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Private practice model of physiotherapy: professional challenges identified through an exploratory qualitative study

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ABSTRACT

Introduction. Community-based primary care physiotherapy has developed through private practice, fee-for-service model in Aotearoa New Zealand where independent businesses operate in competition. **Aim.** We aimed to explore how the private practice model of physiotherapy impacts patient care, physiotherapists, and professional behaviour. **Methods.** Six physiotherapists managing musculoskeletal conditions in a primary care private practice in Aotearoa New Zealand were recruited using maximum variation purposive sampling. In-depth individual face-to-face semi-structured interviews were audio-recorded, transcribed verbatim, and analysed using Interpretive Description. Inductive data analysis synthesised and contextualised data, creating a thematic framework that developed across interviews. **Results.** All physiotherapy participants discussed concerns about culture and professionalism in private practice physiotherapy despite not being asked about these. Three themes were identified. 'Competitive business model and lack of collaboration' – participants thought that competition between practices resulted in a lack of trust, collegiality, and collaboration, and pressure on clinicians to maintain income. '(Un)professional behaviour' – participants thought that physiotherapists were defensive and averse to scrutiny, resulting in reluctance to admit when they needed help, or to undertake peer review or seek second opinions. 'Lack of support and mentoring' – the professional culture in private practice was perceived to reduce support and mentoring, with negative impacts that affected physiotherapists at all stages of career. **Conclusion.** This exploratory qualitative study suggests that competition dominates communication and collaboration in private practice physiotherapy and may have wider implications for professionalism and the quality of patient care. Competitive business models and an aversion to scrutiny may reduce collegial interaction and professional behaviour.

Keywords: economic competition, musculoskeletal, physiotherapy, primary health care, private practice, professional practice, professionalism, qualitative research.

Introduction

Good health care results from effective communication, collaboration, and matching the right practitioner skillsets with the right patients. Essential characteristics of physiotherapy practice include being a communicator and being a collaborator.[1] Effective communication and collaboration require a professional culture that promotes and supports regular safe and effective interaction between colleagues.

Professional growth results from openness to peer engagement, benchmarking, and critique. Expressing vulnerability and exposing thoughts and actions to the scrutiny of others creates the opportunity for a professional to take on new ideas and link concepts in ways not previously considered.[2] Opening oneself to the scrutiny of others encourages reciprocal sharing and helps to increase awareness of, if not alignment with, professional norms and expectations.[2]

Community-based primary care physiotherapy in Aotearoa New Zealand (NZ) is primarily delivered in private clinics with a musculoskeletal health focus. These private

WHAT GAP THIS FILLS

What is already known: Community-based primary care physiotherapy is provided in Aotearoa New Zealand through a private practice, fee-for-service model. The impact of this model on patient care, physiotherapists, and professional behaviour is unknown.

What this study adds: This exploratory study suggests that competition can dominate communication and collaboration in private practice physiotherapy. Competitive business models and an aversion to scrutiny may reduce collegial interaction and professional behaviour.

practices operate a fee-for-service model that is heavily influenced by Accident Compensation Corporation funding. This model has resulted in independent physiotherapy businesses operating in competition with each other.[3] This is similar to other primary care musculoskeletal health providers, such as acupuncturists, chiropractors, osteopaths, and podiatrists. Providing optimal health care and growing a private business may have conflicting priorities that individual physiotherapists need to navigate in relation to individual patients and their practice more generally. Ethical issues arising from private practice physiotherapy have been discussed primarily through the grey literature and the impact of these on patients and physiotherapists is largely unexplored.[4]

This research addresses a different question to that which it initially set out to ask. During a recent qualitative interview study to explore health practitioners' (physiotherapists, general practitioners, medical specialists, insurance case managers) views of integrating an Advanced Practice Physiotherapy scope of practice into musculoskeletal primary health care, physiotherapist participants discussed (unprompted) the impact of private practice business models.[5] This qualitative analysis explores how the private practice model of physiotherapy impacts patient care, physiotherapists, and professional behaviour.

Method

Ethical approval for this study was gained from the University of Otago Human Ethics Committee (D18/316). All participants provided written informed consent. Findings are presented in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Supplementary file S1).[6]

Design

This exploratory qualitative study used the methodology of Interpretive Description, a constructivist methodology that considers context and practice.[7–9]

Participants

Only physiotherapy participants are included in this analysis. Physiotherapists were included if they were vocationally registered and managed musculoskeletal conditions in a primary care practice in NZ. Maximum variation purposive sampling aimed to capture a range of perceptions, depth of understanding, and insights.[10,11] The sampling framework sought variation in relation to years of experience (<10 years or ≥ 10 years), previous qualification as a New Zealand College of Physiotherapy (NZCP) advanced practitioner (yes or no), practice location (urban or rural), and practice size (<5 people or ≥ 5 people). Participation of physiotherapists from different ethnic backgrounds was sought.

