

**The effect of desirable behavioural characteristics of the
chiropractic intern during the management of
mechanical low back pain – a patient perception study.**

By

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A dissertation submitted to the Faculty of Health Sciences in partial compliance with the requirements for a Master's Degree in Technology: Chiropractic at the Durban Institute of Technology.

I, Patrick Gardner,
do hereby declare
that this dissertation
represents my own work
in both conception and execution.

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The effect of desirable behavioural characteristics of the chiropractic intern during the management of mechanical low back pain – a patient perception study.

Abstract:

Background: Scholars, researchers and health care practitioners have long known that patients not only benefit from the specific manual therapy given from their health care providers, but also from the manner in which it is given. The latter is believed to have significant effects on the patient's perception of quality of care and clinical outcome.

Objective: The purpose of this study was to observe a clinical encounter where practitioners exhibit varying levels in desirable behavioural characteristics in order to determine whether these characteristics are perceptible to the patient as determinants of perceived patient satisfaction;

- The first objective was to observe the clinical encounter and establish the verbal and non-verbal behavioural characteristics during the process of clinical intervention.
- The second objective was to ascertain whether patients are aware of these characteristics and whether or not they assign any value to them as determinants of satisfaction.

Design: A descriptive, qualitative study was conducted. Purposive sampling from a group of volunteer interns was utilized to identify two interns, each with a particular behavioural style. Random sampling was employed to select four patients, who were each seen by each intern. Data were collected by observation of the interns in consultation and post consultation interviews. Data was thematically analyzed and results were triangulated.

Results: Of the two behavioural styles, the intern with the relater/socializer approach (interactive socially, open) possessed more of the predetermined desirable behavioural characteristics than the intern with the director/thinker approach (clinical). This was consistent with both patient perceptions and researcher observations.

Conclusion: Certain behavioural characteristics seem to be more important than others to patients. Not only that, but certain chiropractic practitioners, that naturally possess a relater/socializer-type behavioural style, may be at a distinct advantage in treating patients to other practitioners (particularly those with a director/thinker-type style, characteristically task oriented, concerned with outcomes and process). The relater/socializer's utilization of certain behavioural characteristics seems to elicit a potent non-specific effect, which bolsters patient satisfaction thereby improving the quality and ultimately the outcome of the care provided.

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Acknowledgements:

I would like to thank the following:

The "Big Guy" (God), for everything.

My family, for their support, understanding and love.

Dr. C. Myburgh and Ms. K. Roodt for their supervision of this study.

The D.I.T. reception and administration staff, for their assistance and time.

The patients involved in the study, it would not have taken place without you.

Chapter 1-Background and overview of study:

Introduction:

Scholars, researchers and health care practitioners have long known that patients not only benefit from the specific manual therapy given from their health care providers, but also from the manner in which it is given (Cherkin and McCornack, 1989). The latter is believed to have significant effects on the patient's perception of quality of care and clinical outcome.

The historical and clinical rationale for including satisfaction as an indicator of quality of care and outcome is an established research practice in the clinical setting (Yeomans, 2000). This perspective (still prevails, and) is built mainly upon clinical consensus that satisfaction is an important part of quality care. Satisfaction, therefore, is an important component of successful practice. Furthermore the importance of satisfaction is also demonstrated by its effect on financial performance, market share positioning, patient adherence, treatment efficacy, and personal management of health care.

There is, however, the possibility that patient satisfaction, as an outcome of success, relies heavily on the strength of the patient's perception regarding non-specific entities closely associated with, but not part of specific management effects.

This holds true for the chiropractic profession, in particular, as the literature indicates that a significant contributor to the clinical success of chiropractors is attributed to the high levels of satisfaction experienced by their patients. Satisfaction is thought to stem from, not only the mechanistic process of the clinical intervention, but also the way in which it is delivered. Some authors go so far as to suggest that "manner" surpasses the "method", in terms of its effect on satisfaction (Jamison, 1998).

The “manner” of clinical intervention may be portrayed by certain behavioural characteristics of the healthcare practitioner (Jamison, 1998). Certain desirable practitioner behavioural characteristics have been demonstrated as being influential in affecting patient satisfaction (Cherkin and McComack, 1989; Sawyer and Kassak, 1993). However, to date, no studies exist in the local context, which have attempted to directly observe these characteristics during the chiropractic clinical encounter and investigate whether they might be indicators for higher levels of patient satisfaction, have been conducted. Furthermore, it is also not known whether patients have the ability to discern between behavioural characteristics that contribute to greater perceived levels of satisfaction with care.

The following points illustrate the potential usefulness of this study:

1. Patient satisfaction has been shown to be an important indicator of quality of care and thus is as an important component of successful practice.
2. Non-manual intervention in patient management should be understood to a greater degree, as maximization of this phenomenon has the ability to affect clinical effect size.
3. Identifying subjects with suitable behavioural profiles for chiropractic may assist educators when recruiting candidates.
4. Brings awareness to the significance of multidimensional, holistic approaches in health care, i.e. to draw attention to the usefulness of alternative approaches in healthcare.
5. Demonstration of the appropriateness of research methodologies/approaches alternative to traditional quantitative designs, in evaluating chiropractic care.

Therefore this study was aimed at exposing patients to different chiropractors in a clinical setting, in order to ascertain whether certain characteristics are more readily associated with satisfaction and whether patients can articulate the basis for a varied perceived satisfaction, when exposed to otherwise standardized intervention conditions.

The first objective was to observe the clinical encounter and establish the parameters of verbal and non-verbal behavioural characteristics during the process of clinical intervention.

The second objective was to ascertain whether patients are aware of these characteristics and whether or not they assign any value to them as determinants of satisfaction.

Therefore a descriptive, qualitative study was conducted, with purposive sampling of chiropractic interns. Two chiropractic student interns were asked to volunteer for the study. The researcher, from the Chiropractic Day Clinic, recruited four new patients, provided that they complied with the relevant selection criteria. Data was collected by participant observation of videotaped consultations and follow-up unstructured interviews with the patients that were audiotaped.

Triangulating literature, participant observation and interview data by thematic content analysis generated results. The Atlas Ti qualitative data analysis software package was used for the unstructured interviews in order assist with thematic analysis.

The shift in medicine in the next century will undoubtedly be to a more holistic paradigm of health care (Bolton, 1999). We must be vigilant that while medicine moves more and more in this direction and takes with it the research methodologies appropriate to the holistic care model, we are not left behind

clinging exclusively to the old ground occupied by medicine today. Chiropractic research now has the opportunity to move forward, acknowledging the many research designs that can exist together in a complementary fashion. Research is about expanding and enhancing our knowledge and understanding of practice with the ultimate goal of improving clinical care for patients.

Definitions:

Patient satisfaction (with respect to healthcare): the patient's personal evaluation of healthcare services and the service provider i.e. the patient's response to the context, process and results of their experience (Yeomans, 2000).

Outcomes: the states or conditions of patients attributed to healthcare service provided. They include changes in health states, changes in knowledge or behaviour pertinent to future health states, and changes in patient satisfaction (Donabedian, 1992).

Quality of care: the degree of congruency between patient need and the healthcare service actually delivered. The "goodness" of healthcare provided.

Non-specific effect: therapeutic gain/effect in response to non-manual/mechanistic elements of care giving, i.e. the effect of the manner in which the care is given.

Global: generalized view of, i.e. overall observation. In the context of this study the term will be used to characterize the patient's overall retrospective view of the management.

Behavioural style: the type of interactive approach employed by the healthcare practitioner (in this study, the chiropractor) during consultation with patients, i.e. the character of the practitioner with respect to behaviour towards patients.

Congruence: The establishment and maintenance of a shared clinical reality between the healthcare practitioner and the patient (Jamison, 1997).

Chapter 2- Literature review:

2.0 Introduction:

“Research is... expanding and enhancing our knowledge and understanding... with the ultimate aim of improving care for patients.” - (Bolton, 1999).

“The quality of interaction between the physician and the patient can be extremely influential in patient outcomes, and, in some (perhaps many) cases, patient and provider expectations and interactions may be more important than specific treatment.” - (Vernon, 1991).

The evaluation and improvement of healthcare has never been as widely investigated as it has today (Bolton, 1999). Quality improvement assessments are employed worldwide in an effort to provide better care for consumers. This chapter will therefore concern itself with a discussion of the concepts of quality of care and patient satisfaction as an outcome of care. The review also aims to develop a state of the art view of the role of behavioural characteristics of the chiropractic clinician.

The chapter will also discuss patient satisfaction and the importance thereof in the healthcare context, including the intimate relationship between patient satisfaction and the abovementioned concepts. The role of patient satisfaction in the chiropractic profession will also be elaborated upon.

The discussion will then focus on patient satisfaction's relationship with the behavioural characteristics of the health care practitioner and their effects on patient satisfaction.

It is therefore the aim of this chapter to demonstrate that patient satisfaction, an understated component of quality care, can be positively influenced by certain (previously identified) behavioural characteristics of the chiropractic practitioner. Thereby theoretically underpinning the notion that chiropractors with certain traits may have an advantage during the everyday management of common ailments dealt with by chiropractors.

2.1. Patient satisfaction, and its relationship with quality of care and clinical outcomes:

Satisfaction was earlier thought to be only a general indicator of the patient's total response to care. The current conceptualization of satisfaction has been significantly broadened to include patient preferences and personal experiences (Yeomans, 2000). For example, asking patients specifically about problems encountered and personal experience in their health care encounters has permitted a much more comprehensive view of their opinions.

Healthcare has made use of patient satisfaction as a form of service feedback in order to better the quality of the service provided. Patient satisfaction is widely used as a quality assessment tool. It is now routine to see patient satisfaction measures included as part of quality improvement efforts in many countries across the world. In the United States, more than half of all healthcare organizations are using a form of patient satisfaction measurement, with more adding to that number (Yeomans, 2000). Furthermore, the historical and clinical rationale for including satisfaction as an indicator of quality of care and outcome has been established. This perspective is built upon scientific and clinical consensus that satisfaction is an important component of quality care. It is said that without satisfaction there cannot be quality care. In other words, if patients are dissatisfied with their care, then healthcare has not achieved its goal (Yeomans, 2000).

There is a growing awareness, particularly from patients, that what patients want in health care service is important to care and may determine the personal satisfaction with treatment and, later, the personal satisfaction with the outcome of care (Bolton, 1999).

There seems to be a tension between patient satisfaction and other measurement outcomes. This is an important aspect to explore, because patient satisfaction may be more indicative of the relationship components of care rather than the disease components (Verhoef *et al*, 1997).

It has been noted that ratings of satisfaction are highly correlated to global ratings of outcome, moderately correlated with self-reported measures of symptoms, and only slightly related to health care practitioners' findings and outcome.

This is reflected in a study by Verhoef *et al*. (1997), where the authors were of the opinion that overall outcome of care should be combined with other patient outcomes relevant to chiropractic care, such as changes in pain experienced and as well as functional ability in order to gain a more complete picture of patient care. The authors found that general satisfaction was significantly related to an improvement in disability. They also found that patients reported increased satisfaction with care over time, despite no resolution of pain. This was attributed to the development of a more personal relationship between doctor and patient.

Patient satisfaction, in this case, seems to be related to the relationship aspects of intervention rather than specific interventions, such as spinal manipulative therapy. This may be because patient satisfaction is a global indicator of quality of care, which also assesses the non-specific components of clinical care i.e. the relationship aspects of practice.

