How do physiotherapists solicit and explore patients’ concerns in back pain consultations: A conversation analytic approach

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How do physiotherapists solicit and explore patients’ concerns in back pain consultations: A conversation analytic approach
ABSTRACT

Background: Guidelines advocate that non-specific chronic low back pain (NSCLBP) be considered within a multi-dimensional bio-psychosocial (BPS) framework. This BPS approach advocates incorporating the patient’s perspective as part of the treatment process. ‘Agenda setting’ has been introduced as the key to understanding patients’ concerns in medical encounters; however, this has received little attention in physiotherapy. This study explored how physiotherapists solicit and respond to the agenda of concerns that patients’ with NSCLBP bring to initial encounters. Method: The research setting was primary care. Twenty initial physiotherapy consultations were video-recorded, transcribed and analysed using conversation analysis, a qualitative observational method. Both verbal and non-verbal features of the interaction were considered. Results: This data highlights a spectrum of communication styles ranging from more physiotherapist-focused, where the physiotherapists did not attend to patients’ concerns, to a more patient-focused style, which provided greater opportunities for patients to voice their concerns. A physiotherapist-focused style tended to predominate. On occasions patients were willing to pursue their own agenda when their concern was initially overlooked.

Conclusion: This study provides empirical evidence on communication patterns in physiotherapy practice. A demonstrating that a more collaborative style of communication with a shared conversational agenda provided patients with the conversational space to describe their concerns more fully.

Keywords: Patients’ concerns; Communication; Low back pain; Patient-centred care; Physiotherapy
INTRODUCTION

There is strong evidence that non-specific chronic low back pain (NSCLBP) is associated with a complex interaction of factors and should be considered within a multi-dimensional biopsychosocial (BPS) framework (Hill and Fritz, 2011; O'Sullivan, 2012). A BPS approach for low back pain (LBP) has gathered momentum over recent years, which is reflected in current LBP guidelines (NICE, 2016). Underpinning the BPS model is patient-centred care (PCC) which involves incorporating the patient’s perspective as part of the therapeutic process (Epstein, Mauksch, Carroll, and Jaen, 2008; King and Hoppe, 2013; Stewart et al., 2003) to encourage greater mutuality and partnership (Williams and Harrison, 1999) between clinician and patient. There is good evidence from different clinical contexts to support the general efficacy of the PCC approach (Kinmonth et al., 1998; Little et al., 2008). However, addressing the patient as a ‘whole’ and considering the psychosocial factors alongside physical factors is perceived as challenging by physiotherapists (Bishop and Foster, 2005; Foster and Delitto, 2011). This challenge is highlighted in recent studies where traditional physical therapy interventions combined with targeting psychological and social factors, have demonstrated only small differences in pain or disability.

Moreover, although a PCC approach is strongly promoted within the physiotherapy literature (Jensen, Gwyer, and Shepard, 2000; Pinto et al., 2012), there is comparatively little interactional data to support physiotherapists' willingness or ability to successfully achieve a empirical evidence as to the efficacy of a PCC approach in physiotherapy practice. The evidence that is available suggests that the content of the communicative interactions are focused more on pain and biomedical aspects of the patient’s condition (Josephson, Woodward-Kron, Delany, and
Hiller, 2015). Furthermore, physiotherapists typically direct and control the conversation towards these topics without paying regard to the patient’s agenda (Hiller, Guillemin, and Delany, 2015). Given that patients often try to establish their agenda by initiating clues about worries and concerns in subtle ways (Levinson, Gorawara-Bhat, and Lamb, 2000), physiotherapists’ preoccupation with biomedical factors may is likely to make them less responsive to the psychosocial aspects of their patients’ condition or experience. While failure to reconcile differing doctor-patient agendas, and identify patients’ full concerns, has been identified as an impediment to effective medical care (Barry et al., 2000; Byrne and Long, 1976; Mishler, 1984; Peltenburg et al., 2004; Roter and Hall, 1992). Failure to reconcile differing doctor-patient agendas, and identify patients’ full concerns, represents an impediment to effective medical care the implications of which have been documented elsewhere, but so far havethis has not yet not been examined in the context of physiotherapy care.

This paper addresses this very issue by examining the interactional negotiation of ‘agenda setting’. It examines the extent to which physiotherapists solicit and respond to the agenda of concerns that patients with NSCLBP bring to primary care initial encounters focusing on (i) physiotherapists’ questioning strategies for soliciting patient concerns (ii) and how physiotherapists respond to patients’ presentation of concerns. A patient agenda of concern has been broadly defined as a “problem”, either implicit or explicitly stated, which could become the focus of conversation during the clinical encounter (Butler, Campion, and Cox, 1992). Patient agendas include their perspectives on their illness, their expectations, feelings and fears about their condition (Butler et al., 1992), a need for information and understanding, and the desire for partnership in management (King and Hoppe, 2013). Given, the importance of agenda setting as part of a PCC approach (King and Hoppe, 2013; Smith, Fortin, Dwamena, and Frankel, 2013),
our this paper reports on findings revealing how agendas are interactionally negotiated on a turn-by-turn basis (Heritage, 2013). In this study Data data episodes have been selected in which: 1) patients express their concerns (anxiety, fear) about symptom attribution and the future consequences; and 2) express their emotional distress due to loss of capacity and pain (see Appendix A for a data illustration of the concerns selected).

METHODS

Setting and Participants

The setting for this study was two outpatient physiotherapy departments in primary care in the North East London Foundation Trust (NELFT), England. Twenty initial physiotherapy consultations were video-recorded (10 physiotherapists and 20 patients). The local research ethics committee approved the study, and it was successfully reviewed by the (Blinded) NRES committee. All patients and physiotherapists that agreed to participate in the study were sent an invitation and information sheet and provided written informed consent prior to participation in this study. Twelve physiotherapists were purposively sampled based on sex, age, levels of clinical experience and previous BPS training. Physiotherapists’ characteristics are presented in Table 1. This observational study was nested in a larger study, conducted over a three-year duration, examining the training requirements for the implementation of a biopsychosocially oriented behavioural intervention called Cognitive Functional Therapy (CFT) (O'Sullivan et al., 2018), two physiotherapists refused to participate due to time commitments. Twenty-seven patients between the ages of 18-70 years, reporting NSCLBP > 3 months, including a range of risk profiles, were identified in two NELFT physiotherapy departments from either the triage clinic or the musculoskeletal clinical assessment and treatment service. The patients were contacted by a member of the research team (RP), and the NELFT direct care team. For patients
willing to participate an initial face-to-face meeting was then arranged with the lead researcher (IC) to explain the reasons for the study and the requirement for the interaction to be recorded and for the lead researcher to be present. At this meeting the patients completed several questionnaires, which included the Ørebro Musculoskeletal Pain Screening Questionnaire (Ørebro MSPSQ) (Boersma and Linton, 2005), Roland and Morris Disability Questionnaire (RMDQ) (Roland and Morris, 1983) and the STarTBack Screening Tool (Hill et al., 2008), and a measure of pain intensity (Boersma and Linton, 2005). Patients’ characteristics are presented in Table 2. These questionnaires were administered to better understand the risk profile of the patients included in the study in terms of predicting non-recovery from low back pain and were consistent with usual practice in the NELFT physiotherapy departments. One patient refused to participate, as she did not want to be video-recorded, four withdrew due to resolution of symptoms, and two failed to attend their initial assessment. The recorded assessments ranged in duration from 35 minutes to 1-hour. The lead researcher was present at the recorded assessments to adjust the camera as required. There was no discussion with the physiotherapists directly after each recorded assessment, although face-to-face video review sessions of the assessments were included as part of the CFT training programme to provide feedback and enhance awareness of communication practice. Although the lead researcher had access to the assessment documentation these analysis are based on direct observation alone. Follow-up treatment sessions were not recorded. These data were collected in a nine months observational phase prior to formal training in CFT.