The research team identified potential participants who met the inclusion criteria and helped fulfil sampling framework requirements. Potential participants were emailed information about the study and invited to contact the research team if they were interested in taking part. One invited physiotherapist declined to take part due to their negative opinion about the concept of Advanced Practice Physiotherapy. Physiotherapists who were more knowledgeable of advanced physiotherapy practice were recruited prior to those with less direct experience. Constant comparative analysis, dependent on the developing categories and emerging themes, enabled selection of additional participants who could provide further and varied insights[12] Participants were initially recruited from one geographical area. Additional participants from another area were subsequently invited to join the study, as their previous experience indicated that they may add diversity and richness to the data. Recruitment for the wider study ceased when no new themes were identified and information from new interviews fitted into the categories that had already been developed.[11,13]

Interview process

Audio-recorded, individual, face-to-face, semi-structured interviews (Supplementary file S2) were conducted by GS, an experienced physiotherapy clinician and former NZCP advanced pracitioner known to some interviewees (because of a professional role previously held). GS was completing a Master of Primary Health Care degree, with close support from BD and EM who are experienced qualitative researchers. BD and EM are also health professionals with primary care experience: BD is a physiotherapy specialist and EM is a registered nurse. Interviews were undertaken at a time and location convenient to the participants. At the conclusion of the interview, participants completed a demographic questionnaire and field notes were recorded.

Data analysis

Interviews were transcribed and reviewed against the original audio recording to ensure accuracy and remove all

identifying details.[9,14] Consistent with Interpretive Description methodology, transcripts were not checked by participants. Transcripts were imported into NVivo 12 (QSR International, Melbourne, AUS) to organise, manage, and explore the data. Primary coding was undertaken by one researcher with regular discussion with the whole research team. For each transcript, GS listened to the audio and read and re-read the transcript, noting thoughts and field observations in the margin. GS then engaged in memo writing, creative coding, and conceptual mind maps to identify broad categories. Patterns were identified to create initial nodes with illustrative data extracts.

Early inductive data analysis helped to synthesise and contextualise the data to form a thematic framework that informed recruitment of subsequent participants.[7] The thematic framework of overarching themes and subthemes was critiqued by the research team at a workshop after the sixth interview; the interviews included the range of participant types included in the wider study. Each theme was analysed to identify its significance and interpretive meaning and relationship with other themes. An unexpected theme, not directly related to the interview questions, was identified within data from the initial physiotherapy participants. Although not directly asked, participants discussed their experiences and thoughts about professional issues rather than just providing views on advanced practice. Early identification of this as a potential theme enabled the researcher to clarify and delve more deeply into its significance and meaning as data analysis proceeded.

The thematic framework was progressively developed by the research team. Verbatim quotes were chosen to demonstrate themes and subthemes.

Methods to assure the quality of the research

Reflexivity underpinned the research process.[15] GS disclosed experiences, roles, and biases so that other team members could identify influences on analysis.[16,17] Following on from this, GS engaged in memo-writing to record observations and experiences, and increase awareness of any assumptions or bias. Through a process of reflection, GS constantly questioned whether emerging issues contributed to existing categories or required further probing and exploration to evoke new meaning.[18] An audit trail was generated from interviews, observations, reflections, minutes and action plans from the monthly meetings, and critical examination of the data at team workshops.[17] Credibility was enhanced by including a diverse range of participants and having sufficiently long interviews to enable development of trust and rapport and collection of rich data and insights. Regular meetings and workshops involving the entire research team enabled review of data collection and analysis processes and objective discussion of data interpretations to ensure analytic decisions were reliable and defensible.[8,19]

Results

Six physiotherapists were interviewed individually on one occasion as part of the wider study. Four physiotherapists had more than 10 years' clinical experience (two were previously qualified as advanced practitioners, one had a masters, and one had a post-graduate diploma). Two physiotherapists had less than 10 years' experience with no post-graduate qualifications (Table 1). Four interviews were conducted at their own practice or workplace, one participant was interviewed in their own home, and one was interviewed in a private outdoor area. Interviews ranged between 50 and 70 min in duration.

All participants discussed professional challenges they perceived were facing the physiotherapy profession despite not being explicitly asked about these. Challenges related to the competitive business model and lack of collaboration, (un)professional behaviour, and lack of support and mentoring. Verbatim quotes are presented within the text to illustrate these themes, with additional quotations in Box 1.