It is therefore possible that patient satisfaction has been misused in assessment of specific interventions alone, neglecting non-specific components of care. Rather, patient satisfaction is a gauge of both components of care, with the balance between the two shifting with each unique case that chiropractors face in daily practice.

2.2. Satisfaction and the Chiropractic Profession:

Locally and abroad, patients report high levels of satisfaction with chiropractic care. In the study conducted by Cherkin and McCornack (1989), the authors employed a focus group of ¹20 patients to identify the key factors in the care giving process. The term "care" was not clearly defined in the study, however, the factors identified by the patients in their evaluations were: the perception regarding the providers' concern, understanding and skill in providing care for low back pain, the information they were given by the provider, and their satisfaction with the process of care. The sample of completed surveys utilized consisted of 125 from family physician patients and 242 from chiropractic patients. The results of the study indicated that patients who received chiropractic care for their low back pain were three times as likely to report that they were very satisfied with the care they received (66% versus 22% respectively). Furthermore, chiropractic patients were also more likely to have been satisfied with the amount of information given, that their provider was concerned about them and felt that their provider was comfortable and confident dealing with their problem. The authors also found that patients indicated that they were more likely to return to the same chiropractor than physician (87% versus 60% respectively). Although the authors discussed a number of reasons, which could have accounted for the observed results they argued strongly that patient-provider interaction might be a strong contributory factor to the specific benefits of treatment utilized and consequent overall clinical effect.

¹ This was a random sample drawn from a health maintenance organization's enrollees who had either consulted a physician or chiropractor in the 12-month period preceding the study.

Sawyer and Kassak (1993) agreed with Cherkin and McCornack (1989) where they conducted a study aimed at determining the attitudes of patients regarding the process and results of chiropractic care and to identify patient characteristics, which might predict satisfaction. The authors' main motivation for conducting the study was that patient satisfaction measured a non-physical outcome dimension that could be utilized in the evaluation of health service provision. The authors settled on the use of a pre-tested 32-point satisfaction questionnaire to generate this data. The study results indicated that patients generally expressed a high degree of satisfaction with chiropractic care. Sawyer and Kassak (1993) stated that among a variety of factors that might influence patient satisfaction, they found that the patient's perception of treatment outcome was the most important predictive variable. The authors concluded by calling on researchers to investigate the manner in which chiropractors deliver their services and their effect on patient satisfaction.

Patients of 208 practitioners, including primary care physicians, urban chiropractors, rural chiropractors, orthopedic surgeons and primary care providers of a managed healthcare organization, were the subject of a study regarding the care they received for low back pain. After six months of treatment, the researchers concluded that patients were most satisfied with the care they received from chiropractors. The authors point out that the biggest difference in patient satisfaction with chiropractic care for low back pain was in the quality of the provider's: history taking, examination, and explanation of the ailment during the consultation (Goertz *et al.*, 1995). It was stated that it is important to study the clinical outcomes associated with differing chiropractic systems of care and therefore determine the attitudes of patients when under care of doctors noted for their clinical diversity. The authors concluded that such information would be ultimately helpful in establishing guidelines for the evaluation and care of chiropractic patients.

2.3. The Behavioural Characteristics of the Chiropractic Practitioner:

The literature has identified certain behavioral characteristics of the Health Care Practitioner (HCP) that affect patient satisfaction (Cherkin, McCormack and Berg, 1989; Sawyer and Kassak, 1993). According to Jamison (1996) chiropractors in particular employ these characteristics in practice. Jamison (1997) described these as being verbal and non-verbal interactions in a discussion of chiropractic behavioural styles. This may be expanded upon, as developed in the behavioural characteristic list below. According to Jamison (1998), the behavioural characteristics of the practitioner have the potential to influence the "non-specific" component of care and consequently, overall clinical outcome. The author also argues that although the maximization of even marginal non-specific gain in a therapeutic encounter may be a useful adjunct to specific care, this should not be used to substitute specific therapy.

From the literature regarding patient satisfaction and its relationship with practitioner behavioural characteristics, the following characteristics have been identified as important in successful practice; concern for patient, explanation of illness, explanation of treatment, validation of the sick role, caring, respect and courtesy, empowerment of the patient, confidence, influence on patient self-esteem, friendliness, time spent listening to patient and physical interaction "hands-on" time:

2.3.1 Verbal interaction:

This relates to direct verbal communication between the patient and the practitioner providing the care during the clinical encounter. Certain characteristics are indicated through verbal interaction.

2.3.1.1) Concern:

This may be described as the manner in which the health care provider shows concern for the patient and the illness that the patient is suffering from (Vernon, 1991).

2.3.1.2) Explanation of illness:

The practitioner provides a graphic description of the causes of low back pain. This information should include the cause of their pain and clear information about expected recovery time (Cherkin and McCormack (1989).

Patients are also expected to be provided with an acceptable explanation of their illness (Vernon, 1991; Jamison, 1998).

2.3.1.3) Explanation of treatment:

The practitioner explains how they are going to help alleviate the patient's condition (Coulter et al, 1994). This includes biomechanical explanation of the effects of the manual therapy and the predicted results thereof. The prediction that muscular discomfort will be initially aggravated and later relieved confirms that the practitioner can predict the outcome.

Cherkin and McCormack (1989) include the practitioner instructing the patient on how to care for the back after visits. This may take the form of instruction on specific exercises, posture correction and lifting techniques.

2.3.1.4) Validation or legitimization of the sick role by the healthcare provider:

Firstly the practitioner accepts and clarifies the patient's verbal complaints, and then proceeds to verify the ailment on physical examination. Not only validating

the complaint but also defining, verbally and physically, a new health status perception. The practitioner provides a diagnosis, based upon shared palpatory and verbal perception created during the consultation from practitioner-patient interaction (Cherkin and McCormack, 1989; Vernon, 1991; Jamison, 1997).

The clinician's validation of the problem and understanding of the patient's distress provides psychological support and reassurance (Jamison, 1998).

2.3.2 Non-Verbal interaction:

This includes actions or non-verbal communication from the practitioner that conveys a particular characteristic in his or her behaviour with the patient.

2.3.2.1) Caring:

Caring may be demonstrated by numerous actions of the health care practitioner.

Firstly, the manner in which the practitioner elicits and checks his or her understanding of the patient's problem with respect to both pain and/or dysfunction being experienced.

The following four points may not be considered strictly non-verbal:

- The practitioner may display a personal knowledge to the patient of how they usually respond to therapy given in previous consultations.
- The practitioner may inquire about the effects of the patient's condition on patient pain, lifestyle and routine functioning in day-to-day life.
- The patient may be told that they should feel free to contact the practitioner prior to the next appointment if necessary.

- The practitioner may also show a personal interest in the patient's lifestyle, family and/or social interests (Jamison, 1997).

The above actions and an empathetic attitude of the health care provider, providing personalized care, typify good clinical care (Coulter et al, 1994; Vernon, 1991).

2.3.2.2) Respect and courtesy shown by the health care practitioner (Coulter et al, 1994).

The practitioner conducts him/herself in a polite and appropriate manner during the consultation.

2.3.2.3) Health care provider's empowerment of the patient:

The practitioner may actively involve the patient in the decision making process of selecting the appropriate therapy. This may include the clinical therapy in the practice rooms and/or the home therapies that may be advised. Being actively involved empowers the patient by them taking personal responsibility for their health (Coulter et al, 1994; Vernon, 1991; Jamison, 1995).

The patient's certainty that something can and is being done makes them feel more able to cope. The practitioner provides the patient with written, verbal and physical education on how to reduce risk of recurrences. This contributes directly to the patient's sense of control. This sense of control may be bolstered indirectly by feedback from their chiropractor on their progress (Cherkin and McComack, 1989; Jamison, 1997).

2.3.2.4) Practitioner confidence:

Practitioners may possess a personal conviction that they can help. Chiropractors in particular carry the personal experience of previous patient successes and the vicarious experience of a profession with a good record of patient satisfaction into every clinical encounter (Jamison, 1998).

In a comparative satisfaction study by Cherkin and McComack (1989), 60% of patients strongly agreed that their provider seemed confident and comfortable in diagnosing and treating their back pain, with less than a fourth reporting the same with their physician's care.

2.3.2.5) Healthcare practitioner (HCP) influence on patient self-esteem (Vernon, 1991).

The HCP encourages and commends the patient with respect to the clinical setting and outside the clinical setting, i.e. on an interpersonal level. This should positively affect the patient's self-esteem.

2.3.2.6) Happy, friendly practitioner (Coulter et al, 1994).

The practitioner behaves in a manner that is pleasant and appears positive.

2.3.2.7) Time spent listening to the patient:

Practitioners take time to allow their patient's to air their concerns (Jamison, 1997; Vernon, 1991; Cherkin and McComack, 1989).

2.3.2.8) Physical interaction (hands-on time):

The chiropractic consultation is characteristically dominated by physical communication; both diagnostic and therapeutic intervention involves a hands-on approach. Jamison (1997) states that when the education dimension is excluded, more than half of the time of the consultation is spent with the practitioner in direct contact with the patient. With minimal patient education in

consultation or the scenario of a chronic patient seeking regular maintenance care, up to 90 % of the consultation time is spent “touching” the patient.

The importance of touch must not be overlooked in a touch-starved Western culture. A simple touch has the ability to lower a patient’s heart rate and blood pressure. Touch may also stimulate the patient to release endorphins, much like a concerned mother “hugging away” her child’s pain from a grazed knee. The practitioner has the ability to strongly stimulate touch through contact during examination and treatment, the first one of senses to develop and usually the last one to fade (Liggins, 2000).

All of the above behavioural characteristics identified in the literature can therefore be summarized as follows:

Behavioural Characteristic (verbal):	AUTHOR/S:
Concern	Cherkin and MacComack, 1989; Vernon, 1991
Explanation of illness	Cherkin and MacComack, 1989; Vernon, 1991; Coulter et al 1994; Jamison, 1998
Explanation of treatment	Cherkin and MacComack, 1989; Coulter et al, 1994
Validation of the sick role	Cherkin and MacComack, 1989; Vernon, 1991; Coulter et al 1994; Jamison, 1995;

	Jamison 1997; Jamison, 1998
Behavioural Characteristic (non-verbal):	Author/s
Caring	Vernon, 1991; Coulter et al 1994; Jamison, 1997
Respect and courtesy	Coulter et al, 1994
Empowerment of the patient	Cherkin and MacComack, 1989; Jamison, 1990; Vernon, 1991; Coulter et al 1994; Jamison, 1995; Jamison, 1997
Practitioner confidence	Cherkin and MacComack, 1989; Jamison, 1998
Influence on patient self-esteem	Vernon, 1991; Jamison, 1995
Happy, friendly chiropractor	Coulter, 1994
Time spent listening to the patient	Cherkin and MacComack, 1989; Vernon, 1991; Jamison, 1997
Physical interaction (hands-on time)	Jamison, 1997; Liggins, 2000

Table 1: Behavioural characteristics of the HCP and sources.

2.5 Conclusion:

Patient care and the management thereof have developed greatly in recent years. The trend of medicine moving toward a more holistic approach, including regard for patient perceptions, can only improve the therapeutic encounter (Bolton, 1999).

The interpretations and perceptions of the patient may be some of the most important dimensions of illness behaviour (Jamison, 1999). Patient satisfaction's part in providing high quality management of healthcare may be larger than previously thought.

The role of the reviewed behavioural characteristics, of the chiropractic practitioner, is one of determinants of patient satisfaction. Patient satisfaction, it seems, is affected positively by these determinants. Due to the intimate nature of the relationship between patient satisfaction and quality of care, i.e. satisfaction is an important clinical indicator of quality of care; quality of care may be influenced by these determinants. The concept that quality of care is considered an outcome must also be kept in mind. Consequently, the behavioural characteristics of the chiropractic clinician have the potential to positively influence patient satisfaction, quality of care and ultimately clinical outcome.