Analysis

All the data were analysed using conversation analysis (CA), a qualitative data-driven inductive method which observes “naturally occurring interaction” (Maynard and Heritage, 2005). Most
studies analysing physiotherapy communication practice have employed quantitative coding measures (Roberts, Whittle, Cleland, and Wald, 2013). Whilst coding measures allow for the identification of the frequency of utterance types, they often do so at the expense of the context of those utterances (Heritage and Maynard, 2006). The context of action is what gives those utterances their meaning in the first place (Drew, Chatwin, and Collins, 2001). In contrast, CA provides a more dynamic picture of patient-therapist interactivity describing recurring patterns of verbal and non-verbal communicative practices, in terms of their structure, interactional features and consequences (Drew et al., 2001). Initially the data was transcribed verbatim and two separate authors (IC and RP) independently analysed each transcript with the accompanying video-recordings. Each consultation was professionally transcribed in its entirety and each transcript was then independently checked and verified against the video files by two separate authors (IC and RP). Sequences related to patients’ concerns about symptom attribution and loss of capacity and pain were independently identified and viewed by IC and RP. These sequences were presented to the research collaborators in order to refine the direction for further analysis. Shorter extracts of these events were then transcribed manually by IC and RP in more detail using the standardised transcription conventions for verbal and non-verbal activity (Jefferson, 2004) (Table 3 for transcription convention). IC and RP undertook fifteen-days of post-graduate training in conversation analytic research methods prior to commencing the study. Sequences related to patients’ concerns were identified, viewed and presented to the research collaborators in order to refine the direction for further analysis. Shorter extracts of these events were then transcribed in more detail using the standardised transcription conventions for verbal and non-verbal activity (Jefferson, 2004) (See Table 3 for transcription convention). Non-verbal aspects of communication were described in brackets and focused primarily on the
physiotherapists’ posture and gaze-direction during talk in which patients revealed their concerns, and how these non-verbal behaviours related to such talk in the physiotherapy interaction. These shorter extracts were presented to the research collaborators for discussion at data workshops to support the analysis. IC and RP undertook fifteen-days of formal postgraduate training in conversation analytic research methods prior to commencing the study. The extracts presented in this paper represent an illustration of the dominant practices identified in the data corpus.

RESULTS

The extracts described here illustrate a spectrum of communication practices ranging from more physiotherapist-focused to more patient-focused, with physiotherapist-focused being much more common. In the more physiotherapist-focused extracts (1-4) the physiotherapists typically pursued their own agenda largely independent of the patients’ displayed concerns. Whereas, in the more patient-focused extracts (5-6) the physiotherapists were more attuned to the patients’ concerns and actively facilitated the patients’ perspectives. An overview of the key features of each communication style are displayed in Table 4 and will be described in more detail as the extracts are presented.

Question Formats

These data illustrate particular types of questions that can be classified as either Yes/No (Y/N) questions (Raymond, 2003) or Wh-questions (WHQs) (Stivers, 2010), and concern-seeking questions (Robinson, 2006b).

Y/N Questions

Y/N questions, or polar questions, are designed to encourage a brief ‘yes’ or ‘no’ response. These have been referred to as “closed” questions in that they typically limit the contributions
that patients make to interactions (Boyd and Heritage, 2006). We identified two kinds of Yes/No questions: Yes/No interrogative (YNIs) and Yes/No declaratives (YNDs) which have been differentiated in the literature in terms of how they convey the questioners access to information (Heritage, 2010). Here we provide an example of both types from our data set:

**Yes/No interrogative**

01 Physio Do you take any regular medication at all?

The interrogative question suggests that the physiotherapist has no definite knowledge of the patient’s medications and can invite elaboration.

**Yes/No Declarative**

01 Physio So you’re not taking any medication

The declarative question suggests that the physiotherapist has a more definite knowledge and merely invites confirmation that the patient is not taking medication.

**Wh-Questions**

*Wh-questions* are questions using words such as ‘what’, ‘why’, ‘when’, ‘who’, ‘where’ and ‘how’, and are considered less constraining than yes/no questions (Wang, 2006), providing more space for patients to design their response and describe his or her experience in their own terms (Peräkylä and Vehviläinen, 2003). Here is an example from our data set:

01 Physio What do you think is going on?

**Concern–Seeking Questions**

*Concern-seeking questions* are categorized on their content rather than grammatical form, in that that are explicitly formatted in ways that allow for the relevance of concerns to be solicited (Robinson, 2006b). Here is an example from our data set:

01 Physio Have you got any concerns about what was on 02 the x-ray?
Physiotherapist Focused - Pursuing Their Own Agenda

Physiotherapist’s Abrupt Topic Shift Disengaging with the Patient’s Emotional Concerns

Extract 1

01 Pat:  I I I did] I did go to the gym-

*Lines omitted* (PAT reports that he cannot go to the gym because of pain)

02 Phy:  So were you in more pain after you went to the gym

03 Pat:  Yeah

04 Phy:  Yeah

05 Pat:  It’s jus constant

06 I I go I go ho- like :hhh at home time (0.2) when

07 I’m(0.2) at home I sit down an:: I’m jus in agony

08 all I wanna do is sit there and curl up in a ball

09 Phy:  Uhum

10 Pat:  °I just wanna be left alo::ne° ((Looking at

11 physiotherapist))

12 Phy:  Okay ((turns away from the patient refers to the

13 chart))

14 Pat:  ((Patient looks towards the chart))

15 Phy:  So you’re (. you’re at work now ((looking at the

16 chart))

17 Pat:  Yeah

Description of Key Features

Just before the start of this extract the physiotherapist asks the patient about his activity levels.