Competitive business model and lack of collaboration

Most participants spontaneously raised their concerns that private practice physiotherapy was not a supportive and professional culture. They felt individual practices were siloed and did not collaborate, and perceived this had a

Table 1. Physiotherapy participant characteristics.

Code	Age (years)	Gender	Experience	Practice location	Size of practice	Interview duration (min)
PT1	30–39	Male	16–20 years	Small town/Rural	>5 PT	69
PT2	40–49	Male	20+ years (NZCP advanced practitioner)	Suburb	>5 PT	57
PT3	50– 59	Female	20+ years	City	>5 HP	51
PT4	40–49	Female	6–10 years	Suburb	<5 PT	60
PT5	40–49	Female	20+ years (NZCP advanced practitioner)	Large town	<5 HP	64
PT6	20–29	Male	1–5 years	City	>5 HP	68

PT, physiotherapists (unidisciplinary practice); HP, health professionals (interprofessional practice). Ethnicity data not presented to maintain participant anonymity.

Box 1. **Quotations supporting key themes**

Competitive business model and lack of collaboration

They're going to be referred to a physio within their business model. They're not going to get referred back to the physio clinic that referred them and that doesn't leave people with a great feeling. (PT1)

There will be an element of trust, I think. … physios generally being reluctant to refer for second opinions in the first instance but certainly outside of their own clinics because of potential fear that the patient may not return. (PT5)

I think from a profession point of view we are ownership driven of our patients. (PT6)

It's always this fiscal risk of sending a patient away. (PT6)

(Un)professional behaviour and reluctance to seek second opinion

I don't think our profession is good at admitting weakness and asking for support and help …. I do think there's a culture of defensiveness. I think we are as a whole are very averse to scrutiny and peer review. (PT5)

The culture of not really having the pathways or the confidence to ask for support and admit where we don't know what we're doing effectively and ask for help. So, the culture is a big one. (PT5)

You need to have a good rapport with the other physio and the other physio needs to be less defensive about what they've potentially been managing the patient with and open to other suggestions. (PT2)

Lack of support and mentoring

I would have very much panicked with 90% of patients when I was a new grad or otherwise just from an inexperience point of view. I think the ones I still find challenging now are the ones I don't have experience to fall back on. (PT6)

I think a lot of physiotherapists have the potential to work in isolation and not refer and not communicate. (PT5)

What I find the most challenging [complex patients] is how draining they are on me, how much it takes out of me as a clinician … so that I can give them the support that they need. (PT3)

I think the things that make me a good clinician in terms of the caring and the looking at the person as a whole are also the things that work to my detriment in terms of the draining and energy levels. (PT3)

negative impact on patient care. In addition, they felt the competitive business model resulted in a lack of trust and collaboration between practices and therefore a reluctance to share resources between practices.

> Private practices … are very siloed services, they're very closed off to collaboration for the most part which is not great and an enormous limitation of delivering care …. [private practices] keep intellectual property and they keep resources to themselves from a competitive market point of view. (PT6)

Participants talked about the competitive fee-for-service business model in private practice where patients can be seen as income. They were concerned that this created pressure for clinicians to see a certain volume of patients to maintain profits, irrespective of whether this was best for the patient.

> There is a risk with that business model that in an effort to, I guess, increase your margins, that's at the expense of something else which may often be the volume of patients that they require [staff] to see. (PT5)

Most participants were concerned that if patients were referred to another practice for review or second opinion, they would not return to the referring physiotherapist. This was a barrier to collaboration and collegiality between practitioners and created unwillingness to refer for second opinions at competing practices, irrespective of the skills or expertise the patient required.

> I think clinicians are partly nervous about sending people for a second opinion because they don't think they'll get them back. (PT3)

(Un)professional behaviour

Most of the physiotherapists also discussed the reluctance to seek second opinions or peer review. Participants described physiotherapists as being defensive and averse to scrutiny and felt this was unprofessional behaviour. They thought that many physiotherapists held negative views about peer review and seeking second opinions in general.

> I think physios are quite defensive with what they're doing. I would say it's almost a rarity that a physio would be happy for another physio to do a peer review on one of their patients. (PT2)

Participants reflected that they could be unwilling to admit when they did not know something or needed help even though they knew this was a common practice for other disciplines.

[Requesting a second opinion is] like admitting to the client that you aren't up to the job. (PT3)

Participants talked about physiotherapists having inflated egos and being reluctant to accept criticism.