It may be deduced from this that field clinicians with certain behavioural styles that employ these characteristics in practice may be at a distinct advantage in treatment of common ailments seen by chiropractors in daily practice.

What is not known at this point is whether patients notice certain behavioural characteristics readily and whether some are more potent than others, in terms of their effect, that is to say, do patients notice these behavioural characteristics and do they then relate them to their perceptions of satisfaction?

Chapter 3- Methodological issues in patient research:

3.1 Introduction:

Chiropractic has chosen to follow a biomedically-oriented approach to research (Bolton, 1999). The result has been a secure place for the profession, but at the cost that the profession has investigated certain research questions by inappropriate means (Myburgh, 2003).

From the previous chapter one could argue that quantifying patient satisfaction is tantamount to quantifying patient global assessment; which cannot be used to measure specific therapeutic interventions, in that recall that global assessment also includes the non-specific intervention components (Yeomans, 2000).

Therefore this short chapter will be devoted to developing an argument for seeking qualitative approaches to assess patient satisfaction appropriately as one proxy measure for quality of care.

3.1 Methodological problems in assessing patient satisfaction quantitatively:

Quantitative designs have and still do dominate research in healthcare (Bolton, 1999). The same is true for the investigation of patient satisfaction. Quantitative studies have overlooked the important behavioural aspects (non-specific) of clinical management and the patient's personal response to these.

Quantitative study also investigates the patient's opinion of factors of seemingly less importance, for example accessibility of the practice, cost of service and parking availability and lacks the contextual richness that typifies qualitative design.

A further danger of quantitative design is that of oversimplification or exclusion of variables that don't "fit" the study; certain observations, for example, may not fit appropriately into predetermined categories developed by the researcher. This may lead to an old methodological problem which results when "all you have is a hammer, everything begins to look like a nail" (Bolton, 1999). Some observations therefore, may be either incorrectly recorded or excluded altogether. These may be some of the most important variables, but were not conceptualized whilst designing a study.

3.2 The qualitative alternative:

Qualitative methods generate richer and more contextual data in detail (Coulter, 1993), regarding patient satisfaction. They may, therefore, be able to distinguish between satisfaction with the relationship/behavioural aspects and specific manual care. The outcome of care provided may be wholly or partially a result of the non-specific components of clinical management, therefore the use of quantitative assessment of patient satisfaction may be erroneously attributed to specific interventions alone.

Measurement utilizing qualitative methods in assessing patient satisfaction has gained support as the research paradigm matures. Qualitative methodology views the patient's perceptions as important and this allows for a greater understanding of their perception, regarding their therapeutic encounter (Coulter, 1993).

Therefore, the relationship and behavioural factors of the therapeutic encounter may be more appropriately investigated by employing qualitative methodology. Another strength of qualitative methods, cited by Coulter (1993), is that they provide a more dynamic view of the social processes taking place, rather than the "moment-in-time", static picture produced by surveys in quantitative design.

The danger of oversimplifying or excluding variables is also avoided by qualitative methodology, because its flexible nature allows for expansion and development within the study design.

3.3 No perfect solution:

Qualitative methods are also limited; there are reliability and validity issues of observations by either a single observer or a limited number of observers. A recommended approach to limit this problem incorporates the use of multiple methods of data collection. This process, called triangulation, adds scientific rigor to a study.

Both Coulter (1993) and Gatterman (1995) suggest utilizing a combination of qualitative and quantitative measures in assessing chiropractic care. Gatterman (1995) argues that quantitative data triangulated with qualitative observation can be used to satisfy the dominant quantitative paradigm while adding richness provided by the qualitative design.

3.4 Summary:

For the assessment of patient satisfaction in the context of this study, qualitative investigation seems to be the most appropriate. As mentioned, the data generated by qualitative methods takes more cognizance of the patient's personal perspective and produces greater patient satisfaction variables (Yeomans, 2000). And although qualitatively oriented research is less abundant in the literature than quantitative research and often considered the "soft" option in scientific investigation, chiropractic researchers would benefit greatly from the former in order to broaden their research horizon.

Chapter 4- Methodology of this study:

4.1 Introduction:

This chapter describes the design and methodology chosen for the study. As reproducibility of results is a requirement of modern science, it is important to describe the processes involved in this study, so that it may be repeated.

Specifically then this chapter describes the selection criteria, data collection methods and analysis of said data with appropriate reasoning.

4.2 Experimental Design:

A qualitative, descriptive, observational study was proposed to firstly observe the parameters of the verbal and non-verbal behavioural characteristics of the chiropractic clinician during routine consultation for low back pain. And secondly to assess which behavioural characteristics the patient recognizes more readily.

4.3 Sampling and Recruitment:

Have to write something here to introduce this section e.g. Two sampling procedures were required for the study in order to identify appropriate interns to use as well as to identify patients. Therefore the following section will discuss this process.

4.3.1 Chiropractic Intern Selection:

Chiropractic interns from the Durban Institute of Technology were asked to volunteer for the study. Interns from the same institute were asked because their training would have been similar with respect to methods of intervention and this would have brought about some standardization. Ten interns responded, and were assessed using the Discus Behaviour Profiling System (Axiom software, 1994) in order to isolate two types of behavioural styles. The Discus System is a

software program developed to assess the psychometric profiles of individuals. Candidates answer a questionnaire and the coded answers are then computed to generate a descriptive behavioural profile for each candidate (Roodt, 2003). The profiling system was administered by a registered psychologist (Roodt, 2003). These abovementioned behavioural styles are listed and described below:

- Director/Thinker-type style, characteristically task oriented, concerned with outcomes and process.
- Relater/Socializer, typically relationship oriented, concerned with maintaining relationships with patients and lively interaction (Jamison, 1996).

These two very different behavioural styles were selected in an attempt to bring about variability in the expression of the behavioural characteristics (discussed in Chapter 2) during consultation. The two abovementioned behavioural styles were also selected because of they have been identified in chiropractic practice (Jamison, 1996) and for practical design reasons.

The following behavior profiles were identified by the psychologist from the ten respondents (Roodt, 2003):

Respondent A (Active, Driver, Communicator):

A's natural focus is on his own needs rather than those of other people, a fact that clearly affects his style of communication. He uses communication in a direct manner as a way of achieving his goals, and states his opinions (and instructions) in an assertive style. He is prone to deal with disagreements purely by using his forceful style, rather than considering rational arguments.

His self-reliant style approaches relationships with caution, and it is rare for him to completely trust other people. He tends to view associations with other people in terms of his status, and uses contacts of this kind to help him in his career advancement.

Respondent B (Dominant, Impatient):

Passive and unassuming, B can be seen as quite remote by other people. He prefers to maintain a reactive (as apposed to pro-active) approach to communication, responding to others' questions and ideas, but rarely making direct statements himself unless he can be absolutely sure of the way in which these will be received. This is less true, however, in situations where he is completely relaxed, and feels that he understands the people around him well enough to be more outgoing.

In terms of relationships, his basically passive style means that not only under the most unusual circumstances will he make an initiating step in a social situation (or, indeed, in a situation of any kind). More commonly, he will wait for others to make contact, and respond appropriately. He does have a social side to his nature, however, and values friendship with other people.

B's current attempt to present himself as less reliant on others' views may impact on his communication style. The main apparent change from his natural approach will be a slightly more assertive stance on issues that he sees as important.

Respondent C (Analytical, Controlled):

C's communication style is very precise in nature. He considers it important to make his intentions absolutely plain, and he will often consider his words carefully before speaking. His need for certainty that others have understood his

meaning often results in his going to considerable lengths to ensure that this is the case. For example, he can be expected to follow verbal agreements with written confirmation where appropriate.

His cautious, steady communication style can often lead others to believe that he does not have an ambitious or assertive side, but in fact he is highly motivated in these areas, and is not afraid to become involved in direct confrontation should this prove necessary.

Respondent D (Communicator, Planner):

The compressed nature of D's behavioral profile makes his communication style almost completely unpredictable. It would be misleading, therefore, to make any comments on the subject.

Respondent E (Passive):

Communication to people of E's kind is, at least in the work context, purely a practical matter. He responds to requests for information or action, but rarely makes comments himself unless drawn to do so by more assertive individuals. Despite this reserved element, however, he does work well in groups taking advantage of the practical support that such an environment can offer.

Because of his practical turn of mind, E will tend to approach relationships in a somewhat pragmatic manner. His conversation rarely ventures into the realm of personal or emotional matters, and he prefers to remain on a less open level, unless the relationship in question is very close indeed.

Respondent F (Passive):

The compressed nature of F's profile suggests that he feels himself to be under some kind pressure at present, and this is likely to be represented in a somewhat evasive communication style. While none of his factors are particularly well defined, the most significant of them relates to an unwillingness to communicate either facts or personal information without being certain of his position, but because he lacks assertiveness, he will tend to apply a rather equivocal, uncommitted style, rather than simply refusing or denying others' requests.

Respondent G (Communicator):

Undemanding and open to other people, G has a friendly style with a real interest in others' ideas and feelings. She will tend to base her responses on emotional considerations, but this is not to say that she is impulsive in style. On the contrary, she is patient with others, and in addition to her general social ability, she is a capable listener.

Because she responds on an emotional level, as opposed to the more pragmatic and rational approach of some other profiles, she tends to judge others on first appearances. Where she develops close ties, whether in a work situation or in a more general sense, she can be expected to show considerable loyalty, and be prepared to expend effort to maintain the relationship.

Respondent H (Passive, Open Planner)

H's social style could be characterized as amiable rather than overtly friendly. He values positive contact with other people, but his natural reticence makes it difficult for him to take active steps toward developing such contacts. He feels uncomfortable in strange environments, and is generally uneasy when placed in a position where he has to take the initiative.

Relationships are very important to H, but he does not take time to develop close links with other people. His reserved attitude can be mistaken by other people for coldness or lack of interest, but he does possess a need to build relationships and shows great loyalty and persistence in maintaining those social bonds that he succeeds in forging.

Respondent I (Passive, Open Planner)

I's social style could be characterized as amiable, rather than overtly friendly. He values positive contact with other people, but his reticence makes it difficult for him to take active steps toward developing such contacts. He feels uncomfortable in strange environments, and is generally uneasy when placed in a position where he has to take the initiative.

Relationships are very important to I, but he does not take time to develop close links with other people. His reserved attitude can be mistaken by other people for coldness or lack of interest, but he does possess a need to build relationships and shows great loyalty and persistence in maintaining those social bonds that he succeeds in forging.

Respondent J (Controlled, Analyst)

Passive and unassuming, J can be seen as quite remote by other people. He prefers to maintain a reactive (as apposed to pro-active) approach to communication, responding to others' questions and ideas, but rarely making direct statements himself unless he can be absolutely sure of the way in which these will be received. This is less true, however, in situations where he is completely relaxed, and feels that he understands the people around him well enough to be more outgoing.

In terms of relationships, his basically passive style means that only under the most unusual circumstances will he make an initiating step in a social situation (or, indeed, in a situation of any kind). More commonly, he will wait for others to make contact, and respond appropriately. He does have a social side to his nature, however, and values friendship with other people.

From analysis of the results of the psychometric profiling the psychologist (Roodt, 2003) selected the two profiles most closely resembling those of the abovementioned behavioural styles (page 28).

