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Exploring the power balance in physiotherapy

Karen Harrison, Shelley Williams

All social interactions involve an element of power negotiation. In the physiotherapeutic situation, there are a number of interesting opportunities to exercise power to a greater extent than would be possible in normal day-to-day life. The power balance of the clinical encounter is explored from both the patient's and the physiotherapist's perspective.

From a political perspective, patient consumers are increasingly being encouraged to see themselves as active participants, rather than passive recipients in the healthcare process, (Department of Health, 1989; 1991a,b; 1997; 1998; 1999). This impacts not only upon the way in which patients within the NHS view themselves, but also upon health-care professionals and the way in which they come to view their patients (May, 1995). Such a model of patient-centredness demands a model of communication which acknowledges that the patient is in possession of relevant and essential experience and expertise (Thorngrist, 1991; French and Swain, 1997).

PATIENT-CENTRED CARE: A REALITY?

Such changes in the philosophy underpinning the delivery of health care have brought the rights of patients to the fore. The *Patients' Charter* (Department of Health, 1991a) and *Rules of Professional Conduct* (Chartered Society of Physiotherapy, 1996) depict the rights of patients to full information about their condition and treatment strategies available, the right to dignity and respect and the right to equality and access to health-care provision.

This opens the forum of knowledge to all, as barriers of social closure and information guarding begin to be broken down. This means that health-care workers now have an explicit duty to make information available in order to enable patients to make an informed decision (Laurent, 1989). Henson (1997) argues that 'mutuality' balances power and respect and is fundamental for effective provider-client communications. This interactive approach theoretically offers the potential to achieve positive and enduring outcomes in health care (Kaufman, 1992; Leenen,

1996; Henson, 1997). However, the work of Ellis (1993) and more recently that of Myers and MacDonald (1996) highlights a gap between the ideal of user empowerment and the reality of daily practice. This is reinforced by the findings of Oliver and Zarb (1993), which provide evidence for practice lagging behind policy. It is therefore fruitful to consider whether professional and political directives geared towards mutuality have indeed become manifest in the therapeutic power relationship. Have patient-centred care, consumer choice and client autonomy and self-direction become reality for health care service-users?

Despite the recognition that both technical skills and psychosocial relations are significant contributors to professional performance (Donabedian, 1988), there still exists a tendency to consolidate, evaluate and improve the former, rather than the latter (Bithell, 2000; Ritchie, 1999).

Given that therapeutic intervention occurs through the medium of the clinical interview, it would seem logical to seek to pay attention to unravelling the processes which structure this interaction. Ultimately, there is a clear need to understand the experience of health and disease in context if practice is not only to accurately reflect policy initiatives, but also if standards of care are to have social relevance to the individuals involved (Richardson, 1995).

EXPLORING THE LITERATURE BASE

In terms of the availability of a literature base in this field, there is disparity between health-care professions. There is good representation in the fields of medicine (Myerscough, 1989;

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Robinson, 1978; Ogden, 1996), nursing (Brown, 1993; Hewison, 1995; Sully, 1996; May, 1995; Gilbert, 1995; Turnbull, 1994; Sines, 1993) and occupational therapy (Crepeau, 1991; Lyons, 1994; Peloquin, 1990, 1993). Additionally, there is a wealth of information in the fields of psychotherapy and family therapy (Bosch, 1988; Chapmans, 1993; Levold, 1988; Ludewig, 1988; Nichols, 1993; Owen, 1995; Puskar and Hess, 1986; Simon, 1993). In marked contrast, the discipline of physiotherapy appears not to have engaged in this area and is not represented directly within the literature base to any substantial extent (Williams and Harrison, 1999).

POWER RELATIONS WITHIN THERAPEUTIC INTERACTIONS

Power is a very contentious issue, and its meaning is variable depending upon context, value and previous experience. As yet there is no 'single uniform conceptualisation of power' (Hewison, 1995b), but nevertheless it has to be a crucial factor in health-care delivery (Sully, 1996).

The therapeutic relationship has been defined by Gartland (1984) as 'a means of communication wherein both (the) therapist and patient interact to achieve a therapeutic goal'. Here the focus shifts away from the technical and towards the interpersonal aspects of medical care (Ayres and Hasselkus, 1996).

Key factors in this relationship may be considered as:

1. Those associated with the patient
2. Those associated with the therapist
3. Those associated with the clinical environment in which the interaction takes place (Williams and Harrison, 1999) (*Figure 1*).

