designed the research, developed the ethics application, conducted the literature reviews, recruited participants, collected the data, transcribed the interviews, led the data analysis, and led the writing of the manuscripts. The contributions of co-authors, Dr. Elizabeth Anne Kinsella, Dr. David Walton, Dr. Maxi Miciak, and Dr. Gail Teachman were primarily through the supervision of the research, theoretical and methodological guidance, hermeneutic dialogue, and intellectual and editorial support in writing up the research for publication. The integrative review (Chapter 2) was also co-authored by Dr. Erin McCabe who screened studies for inclusion and provided editorial support in writing the manuscript.

Dedication

I dedicate this research to my family and friends who support and encourage me in all that I do; sharing triumphs, challenges, and the everyday with you brings meaning to my life.

A special thank you and much love to my husband, Alex and our children, Nicholas, Kevin, and Katrina – your constant patience, understanding, and love continue to support, encourage, and sustain me.

May you discover and live your passion.

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Engaging in doctoral studies has transformed me in ways that I never imagined. It is the conversations and faces of the people that I shared this journey with that have changed me most profoundly.

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Chapter 1

1 Introduction

This dissertation presents a comprehensive inquiry into the question of what constitutes a ‘good’ physiotherapist. The question arose organically out of my practice-based learning and longstanding experience as a physiotherapist. In this chapter, I open the conversation by situating myself as a researcher and exploring my assumptions in relation to the question of what constitutes a ‘good’ physiotherapist. This is followed by a brief overview of the background, purpose, context, theory, and methodology used to develop an understanding and contribute to the professional discourse on what may be considered ‘good’ in physiotherapy practice.

1.1 Situating the Researcher

I am a registered physiotherapist who graduated from the University of Toronto in 1991. This was a year before the term ‘evidence-based medicine’ would first appear; before the ‘randomized control trial’ would significantly feature in physiotherapy research; and before outcome measures would become a routine part of daily clinical practice. At the time of writing this thesis, I marked the 30th anniversary of my first day ‘on-the-job’ as a novice physiotherapist at Toronto General/Toronto Western Hospitals. As a recent graduate employed by the country’s largest teaching hospital, I had the opportunity to explore various physiotherapy practice areas including cardiorespiratory physiotherapy by working with patients following cardiac and thoracic surgery, as a member of the lung transplant program, and conducting research with the department’s research physiotherapist. I also rotated in and out of the outpatient orthopaedic department; a place where I felt more at home and eventually secured a permanent post. I transitioned to private practice four and half years after graduating, with this experience and having begun continuing professional development with the Orthopaedic Division of the Canadian Physiotherapy Association. After I completed the orthopaedic training, I was credentialed as a Fellow of the Canadian Academy of Manipulative Physical Therapy. In 2016, I attended Western University and completed a Master of Clinical Science in Manipulative Physical Therapy; my research project was a systematic review of dual-task

testing protocols for the evaluation of people post-concussion. Around that time, I was exploring relational ways of practicing to improve my ability to work with patients with chronic pain and complex physical and psychosocial comorbidities. I completed courses in motivational interviewing, cognitive behaviour therapy, acceptance and commitment therapy, and narrative medicine. To this day, I maintain a busy, private orthopaedic practice that also includes vestibular rehabilitation and concussion management. Recently, I partnered with two colleagues to assume ownership of the clinic where I have worked for over 25 years. Over the span of 30 years, I have been fortunate to have worked in the public and private sectors and with patients with a variety of conditions who have challenged and inspired me to consider what it is to be a ‘good’ physiotherapist.

1.2 My assumptions about what constitutes a ‘good’ physiotherapist

I first became aware of the “Good Physio” project when completing my master’s degree. Under the supervision of Drs. Chesworth and Walton, a group of physiotherapy students were conducting a study to identify whether ‘soft skills’ were considered important to the practice of a ‘good’ physiotherapist. After their survey of Canadian physiotherapy school faculty members determined that ‘soft skills’ were important, a second group of students conducted the first two rounds of a Delphi study with Canadian physiotherapists to determine the ‘important’ and ‘essential’ qualities of a ‘good’ physiotherapist. In the fall of 2017, the first semester of my doctoral studies, I completed the third and final round of that study as a co-researcher. Despite a mix of technical, interpersonal, and leadership qualities presented as options in the survey, the findings were disproportionate: 84% of the important qualities and 93% of essential qualities chosen by the respondents represented interpersonal skills (Kleiner, Walton & Chesworth., 2018). These included traits such as being a good listener, friendly, warm, compassionate, collaborative, empathic, respectful, and caring. Speculating that respondents may expect physiotherapists to possess specific professional competence in knowledge, and diagnostic and treatment skills as assured by national regulatory bodies (National Physiotherapy Advisory Group, 2017), we questioned whether the emphasis on

interpersonal qualities identified in this survey may be what separates the ‘good’ physiotherapist from one displaying basic levels of competency.

1.3 A physiotherapy clinician’s transformed understanding

I began my doctoral journey intending to design and validate an instrument to measure the qualities of a ‘good’ physiotherapist. When examining the literature, I soon learned there were no operational frameworks or systematic analyses describing what constitutes a ‘good’ physiotherapist. I transitioned to an examination of the literature related to the concept and read studies and reviews that investigated patients’ expectations, preferences, satisfaction, therapeutic relationship, and practitioner expertise. Most of these studies were qualitative studies and pointed to physiotherapists’ relational ways of practicing, knowledge, and technical skills as important.

These readings transformed my research focus from measurement of the qualities of a ‘good’ physiotherapist to asking how and why Canadian physiotherapy curricula appeared to prioritize technical skills training over interpersonal and communication skills training despite what was depicted in the literature. In our profession, research suggests physiotherapists are practitioner-focused and practice within a biomedical/biomechanical model (Hiller et al., 2015; Larsson et al., 2010; Nicholls, 2018; Nicholls & Gibson, 2010) rather than a biopsychosocial model as contemporary discourses would suggest (Mescouto et al., 2020). Apart from theoretical discourse and empirical research on the implementation of the biopsychosocial model, physiotherapy discourses also include conversations calling for enhanced training of interpersonal skills (Kinney et al., 2018; Kleiner & Walton, 2022; O’Keeffe et al., 2016; Pinto et al., 2012), physiotherapy therapeutic relationship (Miciak, 2015), and implementation of psychological interventions when caring for people with persistent pain (Alexanders & Douglas, 2016). Professional rhetoric suggests there is a ‘ground swell’ towards greater recognition of relational ways of practicing.

My doctoral journey began with a naïve and unquestioned adherence to the positivist tenets of quantitative methodologies and transformed toward a deep respect for qualitative research and how its various methodologies may contribute to understanding

phenomena. This changed my focus from measurement science to phenomenology. In my experience, embracing qualitative research to investigate physiotherapists' perspectives, lived experiences, and their interactions with patients to study what constitutes a 'good' physiotherapist offered a new way of thinking about the practice of physiotherapy. Critical reflexivity on what constitutes disciplinary knowledge (Kinsella & Whiteford, 2009) and ways of practicing (McCorquodale & Kinsella, 2015) invites us to examine what we take for granted as a profession about the practice of a 'good' physiotherapist.

1.4 Background of the research

Contemporary discourses in the profession of physiotherapy suggests that the profession has been slow to consider its culture, identity, and centralizing principles (Gibson et al., 2018; Nicholls & Gibson, 2010). Physiotherapists are asking themselves and the profession more broadly: who are we, how do we work with our patients (Kayes & McPherson, 2012), and why do we do what we do (Gibson, 2016; Walton, 2019)? The last question, put more directly by physiotherapist and scholar, Barbara Gibson, "What are considered good outcomes and why?" (Gibson et al., 2018, p. 52) is possibly one that educators, researchers, clinicians, patients, and physiotherapy funders should contemplate regularly from various perspectives. When considered from the perspective of virtue ethics, all three questions appear to be linked.

Virtue-based ethics, founded on the philosophies of Plato and Aristotle, focus on the agent, as a moral or good person who thinks and acts in ways to do what's right (Gadamer, 1986; Pellegrino, 1995). For Aristotle, a wise or good person's virtuous characteristics orient them to reason and act in ways toward doing the right thing for a particular task that contributes to human flourishing and promotes human good (Jenkins et al., 2019; Kinsella & Pitman, 2012; Pellegrino, 1995; Sellman, 2012). Aristotle's intellectual virtue, *phronesis* or practical wisdom, considered central to making moral judgments and choosing virtuous actions, is proposed as essential to good professional practice (Kinsella & Pitman, 2012). For Sellman (2009), Aristotle's notion of a wise person or "professional *phronimos*...is generally disposed to care deeply about all things to do with providing safe and effective care in ways that enable...the flourishing of patients" (p. 86). Given that every culture has a notion of a virtuous person, a good or

wise person who may reliably act to do what's right or good, it seems important to understand what constitutes a 'good' physiotherapist. Further, if what is considered 'good' is related to what may be socially, culturally, and even politically acceptable, at this time of burgeoning professional self-scrutiny, examining what constitutes a 'good' physiotherapist may be a professional priority.

As members of a professional culture, health care practitioners are proposed to recognize the 'good' practice of an idealized archetype who possesses characteristics, attitudes, behaviours, and practices that lead to 'good' outcomes (Benner, 1997; Pellegrino, 1995). There have been three studies on the concept of a 'good' physiotherapist from patients' perspectives (Kidd et al., 2011; Potter et al., 2003; Rutberg et al., 2013) and none from practitioners' perspectives although the concepts of expert and master physiotherapists have been studied (Jensen et al., 1990, 1992, 2000; Resnick & Jensen, 2003). These studies will appear in the manuscripts to follow in this thesis; other literature related to the concept of a 'good' physiotherapist is more fully explored in an integrative review (Chapter 2). Briefly, studies of the concept of a 'good' physiotherapist, examined from patients' perspectives, were based on experiences of good and bad physiotherapy experiences rather than conceptualizations of a 'good' physiotherapist.

Conceptualizations that approximate the study of a 'good' physiotherapist from practitioners' perspectives have focused on core professional values (Boyczuk et al., 2019; McGinnis et al., 2016), physiotherapist characteristics (Jensen et al., 1990, 1992, 2000), and 'the ends' of their actions or good physiotherapy outcomes (Resnick & Jensen, 2003). Findings from patients' and physiotherapists' perspectives have both included 'patient-centred care' as an important dimension alongside characteristics of a virtuous or 'good' practitioner and the physiotherapist's 'practice style'. The significance of each dimension and how they may interrelate as an overarching concept describing a 'good' physiotherapist have received limited research attention warranting further investigation to advance understanding of what physiotherapy is or what it ought to be.

A technical rational approach to practice is argued to dominate health care and proposed to be based on economic efficiency and science-based or technical 'fixes', which at times are at the expense of human relationships (Pitman & Kinsella, 2019; Sellman, 2012).

Understanding what constitutes a ‘good’ physiotherapist has potential implications for the future practice of physiotherapy as something more than the implementation of science and techniques. Understanding the “balance between technical competence and humanness” (Kayes & McPherson, 2012, p. 1909), proposed as foundational to good physiotherapy practice, may advance knowledge that may inform professional priorities including education curricula, professional practices, competency profiles, and patient interactions. Promoting ‘the good’ and ‘human flourishing’ is proposed as a worthy focus of study and is consistent with calls for phronesis as an important central aim of professional practice (Kinsella & Pitman, 2012).

1.5 Study purpose

The purpose of this research was to examine perceptions of what constitutes a ‘good’ physiotherapist by conducting: a) an integrative review of the literature to examine how physiotherapists and their patients describe the qualities of a ‘good’ physiotherapist; b) a phenomenological investigation of physiotherapists’ perceptions of what constitutes a ‘good’ physiotherapist; and c) a phenomenological investigation into the ways physiotherapists are responsive with patients in the practice of a ‘good’ physiotherapist. The context of these studies was musculoskeletal physiotherapy. This area was chosen for reasons highlighted in the next section. These empirical investigations were used to inductively develop an understanding of a ‘good’ physiotherapist as a contribution to the discourse on what competencies may be emphasized in the education of future physiotherapists and post-professional development of practicing clinicians. The findings may also stimulate dialogue and future research about the theoretical underpinnings of ‘good’ physiotherapy practice and the facilitation of the flourishing of patients.

1.6 Context of the research

My doctoral committee and I share a common interest in musculoskeletal (MSK) practice and agreed that it was a rich context to ascertain various dimensions of the phenomenon of a ‘good’ physiotherapist. It is the area of practice for most Canadian physiotherapists (Canadian Institute for Health Information, 2016), and my interest is in MSK physiotherapy having practiced most of my 30-year career in this context. Further, robust reviews of MSK practice, primarily from patients’ perspectives, consistently include

physiotherapists' attributes as important elements of patients' perceived needs of their health care providers, satisfaction and expectations of physiotherapy, and patient-physiotherapist interactions (Chou et al., 2018; Hopayian & Notley, 2014; Hush et al., 2011; O'Keeffe et al., 2016; Rossetini et al., 2018). Therefore, our team reasoned that MSK practice would provide a rich context in which to study the qualities of a 'good' physiotherapist given our emic perspective and the robust literature in this domain.

Although this research primarily focuses on practitioners' perspectives, the value of patients' lived experiences of physiotherapy is not to be minimized. While physiotherapist and patient perspectives are reviewed in Chapter 2, practitioners' voices are centred in the empirical studies of this dissertation. As noted above, while three studies on the concept of a 'good' physiotherapist from patients' perspectives (Kidd et al., 2011; Potter et al., 2003; Rutberg et al., 2013) have been undertaken, practitioners' perspectives have not previously been examined. To advance knowledge on the concept of a 'good' physiotherapist, the aim of this research was to elicit rich descriptions of physiotherapists' perceptions. This offered an opportunity to study physiotherapists' tacit practical knowledge and way of being with particular attention to the nature of the human encounter between physiotherapists and patients. Through physiotherapists' embedded experience and embodied knowledge, transformed understandings of a 'good' physiotherapist may inform practices of future physiotherapists and practicing clinicians.

1.7 Methodology: hermeneutic phenomenology

The aim of the research presented in this doctoral thesis was to advance understanding of what it is to *be* a 'good' physiotherapist. Understanding what it is to be-in-the-world in a particular way, or in other words, understanding the lifeworld of a 'good' physiotherapist brings phenomenology as a methodology to the fore. As van Manen (2014) explains, a phenomenological question asks what a human experience is like. The studies presented in Chapters 3 and 4 are phenomenological investigations into the phenomenon of a 'good' physiotherapist that may be recognizable as an idealized archetype or potentially challenge what has been taken-for-granted as the 'good' in physiotherapy practice.

Phenomenology is both a philosophy and research methodology which seeks "to understand and describe lived experiences" (Swanson-Kauffman & Schonwald, 1988, p.

97). Hermeneutics may be defined as the “tradition, philosophy, and practice of interpretation” (p. 3) applied to human contexts as a reflective inquiry of what is taken for granted (Moules et al., 2015). Hermeneutic phenomenology aims to interpret phenomena through accounts of lived experience to gain a deeper understanding of what it means to be-in-the-world (van Manen, 2014, 2016). Examining first-hand accounts of human experience as it is lived in the way human beings exist, act, interact with others, or are otherwise involved in the world, has the potential to contribute to understanding who we are and why we do what we do (Dowling, 2007; Park Lala & Kinsella, 2011). Underpinned by the notion that “human life is characterized by practical interaction with others and the world” (Shaw & Connelly, 2012, p.405), a phenomenological methodology was considered well suited to investigate the interactive and intersubjective nature of physiotherapy to complement the more technical aspects of knowing and practicing. It is hoped that applying phenomenological inquiry as a ‘phenomenology of practice’ to reflect on and in clinical practice may lead to more meaningful practice (van Manen, 2014).

A critical lens was employed in the phenomenological studies of what constitutes a ‘good’ and ‘responsive’ physiotherapist (Chapters 3 and 4). Some theorists argue that phenomenology by its very nature is a critical methodology through its questioning and ‘reinterpretation’ of what is taken-for-granted (Crotty, 1998; Weiss et al., 2019). Eliciting first-hand accounts of everyday phenomena allows researchers to investigate previously unexamined cultural assumptions and dominant discourses (Park Lala & Kinsella, 2011). Being critically reflexive about my own assumptions of what constitutes a ‘good’ physiotherapist allowed me to examine my situatedness in the research process and what I have taken-for-granted as a clinician alongside the physiotherapy profession, my colleagues, and study participants (See Chapter 5 for an elaboration).

Eliciting practice-based, taken-for-granted experiences (Hasselkus, 2006) of everyday encounters offers an approach to study a ‘good’ physiotherapist’s tacit practical knowledge and way of being when interacting with patients. By examining accounts of physiotherapists’ lived practice experiences and interactions with patients, the thematic interpretations of what it is to be a ‘good’ physiotherapist may be identified. With the

research aim to produce rich textual descriptions of the phenomenon of a ‘good’ physiotherapist, practitioners, educators, and the profession may advance understandings of a ‘good’ physiotherapist’s way of being-in-the-world in professional practice. By attending to the parts as well as the whole of therapists’ accounts of what it is to be a ‘good’ physiotherapist, critical insights arising from this research may contribute to knowledge, and enrich the curriculum and competencies, of future physiotherapists.

1.8 Theoretical frameworks

Theoretical frameworks can inform a qualitative research study at various points in the research process (Sandelowski, 1993; Varpio et al., 2020). Theoretical frameworks may inform interpretation and presentation of data after preliminary analysis to aid understanding of what may be arising in the data (Sandelowski, 1993). Although, I did not begin with an *a priori* theoretical framework in this work, after preliminary analysis of the data, I looked to relational ethics and ethics of care theories. I found these theories constructive in helping me make sense of what I was thinking about and what I was hearing from the physiotherapists I interviewed. As the work unfolded, the studies’ theoretical frameworks were informed by ethics of care theories, particularly the work of Joan Tronto (1993).

1.8.1 Relational Ethics

Doing what is right and good as a moral action may be viewed through various ethical and theoretical perspectives. Perspectives that are foundationally relational, propose right actions and good character as constituted in the connections, bonds, and interdependency between people (Metz & Miller, 2016). Although relational ethics are broad, they are often identified with an ethic of care. When preliminary analysis of what constitutes a ‘good’ physiotherapist pointed to an ethical orientation to care, ethics of care theory was examined and incorporated as theoretical perspectives informing Chapters 3 and 4 of this dissertation.

Bioethics is concerned with the ethics of biomedical science and technology (Callahan, 1999). In contemporary health care ethics including physiotherapy, the dominant approach is principlism, which is “grounded in the belief that ethical reasoning should

be objective (unemotional) and independent of context” (Austin, 2008, p. 17). In principlism, ethical reasoning involves deliberation based on principles of non-maleficence (doing no harm), beneficence (doing what is right for the patient), respect for autonomy (freedom to make choices), and justice (fairness) (Austin, 2008; Delany, 2017). Rules and codes of conduct grounded in these ethical principles are acknowledged as necessary yet incomplete (Austin, 2008; Moore et al., 2014). Feminist critiques of traditional bioethics include critiques of a) abstract adherence to universal rules applied to a generic person deprived of their unique characteristics and situatedness; b) an emphasis on individual autonomy that isolates individuals from their social context and relationships; and c) power dynamics that perpetuate systemic and practitioner-patient inequalities (Austin, 2008; Marway & Widdows, 2015; Metz & Miller, 2016; Pollard, 2015). Feminist bioethics recognize each person as unique and socially interconnected and promote a relational approach to ethical decisions and action (Marway & Widdows, 2015).

The Canadian physiotherapy code of ethics promotes the four biomedical ethical principles (Canadian Physiotherapy Association, 2021). Physiotherapists’ primary ethical framework is suggested to align with beneficence over respect for autonomy (Delany, 2007; Delany et al., 2010). Studies of physiotherapists’ experience with informed consent (Delany, 2007) and shared decision-making (Larsson et al., 2010) suggest clinical decision-making regarding the most beneficial treatment is often communicated as explanation of proposed treatment rather than offered as a choice. Focusing on their interpretations of patients’ problems and the quest for desirable outcomes, physiotherapists’ communication is argued to be practitioner-centred and theorized to be framed as ‘doing what is right for the patient’ because good outcomes are predicted (Delany, 2007; Delany et al., 2010; Praestegaard & Gard, 2013). Delany and colleagues (2010) propose ethical engagement includes active listening, attentiveness, curiosity, and critical thinking about patients’ perspectives and circumstances. They and others also theorize that physiotherapists’ reflexivity about their own values, emotional reactions, and underlying assumptions of clinical care promote ‘good’ care in the best interests of patients (Delany et al., 2010; Setchell & Dalziel, 2019). This proposition aligns with a relational ethics approach to physiotherapy practice, and points to a need to recognize and

enact practices proposed as inherent to the physiotherapist-patient therapeutic relationship (Miciak, 2015).

Relational ethics situates ethical practice within relationships, including the therapeutic relationships between health care practitioners and patients (Austin, 2008; Moore et al., 2014; Pollard, 2015). Underpinned by interpersonal relationship and connecting with patients as people, relational ethics tenets include attention to mutual respect, engagement, embodied knowledge, the patient's environment, and uncertainty (Moore et al., 2014; Pollard, 2015). Mutual respect is proposed to mitigate power imbalances by recognizing our responsibility to others and acknowledging differences as complementary rather than presuming technical knowledge is superior (Pollard, 2015; Tomaselli et al., 2020). This is argued to necessitate engagement with others by connecting with openness and responsiveness to understand patients' perspectives, needs, preferences, values, and social context (Moore et al., 2014; Pollard, 2015). In partnership and with attention to patients' narratives, embodied knowledge guides relational decision-making (Pollard, 2015; Tomaselli et al., 2020). A relational approach to autonomy is proposed by considering a patient's 'environment', which includes their socially embedded interconnections that shape their identities, values, and perceptions (Ells et al., 2011; Moore et al., 2014; Pollard, 2015). Uncertainty, experienced when balancing the competing demands of clinical practice, is accepted as inherent to ethical action, and best approached with humility, understanding, and in relationships where perspectives are shared, and decisions are made together (Austin, 2008; Pollard, 2015).

1.8.2 Ethics of Care

Relational ethics are central to ethics of care whereby right actions and good character are constituted in the connections, bonds, and interdependency of people. Some theorists (Halwani, 2003; Slote, 2003) view care as a virtue that is instrumental in discerning right action and contributing to the promotion of a flourishing life. They propose ethics of care theory be considered as part of the moral framework of virtue ethics. In the field of nursing, Benner (1997) suggests virtue ethics and care ethics share commonalities noting similar attention to a good practitioner's actions to do what is right, phronesis, and experiential learning. However, rather than focusing on the practitioner's 'virtuous'

character, Benner has proposed care ethics promote respectful practitioner-patient relationships as central to making care an ideal.

Although a number of theorists have promoted ethics of care, its origin is often associated with relational theories of care proposed by Carol Gilligan (1982) and Nel Noddings (1984). Five relational features are proposed to distinguish an ethics of care (Held, 2006; Metz & Miller, 2016):

1. Ethics of care focuses on relationships and their importance in constituting the self and moral agency.
2. Making care as an ideal oriented towards right action, ethics of care theories promote various forms of receptivity, openness, attentiveness, engrossment, and responsiveness to the person in need of care.
3. Emotions are valued for their potential influence on moral reasoning and decision-making.
4. Moral judgments are informed by perspectives of particular others within relationships and the context in which the persons and relationship are situated.
5. The source of our moral responsibility toward others is proposed as recognition of 'being-in-the-world-with-others', and being mutually vulnerable and interdependent such that human flourishing depends on responding to the needs of others.

1.8.3 Joan Tronto's ethic of care theory

Conceptualizing care as a 'practice' largely defined by culture, Joan Tronto (1993, 1998) situates 'care' in a moral and political context. She suggests caring is a social rather than individual activity shaped by human needs that change within historical and cultural contexts. She further proposes power relations affect how care is defined, distributed, and shaped by 'moral boundaries' (Fisher & Tronto, 1990; Tronto, 1993). In her book, *Moral Boundaries: A political argument for an ethic of care*, Tronto (1993) describes three boundaries that limit uptake of 'women's morality' or an ethics of care grounded in feminist bioethics. These boundaries are proposed to include: the traditional boundary

between politics and morality, the abstract, distant ‘moral point of view’, and the lines drawn between public and private life.

Tronto (1993) and her colleague, Bernice Fisher define care:

On the most general level we suggest that caring be viewed as a species activity that includes everything we do to maintain, continue and repair our ‘world’ so that we can live in it as well as possible. That world includes our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web (p. 103).

Drawing on Tronto and Fisher’s definition of care, Krause and Boldt (2018) offered a definition of care in health care as: “a set of relational actions that take place in an institutional context and aim to maintain, improve or restore well-being” (p. 3).

Tronto (1993) theorizes a morally good person’s thoughts and actions are intentional and goal directed. Her theory posits a ‘habit of mind’ that encompasses four ‘phases’ of care and corresponding ethical *elements* of care:

1. ‘caring about’ is a culturally and individually shaped orientation to recognize that care is necessary and involves *attentiveness* to the needs of others;
2. ‘caring for’ assumes *responsibility* to initiate, maintain, and fulfil inherent practice obligations, which involves judgement and being accountable for consequences;
3. ‘caregiving’ requires *competence* to provide good outcomes, which is enacted moment-by-moment or day-by-day based on knowledge, skills, experience, and judgement;
4. ‘care-receiving’ involves *responsiveness* of the care-receiver to the care provided and of the caregiver’s attention to and evaluation of the other’s response, perspective, and experience.

The last element of responsiveness brings Tronto’s phases of care full circle shifting the focus from the caregiver to the relational nature of caring (Clouder, 2005; Tronto, 1998).

Tronto's theory shaped the interpretations of findings presented in integrated manuscript two and three (Chapter 3 and 4).

I would be remiss if I were not to mention that more recently, and positioned within the context of a group of people, Tronto (2015) added a fifth phase, 'caring with' whereby we *trust* one another to reciprocate care and feel *solidarity* with others as partners in giving and receiving care. She bases this notion on redefined definitions of democratic ideals of freedom (absence of domination), equality (as a condition of equal voice), and justice (ongoing assignment of responsibility to care within a framework of non-dominated inclusion). Tronto proposes that this theoretical framework emphasizes relationship and gives people a voice in the allocation of caring responsibilities.

Although, Tronto (2015) positions her 'political' theory and the fifth phase of care specifically on an "entire polity of citizens engaged in a lifetime of commitment to and benefiting from these principles" (p. 14), the first four elements of her ethic of care theory have been taken up in the health professional practice literature (Clouder, 2005; Durocher et al., 2016; Krause & Boldt, 2018; Tronto, 2020) as it was in this dissertation.

1.9 Definition of key terms

Key terms, evidence-based practice, and patient- and person-centred care are briefly defined in this section. Each term is underpinned by history, perspectives, discourses, and at times depicted as "conflicting ontologies" (Anjum, 2016, p. 422), prompting the need for clarification about how they are taken up in the dissertation.

The term, **evidence-based practice** (EBP) emanates from efforts in the medical community in the 1990s to improve the reliability and effectiveness of clinical practice (Dahl-Michelsen et al., 2021; Greenhalgh et al., 2014; Sur et al., 2011). Physiotherapy and other health professions have adopted Sackett and colleagues (1996) definition of evidence-based medicine:

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical

expertise with the best available external clinical evidence from systematic research (p. 7).

In response to critiques about the emphasis on experimental evidence at the expense of tacit knowledge and patients' 'idiosyncrasies' (Greenhalgh, 2014), Sackett and colleagues published a revised definition in 2000: "integration of the best research evidence with clinical expertise and patient values" (p. 1). This definition is adopted in this dissertation. Subtle variations and uptake of this definition appear in the professional discourse on evidence-based practice in physiotherapy (Maher et al., 2004; Mota da Silva et al., 2015; Scurlock-Evans et al., 2014; Veras et al., 2016). Discourses in the profession also include critiques of the emphasis on 'evidence' garnered from randomized control trials over other legitimate ways of knowing including "the standpoint of real patients in real encounters" (Dahl-Michelsen et al., 2021, p. 102).

While there are similarities and differences between patient-centred care and person-centred care, the two terms are often used interchangeably (Eklund, 2019). It is only after undertaking this research that I have come to appreciate the differences. This is reflected in my use of the term '**patient-centred**' in the integrative review (Chapter 2). The review was inspired by Potter and colleagues' (2003) investigation of 'good/bad' physiotherapy experiences; I was influenced by their use of Mead and Bower's (2000) five key dimensions of 'patient-centredness': 1) practitioner understanding of patients' biopsychosocial perspectives; 2) engaging with the 'patient-as-person'; 3) sharing power and responsibility; 4) acknowledging the importance of the therapeutic alliance; and 5) engaging in self-awareness of emotions and behaviour as a 'practitioner-as-person'.

As I was engaging with the data collected in the phenomenological studies, I began to more fully appreciate the subtle but important difference between patient- and person-centred care; I now embrace the latter term in my understanding of the 'good' in physiotherapy practice. Based on a review of reviews by Eklund and colleagues (2019), **person-centered care** is defined as an approach to care that places the person at the center and considers their context, history, family, and perspectives when making shared decisions in the facilitation of a person's recovery to live a meaningful life. As further

expanded upon in Chapter 4, Eklund and colleagues' (2019) posit the goal of patient-centred care as a return to a *functional* life whereas person-centred care is proposed as facilitating a *meaningful* life. For me, this aligns with Aristotle's (transl. 2011) philosophy that suggests the purpose of life is to live a happy and good life, a flourishing life in which we "live well and act well" (p. 5) in the promotion of human good.

1.10 Research questions

- 1. Integrated Manuscript One (Chapter 2):** Integrated manuscript one is an integrative review. The primary purpose of this review was to examine the literature concerning how physiotherapists and their patients describe the qualities of a 'good' physiotherapist. The secondary aim was to critically examine perspectives of what constitutes a 'good' physiotherapist by critiquing 'taken for granted' assumptions about physiotherapists' 'way of being' in everyday practice (Gibson, 2016; Gibson et al., 2018; Setchell et al., 2018). To this end, a critical social science perspective (Eakin et al., 1996) was incorporated along with an integrative review methodology. The literature depicting the qualities of a 'good' physiotherapist as predominantly described within the context of patient satisfaction, patient expectations, and therapeutic alliance/relationship in a musculoskeletal practice context was searched through six databases from inception of the databases to June 14, 2019. This manuscript was published online by the journal, *Physiotherapy Theory and Practice* on December 9, 2021.
- 2. Integrated Manuscript Two (Chapter 3):** Integrated manuscript two is a phenomenological study into practitioners' perspectives of what constitutes a 'good' musculoskeletal physiotherapist. This manuscript has been submitted for publication in the journal, *Physiotherapy Theory and Practice*. The purpose of this empirical research was to understand what constitutes a 'good' physiotherapist by examining physiotherapists' perceptions in the context of musculoskeletal practice. The study was informed by critical bioethics, particularly drawing on Joan Tronto's (1993) ethic of care theory as a theoretical framework, and hermeneutic phenomenology as a methodology.

- 3. Integrated Manuscript Three (Chapter 4):** Integrated manuscript three is a secondary analysis of the data collected in the phenomenological study to examine what constitutes a ‘good’ musculoskeletal physiotherapist. This manuscript has been submitted for publication in the journal, *Physiotherapy Theory and Practice*. In both the review (Chapter 2) and the first empirical study (Chapter 3), responsiveness was identified as an important practice of a ‘good’ physiotherapist. ‘Being’ responsive is explored in greater detail in this manuscript. As a secondary analysis of one predominant theme in the primary study, the purpose of this inquiry was to examine in what ways is responsiveness to patients enacted in the practice of a ‘good’ musculoskeletal physiotherapist? The study’s theoretical framework was informed by ethics of care theories, particularly the work of Joan Tronto (1993), and hermeneutic phenomenology as a methodology.
- 4. Integrated Manuscript Four (Chapter 5):** The primary purpose of this perspective article was to share my transformed reflexive understandings as a researcher. Through critical reflexivity, grounded in my experience as a clinician and doctoral student, questioning what I have taken for granted as a practicing physiotherapist, has transformed my understanding of what knowledge is important in physiotherapy and what may be considered ‘good’ practice. This chapter critiques how physiotherapy’s history and power dynamics have influenced ways of thinking and practicing.

1.11 Researcher reflexivity

In qualitative research, reflexivity features as an important consideration when documenting how the study was conducted to declare how researchers themselves have influenced the collection and interpretation of data (Finlay, 2002). While it is recognized that all research is subject to researcher ‘bias’ (Morrow, 2005), qualitative researchers practice self-awareness to recognize how their values, behaviours, and assumptions actively influence the construction of knowledge as an intersubjective process of interpretations with their participants (Finlay, 2002). In hermeneutic phenomenological research, it is understood that researchers’ own lived experience, pre-understandings, and

historical background will shape how a phenomenon is perceived and interpreted (Finlay, 2002). Being-in-the-world from a hermeneutic perspective means that as researchers, we cannot avoid or ‘bracket’ our pre-understandings but will “think *with* them and we situate them in our understandings” (Moules et al., 2015, p. 121). The research to follow is a dialogue incorporating my own pre-understandings, the research studies undertaken, and the construction of what constitutes a ‘good’ physiotherapist informed by the scholarly literature, the accounts of study participants, and reflexive and situated interpretations. Chapter 5 and the sections to follow outline “why this particular topic for this particular researcher” (Moules et al., 2015, p. 121).

1.11.1 Relational ways of practicing

My assumptions about a ‘good’ physiotherapist are influenced by my belief in the importance of the therapeutic relationship. Miciak and colleagues (2012) propose that a ‘common factors’ model is at play in physiotherapy practice such that outcomes are influenced by the specific effects of the intervention combined with the non-specific effects common to various treatment approaches which include physiotherapist characteristics and the quality of the therapeutic alliance. My interest in examining the qualities of a ‘good’ physiotherapist is further fueled by research findings that suggest a stronger therapeutic alliance is associated with improved outcomes for patients (Ferreira et al., 2013; Hall et al., 2010).

1.11.2 My expectations

At the outset of my research, I expected there would be an interplay of technical competency with a relational way of being in the practice of a ‘good’ physiotherapist. However, Descartes’ philosophy, which scholars argue has perpetuated a theoretical separation of mind and body (Cartesian dualism), significantly dominates the discourses of the health professions (Benner, 2000; Kinsella, 2006, 2007). Cartesian medicine or biomedicine is noted for valuing scientific objectivity, cause-effect relationships, and reduction of the body (as-machine) into separate parts (Benner, 2000; Nicholls, 2012; Shaw et al., 2010). The rehabilitation professions, including physiotherapy and occupational therapy have historically aligned with medicine to presumably establish

professional status, and in doing so have also aligned themselves with biomedicine's emphasis on objectivity and quantitative research (Kinsella & Whiteford, 2009; McPherson et al., 2015; Nicholls, 2017; Shaw et al., 2010). I am concerned that it may be difficult to highlight more humanistic aspects of physiotherapy practice in a profession (and society) that is dominated by the biomedical model and in a climate that reveres the evidence-based practice model and associated hierarchy of evidence exclusively derived from quantitative research rather than the more humanistic and relational dimensions of phenomena often revealed in qualitative research.

Sackett and colleagues (2000) define evidence-based practice as including “the integration of best research evidence *with* clinical expertise *and* patient values [my italics]” (p. 1). However, it is argued that current health care approaches place emphasis on experimental evidence at the expense of clinical experience and tacit knowledge (Greenhalgh et al., 2014). This includes physiotherapy education and research, proposed to emphasize ‘evidence’ and the technical aspects of practice rather than clinical decision-making based on patient preferences and clinician’s experience (Bjorbaekmo & Shaw, 2018).

I am hopeful that this research will contribute to the voices in the profession and others in the health care community who recognize the importance of relational ways of practicing embedded in person-centred approaches. I presented the findings of an integrative review of the qualities of a ‘good’ physiotherapist (Chapter 2) to a section of the Ontario Physiotherapy Association, which were well received by attendees. When interviewing the participants who volunteered for the studies presented in this thesis, all highlighted the importance of balancing technical competency with relational ways of being when working with patients. One participant shared her reason for agreeing to participate:

[A] student stands out in my mind [as]... ‘I’m the expert and you should listen to what I have to say’. And no listening skills...When I saw what the study was about, it made me think of that student ...I don’t want to think that that’s what’s coming. I want to believe that the upcoming therapists ...know the importance of that [listening]. ...one of the major things for me was listening. ...I’m relieved to

hear that you're having some of the same thoughts and feelings about what would make a good physiotherapist. [PT-H]

I believe this work is important as it highlights qualities and practices that are important to the practice of physiotherapy. It has the potential to inform what competencies are prioritized in physiotherapy education curricula. I am hopeful that future physiotherapists will be trained to balance technical competence with relational practices. I believe in the importance of a strong physiotherapist-patient relationship fostered by the relational practices outlined in the studies to follow. Although this research primarily focuses on practitioners' perspectives, I hope this research improves the practice of physiotherapists when working with patients. Every patient is a unique person, to be heard, validated, and cared for by 'good' physiotherapists who listen, communicate, and work responsively, ethically, and collaboratively in the promotion of each patient's human good.

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Chapter 2 ¹

2 An integrative review of the qualities of a ‘good’ physiotherapist

Introduction: Qualities of a physiotherapist may influence the therapeutic alliance and physiotherapy outcomes. Understanding what qualities constitute a ‘good’ physiotherapist has yet to be systematically reviewed notwithstanding potentially profound implications for the future practice of physiotherapy. **Purpose:** The primary purpose of this review was to critically examine how physiotherapists and their patients describe the qualities of a ‘good’ musculoskeletal physiotherapist as depicted in peer-reviewed literature. The secondary aim was to synthesize qualities represented in the literature, and to compare patient and physiotherapist perspectives. **Methods:** An integrative review methodology was used to undertake a comprehensive literature search, quality appraisal of studies, and thematic analysis of findings. An electronic search of CINAHL, EMBASE, Nursing & Allied Health, PsycINFO, PubMed, and Scopus databases was conducted within a time range from database inception to June 14, 2019. **Results:** Twenty-seven studies met the inclusion criteria. Six qualities of a ‘good’ musculoskeletal physiotherapist were identified as: responsive, ethical, communicative, caring, competent, and collaborative. **Conclusions:** The qualities of a ‘good’ physiotherapist identified in the review emphasize the human interaction between physiotherapists and patients and point to the centrality of balancing technical competence with a relational way of being.