Respondent J was selected to represent the director/thinker-type style, and respondent G was selected to represent the relater/socializer. For practical and confidentiality purposes respondent J was referred to as intern 1 and respondent G was referred to as intern 2. This system also attempts to hide the sex of the intern from the reader where possible.

A possible limitation of this selection tool lies in the ability of the potential participant to skew the results of the psychometric profiling by being untruthful. The DISCUS Behaviour Profiling system however has a distortion level built into the system to identify the faking good / faking bad element within the profiles. Two distorted profiles were identified and their profiles were therefore not considered for the exercise. The DISCUS Behaviour Profiling system has been validated in 1997 and was found to be significantly valid and reliable (Rood, 1997).

Each intern had an equal chance of being selected and signed the relevant consent form in lieu of participation. Each respondent had access to his or her psychometric profile result when the fieldwork was complete.

4.3.2 Patient Selection:

Four patients were selected from the Chiropractic Day Clinic by the researcher. The reception staff notified the researcher of new low back pain patients. The researcher then contacted the potential participants to see if they fitted the patient selection criteria. The following patient criteria aided in diversifying practice variability (Jamison, 1997), and in adding validity by some restrictions:

- A patient presenting with low back pain.
- Two acute and two chronic patients.
- Patient's between the ages of thirty and fifty so that a relatively homogenous sample may be obtained. This attempts to bring about standardization.
- Patient's who have not seen a chiropractor before. The use of a "naive" patient helps to minimize preconceptions to chiropractic clinical practice.

The type of patient selected in the study may have been more tolerant and/or cooperative due to the fact that the Chiropractic Day Clinic is a teaching institution and not a private practice. The clinic is run, however like a private practice on an outpatient basis.

Patient demographics were recorded on the standard Chiropractic Day Clinic Admissions forms. Each patient signed the relevant consent form in lieu of participation.

4.4. Data Collection:

The instrumentation and collection methods employed in the study were those of participant observation and an unstructured interview.

4.4.1 Participant Observation:

The researcher conducted the initial consultations, which included history taking, examination and diagnosis. This was done to aid standardization of specific treatment in consultation. The researcher then observed the follow-up consultations with the interns. The researcher observed the interns treating from behind a one-way glass mirror and also videotaped the consultations from a remotely operated camera in the adjacent room. Each patient was seen twice by each intern, i.e. two follow-up visits with both interns in differing sequences:

	Intern1 consult. 1	Intern 2 consult. 1	Intern 1 consult. 2	Intern 2 consult. 2
Patient 1	X	X	X	X
Patient 2	X	X	X	X
	Intern 2 consult. 1	Intern 1 consult. 1	Intern 2 consult. 2	Intern 1 consult. 2
Patient 3	X	X	X	X
Patient 4	X	X	X	X

Table 2: Intern-patient consultation schedule

As the researcher observed the consultation, any specified behavioural characteristics displayed by the chiropractic intern were marked off on a checklist prepared by the researcher (Appendix A). This checklist also contained space for additional notes.

The videotaping was not only useful for post-consultation reflection (certain characteristics may be missed while jotting down notes) but also for optimal accuracy in recording the duration of consultation, "hands-on time and time spent

listening to the patient. The duration of consultation was measured in order to convert "hands-on time and time spent listening to the patient into percentages of the total consultation time.

4.4.2 Unstructured interview:

A qualitative interview is an interaction between an interviewer and a respondent in which the interviewer has a general inquiry but not a specific set of questions that must be asked in particular words and in a particular order. The design is flexible, iterative and continuous. The basic process of gathering information, analyzing it, winnowing it and testing it, brings the researcher closer to a clear model of the investigated phenomenon (Babbie, 1998).

The researcher conducted an audiotaped interview with each patient after his or her final treatment. The tapes were transcribed and the data was entered into a qualitative analysis software program (Atlas Ti Qualitative Analysis Software Package)(Appendix F). The interview entailed a discussion of the treatment received, the patient's satisfaction or dissatisfaction with care received and what determined their perception of the quality of their care, i.e. which determinants they were aware of that may have influenced their satisfaction/dissatisfaction. A template was drawn up listing 5 main themes, in the form of questions (Appendix B). The questions were aimed at eliciting the patient's opinion of their healthcare and whether they recognized any particular behavioural characteristics of the intern that were important to the patient. The interview template assisted in guiding the researcher during the interview whilst still being flexible at the same time.

4.5 Confidentiality:

The data generated by this research will only be available to the researcher's supervisor, co-supervisor and the ethics committee. The paper data collected will be shredded and the tapes will be incinerated after 5 years.

4.6 Analysis of Results:

Results were obtained by triangulating literature, participant observation and interview data by thematic content analysis. The Atlas Ti qualitative data analysis software package was used for the unstructured interviews in order assist with thematic analysis.

Chapter 5. - Results and Analysis:

Please look at the numbering of this section again, I have made some changes to the numbering, so will have to adjust the rest accordingly

5.1 Introduction

This chapter will firstly concern itself with the results from the field research. The first set of results was generated from the data collected during the participant observation of the consultations (Appendix A). The second set of results was generated by analyzing the post-consultation patient interviews, using the Atlas ti qualitative analysis program (Scientific Software Development).

The chapter will then analyze and discuss the integration of the findings from the participant observation and interviews of this study and the integration with current literature relevant to patient satisfaction and quality of care.

The triangulation of these data sources will attempt to bring about a clearer and more comprehensive view of the role of the behavioural characteristics of the chiropractic clinician in providing sound quality healthcare.

5.2 Results:

5.2.1 Results of the participant observation:

From the participant observation the following behavioural characteristics were observed using the developed Behavioural Characteristic Template checklist (Appendix A); concern for patient, explanation of illness, explanation of treatment, validation of the sick role, caring, respect and courtesy, empowerment of the patient, confidence, influence on patient self-esteem, friendliness, time spent listening to patient, physical interaction "hands-on" time and duration of

consultation. The distributions of these observed behavioural; characteristics are discussed below under their subheadings:

Verbal interaction:

5.1.1 Health Care Provider concern for patient illness:

This characteristic did not come through strongly with intern 1 at all. In fact, intern 1 only displayed concern in one consultation with patient C (Behavioural Characteristic Observations, page 7). This may be due to intern 1's more clinical director/thinker behavioural style that is more process oriented than relationship oriented.

Intern 2, however, showed concern for the patient in every one of her consultations (Behavioural Characteristic Observations, pages 9-16).

5.1.2 Explanation of illness:

The illness was explained or discussed in all of intern 1's treatments (Behavioural Characteristic Observations, pages 1-8), but not discussed in three of intern 2's treatments (Behavioural Characteristic Observations, pages 13, 15 and 16). All three consultations in which intern B excluded explaining the illness were the second treatments and it was noted (Behavioural Characteristic Observations, pages 13 and 15) that this may be due to intern 2 believing it not necessary to repeat the explanation of the illness provided in the first consultation.

5.1.3 Explanation of treatment:

Both interns explained or discussed the proposed treatment with their patients (Behavioural Characteristic Observations, pages 1-16). The discussions

included elements of what they would be or were doing, how their intervention affected the patient and how the patient would be expected to react.

Non-verbal Interaction:

5.1.4 Caring, empathetic Health Care Provider, showing personalized care:

Intern 1 only displayed a caring, empathetic attitude in 3 of the intern's consultations (Behavioural Characteristic Observations, pages 1,3 and 6).

Intern 2 displayed a caring attitude providing personalized care in all but one consultation (Behavioural Characteristic Observations, page 14). Intern 2 often inquires about or takes an interest in the patient's personal life (one element of caring), where the intern is very interactive socially (Behavioural Characteristic Observations, pages 9,10,13 and 16). In the second consultation with patient B, intern 2 develops the social relationship with the patient even further.

5.1.5 Respect and courtesy shown by the Health Care Provider:

This attribute was conveyed by intern 1 in all but his first consultation of the study (Behavioural Characteristic Observations, page 1). It was noted that the intern was very serious in conversation and methodical in this consultation, perhaps adjusting to being filmed could explain the difference in this instance.

Intern 2 displayed respect and courtesy in all of the consultations (Behavioural Characteristic Observations, pages 1-16).

5.1.6 Validation/legitimizing of the sick role by the Health Care Provider:

Intern 1 validated the patient's complaints in all but one consultation (Behavioural Characteristic Observations, page 4). It was noted that the intern seemed

uncertain in managing the case; this may explain why the intern did not validate the illness in only this one consultation.

Intern 2 also validated the complaints in all the consultations but one (Behavioural Characteristic Observations, page 10).

5.1.7 Empowerment of the patient:

Both interns displayed this characteristic in all of their consultations (Behavioural Characteristic Observations, pages 1-16). This was generally in the form of providing the patient with home-routines for self- management of their pain and/or lifestyle modification/correction advice. In intern 2's second consultation with patient B it was noted that the intern reinforced the empowerment aspect in the form of more exercises and stretches for self -maintenance in an attempt to bring about patient autonomy.

5.1.8 Practitioner confidence:

Intern 1 came across as confident in almost all consultations except for 2 (Behavioural Characteristic Observations, pages 4 and 7). In intern 1's first consultation with patient C (Behavioural Characteristic Observations, page 4), it was noted that the intern appeared uncertain about the case and not confident during the treatment.

Intern 2 appeared confident in all of the consultations observed (Behavioural Characteristic Observations, pages 1-16).

5.1.9 Health Care Provider influence on patient self-esteem:

Intern 1 did not seem to exert an influence on patient self-esteem in any of his consultations.

Intern 2, however, did seem to do this in all the consultations but one (Behavioural Characteristic Observations, page 15). This may be attributed to intern 2's personally interactive approach, asking about the patient's personal life and showing a genuine interest in the patient, even outside the immediate clinical setting.

5.1.10 "Happy, friendly Health Care Provider":

Intern 1 appeared happy and/or friendly in half of the consultations (Behavioural Characteristic Observations, pages 2,3,4 and 6). In the case of intern 1's first consultation of the study, with patient A, the lack of friendliness may be attributed to the intern adjusting to being filmed (Behavioural Characteristic Observations, page 1). It was noted in this consultation that the intern was very serious in conversation and methodical. In intern 1's second consultation, however, friendliness was observed and it was noted that the intern seemed to have relaxed and was also socially interactive with the patient.

Intern 2 seemed happy and friendly in all consultations (Behavioural Characteristic Observations, pages 9-16). This was especially evident in the first consultation with patient C, where it was noted that the consultation was highly interactive full of laughter and friendly exchange (Behavioural Characteristic Observations, pages 11).

5.1.11 Duration of consultation:

Intern 1 spent an average of approximately 28 minutes with each patient in consultation (Behavioural Characteristic Observations, pages 1-8). With only the first consultation taking considerably more time than the others, again this may be attributed to the intern adjusting to being filmed and overcompensating in the first consultation (Behavioural Characteristic Observations, page 1).

Intern 2 spent an average of approximately 29 minutes with each patient, with time allocation to each consultation being fairly uniform (Behavioural Characteristic Observations, pages 9-16).

5.1.12 Time spent listening to the patient:

Intern 1 spent an average of 10 minutes listening to the patient, which translates to 35% of the duration of the consultation (Behavioural Characteristic Observations, pages 1-8).

Intern 2 spent an average of 15 minutes listening to the patient, which translates to approximately 50% of the duration of the consultation (Behavioural Characteristic Observations, pages 9-16).

The socially interactive nature of intern 2 may prompt the patient to speak more and air their concerns fully.