Physios are quite internally ego driven or competitive in terms of professional skills. (PT6)

Lack of support and mentoring

Participants were concerned that the professional culture in private practice resulted in a lack of support and mentoring. Participants felt levels of supervision and mentoring within physiotherapy practices were often inadequate and lacked formal processes and structure. More recent graduates recalled needing more support but being anxious about imposing on experienced colleagues who may also seem busy or time poor.

It feels like I need more, [support] I need just a little bit more [but, there's] probably a fear as well, as I felt I am taking their time [if I sought a peer review]. (PT4)

Similarly, more experienced physiotherapists thought there was a lack of a robust process, and a lack of time, availability, and expectation of experienced physiotherapists to provide peer review and second opinions. This had a negative impact on recent graduates who did not have the experience or opportunity to seek assistance with some of the more complex presentations.

I think we may be expecting a little too much of them [new graduates] and not giving them the right amount of support. (PT5)

This lack of support may place greater responsibility on the new graduate to upskill and result in their lack of experience being blamed for poor patient outcomes.

A lot of onus [was] on the new graduates to do their own upskilling and learning and everything which is hard … but [that] placed a lot of burden of the [outcome] losses [on the graduate]. I think that they really took that on because perhaps if [the patient had seen] a more experienced clinician, they wouldn't have had that outcome. (PT6)

Concerns were also raised for physiotherapists who work in isolation in sole or small practices, and those in rural areas, who might face additional barriers to seeking peer support and second opinions.

The areas that I see issues with are potentially in sole practices where someone is working in a silo and doesn't have the ability to ask other people within the clinic because they are working by themselves. (PT2)

Experienced physiotherapists described how tough clinical practice can be when there is inadequate support in the face of requirements to manage patients and meet expectations. This often left them feeling alone, isolated, and drained by the workload.

It's hard, it's tough and every person that walks in this rooms takes, I try not to, but I feel like they come in and they take a little piece [of me] and then by the end of the day I'm rooted, like, I'm just had it. (PT4)

Most of the participants identified the importance of having a support network but thought these were often not available, or they didn't know where to go. This included physiotherapists with over 20 years of experience who worked in large urban practices.

I don't think I get the support or know where to look for the support is probably more of the problem or who to talk to about developing the skills I need so that I can just leave that at the door when I go home. (PT3)

One participant who had been helped to develop a support network described this as invaluable.

… nice to know that you're, I suppose, just supported, you're not alone when I feel like I've hit a brick wall, it's like, 'gosh where do I go, you know, where do I go?' and it will be nice to have that one person to just say, 'no, try this.' (PT4)

Discussion

This exploratory qualitative study identified concerns about the culture and lack of professionalism in private practice physiotherapy, despite this not being an area that was actively explored. Participants discussed limited interaction or collaboration with physiotherapists outside of their private practice and reluctance to refer patients for second opinions or for access to different expertise. Findings suggested that competition can dominate communication and collaboration in private practice physiotherapy and that an aversion to scrutiny may impede professional behaviour.

Participants thought that the competitive business model in private practice compromised collegiality and limited interaction with peers. Physiotherapists were reluctant to refer patients outside of their practice due to fear of losing patients to another provider or business. Similar findings emerged in another recent study of Advanced Physiotherapy Practice in NZ.[20] Studies in Australia and Canada have previously identified concerns about losing business revenue as barriers to intra and inter-professional collaboration and referral of patients between practices.[21,22]

Previous physiotherapy workforce surveys have described the private practice landscape as 'cut throat'.[23] Participants in the current study were concerned that resources and innovation are guarded within practices. Sharing one's skills, ideas, and innovations with colleagues requires that the benefit to the wider community and the profession is prioritised over competitive advantage. Participants also discussed the need to maintain profit margins resulting in clinicians being pressured to provide more appointments to each patient, potentially more than required to achieve treatment outcomes. These concerns suggest that the competitive market model forces physiotherapy businesses to prioritise self-interest above the needs of the patient. Concerns about adverse impacts of competitive market forces are not limited to physiotherapy and have been raised in relation to the wider health care system.[24]

A willingness to put client interests ahead of self-interest is proposed as integral to good professional practice.[25] Exposing practice and clinical decisions to colleagues shows that a physiotherapist prioritises improved practice over perceived professional credibility and status. To learn from experience, a professional must be open to reviewing difficult situations, able to be challenged, and able to form trusted relationships with professional colleagues.[26] The current study suggested that some physiotherapists are reluctant to invite physiotherapy peers to review their work due to an aversion to scrutiny and fear of being criticised for their management. Defensive practice protects the professional at the possible expense of the client's well-being.[27] Such behaviour may not be deliberate, but rather have gradually and unconsciously become part of the professional culture.[28]