¹ Kleiner, M. J., Kinsella, E. A., Miciak, M., Teachman, G., McCabe, E., & Walton, D. M. (2021). An integrative review of the qualities of a ‘good’ physiotherapist. *Physiotherapy Theory and Practice*, 1–27. <https://doi.org/10.1080/09593985.2021.1999354>

2.1 Introduction

Practical wisdom, an intellectual virtue that Aristotle called *phronesis* (Kemmis, 2012), is theorized as central to good professional practice (Kinsella & Pitman, 2012). A wise person, or *phronimos*, reasons and acts in ways that are right for the human good and that contribute to human flourishing (Jenkins et al., 2019; Kinsella & Pitman, 2012; Sellman, 2009). For Sellman (2009), “the *professional phronimos*...is generally disposed to care deeply about all things to do with providing safe and effective care in ways that enable...the flourishing of patients” (p. 86). Virtue ethics, which encompass a person’s character and doing the right thing, have underpinned studies on being a ‘good’ nurse (Catlett & Lovan, 2011; Smith & Godfrey, 2002). An ethic of care has been proposed to underscore ‘good’ occupational therapy practice (Wright-St Clair, 2001). Physicians study and debate the appropriate marriage of applied science and humanism to understand what makes a ‘good’ doctor (Hurwitz & Vass, 2002; O’Donnabhain & Friedman, 2018). This latter call aligns with similar propositions from Rutberg et al.’s (2013) exploration of physiotherapy practice and Fadyl et al.’s (2011) interpretation of ‘good-quality’ care; in which both studies call for a “balance between technical competence and humanness” (Kayes & McPherson, 2012, p. 1909) as foundational to good physiotherapy practice.

Studying the concept of a ‘good’ physiotherapist has the potential to advance understanding of what physiotherapy is or what it ought to be. The predominance of a technical rational approach to practice, based on economic efficiency and science based or technical ‘fixes’, has been argued to be insufficient, and to occur at times at the expense of human relationships (Sellman, 2012). Promoting ‘the good’ and ‘human flourishing’, is consistent with calls for *phronesis* (or practical wisdom) as an important central aim of professional practice (Kinsella & Pitman, 2012).

The concept of the ‘good’ physiotherapist was first studied by Potter, Gordon, and Hamer (2003a). In their study, patients in Australia ultimately ranked ‘good’ physiotherapists as those who demonstrated good communication ability, followed by professional behaviours, organisational ability, diagnostic and treatment expertise, and a positive service environment. The ‘good’ physiotherapist concept was next explored by Kidd and

colleagues (2011) who studied patients' perspectives of what is important in encounters with physiotherapists by asking: "In general, what is good physiotherapy?" (p. 156). These results posited attributes such as knowledge, expertise, listening skills, reassurance, and empathy, within the 'transformative inter-relationship' as characterizing a 'good' physiotherapist. The 'transformative inter-relationship', considered integral to patient-centred care, was described as a spiral of therapist self-confidence, expertise, and knowledge that increases patient confidence in the therapist and therapy. Kidd et al. (2011) suggested it contributes to patient engagement in the therapeutic process and entails good communication, reassurance, and therapeutic progress. Later, Rutberg and colleagues (2013) suggested "there are no stereotypes for 'the good/bad physical therapist'; [but] rather the experience of receiving 'good/bad physical therapy'" (p. 1616) and that the qualities of a 'good' physiotherapist had yet to be described. Their phenomenological study of physiotherapy practice with people with migraine headaches, suggested that "meeting a physical therapist with professional tools and a personal touch" (p. 1616) were important lived *experiences of the good physiotherapist* (Rutberg, Kostenius, Ohrling, 2013). Despite these preliminary investigations, a comprehensive understanding of the qualities that constitute a 'good' physiotherapist remain elusive and incomplete.

Physiotherapists aim, in collaboration with patients and other health care professionals, to optimize people's movement and functional ability (World Confederation of Physical Therapy/WCPT, 2016). By tradition, assessment and promotion of movement from a predominantly biomechanical perspective is central to the profession's identity (Nicholls & Gibson, 2010). However, it is theorized that physiotherapy outcomes are influenced by both the specific effects of interventions and the non-specific effects common to various treatment approaches including characteristics of the physiotherapist and the quality of the therapeutic alliance (Miciak, Gross & Joyce, 2012). A review of patient-physiotherapist interactions in musculoskeletal physiotherapy supporting this proposition concluded that clinical skills and organisational factors influence interactions as well as physiotherapist qualities including interpersonal and communication skills, such as listening, empathy, friendliness, confidence and encouragement (O'Keeffe et al., 2016). Interest in examining the qualities of a 'good' physiotherapist was further inspired by

study findings that a stronger therapeutic alliance was associated with improved outcomes for patients (Ferreira et al., 2013; Hall et al., 2010). Therefore, this review examines the qualities of ‘good’ physiotherapists identified in the literature. The aim is to advance knowledge that can inform professional priorities including education curricula, professional practices, competency profiles, and patient interactions.

Reviews of satisfaction with and expectations of musculoskeletal physiotherapy, as well as patients’ perceived needs of their health care professionals, consistently identify attributes such as being caring, friendly, respectful, and competent as important determinants (Chou et al., 2018; Hush, Cameron, & Mackey, 2011; Hopayian & Notley, 2014; Rossetini, Latini et al., 2018). A limitation of these reviews and others specific to physiotherapist-patient interactions (Kinney et al., 2018; O’Keeffe et al., 2016), is that physiotherapist qualities are featured as only one aspect of the review rather than positioned as the central focus. There are no operational frameworks or rigorous, systematic analysis concerning what constitutes a ‘good’ physiotherapist. Therefore, the primary purpose of this review was to examine the literature concerning how physiotherapists and their patients describe the qualities of a ‘good’ physiotherapist. Our team reasoned that musculoskeletal (MSK) practice would provide a rich context in which to study the qualities of a ‘good’ physiotherapist given the robust literature in this domain, and the authors’ interest in MSK practice. The secondary aim was to critically examine perspectives of what constitutes a ‘good’ physiotherapist by critiquing ‘taken for granted’ assumptions about physiotherapists’ ‘way of being’ in everyday practice (Gibson, 2016; Gibson et al., 2018; Setchell et al., 2018). To this end, we incorporated a critical social science perspective (Eakin et al., 1996); the critical perspective provided a lens to reflexively question implicit assumptions, values, and discourses guiding physiotherapy practice, and to explore overlaps and disjunctures between physiotherapist and patient perspectives.

2.2 Methods

2.2.1 Integrative review methodology

Integrative review methodology allows for a synthesis of a variety of perspectives to more fully understand a phenomenon; its hallmark is the inclusion of both qualitative and quantitative experimental studies and theoretical literature as appropriate (Hopia et al., 2016; Whitemore & Knafl, 2005). This integration, in contrast to systematic reviews of quantitative studies and various qualitative evidence syntheses (Grant & Booth, 2009; Whitemore et al., 2014), is suitable for garnering a more comprehensive understanding of the phenomenon of a ‘good’ physiotherapist from both quantitative and qualitative perspectives. The integrative review framework as described by Whitemore & Knafl (2005) includes five stages: problem identification, literature search, data evaluation, data analysis, and presentation of findings.

2.2.2 Problem identification

Physiotherapists engaged in both pre- and post-professional education and development, and educators charged with the preparation of future physiotherapists would benefit from a synthesis of prior knowledge regarding the question of how a ‘good’ physiotherapist can be recognized and defined.

2.2.3 Literature search strategy

A search strategy was created in consultation with research librarians and based on the PICO framework (**P**opulation, **P**henomenon of **I**nterest, and **C**ontext) recommended by Butler, Hall, and Copnell (2016). The search was guided by the following concepts: 1) the phenomenon of ‘good’ qualities of physiotherapists predominantly described as professional and interpersonal qualities and 2) the phenomenon of the ‘good’ physiotherapist predominantly described within the context of patient satisfaction, patient expectations, and therapeutic alliance/relationship. Key words and MeSH terms were combined and adapted for each database (Appendix B). CINAHL, EMBASE, Nursing & Allied Health, PsycINFO, PubMed, and Scopus databases were searched for relevant articles published in English from the inception of the databases until June 14, 2019.

Citations of included studies and relevant reviews were hand searched to identify additional relevant publications.

Two reviewers (MK and EM) independently screened all publications for study eligibility using comprehensive inclusion and exclusion criteria (Table 2.1). Inclusion was determined first by screening titles and abstracts, then by retrieving and screening full texts. Consensus on inclusion at each stage was achieved through discussion. Agreement was measured using the unweighted kappa statistic. To improve richness and manageability of included studies, and to further delimit the included studies as a ‘purposive’ sample (Whittemore, 2007), a 5-point relevancy rating scale was used. The scale was created through author consensus as familiarity with the retrieved studies developed (Appendix C). Studies with scores of ≥ 4 out of 5 (probably or highly relevant to the research question) as rated by 2 independent reviewers were included (MK and EM).

Table 2.1 Inclusion and Exclusion Criteria

Inclusion Criteria
<ol style="list-style-type: none"> 1. Studies that specifically explore physiotherapists and/or adult patient perspectives (over 18 years old) regarding what constitutes ‘good’ physiotherapy practice 2. Studies that explore physiotherapist and/or patients’ perspectives regarding a) professional knowledge, b) professional skills, c) professional behaviours, d) professional competence, e) professional values 3. Studies that explore physiotherapist and/or patients’ perspectives regarding: <ol style="list-style-type: none"> a. “patients’ perceived needs” – ie. “a broad concept involving patients’ capacity to benefit from services, including their expectations of, satisfaction with, and preferences for various services” (Chou et al., 2018, p. 692) b. participants’ experiences of patient satisfaction or related concept (e.g., patient’s perceptions, experience, and perspectives) (Rossettini, Latini, et al., 2018) c. patient centredness or aspects of patient centredness (Wijma et al., 2017) d. patient expectations (Kamper et al., 2018) e. contextual factors (Rossettini, Palese, et al., 2018)

<p>f. therapeutic alliance or relationship constructs (Babatunde et al., 2017; Besley et al., 2011; Kinney et al., 2018; Miciak et al., 2018, 2019)</p> <p>4. Studies that exclusively recruited physiotherapists or patient participants with at least 50% of whom will have participated in outpatient physiotherapy in the area of acute or chronic musculoskeletal injury or pain.</p> <p>5. Studies written in the English language as full-text, peer reviewed articles and limited to human participants.</p> <p>6. Should the sample of studies that meet the above inclusion criteria be large, included studies may be reduced by further delineating the inclusion and exclusion criteria (Whittemore, 2007). Studies evaluated to be highly or probably relevant to the research question (rated as ≥ 4 on a relevancy scale (Goodman et al., 2019)) were included for data analysis. (Appendix C).</p>
<p>Exclusion Criteria</p>
<p>1. Non-peer reviewed articles including grey literature, theoretical, position, and opinion papers, and policy statements.</p> <p>2. Studies with student practitioners or simulated patients.</p> <p>3. Studies conducted in highly specific clinical scenarios e.g., Emergency departments, tele-rehabilitation, homecare.</p> <p>4. Studies with a specific patient population e.g., sub-specialties of musculoskeletal physiotherapy including those with patients with pelvic health conditions, and amputations, and studies with patients with mental illness and/or communication and cognitive impairments.</p> <p>5. Studies that focus on organizational structure or environmental aspects of care from the perspective of patients or physiotherapists.</p> <p>6. Studies that focus on the perspectives of other health care professionals.</p>

7. Studies of people recruited from the community who are not patients of physiotherapy care.
8. Studies in the area of paediatric care (due to the triangle-relationship with children, parents, and therapist (Wijma, et al., 2017)
9. Studies that focus on patients who received treatment as an inpatient or for conditions other than musculoskeletal pain (e.g., neurological, cardiorespiratory conditions) or treatment not delivered by a physiotherapist.

2.2.4 Data evaluation stage

Quality appraisal of included studies as a component of integrative reviews influences the credibility and overall quality of review conclusions (Whittemore, 2007). Quality appraisal was undertaken to evaluate the relative contribution of each study's insights and how these would be weighted in relation to the thematic synthesis of findings (Carroll & Booth, 2015; Hannes, 2011). A judgement of quality (high, moderate, or low) for each study was based on guidelines for appraisal of qualitative research recommended by the Canadian Journal of Public Health (2019), and further informed by Tracy's (2010) and Ravenek and Rudman's (2013) quality appraisal frameworks (Appendix D). The appraisal was oriented by six broad questions that evaluate the topic as worthy of study, rigour and credibility of study design, data collection and analysis, and the quality of the study's results and contributions. A judgement of quality (high, moderate, low) was determined for each of the six questions to inform the appraisal of overall study quality.

Data were extracted from each publication including descriptive information (authors, year, source, title, and country), the construct studied and the relationship to the 'good' physiotherapist (i.e. satisfaction, expectations, therapeutic relationship), practice context, theoretical underpinnings, methodology, sampling information, data collection methods, data analysis methods, significant study results and conclusions. For thematic analysis, relevant data from each publication's 'Results' section were extracted and classified as originating from either the patient or physiotherapist perspective.

2.2.5 Data analysis stage

A qualitative thematic analysis (Whittemore & Knafel, 2005) was conducted using the constant comparison method adapted from Miles, Huberman, & Saldaña (2014). By iteratively comparing commonalities and differences across data displays (spreadsheet, conceptual maps), patterns, themes, and relationships were identified. Coding involved searching each included article for physiotherapist qualities as discussed by physiotherapist and patient participants. ‘Qualities’ were defined as distinctive attributes or characteristics. These were collected and organized in data displays used to simultaneously code similar concepts, undertake a content analysis, and categorize patterns and themes. Data within each theme were compared to interpret unifying physiotherapist qualities which were then verified by returning to the studies. Using this iterative process, qualities were categorized into themes based on how they were discussed in each study (Figure 2.1). Themes were refined and finalized through discussions to achieve consensus among authors (MK, EK, and DW).

2.3 Results

After the initial search and removal of duplicates, 4062 article titles and abstracts were screened (Figure 2.2). Citation searching identified 24 additional full-text articles to screen. Agreement for inclusion after full-text review of 140 studies was substantial ($k = 0.69$; 95% CI 0.56, 0.81; 85% agreement) resulting in inclusion of 52 studies. Nine surveys did not elicit participant-initiated perspectives and therefore rated 2/5 on the relevancy scale; these were excluded given the review’s focus on in-depth participant description of what constitutes a ‘good’ physiotherapist. All 43 remaining studies were qualitative; 27 scored $\geq 4/5$ on the relevancy scale and were included in the analysis (Table 2.2).

2.3.1 Quality appraisal results

Included studies were appraised as high ($n = 9$), moderate ($n = 16$), and low ($n = 2$) quality (Table 2.2, Appendix E). The two lower quality studies were retained because they rated high on the relevancy scale and findings were consistent with other highly ranked papers in the review. Most included studies were descriptive and aligned with a

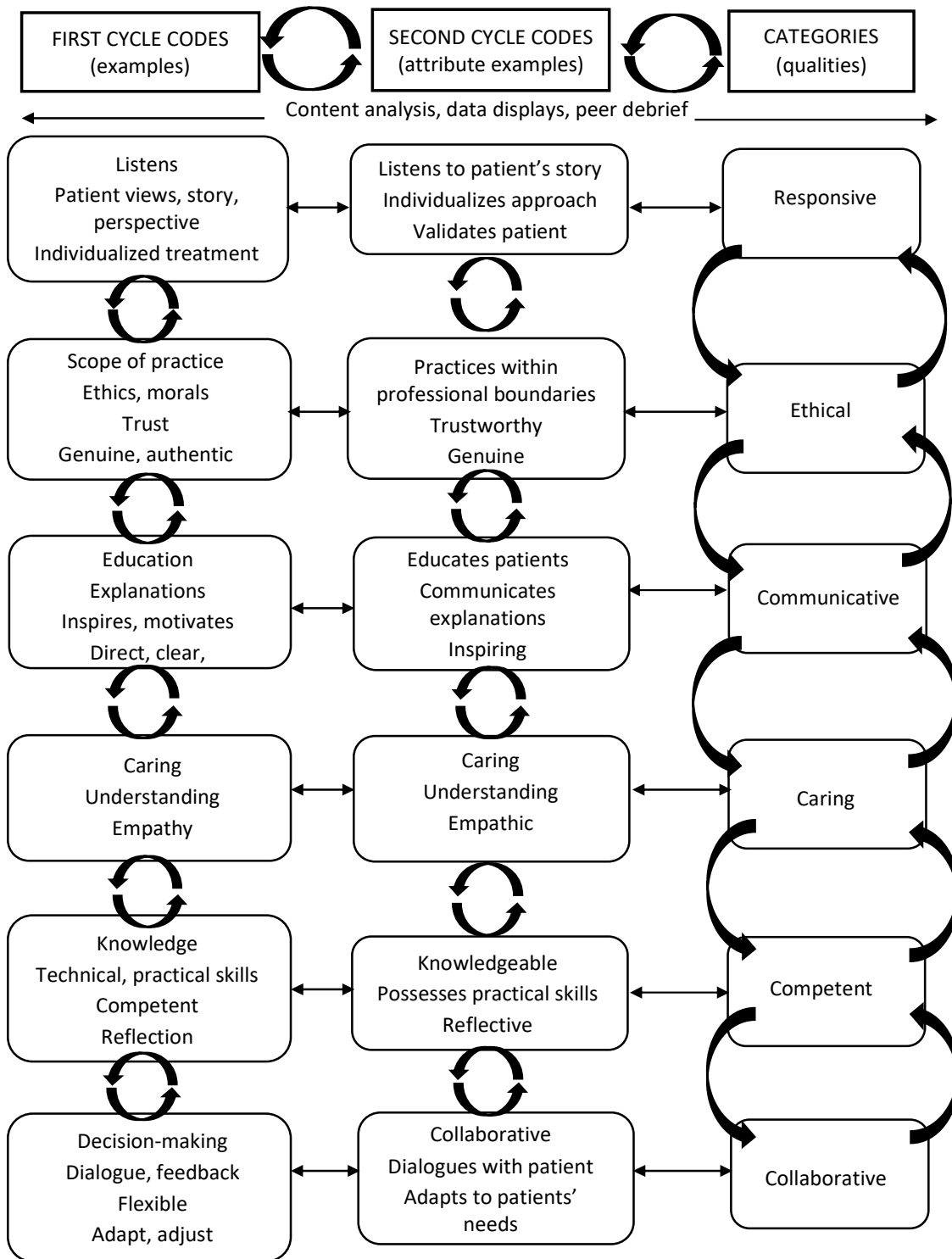


Figure 2.1 Constant Comparison Method of Data Analysis (Miles, Huberman, & Saldana, 2014)

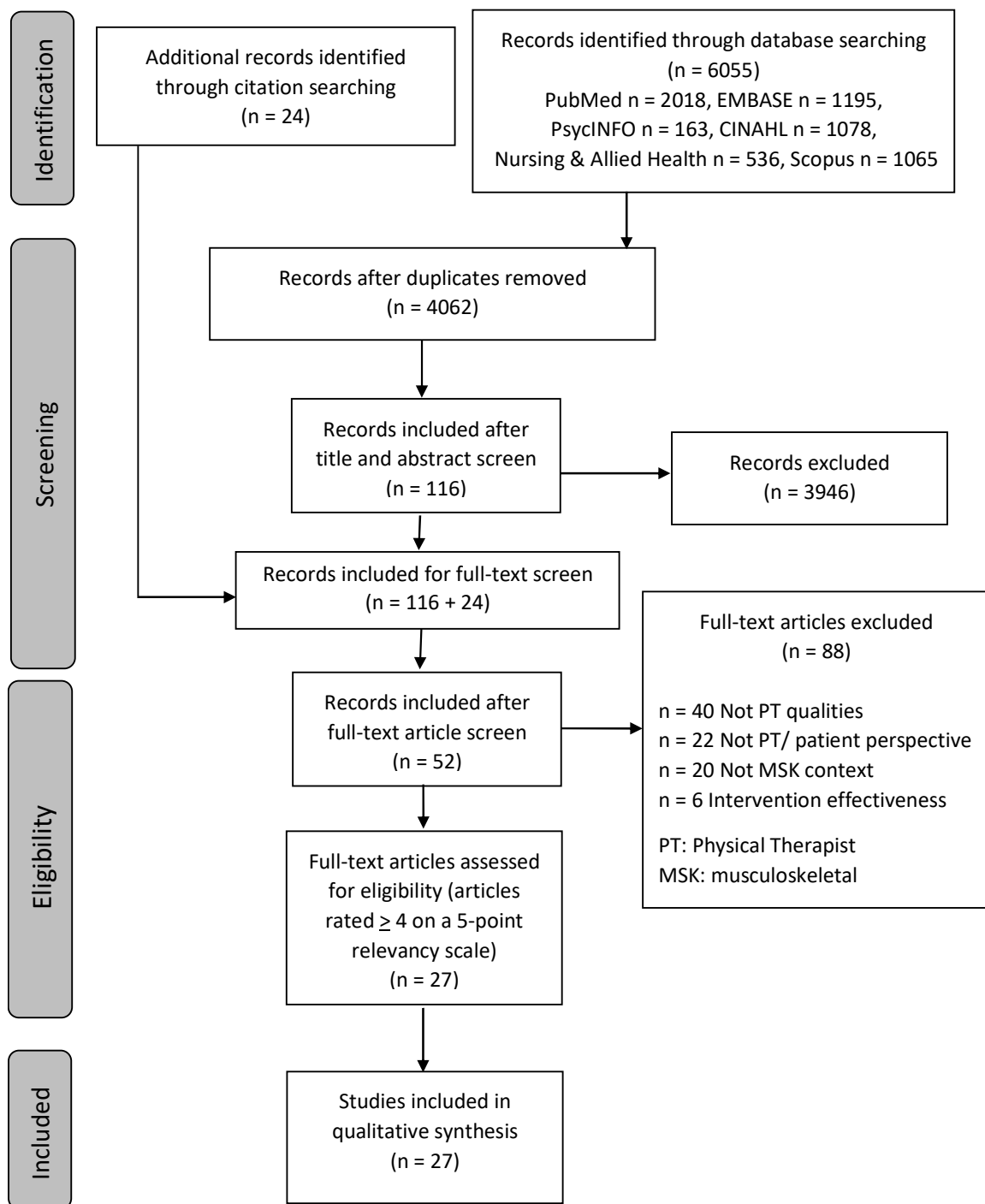


Figure 2.2 Flow Diagram of Study Retrieval and Selection Process (Moher et al., 2009)

Table 2.2 Summary of Included Studies

	Authors	Design and Data Collection Methods	Construct Studied	Purpose	Sample	Quality
1	Aguilar, Stupans, Scutter & King 2013 Australia	Naturalistic approach (Depoy & Gitlin, 2011) Constructivist paradigm Methods: semi-structured interviews, reflective journal	Core professional values	This study aimed to determine the values of the profession by identifying the shared professional values of 14 Australian physiotherapists.	Physiotherapists N=14; 6M/8F Avg years worked: 26	Moderate
2	Ali & May 2017 Egypt	Framework Analysis Methods: focus groups, semi-structured interviews, field notes	Patients' expectations and satisfaction	The objective of this study was to explore expectations and satisfaction with physiotherapy in Egypt for patients attending for back pain.	Patients N=18; 9M/9F Avg age: 40.17 yrs (Range 19-81) 9 acute/9 chronic LBP	Moderate
3	Barradell, Peseta & Barrie	Phenomenologically Oriented Methodology	Professional identity – 'essence' of	The research question was: How do students, recent graduates, and clinical	Physiotherapists and PT students N=45 11 students,	High

	2019 Australia	Methods: semi-structured interviews, small groups, field notes	practice; what physiotherapists do and how they behave	educators as representatives of physiotherapy practitioners experience physiotherapy practice?	20 new grads, 32 PTs Students of year 1-4; New grads within 18- 24 months of grad.	
4	Bernhardsson, Larsson, Johansson & Öberg 2017 Sweden	Explorative Qualitative Research Design with an Inductive Approach Methods: semi-structured interviews, field notes	Patient preferences for physiotherapy treatment methods and participation in clinical decision making	The aim of the study was to improve understanding of patient preferences for physiotherapy treatment methods and participation in clinical decision making, by exploring and describing these preferences among primary care patients with musculoskeletal pain in their back, neck or shoulder.	Patients (Various MSK conditions with median duration 30 months) N=20; 10M/10F Avg 48.56 years (23- 77 years)	High
5	Bernhardsson, Samsson, Johansson,	Explorative Qualitative Study	Patient preferences	The primary aim was to explore perceptions of patients with	Patients (various MSK conditions with	Moderate

	Öberg & Larsson 2019 Sweden	Design with an Inductive Approach Methods: semi-structured interviews		musculoskeletal pain regarding how their preferences were accommodated in clinical decision making and influenced their rehabilitation. A secondary aim was to explore whether the patients perceived that their preferences changed during the rehabilitation.	median duration 24 months) N=18; 9M/9F Avg 49.7 years (23-77 years)	
6	Calner, Isaksson & Michaelson 2017 Sweden	Qualitative Design with Semi-structured Interviews Methods: semi-structured interviews	Patient expectations	The aim of this study was to explore and describe the expectations people with persistent back, neck, or shoulder pain have prior to physiotherapy treatment.	Patients (various MSK conditions with median duration 47.5 months) N=10; 6M/4F Avg 44.2 years (20-74 years)	Moderate

7	Calner, Isaksson & Michaelson 2019 Sweden	Explorative Qualitative Research Design Methods: semi-structured interviews	Physiotherapy experiences of patients with persistent pain	The aim of this study was to explore and describe the physiotherapy treatment experiences of persons with persistent musculoskeletal pain.	Patients (various MSK conditions with median duration 43.2 months) N=11; 3M/8F Avg 48.73 years (25- 74 years)	Moderate
8	Cooper, Smith & Hancock 2008 UK	Qualitative study using semi-structured interviews Methods: semi-structured interviews	Patient- centredness, satisfaction, expectations, patient involvement, needs, coping	The aim of this study was to define patient- centredness, in the context of physiotherapy for Chronic Low Back Pain, from the patient's perspective.	Patients (chronic LBP) N=25; 5M/20F 18-65 years	Moderate
9	Crepeau 2016 USA	Narrative Inquiry/Auto- Ethnography Methods:	Attention and therapeutic alliance	The purpose of this paper is to illuminate the importance of attention in patient care and to explicate the impact of	Patient (knee osteoarthritis) N=1 Female	Moderate

		author selected two (personal) vignettes		attention on one person's recovery.		
10	Del Baño-Aledo, Medina-Mirapeix, Escolar-Reina, Montilla-Herrador & Collins 2014 Spain	Modified Grounded Theory Approach Methods: focus groups	Patients' experiences and perceptions on quality of interaction with PT	The purpose of this study was to identify elements of the physiotherapist-patient interaction that are considered by the patient when evaluating the quality of care in outpatient rehabilitation settings.	Patients (various MSK conditions of unknown duration) N=57; 33M/24F N=12 <30 years, n=21 31 to 45 years, n=24 >45 years	Moderate
11	Ekerholt & Bergland 2004 Norway	Grounded Theory Methods: semi-structured interviews	Patients' first experience of Norwegian Psychomotor Physiotherapy	The purpose of this study was to elucidate patients' experiences of the examination in Norwegian Psychomotor Physiotherapy.	Patients (various MSK disorders of unknown duration) N=10; 1M/9F Age range: 41 – 65 years	Moderate

12	Greenfield 2006 USA	Narrative Inquiry (Interpretive Narrative) Methods: three-stage, in-depth interview process/multiple interviews, memos, member checks	Nature of caring	What is the nature of caring in clinical practice of physical therapy? The purpose of this research is to describe the experiences of five experienced physical therapists to understand the nature of caring in their clinical practice.	Physiotherapists N=5; 2M/3F Avg 49 years, 41-56 years. Avg years of practice 25.2	High
13	Gyllensten, Gard, Salford & Ekdahl 1999 Sweden	Qualitative Case Study with Cross- Case Analysis Methods: sort of important factors or events contributing to the ability to interact with patients, an exemplar, and 2	PT-patient interaction	What factors can be identified as important in the interaction between patients and PTs in primary healthcare? Can any conclusions and recommendations about the impact of interaction skills be made?	Physiotherapists N=10 Females 44-62 years (mean 51); practice experience: 7-41 years (mean 24)	Low

		interviews each participant				
14	Hills & Kitchen 2007 UK	Design as “Focus Groups” Methods: semi-structured interviews	Patient satisfaction	This article reports on the use of focus groups to explore the factors that affect patients’ satisfaction with outpatient physiotherapy.	Patients (various acute and chronic MSK conditions) N=30 Acute: 4M/10F, aged 36-79 years Chronic: 5M/11F, aged 46-82 years	Moderate
15	Jensen, Shepard, Gwyer & Hack 1992 USA	Qualitative Case Study Approach Methods: observation of patient encounter (audiotaped), interviews, review of patient records	Phenomenon of expertise as it relates to the work of the physical therapist in the natural practice environment (physiotherapy	The purpose was to further investigate the work of the physical therapists with a small number of expert or master, clinicians (ie, experienced and proficient therapists) and novice clinicians using a previously identified	Physiotherapists N=6 Master n=3, experienced: n=2 13 years, n=1 23 years; Novice n=3 (< 2 years experience)	High

			therapeutic intervention)	conceptual framework and initial five themes as a basis for elaboration and revision.		
16	Kidd, Bond & Bell 2011 New Zealand	Grounded Theory Methods: semi-structured interviews	Patient-centred physiotherapy	The aim of this study was to develop a patient self-report instrument to be used in the assessment of physiotherapists' clinical performance in the musculoskeletal area by generating qualitative data from patients about what is important to them in encounters with their physiotherapist.	Patients (MSK condition not reported) N=8; 4M/4F Avg 51.75 years, (20-68 years)	Moderate
17	Lindahl, Teljigović, Heegaard Jensen,	Grounded Theory Methods:	Patient-centred approach	The aim of this qualitative study was to identify factors that determine quality of the rehabilitation	Therapists and Patients (with extremity fracture) N=15 PTs, 8 Ots,	Moderate

	Hvalsoe & Juneja 2016 Denmark	semi-structured interviews, focus groups, memos	Quality of rehabilitation process	process for patients of working age with simple or multiple fractures.	7 Patients. PTs : 3M/12F Patients: 5M/2F Patients: Avg 44.86 years; (18 – 64 years)	
18	May 2001 UK	Qualitative Study Methods: semi-structured interviews	Patient satisfaction	The aim of this study was to generate the range of dimensions of care that patients believe are important in their satisfaction with an episode of physiotherapy.	Patients (chronic low back pain) N=34; 14M/20F Avg 53.56 years, 29-77 years	Moderate
19	McGinnis, Guenther & Wainwright 2016 USA	Qualitative design using thematic content analysis with general inductive technique Methods:	Professional core values	The aims of this study were: (1) to gain insight into physical therapists' development of	Physiotherapists N=20; 6M/14F Avg 39.4 years, (24-57 years) mean 11.86 years experience	High

		semi-structured interviews, Core Values Self-Assessment, participant's resume used to complete a resume sort, field notes, reflective memos		professional core values and (2) to gain insight into participants' integration of [APTA's] professional core values into clinical practice.		
20**	Miciak, Mayan, Brown, Joyce & Gross 2018 Canada	Interpretive description using an inductive approach (Thorne, 2008) Methods: semi-structured interviews, interview and analytic notes, memos	Therapeutic relationship	Assuming meaningful engagement relies on a positive supportive relationship between patient and provider, we posed the question: what conditions are necessary for both physiotherapist and patient to engage in a therapeutic relationship?	Physiotherapists and Patients (various acute and chronic MSK conditions) n=11 PTs; 5M/6F, n=7 patients; 4M/3F PTs: mean age 47.8 years, (36-60 years);	High

					patients mean age 42.3 years, (18-62 years); PTs practicing > 10 years	
21**	Miciak, Mayan, Brown, Joyce & Gross 2019 Canada	Interpretive description methodology (Thorne, 2008) Methods: semi-structured interviews, interview and analytic notes, memos	Therapeutic relationship	This research project answers the question: according to physiotherapists and patients, what are the ways that physiotherapists establish meaningful connections with patients?	Physiotherapists and Patients (various acute and chronic MSK conditions) n=11 PTs; 5M/6F, n=7 patients; 4M/3F PTs: mean age 47.8 years, (36-60 years); patients mean age 42.3 yrs, (18-62 yrs); PTs practicing > 10 years	High
22	Morera-Balaguer,	Qualitative Thematic Analysis Study	Person-centred physiotherapy	The aim of this study was to explore barriers and	Patients	Moderate

	Botella-Rico, Catalán-Matamoros, Martínez-Segura, Leal-Clavel & Rodríguez-Nogueira 2019 Spain	Methods: focus groups		facilitators for the establishment of a person-centered relationship, based on the experience of physiotherapy patients.	(various MSK conditions of unknown duration) N=31; 10M/21F Mean age 53 years	
23	Palenius & Nyman 2018 Finland	Qualitative and Phenomenological Design Methods: individual interviews and focus group interviews, note-taking	Patient experience of physiotherapy practice	The aim of this study is to report how patients with shoulder problems, especially supraspinatus tendinitis, experience physiotherapy practice. Do the patients have expectations of physiotherapists? Do the patients themselves want to	Patients (pre- and post-operative shoulder pain) N=26; 14M/12F Avg 53 years, (43–63 years)	Low

				be involved in the process? How are the patients' experiences of physiotherapists?		
24	Potter, Gordon & Hamer 2003a Australia	Nominal Group Technique Methods: facilitated meetings, rank ordering by participants	Good and bad experiences in private practice physiotherapy	This study's aim was to explore patients' perspectives regarding the qualities of a 'good' physiotherapist and to gain insight into the characteristics of good and bad experiences in private practice physiotherapy.	Patients (condition not reported) N=26; 10M/16F Avg 48.8 years, (20-79 years)	Moderate
25	Potter, Gordon & Hamer 2003b Australia	Nominal Group Technique Methods: group meetings, rank ordering by participants	Patient and physiotherapist expectations	The purpose of this study was to ascertain both actual and perceived expectations of PTs and patients in private practice PT settings to assess the concordance	Physiotherapists and Patients (condition not reported) n=37 PTs; 17M/20F and n=26 patients; 10M/16F	Moderate

				of expectations from both parties.	PT years of experience avg 8.63 (0.25-29 years) 18/37 < 5 years experience Patients avg age 48.8 years, (20-79 years)	
26	Resnik & Jensen 2003 USA	Grounded Theory Approach Methods: Retrospective analysis of the data from the Focus On Therapeutic Outcomes Inc database and health-related quality-of-life outcomes data, resumes, written statement of philosophy on	Expert practice	The purposes of our study were to describe the characteristics of clinicians whose patients with lumbar syndromes had excellent outcomes and to build upon the prior theoretical framework of physical therapist expertise.	Physiotherapists N=6 expert, 1M/5F; n=6 average, 2M/4F Expert: experienced n=3 aged 44-59 practicing n=2 > 20 years and n=1 for 13.5 years; novice n=3 aged 31-32 years practicing < 6 years. Average: aged 28-48 years, practicing 4.5 – 19 years	High

		clinical approach, semi-guided interviews, follow-up interviews, telephone calls, letters, e-mails				
27	Rutberg, Kostenius & Öhrling 2013 Sweden	Phenomenology Methods: interviews with a narrative approach supplemented by drawing by participant	Lived experience of physiotherapy	This study aims at exploring the lived experience of physical therapy of persons with migraine.	Patients (with migraine headaches) N=11; 2M/9F 20-69 years	High

PT: Physical Therapist; MSK: musculoskeletal; LBP: low back pain ** Publications are derived from the same participant sample

post-positivist research paradigm. Of note, engagement with theory was low or moderate in 11 studies. There was scant evidence of researchers' reflexivity. On occasion, conflicts were noted between study design and stated claims of authors. For example, claims to co-construct meaning with research participants were discordant in studies with implicit positivist epistemologies (Aguilar et al., 2013; Cooper, Smith, Hancock, 2008). Threats to study coherence were noted when key features of stated research methodologies did not appear to be fully realized (e.g. grounded theory approaches that did not present a grounded theory). Other studies did not provide the depth that is often a strength of qualitative research, for instance presenting data as checklists rather than rich descriptions of participant perspectives (Aguilar et al., 2013; Gyllensten et al., 1999; Morera-Balaguer et al., 2019). Four studies did not report ethics approval (Gyllensten et al., 1999; Jensen, Shepard, Gwyer, & Hack, 1992; Kidd, Bond, & Bell, 2011; Resnick & Jensen, 2003).

2.3.2 Descriptive summary

The 27 studies included in the review were published over 27 years with the greatest number published from 2016-2019 (Figure 2.3). Studies were from Sweden (6), United States (5), Australia (4), United Kingdom (3), Spain (2), Canada (2), and one each from Egypt, New Zealand, Denmark, Finland, and Norway. The most common study designs were generic qualitative research (5), qualitative content analysis (5), and grounded theory (5) (Figure 2.4). Participants of the studies ($n = 537$) included a) patients ($n = 335$: 139 males, 196 females), with various acute and chronic musculoskeletal conditions in 16 studies; b) physiotherapists ($n = 99$: 17 males, 44 females, 38 gender not reported) in 7; and c) both patients ($n = 63$: 25 males, 38 females) and physiotherapists ($n = 40$: 19 males, 21 females) in 4. Across studies, patient and physiotherapist age ranges were 18-82 and 24-59 years respectively. Data collection was most commonly achieved using interviews (13) or in combination with focus groups (5) or questionnaires and document review (4) followed by focus groups (2), rank ordering (2), and personal vignettes (1). Table 2.2 provides participant data, study design, data collection methods, and context for each study.