The extract begins with the patient’s response reporting that he has curtailed his activity levels
and no longer goes to the gym. The physiotherapist (line 02) seeks clarification as to why the patient avoids going to the gym, which is constructed as a **yes/no interrogative question closed-ended question** and makes relevant a simple yes or no response, in this case “Yeah” at line 03.

Following an open continuer (line 04) by the physiotherapist the patient, in the next turn, directs the talk towards his pain related emotional distress (line 05-08 & line 10). Apart from a minimal response continuer “Uhum” at line 09, the physiotherapist does not attend to this emotional disclosure and disengages with the patient. The “Okay”, with a falling intonation, (line 12) is used here to prepare the closing of the sequence (Schegloff, 2007). Further evidence of the move to closing the sequence is found in the non-verbal response of the physiotherapist. Almost simultaneously she withdraws her gaze from the patient and starts recording in the chart (Figure 1) indicating a state of diminished engagement in collaborative action (Goodwin, 1981). The physiotherapist then topicalises the patient’s work status by asking a **yes/no declarative question closed-type declarative question** which appears to be is prompted by information in the chart the physiotherapist is looking at. The patient produces a simple “yeah” response. The patient produces a simple “yeah” response. One consequence of the physiotherapist’s looking at the chart is an adjustment to bodily comportment modifying the engagement display toward the patient and her availability to participate in collaborative action (Goodwin, 1981; Robinson, 2006a). The patient appears to orient to this lack of complete engagement by also shifting his gaze towards the documents (line 14). The way the patient appears to closely monitor the physiotherapist and orient to the non-verbal transition has also been demonstrated in medical interaction (Frankel, 1983).

**Physiotherapist Solicits the Patient’s Concerns but Does not Engage with the Response**

**Extract 2**
Phy: Okay and erm::: ((looks to the chart)) that’s all fine

And any (.).particular worries you’ve got about your back

Pat: :Hhh erm well just generally I’m just (.) just a bit worried that whatever’s going on:: it’s not going to improve it’s gonna get worse and I sort of think what’s it going to be like when I’m older

Phy: Yeah [alright]

Pat: [But]

An you planning on having any more children? [or::]

Pat: [Yeah]

I’d like to have one more yeah

Does that have any concerns around that in terms of your back

Pat: I’ve not really thought about it like that but (0.2) yeah ((smiles))

Phy: No some people get a bit worried after if they’ve had a problem during pregnancy whether it’s gonna impact on something else

Pat: I mean the pain the back pain that I had during pregnancy I would exp- I would expect that that’s [quite normal]

[Yeah]
Description of Key Features

At the start of extract 2 the physiotherapist hesitates and refers to her documentation, which orients to her need to check her position in the information-gathering process, which she evaluates with “that’s all fine” (lines 01-02). The physiotherapist’s question that follows (lines 03-04) appears to be prompted by the assessment chart, which we similarly observed in extract 1 (lines 15-16, pp12). The question here would be grammatically classified as a yes/no interrogative, however in terms of its content it is explicitly formatted as a ‘concern-seeking question’ (Robinson, Tate, and Heritage, 2016) to solicit the patient’s concerns about her back. Although the patient responds by revealing a ‘particular’ worry about the long-term consequences of her back pain getting worse with age, the physiotherapist does not engage with this concern. The rising intonation of “Yeah [alright]” (line 09), in this context, characterises this response as a change-of-activity token (Gardner, 2001) and is used to prepare the closing of the sequence projecting a movement to pursuing information as to the patient’s future plans to have more children (line 11). Having established that the patient does plan to have more children the physiotherapist asks another concern-seeking question: “Does that have any concerns around that in terms of your back”, the patient’s response orients to this not being a ‘particular’ concern to her (lines 16) “I’ve not really thought about it like that”. Although the physiotherapist’s responding turn acknowledges this with the No- preface she continues to pursue her own agenda by citing that it is a common concern for patients to have after having children. The patient’s response suggests that this is not a concern to her: “I would expect that that’s [quite normal]”, which is finally accepted by the physiotherapist. Boyd and Heritage (2006) refer to “checklists” of questions that address predetermined topics, and this resonates with the way the
This adherence to a predetermined questioning sequence may explain her failure to engage with the patient’s expressed concern.

**Physiotherapist’s Selective Treatment of the Patient’s Concerns**

**Extract 3**

01 Phy: And what type of work do you do ((Turns sheet))

*Lines omitted (PAT describes his work duties over several lines)*

02 Pat: Basically the lifting twisting turning (0.4) and

03 getting on the floor (.) getting up ladders

*Lines omitted (PAT describes his work duties over several lines)*—

*Lines omitted*

04 Phy: =So you haven’t been able to do that? Or

05 Pat: No ((shakes head))

06 Phy: Okay ((turns away from the patient and turns sheet))

07 Since when ((recording in chart))

08 Pat: That wa::s (0.6) January I’ve not been (0.2) I’ve not

09 been doing that

*Lines omitted*

10 Pat: Erm (0.2) my doctor (0.2) said to me that you you need

11 to amend your duties at work

12 And I’ve spoken to my managers (.step down (.)) and

13 all I do now is just sit on a chair and just serve

14 people on the sales ((looking at chart))

15 Phy: O[kay] ((recording in chart))

16 Pat: [And] I get people te (.) lift ((looking towards the

URL: http://mc.manuscriptcentral.com/uptp Email: IPTP-peerreview@journals.tandf.co.uk
17 chart))
18 "I feel useless" ((looking at physiotherapist))
19 Phy: ➔ >Okay< ((looks away from the patient and records in chart))
20 And does(.)(does that im- improve you? [with] your back ((Looks back at patient))
21 Pat:                                 [No]

Description of Key Features

Extract 3 starts with the patient responding over several turns to the physiotherapist’s wh-question about his work duties. The physiotherapist’s question (line 04) checks with the patient his ability to perform these work tasks. Although this is a leading y/n declarative question and displays a “knowing” stance (Heritage, 2010) the rising intonation and the tagged “Or” at the end suggests some level of uncertainty about the answer. Following a simple “no” confirmatory response from the patient the physiotherapist attempts to close the sequence with a transitioning “Okay”, embodied by turning away from the patient and referring to her document (line 06). At line 07 the physiotherapist enquires further about how long the patient has modified his activities, whilst she records in the chart. The patient initially orients to the topical narrow-focus of the wh-closed-type question and provides the information required, but then expands his response by reporting that he has modified his work duties on the advice of his GP. The patient’s distress about his loss of work identity is alluded to in lines 12-14 &16, which he delivers whilst looking at the physiotherapist’s chart. His distress is made more explicit in line 18: “I feel useless”, which is coordinated with him looking directly at the physiotherapist, who briefly looks up from the chart. However, the physiotherapist does not attend to the patient’s emotional disclosure and attempts to close the sequence with an
accelerated “>Okay<”, whilst disengaging with the patient by withdrawing her gaze and recording in the chart (lines 19-20) (Figure 2). The interrogative *Y/N*yes/no closed-question that follows (line 21) pursues information as to whether modifying his work role has changed his symptoms. Although this question preserves the connection to the patient’s previous turn by fitting the new aspect to the work topic, it accomplishes a shift into symptom behaviour and away from the patient’s emotional disclosure. *This extract illustrates how patients’ clues about emotional concerns are often embedded within other discussion and how physiotherapists acknowledge but do not always respond to such concerns if preoccupied with their own agenda.*