NZ physiotherapists working in private practice have previously expressed caution about exposing their vulnerabilities, acknowledging weaknesses, admitting lack of knowledge, or asking for help; conflating this with self-doubt or incompetence.[29] An inability or reluctance to share the challenges or strains of clinical practice with peers may reduce opportunities to receive support, to develop different ways of thinking about situations, gain knowledge on new or unfamiliar practice, or grow strategies to manage stress.[2] A competitive industry works against the ability to express vulnerability, instead focusing on maintaining credibility, isolationism, perfectionism, and professional status.[2] Consistent with this, participants described how the need to 'save face' prevented them from asking for help. Such reluctance not only compromises physiotherapy practice, but also effective interprofessional collaborative practice.

Access to peer support and mentoring has been identified as an important factor in job satisfaction and workforce retention, particularly by new graduates and those in rural locations,[30,31] but participants thought this was rarely adequately provided. Participants were concerned that the burden of upskilling was placed on new graduates and blame for poor patient outcomes unfairly attributed to them. This lack of support did not just affect recent graduates or those working rurally, however. Experienced practitioners working in large urban practices discussed their work leaving them feeling isolated, burnt out, and drained. They did not know where to seek support to manage challenging situations. Similarly, a recent review of burnout amongst mental health professionals suggests stress is influenced by: the degree of control over work load, job demand and work environment; psychological factors including self-care strategies used; and characteristics of clients themselves and the type of conditions they have.[32]

Professional supervision is one mechanism through which physiotherapists could receive support, but this is not normalised in private practice.[29] Engagement in professional supervision may be influenced by the capitalistic lens through which physiotherapists view their practice, with physiotherapists balancing the costs against the perceived financial benefits including managing existing clients better, attracting new clients, and enhancing business management.[29]

Limitations

These findings emerged from a small number of interviews with physiotherapists working in musculoskeletal private practice in NZ. As such, caution should be exercised before generalising these to other settings. It is possible that similar concerns would be observed in other primary care musculoskeletal health professions that operate with similar business models, but this would require specific investigation to explore. Qualitative research is open to the emergence of unexpected findings. Given this analysis presents unanticipated themes from a wider qualitative investigation that involved health professionals from multiple disciplines, professional culture data were not explicitly interrogated in relation to saturation. It is possible that further themes and insights would be identified with further interviews, however, these are largely consistent with the related existing research. These findings have value as unprompted thoughts about the state of private practice physiotherapy. The fact that these concerns were sufficiently pertinent for participants to raise them without direct questioning enhances their worth. Although primary analysis was undertaken by a single researcher, several steps were undertaken to ensure quality and rigour, including discussion and review amongst the entire research team. These insights were not based on prior reflection (as these were not related to the aims of the research shared with participants prior to the interviews) or co-constructed with the interviewer based on the nature of questions. In many ways, this adds to the value of these thoughts. Seeking further participants to explicitly explore these concerns was not possible within the resource and ethical parameters of the study and may have resulted in more filtered thoughts.

Implications

Although these findings may only be considered as exploratory given the size of the sample and the nature of the study,

these warrant further exploration given that private practice is the dominant mode of community physiotherapy provision in many regions, including Australia, much of Europe, North America, and South Africa. In NZ, 68% of all registered physiotherapists work in private practice.[33] The concerns raised about competition and impediments to professional behaviour in private practice physiotherapy have the potential to adversely affect the health of the physiotherapy profession and the community it serves. It is important that these findings are shared and discussed to stimulate further research and reflection to explore phenomena identified, enable critical discourse, and stimulate professional debate.

Further corroboration of these findings is necessary prior to designing solutions. Opportunities to improve physiotherapy professional culture may include integrating peer groups into pre-registration training to help normalise this as a part of practice. Graduates could be supported to maintain these peer relationships as they move into practice. The Physiotherapy Board currently requires evidence of peer review as part of the recertification programme to maintain an Annual Practising Certificate. Requiring this peer to be from a different physiotherapy business would encourage external peer interactions. A Board requirement that all new graduate physiotherapists participate in a formal mentoring program and that all physiotherapists participate in professional supervision may also ensure that all physiotherapists receive appropriate support, not just those in practices where this is routine. Increased availability of Advanced Physiotherapy Practitioners and Physiotherapy Specialists may increase opportunity for clinicians to seek second opinions with reduced concern about losing patients, however, this still requires the primary clinician to acknowledge that they may not have all of the answers and to open their patient management to scrutiny.

Supplementary material

Supplementary material is available online.

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Data availability. Qualitative interview data are not available for sharing due to the risk of identifying participants.

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