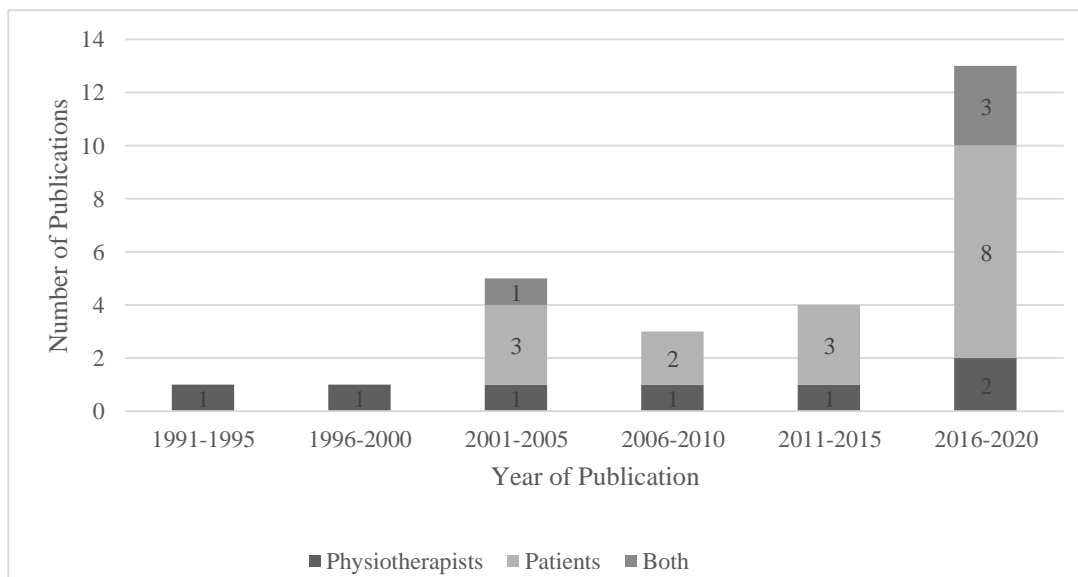


Figure 2.3 Publication Timeframes

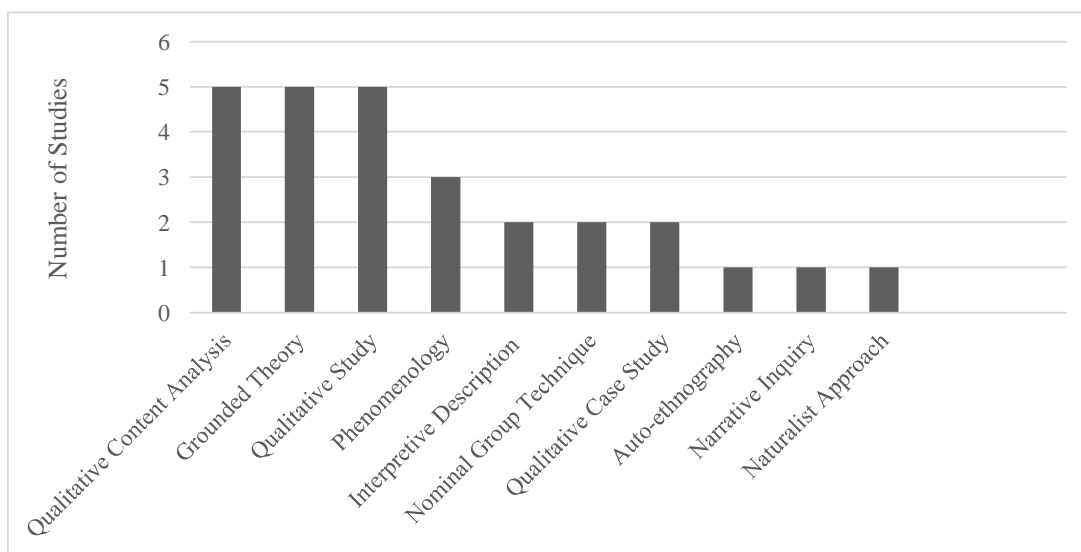


Figure 2.4 Study Design Methodology

2.3.3 Thematic analysis

Six overarching themes representing qualities of a 'good' physiotherapist were identified through the thematic analysis. While presented separately, many qualities could be

categorized under more than one theme suggesting considerable overlap and interconnection. Some qualities were less frequently represented, but robust enough to be included within resonant themes. Occasional outlier qualities were identified and not included in the results. The themes are ordered according to those discussed most frequently, however, no relative value is implied.

2.3.3.1 Theme 1: responsive

The quality of being ‘responsive’ to patients was identified in 25 of the 27 studies. Studies highlighted responsive qualities of physiotherapists such as listening to patients, showing acceptance, being attentive, taking an interest in patients, communicating verbally and non-verbally, and validating patient experiences.

A number of studies pointed to being responsive through “*Listening to what the patient tells you*” (Jensen et al. 1992, p. 716). Barradell and colleagues (2019) highlighted active listening as a way for physiotherapists to be present and better understand their patients. Listening to patients was variously depicted as a trait of master clinicians, important to their clinical reasoning (Jensen et al., 1992), and discussed by both physiotherapists (Gyllensten et al., 1999) and patients (Calner, Isaksson & Michaelson, 2017; Hills & Kitchen, 2007) as leading to better outcomes.

Other responsive qualities such as being open and accepting were identified as important by physiotherapists (Aguilar et al., 2013; Greenfield, 2006; Miciak et al., 2018) and patients (Ekerholt & Bergland, 2004; Morera-Balaguer et al., 2019; Potter et al., 2003a). In a number of studies, physiotherapists identified being open and accepting as fostering deeper connections with patients (Greenfield, 2006; Gyllensten et al., 1999; Miciak et al., 2018) with one physiotherapist describing it as a ‘way of contact’, stating “*it is important to be able to listen without any preconceived notions, about diagnosis or personality, just to listen to what the person has to say*” (Gyllensten et al., 1999, p. 99).

Other studies from the perspective of patients highlighted allowing patients to share their perspectives (Bernhardsson et al., 2017; Calner et al., 2017, 2019; Cooper et al., 2008; Miciak et al., 2018; Palenius & Nyman, 2018). A number of studies identified the

importance of a genuine interest in the person (Calner et al., 2017; Ekerholt & Bergland, 2004; Hills & Kitchen, 2007), and for patients to feel understood (Ekerholt & Bergland, 2004; Kidd et al., 2011; Potter et al., 2003a; Rutberg et al., 2013). Patients' perspectives also reflected a desire for physiotherapists to take an interest (Ekerholt & Bergland, 2004; Rutberg et al., 2013), and put patients' needs first (Potter et al., 2003a) which was associated in one study with positive outcomes (Hills & Kitchen, 2007).

The importance of being responsive through words *and* body language was highlighted by both physiotherapists (Aguilar et al., 2013; Greenfield, 2006) and patients (Crepeau, 2016; Miciak et al., 2018; Potter et al., 2003a). In the words of a patient from Morera-Balaguer and colleagues' (2019) study: *“the way that she looks at you, if she communicates the same thing with her gestures and her words, if she empathizes with you or not, if she is really listening to you or not”* (p. 7). Being responsive to patients in the context of the therapeutic relationship, Miciak et al. (2018, 2019) suggested that verbal and non-verbal communication were required to acknowledge patients as unique individuals and mitigate inherent power imbalances.

Miciak et al. (2018) also highlighted responsiveness in the therapeutic relationship as achieved through the validation of patients' physical experiences and acknowledgement of their “unique personalities, life stories, and social and cultural realities” (p. 6), while others underlined the importance of validation of patient stories and locating patients at the centre of the therapeutic relationship (Kidd et al., 2011; Rutberg et al., 2013). Miciak et al. (2018) further suggested that a physiotherapist who is responsive in this way establishes a safe, “*“bubble”* that allows full engagement” (p. 5). Similarly, Rutberg et al. (2013) described “being respected in a trustful relationship” (p. 1618) as allowing patients to feel important, believed, and free to confide in their physiotherapist.

2.3.3.2 Theme 2: ethical

Attributes related to the quality of being an ‘ethical’ physiotherapist were identified in 25 of the 27 studies. Study findings highlighted qualities such as integrity, being genuine, honest, trustworthy, respectful, practicing within professional boundaries, and maintaining confidentiality.

In a study of core professional values, physiotherapists' integrity was defined as the congruence between values and actions (McGinnis, Guenther, & Wainwright, 2016). In other studies, this congruence was identified by patients (Morera-Balaguer et al., 2019) and physiotherapists (Miciak et al., 2018) as related to perceptions of physiotherapists' genuineness.

The quality of honesty was identified in a number of studies, and linked to actions such as being transparent when disclosing scope of practice or limits of knowledge (Aguilar et al., 2013; Miciak et al., 2018; Potter et al., 2003a; Resnick & Jensen, 2003). In one study of physiotherapists, humility and honesty in acknowledging one's limitations were recognized as traits of expert clinicians (Resnick & Jensen, 2003). In another study, physiotherapists proposed it was essential to be honest with patients about their condition, the rehabilitation process, and their participation and outcome expectations (Miciak et al., 2018). The authors further noted that being committed to understanding patients and acting in their best interests represents "*physiotherapists' professional duty . . . to be of service to others*" (p. 7).

Several studies described ways in which patients' perceptions of physiotherapists as trustworthy was related to impressions of their competence. In three studies (Morera-Balaguer et al., 2019; Potter et al., 2003a; Potter et al., 2003b), patients also highlighted ethical behaviours such as maintaining confidentiality, privacy, and safety as strengthening trust in the physiotherapist and the therapeutic relationship. Confidence in physiotherapists' trustworthiness was also reported to contribute to an "*alliance of trust and safety*" (Calner, 2019, p. 4), and to improve patient engagement, trust in physiotherapist decisions, and expectation of positive treatment results (Bernhardsson et al., 2017).

Several studies also highlighted patients' desire to be *respected* as individuals (Calner et al., 2019; Kidd et al., 2011; Potter et al., 2003a) and as equals (Del Baño-Aledo et al., 2014; Palenius & Nyman, 2018); whereas physiotherapist perspectives more often referred to respecting boundaries, privacy, and confidentiality in relation to being ethical (Aguilar et al., 2013, Gyllensten, et al., 1999). Aguilar et al.'s (2013) study of

physiotherapists identified the importance of developing trust through respectful behaviour such as maintaining professional boundaries, including being sensitive when ‘hands-on’ with patients. Both patients (Rutberg et al., 2013) and physiotherapists (Miciak et al., 2019) indicated that clinicians who projected confidence through touch fostered trust.

2.3.3.3 Theme 3: communicative

Being ‘communicative’ was identified in 24 of the 27 studies. Studies underscored the importance of physiotherapists’ communicative qualities, for instance, capabilities for clear communication when providing education or explanations to patients; communicating in ways that were empowering, inspire confidence, and showed confidence in patients; and communicating with team members, and advocating for patients.

In five studies, physiotherapists emphasized the importance of communication in the context of patient education (Aguilar et al., 2013; Barradell et al., 2019; Gyllensten et al., 1999; Jensen et al., 1992; Resnick & Jensen, 2003). In a study by Jensen et al. (1992), master clinicians identified communication as one of their most important skills, while Resnick & Jensen (2003) identified it as central to expert practice. Patient participants also emphasized communication. Studies variously highlighted patients’ desire for explanations of their assessments (Ali & May, 2017; Bernhardsson et al., 2017; Cooper et al., 2008; Hills & Kitchen, 2007), diagnoses, prognoses, treatments (Del Baño-Aledo et al., 2014; Hills & Kitchen, 2007; May, 2001) and *what* clinicians were doing and *why* (Potter et al., 2003a).

Hills and Kitchen (2007) described failure to communicate the purpose of a patient visit as associated with ‘ambivalent’ physiotherapy outcomes, while positive outcomes were associated with explanations about the problem and treatment effectiveness that were theorized to increase patient confidence. Being ‘communicative’, through dialogue with patients was highlighted in several studies (Bernhardsson et al., 2017; Bernhardsson et al., 2019; Calner et al., 2017; Cooper et al., 2008; Kidd et al., 2011; Lindahl et al., 2016; Miciak et al., 2018; Potter et al., 2003a). Patients also expressed expectations of clear

explanations (Kidd et al., 2011; Miciak et al., 2018, 2019; Potter et al., 2003a), and answers tailored to an appropriate level to foster understanding (Cooper et al., 2008; Lindahl et al., 2016). One patient explained “*a good understanding in layman’s terms*” is important for “*a clear understanding of what exactly is happening...what needs to be done, and how to get back on track*” (Cooper et al., 2008, p. 246).

In Resnick and Jensen’s (2003) study, physiotherapists identified expert clinicians as those who facilitate patient empowerment. Communication strategies identified by patients as empowering included the communication of explanations, treatment options, and a rationale for self-management (Ali & May, 2017; Bernhardsson et al., 2019; May, 2001). Bernhardsson et al. (2017) linked empowering communication to greater patient self-efficacy. In six studies, patients emphasized their desire for communication about self-management strategies. ‘Communicative’ capabilities were theorized to inspire and motivate patients (Aguilar et al., 2013; Potter, et al., 2003b), and to build therapeutic rapport (Miciak et al., 2019). Miciak et al. (2019) reported that clarification of the physical problem, and explanations of solutions tailored to individual patients, creates a connection that “*inspires confidence*” (p. 9), and builds confidence in clinician expertise. In the same study, physiotherapists communicated confidence in the patient by “conveying a belief in the patient’s ability to improve or recover” and in the patient’s role as “an integral part of that process” (p. 7). Kidd and colleagues (2011) indicated that physiotherapists’ confidence in their knowledge-base and the recovery potential of patients is important to communicate, and tied to patient confidence, motivation, and progress in treatment.

Studies identified communication with team members as essential to stay informed and to advocate for patients (Hills & Kitchen, 2007; Potter et al., 2003a, 2003b). Miciak et al. (2019) suggested failure to communicate with other professionals can negatively impact the patient relationship and compromise care, as reflected in one patient’s distress that ““*there wasn’t any communication with the surgeon*” regarding her lack of progress.” (p. 9).

2.3.3.4 Theme 4: caring

The physiotherapist quality of ‘caring’ was highlighted in 23 of the 27 studies. Physiotherapists were identified as being caring by being empathic, compassionate, understanding, reassuring, supportive, encouraging, friendly, and warm.

Resnick and Jensen (2003) described caring as a “fundamental ethic” common to both average and expert clinicians. Values of compassion and caring, identified in another study as the reason physiotherapists entered the profession, were said to be further shaped by practice experiences (McGinnis et al., 2016). Greenfield (2006) described caring as a deep engrossment and “the moral orientation” of physiotherapists who showed “that connection to others was central to what it means to be human” (p. 180). In this study, the meaning of caring was found to expand with clinical experience and to include greater attention to listening to patients and analysis of their overall situation. For instance, experienced practitioners were described as treating patients “*based on what’s unique about that person*” (p. 184) while junior practitioners were more likely to “*look at protocol[s] and think this is how I would treat the patient.*” (p. 183). A caring, therapeutic relationship was noted as giving meaning to clinical practice and as important for clinical and ethical decision making (Greenfield, 2006).

Related to the patient experience of caring, May (2001) reported patients emphasized the importance of physiotherapists’ manner to be friendly and empathic; described as “listening to the patients’ concerns and being understanding of their situation” (p. 13). In another study, patients also ranked physiotherapists’ manner as important (Potter et al., 2003a). The ‘caring’ manner of ‘good’ physiotherapists was characterized as empathic, friendly, supportive, and non-judgemental. One participant discussed: “*The care and concern of my physiotherapist who showed me empathy*” (p. 198) as important to a good experience. Similarly, a patient in another study stated “*...she is really good...she cares about me and makes me feel that I’m not only one in a crowd*” (Rutberg et al., 2013, p. 1618).

In a study of ‘good physiotherapy’, a patient participant stated that what matters is: “*a certain amount of empathy, an understanding of the pain, and a feeling that I matter and*

that I'm a real person" (Kidd et al., 2011, p. 159). In another study, patients indicated that care exhibited by getting "to know the therapist as an empathetic person" (Ekerholt & Bergland, 2004, p. 32) was important when establishing the therapeutic relationship. Miciak et al. (2019) proposed that a moral orientation to care bolstered the patient-centred relationship when physiotherapists "give-of-self", "empathize" and "understand" (p. 8).

One study depicted therapists' willingness to listen to patient concerns as emotionally supportive and suggested a link between encouragement, reassurance, and support (Del Baño-Aledo et al., 2014). Being caring by relating in this way was highlighted in two studies by patients who discussed the importance of receiving reassurance about their pain and the healing process (Kidd et al., 2011; Miciak et al., 2019). In Ekerholt & Bergland's (2004) study, caring was eloquently summarized by one patient:

What I remember the most was the feeling of being taken care of...She radiated calmness, warmth, attention; she was relaxed and had time for me. She seemed genuinely interested in me, it seemed as if she really wanted to get to know me as a person. I cried after the first session. I so strongly felt "this is my hope". It was a very intense experience, that someone really understood (p. 406).

2.3.3.5 Theme 5: competent

Being 'competent' as a physiotherapist was discussed in 22 of the 27 studies. Studies highlighted being competent through being knowledgeable, experienced, reflective, curious, confident, and possessing clinical reasoning and practical skills to achieve good outcomes.

A sample of Australian physiotherapists identified mastering and updating knowledge and skills as a core professional value (Aguilar et al., 2013). Resnick and Jensen (2003) highlighted physiotherapists' perceptions of 'expert' practice as entailing characteristics such as being inquisitive and reflective. In their study, physiotherapists with a high percentage of positive outcomes were found to possess a multi-dimensional knowledge base, clinical reasoning skills, and capabilities for learning through reflection.

Development of expertise through reflection by “*learning something from each patient and using your own failures and successes in your own development*” (p. 101) was proposed in another study to deepen understanding and aid in achieving positive outcomes (Gyllensten et al., 1999). An earlier study of master clinicians theorized that years of clinical experience created a reservoir of knowledge which constituted a framework for clinical reasoning and capabilities to predict patient outcomes (Jensen et al., 1992).

In a study of patient-centred physiotherapy, patients considered knowledge and expertise as “essential elements of good physiotherapy” (Kidd et al., 2011, p158). Patients in another study indicated they trusted physiotherapists’ competence reasoning that their knowledge was “underpinned by science” (Bernhardsson et al., 2019, p. 111). Rutberg and colleagues (2013), drawing on patient perspectives, noted that even if the therapist had credentials and theoretical knowledge, patients recognized whether a physiotherapist “knew what he or she was doing” because “a skilled physical therapist’s touch felt professional and mediated a feeling of knowledge and security.” (p. 1617).

Practical experience, reported in various studies, included patient expectations of: thorough assessments (Bernhardsson et al., 2017, Bernhardsson et al., 2019; Ekerholt & Bergland, 2004; Lindahl et al., 2016; Palenius & Nyman, 2018), expertise in diagnosis (Potter et al., 2003a), and ‘hands on’ treatment skills (Lindahl et al., 2016; Potter et al., 2003a, 2003b). A thorough assessment was identified in two studies, as enabling the individualization of treatment to meet patient needs (Cooper et al., 2008; Hills & Kitchen, 2007). Cooper et al. (2008) noted that if physiotherapists were observed to be thorough, they were “rarely blamed for poor treatment outcome” (p. 249).

In two studies, patients were reported to perceive physiotherapists as competent when they demonstrated confidence when gathering and interpreting clinical findings (Ali & May, 2017; Potter et al., 2003b). A third study reported therapist self-confidence increased patient confidence in the physiotherapist and therapy (Kidd et al., 2011). May (2001) found physiotherapist competence demonstrated through knowledge, a thorough

approach, and expertise in manual skills created confidence and was linked to good patient outcomes.

2.3.3.6 Theme 6: collaborative

The quality of being ‘collaborative’ was discussed in 17 of the 27 studies.

Physiotherapists were identified as being ‘collaborative’ by involving patients in decision making, through dialogue, and a willingness to adjust the treatment to patients’ individual needs. In two studies of patient perspectives, it was proposed that individualizing physiotherapy, by accommodating patient preferences and adjusting treatment based on their feedback, facilitated patient engagement in rehabilitation (Bernhardsson et al., 2019; Cooper et al., 2008). Miciak et al. (2019) characterized physiotherapists as collaborative when individualizing treatment and adapting their approach “from patient to patient, from session to session, and from moment to moment” (p. 7).

Physiotherapists, in a study of core professional values (Aguilar et al., 2013), emphasized the importance of inviting “patients to have a voice” (p. 31) in working collaboratively in equal partnership. Furthermore, understanding patients’ perceptions of their condition, interests, goals, and values was emphasized as important for treatment that aligned with the needs of patients. In Resnick & Jensen’s (2003) study of ‘expert’ practice, physiotherapists who achieved good outcomes were reported to individualize and adapt the examination and intervention by “[putting] their patients first...to address the needs and concerns of each patient” (p. 1101). In their study, ‘expert’ physiotherapists reported the facilitation of patient empowerment, self-efficacy and the resolution of everyday challenges through collaborative problem solving.

Several studies from the patient perspective highlighted the importance of dialogue and involving patients in decision-making. Patients of one study, believing their views were valuable, expressed two-way communication as essential for opportunities to voice perspectives and contribute to treatment decisions (Bernhardsson et al., 2019). In three studies, patients stated expectations to receive adequate explanations and be involved in decision-making (Bernhardsson et al., 2017; Cooper et al., 2008; Rutberg et al., 2013). In

a study by May (2001), patients articulated a desire to be involved in treatment decisions “as a consultative, rather than a prescriptive, process” (p. 14).

A number of studies into patients’ perspectives of patient-centred care identified involving patients in decisions, and individualizing examination and treatment to meet patients’ needs as important (Bernhardsson et al., 2017; Cooper et al., 2008; Kidd, Bond, & Bell, 2011; Rutberg et al., 2013). In contrast, there was limited discussion about collaboratively involving patients in decisions from the perspectives of physiotherapists (Aguilar et al., 2013). Miciak et al. (2019) suggested: “By collaborating and engaging the patient as “. . . a person who is on equal footing” physiotherapists instill a sense of “working together” to achieve goals and demonstrate that they value the patient’s thoughts and perceptions” (p. 6).

2.4 Discussion

Overall, the qualities of a ‘good’ physiotherapist appear to be underpinned by an emphasis on the quality of the human interaction between physiotherapists and patients. These findings point to a central dimension of a ‘good’ physiotherapist as a practitioner who intertwines technical competence with a relational way of being (ie. responsive, ethical, communicative, caring, and collaborative). These results offer preliminary findings that could be used to ground further theoretical and empirical investigations into conceptions of a ‘good’ physiotherapist. The emphasis on balancing relational and technical qualities aligns with aforementioned conceptions of a ‘good’ nurse, doctor, and occupational therapist (Hurwitz & Vass, 2002; Smith & Godfrey, 2002; Wright-St Clair, 2001); the findings promote the value of reasoning and acting in ways that contribute to human flourishing, and support a greater focus in education and practice on pronesis and the conditions that enable it. By integrating perspectives, this review supports other research that suggests patient views and priorities may differ from those of health professionals (Jung et al., 1997; Peersman et al., 2013) and that both perspectives should be recognized as relevant. While many perspectives aligned, the findings highlighted some differences in emphasis, and some disjuncture in perspectives.

Patient perspectives emphasized being recognized as individuals and equals as important and underscored a desire to be respected as equals in the way physiotherapists communicated. Physiotherapists emphasized 'patient education' as an important aspect of communication, which may suggest a relationship in which the therapist is positioned as the expert. Such an orientation may also suggest a tacit, power imbalance mediated by talking *to* rather than *with* patients. Practitioner-oriented communication has been reported to dominate physiotherapy practice (Hiller et al., 2015). In contrast, a systematic review of patient-centred communication found that strategies such as listening to what patients say, discussing options by encouraging questions, answering clearly, and being sensitive to patients' emotions were correlated with a positive therapeutic alliance and facilitation of patient involvement (Pinto et al., 2012). Furthermore, systematic reviews of patient satisfaction highlight the importance of practitioner communication of explanations of diagnosis and self-management strategies (Hush et al., 2011) and endorse clinician training in communication approaches that share information and value patient autonomy (Oliveira et al., 2012).

Being collaborative implies physiotherapists and their patients work together as partners to negotiate care (Trede & Higgs, 2003) within the very real constraints of practice (Durocher et al., 2016). In this review, the patient perspective emphasized two-way communication as an opportunity to contribute to physiotherapy decisions (Bernhardsson et al., 2017, 2019). While being collaborative was acknowledged (Aguilar et al., 2013) and discussed by physiotherapists as important to build rapport (Barradell et al., 2019) and foster empowerment (Resnick & Jensen, 2003), engaging patients in decision-making was not commonly discussed. While a review of patient needs highlighted patients' expressed desire for shared decision-making (Chou et al., 2018), involving patients in decisions has been reported as poorly implemented (Baker et al., 2001; Dierckx et al., 2013) prompting an appeal for greater patient involvement in decisions with their physiotherapists (Hoffmann et al., 2019). In a narrative synthesis of patient participation, Schoeb and Bürge (2012) reported patients wanted clear explanations, attentive listening, and to be taken seriously rather than being directed towards treatment options. In contrast to a paternalistic approach, sharing power with a humanistic approach has been reported to foster patients' voice, allow their contributions to treatment, and result in a greater

sense of control (Trede & Higgs, 2003) and empowerment (Melander Wikman & Fältholm, 2006). Across several studies of the current review, positive outcomes were linked to the following qualities: collaborating with patients by listening (Calner, Isaksson & Michaelson, 2017; Gyllensten et al., 1999; Hills & Kitchen, 2007), explaining their problem (Hills & Kitchen, 2007), taking an interest to put their needs first (Hills & Kitchen, 2007), and individualizing examination and intervention (Resnick & Jensen, 2003). While a stronger therapeutic alliance is associated with improved outcomes (Ferreira et al., 2013; Hall et al., 2010), research is needed to further explore the relative importance of these aspects.

Physiotherapist and patient perspectives on being ethical as a ‘good’ physiotherapist included agreement on the importance of safety, confidentiality, and privacy. While physiotherapist perspectives framed these aspects of being ethical within the discourse of maintaining professional boundaries, patients highlighted more personal dimensions, such as trust and being respected as individuals and equals. This suggests a desire for sharing of power. Engaging in dialogue as equal partners, and identifying needs *with* patients rather than positioning physiotherapists as distant ‘experts’, may be considered as part of beneficence, and as respectful of patients as “moral discussion partners” (Praestegaard and Gard, 2013, p. 107). Greenfield (2010), Romanello and Knight-Abowitz, (2000) caution that when caring is framed as a responsibility in a professional code of ethics, care becomes rules-based which limits physiotherapists to a contractual obligation rather than an ethical relationship. These authors endorse an ethic of care based on Noddings’ (1984) exploration of caring as a moral orientation to decision-making based on receptivity, engrossment, and reciprocity in relationship. In support of a relational ethic of care, Romanello and Knight-Abowitz (2000) call for physiotherapists to relate with their patients as ‘subjects’ rather than ‘objects’.

Rather than seeking the position of privileged ‘expert’, the intersubjective nature of therapeutic interactions (Kinsella, 2005), such as being responsive when attending to and validating patients’ experiences, appears to be important to a ‘good’ physiotherapist. A related review emphasized active listening as one of the most important aspects of patient-physiotherapist interactions (O’Keeffe et al., 2016). From patients’ perspectives,

being responsive by listening and showing genuine interest, and tailoring the physiotherapy approach, frequently emerged as important. These dimensions were not as commonly expressed in physiotherapists' perspectives, suggesting a potential lack of full integration of person-centred approaches. As a 'good' physiotherapist, being responsive by actively engaging with, listening to, and taking an interest in the person may be perceived as recognition of a person's *humanity*. Being responsive, rather than simply receptive, conveys something more than observing from a distance and receiving information for the purpose of classifying the 'other' as 'object' into diagnostic categories (Maric & Nicholls, 2019). The routine use of protocols, underpinned by technical rationality, fails to consider the complexities of physiotherapist-patient interactions, patient values, and practitioners' practical wisdom (Sellman, 2012). Acknowledging the intersubjective nature of practice creates reflective and dialogic possibilities towards shared understanding. Through reflexivity, a 'good' physiotherapist oriented towards *phronesis* may make judgments honouring their own experience and expertise while being responsive to the perspectives of 'others' (Kinsella, 2012). Recognition of the personal, social, and subjective nature of illness and injury, goes beyond physiotherapy's historical emphasis on body-as-machine, offering the opportunity to counterbalance what some have described as hegemonic perspectives in the profession (Nicholls & Holmes, 2012).

Although competence focused toward "cure" has been reported as a primary expectation of physiotherapy practice (Peersman et al., 2013), an "intimate link between competence and caring" (p. 1632) was found in Gillespie et al.'s (2017) review of patients' experience of caring. This link was also highlighted in a study of physiotherapy students, where the taken for granted importance of curing intersected with caring and was proposed to support "patients' perceptions of what makes a good physiotherapist" (Dahl-Michelsen, 2015, p. 14). The findings challenged the notion that physiotherapy is primarily a curing profession and supported an appeal for physiotherapists to "use their skills for care, not just for cure" (Nicholls & Holmes, 2012, p. 462). An appeal to abandon dualistic discourses of curing diseases and caring for patients was made by Saraga and colleagues (2019b). In their phenomenological study, practitioners who take an interest in patients as people "*beyond the scientific*" (p. 7) were described as acknowledging patients'

humanity. They contend that practice is a “unitary lived experience” (p. 48) in response to the demands of a specific situation with a particular patient (Saraga et al., 2019a). When reassured they were recognized as human beings rather than as objects, patients were reported to sense they were cared about and the practitioner was committed to doing their best to cure them (Saraga et al., 2019b). *Caring for* a patient with the aim to cure and *caring about* a patient as a person (Branch, 2000; Greenfield et al., 2008; Ramklass, 2015) describes technical competence balanced with a human approach. The findings of this review support what Ramklass’ (2015) has referred to as a “fusion of the professional and personal self in a genuine expression of care” (p. 129) as central to a ‘good’ physiotherapist.

The findings call for reflexivity on the qualities that physiotherapists bring to interactions with patients on an individual level, at the level of the profession, and in consideration of how we educate and prepare future practitioners. As students socialized into the profession, it has been theorized there are two complementary elements that contribute to professional identity: technical and patient-centred (Hammond, Cross & Moore, 2016; Parry 1997). Yet, prior authors have argued that the biomedical model, underpinned by a taken-for-granted technical or positivist paradigm, dominates physiotherapy curricula, resulting in prioritisation of technical domains of objectivity, measurement, and skill development (Nicholls & Gibson, 2010; Setchell et al., 2018). Some scholars have argued that physiotherapists are not prepared during their education to meaningfully engage with interpersonal, social, or cultural aspects of the person (Nicholls, 2018; Nicholls & Gibson, 2010). The affinity to the biomedical model may stifle the development of those very qualities intrinsic to professional identity that may be most important to patient-centred approaches, good care, and the future practice of physiotherapy as both a science *and* a caring profession. These insights call for a fundamental ontological shift in how the profession thinks about itself, and for consideration about how the design of preparatory education shapes the professional identity of physiotherapists.

In physiotherapy literature, qualities have been divided into interpersonal and professional skills (Reeve & May, 2009), human and professional competence (Rossetini, Latini, et al., 2018), social characteristics, knowledge, and skills (Wijma et

al., 2017), and interpersonal, communication, and practical skills (O’Keeffe et al., 2016). The current review’s findings point to a need to overcome dichotomous thinking, and to reconceptualize assumed dualities as being intertwined; for instance, cure *and* care, professional *and* personal, competence *and* relationality, evidence *and* practical wisdom. Asking not only *why we do what we do* in the technical aspects of professional practice, but also asking *who we are* and what it means to *be with* our patients, helps to identify areas of practice that might be otherwise (Kayes & McPherson, 2012). While these reflections prompt physiotherapists to improve their practice by attending to a broader repertoire of considerations in what constitutes a ‘good’ physiotherapist, it also invites reflection on how biomedical perspectives may have privileged the development of technical over other dimensions of good practice (Nicholls & Gibson, 2010).

The findings also raise a note of caution as it would be naïve not to acknowledge the complex interplay between funding, models of service delivery, and policy mandates. It is critical to recognize how these shape, and potentially distort, physiotherapy practice. Health care practitioners are at times constrained in their capabilities to enact the ideals of a ‘good’ physiotherapist by the very systems in which they work (Durocher et al., 2016). This leaves the individual musculoskeletal physiotherapist vulnerable to being held to account for an ethos of care that systems of health care may unwittingly fail to support. While health care trends point to greater emphasis on person-centred approaches and neoliberal notions of who is responsible for health care (i.e. more responsibility given to patients as governments withdraw funding) (Nicholls, 2018), we anticipate the concept of a ‘good’ physiotherapist will change to adapt to these trends. It is crucial that we consider the qualities of a ‘good’ physiotherapist not only at the individual level but in relation to how the systems of health care enable or create barriers to their enactment.

Principally, the qualities of a ‘good’ physiotherapist identified in this review underscore the high importance of the *human encounter* between a physiotherapist and their patient, in addition to the essential focus on technical competence. As practitioners, this implies that we consider how we communicate with our patients, respond to their stories, interact in ethical ways, care about and for them, and collaborate as partners in the work of physiotherapy. As a profession, this signifies a call to examine the systems in which

physiotherapists work, and how policies and entrenched practices shape what is possible for individual physiotherapists. In addition, the findings prompt reflection on how we educate and shape the professional identity of the next generation. Acknowledging these considerations, our profession is called to *explicitly* recognize the importance of the human encounter in professional practice. This implies the creation of pre- and post-licensure courses focused on advancing aspects of physiotherapy *beyond biomedical* domains. Furthermore, limited research, warrants greater attention by our profession on the qualities identified in the review and more broadly, to what it is to be a ‘good’ physiotherapist, and how systems may enable or constrain physiotherapists and the profession in realizing a more holistic vision.

2.4.1 Strengths and limitations

Given there were half as many studies from the physiotherapist as the patient perspective, any collective difference in perspective must be interpreted with caution. Further, the exclusion of grey literature and studies not published in English must be considered. A key strength of this study was the implementation of a rigorous and systematic methodological approach. A comprehensive search strategy was created in consultation with a research librarian. However, because the phenomenon of the ‘good’ physiotherapist has not been well defined and is not limited to a specific context, it was necessary to include and synthesize a number of interrelated constructs including patient satisfaction, preferences, patient-centred care, and therapeutic relationship. A diverse range of qualities were found across all included constructs. While the findings appear to be resonant with areas of physiotherapy practice more broadly, it is important to note that retrieved studies were from the context of musculoskeletal practice and should be interpreted with this in mind. The failure to consider age and gender may be a limitation of the included studies that demands greater attention in future research. A strength of this review is the quality appraisal which enriched familiarization of the study designs. Data analysis was conducted in a rigorous, iterative manner in consultation with research team members. Transparency was maintained with an audit trail of decision-making during the research.

2.5 Conclusion

The qualities of a ‘good’ physiotherapist identified in this review, and supported by the wider literature, include being responsive, ethical, communicative, caring, competent, and collaborative. The overarching conclusion is that a ‘good’ physiotherapist balances technical competence with a human way of being when interacting with patients.

Advancing knowledge about the qualities of a ‘good’ physiotherapist contributes meaningful dialogue on professional priorities that can guide the education of future physiotherapists and inform current musculoskeletal practice. As a challenge to the physiotherapy profession’s biomedical model and body-as-machine approach to education and practice, the findings of the study suggest that to be a ‘good’ physiotherapist is: to be technically competent, but also to be practically wise; to hold an ethical orientation to practice; to be caring and responsive to the person who faces us; to be more fully engaged with patients through genuine relationships; to communicate and collaborate with patients on decisions related to physiotherapy interventions and goals; and to enhance interactions with patients with the potential to improve patient satisfaction and participation, and optimize physiotherapy outcomes.

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Chapter 3

3 “Passion to do the right thing”: Searching for the ‘good’ in physiotherapist practice

Background: Practitioners’ perspectives of what constitutes a ‘good’ physiotherapist have not been explicitly examined despite their potential implications for the future practice of physiotherapy. Physiotherapists’ perceptions may inform professional priorities including education curricula, professional practices, competency profiles, and patient interactions. **Purpose:** The purpose of this research was to examine physiotherapists’ perceptions of what constitutes a ‘good’ physiotherapist in the context of musculoskeletal practice (MSK). **Methods:** A hermeneutic phenomenological investigation was undertaken. Semi-structured interviews were conducted with twelve experienced MSK physiotherapists to examine their perceptions of what constitutes a ‘good’ physiotherapist. **Findings:** Seven themes were identified. Two broad themes highlighted an ethical orientation to care and the integration of person-centered care with evidence-based practice. These were underpinned by more specific themes of ‘being’ competent, responsive, reflective, communicative, and ‘using’ reasoning. **Conclusions:** This study contributes knowledge about an ethic of care as an important dimension of a ‘good’ physiotherapist. It highlights practices that may underpin an ethic of care including the pivotal role of person-centered and relational dimensions of practice. The findings call into question the profession’s emphasis on a technical rationalist approach to education and clinical practice and invites conversation about future directions that balance technical competence with relational dimensions of practice.

3.1 Introduction

As members of a professional culture, health care practitioners recognize the ‘good’ practice of an idealized practitioner who possesses characteristics, attitudes, behaviours, and practices that lead to ‘good’ outcomes (Benner, 1997; Pellegrino, 1995). The concept of the ‘good’ is character-based and purpose-driven from a virtue ethics perspective. Virtue ethics, grounded in Platonic-Aristotelian philosophy, focuses on the agent, as one

who uses practical wisdom to make moral judgments and chooses means to do what is right (Gadamer, 1986; Pellegrino, 1995). For Aristotle, a wise person's characteristics orient them to reason and act in ways that contribute to human flourishing, promote human good, and toward doing the right thing (Jenkins et al., 2019; Kinsella & Pitman, 2012; Pellegrino, 1995; Sellman, 2012). Aristotle's *phronesis* or practical wisdom, considered central to choosing virtuous actions, is proposed as essential to good professional practice (Kinsella & Pitman, 2012).