Power is an aspect of all human relationships (Giddens, 1989). There is, however, an inherent power inequality in the relationship between patient and health-care professional

(Buchanan, 1995), with the balance tipped firmly away from the patient. This is sourced by the 'professional prestige and situational authority of the health agent, and the situational dependency of the patient' (Bloom et al, 1979). Consequently, the unequal distribution of power is 'integral to patient-provider relations' (Johnson and Webb, 1995).

Although the balance is an unequal one, the onus of power does not lie solely with the therapist. Patients also hold power, but to a lesser extent than the therapist.

Exertion of power is different from conscious awareness of that exertion. It is questionable whether health-care professionals or clients are consciously aware of the power variable during therapeutic interaction.

KEY AREAS OF EXPLANATION

The research investigation sought to explore three key areas:

1. The nature of interpersonal power in the therapeutic relationship
2. The degree of awareness of power exertion in the therapeutic relationship, from both the patient's and therapist's perspective
3. The degree to which open and collaborative relationships, as promoted in current government policy, are affected by power differentials inherent in interaction.

SELECTING THE BEST METHOD OF INVESTIGATION

The research objective was to explore the nature of the power relationship in a physiotherapy treatment situation and to consider both the perspective of the patient and the therapist. Consequently, a qualitative research approach was selected, based on the philosophy of phenomenology. This philosophy seeks to understand social phenomena from the perspective of the people under study (Shepard et al, 1993). It offers insight into unique experiences and gives an in-depth picture of the meaning of the situation as defined by its participants (Nichols, 2000).

IMPLEMENTING THE METHODOLOGY

In-depth, semi-structured interviews were to be carried out with five physiotherapists and five patients. The therapists were currently working in physiotherapy outpatient departments; the patients had all received treatment for a musculoskeletal condition in a physiotherapy outpatient department within the previous year.

Ethical approval was gained from the Research

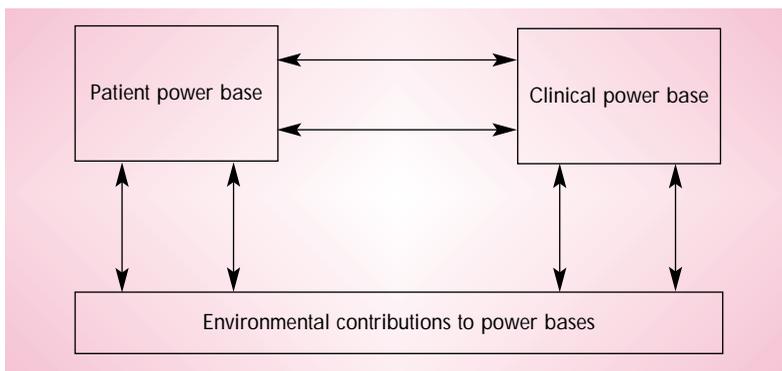


Figure 1. Forces involved in sustaining the therapeutic power balance.

Ethics Committee of the School of Health and Social Sciences of Coventry University. The research proposal addressed issues of confidentiality, informed consent, non-maleficence, autonomy and veracity.

Each interview took approximately 40 minutes, was tape-recorded, and a full transcript was taken.

Data generated were to be considered and analysed in the light of information available in the current literature. This is a cyclical process, as the researcher moves repeatedly from existing theory into the new data generated and back again (Carpenter, 1997; Case et al, 2000) (Figure 2).

The literature search was carried out using CINAHL, Medline, ASSIA, physiotherapy, occupational therapy and rehabilitation indexes, Embase: Physical Medicine and Rehabilitation; WCPT Proceedings, Cochrane Library and CSP research and document databases. Additionally, a media search was carried out using the *Independent CD-Rom index*.

Two pilot interviews were carried out with one patient and one therapist. Transcript analysis resulted in amendment and simplification of the question topic areas for use in the main study. These are shown in *Tables 1* and *2*.