Patient Expands Their Response in Pursuit of Their Own Agenda

**Extract 4**

01 Pat: [And] that- that’s when I panic coz I think myself  
02 I’m bent in half and I can’t do nothink=  
03 =it ju- sometimes it just sometimes it just go::es  
04 (.). jus like that  
05 Phy: And how long does it take you to kinda recover  
06 ((looks down to his notes))  
07 (0.2)  
08 Pat: Hhh. a good whi::le (.) a good couple of hours [until  
09 the] pi- pa- pa- pains(.). the pills have kicked in=  
10 Phy: [couple  
11 of hours]  
12 Phy: Uhum
Pat: (0.2)

I fink if I didn’t have the pills I f- I don’t know
I’d do to be quite honest
Phy: Okay

Because I fink it’s you’re frightened to move
in case it brea::ks [that] woz my main point I fink
myself:
Phy: [Uhum]

I- when I went to the doctors I said a- is it goin to
break (. ) coz that’s how it f:elt (. ) y’know when yo-
you [get so:]
Phy: [WHAT YOUR BACK]

Yeah (0.2) that’s exactly how I felt I felt like it
was gonna break ((gestures a breaking back))
Phy: ;Okay
(0.4) ((nods))
Phy: Right that’s fine okay
((withdraws eye gaze and turns away from the patient
and writes in chart))
Pat: ((looks to the chart))

But when [he turned round] an told me (. ) the last
time I see X he went no: it won’t break it give me a
bit of reassurance
((Looks from the chart to the physiotherapist and
38 moves right arm towards the physio))
39 Phy: [So does] ((Returns gaze back to the patient))
40 Pat: Uhum
41 Phy: Is that your:- (. ) do you think that your back ↑ca:n
42 break then ((looking at patient))
43 Pat: That’s how it felt (0.2) [that’s] how it feels at the
44 moment, it feel like I cn- its feels like it’s(0.2) s
45 (. )ready to snap

Description of Key Features

Prior to the beginning of this sequence the physiotherapist had been clarifying with the patient her region of pain and extract 4 starts with the patient describing her episodes of acute low back pain and the resulting incapacity: “that’s when I panic’… I can’t do nothink”. The patient constructs her problem here as particularly incapacitating and it has been suggested that such extreme case formulations legitimize complaints (Pomerantz, 1986).

The physiotherapist’s wh-question that follows, which is asked whilst simultaneously referring to the chart (line 05-06), enquires about her period of resulting incapacity. Although this question is ‘fitted’ to the patient’s last turn it moves away from the patient’s clear concerns by focusing on recovery therefore potentially limiting the space for the patient to expand her feelings. This feature was similarly noted in extract 3 (Extract 3, line 21, pp17 “And does (. ) does that
im- improve you? [with] your back”), and offers another example of the subtle ways in which physiotherapists introduce topics more aligned to their own agenda. However, the difference in question type produces different patient responses. The yes/no interrogative question in extract 3 simply seeks confirmation or denial from the patient and receives a simple “No” response, whereas in this extract the wh-question (line 05-06) allows the patient to extend
her turn. This illustrates how yes/no questions can constrain an addressee to a greater degree than
wh-questions (Wang, 2006). Although the patient’s initial response in this extract conforms to
the topical agenda set by the physiotherapist’s question, what follows over several turns are a
series of patient reformulations which go beyond simply answering the question. It is possible
that the acknowledgment token (line 16) and the small silence (line 17) may have indicated to the
patient that there was space available to continue and that the physiotherapist was not going to
take the turn. The physiotherapist’s question that follows, which is asked whilst simultaneously
referring to the chart (line 05-06), enquires about her period of resulting incapacity. Although
this question is ‘fitted’ to the patient’s last turn it moves away from the patient’s clear concerns
by focusing on recovery therefore potentially limiting the space for the patient to expand her
feelings. This feature was similarly noted in extract 3 (Extract 3, line 21 “And does(...) does
that im—improve you? [with] your back”), and offers another example of the
subtle ways in which physiotherapists’ introduce topics more aligned to their own agenda. The
patient’s initial response conforms to both the topic and grammatical agenda set by the
physiotherapist’s question, but what follows over several turns are a series of patient
reformulations which go beyond simply answering the question. The patient-initiated
formulations that follow suggest that she treats it as an opportunity to voice her concerns more
fully, making explicit her anxiety about unpredictable pain episodes and incapacity, with a
concern that her back could ‘break’. However, the patient does not succeed in eliciting anymore
than an acknowledging response from the physiotherapist: “[Uhum], Okay”. The patient’s
further expansion (lines 22-24) once again makes explicit her anxiety about her back ‘breaking’
such that she sought her GP’s opinion. The physiotherapist’s high volume response (line 25):
“What your back” suggests some skepticism but no evaluation is forthcoming. The
physiotherapist then closes the sequence: “Right that’s fine okay”, whilst turning away from the patient and writing in the chart (line 30-32) (Figure 3), signalling a return to the ‘primary business’ of the consultation. The patient’s reformulation (lines 34-36) orients to the need for reassurance, which has not been forthcoming. This reformulation is coordinated with the patient redirecting her gaze from the documents towards the physiotherapist and moving her arm in his direction (lines 37-38) (Figure 4), possibly in an attempt to attract the physiotherapist’s attention. Both the patient’s verbal and non-verbal behaviours invite the physiotherapist to re-engage with the patient. Consequently, the physiotherapist re-orient his gaze toward the patient (Figure 4) and he explores the patient’s perceptions further: “do you think that your back can break then”, allowing the patient to expand on her concerns: “feels like it’s ..ready to snap”. Such sequences demonstrate that questions cannot be categorized on their form alone and need to take into account their “pragmatic meaning” (Holmes and Chiles, 2010). Although the question in lines 41-42 is strictly a yes/no interrogative in grammatical form, the “do you think” clearly seeks the patient’s perspectives and rather than a simple yes/no response allows the patient to develop her concerns. This extract illustrates a case where the patient utilizes different interactional practices to engage the physiotherapist in responding to her concerns. It provides another example of patients’ capacity to overcome institutional constraints, such as turn taking projected by the design of physiotherapists’ questions, and the impact of documentation, to assume a more active role in consultations (Collins, Drew, Watt, and Entwistle, 2005; Stivers, 2005). It provides another example of patients’ capacity to overcome the institutional constraints of medical interaction and assume a more active role in consultations (Collins, Drew, Watt, & Entwistle, 2005; Stivers, 2005).
Patient Focused - ‘Collaborative’ Sequences