In the field of nursing, two studies investigating what it means to be a 'good' nurse drew on a virtue ethics perspective to identify practitioner characteristics, knowledge, technical skills, critical thinking, caring and caring behaviours as important factors in doing the right thing (Catlett & Lovan, 2011; Smith & Godfrey, 2002). Nursing scholar Benner (1997) has discussed 'care ethics' as having commonalities with virtue ethics, with care as the ends of a good practitioner's actions. Benner has proposed a distinction between care ethics and virtue ethics, with care ethics focusing to a greater extent on practitioner-patient relationships and emotion as a guide to moral action. Similarly, Wright-St Clair (2001) posits an ethic of care as the moral motivation for good occupational therapy practice. Amidst debates on what makes a 'good' doctor (Hurwitz & Vass, 2002; O'Donnabhain & Friedman, 2018), medicine is rethinking views of ethics based on normative principles (Martinsen, 2011; Schuchter & Heller, 2018) through conversations about character-based, context specific, and relational views of ethics such as those posited by virtue and care ethics.

The concept of the 'good physiotherapist', first studied by Potter, Gordon, and Hamer (2003), was developed based on an examination of patient perspectives on good and bad experiences in physiotherapy practice. When describing good experiences, they found patients highlighted physiotherapists' communication capabilities and the treatment they provided. Two further studies from the patient perspective have examined a similar concept. In the context of patient-centered therapy, Kidd and colleagues (2011) identified attributes such as knowledge, expertise, listening skills, reassurance, and empathy as characteristic of a 'good' physiotherapist. Rutberg and colleagues (2013) drawing on perspectives of patients with migraine headaches, suggested "there are no stereotypes for

‘the good/bad physical therapist’; [but] rather the experience of receiving ‘good/bad physical therapy’”(p. 1616); they argued that the concept of a ‘good’ physiotherapist had yet to be described.

Provisional conceptualizations of a ‘good’ physiotherapist from practitioners’ perspectives have primarily aligned with virtue ethics by focusing on core professional values, physiotherapist characteristics, and ‘the ends’ of their actions. The American (*Core Values for the Physical Therapist and Physical Therapist Assistant*, 2019; McGinnis et al., 2016) and Canadian (Boyczuk et al., 2019; Miller et al., 2020) professional associations articulated the same core values including accountability, altruism, compassion, excellence, and integrity; Americans also included professional duty and social responsibility, while Canadians included advocacy, client-centeredness, equity, and respect. Scholars have examined the attributes of master (Jensen et al., 1992), experienced (Jensen et al., 1990), and expert clinicians (Jensen et al., 2000; Resnick & Jensen, 2003). Resnick and Jensen (2003) recruited physiotherapists identified as ‘expert’ based on patient-reported outcomes. These studies culminated in Jensen and colleagues’ (Jensen et al., 2000; Resnick & Jensen, 2003) theory of expert practice as a patient-centered approach supported by an interplay of clinical reasoning, virtues/values, therapist knowledge, and practice style. Notably, ‘patient-centered care’ is an important dimension of a virtuous or ‘good’ practitioner in both patients’ perspectives of ‘good’ physiotherapy practice and physiotherapists’ perspectives of ‘expert’ practice. The significance of each dimension and limited research on the concept of a ‘good’ physiotherapist warrant further investigation.

As the first step to advance knowledge on the qualities of a ‘good’ musculoskeletal physiotherapist, an integrative review of 27 studies that included physiotherapist (7 studies), patient (16), and both (4) perspectives was undertaken by our team to bring patient and physiotherapist perspectives into dialogue (Kleiner et al., 2021). The findings emphasized a ‘good’ physiotherapist as a practitioner who intertwines technical competence with a relational way of being (responsive, ethical, communicative, caring, and collaborative). As a complement to the profession’s biomedical approaches, the review underscored the importance of the *human encounter* between a physiotherapist

and patient. This conclusion and the limited research, especially from the perspective of physiotherapists, inspired the current phenomenological investigation of a ‘good’ physiotherapist in the context of everyday practice.

The purpose of this empirical research was to understand what constitutes a ‘good’ physiotherapist by examining physiotherapists’ perceptions in the context of musculoskeletal practice. Musculoskeletal physiotherapy was proposed as a rich context for the study, given it comprises a large segment of Canadian physiotherapy practice (Canadian Institute for Health Information, 2016). Further, reviews of musculoskeletal practice, primarily from patients’ perspectives, consistently include physiotherapists’ attributes as important elements of patients’ perceived needs of their health care providers, satisfaction and expectations of physiotherapy, and patient-physiotherapist interactions (Chou et al., 2018; Hopayian & Notley, 2014; Hush et al., 2011; O’Keeffe et al., 2016; Rossetini et al., 2018). How physiotherapists perceive what constitutes a ‘good’ physiotherapist has potential implications for the future practice of physiotherapy. Improved understanding of the “balance between technical competence and humanness” (Kayes & McPherson, 2012, p. 1909), proposed as foundational to good physiotherapy practice, has potential to inform professional priorities including education curricula, professional practices, competency profiles, and patient interactions.

3.2 Methods

The theoretical framework of the study was informed by critical bioethics, particularly drawing on Joan Tronto’s (1993) ethic of care theory. Ethics of care share some premises with Aristotelian virtue ethics, particularly the notion that a virtuous person chooses right actions to achieve good ends; ethics of care theories however, highlight care and relationship as the context and source of moral responsibility (Held, 2006; Tronto, 1993). Human flourishing is theorized to depend on right actions constituted in the caring connections and interdependence inherent in relationships including practitioner-patient relationships (Benner, 1997; Held, 2006; Tronto, 1993).

Hermeneutic phenomenology elicits interpretations through lived experience of phenomena to gain a deeper understanding of what it means to ‘be-in-the-world’ (van

Manen, 2014, 2016). van Manen's (2014) 'phenomenology of practice' informed the examination of physiotherapists' first-hand accounts. This approach allowed us to explore what constitutes a 'good' physiotherapist and why they do what they do (Dowling, 2007; Park Lala & Kinsella, 2011), and to study physiotherapists' practice as it is lived, the way they or their colleagues act, interact with others, or are otherwise involved in the world. Underpinned by the notion that "human life is characterized by practical interaction with others and the world" (Shaw & Connelly, 2012, p. 405), a phenomenological approach was well-suited to investigate physiotherapists' perceptions. Eliciting practice-based, taken-for-granted experiences (Hasselkus, 2006) offered an avenue to study perceptions of how a 'good' physiotherapist enacts practical knowledge and ways of being with patients.

3.2.1 Research team and reflexivity

The research team included three physiotherapy and two occupational therapy scholars. The primary author is a doctoral candidate and practitioner scholar with 30 years of practice experience. Two team members are physiotherapy professors with expertise in MSK practice, patient-centered care, measurement science, and critical social science. Two team members are occupational therapy and health professions education professors who bring expertise in practice theories, ethical theory, critical social science, and qualitative methodologies. The team viewed phenomenology as a critical methodology given its potential for critical questioning and 'reinterpretation' of what is taken-for-granted (Crotty, 1998; Weiss et al., 2019). The team recognize that researchers' pre-understandings shape interpretations of the data (Finlay, 2002).

3.2.2 Participants

Purposive sampling was used to identify participants. English-speaking, musculoskeletal physiotherapists licenced to practice in Canada with seven or more years of clinical experience with at least one year of experience in musculoskeletal practice and working directly with patients at least 50% of the time were eligible to participate. Based on prior research, it was theorized that a sample of experienced physiotherapists would offer rich perspectives to advance understanding of the phenomenon of a 'good' physiotherapist

(Brosky & Scott, 2007; Di Tondo et al., 2018; Jensen et al., 1990, 1992, 2000; Kleiner et al., 2021; Resnick & Jensen, 2003).

Following ethics approval from the Health Sciences Research Ethics Board at Western University, participants were recruited through Canadian and Ontario Physiotherapy Associations' email newsletters. Recruitment of eligible participants continued until experientially rich data demonstrated resonant examples of the concept of a 'good' physiotherapist. This resonance across the data set is characterized by what van Manen (2016) describes as 'the phenomenological nod' whereby the reader may recognize the experience as one they had or could have had.

Twelve musculoskeletal physiotherapists (6 females, 6 males) ranging in age from 32 to 71 years (average age: 46 years) from Ontario (n = 7), Alberta (n = 4), and British Columbia (n = 1) consented to participate. Two physiotherapists also had an interest in pelvic health and a third also practiced as a sport physiotherapist. Eleven worked in the private sector; nine practiced in community clinics, one in patients' homes, and one in both settings. The twelfth participant practiced in a hospital outpatient department.

3.2.3 Data collection methods

Eligible participants completed a preparatory reflective writing exercise (Ajjawi & Higgs, 2007) two weeks prior to an in-depth, semi-structured interview (with MK). The reflective exercise (Appendix F) aimed to: 1) establish the physiotherapists' understanding of the research phenomenon to enhance their ability to articulate their experiences; 2) increase participants' reflections on and awareness of the phenomenon of being a 'good' physiotherapist in everyday clinical practice; and 3) identify areas for probing in the interview. The reflective exercise was administered online using the Qualtrics platform (Qualtrics Labs Inc., Provo Utah); participants' responses were included in the data set.

Individual, semi-structured interviews were conducted and recorded over a secure online video platform (Zoom Video Communications, Inc., 2020). Drawing on the research aims, the interview guide was iteratively designed by the research team, pilot-tested with

two physiotherapists, and refined. The guide aimed to elicit examples of “experiences as they are lived through” (van Manen, 2014, p. 298) and was comprised of 14 open-ended questions (Appendix G). Interviews elicited experiential accounts with the aim to “make contact with life as it is lived” (van Manen, 2014, p. 353). Interviews focused on participants’ everyday encounters with patients, witnessed interactions of colleagues with patients, as well as qualities, behaviours, values, and competencies that exemplify a ‘good’ physiotherapist. Interviews averaged 90 minutes (ranging from 60 to 120 minutes). Field notes, an audit trail, and a reflexive journal were used to foster transparency of the research process (Finlay, 2009; Wright-St Clair, 2015). Field notes were recorded after each interview to track researcher insights and observations. Analysis was conducted alongside data collection to “reveal new ways of thinking about the phenomenon of interest and new questions to ask”(Wright-St Clair, 2015, p. 60).

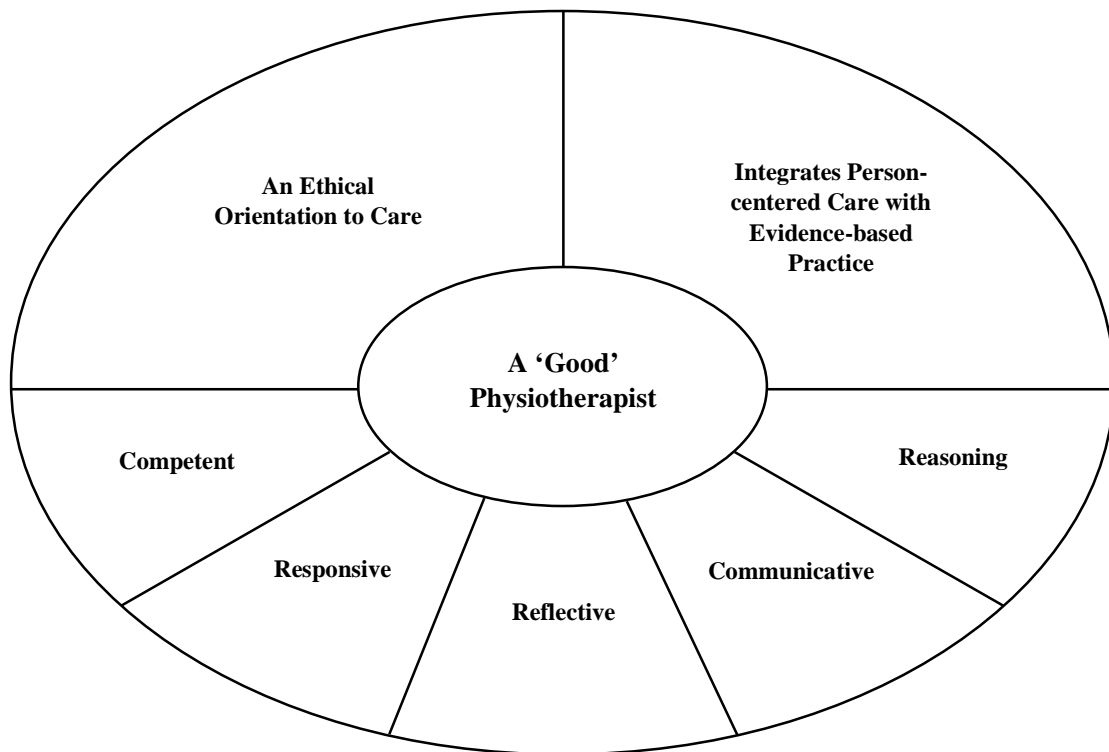
3.2.4 Data analysis methods

The primary author (MK) was immersed in the data by listening to each interview and reviewing field notes. After transcription, MK listened to each interview a second time to dwell in the data to get a sense of the whole (Finlay, 2014). While relistening a third time, MK created mind maps (Buzan, 2018; Whiting & Sines, 2012) of each interview as a ‘wholistic reading approach’ (van Manen, 2014). Next, using a ‘selective reading approach’(van Manen, 2014), statements and phrases were created in response to the primary research purpose. Quirkos (2021) software was used to code and organize the data as a ‘detailed reading approach’ to analyze what sentences or sentence clusters revealed about the phenomenon (van Manen, 2014). Transcriptions, field notes, mind maps, summaries of the research questions, and responses to preparatory questions were grouped for each participant. By iteratively attending to the parts as well as the whole of the phenomenon of what it is to be a ‘good’ physiotherapist, critical insights were identified and organized in spreadsheets. As patterns were identified, data were clustered into themes. Consensus on themes was determined among team members by iteratively discussing findings and comparing mind maps.

3.3 Results

Seven themes of a ‘good’ physiotherapist were identified in the data. These included two broad themes of an *ethical orientation to care* and *integration of person-centered care with evidence-based practice*. These broad themes were intertwined with more specific themes of ‘being’ *competent, responsive, reflective, communicative*, and ‘using’ *reasoning* (Figure 2.1).

Figure 3.1 Musculoskeletal physiotherapists' perceptions of a 'good' physiotherapist



3.3.1 Theme 1: ethical orientation to care

An ethical orientation to care was evident in how participants discussed the way a ‘good’ physiotherapist interacts and works with patients. Participants depicted a ‘good’ physiotherapist as showing care in various ways such as being committed, attentive, accountable, passionate, equitable, humble, respectful, honest, trustworthy, and genuine.

Many participants depicted a 'good' physiotherapist as showing an ethical orientation to care by being committed to patients and their goals. PT-B described it as being "attentive to what [their] responsibilities are..." and "...committed to excellence, committed to getting a good result...committed to their patients." PT-C spoke of "an ethical obligation...to place the values and the best interests...of the patient first and foremost."

Many participants discussed being passionate about helping, or doing the right thing for patients, which PT-G described as: "Passion to do the right thing for them. Passion to help them. Passion to fulfill a need. Passion to bring even something as simple as physiotherapy knowledge to change somebody's life in even a minor way."

An ethical orientation to care was also evident in therapists' concern for the ethical use of power. A 'good' physiotherapist was variously described as being equitable, inclusive, and aware of power imbalances in the physiotherapist-patient encounter. PT-K acknowledged "there will always be a slight power imbalance just because ... the therapist is being given the privilege of helping somebody." PT-K suggested that the ethical use of power was evident in how practitioners' "hold themselves, how they speak to that person, and ensure that that client knows that their story is heard, and that there's hope to move forward."

An ethical orientation to care was also evident in participants' comments about qualities of a 'good' physiotherapist. Caring qualities such as being respectful, humble, genuine, and honest were regularly discussed. The importance of relationship building and establishing trust was frequently noted. "Genuine caring. That's so key" summarized one clinician's view that a 'good' physiotherapist is "someone that has a genuine interest in helping others" (PT-E).

3.3.2 Theme 2: integrates person-centered care² with evidence-based practice³

When considering what constitutes a ‘good’ physiotherapist, each participant spoke about the importance of clinical competency *and* relational ways of being when working with patients. While some highlighted one more than the other, across interviews, participants discussed the integration of evidence-based practices with person-centered approaches; to “integrate what’s scientifically known...with...clinical practice” (PT-E) by “titrating soft and hard skills” (PT-E), to “marry the two worlds between evidence-based and individualization” (PT-F). Three physiotherapists, B, F, and G used the phrase “art and science” to describe practicing as a ‘good’ physiotherapist. PT-F summarized this perspective:

We've talked a lot about the soft skills, the relationship skills, power skills, the listening, the communicating... you need to be safe and really technical in your practice as well. ...that's the science, and then the art is how we adapt that knowledge to the individual. But you can't have one without the other...for a good physio... there are lots out there that ...have the science but not the art and there's some that have the art but not the science. And the good ones are the ones that have both.

Descriptions of person-centered practices included sharing power with patients, understanding their perspectives and what they valued, and collaborating on their goals. A ‘good’ physiotherapist, as conceived by PT-C, “truly and authentically has the best interest of their patient foremost in their approach to care. ...[and] seeks to minimize the power imbalance that's embedded in the rehab encounter by really seeking a collaborative relationship with the patient.”

² Based on a review of reviews by Eklund and colleagues (2019), person-centered care is defined as an approach to care that places the person at the center and considers their context, history, family, and perspectives when making shared decisions in the facilitation of a person’s recovery to live a meaningful life.

³ Sackett and colleagues (2000) define evidence-based practice as including “the integration of best research evidence with clinical expertise and patient values” (p. 1).

Tensions integrating evidence while being person-centered were evident, as described by PT-F:

A patient-centered interaction then would be being very collaborative. ...adjusting my approach to the individual, whether that's how we are interacting, whether that's the type of treatment that I'm providing, whether that's taking into account their environment or their experiences into the treatment plan. I think if their expectations and their desires are going too far away from the evidence base then we sometimes then have to have some educational collaboration.

When discussing integration of evidence from randomized control trials within patient-specific contexts, PT-E cautioned, “you don’t want the pendulum to swing too far in either direction.” He suggested, “integrate what's scientifically known ...with what perhaps still needs some study but seems to be effective in clinical practice and [use] them in a harmonious way.” Participants shared examples of providing treatment considered to have low evidence of effectiveness such as hot packs, electrical modalities, or manual therapy in favour of being person-centered. As PT-K explained,

You're not using the hot pack as a treatment, but almost as a decision to help let that person know that they were heard that they need some current comfort...you can give it to them at that moment, so long as it aligns with other management approaches that are effective and not short-term and passive in nature.

All participants discussed a desire to ensure patients had a positive physiotherapy experience. PT-H highlighted effectiveness as “the client being happy on both a physical level [and] experience level.” PT-F offered:

I don't get to decide how good I am. It has to come from the patient and if I'm not providing what that patient needs in order to feel like they got what they wanted or needed out of that interaction then it doesn't matter what I think.

Satisfaction was an important aspect of care for the physiotherapists in this study and factored into how they described a ‘good’ physiotherapist.

3.3.3 Theme 3: competent

Being competent was universally identified by participants as essential to be a ‘good’ physiotherapist. Possessing foundational knowledge was acknowledged as important, but participants frequently spoke of a ‘good’ physiotherapist as one who updates their knowledge on a regular basis. Practical skills, noted as important to be effective at achieving positive outcomes, included diagnostic expertise, manual skills, exercise prescription, and patient education. Participants also discussed being committed, confident, creative, inquisitive, and flexible in the context of being competent.

Foundational courses and continuing education were discussed as important for competence. PT-I stated she was “a strong believer in understanding your anatomy, your biomechanics.” When referring to continuing education, she further noted, “those courses are tough...they teach you how to think ...particularly if I’m thinking of orthopaedics or pelvic health...ortho[paedic] level[s]...was a ton of work...but it gives you the foundation to reason.”

All participants endorsed the importance of and “obligation to be informed...regarding current policies, practices, [and] professional standards” (PT-C). Further, participants talked about staying up to date on practice knowledge and scholarly literature. PT-C stated: “we take courses, we read literature, we connect with others who are practicing so we learn from their clinical experience.” This latter strategy for several participants included finding mentors or regular consultation with colleagues. Some participants described a ‘good’ physiotherapist as inquisitive, curious, or committed to patients in the context of staying up to date to achieve excellence in care.

The development of manual skills was highlighted by participants as important for skilled assessment and treatment. PT-J advocated “specificity in your technique” to accurately assess and treat physical ‘dysfunction’ and to “practice your techniques until you know them inside out.” PT-A concurred and further noted, “you can foster trust with your handling... [and when you are] confident in your care.”

Being effective was commonly discussed by participants and often equated with the term ‘good’ when describing a ‘good’ physiotherapist. “Be as effective as you can be at your job... use a skill or a technique or a modality or whatever [intervention] that may be with the client to get a positive outcome” stated PT-H. Some participants stated that achieving positive outcomes required creativity and flexibility such as when designing an exercise program individualized for a patient.

3.3.4 Theme 4: responsive

Being responsive was identified in participants’ accounts of listening to patients’ stories, validating their experience, taking an interest in the person, and individualizing care. Various behaviours related to being responsive were described such as being attentive, accepting, open, patient, approachable, and empathic. PT-B summarized behaviours of a ‘good’ physiotherapist that demonstrate responsiveness:

You’re present and you're engaged... it's the language that's being used, ...weaving things together... You're asking questions and you’re using little phrases that demonstrate to the person who's telling the story that you're listening...you’re taking in their story and you’re synthesizing it, you're absorbing it.

Listening was an aspect of being responsive endorsed by all participants. PT-F described “listening to listen rather than listening to respond”, framing active listening as an intentional choice “to be human and build relationships” demonstrated by “eye contact, focus, patience, paraphrasing for clarification, ...body language...creating that sense of comfort.” PT-H cautioned, “if you’re not listening...the rapport is not there and then when the person leaves, they feel like they were talked at as opposed to communicated with.” She explained this may be perceived as a “judgment attitude” rather than when listening with “empathy” which “shows that you’ve heard what they’ve said, that you can relate to what they are saying, and it validates that.”

Responsive qualities such as openness, approachability, and being accepting of others were frequently described. PT-K shared an example of a ‘good’ physiotherapist: “she

does a really good job of opening herself up to the point where people feel comfortable telling her things that they might not have told her otherwise.” PT-C shared, “if I follow their lead, and the space feels like they can either articulate or share through emotion, then I simply have to be.”

Responding to the patient as a person was frequently discussed. PT-L talked about the importance of being “able to listen and understand and know that patient as a person as opposed to a patient with symptoms.” As an example of responding to the whole person, PT-L discussed working on mobility goals with a patient with a terminal illness and stated, “sometimes it’s good to be realistic, but also take into account why that person wants to do something.” PT-F described adapting an approach with a patient to be relationship-centered: “I adapted my clinical goals...and approached a relationship on an individual level that then resonated with him and fostered engagement.”

3.3.5 Theme 5: reflective

Across participants, it was universally suggested that a ‘good’ physiotherapist is reflective. PT-E stated, “a year of reflective practice is worth...five years of normal practice or just going through the motions.” As a reflective practitioner, PT-B explained, “I’m constantly thinking when I’m charting, when I’m assessing. I’m thinking, ‘What am I trying to do? What am I trying to achieve? What’s my rationale?’” All participants shared examples of reflection that was either anticipatory, retrospective, or that occurred ‘in-the-moment’.

Anticipatory reflection was described by participants who spoke about reviewing charts prior to commencing an encounter with a patient. PT-C shared: “I...have that one-minute glance and go, ‘Oh yeah!’ So, I try to avoid being surprised because I’ve been neglectful...of what the file is going to tell me.” As an example of anticipatory reflection, PT-A discussed returning to the research in preparation for future patient visits “to research what you could have done better like a technique or [to] read more about something.”

Many therapists described charting patients' findings and treatment plans, and the retrospective reflection that this process fueled. PT-A commented on "making sure you do your treatment notes ...so that you can reflect on the previous treatment and then figure out what your short-term and long-term goals are for the patient." Similarly, PT-E noted that's when he does his reflection: "I'll go through the chart later and re-think about things. I'll fill in my hypothesis section and then the treatment plan will develop." As a novice physiotherapist, PT-C sat with her charts on Friday afternoons recalling:

I looked at their name, I thought about where we were in the process of treatment ...the process really made me think about what went on not just from a clinical perspective but from a social perspective within the appointment or within the series of appointments that might have happened between my looking at a chart from a Friday to a Friday. ... The practice of file review... done really systematically was probably an elementary or introduction to the notion of: 'Wow, look what I learn when I sit and think about these files in front of me that then become the people in front of me.'

Being intentionally reflective 'in-the-moment' was often framed by participants as an ability to 'read' and reflect on patients' personality, demeanor, non-verbal, or verbal communication. PT-D explained, "there's a lot of non-verbal communication that occurs in an interaction and if I see that...I read it." Recalling patient encounters, PT-H explained, "you're constantly evaluating. Are they looking like they're understanding what I'm saying? Or do I need to change my language?" When describing conversations with patients, PT-B noted: "inevitably they tell you things...little alarm bells go off...that informs your thinking, that redirects your treatment, that helps you fine tune the treatment." When working hands-on with patients, an embodied kind of reflection-in-action was described. For instance, PT-J stated: "Listen with your fingers...so when they tense up, you don't push too hard."

3.3.6 Theme 6: communicative

Communication, or what PT-D described as "ability to connect with people and communicate" was discussed in one way or another by all participants as essential to be a

‘good’ physiotherapist. Being communicative was framed by most participants as having two dimensions: as health care practitioners who shared their expertise and as people who engaged in more casual forms of conversation to establish connection and rapport.

When communicating to share their expertise as health care practitioners, participants variously described the importance of effectively communicating a diagnosis, prognosis, treatment plan, expectations, and patients’ rehabilitation progress. Many participants discussed the importance of providing patients with explanations. For PT-E this included “explanations for what was happening from the very beginning of the assessment to the end of the session.” Similarly, PT-B noted it was important to let patients “know what your findings are” and “what they need to work on.” Many therapists spoke of their role as educators who communicate their expertise, which PT-F stated required an ability “to convey that message in an individualized way.” As PT-E explained, “[I] read what language they use to describe their own bodies first and then I’ll mirror that language.”

All participants spoke about the importance of having two-way communication with patients. For many participants that included asking open-ended questions and sharing of perspectives, while others discussed creating welcoming or safe spaces, and opportunities for shared understanding. PT-C commented that ‘good’ physiotherapists “demonstrate their valuing of the patient by eye contact, creating space that is comfortable. ...They listen well. They try to communicate effectively.” Emphasizing face to face communication and “caring body language”, PT-F shared that “while taking a history, I tend to put the pen aside...then have a face-to-face conversation about, ‘Well, why are you here? What’s your story? I want to learn more about your experience.’”

Being communicative was evident in comments related to establishing rapport with patients. In this context, participants spoke about being encouraging, reassuring, supportive, positive, and kind as qualities important to connecting well with patients. When discussing hiring a physiotherapist for his clinic, PT-E stated he considered clinicians’ ‘soft skills’ over ‘hard skills’ sharing, “Can they have casual conversation and be actively present? Are they pleasant to talk to? Some of those soft skills are so key.” He went on to describe his own practice, “you can just be chatting and making them

[patients] feel more comfortable. It's part of the treatment because it makes clients relax in their body." PT-K shared a moving story about working with a man who unbeknownst to her had recently lost his son to suicide. She recounted that a few years after his care, he returned to share: "I've come back to tell you...being kind and listening and just having a light banter goes a long way...that's an important part of what you do."

3.3.7 Theme 7: reasoning

Reasoning was often named specifically and discussed by participants as fundamental to practice as a 'good' physiotherapist. Participants often referred to 'clinical reasoning', but also referred to 'analytical thinking', 'pattern recognition', 'experience' or 'decision-making' in relation to reasoning. Various forms of reasoning were discussed as informed by knowledge from courses, continuing education, or developed through experience. Reasoning in its various forms was often discussed as important when determining assessment and treatment priorities. When critically evaluating a breadth of options, many participants endorsed individualized assessment and treatment approaches based on patients' perspectives, physical findings, function or mobility, or context. Additionally, most participants discussed the importance of understanding patients' goals when planning treatment. Noting the importance of understanding patients' goals, PT-G stated, "their goals help me formulate mine."

Several participants distinguished between experientially and theoretically informed reasoning. PT-F distinguished the two as follows: "experience that [a 'good' physiotherapist] can relate back to 'how did this go?' as opposed to more theoretical knowledge of 'I think this is why this is but we're going to apply it for the first time here.'" PT-E offered: "Being able to effectively appraise the research evidence to inform practice that allows for practical application of what is known" as well as "applying sound clinical reasoning for practices that aren't fully understood yet." Many participants described the importance of experience in developing reasoning capabilities. Explaining that "clinical reasoning develops over time", PT-D and a few others commented that with experience comes an improved ability to recognize patterns in the presentation of patients' signs and symptoms. Recognizing patterns informed by experience, PT-H stated

a ‘good’ physiotherapist may then choose “a clinical skill that [is] appropriate for the situation.”

With experience also comes an ability to reason “how quickly your patients should be improving” appraised PT-J. Within one treatment or over time, several participants discussed using “milestones” or “test/retest” to evaluate patients’ progress and treatment effectiveness. Explaining the reasoning process with patients was noted by most participants as important. PT-A highlighted, “make sure they understand why we prescribe the exercises...why we look at certain assessment findings.” PT-B indicated it was important that patients know “there is a thinking and a rationale that goes into treatment...that’s science-based.”

3.4 Discussion

This investigation into physiotherapists’ perceptions of what constitutes a ‘good’ physiotherapist revealed the centrality of ‘care’ in physiotherapists’ conceptions of the good. Two overarching themes, *an ethical orientation to care* and *integration of person-centered care with evidence-based practice* were identified, suggesting an ‘ethic of care’ at the heart of what physiotherapists identify as ‘good’ practice. These broad themes were intertwined with more specific themes of ‘being’ *competent, responsive, reflective, communicative*, and ‘using’ *reasoning*. These findings are consistent with a recent review conducted by our team that pointed to a ‘good’ physiotherapist as one who balances technical competence with relational ways of practicing (Kleiner et al., 2021).

Despite findings that seem to suggest an ethic of care as central to what constitutes a ‘good’ physiotherapist, the concept of caring in physiotherapy has received scant research attention. More than a decade ago, Greenfield and colleagues’ (2006, 2008) investigations into the nature of caring in the practice of physiotherapists concluded clinicians viewed caring as their moral orientation to practice. More recent studies of students’ experiences of physiotherapy education suggest that education curricula remain focused on technical competencies aimed at ‘curing’ with less emphasis on the relational practices considered fundamental to ‘caring’ (Dahl-Michelsen, 2015; Ramklass, 2015). When discussing what constitutes a ‘good’ physiotherapist, physiotherapists in the

current study spoke about the importance of various relational practices, with less explicit discussion of technical competencies.

Care ethics recognize everyday encounters with patients as a “relationship-based *moral practice*” (Monteux & Monteux, 2020, p. 3). Care may be variously defined as a virtue, value, or attitude, yet when viewed as a relational competence of acting and responding, it becomes a practice (Martinsen, 2011). Conceptualizing care as a ‘practice’, Tronto (1993, 1998) situates ‘care’ in a moral and political context noting it is largely defined by culture. Tronto theorizes a morally good person’s thoughts and actions as directed towards an end. Tronto’s theory posits a ‘habit of mind’ that encompasses *ethical elements* of care: ‘caring about’ involves *attentiveness* to the needs of others; ‘caring for’ assumes *responsibility* to fulfil inherent practice obligations; ‘caregiving’ requires *competence* to provide good outcomes; and ‘care-receiving’ involves *responsiveness* of the care-receiver to the care provided and of the caregiver’s attention to the other’s response, perspective, and experience. This element of responsiveness brings Tronto’s theory of care full circle, shifting the focus from the caregiver to the relational nature of caring (Clouder, 2005; Tronto, 1998). These four elements of care were represented across the findings, suggesting an ethical orientation to care as a practice, as resonant with understandings of a ‘good’ physiotherapist.

The findings appear to support the proposition that a ‘good’ physiotherapist approaches their responsibility by recognizing a moral obligation to take care of their patients first and foremost. Tronto proposes caregiving requires competence. Physiotherapists in this study identified assuming responsibility for technical competence when ‘caring for’ patients. Participants suggested identifying patients’ needs, determining how best to intervene to achieve good outcomes, and maintaining competency as important aspects of care. They variously noted the need for practical assessment skills, determining and communicating a diagnosis, or for specific treatment approaches such as manual therapy, education, and exercise prescription. Beyond a technical orientation to care, Martinsen (2011) posits ‘care’ at times is viewed as a collection of altruistic virtues rather than a competently enacted practice arguing for the relational ontology found in an ethic of care. She notes that a virtuous practitioner with a compassionate, kind, or empathic disposition

may be ‘caring’, but enact competence in the delivery of health ‘care’ with detached concern and objectivity. Similarly, Romanello and Knight-Abowitz (2000) suggest when framing caring as a duty or responsibility in a professional code of ethics, care becomes rules-based rather than a relational practice whereby context or circumstances are considered to aid a practitioner in choosing the right way to act between two or more conflicting goods. The findings of this study point to an ethic of care that integrates evidence-based approaches *with* person-centered approaches. This is consistent with scholars who posit that person-centered care is more than the kind or compassionate application of evidence and technical fixes, but rather demands ‘caring about’ patients, including but not limited to recognition of their values and preferences (Miles, 2018; Miles et al., 2015).

The findings that a ‘good’ physiotherapist is responsive and communicative with patients are consistent with behaviours that Miciak and colleagues (Miciak et al., 2018, 2019; Miciak, 2015) identified as important to the physiotherapy therapeutic relationship. Participants described taking an interest in patients as people, being supportive, and engaging in dialogue, which Miciak and colleagues identified as important to engagement, connection, and bonds between physiotherapists and patients. These behaviours exemplify an ethical orientation to care that values relationship. ‘Caring about’ a patient’s experience and values were proposed by participants in this study as important for determining treatment approaches that were collaborative, positive, satisfying, *and* evidence-based. Various relational practices were discussed by participants as important to the practice of a ‘good’ physiotherapist yet relational practices generally receive minimal recognition in physiotherapy curricula that are typically dominated by the biomedical model, technical knowledge, and skill acquisition (Barradell, 2021; Nicholls & Gibson, 2010; Setchell et al., 2018). Relational practices are not explicitly privileged as part of the socialization into a professional culture that is posited to value curing over caring (Nicholls & Holmes, 2012), suggesting that a ‘good’ physiotherapist appears to engage in relational practices *despite* their training.

Participants in this study spoke about being responsive and communicative with patients by being attentive, open, focused, taking time to listen, showing empathy, and through a

desire to understand the patient as a person. For Tronto, being attentive and responsive are fundamental to human relationships. Being attentive and responsive to emotion are valuable sources of moral understanding in ethical theories of care (Benner, 1997; Held, 2006; Noddings, 1984). Putting patients' needs "first and foremost" was frequently discussed by participants as part of being a 'good' physiotherapist and was demonstrated through participants' attention to providing a positive or satisfying patient experience. Scholars contend that "flourishing of the patient on their own terms" (Braithwaite et al., 2021, p. 207) is facilitated when patients receive care they value and that a patient's response may communicate that "good work has been done" (Barradell, 2021, p. 664).

Tronto (1998) and other scholars (Benner, 1997; Held, 2006; Sellman, 2012) propose care requires practical wisdom (or phronesis) when balancing technical competence with person-centered approaches. The findings offer insights into how a 'good' physiotherapist may use phronesis or wise judgement to bring patient preferences and evidence into a plan of care. Reflection was consistently highlighted by study participants as an important practice of a 'good' physiotherapist. Notably, reflection is posited by Kinsella (2012) to inform judgements and actions oriented toward practical wisdom. Participants and others acknowledge physiotherapy as an art and a science (Brun-Cottan et al., 2020; Peat, 1981), supporting the notion that a 'good' physiotherapist's practice is more than the application of technical competence.

Participants' accounts highlighted the intersubjective nature of practice through being responsive and communicative, aspects of practice proposed as art (Brun-Cottan et al., 2020). The importance of the therapeutic relationship was implicitly and explicitly discussed when participants spoke about 'reading' patients, being reflective, and communicating their reasoning. Valuing relationship as advocated by participants' emphasis on being responsive and communicative supports the proposition that a 'good' physiotherapist may create dialogic possibilities for shared understanding and treatment approaches. Practicing reflection, reasoning, and two-way communication creates the potential for patient encounters to be informed by a practitioner's practical wisdom and patient preferences.

Although the technical rationalist perspective has established an important evidence base to evaluate the efficacy of physiotherapy interventions (Shaw et al., 2010), Kinsella (2007) argues this reductionistic approach does not address the complexities of practice that philosopher, Donald Schon refers to as the ‘indeterminate zones’. He conceived of these ‘zones’ as comprising the majority of professional practice and analogous to a swampy lowland where uncertainty, uniqueness, and the messiness of the human experience often defy technical solutions (Kinsella, 2007). Although evidence-based practice has evolved to include patient preferences and clinician’s experience, these domains have received less attention in physiotherapy education and research (Bjorbaekmo & Shaw, 2018). This insight alongside Bjorbaekmo and Shaw’s (2018) proposition that physiotherapists may use evidence-based practice guidelines as frameworks to guide approaches, coincides with findings in this current study, whereby physiotherapists’ accounts suggest a ‘good’ physiotherapist also attends to the human encounter to guide assessment and treatment decisions. Integration of person-centered care and evidence-based practice informed by responsiveness, reflection, and reasoning in context, as suggested by the findings, support the notion that a ‘good’ physiotherapist’s practice may involve ‘tinkering’, such as using a hot pack when discerning a need for comfort or sharing knowledge in a collaborative manner as needed. Drawing on philosopher Annemarie Mol (2002), Gibson and colleagues (2020) described ‘tinkering’ as “a flexible approach to care that adapts to the situation at hand” (p. 7). These authors proposed similar person-centered practices following their analysis of ‘care events’. Mol (2002) suggests clinical uncertainty leads to questioning what to do, which cannot be known in advance because facts and values intertwine. The findings suggest that with care as a practice, a ‘good’ physiotherapist balances evidence and patient values, and through competence, responsiveness, reflection, communication, and reasoning, works toward doing ‘the right thing’. A ‘good’ physiotherapist appears to adopt “a flexible approach to care that adapts to the situation at hand” (Gibson et al., 2020, p. 7) and in this way to enact phronesis to facilitate human flourishing.