5.1.13 Time spent in physical contact (hands-on time):

Intern 1 spent an average of 18 minutes touching the patient in either diagnostic investigation or manual treatment, which translates to approximately 63% of the consultation duration (Behavioural Characteristic Observations, pages 1-9).

Intern 2 spent an average of 22 minutes touching the patient in either diagnostic investigation or manual treatment, which translates to approximately 75% of the consultation duration (Behavioural Characteristic Observations, pages 1-9). In one particular case the intern spent as much as 85% of the time in contact with the patient (Behavioural Characteristic Observations, page 13).

5.2 Results of the interviews:

The outputs generated by the Atlas t/i qualitative analysis software program are available as Appendix C.

5.3 Summary:

From the above results it can be noted that both interns displayed almost all of the behavioral characteristics during the consultations. Intern 2, however, displayed the personal behavioural characteristics of the Health Care Provider either to a greater extent or exclusively. These included concern for patient, caring attitude, influence on patient self-esteem and friendliness of the HCP. This was expected due to the intern's socializer/relater behavioural style, for which intern 2 was selected for the study.

Although the mean duration of consultation was very similar with both interns, a difference in mean time spent listening to the patient (35% intern1 vs. 50% intern2) and "hands-on" time (63% intern1 vs. 75% intern2) was noted. Intern 2 appeared to be far more interactive with the patients and this may account for the difference in mean times.

5.4 Analysis of the identified behavioural characteristics:

The explanation of the illness and the explanation of the treatment were the two of the most noted behavioural characteristics in both participant observation and patient interviews from the study. These characteristics were recognized and mentioned by all of the patients during the interviews (Code: B.C. - Explanation of illness {6-0} P 2: Patient C interview.txt 29 - 36, 56 - 65; P 3: Patient D interview.txt 14 - 17; P 6: Patient A interview.txt 35 - 38, 46 - 49; P 7: Patient B interview.txt 22 - 29 and Code: B.C. - Explanation of Treatment {5-0} P 2: Patient C interview.txt 56 - 65; P 3: Patient D interview.txt 14 - 17; P 6: Patient A

interview.txt17 - 20, 46 – 49; P 7: Patient B interview.txt 22 – 29). This may not be surprising, because in an earlier patient satisfaction study, Cherkin and McComack (1989) found that these were two of the important elements patients cited for their satisfaction with chiropractic care. In fact, they were almost three times more satisfied with this element of care from their chiropractors compared to their medical doctors (54% vs. 17%).

The characteristic of a happy, friendly practitioner was noted again widely in both the patient interviews and observation of the consultations. Intern 1 did not display this as much as intern 2, however; in the case of intern 1's first consultation of the study, with patient A, the lack of friendliness may be attributed to the intern adjusting to being filmed (Behavioural Characteristic Observations, page 1). It was noted in this consultation that the intern was very serious in conversation and methodical. In intern 1's second consultation, however, friendliness was observed and it was noted that the intern seemed to have relaxed and was also socially interactive with the patient. The patients seemed to be able relate to intern 2 more, again this may be explained by the highly, socially interactive nature of intern 2. Intern 2 seemed happy and friendly in all consultations (Behavioural Characteristic Observations, pages 9-16). This was especially evident in the first consultation with patient C, where it was noted that the consultation was highly interactive full of laughter and friendly exchange (Behavioural Characteristic Observations, pages 11).

Practitioner confidence came across strongly in the participant observation aspect and was also well recognized by patients in the interviews. Although in intern 1's first consultation with patient C (Behavioural Characteristic Observations, page 4), it was noted that the intern appeared uncertain about the case and therefore not confident during the treatment. On the whole, however, both interns appeared to be confident in their consultation with their patients.

Practitioner concern featured strongly with intern 2 in the participant observation but not with intern 1. In the interviews too, only intern 2 was mentioned as showing concern. Again this may be attributed to the behavioural style of intern 2.

Both interns showed respect and courtesy in almost all of the observed consultations. This attribute was conveyed by intern 1 in all but his first consultation of the study (Behavioural Characteristic Observations, page 1). It was noted that the intern was very serious in conversation and methodical in this consultation, perhaps adjusting to being filmed could explain the difference in this instance. This characteristic was also noted by one of the patients in the interviews.

The characteristic of exerting an effect on patient self-esteem was largely observed in intern 2's consultations. Again, intern 2 may be more able to do this due to her highly interactive nature.

Validation of illness was observed in almost all of both intern's consultations and recognized in the interviews with the patients.

Practitioner empowerment featured strongly in all the observations and was mentioned in the patient interviews, particularly by patient C, who found this characteristic very important.

Caring was one of those characteristics which was observed, unsurprisingly, mostly with intern 2. This characteristic was not however, mentioned by the patients in the interviews. This may be one of those characteristics that are present in consultation that patients do not identify verbally, although it may be important.

It was also observed that the duration of consultation and time spent touching the patient (hands-on time) was significantly greater in intern 2's consultations. Again, Intern 2 appeared to be far more interactive with the patients and this may account for the difference in mean times.

5.5 Analysis of miscellaneous factors identified in consultation through patient interviews:

The following factors were identified from the interviews with the patients post-consultation:

Congruence between the patient and HCP was one of the commonly identified factors. Although this aspect was not included in the observational section of the study, it is obviously one of the prominent factors in HCP-patient interaction. Jamison (1997) stated that chiropractors establish this shared clinical reality in practice, which is conducive to a healing environment.

HCP-patient incongruence was also noted between patient C and intern 1. This may have just been a personality clash or may have been avoided by intern 2, due to intern 2's relationship-maintaining, accommodating approach.

The patients' global perception of their care was strongly identified by patients as being very happy or satisfied. This overall assessment was common to all the patients. This high degree of satisfaction or favorable patient assessment of chiropractic care is consistent with the literature (Goertz *et. al.*, 1995). Recall that global perception of satisfaction may encompass both specific and non-specific components of care.

The clinical, professional approach of intern 1 was recognized by half of the patients from their consultations (Code: Professional - aloof, cold. {2-1} P 3: Patient D interview.txt - 3:7 24:27).

The open, happy and social approach of intern 2 was twice as widely recognized by the patients. It could be argued that the patients more readily identified this approach due to their favor of it. Some of the patients did state that they found it easier to relate to intern 2.

Health Care Provider competence was also strongly identified by the patients; this was identified with both the interns.

Under the code of milieu, patients again widely identified a calm, relaxed atmosphere.

Relationship building was another factor identified from the interviews, the comments seem to be directed to intern 2 more than intern 1, which is congruent with the relationship-oriented approach of intern 2.

An interesting factor identified with one patient was the patient's perception of chiropractic, where they stated they found it gentler than expected and not "violent". The patient's preconceptions were obviously different to the actual intervention.

The same patient also recognized the differences in approach regarding professional boundaries and sex role in practice, where patients and practitioners of opposite sex may have been more restrained in their interaction.

Intern 1's director/thinker approach, characterized by its process/clinical orientation may have given rise to the code of "professional – aloofness". This was fairly well recognized by patients in the interviews.

Lastly, a factor that also was identified by one patient was that of the quality clinical consult where the patient identified the consultation as very comprehensive and thorough.

5.6 Networks developed from the patient interviews:

The Atlas ti qualitative analysis software program allows the researcher to develop networks between various codes identified in the interviews. This is done by linking two codes visually and then identifying their relationship with one another. The first network identified here centers on healthcare practitioner-patient congruence, the factors that bring it about and the effects thereof. This network also displays the role of empowerment of the patient and how it is affected (following page):

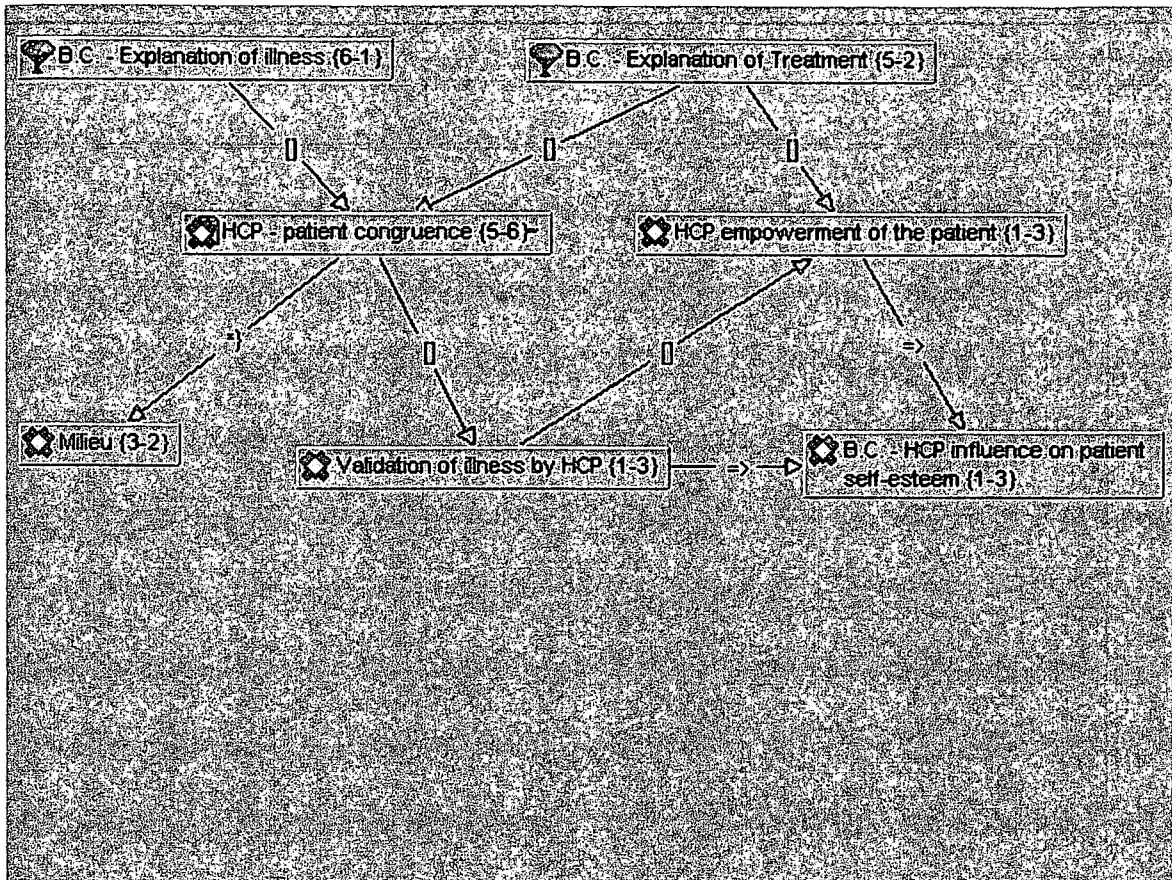


Table 3: Congruence network.

Key:

[] is a part of

=> is a cause of

== is associated with

*) is a property of

The above network demonstrates which behavioural characteristics (explanation of illness and explanation of treatment) give rise to HCP-patient congruence and how HCP-patient congruence is related to other factors (milieu and validation).