Physiotherapist Explores Patient’s Concerns with ‘Prompts’ and Second Questions

Extract 5

01 Pat: [It] stops me doing a lot of things [with me back
02 y’know]
03 Phy: ➔ [Yeah talk me
04 through that] what does it stop you doing ((open hand 05
06 invite to continue))
06 Pat: I used to do a lot of bow::ling play like snooker but
07 I’m I’m like (0.2) erh pool and that=
08 =but it puts you off like bending up and down
09 (0.2)
10 Y’know what I mean it’s like (0.2) it’s it’s get’s in 11
11 your head as well
12 Phy: ➔ ((Stops recording returns gaze to the patient and uses
13 an open hand gesture to continue))
14 Pat: Coz if it’s going to hurt (0.2) you don’t wanna do it
15 like y’know
16 Phy: ➔ ((nodding))
17 Phy: Yeah I can under[stand that]
18 Pat: [Y’know]
19 Phy: ➔ So what’d- ye- when you say get’s in get’s in your
20 he:ad what’d describe that to me, what are you
21 thinking about when you go t- when you bending what
22 is it that that’s going through your head
23 Pat: Well (.)I finking it’s gonna hurt me like y’know what 24
I mean coz it’s been going on for so long y’know I
25 mean I it’s sometimes it’s get’s in your head as well 26
so

Description of Key Points

In extract 5 the patient responds to the physiotherapist’s question about hobbies by reporting the functional limitations of his back pain (lines 01-02). The physiotherapist’s *wh-question open-focused question* (Chester, Robinson, & Roberts, 2014; Marvel, Epstein, Flowers, & Beckman, 1999) (lines 03-04) maintains the focus on the patient’s specific concern, and provides explicit permission for the patient to hold the floor. Consequently the patient reveals that he avoids pool and snooker due to concerns about bending. After a short inter-turn pause the patient expands the sequence with: “it’s get’s in your head as well”. The physiotherapist’s shift in gaze orientation and open hand gesture (lines 12-13) (Figure 5), displays engagement (Goodwin, 1981), which provides an invitation for the patient to explain what he means. This non-verbal continuer prompts the patient to explain his pain-avoidance behaviour, which receives an empathic acknowledgment from the physiotherapist (line 17). In the next turn (lines 19-22) the physiotherapist’s *so*-prefaced *wh-question open-focused question* pursues the patient for clarification. The ‘so’ here used as an interactional resource to demonstrate engagement with and interest in the patient’s expressed concern (Bolden, 2006). The patient’s response reaffirms his concern (lines 23-26), which orients to the psychological impact of having persistent pain. Of note in this extract is that the physiotherapist’s assessment records are placed on his lap (Figure 5), which appears to be less disruptive to the process of mutual engagement between physiotherapist and patient and conducive to *enhanced fuller* patient participation.

Physiotherapist’s Formulations and Elaborated Patient Concerns


**Extract 6**

01 Pat: Y’know so that’s my only regret that I never kept up really doing ((indicates bending forward))y’know

03 stretching

04 Phy: So d’you f::eel that something’s happened because you haven’t done that?

06 ((looking towards the patient))

07 Pat: In in my mind I feel it’s probably my fault where I didn’t keep up with the exercises .hhh everyday everyday tryin-, coz i in my mi- tha’s in the back of my mind what he said if you don’t keep them up it will heal ((indicates with finger))even if its like 6 [months] after the operation when I started slacking=  

13 Phy: [Right]

14 Yeah

15 Pat: =On the what’s names coz I I was pain free

16 Phy: So 6 months later you’re thinking I haven’t done enough here=

18 ((looking towards the patient))

19 Pat: Yeah

20 Phy: = to keep me out of [pain]

21 Pat: [yeah] I started feeling a little bit (. I was getting a little bit stiff::

23 Phy: Right

24 Pat: But nothing like it woz it’s only these last (.I woulda said last 6 months it’s really got( . it
Description of Key Points

In extract 6 the patient (lines 01-03) implicitly expresses his concerns that his current symptoms may relate to his non-adherence to an exercise program following spinal surgery 20 years ago. The physiotherapist picks up the cue (line 04-05) with a so-prefaced formulation, i.e a candidate interpretation of the patient’s prior talk (Heritage and Watson, 1979). As illustrated in extract 5 the physiotherapist’s postural orientation and direction of gaze, displays engagement and interest in the patient and maintains a mutual orientation (Goodwin, 1981; Ruusuvuori, 2001) (See Figure 6). The so-prefaced formulation works here to encourage further talk from the patient whose response expresses a concern that the nerve has healed in an arched position, which he perceives to be of his own making. Having established the patient’s concerns about symptom attribution the physiotherapist employs another formulation (lines 16-17 & 20), this time with a more definitive interpretation, which produces further elaboration from the patient.

DISCUSSION

Encouraging patients to express their ideas, feelings and concerns is fundamental to successfully implementing a PCC approach (Zandbelt et al., 2007b). This requires that clinicians balance their own professional agendas with those of the patient. To successfully share agendas requires a more collaborative style of communication (Levenstein et al., 1986), where the traditional power imbalance of medical interaction is redressed and the patient is given greater opportunities to voice their concerns. Although a relatively small sample size, the findings from this analysis indicate that a full expression of patients’ concerns in a physiotherapy consultation is contingent on subtle communication behaviours, which can either encourage or hinder patients’ involvement.

In extracts 1-4, the physiotherapists predominantly controlled the interaction and were more...
oriented towards their own agenda, often focussing on patients’ clinical signs and symptoms and their interpretation, rather than the patient’s emotional distress and concerns about symptom attribution and their future consequences. In extracts 1-4, the physiotherapists predominantly controlled the interaction and were more oriented towards their own agenda, often focussing on patients’ clinical signs and symptoms and their interpretation, rather than the wider concerns of the patients. For example, in extracts 1-4 the physiotherapists framed their questions in ways that restricted patients’ responses by using closed-ended questions designed to both control the topical agenda and constrain patients’ responses. Although at times the physiotherapists took the interactional initiative with concern-seeking questions, they often refrained from engaging with the patient’s response. Moreover, expressions of acknowledgement were used in the third turn, (“okay”, “alright”), as well as changes in pitch (decreasing or increasing at the end of the turn), and embodied actions (gaze shift, turning away from the patient and writing in documents), as ways of pre-closing the sequence to shift the topic towards their own agenda. These verbal and non-verbal NV behaviours for communicating transitions have been identified previously in medical encounters (Robinson and Stivers, 2001; Ruusuvuori, 2001).