3.4.1 Strengths and limitations

Through recruitment of experienced physiotherapists, rich and evocative descriptions of the lived experience of what may constitute a ‘good’ physiotherapist were elicited. It may be argued that participants self-identified as ‘good’ physiotherapists and should have been nominated by their peers similar to studies of ‘expert’ practice. However, interview questions asked participants to describe practices that exemplify a ‘good’ physiotherapist not whether they were ‘good’ physiotherapists. A relatively unique aspect of the study was the preparatory exercise that may have encouraged participants to access their experience of the phenomenon prior to their interviews. Many participants expressed gratitude for the opportunity to reflect on their practice suggesting that ‘good’ work had been done in preparing and conducting the interviews. After the first two interviews, wording of the interview guide was scrutinized to evaluate whether questions were leading. For example, ‘interacting with patients’ was changed to ‘working with patients’. As interviews proceeded and at their conclusion, select participants were asked if they felt questions were leading them; they stated they did not feel led in any particular direction.

We acknowledge there is more that may be explored in what constitutes a ‘good’ physiotherapist. The richness and breadth of participants’ perspectives offered further interpretive avenues that were beyond the space afforded here. There is no attempt to generalize the data in phenomenological research. Rather, findings that are resonant may move readers to consider participants’ insights in light of their own experience and foster new understandings of the phenomenon (van Manen, 2016) of a ‘good’ physiotherapist.

3.5 Conclusion

Seeking to understand what constitutes a ‘good’ physiotherapist, it was learned that an ethical orientation to care was central. Further, a foundational ethic of care may facilitate person-centered care, evidence-based practice, and their integration. While limited in number, other studies have called for greater emphasis on an ethic of care in physiotherapy. This study contributes knowledge about an ethic of care as an important dimension of a ‘good’ physiotherapist, and highlights practices that may underpin that

orientation, and the pivotal role of relational ways of practicing. Physiotherapists' perceptions that an ethic of care is central to a 'good' physiotherapist's practice challenges the profession's emphasis on a technical rationalist approach to education, and clinical practice, and invites conversation about future directions for the profession.

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3.6 References

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Chapter 4

4 The ‘responsive’ practitioner: Physiotherapists’ reflections on the ‘good’ in physiotherapy practice

Background: Being ‘responsive’ is named as an element of ethic of care theories, yet how it is enacted is not clearly described in health professional practice. Being ‘responsive’ is implied within patient-centred approaches and promoted as important to health care practices, including physiotherapy. However, ways of being a responsive practitioner have not been explicitly examined. Practitioners’ perspectives about how a ‘good’ physiotherapist enacts responsiveness have potential implications for the future practice of physiotherapy. Physiotherapists’ perceptions may inform professional priorities including education curricula, professional practices, and patient interactions.

Purpose: The purpose of this research was to explore experienced musculoskeletal (MSK) practitioners’ perceptions of ‘responsiveness’ in the practice of a ‘good’ physiotherapist. **Methods:** A secondary analysis of data arising from a hermeneutic phenomenological study into physiotherapists’ perceptions of what constitutes a ‘good’ physiotherapist was undertaken. The secondary analysis focused on ‘responsiveness’, which emerged as a major theme in the original study. **Findings:** Six themes were identified related to ‘Being responsive’ in a ‘good’ physiotherapist: Being person-centred, Being attentive, Being open, Being a listener, Being validating, and Being positive. **Conclusions:** As a relational way of practicing, being responsive may facilitate person-centred approaches including a relational understanding of autonomy, inviting dialogue, and sharing power and decision-making with patients. Pivotal to the practice of a ‘good’ physiotherapist, being responsive in the ways underscored by participants suggests researchers, educators, and practitioners consider relational ways of practicing as a balance to the technical aspects of physiotherapy.

4.1 Introduction

World Physiotherapy (World Physiotherapy, 2019) states physiotherapy practice is “dynamic and *responsive* [emphasis added] to patient/client and societal health needs” (p. 1). Although being ‘responsive’ is promoted by the global physiotherapy organization,

‘responsiveness’ as a concept and how it is enacted has not yet been clearly described in the physiotherapy literature. In feminist ethics literature, ‘responsiveness’ is identified as an essential element of care, as an important characteristic of care-receivers and caregivers, and as central to what some refer to as an ‘ethic of care’ (Benner, 1997; Held, 2006; Tronto, 1993). From an ethic of care perspective, a caregiver is responsive by assuming responsibility for care and being attentive to patients’ changing health care needs. In turn, the patient must be responsive to the ‘caregiving’ or treatment provided (Tronto, 1993). A practitioner’s sense of moral responsibility for care fostered through responsiveness is juxtaposed to conceptions of responsibility as a detached and emotionally distant obligation (Clouder, 2005). The development of ‘responsive’ health care practitioners through the cultivation of affective capabilities has been highlighted as a challenge amidst a pre-dominance of technical rationalist approaches to education and practice (Clouder, 2005).

Attention to an ethic of care, and the inherent links to responsiveness, have only been sparingly described in the physiotherapy literature. This despite claims that caring is the moral orientation to physiotherapy practice (Greenfield, 2006; Kleiner, Kinsella, Miciak, Teachman, & Walton, 2021) and that caring underpins the practices that students consider important for professional practice (Dahl-Michelsen, 2015; Ramklass, 2015). Although drawing on different terminology, Trede and McEwen (2016) acknowledge the importance of ‘responsiveness’ in physiotherapy practice. The ‘deliberate’ practitioner is one who “make[s] a deliberate choice about what to say and what not to say, how to act and how to relate to others for each particular practice situation” (p. 7). Deliberate practitioners “understand that their actions are not isolated activities, but rather happen in context and have consequences” (p. 7). Further, the importance of responsiveness is signalled by Miciak and colleagues (2019) in research that shows collaborating with patients as equals, validating patient experiences, and individualizing treatment approaches as important for establishing physiotherapist-patient relationships.

In the context of nursing, Benner (2009) describes a ‘response-based’ approach in expert practice, whereby an expert practitioner alters their care in response to the situation and the patient's responses. An expert practitioner perceives and interprets patient responses

in-the-moment, then responds to what is most important in the situation (Benner et al., 2009). Benner (2009) links this to an “ethos of openness” (p. 107) guided by emotional attunement and responsiveness to a situation. She characterizes an expert’s performance as ‘embodied, skilled know-how’ that informs understanding and ways of being in an encounter. Benner (2009) contends that practitioners who adopt an ethos of openness can respond to patients’ unique needs and situations, which can change over an episode of care. Being open allows them to approach patients with a practical, experiential understanding rather than as a set of objective data points.

‘Responsiveness’ as a construct is not often explicitly discussed in physiotherapy research, education, or practice. There are studies on the reflective physiotherapist (Ziebart & MacDermid, 2019), the clinically reasoning physiotherapist, (Elvén & Dean, 2017), the deliberate physiotherapy practitioner (Trede & McEwen, 2016), but not the responsive one. This may be related to the professions’ historical emphasis on a rationalist approach that privileges biomedical knowledge and technical skills over humanistic dimensions, which are central to caring practices that embrace the dynamic nature of care (Nicholls, 2018; Nicholls & Holmes, 2012).

Developing phronesis or practical wisdom and balancing applied science and humanism have been proposed as foundational to good physiotherapy practice and the promotion of ‘human flourishing’ (Fadyl et al., 2011; Kinsella & Pitman, 2012; Sellman, 2009). This proposition is supported by recent studies conducted by our team into what constitutes a ‘good’ physiotherapist suggesting practitioners balance technical competence with relational ways of practicing oriented toward doing what is right (Kleiner, Kinsella, Miciak, Teachman, McCabe, & Walton, 2021; Kleiner, Kinsella, Miciak, Teachman, & Walton, 2021). Responsiveness was one of six qualities of a ‘good’ musculoskeletal physiotherapist (alongside being ethical, communicative, competent, caring, and collaborative), we identified in an integrative review of patient and physiotherapist perspectives (Kleiner, Kinsella, Miciak, Teachman, McCabe, & Walton, 2021).

In our phenomenological study of what constitutes a ‘good’ physiotherapist, a central finding was that physiotherapists’ conception of the ‘good’ was underpinned by an

ethical orientation to care (Kleiner, Kinsella, Miciak, Teachman, & Walton, 2021). Practicing with an ethic of care appeared to support integration of person-centred care with evidence-based practice. The study identified being responsive, competent, communicative, reflective, and using reasoning as underpinnings of ‘good’ practice. Ethic of care theories also include ‘responsiveness’ as an important element (Benner, 1997; Held, 2006; Tronto, 1993).

Given the strong theme of ‘responsiveness’ that emerged in the primary data set of what constitutes a ‘good’ physiotherapist, a secondary analysis was undertaken to understand the phenomenon of ‘responsiveness’ more deeply. For the secondary analysis we asked: *In what ways is responsiveness to patients enacted in the practice of a ‘good’ musculoskeletal physiotherapist?*

4.2 Methodology

The current study focused on a secondary analysis of hermeneutic phenomenological data arising from a broader study into physiotherapists’ perceptions of what constitutes a ‘good’ physiotherapist. Given the richness and breadth of the data on responsiveness in the primary data set, this secondary analysis was undertaken to examine this phenomenon in greater depth.

Hermeneutic phenomenological methodology aims to describe and interpret aspects of phenomena through lived experience. Hermeneutic phenomenology is both a philosophy and a methodology (Park Lala & Kinsella, 2011). As such, theoretical insights from Heidegger (1927/1996) and methodological insights from van Manen’s ‘phenomenology of practice’ (2014, 2016) were drawn on to ground the study. Hermeneutic phenomenology draws on Heidegger’s contention that our ‘Being’ is influenced by our connections to and interpretations of the world in which we live, which is reflected in his term, ‘being-in-the-world’ (Dowling, 2007; Lopez & Willis, 2004). Heidegger (1927/1996) states, “being-in-the-world is essentially care” (p. 187), in the sense that our attention is directed toward that which we care about. Accordingly, the study’s theoretical framework was further oriented by ethics of care theories, particularly the work of Joan Tronto (1993).

4.2.1 Research team and reflexivity

The research team included three physiotherapy and two occupational therapy scholars. The study was completed as a part of the first author's doctoral research and was informed by her 30 years of clinical practice experience. Two team members are physiotherapy professors with expertise in MSK practice, patient-centered care, measurement science, and critical social science. Two team members are occupational therapy professors with expertise in health professional education, practice theories, ethical theory, critical social science, and qualitative methodologies. The team recognized that researchers' pre-understandings shaped interpretations of the data (Finlay, 2002). The researchers engaged in reflexivity in the form of ongoing questioning of taken-for-granted perspectives throughout the research process (Crotty, 1998; Weiss et al., 2019).

4.2.2 Participants

Musculoskeletal physiotherapy was chosen as the context of this study given the authors' interest in MSK practice, and its focus for most Canadian physiotherapists (Canadian Institute for Health Information, 2016). English-speaking, MSK physiotherapists licenced to practice in Canada who worked directly with patients at least 50% of the time were purposively sampled. Physiotherapists with seven or more years of clinical experience and with at least one year of experience in MSK practice were eligible to participate. As proposed by prior research (Brosky & Scott, 2007; Di Tondo et al., 2018; Jensen et al., 1990, 1992; Resnick & Jensen, 2003), experienced practitioners were theorized to possess and recognize the qualities and attributes of a 'good' physiotherapist identified in our integrative review (Kleiner, Kinsella, Miciak, Teachman, McCabe, et al., 2021). Accordingly, a diverse sample of experienced physiotherapists was expected to offer rich perspectives to advance understanding of the phenomenon of a 'good' physiotherapist.

Ethics approval from the Health Sciences Research Ethics Board at Western University was obtained prior to recruiting twelve participants through email newsletters to Canadian and Ontario Physiotherapy Associations' members. Twelve is considered a robust sample size in phenomenological research (Boddy, 2016). Phenomenology seeks experientially rich data in which readers recognize the experience as one they had or

could have had; this recognition is referred to as ‘the phenomenological nod’ (van Manen, 2016).

The physiotherapists (6 females, 6 males) ranged in age from 32 to 71 years (average 46) and practiced in Ontario (n = 7), Alberta (n = 4), and British Columbia (n = 1). All were musculoskeletal physiotherapists; two also had an interest in pelvic health and one also worked with elite athletes as a sport physiotherapist. Eleven practiced in the private sector, with nine working in community clinics, one in patients’ homes, and one in both settings. The twelfth participant practiced in a hospital outpatient department.

4.2.3 Data collection methods

Data for the primary study was collected as follows. Participants completed a preparatory reflective writing exercise (Ajjawi & Higgs, 2007) two weeks prior to participating in an interview. The preparatory exercise (Appendix F) had three aims: 1) establish the physiotherapists’ understanding of the research phenomenon; 2) promote participants’ reflection on the phenomenon of being a ‘good’ physiotherapist; and 3) identify topics to probe during the interviews. Questions and responses were exchanged online over the Qualtrics platform (Qualtrics Labs Inc., Provo, Utah); participants’ responses were included in the data set.

From November 2020 to February 2021, individual, semi-structured interviews were conducted by the primary author (MK) and recorded over a secure online video platform (Zoom Video Communications, Inc., 2020). The semi-structured interview guide aimed to elicit examples of what constitutes a ‘good’ physiotherapist, through elicitation of participants’ “experiences as they are lived through” (van Manen, 2014, p. 298). The interview guide was designed by the research team, pilot-tested with two physiotherapists, and refined iteratively to include 14 open-ended questions that allowed for new ideas to emerge within and across the interviews (Appendix G). Questions related to participants’ experiences of a ‘good’ physiotherapist were sought, including experiences of everyday encounters with patients, witnessed interactions of colleagues with patients, as well as qualities, behaviours, values, and competencies that exemplify the ‘good’ physiotherapist. Participants’ accounts were elicited in a conversational

manner during interviews that averaged 90 minutes (ranging from 60 to 120 minutes). Following each interview, researcher field notes were recorded. To maintain transparency and trustworthiness, observations, thoughts, insights, and reflections were recorded in a reflexive journal throughout data collection and analysis. Data collection and inductive analysis were iteratively conducted (Wright-St Clair, 2015). Research decisions were recorded in an audit trail (Finlay, 2009; Wright-St Clair, 2015).

4.2.4 Data analysis methods

In the primary analysis, the primary author (MK) was immersed in the data by listening to each interview and recording insights in corresponding field notes. After verbatim transcription of each interview, MK relistened to the interviews to check for accuracy of transcription and dwell in the data to get a sense of the whole (Finlay, 2014). When listening a third time, MK created mind maps (Buzan, 2018; Whiting & Sines, 2012) of each participant's interview as a strategy for guiding a more "wholistic reading approach" (p. 320) as recommended by van Manen (2014) to distinguish the experience of being a 'good' physiotherapist from other related experiences. As a "selective reading approach" (van Manen, 2014, p. 320), phrases were created in response to the primary research question. As a "detailed reading approach" (van Manen, 2014, p. 320), Quirkos (2021) software was used to organize and code the data to analyze what each sentence or sentence cluster revealed about the phenomenon or experience being described (van Manen, 2014). As patterns were identified, co-authors (MK, EAK, DW) discussed findings to reach consensus on themes, these were reviewed for resonance with co-authors (GT, MM).

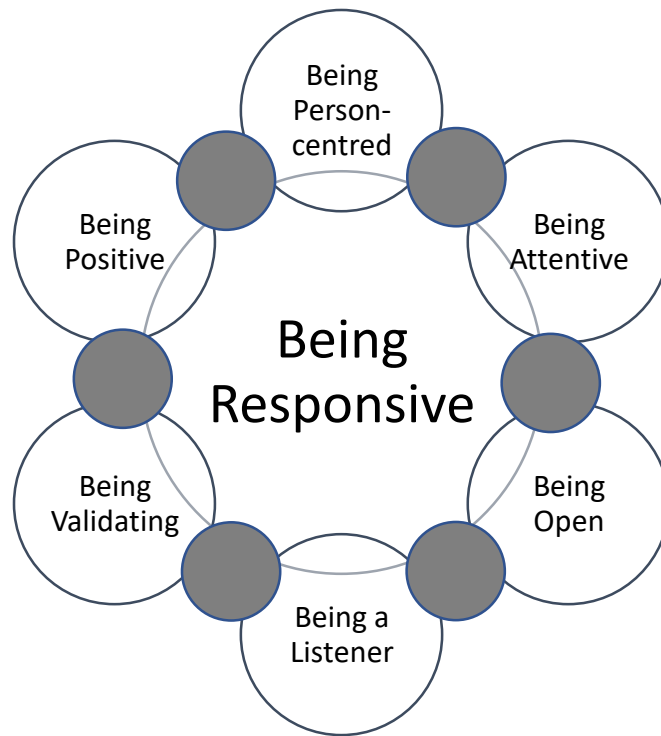
In the primary analysis, being 'responsive' was a major theme. In the secondary analysis, the full data set was re-examined following the mind mapping, coding process, and iterative team meetings described above. Patterns were identified, and clustered by themes (MK, EAK, DW), and reviewed for resonance (GT, MM).

4.3 Results

In this in-depth analysis, six themes related to ways of 'Being' responsive to patients were identified (Figure 4.1). These included 'Being' person-centred, 'Being' attentive,

‘Being’ open, ‘Being’ a listener, ‘Being’ validating, and ‘Being’ positive. These are presented separately below, however, were intertwined in the data.

Figure 4.1 The six intertwined themes of being a 'responsive' physiotherapist



4.3.1 Theme 1: Being person-centred

Being person-centred was one form of being responsive frequently identified as central to a ‘good’ physiotherapist. Being person-centred was described as acknowledging the uniqueness of patients, individualizing the approach to patient care, responding to patients’ leads, inviting patient perspectives, and sharing decisions.

Many participants described a ‘good’ physiotherapist as responsive to the uniqueness of patients, for instance as “somebody who can understand their [patient’s] unique situation” (PT-I) and who “must always treat each patient as a unique patient” (PT-J). PT-A highlighted a ‘good’ physiotherapist as one who is responsive to difference: “every person is different. Even if they may come in with the same thing...they have a different personality, they have a different pain threshold, everything is different.” PT-E discussed

the importance of responding to patients' unique interpretations of their experience, stating that "you can never tell anyone how it is" because "you don't know their reality. You don't know what they feel in their body."

Many participants also spoke about being responsive by individualizing approaches to patients. PT-F indicated that he was "intentional about individualizing care." PT-L explained "something that worked for one patient might not work for another, so you can't copy and paste and expect the same results all the time." PT-F described the importance of responding to individual patients' needs and expectations: "the interaction needs to be driven by them...what they are needing or expecting, what they would like to achieve."

Physiotherapists frequently spoke about being responsive by supporting patients to take the lead in their sessions. PT-E indicated that he empowers patients to "lead the session to wherever they want to take it" because "I don't want to define the session for them." Other participants also spoke about inviting patients to set agendas and provide feedback. PT-K shared, "I usually start off the session with, 'At the end of this half hour, what do you want to get out of this session?' and come the end of the session, 'Did we address your main goals for today?'" Consistent with empowering patients to take the lead, participants spoke about avoiding talking too much or interrupting patients. PT-K shared, "I was actually taught that you have to control the interview or the questions. ...where I've gotten better, is not stopping that conversation." Being responsive to patients, as PT-A explained, involved "making sure that we're going to ask and answer any questions that they have and [address] whatever frustrations that they may have."

Many participants described responding to patients' perspectives by working toward shared understanding and decision-making. PT-C commented that "a good physiotherapist seeks what it is the patient values" noting the importance of supporting patients "to engage socially or physically in the manners that they wish." For PT-A, inviting patients' perspectives ensured the therapist and patient were "on the same page with each other throughout the entire physiotherapy process." PT-K described the importance of establishing shared understanding of the 'physiotherapy process', noting it

was important to “help them [patients] navigate that experience so that they can get what they want, and I can get what I think I need, to ensure that that person moves forward.” She further shared that in some cases patients “want the physio[therapist] to make the decision, but you have to be clear that that's what they [patients] really want.” As an example, she noted, “when someone's in a lot of pain, they don't know what they want and then they do trust the physiotherapist to make recommendations.” PT-F discussed that when physiotherapists invite shared decision-making, patient-centred interactions are “very collaborative.”

4.3.2 Theme 2: Being attentive

Being attentive was revealed in descriptions of a ‘good’ physiotherapist as one who suspends their own concerns to notice and recognize patient needs. Participants described responsiveness through placing patients at the centre of their attention. More implicit forms of attentiveness were identified in participants’ descriptions of ‘reading’ patients’ verbal and non-verbal cues, using intuition, or attending to patients’ (or their own) emotional cues.

Two participants described being attentive by making patients feel “they are the centre of attention” (PT-B and F). PT-K noted how you need to be attentive to the particular person in front of you: “you can't bring your day to someone else's visit. You can't bring your visit from the prior client that you might be mad at or happy at into the next visit...that person needs you to be there for them.” When describing his attentiveness to a patient seeking help, PT-E recalled, “I really need to focus here ‘cause this guy is really looking for help.” Highlighting the attentiveness of a colleague considered to be a ‘good’ physiotherapist, PT-G shared, “She makes everybody feel special around her... the moment you're talking to her, you are the centre of her universe.”

Attentiveness to patients’ verbal and non-verbal cues was frequently described as ‘reading patients’. PT-E explained it was important “to ascertain the best way to intervene based on the presentation of the patient in the moment” going on to note the importance of “paying close attention to how the patient responds verbally and non-verbally.” PT-A described reading patients’ non-verbal cues: “knowing what patient you

have in front of you...knowing what their personality is...whether they're fearful or whether they're anxious...you have to know how to read your patients." By reading verbal and non-verbal cues, PT-H was "looking for something that encourages me to move on with the idea or something that discourages me from ever mentioning it again."

Attentiveness to patients also seemed to be depicted as intuitive or emotional. PT-E noted "intuition about people in general" was important to discern "what they need." PT-A similarly offered that it was important to "trust your gut" when working with patients. Attentiveness to emotional cues was often mentioned. When speaking about patients, PT-J stated, "you have to be the type of person that can pick up when someone is upset or worried or scared." PT-L further explained, "the way they stand, the way they walk in, the way they talk to you...just pick it [mood] up in body language and other cues." Being responsive by attending to their own emotional cues was also noted by participants. During a difficult session with a patient who wasn't progressing, PT-C shared that she was "getting angry" and "wrapped up the session, then sat down and thought: 'what am I going to do?'" Similarly, when recalling sessions that did not go well, several participants recalled feeling "badly" as a stimulus to reflect on their approaches and be more attentive to patient concerns. Referring to a difficult experience when she misjudged a patient's sensitivity to touch, PT-H expressed, "I wish I had picked that up before I did that."

4.3.3 Theme 3: Being open

Physiotherapists described being responsive through showing openness to patients. Being open was evident in participants' descriptions of openness to the uniqueness of patients, openness to sharing power, openness to changing one's practice, and approaches to establishing rapport and helping patients feel comfortable and safe.

Openness to patients was frequently portrayed through valuing of each unique patient. PT-C shared, "a particularly good therapist authentically values each individual for who they are and the social realities of their lives." She further described openness as a "wish to work with each and every person that comes in the door" no matter their differences. PT-E framed a 'good' physiotherapist as someone who embodies "genuine caring" and "a genuine interest in helping others." When describing a 'good' physiotherapist, PT-F

spoke of clinicians who “in their heart of hearts, they just want this person to feel better”, no matter who that person is.

Openness to share power was discussed by therapists, many of whom recognized the power imbalance between a physiotherapist and patient. PT-C noted a good practitioner “prioritizes the equitable sharing of power with each patient.” PT-F explained how being open to sharing power fostered trust and honesty: “a patient will be honest with you...not just say what they think you want to hear.”

PT-F further discussed the importance of openness to change your practice based on new information commenting, “maybe what I was doing before isn’t the best care for whatever reason based on this new information.” He noted how openness was important to allow one “to pivot and adjust” and “to incorporate” other perspectives.

Relating in an open manner that makes patients feel comfortable was described by PT-E:

How well can you make someone feel comfortable enough to open up to you and talk to you in a real way...There's a way that you talk to someone that you're a little bit more comfortable...being able to bring that out of people by relating to their experiences, by actively listening to what they're saying, by showing that you somehow relate to them that “I really care about what you're telling me.”...making them feel not judged, ...feeling safe enough to share their story and...giving them the time to speak.

PT-B conveyed openness to patients through body positioning: “I never sit on a treatment table that’s higher than the patient. I won’t look down on them. I try to be at their level or lower.” PT-E shared the perspective that open-mindedness is important for “building a rapport even before you get to the objective exam ...it really impacts how the patient experiences the relationship.” PT-J described openness as important to establishing “a connection with that person so that they feel like they have someone that can help, so that they can tell you things”, while PT-H linked openness to helping patients “feel safe.” For PT-E being open meant patients were “feeling safe enough” to know “you’re not going to judge me, you’re just going to help me.”

4.3.4 Theme 4: Being a listener

All participants described examples of being responsive to patients through listening. Listening was often framed as enabling patients to tell their story and letting them know they were heard. Listening was noted as requiring patience and as taking time. PT-C highlighted, “a good physiotherapist is not only talented in asking questions, she or he is very skilled at listening.”

The importance of listening to patients’ ‘stories’ was frequently noted. For PT-F, listening to patients’ stories was “an intentional choice” he made to foster engagement. PT-D framed listening as “being emotionally available” and “able to listen to peoples’ struggles and how their pain is negatively affecting their lives.” She explained that if a physiotherapist wasn’t listening, a patient might feel like they were “trying to reach out for an answer” but the physiotherapist “kind of shut it down.”

PT-H shared how problematic it could be when physiotherapists “think they know everything and they’re talking at people and not listening.” She noted this may convey “I’m the expert and you should listen to what I have to say.” PT-D contrasted this with an interaction where a patient feels heard: “you [the patient] leave that interaction, you feel like you were heard, you feel understood, you feel inspired and motivated.” For PT-E, it was important to listen by “hearing this story, integrating what they say...actively listening to the details of what they’re saying” and reflecting on “what are they missing in their plan of care or what are they needing from me right now?”

When describing active listening, PT-A noted: “it can only happen if we are patient. We take our time.” As PT-K described: “It’s how well I am listening, trying not to fidget or move or look at my watch or the clock, or anything else in the room. Just try to stay focused on what they’re saying and ensure that I get the information that’s necessary to help make that shared decision.” She noted that a ‘good’ physiotherapist “genuinely wants to hear their story.”

4.3.5 Theme 5: Being validating

Responsiveness was also revealed in many participants descriptions of efforts to validate or affirm patients' experiences. For some, this included efforts to acknowledge patients, or to express empathy or understanding. This was reflected in PT-B's statement, "it's important that each person feels valued."

For PT-C, strong communication skills include "validation of [a] patient's lived experience." When describing a colleague's interactions with a patient, PT-H shared that he used "lots of acknowledgement", saying "I hear what you're saying. I understand why this is happening to you and I'm going to help."

Expressing empathy was important to validating patients noted by many participants. For PT-L "a good physio[therapist] is empathetic, understanding, ...and tries to put themselves in their [patients'] shoes." PT-H commented, "empathy helps to validate the client's concerns...showing ...understanding...that they can't do whatever it is they want ...because of the pain." PT-A pointed out that empathy was especially important with some patients: "You have to know how to show empathy when we deal with more complex patients, emotional patients." PT-G described how someone he considered a 'good' physiotherapist used her body language, positioning, and voice to show empathy and validate patients:

If the client were in distress, she'd do exactly what I would do in the body language of [leans forward and makes eye contact] ...and the soft voice [quiet voice], the proximity, perhaps touch if appropriate...reiteration of what the client's distress is...making sure that the client hears that you're hearing them. Those sorts of things that show strong empathy skills.

4.3.6 Theme 6: Being positive

Responsiveness was also revealed through participants' descriptions of a positive disposition as an aspect of a 'good' physiotherapist. Participants spoke about positive intentions such as being passionate, encouraging, optimistic, and empowering patients toward positive change. PT-C highlighted the importance of being positive:

Having a positive disposition ...contributes to a good rehab encounter because lots of our patients come to us with the loss of energy, or a loss of self or...they're a bit diminished in themselves... [a positive disposition] helps me be a good physiotherapist, because I've got a little bit to spare when other people do not.

Positive intentions were frequently revealed in descriptions of passion and goodwill. PT-C commented that a 'good' physiotherapist has a "passion for people" and "assisting people to flourish." To be a 'good' physiotherapist, PT-D discussed bringing one's positivity *for* the patient: "you're tapping into your own reservoir of energy and positivity for that patient." PT-L discussed the importance of trying to be "positive and encouraging" even when you don't feel like it: "if you have a bad day, you ...try to hide that for the 30 minutes you're with a patient ...staying positive, optimistic and...to be there for the patient so they feel supported." He also cautioned that a 'good' physiotherapist is "encouraging but also realistic and doesn't make any over-the-top promises." PT-H stated that giving patients "lots of encouragement" and being positive such as reassuring patients that "we're going to do it together...I'm here, I'm helping you" are important.

Being positive was also linked to empowering patients. When discussing empowering patients' behaviour change, PT-F noted, "my job is to create environments that make that easier. To give them [patients] tools when they are ready ...and to help them feel like they are supported." Being positive was noted by PT-K as important "to help someone achieve their goals" and to give patients "hope to move forward."

4.4 Discussion

This secondary analysis constituted an in-depth examination of '*responsiveness to patients*', which musculoskeletal practitioners' identified as central to the practice of a 'good' physiotherapist. Six themes related to ways of 'Being' responsive to patients were identified: 'Being' person-centred, 'Being' attentive, 'Being' open, 'Being' a listener, 'Being' validating, and 'Being' positive.

Being responsive in the practice of physiotherapy may be viewed as a moral imperative. While for Heidegger, care is central to being human and living in the world with others (Ahlsen et al., 2021), for philosopher Emmanuel Levinas, to take care of someone is a moral obligation (Lavoie et al., 2006). Levinas' work informs a conception of the practitioner-as-person, as one who takes responsibility to take care "of that Other person who faces us" (Lavoie et al., 2006, p. 226). This involves being responsive to patients' experiences, interpretations, and seeing them as *human beings* rather than as bio-psycho-social specimens or objects (Lavoie et al., 2006). Clifton-Soderstrom (2003) draws on Levinas to argue against the objectification of patients and to endorse responsiveness through narrative-based practice "not to hear the Other in order to receive but to respond" (p. 453). The moral imperative to respond to the 'Other' - the patient - appears to be supported by the findings reported here. Further resonance is noted with what Benda Hofmeyr (2016) describes as 'ethical responsiveness' enacted by being attentive, open, letting Others be heard, and sharing decision-making.

The findings of this analysis align with ethic of care theories in a number of ways. The findings speak to the reciprocal nature of responsiveness between a caregiver and care-receiver (Tronto, 1993). Being responsive, described by Tronto (1993) as an essential element of ethics of care, includes the response of the care-receiver to the care provided. As she explains, needing care denotes being in a position of vulnerability and inequality rather than being self-supporting and autonomous. Participants' accounts point to a 'good' physiotherapist's awareness of a patient's vulnerability. This was evident in discussions that included responding to patients' leads, inviting their perspectives, efforts to make patients comfortable, establishing rapport, and being non-judgmental and equitable. As responsive caregivers, physiotherapists described intentionally acknowledging and validating their patients' viewpoints and differences by being person-centred, listening, and being validating. Tronto also names attentiveness, moral responsibility for care, and competence as essential elements of an ethic of care. She states that responsiveness requires attentiveness noting the two elements are intertwined and bring the caring process full circle (Tronto, 1998). In the current study, being attentive was an important aspect of being responsive, aligning with an ethical orientation to care.

As portrayed by the findings, a ‘good’ physiotherapist may be a ‘deliberate’ practitioner (Trede & McEwen, 2016) choosing to intentionally act in ways that could be characterized as responsive to patients. Trede and McEwen (2016) conceptualized the ‘deliberate’ practitioner in response to concerning trends toward neoliberal ideologies argued to place economic efficiency above the common good. In their conception, a ‘deliberate’ practitioner invites dialogue, and practices collaboratively, thoughtfully, and decisively, in each encounter. A ‘deliberate’ practitioner considers others, is socially responsible, is morally committed to equity, and recognizes a responsibility to care. The ‘deliberate’ disposition counterbalances one-dimensional, technical practices by responsively taking an active and moral stance oriented toward humanism and good practice. The findings suggest parallels between a ‘responsive’ and a ‘deliberate’ physiotherapist; the responsive physiotherapist enacts responsibility for care by being person-centred, attentive, open, validating and listening to others’ perspectives.

The notion of being responsive bears similarity to practices that Miciak and colleagues (2019) propose are important to the therapeutic relationship. They suggest that recognizing the uniqueness of patients’ situations by listening to their stories, validating and empathizing with their experiences, collaborating with them as equals, and individualizing treatment are important ways to establish connections in physiotherapist-patient relationships. They suggest similarities between psychotherapists and physiotherapists when establishing connections with patients and propose physiotherapy researchers judiciously look to psychotherapy theories to understand therapeutic relationship. Interestingly, in the psychotherapy literature, responsiveness appears to be more clearly defined. Reis and Clark (2018) contend that when attending and responding supportively to a person’s needs, concerns, and goals, the other perceives that responsiveness, which is often enacted in ways that verbally or non-verbally communicate attentiveness, openness, listening, understanding, validation, or caring. They contend that responsiveness fosters trust and commitment to the relationship.

Being person-centred was identified as an important dimension of a responsive physiotherapist. Similarly, a qualitative synthesis of studies related to ‘patient-centredness’ in physiotherapy highlighted the importance of individualizing treatment,

ongoing physiotherapist-patient dialogue, and supporting and empowering patients to achieve patient-defined goals (Wijma et al., 2017). Wijma and colleagues' (2017) proposed a conceptual framework of patient-centred physiotherapy that included a physiotherapist's 'patient-centred social characteristics' including being respectful, non-judgmental, open, supportive, genuine, positive, caring, and attuned to emotion. These conclusions align with the current study's findings that highlight responsiveness as described in being attentive (reading patients' emotions), being open (non-judgmental, open, and genuine), and being positive (supportive and empowering).

There may be a subtle but important difference between patient- and person-centred care not yet fully appreciated in physiotherapy research and education. The profession's emphasis on biomedical perspectives may create conflict for some therapists when implementing person-centred approaches (Mudge et al., 2014; Nicholls & Gibson, 2010; Setchell et al., 2018). In Eklund and colleagues' (2019) review of reviews across health care disciplines, the goal of *patient*-centred care was posited as a return to a *functional* life whereas *person*-centred care was proposed as facilitating a *meaningful* life. Although the authors suggested each model involved empathy, communication, and a holistic focus, they theorized that with a person-centred approach, a practitioner empathically looks beyond the moment of care and considers a person's perspective and what gives their life meaning. Through narrative and dialogue, a practitioner gains understanding of what matters to the person by holistically considering the interdependence of biological, psychological, and social dimensions rather than 'adding' the latter two dimensions to a predominantly biological focus of care (Daluiso-King & Hebron, 2020; Eklund et al., 2019; Mescouto et al., 2020). Relating holistically was suggested to foster relationship and inform shared decision-making. Participants' accounts of a 'good' physiotherapist's responsiveness appeared to be enacted through *person*-centred approaches toward doing what's right. Participants described placing patients at the centre, acknowledging their uniqueness, inviting them to share their perspectives including how they meaningfully engage socially and physically, and listening to and validating patients' perspectives, emotions, and experiences. Being responsive supports the proposition that a 'good' physiotherapist may work toward doing 'the right thing' in the promotion of human flourishing (Jenkins et al., 2019; Kleiner, Kinsella, Miciak, Teachman, & Walton, 2021).

The findings suggest that being responsive may be enacted with a *relational* understanding of autonomy. Traditional conceptions of autonomy promote a person's agency or right to make decisions free from controlling influences (Durocher et al., 2019; Ells et al., 2011; Sherwin & Winsby, 2011). For example, this approach underpins the process of informed consent familiar to health professionals (Sherwin & Winsby, 2011). In contrast, various forms of relational autonomy expand the concept by promoting recognition of a person's social context (political, economic, cultural, etc) and how that may shape their identity, priorities, beliefs, values (Ells et al., 2011; Sherwin & Winsby, 2011), and "possibilities for a good life" (Ells et al., 2011, p. 86). Feminist critiques of traditional approaches to autonomy in favour of relational approaches relevant to the practice of a 'responsive' physiotherapist have been discussed by Durocher and colleagues (2019). Traditional conceptions are critiqued as not recognizing people as socially embedded and interdependent within a network of social relationships that may be considered when making decisions. Traditional conceptions also appear to promote the provision of generic information rather than tailoring its content and delivery to the unique person. The findings of this study suggest that by being responsive, a 'good' physiotherapist may adopt a relational approach to autonomy. This was evident in participants' descriptions of placing patients at the centre of attention, encouraging them to share their stories, and acknowledging their uniqueness, perspectives, emotions, and situations. Being responsive appears to support relational autonomy through collaboration, shared decision-making, and individualized approaches in the spirit of person-centred care and good practice.