ANALYSIS OF QUALITATIVE DATA GENERATED

Data were analysed through a process of content-thematic analysis, whereby emerging patterns were developed into several thematic categories. Evidence from the set of transcripts was considered in the light of existing knowledge and theory in the literature (Carpenter, 1997). Essentially a four-stage cognitive process was employed in order to define each

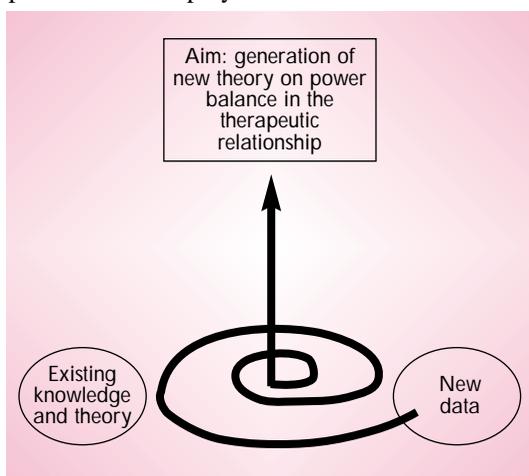


Figure 2. Researchers' movements between theory and new data.

key theme area in the analysis: comprehending, synthesizing, theorizing and recontextualizing (Morse, 1994).

The analysis was strengthened by the use of triangulation and corroboration (Silveman, 1993; Lincoln and Guba, 1985). Three individuals, with backgrounds in psychology, occupational therapy and physiotherapy, were given general information about the nature of the study and then asked to see if they could identify any recurring themes or patterns in the responses.

TABLE 1.
Questions for the client as asked in interview

1. How much information were you given about your condition?
2. Given your condition, did you discuss and set a target with the physiotherapist that you aimed to achieve?
3. Did you feel involved in this process of setting a target?
4. Were your targets compatible with those set by the physiotherapist?
5. How much did you feel you wanted to contribute to your own treatment?
6. Over the last few years changes in the health service have been geared towards giving patients more say in the treatment they receive. In your experience of physiotherapy, have you found this to be true? Can you give examples?
7. Do you think it is a good idea that patients have more say? Why?
8. How would you describe your relationship with your physiotherapist?
9. There is potential for the exertion of power on both sides of the relationship. Were you aware of either yourself or the therapist having more control at any time?

TABLE 2.
Questions for the physiotherapist as asked in interview

1. Could you briefly describe how you go about setting aims, objectives and goals for a patient?
2. How large a part might the patient play in this process?
3. There is a current push in physiotherapy for the introduction of formal guidelines and explicit contracts. Considering the idea of formal guidelines:
By formal guidelines I mean standardised recommendations set by the CSP for the treatment of specific conditions.
How do you feel about this?/How do you feel this would affect your practice and your relationship with patients?
By explicit contracts I mean a document clearly identifying the aims, objectives and goals of treatment that have been agreed by therapist and patient.
How do you feel about that?
How do you feel this may effect your relationship with patients?
4. In your experience, what major factors do you see as having an effect on patient compliance or lack of it?
5. What strategies do you employ to encourage compliance?
6. Have you ever been in situation where a patient has acted aggressively or inappropriately towards you?
Could you describe this experience?
How did you handle it?
7. There is potential for the exertion of power on both sides of the relationship. Could we explore the idea of therapist control in the therapeutic relationship?
Do you recognize yourself as being in a position of power?

The four analyses (researcher plus three corroborators) were then compared, and an agreement was reached on final categorization. There was a strong level of consent on the evidence explored and themes identified.

FINDINGS AND DISCUSSION

Key factors which inter-reacted in the therapeutic power relationship have previously been identified as being those of the patient power base, the therapist power base and the environment contribution to both of these power bases (Williams and Harrison, 1999) (*Figure 1*).

Themes and components of these three key areas are detailed in *Table 3*. The defining components were all identified directly from explicit transcript data. In each instance, an identified

theme, such as ‘patient personal characteristics’, is supported by a number of component descriptors. Where these have both positive and negative subcomponents, such as ‘keen’ or ‘disinterested’, these are subgrouped accordingly.

Again, with reference to *Figure 1*, a number of force lines are shown, linking the three key areas of patient, therapist and environmental force bases. These forces may be subdivided into two key categories: those which are collaborative and supportive and those which are conflict related. *Table 4* shows these key forces, and identifies themes and components from the transcript data.