It may also be observed from the above network that certain behavioural characteristics (explanation of illness and explanation of treatment) have a “domino effect” in enhancing other behavioral characteristics or desirable clinical effects. Explain this a bit more, like the way you are going here. The visual representation of the interrelating codes, developed during the interviews, helps bring about a clearer understanding of the generated data,

The following network highlights the two different healthcare practitioner approaches and the characteristics that were identified with in the interviews:

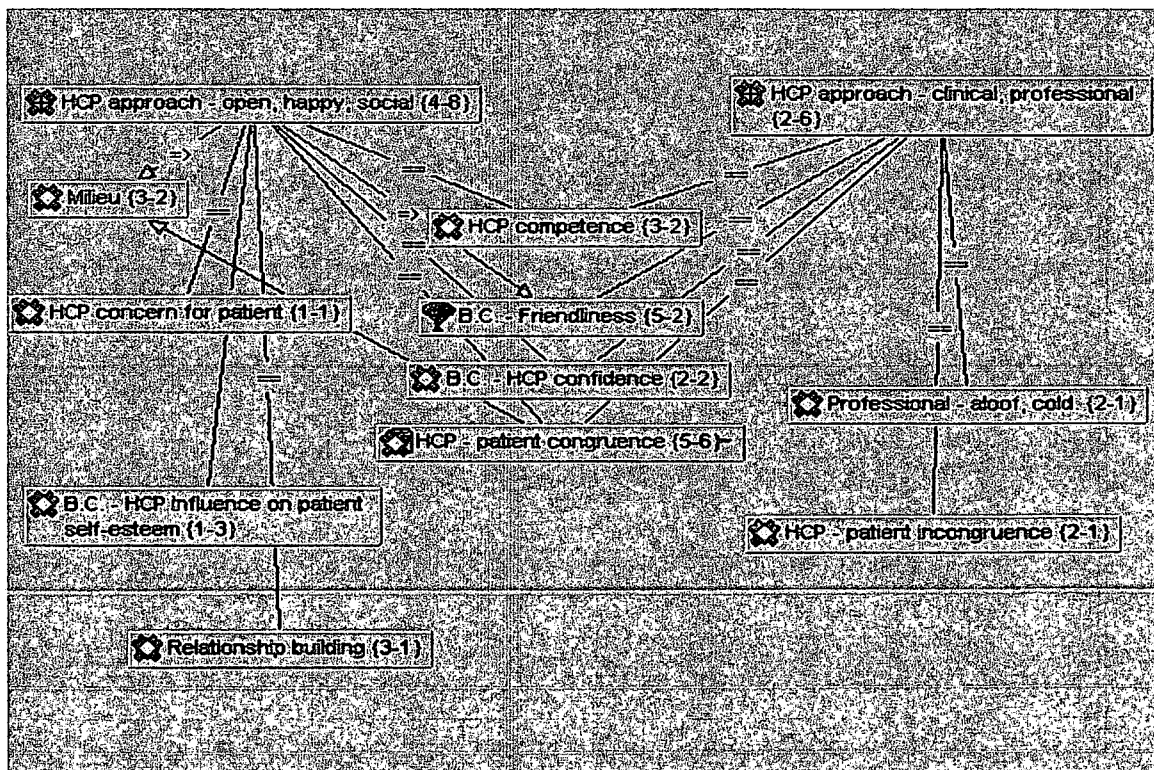


Table 4: HCP Approach network.

The above network visually demonstrates how many more desirable behavioural characteristics the HCP with the open, happy and social approach was perceived to possess. Also note the behavioural characteristics both the approaches seem to have in common. Please interpret a bit more, remember the network is essentially a creation of your mind with the help of the data so it must be explained fully so that your interpretation comes through.

Chapter 6- Recommendations and Conclusion:

6.1 Introduction:

This chapter concerns itself with the discussion of problems encountered during the study (largely design flaws) and recommendations for possible solutions to these problems.

The chapter then concludes the study with a broad discussion of healthcare, quality thereof and their relationship with patient satisfaction, the literature and the findings of this study.

6.2 Recommendations:

A methodological issue concerning the observation section of the study was the limited observation environment. The patients present at the reception and the intern meets them there and escorts them to the observation/consultation room. Important interaction between the HCP and the patient may be missed in this time. Having the receptionist lead the patient to the consultation room may have overcome this problem.

The two interns selected were chosen because they best suited the behavioural profiles needed for the study. The two chosen happened to be of opposite sex. Same sex volunteers (interns) should be used in the future, as patients were aware of inter-relational differences between the interns and attributed some to the sex of the intern. This would help in bringing about greater standardization.

Although interns from the same institution were used to strengthen standardization, the use of field clinicians may bring about greater variation in the expression of practitioner behavioural characteristics.

This study is also limited in that the interview section only investigates behavioral characteristics that the patient is aware of, i.e. the patient may not have conceptualized certain characteristics or be conscious of them being present

even though they were. An example of this may be empowerment of the patient, this is a concept that the patient is not aware of but is present in consultation.

Refinement of the behavioural characteristic checklist in the observations may also be beneficial, because although both interns may have displayed a particular behavioural characteristic in each consultation, one may have done so more often and comprehensively.

Greater cultural variation may have been used; the selected patients were largely from one racial group. This may be explained by chiropractic still not being widely available to the greater population.

The researcher did not perform member checks in this study, whereby interviewees are contacted and the researcher checks if he or she interpreted the interview correctly. Although for the purposes of this study the researcher did not have to perform these, it would have strengthened the study to verify the interpreted data.

6.3 In Conclusion:

The course of healthcare seems to have looped back on itself: pre-scientific medical care seemed to rely more on ritual and the non-specific effect to elicit outcomes while treating patients, rather than utilizing scientific, proven therapy. This may have been unbeknown not only to the patients, but the practitioners too.

The advent of the very successful scientific method and the reductionistic, clinical control trial shifted the reliance of therapy from non-specific to specific care (Bolton, 1999).

Patient, practitioner and academic attention has once again been interested by placebo in healthcare. The powerful effect of non-specific intervention is, again, being recognized.

Instead of substituting one intervention model for another, specific and non-specific intervention may be utilized to supplement each other.

This study concerns itself with the development and refinement of our understanding of the non-specific component of therapeutic intervention. With this in mind, the ultimate goal is providing higher quality, improved healthcare.

Due to patient satisfaction being an important component of quality care, the utilization of patient satisfaction as a true indicator of quality of care has been established.

Research tools have been further refined to develop patient satisfaction into an even better measure of quality of care.

The use of qualitative methodology for the assessment of patient satisfaction has also been established. The rich and contextual data produced by qualitative research seems to be well suited to the complex multi-dimensionality of patient satisfaction. It is able to explore the non-specific components of care and attempts to distinguish them from specific interventions. Whereas in the past quantitative design may have erroneously attributed patient satisfaction to specific therapy alone and excluded important non-specific components of patient care. This is congruent with the growing awareness, particularly from patients, that what patients want in health care service (non-specific components) is important to care and may determine the personal satisfaction with treatment and, later, the personal satisfaction with the outcome of care.

It has been indicated in the literature that patient satisfaction may be determined by certain behavioural characteristics of the healthcare practitioner. In the observation component of this study these characteristics were observed and it was noted that healthcare practitioners with a particular behavioural style, that of a relater/socializer, typically relationship oriented, concerned with maintaining relationships with patients and lively interaction, possessed far more of the behavioural characteristics identified in the literature. It was noted that this practitioner displayed the personal behavioural characteristics of the healthcare practitioner to a greater extent. These were concern for patient, caring attitude, influence on patient self-esteem and friendliness of the healthcare practitioner. This was expected because these social, interpersonal characteristics characterize the practitioner behavioural style for which this practitioner was selected for the study.

The interviews revealed that patients do notice certain behavioural characteristics more readily than others, particularly the characteristics to which patients have assigned high satisfaction values in past research. It was also noted that patients seem to be more aware of the behavioural characteristics and approach of the practitioner with a relater/socializer-type behavioural style.

From the results of this study it may be seen that certain behavioural characteristics seem to be more important than others to patients. Not only that, but certain chiropractic practitioners, that naturally possess a relater/socializer-type behavioural style, may be at a distinct advantage in treating patients to other practitioners (particularly those with a director/thinker-type style, characteristically task oriented, concerned with outcomes and process). The relater/socializer's utilization of certain behavioural characteristics seems to elicit a potent non-specific effect, which bolsters patient satisfaction thereby improving the quality and ultimately the outcome of the care provided.

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Appendix A
Behavioural Characteristic Template

Date:

Patient:

Intern:

Treatment:

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness
- Discussion of treatment

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP
- Validation/legitimizing sick role by HCP
- HCP empowerment of the patient to take personal control of their health
- Practitioner confidence
- HCP influence on patient self-esteem
- Happy, friendly practitioner
- Time spent listening to the patient
- Time spent in "hands-on" interaction
- Duration of consultation

Notes:

Appendix C

The following is a list of codes developed to identify behavioural interaction from the interview transcriptions, using the Atlas Ti qualitative analysis program and the distributions of the codes in the various interviews (full names of codes may be found in Appendix D):

Codes-Primary-Documents-Table

Code-Filter: All

PD-Filter: All

CODES	PRIMARY DOCS				Totals
	2	3	6	7	
B.C. - Explanation o	2	1	2	1	6
B.C. - Explanation o	1	1	2	1	5
B.C. - Friendliness	0	2	1	2	5
B.C. - HCP confidenc	0	0	2	0	2
B.C. - HCP influence	0	0	0	1	1
B.C. Respect and cou	0	0	0	1	1
HCP - patient congru	2	0	1	2	5
HCP - patient incong	2	0	0	0	2
HCP approach - clini	0	1	0	1	2
HCP approach - open,	1	2	0	1	4
HCP competence	0	0	3	0	3
HCP concern for pati	1	0	0	0	1
HCP empowerment of t	1	0	0	0	1
Milieu	1	0	0	2	3
Patient global persp	1	1	1	1	4
Patient impression o	0	0	1	0	1
patient perception o	0	0	0	1	1
Professional - aloof	0	1	0	1	2
Professional boundri	0	0	0	1	1
Quality of clinical	0	0	1	0	1
Relationship buildin	1	0	0	2	3
Validation of illnes	0	0	1	0	1
Totals	13	9	15	18	55

Table 6: Behavioural characteristic distributions

The following includes the concerned code and the quotation from the interviews from where it was identified:

Codes-quotations list

Code-Filter: All

Code: B.C. - Explanation of illness {6-1}

P 2: Patient C interview.txt - 2:3 (29:35) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness]

Well (intern 1) kinda played it both ways, because (intern 1) took five minutes, lowered his voice and sort of asked you a question and was more intense with you. Being more kinda bearable but not bearable...(laughs)... you know. You kinda share a space and you are both there about your injury, so to speak.

P 2: Patient C interview.txt - 2:8 (56:65) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]

What I think is really is good about (intern 2), is, especially if you haven't been to this kind of thing before in any patient doctor relationship you explain something and like use a visual aid. I mean some oke going on about what your fourth vertebra is connected to... you don't know what the hell it is. And its not about being treated like a child by visually drawing a picture and also explaining what you are about to do, which (intern 1) did as well, in some cases and not in others.

P 3: Patient D interview.txt - 3:2 (14:17) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]
[B.C. - Friendliness]

Very friendly, very down to earth about things... and also the way they explain things... drawing pictures, it just makes it more layman's terms, ja it's nice.

P 6: Patient A interview.txt - 6:10 (35:38) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness]

They speak to me... from previous tests, they notice things and they tell me that um... like the last test, the leg lifting, (intern 2) took it up to a certain degree and then finally (last treatment) she took it to a certain degree, it went further.

P 6: Patient A interview.txt - 6:13 (46:49) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]
[Validation of illness by HCP]

No, I think that their approach is almost similar. If there is something that is gonna hurt me they will tell me this is where the pain is coming from, which was correct, and I experienced that. Beforehand, there is prior warning that this is what you can expect. They then do their thing.