Participants' descriptions of a responsive physiotherapist included a multi-directional sharing of power through listening and dialogue. Dialogue welcomes contributions of physiotherapists' practice knowledge and patients' perspectives and experiences (Ekman et al., 2011; Trede & Higgs, 2003). As identified in participants' descriptions, by being open and non-judgmental, patients may be encouraged to ask questions and voice their concerns. By allowing patients to share their stories and feel heard, a responsive physiotherapist may learn what patients need and value. Being responsive by listening, validating, and inviting dialogue coincides with other studies of what patients expressed were important to their experience of partnership and shared decision-making

(Bernhardsson et al., 2017, 2019; Kleiner, Kinsella, Miciak, Teachman, McCabe, et al., 2021). However, in a study of physiotherapists' experience of patient participation, Larsson et al. (2010) identified 'paternalistic partnership' with physiotherapist expertise underpinning treatment decisions and goals. In contrast, sharing power is proposed to foster patients' voice, a sense of control, and to empower patients (Melander Wikman & Fältholm, 2006; Trede & Higgs, 2003). In a review of person-centred goal setting, researchers theorized a mutual understanding with patients was facilitated by a physiotherapist's 'responsiveness' (Melin et al., 2019). They proposed that taking time, mindful listening, and attending to patients' narratives, fostered the establishment of meaningful goals.

The findings point to the importance of responsiveness, as an element of 'good' practice, when caring for patients. Lavoie (2006) quotes Collière to suggest a health professional's care "makes sense and has value only if it takes into account what is precious *for* people, what has meaning *for* them or contributes to give meaning again to *their* life" (p. 232). Participants' descriptions of being responsive as part of what constitutes a 'good' physiotherapist suggest that what patients' value and the meanings they bring to the clinical encounter are important considerations. The findings highlight responsiveness as a moral imperative and an essential dimension of a 'good' physiotherapist.

4.4.1 Strengths and limitations

Recruiting experienced physiotherapists from across Canada proved fruitful; participants were quick to volunteer and openly shared rich and evocative descriptions of their experiences and perceptions. Rich descriptions were facilitated by the preparatory exercise, prompting participants to consider responses prior to their interviews. In studies of expert practice, physiotherapist participants were nominated by their peers unlike participants of the current study. However, in the current study, participants were not asked whether they were 'good' physiotherapists, but to describe practices that exemplify a 'good' physiotherapist. Many participants communicated gratitude for the opportunity to reflect on their practice suggesting that 'good' work had occurred in preparing and conducting the interviews.

We acknowledge that this study is an in-depth analysis of the theme of responsiveness that emerged from a study in which participants were asked questions concerning what constitutes a 'good' physiotherapist. The depth of data surrounding this theme offered rich insights, worthy of further exploration. The findings support an ethic of care as central to the practice of a 'good' physiotherapist. While not generalizable, phenomenological findings that are evocative and resonate with readers may be transferable to similar settings. The data is considered in the spirit of van Manen's (2016) 'phenomenological nod' whereby readers are invited to judge whether the findings hold resonance and are plausible.

4.5 Conclusion

This study contributes knowledge about how 'Being responsive' may be enacted in the practice of a 'good' physiotherapist through 'Being' person-centred, 'Being' attentive, 'Being' open, 'Being' a listener, 'Being' validating, and 'Being' positive. The findings point to being responsive as a moral imperative of a 'good' physiotherapist, and as rooted in an ethic of care. As a dimension of a humanistic approach, being responsive may facilitate person-centred approaches including a relational understanding of autonomy and sharing power and decision-making with patients when navigating the complexities of health care. Participants' rich descriptions may be used by practitioners to understand and reflect on practice and change as needed - responsively. The findings promote the importance of researchers, educators, regulators, and practitioners attending to relational dimensions of practice. A relational way of practicing may not simply balance the more technical aspects of physiotherapy; being responsive may improve the appropriate implementation of technical aspects of care. The profession and physiotherapists are invited to consider their moral responsibility to care, which includes responsiveness as a 'good' physiotherapist who engages with patients to facilitate human flourishing. Bringing an ethic of care to patient engagement and advancing relational ways of practicing is proposed as a moral imperative.

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Chapter 5

5 What counts as knowledge in physiotherapy practice: critical reflexivity and transformed understandings

5.1 Introduction

As direct access primary health care professionals involved in health promotion and treatment of injury and disease (Canadian Physiotherapy Association, 2021), physiotherapists possess knowledge, skills, and behaviours that facilitate a person's optimal social and physical capabilities. Traditionally, physiotherapy research, education, and practice have prioritized a biomechanical perspective of health and illness, with emphasis on biomedical knowledge and technical skills (Nicholls & Cheek, 2006). This history has promoted the scientific method, evidence-based practice, and a hierarchy of evidence to guide practice. Conspicuously, the hierarchy of (quantitative) evidence does not recognize knowledge garnered through qualitative research (Gibson & Martin, 2003; Kinsella & Whiteford, 2009). Contemporary rhetoric around the importance of biopsychosocial and patient-centred approaches to practice (Hutting et al., 2021) suggests the profession considers theoretical and social dimensions of practice are important. Yet, qualitative methodologies, which scholars contend are rigorous and trustworthy ways to investigate social aspects of practice, are often excluded as legitimate ways of knowing and subsequently underrepresented in physiotherapy literature (Gibson & Martin, 2003; Jette et al., 2019; McPherson & Kayes, 2012).

In this chapter, I reflect on my formative and transformative understanding of what counts as legitimate knowledge in physiotherapy. This chapter is more than a reflective exercise, it is *reflexive* and offered as a critique of how physiotherapy's history and power dynamics benefit from, but also unwittingly disadvantage or even silence, other ways of thinking and practicing. Being reflexive or thinking critically about what I have taken for granted as a practicing physiotherapist prompted me to question my and the profession's beliefs, values, and assumptions leading me to evaluate how physiotherapy knowledge claims have been generated and accepted. Scholars suggest the physiotherapy profession has been slow to consider its culture, identity, and foundational principles

(Gibson et al., 2018; Nicholls & Gibson, 2010). From my perspective as a doctoral student and experienced practitioner, I reflexively examine physiotherapy's biomedical roots and practice-based knowledge, including interpretivist practice, therapeutic relationship, and clinical uncertainty, as an invitation to consider what counts as physiotherapy knowledge. Critical reflexivity has afforded me opportunity for growth and transformed understanding.

5.1.1 Physiotherapy's positivist and biomedical roots

As a physiotherapist, I was schooled in the adage, "if something cannot be measured, it cannot be improved" (Berenson, 2016, p. 645). Socialized in the practice of physiotherapy as an undergraduate then as an experienced practitioner, quantitative research has underpinned my clinical practice. I began my doctoral journey intending to design and validate an instrument to measure the qualities of a 'good' physiotherapist. A preliminary proposition was that the tool could be used to track a physiotherapist's post-professional development to identify areas they might consider improving. During the first 18 months of my doctoral studies, I examined the literature related to the concept of a 'good' physiotherapist. There were no operational frameworks or rigorous, systematic analyses concerning what constitutes a 'good' physiotherapist. Therefore, I read studies and reviews that investigated patients' expectations, preferences, satisfaction, therapeutic relationship, and practitioner expertise. Most of these studies were qualitative, not quantitative studies.

Buoyed by over 400 years of momentum, the scientific method and a belief in a single 'truth' dominate the sciences, including medicine and rehabilitation, leading to efforts to understand phenomena by experimentation that includes observation and measurement to either verify (positivism) or falsify (post-positivism) hypotheses or theories (Guba & Lincoln, 1994; Nicholls, 2017). Hypotheses are often stated as mathematical formulae, a quantitative language developed by René Descartes and Isaac Newton who were instrumental in advancing the scientific method (Betz, 2010). By the 19th century, the scientific method along with Descartes' dualist philosophy which separated body from mind (Cartesian dualism) were widespread and have dominated health professional discourse to this day (Benner, 2000; Kinsella, 2006, 2007). Cartesian medicine or

biomedicine is noted for valuing scientific objectivity, cause-effect relationships, and reduction of the body (as-machine) into separate parts (Benner, 2000; Nicholls, 2012; Shaw et al., 2010). The rehabilitation professions, including physiotherapy and occupational therapy have historically aligned with medicine, presumably to establish professional status, and in doing so have also aligned with biomedicine's belief in the superiority of quantitative research (Kinsella & Whiteford, 2009; McPherson et al., 2015; Nicholls, 2017; Shaw et al., 2010). In health care, where "positivism is king" (Nicholls, 2017, p. 28), the principles of quantitative research and the scientific method including objectivity and deductive reasoning have "reigned supreme" (Kinsella, 2007, p. 105).

Nicholls and colleagues (Nicholls, 2018; Nicholls & Cheek, 2006; Nicholls & Gibson, 2010) argue that as a profession founded in Victorian England, the social, cultural, and political views of the time prompted physiotherapy to seek medical patronage to legitimize therapeutic touch. Historically, the physiotherapy profession has maintained a biomedical focus with an emphasis on biological knowledge and technical skills at the expense of humanistic qualities (Nicholls, 2018). Because the assessment and promotion of movement from a predominantly biomechanical perspective is central to the profession's identity, physiotherapy education emphasizes a biological focus that privileges anatomy, biomechanics, and pathology in comparison to social, cultural, economic, philosophical, and political dimensions of health (Nicholls & Gibson, 2010).

5.1.2 Calls on health professions for critical reflexivity

In rehabilitation, there has been a call to examine 'taken-for-granted' assumptions to address the social and cultural aspects of practice (Setchell et al., 2018). Scholars argue that self-scrutiny of our culture, identity, and centralizing principles is an exercise physiotherapists have been relatively slow to take up in comparison to other health professions (Gibson et al., 2018). The professionalization of physiotherapy education and pursuit of graduate degrees has presented physiotherapists with opportunities to study the humanities, social sciences, ethics, and to engage in research (Gibson et al., 2018). However, our biomedical ways of thinking and the domination of physiotherapy research by quantitative methodologies has limited examination of our ways of knowing, forestalling calls to consider an 'otherwise physiotherapy'. It has been argued that

neoliberal reforms that demand accountability in the form of ‘evidence-based practice’, standardized outcomes, and indicators of efficiency alongside the profession’s historical need to legitimize itself as ‘scientific’ influence an adherence to a limited ‘body-as-machine’ view of health and physiotherapy knowledge and practice (Gibson et al., 2018; Kinsella & Whiteford, 2009; Nicholls & Gibson, 2010).

Reflexivity involves the examination of the social and historical conditions under which knowledge claims are constructed and accepted (Kinsella & Whiteford, 2009).

Understanding the context of the physiotherapy profession’s origin and history illuminates how social processes shape how we have come to think and act in practice and generate future knowledge through research. Epistemic reflexivity, a phrase coined by Bourdieu (Bourdieu & Wacquant, 1992) involves critically reflecting on the social conditions that influence what constitutes legitimate disciplinary knowledge that is often taken-for-granted and not questioned limiting the possibility for new ways of thinking, being, and doing (Kinsella & Whiteford, 2009; Phelan, 2011).

Engaging in qualitative research (and practice) with a critical lens disrupts and challenges the status quo. By identifying and questioning taken-for-granted ‘truths’ that underpin health care practices, we may be empowered toward change supporting new ways of knowing and practicing in the promotion of equity (Nixon et al., 2017; Ponterotto, 2005). Critical research, founded in the thoughts of a number of theorists including those from the Frankfurt School, is emancipatory by seeking to critique socially, culturally, and historically embedded beliefs that shape how we think and practice (Kincheloe et al., 2011). Critical scholarship in the rehabilitation professions encourages us to consider what constitutes legitimate knowledge and taken-for-granted approaches to knowledge generation (Kinsella, 2012; Setchell et al., 2018). As noted by Kincheloe et al. (2011), well-known critical theorist, Paulo Freire encouraged people “to begin thinking about their thinking” (p. 164). Similarly, scholar and physiotherapist, Barbara Gibson (2018) has encouraged physiotherapists to maintain an ‘ethic of openness’ and be sensitive to the hidden aspects of practice and their unintended harms by asking ourselves, “What are we (physiotherapists) doing and why?” (p.43).

5.2 Practice-based knowledge

As a health professional with an education dominated by the biomedical approach, I have experienced tensions resulting from the contradictions between the objectivity this approach demands and the interactive and intersubjective nature of physiotherapy practice. Inspired by my professional education, my early post-professional training focused on the development of my technical competence and credentials. Diagnosis of musculoskeletal conditions and injuries requires objectivity and logical reasoning to arrive at ‘the truth’. Clinical prediction rules and guidelines steer me towards interventions calculated to be effective.

However, in practice, I came to recognize that despite consistent applications of my technical expertise, the outcomes that my patients achieved were not equal. Through reflection on my practice, I realized that my interactions and successes with patients were not entirely dependent on the technical skills that I possessed to make a diagnosis, choose and implement an intervention. I, like other physiotherapists I have talked to, realized that my training had not prepared me to meaningfully engage with patients who present with “a messy combination of complex subjective and interpersonal elements that often defies easy [biomechanical, biomedical, or], even rational, explanation” (Nicholls, 2018, p. 132). This realization was further influenced by a rise in the physiotherapy community’s support of Engel’s biopsychosocial model of care (Engel, 1977). Rejecting dehumanizing biomedical perspectives which separate the body-as-machine from people’s narratives, perceptions, and responses to pain and illness, Engel endorsed an integrative model which considered the interaction of biological, psychological, and sociocultural factors inherent in disease and illness (Borrell-Carrio, 2004; Gatchel et al., 2007).

Emboldened by my practice experiences and research encouraging the integration of psychological interventions in physiotherapy to address the psychological components of people’s persistent pain (Nicholas & George, 2011), I looked outside the profession of physiotherapy to social work and psychology to train and improve my interpersonal skills. Striving to balance my technical competence to address the biological aspects of injury and disability with a human way of being when interacting with my patients by also considering the psychological and social aspects of their experiences has shifted my

practice beyond biomedical domains. I've become very much aware of the importance of the professional working alliance between myself and my patients as we collaborate on the activities and goals of therapy (Bordin, 1979). I've also come to value the personal, 'real relationship', common to human encounters (Gelso, 2014) as expressed in the camaraderie of a personal rapport as a component of the therapeutic relationship (Miciak, 2015) and as important to person-centred care (Miles et al., 2015).

5.2.1 Interpretivist practice

Working with my patients, I increasingly recognized the multiple perspectives each patient possesses about their condition or injury. As people, I also recognized their uniquely constructed understanding of their condition influenced by psychological and sociocultural factors and experiences. As I shared my physiotherapy knowledge of movement and pain science with my patients, and they shared their lived experiences and beliefs about their pain and abilities, we interactively constructed new ways of understanding through dialogue, creating deeper meaning of experiences and interpretations together. Little did I know that I was being drawn toward interpretivist perspectives in my practice, which may explain the tension I was feeling when attempting to reconcile this approach with post-positivist ways of knowing. The interpretivist paradigm "assumes multiple, apprehendable... realities" resulting from the socially 'lived experience' of each "person [or patient] ... who is experiencing, processing, and labeling the reality" (Ponterotto, 2005, p. 129).

5.2.2 Indeterminate zones of practice

Although the positivist biomedical perspective has been important to establish a quantitative evidence base for aspects of clinical practice such as measurement of movement and functional ability, and response to treatment intervention (Shaw & Connelly, 2012), this reductionist approach does not address the complexities of practice that lie in the 'indeterminate zones' (Kinsella, 2007). As highlighted by Kinsella (2007), philosopher Donald Schön conceived of the majority of professional practice as occurring in 'indeterminate zones', swampy lowlands where uncertainty, uniqueness, and the messiness of the human experience defy technical or scientific solutions. This is

recognized in Sackett and colleagues (2000) definition of evidence-based practice as including “the integration of best research evidence *with* clinical expertise *and* patient values [italics added]” (p. 1). However, current health care approaches place emphasis on experimental evidence at the expense of clinical experience and tacit knowledge (Dahl-Michelsen et al., 2021; Greenhalgh et al., 2014). The complex subjectivities of practitioner and patient values that lie in the indeterminate zones of practice and how they are navigated with clinical expertise are not easily quantified, perhaps not even quantifiable, yet systematic research evidence garnered from quantitative methodologies dominate the epistemology of physiotherapy and occupational therapy research and practice (Kerry, 2017; Kinsella & Whiteford, 2009). Although historically, the rehabilitation professions have shown little interest in the social sciences, exploring the ‘how’, ‘what’, and ‘why’ of social and cultural situatedness, the various beliefs of patients and practitioners, and the meanings people attribute to their experiences encourages us to broaden our understanding beyond biomedical perspectives and assumptions (Finlay & Ballinger, 2006; Guba & Lincoln, 1994; McPherson et al., 2015).

5.2.3 Therapeutic relationship

Physiotherapy outcomes are suggested to be influenced by the specific effects of the intervention combined with the non-specific effects common across various treatment approaches (Miciak et al., 2012). Miciak and colleagues (2012) theorize that a psychotherapy ‘common factors’ model that includes the non-specific effects of therapist characteristics and the quality of the therapeutic relationship is applicable to physiotherapy practice. Physiotherapy research supports this proposition.

Musculoskeletal physiotherapists and other health care professionals’ attributes such as being caring, friendly, respectful, and competent were consistently identified as important determinants in reviews of patient expectations, perceived needs, and satisfaction (Chou et al., 2018; Hopayian & Notley, 2014; Hush et al., 2011; Rossettini et al., 2018). A strong therapeutic relationship, briefly defined as the safe, affective bond between patient and practitioner, developed both professionally and personally when establishing connections and engaging in the collaborative work of physiotherapy (Miciak, 2015), is suggested to result in improved outcomes for patients (Ferreira et al., 2013; Hall et al.,

2010). Miciak and colleagues (2012) propose a physiotherapy common factors model that includes attention to contextual factors inherent within patient encounters may assist in understanding and addressing clinical complexity and facilitate holistic approaches.

As a practicing physiotherapist, I have witnessed and experienced a range of professional and interpersonal qualities at play in ‘good’ physiotherapy practice. Encouraged by research into the components important to the therapeutic relationship (Miciak et al., 2018, 2019) and my own experience with patients, I endeavour to be present, responsive, respectful, caring, genuine, and most importantly, to listen and validate their experiences to collaborate as equals. Patient advocates who live with persistent pain, share stories of feeling empowered towards greater understanding and self-management of their conditions when invited into dialogue by their practitioners as one human with another where ‘lived experiences’ are shared and validated (Belton & Meldrum, 2020). Sharing in this way contrasts stories of being objectified by health care practitioners who offer biomechanical approaches and ‘fixes’ for the body-as-machine that are not person-centred and do not consider psychosocial aspects of patients’ experiences of pain. Stories like these, inspire me to reflect on my own physiotherapy practice and I continue to seek new ways of knowing and practicing that will empower patients, clinicians, and our profession beyond biomedical perspectives. With increased reflection on my own experiences with patients and my training outside the profession, I realize how my physiotherapy practice has, in some ways, transformed despite my socially and historically constituted biomechanical training.

5.3 Power relations

As an experienced physiotherapy practitioner, I have become increasingly aware of the power of the more dominant discourses of biomedicine. As a doctoral student, I came to understand there is a relationship between power and knowledge (Kincheloe et al., 2011). Understanding how knowledge is constructed socially and historically and may be privileged to become a “regime of truth” (p. 181) has helped me understand how the power of the evidence-based discourse has saturated physiotherapy knowledge and practice (Holmes et al., 2006). Aligning with a singular, post-positivist view of what counts as legitimate knowledge marginalizes other ways of knowing that may aid in

understanding the complexities of health and illness (Gibson, 2016). Biomedical perspectives in physiotherapy have privileged technical competency over humanistic dimensions of good practice (Nicholls & Gibson, 2010). Incorporating a critical social science perspective (Eakin et al., 1996) in my research presented an opportunity to critique 'taken-for-granted' assumptions that dominate the profession and physiotherapists' 'way of being' in everyday practice. Questioning what power relations may be at play in physiotherapy disrupts sedimented ways of thinking creating possibilities for other ways of thinking, knowing, and practicing in the search for the 'good' in physiotherapist practice. With increasing consciousness of the multiple perceptions at play, mine and my patients', I offer a critique of normative professional practice and practitioner-centred discourses of physiotherapy and call for us to highlight more humanistic aspects of practice.

5.4 Rethinking professional knowledge/transformational understandings

As a practicing health professional learning to think qualitatively has been a challenging and transformational journey. Choosing to continue my post-graduate work as a doctoral student with an interest in health professional education, I originally and naïvely looked to quantitative research methodologies to contribute to the rehabilitation evidence base by creating a measurement tool. One of my first steps to develop an instrument that would be clinically meaningful was to collect qualitative data from its intended users, patients and physiotherapists who interact in everyday clinical practice (McPherson & Kayes, 2012). To broaden my knowledge to that end, I enrolled in a qualitative research methods course where I was confronted with questions about the philosophy of science and what counts as legitimate knowledge prompting me to re-examine my beliefs about health science research and clinical practice.

After more than two decades of clinical practice, it was not until graduate school that I was encouraged to consider the philosophical and conceptual underpinnings of what counts as legitimate knowledge. I was introduced to research paradigms and multiple ways of understanding what counts as knowledge and how it can be known (epistemology). I had never stopped to consider different research paradigms, my

collection of intertwined assumptions and beliefs about the justification of knowledge claims, nor what philosophical and conceptual frameworks underpinned my beliefs (Ponterotto, 2005). I had never previously been exposed to considerations of differing epistemologies, such as those reflected in post-positivist, interpretivist, or critical paradigms.

I relinquished my plans to develop a measurement tool. I embraced qualitative research and phenomenology to investigate physiotherapists' perspectives, lived experiences, and their interactions with patients to study what constitutes a 'good' physiotherapist. Investigating physiotherapists' situatedness may advance our understandings of a 'good' physiotherapist's way of 'being-in-the-world' and ways of interacting with patients. I have left my focus on measurement to focus on the relational to study how as physiotherapists, we may balance technical competence with relational ways of practicing. Understanding patients' and physiotherapists' perceptions of what constitutes a 'good' physiotherapist has potential implications for how we educate future physiotherapists and how clinicians may navigate the indeterminate zones of practice with person-centred care *and* evidence-based approaches.

5.5 Conclusion

Critical reflexivity on what constitutes physiotherapy knowledge invites us to examine what we take for granted as a profession. Exploring our underlying beliefs, values, and assumptions that underpin what knowledge is privileged over other ways of knowing fosters an ethic of openness allowing us to consider other perspectives and potentially transform understandings. Appreciating physiotherapy's history, taken-for-granted assumptions, and the value of qualitative alongside quantitative research advances our understanding of illness and injury towards a holistic understanding of health.

Broadening our understanding of social, cultural, and political dimensions of practice beyond biomedical ways of knowing and practicing provides opportunity to inform disciplinary research, education curricula, clinical practice, patient interactions, and perhaps transform our profession. Not all aspects of the physiotherapy experience may be explained through biomedical perspectives and quantitative research as attested to by professional discourse on the biopsychosocial model, therapeutic relationship, patient

experience of physiotherapy, and the role of physiotherapist expertise and practical wisdom. The complexity of the human experience, oftentimes represented in the physiotherapist-patient encounter, includes indeterminate zones where relational ways of practicing and reflexivity on physiotherapist and patient experience, values, and expertise may transform understandings and physiotherapy practice.

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Chapter 6

6 Conclusion

6.1 Introduction

In this concluding chapter, I highlight insights garnered from the various investigations into a ‘good’ physiotherapist presented in this dissertation. The chapter begins with a summary of three key contributions of this work to understandings of a ‘good’ physiotherapist. This is followed by a discussion of the quality criteria by which the findings may be judged, possibilities for future research, and implications for the education and practice of physiotherapists and practicing clinicians.

6.2 Key Contributions

6.2.1 A ‘good’ physiotherapist balances technical competence with a relational way of being

The findings of this dissertation draw on scholarly literature and practitioners’ perspectives to paint a picture of a ‘good’ physiotherapist as a practitioner who intertwines technical competence with a relational way of being. This proposition is supported by Rutberg et al.’s (2013) investigation of ‘good’ physiotherapy practice and Fadyl et al.’s (2011) interpretation of ‘good-quality’ care in their study with people experiencing disability. The need for balance between relational and technical practices aligns with conceptions of ‘good’ practitioners as depicted in the literature in other fields, such as medicine (Hurwitz & Vass, 2002), nursing (Smith & Godfrey, 2002), and occupational therapy (Wright-St Clair, 2001). A balance of technical competence and a human approach is suggested as fostering individualized care that is context appropriate and responsive to patients’ individual needs (Fadyl et al., 2011). These findings are echoed in Gillespie et al.’s (2017) review of patients’ experience of caring. Their findings pointed to a link between competence and caring suggesting “both are important but neither alone is sufficient.” (p. 1633).

In the current study, a ‘good’ physiotherapist was described as emphasizing technical competency *and* the therapeutic relationship between physiotherapists and patients and

the relational practices that support it. Findings of this dissertation align with the concept of therapeutic relationship in the context of occupational therapy as proposed by Crepeau and Garren (2011) who suggest the therapeutic relationship in rehabilitation relies on “a complex interplay of technical skill, communicative competence, and the reflective capacity of the therapist to respond to the patient in the moment of therapy” (p.873). The various qualities and practices of a ‘good’ physiotherapist identified in participants’ accounts are also consistent with Miciak and colleagues’ (McCabe et al., 2021; Miciak et al., 2018, 2019) proposed physiotherapist-patient relationship framework. Being communicative and responsive, collaborating with patients, validating patient experiences, and individualizing treatment approaches are consistent with the behaviours that Miciak and colleagues theorize are important to engagement, connection, and bonds between physiotherapists and patients. The qualities and practices of a ‘good’ physiotherapist point to an emphasis on the quality of the human interaction between physiotherapists and patients suggesting an intertwining of ‘good’ practice and therapeutic relationship. Ethic of care theories emphasize relationship as the context that shapes our moral responsibility (Held, 2006). Consistent with an ethic of care, a ‘good’ physiotherapist was found to practice with a relational approach and to emphasize the quality of the therapeutic relationship with patients.

6.2.2 An ethic of care is central to a ‘good’ physiotherapist’s practice

The findings of this study point to the practice of a ‘good’ physiotherapist as underpinned by an emphasis on ‘care’ consistent with Joan Tronto’s (1993) ethic of care theory. As described in Chapters 3 and 4, Tronto’s theory conceptualizes care as a practice involving the relational competence of acting and responding. As a ‘habit of mind’, she proposes an ethics of care comprised of attentiveness, responsibility, competence, and responsiveness. Tronto’s elements of care are represented in this dissertation’s findings. As overarching themes, *an ethical orientation to care* and *integration of person-centered care with evidence-based practice*, were intertwined with themes of ‘being’ *competent, responsive, reflective, communicative*, and ‘using’ *reasoning*, lending support to the proposition that an ethic of care is central to the practice of a ‘good’ physiotherapist. By studying

responsiveness in greater depth (Chapter 4), I found that participants' accounts pointed to a 'good' physiotherapist as one who practices responsiveness by *'being' person-centred, attentive, open, a listener, validating, and positive*. As proposed by Tronto, these elements are intertwined: 'care-receiving' involves *responsiveness* of the care-receiver to the care provided and *attentiveness* of the caregiver who may then be *responsive* to the other.

Provisional conceptualizations of a 'good' physiotherapist from practitioners' perspectives have primarily aligned with virtue ethics through investigations into the attributes of master (Jensen et al., 1992), experienced (Jensen et al., 1990), and expert clinicians (Jensen et al., 2000; Resnick & Jensen, 2003). These research studies culminated in a theory of expert practice proposed by Resnick and Jensen (2003) whereby an expert physiotherapist is theorized to practice a patient-centered approach supported by an interplay of clinical reasoning, virtues/values, therapist knowledge, and practice style. They suggest the virtues of caring and commitment are linked to an 'ethic of caring' as the 'foundation' of an expert physiotherapist's approach (Resnick & Jensen, 2003). They propose caring and commitment as important "personal character traits and personal attributes" (Jensen et al., 2000, p. 39), which seems to place the focus on an expert physiotherapist's 'caring dispositions' rather than on conceptualizing care as a 'practice' of deliberately acting and responding in particular ways (Martinsen, 2011). The findings of the current study point to a 'good' physiotherapist's 'caring' as a practice as identified in an ethical orientation to care underpinned by various *ways of being* when integrating person-centred care with evidence-based practice. Viewing care in this way, as a relational competence that can be developed and practiced, conceptualizes encounters with patients as relational and intersubjective. In contrast, a physiotherapist may possess a caring disposition but practice as a detached 'expert' and which may render patients as objects rather than subjects.

This dissertation expands on Jensen and colleagues (Jensen et al., 1990, 1992, 2000; Resnick & Jensen, 2003) research by proposing that 'care' may be seen as *both* a disposition *and* a practice, as evident in the findings that describe the practices of a 'good' physiotherapist whose actions appear to be intentional and ethically oriented. While similar, the difference between a 'good' and 'expert' physiotherapist may be found

in the ends of their actions and how they choose to do what is right. For Resnick and Jensen (2003), 'experts' were identified based on their capability to achieve the best functional outcomes for patients as measured by an overall health status measure of physical and mental health. They theorize an expert therapist's capability as informed by clinical reasoning and professional knowledge (Resnick & Jensen, 2003).

Aligning with the findings of this dissertation, when Greenfield and colleagues' (2006, 2008) examined the nature of caring in physiotherapists' practice, they concluded clinicians viewed caring as their moral orientation to practice, which influenced ethical and clinical decision-making. This implies a moral orientation to practice that is embedded within a therapeutic relationship in which physiotherapists and patients collaborate on treatment approaches to facilitate a return to what is meaningful for patients. This is contrasted with an approach that focuses solely on functional outcomes, with the physiotherapist positioned as detached expert.

Although clinical reasoning was theorized as important to 'expert' practice, 'reasoning' in this dissertation was interpreted to involve an ethical dimension. When analyzing participants' accounts of what constitutes a 'good' physiotherapist (Chapter 3), an ethical orientation to 'good' practice was identified. One participant, PT-C conveyed this notion as follows: "a good physiotherapist seeks what it is the patient values in a respectful manner highly informed by best practices, and by a moral or an ethical compass that places those best interests of the patient first and foremost." Rather than drawing on evidence alone, participants' accounts support that with an ethical orientation to practice, a 'good' physiotherapist uses reasoning to make the morally right decision, which at times conflicts with the science but is person-centred. Aristotle theorized practical wisdom as central to choosing virtuous actions (Kinsella & Pitman, 2012). When balancing technical competence with person-centred approaches, Tronto (1998) proposes practical wisdom is required. This suggests that practical wisdom may be invoked when therapists integrate person-centred approaches with evidence-based practices.

6.2.3 Being responsive is a moral imperative of a ‘good’ physiotherapist

Monteux and Monteux (2020) contend “relationships are central within ‘people work’” (p. 1) and the human encounter between a caregiver and care-receiver constitutes a “relationship-based *moral* practice” (p. 3). Consistent with ethic of care theories that promote the centrality of relationships as the source of our moral responsibility (Held, 2006), empirical findings of this dissertation point to a ‘good’ physiotherapist as one who practices an ethical orientation to care that values relationship. As a way of being, ‘being’ responsive was found to be important to the encounters between physiotherapists and patients as exemplified in being person-centred, attentive, open, a listener, validating, and positive. These findings highlight one or more aspects of care identified by Miciak and colleagues (2019) as important to physiotherapy therapeutic relationships.

Drawing on the work of Emmanuel Levinas, Benda Hofmeyr (2016) proposes “the possibility of goodness arises when I am overcome by an encounter with a face that stops me in my tracks” (p. 10). For Levinas, encountering the face of the Other is an ethical demand, a face-to-face relationship with *someone* not a relationship to *something* that is observed or perceived (Perpich, 2019). In Chapter 4, it was proposed that a responsive physiotherapist acknowledges the uniqueness of patients, individualizes the approach to patient care, responds to patients’ leads, invites patient perspectives, and shares decisions. Engaging as a practitioner who is responsive to the needs of a particular patient within the demands of a specific context recognizes patients as people, rather than as objects to be classified into diagnostic categories or clinical practice guidelines (Maric & Nicholls, 2019; Saraga et al., 2019). As a moral imperative, a relational ethic of care that includes being responsive answers the call for physiotherapists to relate with their patients as ‘subjects’ rather than ‘objects’ (Romanello & Knight-Abowitz, 2000).

The findings of this dissertation support the proposition that the moral orientation of a ‘good’ physiotherapist is underpinned by an ethic of care and informed by a relational competence of acting and responding. Rather than seeking the position of privileged ‘expert’, recognizing the intersubjective nature of therapeutic interactions (Kinsella, 2005) appears important to the practice of a ‘good’ physiotherapist. Resnick and Jensen

(2003) point to an ‘ethic of caring’ in their theory of ‘expert’ physiotherapy practice, but do not underpin their proposition with an ethic of care theory nor do they specifically highlight the importance of being responsive. Although they suggest caring as a “fundamental ethic” of a physiotherapist, ‘caring’ is sparingly described in the context of participants’ descriptions of “a strong desire to help others” and “as good listeners” (p. 1102). The findings of this dissertation highlight aspects of physiotherapy practice that may be overlooked when considering ‘expert’ rather than ‘good’ practice. Drawing on the writings of Levinas, Perpich (2019) suggests “there is a difference between looking at the other and being in relation *to* the other.” Viewed from a relational ethic of care perspective, her proposition suggests that from within the therapeutic relationship and when face-to-face with a patient, being responsive may be viewed as a moral imperative of ‘good’ physiotherapy practice.

6.3 Quality Appraisal

6.3.1 Enhancing rigour in the phenomenological studies of a ‘good’ and ‘responsive’ physiotherapist

While van Manen (2016) states, “the method of phenomenology is that there is no method”, he explains “the broad field of phenomenological scholarship can be considered as a set of guides and recommendations for a principled form of inquiry” (p. 30) demonstrated in a ‘phenomenological attitude’. van Manen’s (2014, 2016) ‘phenomenology of practice’ and the recommendations of various phenomenological health science researchers (Annells, 1999; Caelli, 2001; Finlay, 2009; Shaw & Connelly, 2012; Wilding & Whiteford, 2005; Wright-St Clair, 2015) were integrated with Tracy’s (2010) ‘Eight ‘Big Tent’ Criteria’ as a quality appraisal framework. How each scholar’s recommendations guided the quality appraisal of the dissertation is outlined in Appendix L. Tracy (2010) proposes eight criteria to appraise qualitative research quality: worthy topic, rich rigour, credibility, sincerity, resonance, significant contribution, meaningful coherence, and ethical study conduct. The various means, practices, and methods through which the study trustworthiness was enhanced are outlined in the following sections on the phenomenological attitude and Tracy’s (2010) eight criteria.

6.3.1.1 Phenomenological attitude

A phenomenological approach involves a ‘phenomenological attitude’ whereby assumptions and what is taken-for-granted are reflexively articulated allowing a researcher to approach phenomena with wonder, critique, and curiosity (Dowling, 2007; Finlay, 2009; Park Lala & Kinsella, 2011; van Manen, 2014). A stance of naiveté and openness allows for new understanding of phenomena (Park Lala & Kinsella, 2011).

Finlay (2009) proposes rigorous phenomenological research is appropriately underpinned by phenomenological philosophy. Insights from philosophical works that underpin hermeneutic phenomenology were incorporated from *Being and Time* by Martin Heidegger (Heidegger, 1927/1996) and *Totality and Infinity* by Emmanuel Levinas (Levinas, 1961/1969). Heidegger integrates hermeneutics with phenomenology to understand the meaning of ‘Being’. Theorizing that Being is linked to the experience of living in the world, Heidegger contends we are always interpreting to understand what being-in-the-world means. For Heidegger (1927/1996), “phenomenological description is *interpretation*.” (p. 35). Moules and colleagues (2015) suggest that as Heidegger theorized, “we are in the world, fully implicated in an already interpreted way of life, operating in a language full of sedimented (i.e. historical) meanings, and oriented by our relationships toward the world in a particular way” (p. 25). Therefore, being-in-the-world means that as hermeneutic phenomenologists, we recognize the impossibility of fully ‘bracketing’ our pre-understandings and we are reflexive about how they influence our interpretations (Finlay, 2002; Moules et al., 2015).

6.3.1.2 Worthy topic

For Tracy (2010), a worthy topic of research is one that is considered a timely examination of disciplinary priorities or taken-for-granted assumptions. I argue that the current study is a worthy topic for a number of reasons. First, the study responds to a tension that I have experienced as a clinician: the objective, technical aspects of practice juxtaposed with relational approaches that person-centred care requires. Second, what constitutes a ‘good’ physiotherapist may adapt to changing social, cultural, and political contexts, which necessitate re-examination from time-to-time. As suggested in the

introduction, more recently, the physiotherapy profession is questioning the theoretical underpinnings and ways of knowing as applied to practice (Gibson et al., 2018; Nicholls et al., 2021). Professional self-scrutiny of taken-for-granted assumptions and “criticality for an otherwise physiotherapy” (Gibson et al, 2018, p.14) suggests examining what constitutes a ‘good’ physiotherapist is a professional priority and a worthy topic of investigation.

6.3.1.3 Rigour and credibility

Tracy (2010) proposes rigour and credibility are important criteria in qualitative research. Rigour is achieved when a study uses sufficient and appropriate theoretical constructs, sample, context, and methods of data collection and analysis. Credibility is characterized by thick description that fosters plausibility and trustworthiness of the findings.

Sample sizes are generally smaller in qualitative research with twelve considered a robust sample size in phenomenological research (Boddy, 2016). Care was taken to recruit a purposive sample of experienced physiotherapists who could offer rich perspectives to advance understanding of the phenomenon of interest (Brosky & Scott, 2007; Di Tondo et al., 2018; Jensen et al., 1990, 1992, 2000; Resnick & Jensen, 2003). Congruent with the philosophy of hermeneutic phenomenology, data collection included time in the field to gather participants’ deep and rich experiential accounts and to interpret and “make contact with life as it is lived” (van Manen, 2014, p. 353). To develop a rich, phenomenological understanding, participants were prepared for the interviews through a preparatory reflective writing exercise. Further, within the semi-structured interview, participants’ accounts were elicited in a conversational manner by paraphrasing, mirroring, summarizing, and probing responses. When writing the findings of the study, I was attentive to include concrete detail to *show* meaning rather than *tell* readers what to think (Tracy, 2010).