THE THERAPIST POWER BASE

Physiotherapists described the whole goal-setting process as a patient-orientated exercise,

TABLE 3.
Categories, themes and defining characteristics generated from the data in relation to patient, therapist and environmental power bases

Category	Theme	Defining and relevant components
Therapist power base	Therapist professional characteristics	Skills, status, knowledge, expertise, authority, jargon, procedures, power of discharge
	Therapist personal characteristics	Positive: honest, trustworthy, empathetic, friendly, open, communicative, actively listening, genuine interest Negative: formal, rushed, distracted, threatening, patronising, disinterested
Patient power base	Patient personal characteristics	Positive: responsibility, motivation, compliance, keen, self-helpers, beliefs about locus of control, involvement Negative: aloof, apathetic, demanding, hostile, aggressive, disinterested
Environmental contribution to power base	Formal regulation	Rules of conduct, formal guidelines, professional autonomy, patients rights
	Privacy and confidentiality	Lack of privacy, space, inadequacy and enforced proximity, lack of soundproofing
	Physical environment	Differential familiarity, differential position (standing v lying, patient undress v therapist uniform)

TABLE 4.
Categories, themes and defining characteristics generated from the data in relation to the forces between the patient and therapist power base

Category	Theme	Defining and relevant components
Collaborative behaviour forces	Goalsetting	Positive: negotiation, mutuality, discussion, patient focussed, respect, autonomy, experience Negative: incompatible, omission, lack of involvement
	Explicit contracts	Positive: collaboration, mutuality, dual responsibility, clarity, understanding, honesty, communications, flexibility Negative: rigidity, negative effects, unfulfilled expectations
Conflict related behaviour forces	Uncontrollable influences	Previous experience and expectations, physical environment, waiting list, acute pain, preconceived ideas, attendance compulsion
	Controllable influences	Attitude, waiting time, appointment alterations
Gender behaviour	Inappropriate sexual behaviour	Vulnerability, isolation, fear, power/powerlessness related to gender behaviour

which involved a high level of discussion and patient input:

'We'll write down between us what we think is a realistic goal for them.'

During interaction, therapists described themselves as respecting patient autonomy and valuing their experience and knowledge. This approach supports that of patient-centred care, which is at the heart of current government policy in the field of health (Thornquist, 1991; Department of Health, 1997, 1999).

The physiotherapists described themselves as experts with role status, which enabled them to control the assessment procedure, to decide which treatment regimens to apply, and to determine the way in which those regimens would be implemented:

'I can dictate how many appointments a patient is going to get, and...I am the one that decides whether or not they will get discharged.'

Considerable power lay in the ability to give the patient information about their condition. This power was reinforced by the use of medically related language (Hewison, 1995a,b).

'I try to avoid the problem of non-compliance to begin with by really explaining quite thoroughly why the exercise will work and how you do it and to establish whether or not the patient can do it. So I hope by giving lots of information with the rationale behind the treatment approach, the physiotherapist approach will be clear.'

Patients felt that the therapist's personality was a major factor, in terms of the manner in which the power of the therapist would be utilized. That power had the potential to be either supportive and facilitative, or to be dominating and restrictive.

Patient perceptions of therapist personality characteristics were very variable indeed. Most were positive, with the therapists being described as 'friendly', 'enthusiastic', 'positive' and 'cheerful'. However, those with less good experiences described their therapists as being 'regimental', 'controlling' and having 'old school attitudes'.

THE PATIENT POWER BASE

In marked contrast to the opinions of the therapists, patients overall did not feel that they were being involved in the decision-making process about the treatment which they would receive:

'It was very much therapist-set...he just sort of told me...He didn't really ask me or give me a choice...I had no say in

what my target was.'

The feeling of the patients was that the role which their experience played in the therapeutic interaction was a marginal one, with the therapist playing the dominant role in structuring interactions. This is an example of the gap between empowerment theory and empowerment practice, identified by Ellis (1993). Some patients described themselves as feeling restricted because of the therapist's controlling position:

'I could have helped myself a lot more if I'd known what was going on.'

Patients expressed feeling devalued, feeling that they were not in a position to question and patronized if they tried to do so:

'"Are you doing your exercises? If you don't do your exercises you won't get better", which again belittled me because...I was doing my exercises. I wanted to get myself better.'

The patient's perception of their own power base was that it was a very low one.

'The only control I had was to keep my appointments. And that was it.'

However, there are situations where therapists feel that the balance of power may be with the patient, and these often centred around aggressive behaviour on the part of the patient:

'The patient was very aggressive...his symptoms had been worsened by the wait.'

Hospitality and aggression were primary examples of overt patient dominance in interaction. This generates powerful negative emotions, which are detrimental to therapeutic effectiveness (Burnel, 1997). They were perceived by therapists to occur fairly frequently in different guises (Lawrence, 1997).