Some physiotherapists responded selectively to patients’ concerns by ‘fitting’ secondary questions, which although related to the patients’ prior talk, were again more focused on their own agenda. This selective responding to patient cues is similar to what Schegloff and Sacks (1973) referred to as “topic shading”, and was employed to direct the agenda to symptom behaviour and information gathering and often away from patients’ cognitive and emotional concerns e.g. “And does...does that improve you? [with] your back” (Extract 3, line 21, pp18). It is difficult to claim whether these topic shifts, or more subtle topic shading, represent physiotherapist avoidance of sensitive issues or a lack of communication awareness, but
certainly they effectively maintained the physiotherapist’s control over the turn-taking process and the topical agenda. This may have important implications as a failure to engage patients’ emotional distress may enhance patients’ negative affect (Linton, 2015) and potentially weaken the therapeutic relationship (Levinson et al., 2000).

In the physiotherapist-centred extracts the physiotherapists appeared more strongly oriented to the organisation of the interview and data-collection, asking questions that were seemingly prompted by a template guide (Jones, 2009). The intrusive impact of assessment documents was reflected in the physiotherapists lack of direct body orientation and abrupt withdrawal of eye gaze, communicating a reduced state of engagement (Robinson, 1998). This observed preoccupation with documentation and its negative impact on achieving patient-centred communication has been described in medical (Robinson, 2006a; Ruusuvuori, 2001) and physiotherapy (Schoeb and Hiller, 2018) interactions, and in the data presented here appeared to curtail opportunities for patients to develop their perspectives and ‘voice’ their underlying concerns.

However, the physiotherapists’ dominating style was not always related to patients’ relative contribution as in some extracts (highlighted in extract 4), where physiotherapists attempted to close the sequence, patients continued to pursue their own agenda when their concern was overlooked. This has been noted previously in medical interactions, where patients voiced their perspectives and expressed even more concerns when physicians displayed inhibiting communicative behaviours (Zandbelt et al., 2007a). In some extracts where patients pushed their own agenda it made it conditionally relevant for the physiotherapist to explore the patient’s concerns further and suspend the pursuit of their own agenda. Street and Millay (2001) have described a “cycle” of collaboration facilitated by such patient initiated turns, and this was
demonstrated in these data by the physiotherapist re-orienting their body position and gaze toward the patient and asking more about their concerns. Another feature of these particular extracts was that the design of the physiotherapist’s questions appeared less consequential for the length and content of the patient’s presentation of concerns. Even after closed-ended questions seeking specific pieces of information, patients’ responses were not always grammatically fitted to the questions, in that they were prepared to expand their responses to voice their concerns (see extract 3 lines 10-14, pp17).

Although the data reflected a predominantly practitioner-centred model of communication there were some extracts where physiotherapists demonstrated greater receptiveness to patients’ concerns (extracts 5 and 6). Typically, these physiotherapists engaged with implicit and explicitly expressed patient cues and provided opportunities for patients to express their concerns more fully. These extracts illustrated a more collaborative and patient-focused strategy featuring open wh-questions, typically in the third turn position, and that were focusing on the patient’s agenda. Although we also observed wh-questions in the more physiotherapist-centred extracts e.g. “And how long does it take you to kinda recover” (Extract 4, line 05, pp19) they were typically seeking information about patients’ symptom behaviour in preference to exploring patients’ concerns. Whereas the wh-questions observed in the more patient-focused extracts e.g.”So what’d- ye- when you say get’s in get’s in your he:ad what’d describe that to me, what are you thinking.. ” (Extract 5, line 19-22, pp25) were focused on the patients’ concerns and eliciting further the patients’ perspectives. This is consistent with the distinction made by Fox and Thompson (2010) between two types of wh-questions, “specifying questions” that seek specific information and “telling questions” which seek more extended responses.
Non-verbal NV displays of engagement with the patient (e.g. postural orientation and direction of gaze) combined with facilitatory non-verbal NV prompts (e.g. hand gestures) were also observed in the patient-focused extracts. In these extracts the use of medical documentation was either not employed, or more smoothly and appropriately integrated into the assessment by the physiotherapist, with more appropriate timing of their shifts in gaze. This careful integration of documentation suggests some sensitivity to limit the intrusive nature of documentation when addressing patients’ concerns and demonstrated that the patient was the main focus rather than not the medical documentation (Robinson, 1998).

An additional interactional feature common in patient-focused extracts was the use of physiotherapists’ formulations (interpretations of patient’s talk), following the disclosure of a patient’s concern. Formulation sequences preserved connection to the patient’s concerns and achieved a greater sense of collaboration. It has also been demonstrated that confirmations or agreements are the preferred option following formulations (Heritage and Watson, 1979), and certainly in these data they were often followed by extended patient agreements. In offering accurate interpretations of the meaning behind the words used by the patient, such formulations seem consistent with the kinds of activities defined as ‘active listening’ (Hutchby, 2005), and demonstrated that the physiotherapist wanted to fully understand the patient’s concerns.

Patients are likely to feel less distressed and more satisfied (Maguire and Pitceathly, 2002) if they are given the conversational space to disclose their perceptions and feelings about their problem in pursuit of their own agenda (Maguire and Pitceathly, 2002). Furthermore patients’ priorities and preferences may differ from those of the physiotherapist and if differences in agendas are not reconciled then adherence to treatment recommendations and advice on
behaviour change are likely to be poor (Chewning and Wiederholt, 2003; Maguire and Pitceathly, 2002). These data, however, suggests that physiotherapists will require a greater appreciation of the interactional consequences of communication practice to achieve this effectively. One possible explanation for the differences in the physiotherapists’ communication style in this study is levels of BPS training, as physiotherapists with higher levels of BPS training (Table 1) employed a more patient facilitating collaborative approach, which accommodated greater patient input. Whereas, physiotherapists who had limited or no exposure to BPS training were typically more focused on their own agenda and less on eliciting and exploring patients’ concerns. However, this preliminary finding would require further exploration given the small sample size employed in this study, and limited data currently available on the content and effects of bio-psychosocially oriented training in physiotherapy (Jacobs et al., 2016; Overmeer, Boersma, Denison, and Linton, 2011). It is also acknowledged that styles of communication can be influenced by a variety of other factors including gender (Loffler-Stastka et al., 2016), time constraints (Malhotra et al., 2009), and being uncomfortable with emotional disclosure (Maguire and Pitceathly, 2002).