6.3.1.4 Sincerity

Tracy (2010) proposes sincerity as a criterion of quality in qualitative research that involves transparency about study methods and challenges and reflexivity about researcher values and assumptions. Tracy (2010) contends that both aspects of sincerity

relate to notions of ongoing authenticity regarding the researcher and the research process.

Transparency of the research process was fostered through field notes, an audit trail, and a reflexive journal (Finlay, 2009; Wright-St Clair, 2015). Field notes were recorded after each interview to track researcher insights and observations including challenges encountered in the research. Challenges included a) whether interview questions were leading participants to speak about relational practices over technical ones; b) time required to transcribe interviews and finding an appropriate solution; and c) organizing the analysis of the wealth of data collected. Research decisions were recorded in an audit trail (Finlay, 2009; Wright-St Clair, 2015). Reflexive journaling began in the early stages of the research and was ongoing.

Being reflexive of one's pre-understandings is argued to enhance methodological trustworthiness (Finlay 2002; Wright-St Clair, 2015). When preparing the proposal for the study of a 'good' physiotherapist, researcher assumptions, expectations, and hopes were openly and honestly recorded (Chapter 1). The research process was reflexively conducted when preparing the interview guide and conducting interviews; the guide was iteratively refined, and reflexive notes were recorded following each interview. Reflexive notes included observations and insights related to interviewee and interviewer demeanor and behaviour. They also included preliminary insights garnered from participants' accounts individually and in the context of prior interviews. Observations included comments about difficulty eliciting participants' accounts of everyday practice experiences, encouraging participants to share their particular experiences rather than generalizations, and noting the use of leading questions.

6.3.1.5 Resonance/phenomenological nod

Resonance across the data set is characterized by what van Manen (2016) describes as 'the phenomenological nod' whereby the reader may recognize the experience as one they had or could have had. van Manen (2016) suggests a phenomenological text that is descriptively rich and recognizable evokes 'contemplative wonder' and offers insights that go beyond taken-for-granted understandings of every-day life. It is hoped that

participants' accounts are evocative in their descriptions of a 'good' physiotherapist's practice, and that they offer food for readers' reflections.

In light of my own experience as a practicing physiotherapy clinician, I experienced resonance with participant perspectives when conducting interviews and analyzing participants' data. My doctoral committee members also communicated that the study findings held resonance for them.

6.3.1.6 Significant contribution

Applying phenomenological inquiry as a 'phenomenology of practice' to reflect *on* and *in* clinical practice may lead to more meaningful practice (van Manen, 2014). van Manen (2016) refers to an 'inceptual epiphany' whereby a study may offer deep and original insight into life's practices. The findings of the empirical studies presented in this thesis offer contributions to professional conversations about the future practice of physiotherapy. Understanding what constitutes a 'good' and 'responsive' physiotherapist may inform entry-to-practice curriculum, competency profiles, and everyday patient interactions. It is my hope that the findings will extend physiotherapy knowledge and improve practice.

6.3.1.7 Meaningful coherence

I was attentive to underpinnings and coherence across the research process consistent with hermeneutic phenomenology to ensure the study would "hang together well" (Tracy, 2010, p. 848). This involved connecting a wider body of literature with the research questions, theoretical framework, findings, and interpretations to support the knowledge claims proposed.

6.3.1.8 Ethical

Ethical considerations were important throughout the research process. Procedural ethics were ensured by Western University's Health Sciences Research Ethics Board prior to initiating participant recruitment or data collection (Project ID: 116455). Two amendments regarding use of transcription programs were submitted and approved. Participants' anonymity was maintained throughout the research process and in the

presentation of the findings. Communications and interviews were conducted with respectful dialogue and ongoing consent. Transcripts and study findings will be shared with participants.

As a researcher and experienced clinician, I was mindful of the situational and relational ethics the research presented. It was important to establish a relationship of trust with participants from the moment they first expressed interest in participating in the study and especially at the beginning of their interviews. Creating connection with each participant was undertaken by disclosing my professional background as a fellow musculoskeletal physiotherapist. At the time of the interviews, many of us shared the common experience of transitioning practice online in response to the COVID-19 pandemic. Communicating via Zoom has become a common practice for each of us. At the conclusion of the interviews, many participants expressed gratitude for the opportunity to participate in the study and reflect on their practice.

6.4 Implications of this research

This research highlights the importance of relational practices within conceptions of a ‘good’ physiotherapist. This is distinct from the general focus in the profession, which has tended to focus more on technical competencies (Glover Takahashi et al., 2017; Nicholls, 2018).

6.4.1 Practice

As a clinician, it is my hope that the findings of this dissertation will improve the practice of physiotherapists when working with patients. Clinicians may relate to findings that suggest that a technical rationalist perspective is not sufficient to address the complex nature of clinical practice and patient encounters (Kerry, 2017; Kinsella, 2007; Shaw et al., 2010). Finding that a ‘good’ physiotherapist balances technical competence with relational ways of practicing is consistent with Nicholls’ (2018) proposition that “most of the really good physiotherapists...find a way to engage meaningfully with the people who made [sic] up their practice” (p. 132). The findings of this dissertation suggest that placing relationship at the centre of practice supports the therapeutic relationship as fundamental to good practice and the caring work of physiotherapy. Approaching

practice with an ethic of care invites reflection on taken-for-granted approaches to patient interactions based on objectivity, and draws greater attention to communication, respect for autonomy, shared decision-making, and a practical orientation toward outcomes that facilitate a flourishing life.

Being communicative is proposed as an important aspect of what constitutes a 'good' physiotherapist. Physiotherapists' descriptions suggested communicating a diagnosis, prognosis, treatment plan, expectations, and patients' rehabilitation progress were important. They also noted it was important to be patient, and take time to listen and answer questions, aligning with patients' preference to be provided explanations (Ali & May, 2017; Bernhardsson et al., 2017; Cooper et al., 2008; Hills & Kitchen, 2007). Diener and colleagues (2016) argue, "listening is therapy" (p. 356) and engaging with patients requires more than collecting information. Within the studies in this dissertation, being a listener was identified as one way a 'good' physiotherapist may be a responsive physiotherapist. Holopainen and colleagues (2021) suggest physiotherapists may be reluctant to adopt person-centred communication that includes open-ended questions and allows patients to share their stories because it will take too much time. Their research found, however, that such 'validating' communication did not take more time and further proposed it may build trust, enhance treatment effects, and improve patient engagement and satisfaction; when discussing what constitutes a 'good' physiotherapist, similar sentiments were expressed by the physiotherapists that I interviewed.

Across the findings in this dissertation, physiotherapists highlighted the importance of two-way communication rather than positioning themselves as the 'expert'. For physiotherapists interviewed in this study, inviting dialogue was viewed as important to establishing rapport, creating trust in the therapeutic relationship, and collaborating on treatment approaches and goals. Participants' emphasis on shared decision-making as a practice of a 'good' physiotherapist contrasts research that suggests shared decision-making is poorly implemented despite patients' expressed desire to be involved (Baker, 2001; Chou et al., 2018; Dierckx et al., 2013). Clinicians may wish to take heed of the importance of shared decision-making highlighted in this dissertation as an ideal of 'good' practice.

Respect for autonomy is a widely adopted ethical principle, whereby when making decisions patients are free to make choices (Ells et al., 2011). While respect for autonomy may be codified in a professional code of ethics (Delany, 2017), *relational* autonomy may be an unfamiliar concept to many clinicians. A relational approach to autonomy is discussed in Chapter 4 and proposed to be facilitated by being responsive as a ‘good’ physiotherapist. The call to recognize a patient’s social context, central to relational autonomy, suggests the importance of placing patients at the centre, encouraging sharing of stories, and acknowledging patients’ uniqueness, perspectives, emotions, and situations in clinical practice, each aspect found in participants’ descriptions of a ‘good’ physiotherapist. Further, being responsive was found to involve being open, taking time to understand patients and their situations, being ‘emotionally available’, validating patients when communicating, and individualizing approaches. At times, patients may choose approaches or goals that may not align with what a practitioner considers the ‘best’ option. When integrating person-centred care with evidence-based practice as a ‘good’ physiotherapist, the findings of this dissertation suggest it is important to understand and acknowledge *why* a person may want to do something a particular way.

Aligning with an ethical orientation to care as central to the practice of a ‘good’ physiotherapist, participants often spoke of ensuring physiotherapy experiences were positive and satisfying for patients. Collaborating with patients to achieve outcomes that promote human flourishing aligns with Eklund and colleagues’ (2019) proposition that *person-centred* care facilitates a return to a *meaningful* life. Participants’ accounts describing a ‘good’ physiotherapist as person-centred suggests physiotherapists consider a person’s perspective and seek to understand what gives their life meaning. Placing patients at the centre, acknowledging their uniqueness, and inviting them to share their perspectives including how they meaningfully engage socially and physically has the potential to transform practitioner communication (Hiller et al., 2015), decision-making (Larsson et al., 2010), and ethical practice (Delany, 2007; Delany et al., 2010). Practicing with a relational approach to autonomy creates dialogic possibilities for facilitating care within a framework of practical wisdom (Kinsella & Pitman, 2012) and for achieving patient-defined goals (Wijma et al., 2017).

6.4.2 Education

These investigations of a ‘good’ physiotherapist are offered as a contribution to the discourse on what competencies may be emphasized in the education of future physiotherapists. The contention that an ethic of care is central to a ‘good’ physiotherapist’s practice challenges the profession’s emphasis on a technical rationalist approach to education. The biomedical model has been argued to dominate education curricula, suggesting that students are socialized into a profession that prioritizes the body-as-machine and the technical practices of objectivity, measurement, and skill (Nicholls & Gibson, 2010; Setchell et al., 2017). Nicholls and Larmer (2005) have argued that the emphasis on anatomy, pathology, and biomechanics in professional education prioritizes a body’s form and function detaching a physiotherapist from the patient-as-person. The findings of this dissertation are supportive of curricula that deliberately integrates relational competencies in physiotherapy educational design, as a means to support education that may foster an ethic of care.

Entry-to-practice physiotherapists are argued to be ill-prepared to engage with interpersonal, social, and cultural aspects that person-centred approaches demand (Nicholls, 2018; Nicholls & Gibson, 2010). Person-centred approaches are theorized to involve empathy, respect, engagement, partnership, mutual trust, therapeutic relationship, communication, shared decision-making, holistic focus, and individualized focus (Eklund, 2019). Similar themes were highlighted in the qualities and practices of a ‘good’ physiotherapist identified in the study findings in this dissertation. In the integrative review (Chapter 2), patient perspectives suggested being responsive by listening, validating patients’ experiences, and tailoring the physiotherapy approach was important. Patient perspectives also underscored a desire to be respected as equals in the way physiotherapists communicated including providing explanations and sharing in decision-making. These dimensions were not as commonly expressed in physiotherapists’ perspectives, suggesting a potential lack of full integration of person-centred approaches. In contrast, the phenomenological study findings suggest that ‘good’ physiotherapists may engage in relational practices *despite* their training. Nonetheless, these were experienced therapists and it appeared to take time until they were comfortable adopting

relational approaches in their work. This underlines the importance of including more curricular content that balances knowledge about relational approaches to practice with those of a more technical nature.

Being reflective and ‘using’ reasoning were identified in this dissertation as practices that may foster ‘good’ physiotherapy practice. Reviews suggest reflection (Ziebart & MacDermid, 2019) and clinical reasoning (Elvén & Dean, 2017) are important practices in physiotherapy, yet they have received limited research attention and they are not well conceptualized in education and practice (Elvén & Dean, 2017; Ziebart & MacDermid, 2019). How they may be involved in a ‘good’ physiotherapist’s practice requires further study. The value participants placed on being reflective and using reasoning supports a greater focus on their development in physiotherapy education.

Cowell and colleagues (2021) contend physiotherapists’ communication behaviours are receptive to training. After a course in psychologically informed practice, they found physiotherapists’ communication style became more responsive, which included exploring patients’ emotions and concerns, validating their experiences, expressing empathy, and being attentive. Similar to the proposed implications of the current study findings, Cowell and colleagues (2021) proposed being responsive as important to developing a therapeutic relationship and ‘good’ clinical interactions yet noted that training practices that support the development of responsiveness are lacking. In a pan-Canadian study into physiotherapy academics’ and clinicians’ perspectives of educational priorities, interpersonal skills were frequently identified as important (Kleiner & Walton, 2022b). Participants emphasized the importance of active listening, empathy, and collaborative skills suggesting they “be given the same level of value and priority as traditional technical skills” (p. 9) and integrated throughout the curriculum. This aligns with findings of this dissertation that identified communication and responsiveness as important.

An ethic of care could be integrated into training programs by socializing students within a professional culture that nurtures the ethical attitudes and behaviours of a caring profession (Greenfield, 2008). Balancing technical competence with humanistic qualities

and intersubjective practices means philosophy and social sciences must also be recognized as important in the education of future practitioners. Including the humanities within curricula recognizes the personal, social, and subjective nature of illness and injury, with the potential to transform physiotherapy beyond its historical emphasis on body-as-machine (Nicholls & Gibson, 2010). Embracing relational practices to fully realize person-centred approaches has the potential to strengthen the quality of therapeutic relationships, a centralizing principle of an ethic of care and an aspect of practice proposed to improve patient outcomes (Ferreira et al., 2013; Hall et al., 2010). Nicholls and Larmer (2005) suggest that the integration of biological with social, psychological, and cultural philosophies of health promotes a holistic model of health enabling physiotherapists to become ‘complete’ rehabilitation professionals.

6.4.3 Research

The results and conclusions offered in these studies into what constitutes a ‘good’ physiotherapist suggest grounds for further theoretical and empirical investigations. The significance of each dimension in the practice of a ‘good’ physiotherapist identified in these studies needs to be determined keeping in mind that some have received more prior research attention than others. This will require examination of the importance of the various qualities identified in the integrative review (Chapter 2) (responsive, ethical, communicative, caring, competent, collaborative) and dimensions of a ‘good’ physiotherapist identified in the first phenomenological study (Chapter 3) (an ethical orientation to care, integration of person-centred care with evidence-based practice, and being competent, responsive, reflective, communicative, and using reasoning). To fill a gap in knowledge, a deeper exploration of a ‘responsive’ physiotherapist was undertaken in the second phenomenological study (Chapter 4). However, the relative importance and how each element of responsiveness (being person-centred, attentive, open, a listener, validating, positive) is enacted in patient encounters warrants further investigation. A fruitful avenue of research may lie in the direction of phronesis, to investigate how reasoning may be fostered and enabled allowing a physiotherapist to integrate practices to do the right thing. Overall, ongoing study of the qualities and practices identified in these studies, and examination of the ways a ‘good’ physiotherapist acts to contribute to human

flourishing, are fruitful avenues of research that may support the development of future physiotherapists and practicing clinicians.

Proposing an ethic of care as central to the practice of a ‘good’ physiotherapist, which is supported by the work of prior authors (Dahl-Michelsen, 2015; Greenfield, 2006; Ramklass, 2015; Resnick & Jensen, 2003), suggests the profession consider the educational implications of this research. Researchers and educators must determine whether caring and person-centred approaches can be taught (Miles et al., 2008). In his book, *The End of Physiotherapy*, David Nicholls (2018) shares the various challenges that he and his colleagues experienced when implementing a ‘more inclusive’ curriculum that attempted to integrate social, cultural, psychological, and biological aspects of health. With this experience, Nicholls contends designing a curriculum that includes both technical and relational competencies requires investigation of different educational approaches (2018). If education programs integrate and determine how best to nurture an ethic of care, person-centred and relational approaches, how to assess these as competencies will need to be investigated. As far as we know, knowledge about how best to assess ‘caring’ as a competency is limited or non-existent.

Overall, it must be ascertained whether the qualities and approaches of a ‘good’ physiotherapist improve patient outcomes (Catlett & Lovan, 2011; Miles et al., 2008). As noted in Chapter 2, several studies included in the integrative review suggested positive outcomes may be linked to the following qualities: collaborating with patients by listening (Calner et al., 2017; Gyllensten et al., 1999; Hills & Kitchen, 2007), explaining their problem (Hills & Kitchen, 2007), taking an interest to put their needs first (Hills & Kitchen, 2007), and individualizing examination and intervention (Resnick & Jensen, 2003). In the empirical studies, these practices were depicted in participants’ perspectives of a ‘good physiotherapist. In a systematic review, similar patient-centred communication strategies including listening to what patients say, encouraging questions, and being sensitive to patients’ emotional concerns were positively correlated with a positive therapeutic alliance and facilitation of patient involvement (Pinto et al., 2012). While a stronger therapeutic alliance is associated with improved outcomes (Ferreira et al., 2013; Hall et al., 2010), research is needed to further explore the relative importance of these

aspects and the potential contribution of the other relational practices described in this dissertation.

As noted in Chapter 4, there may be a subtle but important difference between patient- and person-centred care not yet fully appreciated in physiotherapy discourse. Eklund and colleagues (2019) theorize the goal of *patient*-centred care is a return to a *functional* life while *person*-centred care facilitates a *meaningful* life. While a contention arising from the findings of this study is that a ‘good’ physiotherapist engages in person-centred approaches, scholars suggest the physiotherapy profession struggles to adopt person-centred care amidst the predominance of biomechanical professional discourse (Mudge et al., 2014). Person-centered practices that include sharing power with patients, understanding their perspectives and what they value, and collaborating on patient goals are proposed as a way to support the integration of person-centred care with evidence-based practice as a ‘good’ physiotherapist. How systems may enable or constrain physiotherapists and the profession in realizing a more holistic vision warrants further research.

A holistic vision for physiotherapy requires greater integration of ‘epistemological pluralism’ in what the profession considers legitimate disciplinary knowledge (Kinsella, 2012). Quantitative methodologies dominate physiotherapy research and the hierarchy of evidence applied in practice (Kerry, 2017). Increased recognition of the value of qualitative research to understand the lived experiences of both patients and physiotherapists may transform understandings toward more holistic practices. Examination of relational ways of practicing may be underpinned by various cultural, social, ethical, or political theories necessitating diverse philosophical viewpoints and qualitative methodologies. Although evidence-based practice has evolved to include patient preferences and clinician’s experience, these domains have received less attention in physiotherapy research (Bjorbaekmo & Shaw, 2018). As proposed by the conceptualization of a ‘good’ physiotherapist, valuing patients’ perspectives and the meanings they attribute to their experiences may encourage researchers to broaden their examination of ‘good’ practice beyond positivist biomedical perspectives transforming

assumptions that garnering physiotherapy knowledge is best achieved quantitatively with detached objectivity.

6.4.4 Policy

It is important to note that funding for physiotherapy, models of service delivery, and policy mandates shape physiotherapy practice. At times, neoliberal notions of the role of health care, who is responsible for health, and tensions related to institutional policies aimed at economic efficiency may constrain practitioners' abilities to enact the ideals of a 'good' physiotherapist (Durocher et al., 2016; Nicholls, 2018). What constitutes a 'good' physiotherapist is anticipated to change in relation to societal trends; currently, the trend toward person-centred care that supports relational practices may be in conflict with neoliberal notions of best practice (Monteux & Monteux, 2020; Nicholls, 2018). This points to a potential tension between a physiotherapist's ethical responsibility to patients in the service of human good and their accountability to mandated protocols (Durocher, 2015; Pitman in 2012). Durocher and colleagues (2016) suggest systemic constraints may create barriers to the enactment of an ethic of care and potentially cause 'occupational alienation', a form of occupational injustice in which therapists may experience "disconnection, isolation, emptiness, limited expression, or meaninglessness" (p. 223).

Ahlsen and colleagues (2021) suggest physiotherapy's tendency to focus on curing has limited the professional discourse on the role of care in physiotherapy practice and research. They argue that physiotherapy is required to adhere to evidence-based practice and yield results as evaluated by measurements of pain, function, independence, and quality of life. Funders often require outcome measures as a compulsory aspect of physiotherapy treatment plans to track effectiveness toward functional goals and discharge once 'quality of life' has been restored (Gibson, 2016; McPherson et al., 2015). Consequently, Ahlsen and colleagues (2021) contend care is viewed as "an optional 'soft supplement'" (p. 49) not supported by the "hard facts" (p. 47) of the biomedical paradigm that shapes health care, including physiotherapy. Aligning with the findings of this dissertation, Ahlsen and colleagues (2021) further argue for the centrality of care in physiotherapy. They suggest there is a role for listening, acknowledging patients' needs and contexts, and for *caring* for patients in support of their' well-being, needs, and

preferences that goes beyond health care systems' guidelines, rules, and regulations. They argue that neoliberal notions of autonomy, independence, and decision-making may constrain the everyday practice of caring (Ahlsen et al., 2021). This conflict between health care practices and personal and professional values may create ethical tensions for physiotherapists when caring practices are constrained (Durocher et al., 2016). Health care policy makers and professional bodies are called upon to shift the focus away from the reification of instrumental and neoliberal discourses and practices. Explicitly making care central to the practice of a 'good' physiotherapist as a principal finding of this dissertation may help to ameliorate the tension created when managerialism is prioritized over an ethic of care.

Philosopher, Annemarie Mol argues that ideologies that promote autonomy and independence allow for patient choice about treatments and goals of health care (Mol, 2008; Struhkamp et al., 2009). What Mol describes as the 'logic of choice' (Mol, 2008) has led to the practices of shared-decision making (Hoffmann et al., 2019), patient empowerment (Melander Wikman & Fältholm, 2006), and self-management (Hurley et al., 2016), each endorsed as worthy practices of physiotherapy. Similar to a relational approach to autonomy as discussed in Chapter 4, Ahlsen and colleagues (2021) contend Mol's (2008) contrasting 'logic of care' proposes people are interdependent, at times vulnerable, and socially embedded within a network of relationships. They theorize this viewpoint means "care has neither a beginning nor an end" and a patient may find "comfort in the fact that she can come for her physiotherapy every now and then" (Ahlsen et al., 2021, p. 50). The findings of this dissertation support being person-centred as underpinned by acknowledging the uniqueness of patients and individualizing the approach to patient care. Respect for patients as equals implies they will be allowed to contribute to definitions of health and the purpose or "end of physiotherapy" (p. 71) and calls into question the detached allocation of resources by third parties (Poulis, 2007); especially in light of funding decisions based on functional outcomes (McPherson et al., 2015) rather than on what may facilitate a flourishing life.

6.4.5 Summary of the implications of this research

Overall, the findings of this dissertation contribute to knowledge of what may be considered ‘good’ practice that may inform the practices of clinicians and future physiotherapists. This dissertation offers an invitation to consider a ‘good’ physiotherapist beyond historical definitions and biomedical dimensions as one who balances their technical competence with relational approaches and an ethic of care. Approaching practice with an ethic of care invites reflection on taken-for-granted approaches to patient interactions based on objectivity and draws greater attention to the importance of the therapeutic relationship and the pivotal role of practices that may support it including responsiveness, communicative capabilities, a relational approach to autonomy, shared decision-making, and a practical orientation toward outcomes that may facilitate a flourishing life. Findings of this dissertation are supportive of the education of future practitioners with curricula that deliberately integrates relational competencies to balance the essential technical aspects of physiotherapy practice. Including ethical and social theory in the education of future practitioners, as a means to foster an ethic of care, has the potential to support physiotherapists’ in relating with patients as subjects rather than objects, and recognizing this as a moral imperative inherent in the human encounter between a physiotherapist and patient.

6.4.6 Directions for future research

Ongoing study of the qualities and practices identified in these studies, and examination of the ways a ‘good’ physiotherapist acts to contribute to human flourishing, are fruitful avenues of research that may support the development of practicing clinicians and future physiotherapists. Given the strong themes that emerged in the primary data set of what constitutes a ‘good’ physiotherapist, secondary analyses to understand the reflective practitioner and how phronesis is enacted in the promotion of human good may be fruitful for the future. These studies may promote the value of reasoning and acting in ways that contribute to human flourishing and may support a greater focus in education and practice on phronesis and the conditions that enable it. How health care systems and professional regulatory bodies may constrain practitioners from reasoning toward the ‘good’ and doing the right thing in realizing more holistic approaches warrants further

research. Answering the call to examine ‘taken-for-granted’ assumptions that dominate the practice of physiotherapy necessitates inquiry of the power relations that shape the systems and discourses that influence clinical practitioners’ ethical orientation and the education of the future generation of ‘good’ physiotherapists.

6.5 Research strengths and limitations

Although strengths and limitations have been discussed in each of the integrated manuscripts (Chapters 2, 3, and 4), a brief overarching critique of this research is a worthy consideration. A key strength of the integrative review (Chapter 2) and the two phenomenological studies (Chapters 3 and 4) was the implementation of rigorous and systematic methodological approaches. The novel approach to integrating physiotherapists’ and patients’ perspectives in the review suggests patients’ views and priorities may differ from physiotherapists’ and both perspectives should be recognized as relevant and important. The quality appraisal framework that was implemented to evaluate the studies included in the review was also a novel approach that promoted a substantive judgement and enriched familiarization of the study designs. A relatively unique aspect of the phenomenological studies was the preparatory reflective writing exercise that may have encouraged participants to access their experience of the phenomenon of a ‘good’ physiotherapist prior to their interviews. Participants openly shared rich and evocative descriptions of their experiences and perceptions.

Many participants expressed gratitude for the opportunity to reflect on their practice suggesting that ‘good’ work had been done in preparing and conducting the interviews. However, while wording of the interview guide was scrutinized to evaluate whether questions were leading (as noted in Chapters 3 and 4), including more explicit lines of questions regarding systemic constraints to ‘good’ practice, may have yielded important insights. By investigating what is taken-for-granted through questioning and interpretation of the tensions presented in participants’ first-hand accounts, a greater understanding of what the physiotherapists’ perceptions of constraints in working for the ‘good’ may have been examined. Further, although participants spoke about diversity, these perspectives were scant and limited to the themes of ‘Being’ person-centred and

open as a responsive physiotherapist; greater attention to equity, diversity, and inclusion could have been included in the interview questions.

In the integrative review, the failure to consider age and gender may be a limitation of the included studies that demands greater attention in future research. Similarly, examining the influence of gender on participants' taken-for-granted assumptions of 'good' practice in the phenomenological studies may have fostered additional insights and may be considered a missed opportunity. However, while the sample ($n = 12$) was not large enough to ascertain trends, I was sensitive to gender as a potential influence on elicited examples of everyday practice. For example, males and females spoke equally about the importance of the therapeutic relationship in consideration of 'good' practice. Finally, while the findings across the three studies appear to be resonant with areas of physiotherapy practice more broadly, it is important to note that retrieved studies of the integrative review and phenomenological studies were from the context of musculoskeletal practice and should be interpreted with this in mind. While not generalizable, phenomenological findings that are evocative and resonate with readers may be transferable to similar settings. The data is considered in the spirit of van Manen's (2016) 'phenomenological nod' whereby findings that hold resonance may move readers to consider participants' insights in light of their own experience and foster new understandings of the phenomenon of a 'good' physiotherapist.

6.6 Knowledge translation

As noted in the introduction, dissemination of dissertation findings has begun. Integrative review findings (Chapter 2) were presented to a section of the Ontario Physiotherapy Association in January 2021. The findings were well received and facilitated a discussion amongst practicing clinicians. Future opportunities to share these findings through conference presentations are planned. Chapter 2, *An integrative review of the qualities of a 'good' physiotherapist* was published in *Physiotherapy Theory and Practice* in December 2021. The two subsequent empirical studies (Chapters 3 and 4) have also been submitted for peer review. It is hoped scholars and clinicians will be able to easily access these articles through public repositories.

The study findings have also been the focus of conversations with physiotherapy colleagues and professional educational and regulatory leaders, an examiner/instructor in the Physiotherapy Orthopaedic Division, and a university lecturer of musculoskeletal physiotherapy. As articles are published, they will be promoted on social media such as Twitter and shared with interested colleagues. Finally, findings will be shared with study participants.

6.7 Conclusion

While writing the proposal for the phenomenological research presented in this thesis, the world was in the early stages of the COVID-19 pandemic and the Canadian Physiotherapy Association celebrated its 100th anniversary. By documenting the physiotherapy profession's history, Nicholls (2018) has suggested that global influenza and polio epidemics have significantly shaped the development of the physiotherapy profession. The COVID-19 pandemic forced many physiotherapists to adopt online care delivery; a format that highlights communicative capabilities, interpersonal skills, therapeutic relationship, patient empowerment, and self-management over technical 'hands-on' approaches to care (Fernandes et al., 2021; Hinman et al., 2017). It is striking that as Canadian physiotherapists who may be tempted to look back over our 100-year history and reminisce, we must look forward and prepare for how the echoes of the pandemic will change how we practice as 'good' physiotherapists online and in-person. Nicholls (2018) and other scholars (Cook et al., 2021; Gibson et al., 2018; Kleiner & Walton, 2022a, 2022b; Walton, 2019) call on physiotherapists to become critical thinkers to scrutinize how we practice and train future physiotherapists.

After conducting this doctoral research, my wish for the profession is a reconceptualization of the artificial dualities of quantitative and qualitative research, competence and relationality, evidence and practical wisdom, curing and caring. Overcoming dichotomous thinking by viewing each as intertwined and making care central to 'good' physiotherapy has the potential to transform the profession toward more holistic approaches that include technical competence and relational practices. By centring care as an ideal of physiotherapy, future practitioners may be holistically nurtured by the profession and supported in realizing their potential as 'good'

physiotherapists as they form their professional identity throughout their careers. Rather than swimming upstream and practicing on the margins, as I often felt I had to do to navigate the complexities of caring for patients, with an ethic of care, physiotherapists may realize their moral responsibility in the facilitation of meaningful lives for the patients who seek our care. The tensions that I felt between evidence-based practice and person-centred care may be ethically negotiated by future physiotherapists through both technical and relational competencies. This dissertation offers an invitation to consider a ‘good’ physiotherapist beyond historical definitions and biomedical dimensions as one who balances their technical competence with relational approaches and an ethic of care.

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Appendices

Appendix A: Search Strategy Concepts⁴:

The search strategy was designed based on 3 concepts that correspond to the PICO framework (**P**opulation, **P**henomenon of **I**nterest, and **C**ontext) recommended by Butler, Hall, and Copnell (2016) for the organization of effective search strategies.

The search strategy was designed based on 3 concepts that correspond to the

1. **Population:** Physiotherapy/physical therapy (See Table, Concept 1)
2. Phenomenon of **Interest:** The phenomenon of ‘good’ qualities predominantly described and potentially categorized as professional and interpersonal qualities (See Table, Concept 2)
3. **Context:** Phenomenon of the ‘good’ predominantly described within the context of patient satisfaction, patient expectations, and therapeutic alliance/relationship (See Table, Concept 3)

Table: Search Strategy

Search Strategy Concepts				
Concept 1: Population		Concept 2: Phenomenon of Interest		Concept 3: Context
physiotherapy [tiab] OR "physical therapy"[tiab] OR Physical Therapy Specialty[mesh] OR Physical Therapy Modalities[mesh] OR Physical Therapists[mesh] OR "physical therapist"[tiab] OR "physical therapists"[tiab]	A N D	skills OR knowledge OR professional behaviours OR professional behaviors OR professional behaviour OR professional behavior OR professional competence OR Health Knowledge, Attitudes, Practice[mesh] OR clinical competence[mesh] OR clinical competence OR clinical skills	A N D	Patient Satisfaction OR expectations OR expectation OR Motivation OR preference OR preferences OR Patient Centred Care OR patient-centered care OR therapeutic alliance OR therapeutic alliances OR therapeutic relationship OR therapeutic relationships OR working alliance OR Professional-patient Relations

⁴ Search strategy created in collaboration with research librarians, Roxanne Isard and David LeSavage

PubMed

(physiotherapy[tiab] OR "physical therapy"[tiab] OR Physical Therapy Specialty[mesh] OR Physical Therapy Modalities[mesh] OR physical therapists[mesh] OR "physical therapist"[tiab] OR "physical therapists"[tiab]) AND (Skills OR knowledge OR professional behaviours OR professional behaviors OR professional behaviour OR professional behavior OR professional competence OR Health Knowledge, Attitudes, Practice[mesh] OR clinical competence[mesh] OR clinical competence OR clinical skills) AND (Patient Satisfaction OR expectations OR expectation OR Motivation OR preference OR preferences OR Patient Centred Care OR patient-centered care OR therapeutic alliance OR therapeutic alliances OR therapeutic relationship OR therapeutic relationships OR working alliance OR Professional-patient relations)

CINAHL

1. "physiotherapy"
2. (MH "Physical Therapy+") OR "physical therapy"
3. (MH "Physical Therapists") OR "physical therapist"
4. "physical therapists"
5. S1 OR S2 OR S3 OR S4
6. "skills"
7. (MH "Knowledge") OR "knowledge"
8. "professional behaviours"
9. "professional behaviors"
10. "professional behaviour"

11. "professional behavior"
12. (MH "Professional Competence") OR "professional competence"
13. "health knowledge, attitudes, practice" OR (MH "Physical Therapist Attitudes")
14. (MH "Clinical Competence") OR "clinical competence"
15. "clinical skills"
16. S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15
17. (MH "Patient Satisfaction") OR "patient satisfaction"
18. "expectations"
19. "expectation"
20. (MH "Motivation") OR "motivation"
21. "preferences"
22. "preference"
23. "patient centred care"
24. (MH "Patient Centered Care") OR "patient centered care"
25. (MH "Therapeutic Alliance") OR "therapeutic alliance"
26. therapeutic alliances"
27. "therapeutic relationship"
28. "therapeutic relationships"
29. "working alliance"
30. (MH "Professional-Patient Relations") OR "professional-patient relations"

31. S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26
OR S27 OR S28 OR S29 OR S30

32. S5 AND S16 AND S31

Scopus

(TITLE-ABS-KEY (physiotherapy OR "physical therapy" OR "physical therapist" OR "physical therapists")) AND (TITLE-ABS-KEY (skills OR knowledge OR "professional behaviours" OR "professional behaviors" OR "professional behaviour" OR "professional behavior" OR "professional competence" OR "health knowledge, attitudes, practice" OR "clinical competence" OR "clinical skills")) AND (TITLE-ABS-KEY ("patient satisfaction" OR expectations OR expectation OR motivation OR preference OR preferences OR "patient centred care" OR "patient-centered care" OR "therapeutic alliance" OR "therapeutic alliances" OR "therapeutic relationship" OR "therapeutic relationships" OR "working alliance" OR "professional-patient relations")))

Nursing and Allied Health Database

noft(physiotherapy OR physical therapy OR physical therapist OR physical therapists)
AND noft(skills OR knowledge OR professional behaviours OR professional behaviors
OR professional behaviour OR professional behavior OR professional competence OR
health knowledge, attitudes, practice OR clinical competence OR clinical skills) AND
noft(patient satisfaction OR expectations OR expectation OR motivation OR preference
OR preferences OR patient centred care OR patient-centered care OR therapeutic alliance
OR therapeutic alliances OR therapeutic relationship OR therapeutic relationships OR
working alliance OR professional-patient relations)

PsycINFO and Embase

1. physiotherapy.mp.
2. physical therapy.mp. or exp Physical Therapy/

3. exp Physical Therapists/ or physical therapists.mp.
4. physical therapist.mp.
5. 1 or 2 or 3 or 4
6. skills.mp.
7. exp Health Knowledge/ or knowledge.mp.
8. professional behaviours.mp.
9. professional behaviors.mp.
10. professional behaviour.mp.
11. professional behavior.mp.
12. professional competence.mp. or exp Professional Competence/
13. clinical competence.mp.
14. clinical skills.mp.
15. 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
16. patient satisfaction.mp. or exp Client Satisfaction/
17. exp Expectations/ or expectations.mp.
18. expectation.mp.
19. motivation.mp. or exp Motivation/
20. preference.mp.
21. preferences.mp. or exp Preferences/
22. patient-centered care.mp.

23. patient-centred care.mp.
24. therapeutic alliance.mp. or exp Therapeutic Alliance/
25. therapeutic alliances.mp.
26. therapeutic relationship.mp.
27. therapeutic relationships.mp.
28. working alliance.mp.
29. professional-patient relations.mp.
30. 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29
31. 5 and 15 and 30

Appendix B: Relevancy Scale

5 = Highly Relevant; 1 = Low Relevancy

	Relevancy	Defined
5	Definitely and highly relevant	The study specifically addresses physiotherapist and/or patient perspectives on qualities of a 'good' physiotherapist either in the study's aim or the results in the provision of musculoskeletal (MSK) physiotherapy.
4	Probably relevant	The study describes physiotherapist and/or patient perspectives on qualities of a 'good' physiotherapist in the provision of physiotherapy with $\geq 50\%$ of participants from an MSK outpatient setting. Physiotherapy practitioners' perspectives are included with students and/or other allied health professionals' perspectives in participant sample, but their perspectives may be separated from the others.
3	Possibly relevant	The study's construct is narrow and focuses on implementation of a specific intervention, technique, method, or construct to assess its effectiveness (eg shared decision-making, adherence, support, ethics, extended scope practitioners, or psychological intervention) rather than on perspectives on qualities of a 'good' physiotherapist. Negligible or minor emphasis on qualities included in the results or are sparsely described in the study's findings.
2	Probably not relevant	Qualities of a 'good' physiotherapist are based on scores, frequencies, or correlations as measured by pre-existing or researcher-designed questionnaire/survey of patient satisfaction, experiences, or expectations. Study results are based on participant responses to close-ended questions/items rather than <i>their own</i> perspectives.