P 7: Patient B interview.txt - 7:4 (22:29) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]

Well, they chat to you. And the way I think it should be, when you're sort of relaxed with each other and quite happy to ask questions or just chat generally.

"And you have had answers to your questions?"

Yes.

Code: B.C. - Explanation of Treatment {5-2}

P 2: Patient C interview.txt - 2:8 (56:65) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]

What I think is really is good about (intern 2), is, especially if you haven't been to this kind of thing before in any patient doctor relationship you explain something and like use a visual aid. I mean some oke going on about what your fourth vertebra is connected to... you don't know

what the hell it is. And its not about being treated like a child by visually drawing a picture and also explaining what you are about to do, which (intern 1) did as well, in some cases and not in others.

P 3: Patient D interview.txt - 3:2 (14:17) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]
[B.C. - Friendliness]

Very friendly, very down to earth about things... and also the way they explain things... drawing pictures, it just makes it more layman's terms, ja it's nice.

P 6: Patient A interview.txt - 6:3 (17:20) (Super)

Media: ANSI

Codes: [B.C. - Explanation of Treatment]

Before they do anything they inform you what's gonna be done. Later, which part of your body is gonna be effected and where I can expect pain and where I'll feel releases.

P 6: Patient A interview.txt - 6:13 (46:49) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]
[Validation of illness by HCP]

No, I think that their approach is almost similar. If there is something that is gonna hurt me they will tell me this is where the pain is coming from, which was correct, and I experienced that. Beforehand, there is prior warning that this is what you can expect. They then do their thing.

P 7: Patient B interview.txt - 7:4 (22:29) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]

Well, they chat to you. And the way I think it should be, when you're sort of relaxed with each other and quite happy to ask questions or just chat generally.

"And you have had answers to your questions?"

Yes.

Code: B.C. - Friendliness {5-2}

P 3: Patient D interview.txt - 3:2 (14:17) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]
[B.C. - Friendliness]

Very friendly, very down to earth about things... and also the way they explain things... drawing pictures, it just makes it more layman's terms, ja it's nice.

P 3: Patient D interview.txt - 3:6 (45:46) (Super)

Media: ANSI

Codes: [B.C. - Friendliness]

Well they both seem like very friendly people, pleasant to talk to.

P 6: Patient A interview.txt - 6:7 (23:25) (Super)

Media: ANSI

Codes: [B.C. - Friendliness]

Very friendly hey. They know what they are doing and you can see that they are having fun what they are doing.

P 7: Patient B interview.txt - 7:3 (17:18) (Super)

Media: ANSI

Codes: [B.C. - Friendliness] [B.C. Respect and courtesy]

Fine. They seemed very friendly and nice and polite.

P 7: Patient B interview.txt - 7:9 (49:53) (Super)

Media: ANSI

Codes: [B.C. - Friendliness] [HCP approach - clinical, professional]
[HCP approach - open, happy, social] [Professional boundaries]

I'd say that (intern 1) is a lot more professional about things and aware of the boundaries of having female patients type thing, whereas (intern 2) is more friendly I think because we're both women.

Code: B.C. - HCP confidence {2-2}

P 6: Patient A interview.txt - 6:8 (24:25) (Super)

Media: ANSI

Codes: [B.C. - HCP confidence]

They know what they are doing and you can see that they are having fun what they are doing.

P 6: Patient A interview.txt - 6:9 (32:39) (Super)

Media: ANSI

Codes: [B.C. - HCP confidence]

They aren't difficult people at all (laughs)... What can I say, they're good people and they know what they are doing... they seem to know what they do. They speak to me... from previous tests, they notice things and they tell me that um... like the last test, the leg lifting, (intern 2) took it up to a certain degree and then finally (last treatment) she took it to a certain degree, it went further. There was a change; you could see the change. They know, I'll go back to that, they know what they doing.

Code: B.C. - HCP influence on patient self-esteem {1-3}

P 7: Patient B interview.txt - 7:8 (35:38) (Super)

Media: ANSI

Codes: [B.C. - HCP influence on patient self-esteem] [Relationship building]

I'm coming in here as a person who has probably not looked after their back properly, but I'm not made to feel stupid about it. I think that's quite good.

Code: B.C. Respect and courtesy {1-0}

P 7: Patient B interview.txt - 7:3 (17:18) (Super)

Media: ANSI

Codes: [B.C. - Friendliness] [B.C. Respect and courtesy]

Fine. They seemed very friendly and nice and polite.

Code: HCP - patient congruence {5-6}~

P 2: Patient C interview.txt - 2:4 (34:35) (Super)

Media: ANSI

Codes: [HCP - patient congruence]

You kinda share a space and you are both there about your injury, so to speak.

P 2: Patient C interview.txt - 2:7 (48:51) (Super)

Media: ANSI

Codes: [HCP - patient congruence]

Which I think you find in all kinds of treatment centers, you find different types. And that's generally the kinda type of person you go back to.

P 6: Patient A interview.txt - 6:11 (35:39) (Super)

Media: ANSI

Codes: [HCP - patient congruence]

They speak to me... from previous tests, they notice things and they tell me that um... like the last test, the leg lifting, (intern 2) took it up to a certain degree and then finally (last treatment) she took it to a certain degree, it went further. There was a change; you could see the change. They know, I'll go back to that, they know what they doing.

P 7: Patient B interview.txt - 7:6 (23:25) (Super)

Media: ANSI

Codes: [HCP - patient congruence]

Well, they chat to you. And the way I think it should be, when you're sort of relaxed with each other and quite happy to ask questions or just chat generally.

P 7: Patient B interview.txt - 7:7 (34:38) (Super)

Media: ANSI

Codes: [HCP - patient congruence] [Milieu]

Just that it's um... just a relaxed atmosphere. I'm coming in here as a person who has probably not looked after their back properly, but I'm not made to feel stupid about it. I think that's quite good.

Code: HCP - patient incongruence {2-1}

P 2: Patient C interview.txt - 2:2 (18:26) (Super)

Media: ANSI

Codes: [HCP - patient incongruence]

Ja, well, I mean clearly (intern 1) was a little bit abrasive. Especially when walking into a room and being sort of very in your face and "take your shirt off". Nobody likes that kind of energy from anybody. So, in terms of making somebody feel comfortable and sort of relaxed in an environment, especially if you injured because generally if you're injured you feel a little bit sensitive. Anything abrasive is never gonna go down well with anybody.

P 2: Patient C interview.txt - 2:11 (79:83) (Super)

Media: ANSI

Codes: [HCP - patient incongruence]

One thing that really pissed me off about (intern 1) was that obviously its standard that every new patient gets a towel to lie on. Essentially, at the end of the day, its all about making people feel as comfortable as possible.

Code: HCP approach - clinical, professional {2-6}

P 3: Patient D interview.txt - 3:7 (24:27) (Super)

Media: ANSI

Codes: [HCP approach - clinical, professional] [Professional - aloof, cold.]

What would you say makes them different? Um, about (intern 2) I found that she tended to talk about other things more, and more of a conversation going on. Where (intern 1) was like more about the process.

P 7: Patient B interview.txt - 7:9 (49:53) (Super)

Media: ANSI

Codes: [B.C. - Friendliness] [HCP approach - clinical, professional] [HCP approach - open, happy, social] [Professional boundaries]

I'd say that (intern 1) is a lot more professional about things and aware of the boundaries of having female patients type thing, whereas (intern 2) is more friendly I think because we're both women.

Code: HCP approach - open, happy, social {4-8}

P 2: Patient C interview.txt - 2:6 (40:46) (Super)

Media: ANSI

Codes: [HCP approach - open, happy, social] [HCP concern for patient]

Um, well I really liked (intern 2), the whole sort of attitude and the way (intern 2) deals with you in terms of making you feel comfortable and showing concern and I think you can relate to (intern 2) and share what ever the problem is... that goes down well because a lot of people say a lot of things that they wouldn't normally say offhand, because there may be something niggling in the back of their head.

P 3: Patient D interview.txt - 3:3 (25:26) (Super)

Media: ANSI

Codes: [HCP approach - open, happy, social]

Um, about (intern 2) I found that she tended to talk about other things more, and more of a conversation going on.

P 3: Patient D interview.txt - 3:5 (35:37) (Super)

Media: ANSI

Codes: [HCP approach - open, happy, social]

I think I could relate more to (intern 2) because she is a woman, she could relate to me, I could relate to her.

P 7: Patient B interview.txt - 7:9 (49:53) (Super)

Media: ANSI

Codes: [B.C. - Friendliness] [HCP approach - clinical, professional]
[HCP approach - open, happy, social] [Professional boundaries]

I'd say that (intern 1) is a lot more professional about things and aware of the boundaries of having female patients type thing, whereas (intern 2) is more friendly I think because we're both women.

Code: HCP competence {3-2}

P 6: Patient A interview.txt - 6:4 (11:13) (Super)

Media: ANSI

Codes: [HCP competence]

I think it was very thorough, and very comprehensive. I think it was very nicely done.

P 6: Patient A interview.txt - 6:5 (23:25) (Super)

Media: ANSI

Codes: [HCP competence]

Very friendly hey. They know what they are doing and you can see that they are having fun what they are doing.

P 6: Patient A interview.txt - 6:6 (32:34) (Super)

Media: ANSI

Codes: [HCP competence]

They aren't difficult people at all (laughs)... What can I say, they're good people and they know what they are doing... they seem to know what they doing.

Code: HCP concern for patient {1-1}

P 2: Patient C interview.txt - 2:6 (40:46) (Super)

Media: ANSI

Codes: [HCP approach - open, happy, social] [HCP concern for patient]

Um, well I really liked (intern 2), the whole sort of attitude and the way (intern 2) deals with you in terms of making you feel comfortable and showing concern and I think you can relate to (intern 2) and share what ever the problem is... that goes down well because a lot of people say a lot of things that they wouldn't normally say offhand, because there may be something niggling in the back of their head.

Code: HCP empowerment of the patient {1-3}

P 2: Patient C interview.txt - 2:9 (65:71) (Super)

Media: ANSI

Codes: [HCP empowerment of the patient]

This makes a huge difference cause at least the person has a basic understanding of what you are doing with them. Which is very important because you sort of know what's going on in your own body. People are generally so in

denial of their body anyway. You put them in touch with it and that helps with their process, so to speak.

Code: Milieu {3-2}

P 2: Patient C interview.txt - 2:5 (40:48) (Super)

Media: ANSI

Codes: [Milieu]

Um, well I really liked (intern 2), the whole sort of attitude and the way (intern 2) deals with you in terms of making you feel comfortable and showing concern and I think you can relate to (intern 2) and share what ever the problem is... that goes down well because a lot of people say a lot of things that they wouldn't normally say offhand, because there may be something niggling in the back of their head. In that kind of environment you feel more relaxed, you do speak more openly about things.

P 7: Patient B interview.txt - 7:5 (23:25) (Super)

Media: ANSI

Codes: [Milieu]

Well, they chat to you. And the way I think it should be, when you're sort of relaxed with each other and quite happy to ask questions or just chat generally.

P 7: Patient B interview.txt - 7:7 (34:38) (Super)

Media: ANSI

Codes: [HCP - patient congruence] [Milieu]

Just that it's um... just a relaxed atmosphere. I'm coming in here as a person who has probably not looked after their back properly, but I'm not made to feel stupid about it. I think that's quite good.