Consistent with studies in medical interaction elsewhere (Collins et al., 2005; Stivers, 2002, 2005) these findings also challenges the notion of patients as always ‘passive’ participants, and suggests that some patients are capable of finding ways around the physiotherapist-centred style of interaction to make their concerns heard. Although this study was not designed to identify the characteristics of patients more likely or capable of ‘pushing’ their own agenda, it would be an interesting focus for future work.

A change in patient-physiotherapist relationship, from one where the physiotherapist is positioned as an ‘expert’ with a strong biomedical focus, to one of mutuality where psychosocial
factors are considered, underpins a PCC approach (Cooper, Smith, and Hancock, 2008). It has been suggested that this shift to a more collaborative relationship will strengthen therapeutic alliance (Babatunde, MacDermid, and MacIntyre, 2017; Ferreira et al., 2013). This data would suggest that fostering such therapeutic collaboration, in the pursuit of understanding patient concerns, requires physiotherapists to actively engage in specific ways with their patients, both verbally and non-verbally. It also suggests that patients orient to the asymmetrical nature of the encounter in particular and varied ways.

5. Limitations of the Study

This dataset size is congruent with previous studies that have used CA methodology to explore in-depth physiotherapist-patient interaction and functioning of communication practices in an outpatient musculoskeletal setting. However, it is acknowledged future research with a wider data set of physiotherapists and patients would further enhance knowledge in the field. The video-recordings were done in two settings in primary care only, therefore no representation of practice can be claimed. It is acknowledged this is a relatively small sample size and therefore the findings discussed are suggestive of the types of practices employed by physiotherapists in real-life interactions, yet perhaps not representative of all communication practices. Future research with a wider data set of physiotherapists and patients would further enhance knowledge in the field. The video-recordings were done in two settings in primary care only; therefore, no representation of practices can be claimed. It is also recognized that using video-recording might have had an influence on how participants behave (Parry, 2010) and that the presence of the lead researcher may have disrupted natural interaction.

CONCLUSION AND RECOMMENDATIONS
Although best evidence guidelines promote PCC models of communication with a greater focus on the patient’s perspective, this ‘ideal’ of best practice is not currently underpinned by detailed evidence within a physiotherapy context. This study provides empirical evidence on verbal and non-verbal communication patterns in physiotherapy practice and demonstrated a spectrum of communication styles. These styles ranged from physiotherapist-focused, where the physiotherapists predominantly controlled the interaction typically disengaging with the patients concerns and shifting the topical focus to their own agenda, to a more collaborative patient-focused approach where the physiotherapist attempted to better understand the patient’s concerns. The physiotherapist-focused style tended to be predominant in this data set. These data also highlighted that some patients are quite prepared to push their own agenda if their concerns are not met. Raising awareness of both the interactional consequences of different physiotherapist communication styles and patients’ responses may help to identify gaps between theory and practice and develop an understanding of how to incorporate principles from person-centred communication practice into physiotherapy. Physiotherapists could reflect on the how best to prioritize and enable patients to express their full agenda of concerns, and consider the impact of documentation on their eye gaze and posture, and how employing checklists of questions addressing predetermined topics, may impact on how they engage with patients concerns.
REFERENCES


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Cooper, K, Smith, B H Hancock, E 2008 Patient-centredness in physiotherapy from the perspective of the chronic low back pain patient. Physiotherapy, 94: 244-252.


Fox, B Thompson, S 2010 Responses to Wh-Questions in English Conversation. Research on Language and Social Interaction, 43: 133-156.


Maguire, P Pitceathly, C 2002 Key communication skills and how to acquire them. BMJ (Clinical research ed.), 325: 697-700.


Table 1. Physiotherapists’ characteristics

<table>
<thead>
<tr>
<th>ID</th>
<th>Sex</th>
<th>Years qualified</th>
<th>Years working in MSK*</th>
<th>Band**</th>
<th>Post-graduate Qualifications</th>
<th>BPS CPD training***</th>
<th>Extract</th>
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<tr>
<td>P01</td>
<td>M</td>
<td>&gt;14</td>
<td>&gt;14</td>
<td>Band 7</td>
<td>MSc NMS Physio****</td>
<td>2 workshops (6 days)</td>
<td></td>
</tr>
<tr>
<td>P02</td>
<td>M</td>
<td>7-10</td>
<td>7</td>
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<td>Working towards NMS MSc</td>
<td>2 workshops (6 days)</td>
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<tr>
<td>P03</td>
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<td>7-10</td>
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<td>Band 7</td>
<td>MSc NMS Physio.</td>
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<tr>
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<td>4-6</td>
<td>4</td>
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<td></td>
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<td>7-10</td>
<td>4</td>
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<td>physiotherapy specialist</td>
<td>3 workshops (9 days)</td>
<td></td>
</tr>
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<td>P06</td>
<td>M</td>
<td>4-6</td>
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<td>Band 5</td>
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<td>None</td>
<td>Featured in extract 4</td>
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<td>4-6</td>
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<td>7</td>
<td>Band 6</td>
<td>physiotherapy specialist</td>
<td>MSc in Sports Physiotherapy</td>
<td>4 workshops (12 days)</td>
</tr>
</tbody>
</table>

* (MSK) Musculoskeletal
** Bands relate to the Agenda for Change Framework (Agenda for Change Final Agreement. Department of Health; 2004)
*** (BPS CPD) Bio-psychosocial continual professional development
**** (MSc NMS) Master of science Neuro-musculoskeletal physiotherapy
Table 2. Patients’ characteristics

<table>
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<th>ID</th>
<th>Sex</th>
<th>Age</th>
<th>Ørebro* MSPSQ</th>
<th>RMDQ**</th>
<th>StartBack risk profile</th>
<th>Pain intensity ***</th>
<th>Extract</th>
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<td>69</td>
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<tr>
<td>P03</td>
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<td>95</td>
<td>8</td>
<td>Medium</td>
<td>6</td>
<td></td>
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<tr>
<td>P04</td>
<td>F</td>
<td>X****</td>
<td>77</td>
<td>4</td>
<td>Low</td>
<td>5</td>
<td></td>
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<tr>
<td>P05</td>
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<td></td>
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<tr>
<td>P06</td>
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<tr>
<td>P07</td>
<td>M</td>
<td>53</td>
<td>129</td>
<td>13</td>
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<td>8</td>
<td>Featured in extract 6</td>
</tr>
<tr>
<td>P08</td>
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<td>6</td>
<td>Low</td>
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<td>M</td>
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<td>105</td>
<td>6</td>
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<td>Medium</td>
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<td>Featured in extracts 1 &amp; 3</td>
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<td>107</td>
<td>4</td>
<td>Medium</td>
<td>6</td>
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</tr>
</tbody>
</table>