1	Definitely not relevant	<p>Focus of the study is on the <i>process of 'care'</i> rather than physiotherapist qualities (e.g. wait times, access to care, clinical pathways).</p> <p>< 50% of patients with MSK conditions.</p> <p>Inpatients or practice setting is not stated, or patients had not actively received physiotherapy.</p> <p>Perspectives are based on clinical vignettes or videos rather than direct physiotherapist-patient interaction.</p>
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Appendix C: Quality Appraisal Framework

Citation:		
1	<p>How well is the purpose and focus of the paper expressed? [Worthy Topic]</p> <p>Clearly defined purpose</p> <p>Focused discussion of a distinguishable core concern</p>	<p>Relevant, Timely, Significant, Interesting, Evocative</p> <p>-disciplinary priorities, timely societal or personal events, current political or contemporary controversies</p> <p>-raised level of awareness, counterintuitive, questions taken-for-granted assumptions, or challenges well-accepted ideas</p> <p>Explicitness (Whittemore 2001)</p>
2	<p>How effectively has the paper's study been designed and conducted? (Strengths and weaknesses of the research methodology) [Rigour & Credibility]</p> <p>Study design permits readers to situate and assess the analysis of data and the findings</p> <p>Authors successfully realized the key features (and potential) of the research methodology they claim to have used (setting, sampling, data collection, time in the field)</p> <p>Institutional research ethics approval or explanation of its absence [Ethical]</p>	<p>Thoroughness of Data Collection:</p> <p>-Enough data to support significant claims (including discrepant data)</p> <p>-Enough time in the field to gather significant data</p> <p>-Context or sample appropriate given the goals of the study</p> <p>-Appropriate and various methods e.g. fieldnote style/timing, interviewing practices (breadth, transcription detail & accuracy) to create richness to see nuance and complexity</p> <p>Systematic Research Conduct: E.g. triangulation, crystallization, multivocality, member reflections</p> <p>Ethical:</p> <p>- procedural, situational & culturally specific, relational, and exiting ethics for well-being of participants</p>
3	<p>How successfully do the authors analyze their data?</p>	<p>Thoroughness of Interpretation:</p>

	<p>The quality of how well the authors have analyzed and interpreted their data and distinguished their own analytic voice from the voices of the research participants or texts. (thick description, concrete detail, e.g. data extracts)</p> <p>[Rigour/Sincerity/Reflexivity]</p> <p>(transparency and interpretation of data as thoroughly as one would expect, i.e., different levels of coding, etc)</p>	<ul style="list-style-type: none"> - different levels of coding, multiple coders, involvement of multiple authors and/or participants -thick description that explains culturally situated meanings, concrete detail, tacit (non-textual) knowledge -showing meaning rather than telling providing enough detail that readers may come to their own conclusion Sincerity/Reflexivity: <ul style="list-style-type: none"> -reflexivity about influence of values, biases, and inclinations of the researcher(s) consistent with research approach - transparency and honesty about methods, challenges, and completeness of data and findings e.g. audit trail of decisions
4	<p>How effectively do the authors engage theory in their research and in the paper?</p> <p>How effectively authors articulate the theoretical/conceptual footing of the project and engage theory in interpreting their data.</p> <p>(Analytic lens through which the data are examined)</p> <p>Does the report connect to a wider body of knowledge or existing theoretical framework? If so, is this appropriate?</p>	<p>What assumptions have the authors made to explain their data?</p> <p>What are they thinking is true? Ontology? Epistemology?</p> <p>Implicit or explicit positionality consistent with approach?</p> <p>What do they believe about their research?</p>
5	<p>What is the quality of the argument made in the paper? [Meaningful Coherence]</p> <p>Clarity, consistency & coherence of the paper's argument [aim, methodology, methods, knowledge claims]</p>	<p>Meaningful Coherence:</p> <ul style="list-style-type: none"> -between literature, research aim/purpose, methodology and methods, interpretation, knowledge claim

	Extent to which it is successfully supported by the analysis of research findings.	- researcher ontology/epistemology and methodology are consistent allowing study to “hang together well”
6	<p>What contribution does the paper make?</p> <p>Nature of the paper’s contribution to physiotherapy, whether to scholarship, policy, practice, theory, discipline, or other area.</p> <p>Does the study extend knowledge? Improve practice? Generate ongoing research? Liberate or empower?</p> <p>[Resonance, Transferability, Significant Contribution]</p>	<p>Resonance/Transferability:</p> <ul style="list-style-type: none"> -aesthetic, evocative representation -may lead to improved practice -transferable findings (across contexts or situations) <p>Significant Contribution:</p> <ul style="list-style-type: none"> - Conceptually/theoretically, Practically, Morally, Methodologically, Heuristically
<p>Other Comments:</p> <p>Strengths:</p> <p>Weaknesses:</p> <p>Implications:</p>		
<p>Overall Rating of Quality (low, moderate, high)</p>		
<p>Canadian Journal of Public Health. (2019). Guide for Appraisal of Qualitative Manuscripts. Canadian Journal of Public Health. http://www.springer.com/cda/content/document/cda_downloadocument/CJPH+Guide+for+Appraisal+of+Qualitative+Manuscripts_2019.pdf?SGWID=0-0-45-1661914-p180933963</p> <p>Ravenek, M. J., & Rudman, D. L. (2013). Bridging Conceptions of Quality in Moments of Qualitative Research. <i>International Journal of Qualitative Methods</i>, 12(1), 436–456.</p> <p>Tracy, S. J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research. <i>Qualitative Inquiry</i>, 16(10), 837–851. https://doi.org/10.1177/1077800410383121</p>		

Appendix D: Quality Appraisal Summary of Included Studies

	Authors	Purpose and focus of paper expressed. (Worthy topic)	Study designed and conducted effectively. (Rigor, Credibility)	Ethics	Successful analysis of data. (Rigour, Sincerity, Reflexivity)	Effective engagement of theory.	Quality of argument. (Meaningful coherence)	Contribution of the research. (Resonance, Transferability, Significant Contribution)	Overall Quality
1	Aguilar, Stupans, Scutter & King 2013	Low	Moderate	Yes	Low	Moderate	Moderate	Moderate	Moderate
2	Ali & May 2017	Moderate	High	Yes	Moderate	Moderate	Moderate	Moderate	Moderate
3	Barradell, Peseta & Barrie 2019	High	High	Yes	High	High	High	High	High

4	Bernhardsson, Larsson, Johansson & Öberg 2017	Moderate	High	Yes	High	High	High	High	High
5	Bernhardsson, Samsson, Johansson, Öberg & Larsson 2019	High	Moderate	Yes	High	Low	Moderate	Moderate	Moderate
6	Calner, Isaksson & Michaelson 2017	Moderate	Moderate	Yes	Moderate	Low	Moderate	Moderate	Moderate
7	Calner, Isaksson & Michaelson 2019	High	Moderate	Yes	Moderate	Moderate	Moderate	Moderate	Moderate

8	Cooper, Smith & Hancock 2008	High	Moderate	Yes	Moderate	Moderate	Moderate	High	Moderate
9	Crepeau 2016	High	Moderate	Yes	Moderate	Moderate	Moderate	Moderate	Moderate
10	Del Baño- Aledo, Medina- Mirapeix, Escolar- Reina, Montilla- Herrador & Collins 2014	High	Moderate	Yes	Moderate	Low	Low	High	Moderate
11	Ekerholt & Bergland 2004	Moderate	Low	Yes	Moderate	Moderate	Moderate	Moderate	Moderate

12	Greenfield 2006	High	High	Yes	High	High	High	High	High
13	Gyllensten, Gard, Salford & Ekdahl 1999	High	Moderate	No	Low	Low	Moderate	Low	Low
14	Hills & Kitchen 2007	High	Moderate	Yes	Moderate	Low	Moderate	Moderate	Moderate
15	Jensen, Shepard, Gwyer & Hack 1992	Moderate	Moderate	No	High	High	High	High	High*
16	Kidd, Bond & Bell 2011	High	Moderate	Not clear	Moderate	Low	High	High	Moderate
17	Lindahl, Teljigović, Heegaard	High	High	Yes	Moderate	Moderate	Moderate	Moderate	Moderate

	Jensen, Hvalsoe & Juneja 2016								
18	May 2001	Low	Moderate	Yes	Moderate	Low	Moderate	Moderate	Moderate
19	McGinnis, Guenther & Wainwright 2016	High	High	Yes	High	Moderate	Moderate	Moderate	Moderate
20	Miciak, Mayan, Brown, Joyce & Gross 2018	High	High	Yes	High	High	High	High	High
21	Miciak, Mayan, Brown, Joyce & Gross 2019	High	High	Yes	High	Moderate	High	High	High

22	Morera-Balaguer, Botella-Rico, Catalán-Matamoros, Martínez-Segura, Leal-Clavel & Rodríguez-Nogueira 2019	High	Moderate	Yes	Low	Moderate	Moderate	Moderate	Moderate
23	Palenius & Nyman 2018	Low	Moderate	Yes	Low	Moderate	Low	Low	Low
24	Potter, Gordon & Hamer 2003a	Moderate	Moderate	Yes	Moderate	Low	Moderate	High	Moderate

25	Potter, Gordon & Hamer 2003b	High	High	Yes	Low	Low	Moderate	High	Moderate
26	Resnik & Jensen 2003	High	High	No	High	Moderate	High	High	High*
27	Rutberg, Kostenius & Öhrling 2013	Moderate	High	Yes	High	Moderate	High	High	High
*Study quality does not account for lack of reporting of ethics approval.									

Appendix E: Reflective Writing Exercise

These questions are meant to allow you to reflect on the concept of a 'good' physiotherapist.

These and similar questions will be asked and further explored in the interview.

Please answer the following questions (you may use point form).

1. What does the concept of a 'good' physiotherapist mean to you?
2. Take a moment to think of a physiotherapist who you consider to be a particularly 'good' physiotherapist. This could be yourself or someone you consider to be an exemplary practitioner, role model, or mentor.
 - a) What qualities does this person possess that stand out for you as qualities of a 'good' physiotherapist?
 - b) When you think about an encounter when this physiotherapist interacted with a patient or patients, what do you recall?
 - c) What about this physiotherapist's qualities or way of being in this interaction stands out for you as being particularly 'good'?
 - d) Is there anything about this person's attitude, behaviours, or actions that stand out for you as being particularly 'good'?

Appendix F: Interview Guide

[Each question (number) is followed by potential probing questions (letter).]

1. (Thinking generally,) What does the concept of a ‘good’ physiotherapist mean to you?
 - a. how would you define a ‘good’ physiotherapist (by summing it up in one or two sentences)?
 - b. When you think of this concept, what is your understanding of the word/term ‘good’?
 - Good vs bad
2. Can you briefly describe what it means for you to be/act like a ‘good’ physiotherapist in your own clinical practice?
 - a. what does it look like?
 - b. what do you feel is important (when interacting with patients or colleagues in your clinical practice)? **“interacting”* was changed to *“working”* after the second interview
 - c. what values, if any, are relevant to be a ‘good’ physiotherapist?
 - d. how do you know you are being a ‘good’ physiotherapist (when interacting with patients or colleagues)? **“interacting”* was changed to *“working”* after the second interview
 - e. Are there behaviours/actions you engage in or avoid?
3. What qualities do you think constitute a ‘good’ physiotherapist?
 - a. Can you give me some examples (of these qualities from your clinical practice or someone you think of as a ‘good’ physiotherapist)?
4. I’d like you to think about someone who is a particularly ‘good’ physiotherapist.
 - a. Why do you think they’re a ‘good’ physiotherapist?
 - What is it about this person that stands out for you as being particularly ‘good’?

- What was it about this person that brought them to your mind as a ‘good’ physiotherapist?
 - b. What qualities does this person possess?
 - c. What do they *do* that makes them stand out as ‘good’?
- 5. Think back to a time when you felt *you* were being a ‘good’ physiotherapist? Tell me a little more about that time/experience.
 - a. Tell me about a time when you think your interaction with a patient worked particularly well?
 - What were you doing?
 - How did you feel?
 - How did you engage with your patient or colleagues?
 - What did you do?
 - What did you say?
 - What did you think?
 - b. What about a time when an interaction with a patient didn’t work well?
- 6. Think back to a time when you witnessed someone else being a ‘good’ physiotherapist? Can you tell me a little more about that time or describe the experience?
 - a. What were they doing?
 - b. How did they engage with patients or colleagues?
 - c. What did they do?
 - d. What did they say?
 - e. How did you interpret their words or behaviour?
 - f. How did it make you feel?
- 7. Are there any stories from your clinical experience that come to mind that exemplify what a ‘good’ physiotherapist looks like?

MIDPOINT – check in for time

- 8. If you were to speak with a physiotherapy student or group of students, how would you describe what constitutes a ‘good’ physiotherapist?
- 9. Do you have any thoughts on how the notion of a ‘good’ physiotherapist might relate to the notion of a wise physiotherapist?
- 10. Are there particular relational qualities that you think ‘good’ physiotherapists demonstrate?

- a. what are they?
 - b. what do they look like in practice?
 - c. how do good physiotherapists engage with patients?
 - d. how do good physiotherapists engage with colleagues?
11. Are there particular professional competencies that you think ‘good’ physiotherapists demonstrate?
- a. what are they?
 - b. what do they look like in practice?
12. (In light of this interview, is there anything you would add or change about your thoughts on) What is your understanding of ‘good’?
13. Is there anything else you’d like to share with me regarding what constitutes a ‘good’ physiotherapist?

Appendix G: Research Ethics Board Approval Letter



Date: 5 October 2020

To: Dr. Dave Walton

Project ID: 116455

Study Title: Being a 'Good' Physiotherapist in Musculoskeletal Practice: An Inquiry into Practitioners' Perspectives

Application Type: HSREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 20/Oct/2020

Date Approval Issued: 05/Oct/2020

REB Approval Expiry Date: 05/Oct/2021

Dear Dr. Dave Walton

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	
Being a Good Physiotherapist Study Budget	Study budget	30/Jul/2020	
Being a Good Physiotherapist Interview Guide	Interview Guide	30/Jul/2020	
Being a Good Physiotherapist Reflective Writing Questions v2.0	Online Survey	12/Sep/2020	2
Being a Good Physiotherapist Script for Recruitment v2.0	Recruitment	12/Sep/2020	2
Being a Good Physiotherapist Email Script v2.0	Email Script	12/Sep/2020	2
Being a Good Physio Letter of Information and Consent v2.0	Written	12/Sep/2020	2
Being a Good Physiotherapist Research Plan v2.0	Protocol	12/Sep/2020	2

Being a Good Physiotherapist Second Email Script for Email Script 28/Sep/2020 1

Documents Acknowledged:

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB , except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Karen Gopaul, Ethics Officer on behalf of Dr. Philip Jones, HSREB Vice-Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix H: Script for Recruitment



Invitation to participate in research on Being a 'Good' Physiotherapist in Musculoskeletal Practice

Hello,

You are invited to participate in a study conducted by Michelle Kleiner and Dr. Dave Walton. The study involves participation in a 30 minute written exercise and 60-90 minute interview to explore what it is to be a 'good' musculoskeletal physiotherapist. Data collected in this study have the potential to inform professional practice and education and evaluation of future physiotherapists. Your time and participation in this study will be acknowledged with an electronic gift card.

You may be eligible to participate if you: (a) are licenced to practice physiotherapy in Canada, (b) have 7 or more years of clinical practice experience, (c) are in involved direct patient care in a musculoskeletal practice setting at least 50% of the time, and (d) read and write in English.

If you would like more information on this study or would like to receive a letter of information about this study, please contact Michelle Kleiner at

Thank you,

David M. Walton PT PhD
Associate Professor, School of Physical Therapy, Western University
Director, Pain and Quality of Life Integrative Research Lab

Michelle Kleiner PT PhD(c)
Doctoral Student, Health and Rehabilitation Sciences Graduate Program
Faculty of Health Sciences, Western University

Appendix I: Letter of Information



Health and Rehabilitation Sciences

Being a 'Good' Physiotherapist in Musculoskeletal Practice: An Inquiry into Practitioners' Perspectives

Principal Investigator: Dr. David M. Walton, PT, PhD
Faculty of Health and Rehabilitation Sciences, Western University

Student Investigator: Michelle Kleiner, BScPT, MCISc, PhD (candidate)
Faculty of Health and Rehabilitation Sciences, Western University

Co-investigators: Dr. Elizabeth Anne Kinsella, PhD, OT Reg. (ONT)
Faculty of Health and Rehabilitation Sciences, Western University
Dr. Gail Teachman, PhD, OT Reg. (ONT)
Faculty of Health and Rehabilitation Sciences, Western University
Dr. Maxi Miciak, BScPT, PhD
Faculty of Rehabilitation Medicine, University of Alberta

Contact Information: If you have any questions about the study, you may contact Dr. Walton at [REDACTED] or Michelle Kleiner at [REDACTED]

Sponsor: Dr. Walton is receiving financial reimbursement from the Western University teaching support centre in the form of a Teaching Fellowship grant to help offset the costs of conducting this research.

Background: A recent integrative review suggested a 'good' physiotherapist balances technical competence with a relational way of being when interacting with patients. By exploring physiotherapists' everyday interactions with patients, the essential meaning structures of what it is to be a 'good' physiotherapist may be further identified.

Inclusion Criteria: You may be eligible to participate if you: (a) are licenced to practice physiotherapy in Canada, (b) have 7 or more years of clinical practice experience, (c) are involved in direct patient care in a musculoskeletal practice setting at least 50% of the time, and (d) read and write in English.

Purpose: You are invited to participate in this research study to help us better understand what constitutes a ‘good’ physiotherapist. Your insights may enrich the professional development of practitioners, educational programs’ curriculum, and competencies of future physiotherapists.

Procedures: The study will involve both reflective writing and interviews. If you agree to participate, about two weeks prior to the agreed upon interview date, you will be asked to respond to two short-answer questions to stimulate thinking about the concept of a ‘good’ physiotherapist. This will take approximately 30 minutes. Your responses will be reviewed before participating in an on-line interview with me to discuss your responses and further explore interactions with your patients. The interview will take approximately 60-90 minutes. I may ask you to participate in a follow-up interview of similar or shorter length to answer questions and will provide you with a copy of the interview transcriptions if you wish.

Survey and video recording devices/methods will be used (i.e., it is encrypted, password protected and meets all Western University related requirements). Personal recording devices will not be used. The recording device will be securely stored under the control of Western research personnel while it contains the recordings. Video recordings will be transferred to and stored on secure Western servers and will be deleted from the recording device after review and within 7 years. Recordings may be shared with research collaborators, Drs. Walton and Kinsella to assist in data analysis as needed.

NVivo transcription software will be used to transcribe the last 3 interviews conducted after December 11, 2020. Audio files are stored on QSR International servers located in Canada; members of this organization will not have access to participants’ identifying information contained in the recordings. Uploaded audio files and transcriptions are saved on QSR International’s servers as backup for 90 days once transcription is completed. Transcriptions will be stored with other study data, separate from identifying information, in accordance with the provisions set out in the main study protocol. Your contact information will be stored separately from study data on secure Western servers and will be accessible to authorized personnel only.

Possible Benefits: You may develop a better understanding of what it is to be a ‘good’ physiotherapist which you may choose to use in future interactions with your patients and to guide professional development. You may contribute to professional knowledge.

Possible Risks: Because information is exchanged and stored electronically, there is a risk of privacy breach.

Confidentiality: Your written responses will be collected through a secure online platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western’s Qualtrics server is in Ireland, where privacy standards are maintained under the European Union safe harbour framework. The data will then be exported from Qualtrics and securely stored on Western University's server (OneDrive cloud storage). Your name will be removed from the files of your written responses. Direct quotes from written material and interviews may be published attributed to a code in lieu of your name.

Demographic information will be collected (including age, years of physiotherapy practice, province of physiotherapy practice, practice specialty and setting). Participant's anonymity will be protected. Your name will not be used on the typed copy of the transcripts, articles, or presentations. A code will be used in lieu of your name and only the researchers will see your personal information which will be stored in a secure place separate from your study file. All information will be securely stored on Western University’s server for no more than 7 years.

Voluntary Participation: You do not waive any legal right by consenting to this study. Your participation in this study is voluntary and you may withdraw or decline to participate at any time during the study. You can choose not to answer questions. If you decide to withdraw from the study, you have the right to request (e.g., by phone, in writing, etc.) withdrawal of information collected about you. If you wish to have your information removed please let Michelle Kleiner know and your information will be destroyed from our records. However, if you choose to withdraw from the study, a record of your participation, (e.g. letter of information or name on master list), must be retained for 7 years. Once the study has been published, we will not be able to withdraw your information.

Your time and participation in this study will be acknowledged with an electronic gift card in the amount of \$50.

If you have questions or concerns about your rights as a participant, please contact the Western University, Office of Human Research Ethics [REDACTED], email: XX This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.

This letter is yours to keep for future reference.

Appendix J: Consent Form

Project Title: Being a 'Good' Physiotherapist in Musculoskeletal Practice

Principal Investigator: Dr. David M. Walton

Co-Investigator: Michelle Kleiner, Email [REDACTED]

(Please place an x in the appropriate box)

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached Information Sheet? Yes No

Do you understand the benefits and risks involved in taking part in this research study?
 Yes No

Have you had an opportunity to ask questions and discuss this study? Yes No

Do you understand that your participation will involve completion of preparatory questions that will take approximately 30 minutes and video recording of an interview of approximately 60-90 minutes? Yes No

Do you understand that you are free to withdraw from the study at any time without having to give a reason? Yes No

Have you been informed that the confidentiality of the information you provide will be safeguarded subject to any legal requirements? Yes No

Do you consent to transcription of your audio recording via NVivo software? Yes No

Do you understand who will have access to you records? Yes No

I agree to take part in this study. Yes No

I consent to submitting responses to short answer questions via an emailed link.
 Yes No

I consent to participate in an on-line and video-recorded interview. Yes No

I wish to review my transcript and/or narratives once interpreted and edited. Yes No

I consent to use of direct quotes in publications of this research. Yes No

I wish to receive a summary document of the key research findings. Yes No

Signature of Research Participant

(Printed Name) _____ Date: _____

I have explained the procedures, risks, and benefits of the research study and obtained the research participant's consent to participate. Yes No

Signature of Person Obtaining Consent _____

(Printed Name) _____ Date: _____

Appendix K: Quality Appraisal Framework for Phenomenological Study Design and Conduct

Tracy's (2010) Eight 'Big Tent' Criteria to Appraise Quality	Various means, practices, and methods through which to achieve quality	
Worthy Topic	<p>The topic of the research:</p> <ul style="list-style-type: none"> - is relevant, timely, significant, interesting, evocative, or points out surprises - studies disciplinary priorities, timely societal or personal events, current political or contemporary controversies, provide “educative authenticity” or raised level of awareness, counterintuitive, questions taken-for-granted assumptions, or challenges well-accepted ideas - promotes issues that shake readers from their common-sense assumptions and practices 	<p>Van Manen (2016a) – (Inceptual epiphany) - study offers the possibility of deeper and original insight, perhaps an intuitive grasp of the ethics or ethos of life commitments and practices; Study is based on valid phenomenological question ie What is this human experience like? How is this or that phenomenon or event experienced?</p> <p>Wright-St. Clair (2015) - the phenomenon of interest is clearly stated</p>
Rich rigor	<p>The study uses sufficient, abundant, appropriate, and complex:</p> <ul style="list-style-type: none"> • Theoretical constructs, data and time in the field, sample(s), context(s), Data collection and analysis processes (of variety & complexity to create richness to see nuance and complexity) - face validity—whether a study appears, on its face, to be reasonable and appropriate - Enough data to support significant claims - Enough time to gather interesting and significant data 	<p>Caelli (2001) - studies by which authors clarify their approach are judiciously informed by the philosophy that is held to guide them</p> <p>Finlay (2009) - uses the phenomenological reductions; explores the intentional relationship between persons and situations; discloses the essences, or structures, of meaning immanent in human experiences using imaginative variation</p> <p>Shaw & Connelly (2012) - how authentically a study integrates the philosophical positions and</p>

	<p>- Context or sample appropriate given the goals of the study</p> <p>- Appropriate procedures in terms of fieldnote style/timing, interviewing practices (breadth, transcription detail & accuracy), transparency of analysis procedures – all conducted with care</p> <ul style="list-style-type: none"> • For qualitative research to be of high quality, it must be rigorous. <p>Ballinger (2006): Convincing and Relevant Interpretation – plausibility, “face validity”, research makes important contribution, communicative truth (meaning constructed, should be tested in similar ways)</p> <p>Ravenek and Rudman (2013): Thoroughness of Data Collection and Interpretation:</p> <p>Given the type of research conducted, did the authors collect data as thoroughly as one would expect, i.e., variety of sources, variety of methods, including discrepant data?</p> <p>Given the type of research conducted, did the authors interpret the data as thoroughly as one would expect, i.e., different levels of coding, multiple coders, involvement of multiple authors and/or participants?</p>	<p>ideals of the philosophers from whom the methodology is derived</p> <p>van Manen (2016a) – Distinctive rigour - text remains guided by self-critical question of distinct meaning of the phenomenon or event; Underpinned by primary phenomenological literature</p> <p>Wright-St. Clair (2015) - Ontological nature of the methodology clearly stated and justified; authors state what variant of phenomenology is being used; the research question aimed at exploring lived experience or meaning of the phenomenon (ie appropriate methodology for the question being asked); philosophical writings are used to deepen interpretations</p>
Credibility	<p>Trustworthiness, plausibility of findings, credible account, dependable enough to act on</p> <p>The research is marked by:</p> <ul style="list-style-type: none"> • Thick description or in-depth illustration that explicates culturally situated meanings, concrete detail, explication of tacit (non-textual) knowledge, and showing meaning rather than telling providing enough detail that readers may come to their own conclusion • Triangulation (if ≥ 2 sources of data, theoretical frameworks, types of data collected, or researchers converge on the same conclusion, then more credible) keeping in mind 	<p>Finlay (2009) - involves both rich description of the lifeworld or lived experience</p> <p>Van Manen (2016a) - No right number of interviewees or interviews – gather enough rich accounts to make contact with life as it is lived. No data saturation as what is singular may be an insight in its uniqueness. Analysis of experiential, descriptive accounts, transcripts. Does the text show rich reflective allusions and surprising insights?</p>

	<p>that different methods, data, or researchers often do yield different results</p> <ul style="list-style-type: none"> • Crystallization - using multiple data sources, researchers, and lenses—but is motivated by post-structural and performative assumptions – towards more complex understanding of facets of a phenomenon not one ‘truth’ • Multivocality - multiple and varied voices in report and analysis • Member reflections - seeking input during analysis and report (terms: member checks, validation, and verification suggest a single true reality) <p>Ballinger (2006): Evidence of Systematic and Careful Research Conduct</p>	<p>Wilding & Whiteford (2005) - strategies of becoming immersed in the data, embracing an attitude of passivity, gathering “original” descriptions of experiences, engaging in a hermeneutic circle of analysis, and examining the data to reveal concepts of Being were used eg listening to the interviews two or three times and re-reading the transcripts many times. Data immersion phase may take a long time; participants were encouraged to speak about particular experiences, located in time and space... vividly recall and, thus, richly describe these actual experiences almost as if they were reliving them. Reading the transcripts as wholes and forming an initial impression, and then analyzing “pieces” or “chunks” of script and relating these pieces back to the whole.</p> <p>Wright-St. Clair (2015) - adequate experience of the phenomenon evident in the participant inclusion criteria; evident stories about particular experiential moments were gathered; participants’ interpretations of things also evident; authors described how they analyzed each participant’s stories and how they analyzed across the whole text; meaning of the phenomenon of interest interpreted and described</p>
<p>Sincerity</p>	<p>The study is characterized by:</p> <ul style="list-style-type: none"> • Self-reflexivity about subjective values, biases, and inclinations of the researcher(s); researcher impact on the 	<p>Finlay (2009) - the researcher has adopted a special, open phenomenological attitude which, at least initially, refrains from importing external frameworks and sets aside judgements about the</p>

<p>scene and note of others' reactions to them – show rather than tell of self-as-instrument throughout the report</p> <ul style="list-style-type: none"> - “How did the author come to write this text?” - “Is there adequate self-awareness and self-exposure for the reader to make judgments about the point of view?” <ul style="list-style-type: none"> • Transparency and honesty about the methods and challenges eg audit trail of research decisions and activities (access to context, fieldnote practices, level of transcription), give credit <p>Ballinger (2006): The Role of the Researcher is Accounted for in a Way that is Consistent with the Orientation of the Research – reflection or reflexivity</p> <ul style="list-style-type: none"> • Important that researchers are clear about their position: <ul style="list-style-type: none"> - How are reality and truth represented? - What does the researcher claim to be accessing when generating data? - How stable and universal do they claim their interpretation is? - What are the roles of any fellow researchers/supervisors, especially when interpreting data? - How would the authors deal with competing explanations about their phenomena under investigation? - How do their own views, agendas and experiences feature in their descriptions of their work? • Worldviews rarely explicit – look for hints in language and writing: <ul style="list-style-type: none"> - Do you view data as ‘out there’ to be found or elicited? - Are interpretations described as constructions by myself or jointly with participants? - Are you interested in participants' beliefs? Or accounts and representations? 	<p>realness of the phenomenon. Researchers need to bring a “critical self-awareness of their own subjectivity, vested interests, predilections and assumptions and to be conscious of how these might impact on the research process and findings”</p> <ul style="list-style-type: none"> - placed in the foreground so as to begin the process of separating out what belongs to the researcher rather than the researched ie preconceived biases and pre-suppositions need to be brought into awareness to separate them out from participants' descriptions <p>Shaw & Connelly (2012) - Researchers may integrate philosophical assumptions that are derived from outside of the phenomenological tradition, and these assumptions must be discussed in terms of their impact on the methodology and explicitly recognizing and making clear their influence on the research process</p> <p>Wilding & Whiteford (2005) - in Heideggerian phenomenology, we acknowledge and foreground our own particular horizon of understanding in approaching phenomena. Each individual has a “horizon” of understanding. This horizon is basically the sum total of all influences that make individuals who they are, including the social, historical, and political contexts in which they live. Heideggerian phenomenology acknowledges that researchers bring pre-understandings to their work and, although attempts are made to identify these and to put them aside to see the research</p>
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	<ul style="list-style-type: none"> - Do additional researchers/authors provide independent evidence to support analysis? Or guidance in analysis? - Do you claim that your interpretation is correct way to understand data? Or acknowledge potential for alternative interpretations? - Is impartiality stressed in research and with participants for fear of bias? Or is it important to explain how your experiences and roles lead to understanding data a particular way? <p>Ravenek & Rudman (2013): Transparency and Reflexivity of the Authors: Have the authors clearly described how the research was conducted, including any problems that arose and how the authors dealt with them? Have the authors talked about the completeness of the data and their findings? Have the authors been critical, or reflexive, of their influence on or contributions to the research process and end points?</p>	<p>phenomenon with fresh eyes, there is an understanding that they are never actually transcended.</p> <p>Wright St Clair (2015) - Have the authors used reflective journaling as part of rigor?</p>
Resonance	<p>The research influences, affects, impacts, or moves readers or a variety of audiences through:</p> <ul style="list-style-type: none"> • Aesthetic, evocative representation “Did this affect me?” <p>Valuable across a variety of contexts or situations.</p> <ul style="list-style-type: none"> • Naturalistic generalizations – vicarious experience or personal knowing and experience may lead to improved practice • Transferable findings – research story overlaps with readers’ own situation and intuitively transfer the research to their own action eg ‘empathic validity’ <p>Ballinger (2006): Convincing and relevant interpretation</p>	<p>Annells (1999) - Understandable and appreciable product – interesting, pleasing aesthetically; Useful product – potential to inform practice, relevant</p> <p>Van Manen (2016a) - induce contemplative wonder and questioning attentiveness; text speaks to and addresses our sense of embodied being</p> <p>- Experiential awakening - text awakens pre-reflective or primal experience through vocative and presentative language</p> <p>Van Manen (2016b) - ‘phenomenological nod’ - Descriptive richness – rich and recognizable experiential material?</p>

<p>Significant Contribution</p>	<p>The research provides a significant contribution: Conceptually/theoretically, practically, morally, methodologically, heuristically “Does the study extend knowledge?” “Improve practice?” “Generate ongoing research?” “Liberate or empower?” Ravenek & Rudman (2013): Social Value and Significance of the Research: Is the importance of the research and/or the value of the findings clearly presented and discussed by the authors in the work?</p>	<p>Van Manen (2016a) - depthful insights have been gained through this study; – text offers reflective insights that go beyond the taken-for-granted understanding of everyday life; text show rich reflective allusions and surprising insights</p>
<p>Meaningful Coherence</p>	<p>The study</p> <ul style="list-style-type: none"> • Achieves what it purports to be about with clear purpose statement • Uses methods and procedures that fit its stated goals; Study “hangs together well” • Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other consistent with onto-epistemology and presentation matches research goals <p>Ballinger (2006): Coherence – matching research aim, view of research endeavour, researchers’ accounting of their role, and how research to be evaluated with epistemological approach used (eg Grounded Theory) Ravenek & Rudman (2013): Coherence of the Research Approach: Given the type of research conducted and the question(s) being asked, is there a “good fit” with the research methodology used?</p>	<p>Annells (1999) - How congruent is the approach to the research question ie inquiries about the meaning and experience of a phenomenon which can be found; interpretive or descriptive Caelli (2001) - the approach employed to pursue a particular study should emerge from the philosophical implications inherent in the question Finlay (2009) - researchers should be clear about which philosophical and/or research traditions they are following and remain consistent throughout the research process and the recounting of it - a phenomenological method is sound if it links appropriately to some phenomenological philosophy or theory, and if its claims about method are justified and consistent - Any research which does not have at its core the description of “the things in their appearing,”</p>

	<p>Given the type of research conducted, the question(s) being asked, and the research methodology used, is there a “good fit” with the research methods used?</p> <p>Given the type of research conducted, the question(s) being asked, and the research methodology and methods used, are the knowledge claims and applications described by the authors appropriate?</p>	<p>focusing on experience as lived, cannot be considered phenomenological</p> <p>Shaw & Connelly (2012) - clear connections between the beliefs they consider to be foundational for their given approach to phenomenology and the procedural decisions made throughout the research process (Congruence)</p> <p>- judging whether the procedures, interpretations, and implications are consistent with the philosophical orientation to knowledge and truth that is stated at the outset of the research.</p> <p>Wilding & Whiteford (2005) - when using Heideggerian phenomenology, dimensions of “Being” must be considered in relation to the research question and findings because this concept is of central concern within this approach; phenomenology is used to study and learn about phenomena that are difficult to observe or measure</p>
Ethical	<p>The research considers</p> <ul style="list-style-type: none"> • Procedural ethics (such as human subjects) as per IRB • Situational and culturally specific ethics – moments that come up in the field • Relational ethics – researcher mindful of their influence on others • Exiting ethics (leaving the scene and sharing the research) <p>Ravenek & Rudman (2013): Due Regard for the Research Participants: Beyond meeting institutional requirements for ethics approval, have the authors in their description of how the research was conducted demonstrated responsibility for the well-being of the participants throughout the research process?</p>	
<p>*all of the above sentences and phrases are direct quotes from cited sources</p>		

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Curriculum Vitae

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Post-secondary Education and Degrees: University of Toronto
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1987-1991 B.Sc.PT

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Post-professional Education: Cognitive Behavioural Therapy Level II Certificate,
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Vestibular Rehabilitation Certificate,
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Acupuncture Foundation of Canada Institute Certificate, 2004
Diploma of Advanced Manual and Manipulative Physiotherapy,
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Publications:

Thomas, J., DeHuek, A., **Kleiner, M.**, Newton, J., Crowe, J., & Mahler, S. (1995). To vibrate or not vibrate: Usefulness of the mechanical vibrator for clearing bronchial secretions. *Physiotherapy Canada*. 47(2):120-125.

Kleiner M., Wong L., Dubé A., Wnuk K., Hunter S. W., Graham L. J. (2018) Dual-task assessment protocols in concussion assessment: A systematic literature review. *J Orthop Sports Phys Ther*. 48(2): 87-103.

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Kleiner M. J., Walton D. M. (2022) A pan Canadian perspective on education and training priorities for physiotherapists. Part 1: Foundations for clinical practice. *Physiotherapy Canada*.

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Kleiner M. J., Kinsella E. A., Miciak M, Teachman, G, Walton DM. (2021). “Passion to do the right thing”: Searching for the ‘good’ in physiotherapist practice. Manuscript submitted for publication.

Kleiner M. J., Kinsella E. A., Miciak M., Teachman, G., Walton D. M. (2021). The ‘responsive’ practitioner: Physiotherapists’ reflections on the ‘good’ in physiotherapy practice. Manuscript submitted for publication.

Academic Presentations:

Kleiner M. J., Thomas J. A. (1995, June 28). *A New Graded Exercise Test for Patients with End-Stage Lung Disease Awaiting Lung Transplant* [Conference Presentation]. World Confederation for Physical Therapy Congress, Washington DC.

Kleiner M., Wong L., Dubé A., Wnuk K., Hunter S. W., Graham L. J. (2017, October 6) *Dual-task assessment protocols in concussion assessment: a systematic literature review* [Poster Presentation by K. Wnuk]. SPort INnovation (SPIN) Summit, Richmond, BC, Canada.

Kleiner M. J. (2021, January 28) *What’s a ‘Good’ Physiotherapist? And how to become one?* London District of the Ontario Physiotherapy Association, Virtual Panel on ‘Comprehensive Practice and Mental Health’, London, ON, Canada.

Kleiner, M. J. (2022, April 2). *Searching for the ‘Good’ in Physiotherapist Practice* [Annual General Meeting Keynote presentation]. Nova Scotia Physiotherapy Association, Halifax, NS, Canada.

Kleiner, M. J., Kinsella, E. A., Miciak, M., Teachman, G., & Walton, D. M. (2022, April 21–23). “*Passion to do the right thing*”: *Searching for the ‘Good’ in Physiotherapist Practice* [Conference presentation]. Canadian Association for Health Humanities 2022 Creating Space 12 Conference, Calgary, AB, Canada.

Peer Review:

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Manuscript Reviewer for Child & Youth Care Forum (Journal), February 2021.