Therapists reported inappropriate sexual behaviour by patients to be a relatively rare occurrence, which, nevertheless, all had some experience of. McComas et al (1993, 1995) have suggested that this can have higher incidence in some areas.

THE ENVIRONMENTAL CONTRIBUTION TO POWER BASES

The overwhelming effect of the clinical outpatient environment is that of empowering the therapist and at the same time disempowering the patient. Although home territory to the therapist, to the patient the sights, sounds and smells are all foreign ones:

'You go in and you're instantly tense...your brain doesn't forget smells very easily.'

The lack of sound privacy, because of partitioning by use of curtains between cubicles, was felt to be a major cause of embarrassment and disempowerment by patients:

‘When you’ve got other physios working in the area, you’ve got other patients in the same area, and there’s only a curtain between you, it’s very embarrassing...One of the rules at the School is that you don’t discuss what happened outside work, and there I am sat in hospital discussing it...so the person in the cubicle could broadcast it in town. It’s wrong for me, it’s wrong for my employers and it’s just uncomfortable to discuss things.’

For the patients, this constituted an undesirable form of exposure, which caused them to feel uneasy and vulnerable in an imposing alien environment. In this context they were relatively powerless.

In operational terms, time pressure was a factor which was perceived by patients to be disempowering.

‘Everything was done fast...you’re a number...I just felt as though I was in the way.’

Thus pressure on therapists to increase patient throughput was reinterpreted by the patient as a lack of interest in themselves and their case as a person. Consequently, they felt unvalued and powerless. At the other end of the spectrum, patients described how the therapist ‘with a lot of time...(who) explains exactly,’ made them feel that they were important. In this case, the personal characteristics of the therapist were influential in structuring therapeutic relations, even within existing time constraints (Dowd, 1993).

CONCLUSIONS AND IMPLICATIONS FOR CLINICAL PRACTICE

This phenomenological study illustrates the diversity of power manifestation which occurs as part of therapeutic interaction. A complex interplay of patient, therapist and environmental variables was demonstrated.

Physiotherapists seemed to be aware of power differentials relating to their expert status and role and took steps to minimize the imbalance through their behaviour. However, assertions of patient power were often considered non-legitimate, threatening and improper.

Patients described the way in which the power differential was perpetuated through therapists’ attitudes, expertise and professional control over both processes and information. This side of the therapeutic dyad viewed themselves as having little or no control during the clinical encounter. Ultimately patient experiences did not reflect the collaborative patient-centred care model promoted by current government policy. However, their comments indicated that this situation would be preferred over current practice.

As highlighted, possession of power is not in itself a bad thing. Used wisely, power can be facilitative and enabling, giving support to a positive therapeutic interaction. Used badly, power can be restrictive and controlling; at worse a form of professional coercion. *Table 5* lists some recommendations to try and establish a balance of power between the therapist and the patient.

A key finding was the mismatch of perceptions between therapists and patients. The therapists perceived that there was a power imbalance in their favour, but it was not great. The patients on the other hand, considered the imbalance overwhelming, with their own position one of relative powerlessness. Such a mismatch in perception and expectation offers confusion to the boundaries of roles, responsibilities and autonomy and needs to be addressed.

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TABLE 5.

Recommendations for establishing power equality in clinical interaction

Deliver clear information regarding treatment plan, method and discharge (Connolly, 1991; Cameron, 1996)

Make contracts explicit (Sully, 1996)

Both parties to be dressed and sitting during discursive dialogue (Thornquist, 1991; Chartered Society of Physiotherapy, 1996)

Avoid ambiguities with individuals of opposite sex (Connolly, 1991)

Acknowledge dual responsibilities (Connolly, 1991)

Understand motives, demands, expectations and health beliefs (David, 1993; Wagstaff, 1982)

Reflect on critical discourse: identify who is marginalized, how and why (Gouldner, 1993)

Adapted from Williams and Harrison, 1999

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KEY POINTS

- All social interactions involve an element of power negotiation.
- In the therapeutic interaction, there are more opportunities for the exercise of power than usual.
- The power balance is explored from the point of view of both patient and therapist.
- Key sources of power are identified and discussed.
- Both patients and therapists agree that the power balance is tipped in favour of the therapist.
- Therapists consider the power imbalance is much less great than patients do.
- Patients consider the power imbalance to be overwhelming and themselves to have little or no control of treatment given.