Code: Patient global perspective {4-0}

P 2: Patient C interview.txt - 2:1 (7:13) (Super)

Media: ANSI

Codes: [Patient global perspective]

Um, obviously I'd never been to a chiropractor before, so um...I had no expectations. And also because my injury is

sort of like in a dormant stage, you know normally when you're injured you get that injury immediate response so that you can feel if its getting better or not. So I thought it was interesting and I think I did benefit from it. Um... ja.

P 3: Patient D interview.txt - 3:1 (6:7) (Super)
Media: ANSI
Codes: [Patient global perspective]

I'm very happy with the treatment I received.

P 6: Patient A interview.txt - 6:2 (5:7) (Super)
Media: ANSI
Codes: [Patient global perspective]

Very good, generally ja, it was very nice, very in depth consult. I'd say it was a very thorough consult. It was good.

P 7: Patient B interview.txt - 7:1 (5:7) (Super)
Media: ANSI
Codes: [Patient global perspective]

"What was your overall impression of your treatment?"

Really good, I feel a lot better.

Code: Patient impression of interns {1-0}

P 6: Patient A interview.txt - 6:12 (41:46) (Super)
Media: ANSI
Codes: [Patient impression of interns]

Do you find the two interns different?

Nah, they seem the same.

Not necessarily that the one is better than the other, just how they do things? No, I think that their approach is almost similar.

Code: patient perception of chiropractic {1-0}

P 7: Patient B interview.txt - 7:2 (11:13) (Super)
Media: ANSI
Codes: [patient perception of chiropractic]

It hasn't been violent or... I haven't had any severe pain or anything; it's been a gentle release. So yeah.

Code: Professional - aloof, cold. {2-1}

P 3: Patient D interview.txt - 3:7 (24:27) (Super)
Media: ANSI
Codes: [HCP approach - clinical, professional] [Professional - aloof, cold.]

What would you say makes them different? Um, about (intern 2) I found that she tended to talk about other things more, and more of a conversation going on. Where (intern 1) was like more about the process.

P 7: Patient B interview.txt - 7:11 (49:53) (Super)
Media: ANSI
Codes: [Professional - aloof, cold.]

I'd say that (intern 1) is a lot more professional about things and aware of the boundaries of having female patients type thing, whereas (intern 2) is more friendly I think because we're both women

Code: Professional boundaries {1-0}

P 7: Patient B interview.txt - 7:9 (49:53) (Super)
Media: ANSI
Codes: [B.C. - Friendliness] [HCP approach - clinical, professional] [HCP approach - open, happy, social] [Professional boundaries]

I'd say that (intern 1) is a lot more professional about things and aware of the boundaries of having female patients type thing, whereas (intern 2) is more friendly I think because we're both women.

Code: Quality of clinical consult {1-0}

P 6: Patient A interview.txt - 6:1 (5:20) (Super)

Media: ANSI

Codes: [Quality of clinical consult]

Very good, generally ja, it was very nice, very in depth consult. I'd say it was a very thorough consult. It was good.

What did you think about the way in which the consultations were conducted, the manner of the interns themselves?

I think it was very thorough, and very comprehensive. I think it was very nicely done.

That thoroughness and comprehensiveness, what did they do so that you noticed this?

Before they do anything they inform you what's gonna be done. Later, which part of your body is gonna be effected and where I can expect pain and where I'll feel releases.

Code: Relationship building {3-1}

P 2: Patient C interview.txt - 2:12 (57:60) (Super)

Media: ANSI

Codes: [Relationship building]

What I think is really is good about (intern 2), is, especially if you haven't been to this kind of thing before in any patient doctor relationship you explain something and like use a visual aid.

P 7: Patient B interview.txt - 7:8 (35:38) (Super)

Media: ANSI

Codes: [B.C. - HCP influence on patient self-esteem] [Relationship building]

I'm coming in here as a person who has probably not looked after their back properly, but I'm not made to feel stupid about it. I think that's quite good.

P 7: Patient B interview.txt - 7:10 (23:25) (Super)

Media: ANSI

Codes: [Relationship building]

And the way I think it should be, when you're sort of relaxed with each other and quite happy to ask questions or just chat generally.

Code: Validation of illness by HCP {1-3}

P 6: Patient A interview.txt - 6:13 (46:49) (Super)

Media: ANSI

Codes: [B.C. - Explanation of illness] [B.C. - Explanation of Treatment]
[Validation of illness by HCP]

No, I think that their approach is almost similar. If there is something that is gonna hurt me they will tell me this is where the pain is coming from, which was correct, and I experienced that. Beforehand, there is prior warning that this is what you can expect. They then do their thing.

Appendix D

The following is the list of codes (in full) developed to identify behavioural interaction from the interview transcriptions, using the Atlas Ti qualitative analysis program:

|HU: patient satisfaction and its determinants
File: [c:\documents and settings\mike kretzmann\my documents\interviews\patient satisfaction and its determinants]
Edited by: Super
Date/Time: 2003/10/24 - 09:35:09

Code-Filter: All
-----!

B.C. - Explanation of illness
B.C. - Explanation of Treatment
B.C. - Friendliness
B.C. - HCP confidence
B.C. - HCP influence on patient self-esteem
B.C. Respect and courtesy
Clinical consult comprehensive
HCP - patient congruence
HCP - patient incongruence
HCP approach - clinical, professional
HCP approach - open, happy, social
HCP competence
HCP concern for patient
HCP empowerment of the patient
Milieu
Patient global perspective
Patient impression of interns
Patient perception of chiropractic
Professional boundaries
Relationship building
Validation of illness by HCP

Appendix E

Behavioural Characteristic Observations

Behavioural Characteristic Template

Date:

1/10/03

Patient:

Mr. J. R. E.

Intern:

Dr. J. R. E.

Treatment:

One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- ✓ • Explanation of illness
- ✓ • Discussion of treatment

b) Non-Verbal interaction:

- ✓ • Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP
- ✓ • Validation/legitimizing sick role by HCP
- ✓ • HCP empowerment of the patient to take personal control of their health
- ✓ • Practitioner confidence
- HCP influence on patient self-esteem
- Happy, friendly practitioner
- ✓ • Time spent listening to the patient 7
- ✓ • Time spent in "hands-on" interaction 28min
- ✓ • Duration of consultation 62min

Notes:

Impassive methodical & serious in conversation.

Behavioural Characteristic Template

Date: 16/10/03
Patient: [unclear]
Intern: [unclear]
Treatment: One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem
- Happy, friendly practitioner ✓
- Time spent listening to the patient 5,22
- Time spent in "hands-on" interaction 21min
- Duration of consultation 31,4min

Notes:

Intern very relaxed & friendly with patient. Behaving more like a relative - interested in personal life
- joking
- socializing

Behavioural Characteristic Template

Date: 6/10/03

Patient:

Intern:

Treatment: 2

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem
- Happy, friendly practitioner ✓
- Time spent listening to the patient 7 min
- Time spent in "hands-on" interaction 11 min
- Duration of consultation 16 min

Notes:

more personal than 1st consultation (ring).

Behavioural Characteristic Template

Date: 10/6/03
 Patient: [faded]
 Intern: [faded]
 Treatment: One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence
- HCP influence on patient self-esteem
- Happy, friendly practitioner ✓
- Time spent listening to the patient 8 min
- Time spent in "hands-on" interaction 12 min
- Duration of consultation 18 min

Notes:

Intern seems uncertain of case, not confident.

Behavioural Characteristic Template

Date:

6/10/12

Patient:

[Faint handwritten text]

Intern:

[Faint handwritten text]

Treatment:

One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem
- Happy, friendly practitioner
- Time spent listening to the patient 10min
- Time spent in "hands-on" interaction 17min
- Duration of consultation 24min

Notes:

Behavioural Characteristic Template

Date: 3/10/07
 Patient: [Handwritten scribble]
 Intern: [Handwritten scribble]
 Treatment: Two

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem
- Happy, friendly practitioner ✓
- Time spent listening to the patient 9 min
- Time spent in "hands-on" interaction 15 min
- Duration of consultation 22 min

Notes:

Behavioural Characteristic Template

Date: 8/10/03

Patient: [Handwritten name]

Intern: [Handwritten name]

Treatment: (Two)

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence
- HCP influence on patient self-esteem
- Happy, friendly practitioner
- Time spent listening to the patient 7 min
- Time spent in "hands-on" interaction 12 min
- Duration of consultation 18 min

Notes:

[Empty rectangular box for notes]

Behavioural Characteristic Template

Date: 9/10/03

Patient:

Intern:

Treatment: Two

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem
- Happy, friendly practitioner
- Time spent listening to the patient 15 min
- Time spent in "hands-on" interaction 24, 05
- Duration of consultation 32, 03

Notes:

[Empty rectangular box for notes]

Behavioural Characteristic Template

Date: 10/10/03

Patient: [faded]

Intern: [faded]

Treatment: One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient 9 min
- Time spent in "hands-on" interaction 19, 53
- Duration of consultation 27, 44

Notes:

Intern very interactive socially, on a personal level; ^{discusses other topics -} outside of health condition.

Behavioural Characteristic Template

Date: 10/10/03.....
 Patient:
 Intern:
 Treatment: Am.....

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient 16min
- Time spent in "hands-on" interaction 18.20
- Duration of consultation 22.50

Notes:

Again, intern very conversational, and aside from clinical interaction, also takes an interest in the patient's personal life.

Behavioural Characteristic Template

Date: 10/10/03

Patient: [Handwritten Name]

Intern: [Handwritten Name]

Treatment: One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient 12 min
- Time spent in "hands-on" interaction 18, 09
- Duration of consultation 29 .03

Notes:

Highly interactive, lots of laughter & friendly exchange

Behavioural Characteristic Template

Date: 10/10/03
 Patient: [Handwritten name]
 Intern: [Handwritten name]
 Treatment: One

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient 20 min
- Time spent in "hands-on" interaction 34/08
- Duration of consultation 48/09

Notes:

Behavioural Characteristic Template

Date: 19/10/03

Patient:

Intern:

Treatment: Two

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient ~~21~~ 18
- Time spent in "hands-on" interaction 24
- Duration of consultation 28,04

Notes:

Again, extra-clinical conversation, intern taking interest in pt's personal life.
 Explanation of illness excluded - explained in prev. consult not
 necessary 2
 report?

Behavioural Characteristic Template

Date: 13/10/03.....

Patient:

Intern:

Treatment: Two.....

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness ✓
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient 15
- Time spent in "hands-on" interaction 23, 18
- Duration of consultation 29.4

Notes:

[Empty rectangular box for notes]

Behavioural Characteristic Template

Date:

13/10/03.....

Patient:

Intern:

Treatment:

Two.....

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem
- Happy, friendly practitioner ✓
- Time spent listening to the patient 16
- Time spent in "hands-on" interaction 20
- Duration of consultation 26, 03

Notes:

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Behavioural Characteristic Template

Date:

3/10/03

Patient:

.....

Intern:

.....

Treatment:

Two

Characteristics:

a) Verbal interaction:

- HCP concern for patient illness ✓
- Explanation of illness
- Discussion of treatment ✓

b) Non-Verbal interaction:

- Caring, empathetic HCP providing personalized care ✓
- Respect and courtesy shown by HCP ✓
- Validation/legitimizing sick role by HCP ✓
- HCP empowerment of the patient to take personal control of their health ✓
- Practitioner confidence ✓
- HCP influence on patient self-esteem ✓
- Happy, friendly practitioner ✓
- Time spent listening to the patient 15
- Time spent in "hands-on" interaction 20
- Duration of consultation 2432

Notes:

Made "empowerment" in the form of exercises/stretching for self-maintenance (autonomy)
 Also, social relationship built upon more-conversation about extra-clinical life.