* Ørebro Musculoskeletal Pain Screening Questionnaire ranges from 0-120, a score of < 105 points indicates a low disability, that between 105 and 130 points indicates a moderate disability and that > 130 points indicates a high disability

** Roland and Morris Disability Questionnaire the scores ranges from 0 (no disability) to 24 (maximum disability)

*** Pain intensity 0 is equal to no pain and 10 is equal to worst possible pain

**** X Missing data
Table 3. Transcription convention used in extracts

<table>
<thead>
<tr>
<th>Like</th>
<th>Underlining denotes accentuated intonation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1.6)</td>
<td>Indicates a pause timed in seconds and tenths of seconds</td>
</tr>
<tr>
<td>(.)</td>
<td>Indicates a pause of less than 0.4 of a second</td>
</tr>
<tr>
<td>[Or::]</td>
<td>Square brackets indicates the point where overlap begins and ends</td>
</tr>
<tr>
<td>[Yeah]</td>
<td></td>
</tr>
<tr>
<td>again=</td>
<td>Equals signs indicate that there is no space between utterances</td>
</tr>
<tr>
<td>=so</td>
<td></td>
</tr>
<tr>
<td>mi-</td>
<td>A dash following a word or part of a word indicates that the last sound has been cut short</td>
</tr>
<tr>
<td>or::</td>
<td>Colons indicate stretched sounds</td>
</tr>
<tr>
<td>°That (.) I don’t knô:w.°</td>
<td>Speech contained within degree symbols is notably quieter than the surrounding speech</td>
</tr>
<tr>
<td>↑</td>
<td>An upward facing arrow indicates a step up in pitch</td>
</tr>
<tr>
<td>↓</td>
<td>A downward facing arrow indicates a step down in pitch</td>
</tr>
<tr>
<td>((Writing in chart))</td>
<td>Double brackets contain descriptions of non-verbal actions</td>
</tr>
<tr>
<td>&gt; &lt;</td>
<td>Indicates speeding-up</td>
</tr>
<tr>
<td>.hhh</td>
<td>In-breath</td>
</tr>
<tr>
<td>hhh</td>
<td>Out-breath</td>
</tr>
<tr>
<td>?</td>
<td>Indicates a rising intonation</td>
</tr>
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Appendix A: Data example of concerns selected for analysis

<table>
<thead>
<tr>
<th>Description of concern</th>
<th>Simplified data illustration</th>
<th>Extract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional concerns due to loss of capacity and pain</td>
<td>“I’m at home I sit down an I’m jus in agony all I wanna do is sit there and curl up in a ball”</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>“I just wanna be left alone”</td>
<td></td>
</tr>
<tr>
<td>Concerns about symptom attribution and the future consequences</td>
<td>“just a bit worried that whatever’s going on:: it’s it’s not going to improve it’s gonna get worse … what’s it going to be like when I’m older”</td>
<td>2</td>
</tr>
<tr>
<td>Emotional concerns due to loss of capacity and pain</td>
<td>“all I do now is just sit on a chair and just serve people on the sales And I get people te (.) lift .. I feel useless’</td>
<td>3</td>
</tr>
<tr>
<td>Concerns about symptom attribution</td>
<td>I fink you’re frightened to move in case it brea::ks [that] woz my main point</td>
<td>4</td>
</tr>
<tr>
<td>Concerns due to loss of capacity and pain</td>
<td>It] stops me doing a lot of things It’s get’s in your head as well Coz if it’s going to hurt (0.2) you don’t wanna do it</td>
<td>5</td>
</tr>
<tr>
<td>Concerns about symptom attribution and the future consequences</td>
<td>“In the back of my mind what he said if you don’t keep them up (exercises) it will heal ((indicates bent forward)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>“it’s the pain there all the time now”</td>
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</tbody>
</table>
### Physiotherapist agenda

<table>
<thead>
<tr>
<th>Structural features</th>
<th>Extract 1</th>
<th>Extract 2</th>
<th>Extract 3</th>
<th>Extract 4</th>
<th>Extract 5</th>
<th>Extract 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question design</td>
<td>PT uses Y/N interrogative (YNQ) (line 02)</td>
<td>PT uses concern-seeking questions (lines 03-04, 14-15)</td>
<td>PT uses <em>Wh</em>-questions (<em>WH</em>-Q) (line 01,07)</td>
<td>PT uses <em>WH</em>-I (line 05)</td>
<td>PT uses <em>WH</em>-I (lines 03-04 &amp; 19-22)</td>
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<tr>
<td></td>
<td>PT uses Y/N declarative (YND) (line 15)</td>
<td>PT uses YND (line 04)</td>
<td>PT uses YNI (line 21)</td>
<td>PT uses YNI (lines 41-42)</td>
<td></td>
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<tr>
<td>Response features (third turn)</td>
<td>PT prepares a closing of the PAT’s** sequence in the responsive 3rd turn (line 12)</td>
<td>PT prepares a closing of the PAT’s sequence in the responsive 3rd turn (line 09)</td>
<td>PT prepares a closing of the PAT’s sequence in the responsive 3rd turn (lines 06 &amp; 19)</td>
<td>PT prepares a closing of the PAT’s sequence in the responsive 3rd turn (lines 28 &amp; 30)</td>
<td>PT prepares a closing of the PAT’s sequence in the responsive 3rd turn (lines 06 &amp; 19)</td>
<td>PT uses formulations* (Lines 04-05 &amp; 16-17 &amp; 20)</td>
</tr>
<tr>
<td>Non-verbal practices during talk in which patients reveal their concerns</td>
<td>PT withdraws bodily orientation and eye gaze from the PAT (lines 12-13) and focuses on documentation (lines 14-16, Fig.1)</td>
<td>PT withdraws bodily orientation and eye gaze from the PAT and focuses on documentation (lines 06 &amp; 19-20, Fig.2)</td>
<td>PT withdraws bodily orientation and eye gaze from the PAT and focuses on documentation (lines 31-32, Fig.3)</td>
<td>PT remains bodily orientated with the PAT and maintains eye gaze (lines 04-05 &amp; 12-13 Fig. 5)</td>
<td>PT uses open-hand invitation (lines 04-05 &amp; 12-13, Fig. 5)</td>
<td>PT remains bodily orientated with the PAT and maintains eye gaze and does not use documentation (Fig. 6)</td>
</tr>
<tr>
<td>Action and topical agendas</td>
<td>PT shifts the topical agenda</td>
<td>PAT does not engage with the restricted action agenda and expands their responses and pursues their concerns</td>
<td>PT retains the PAT’S topical agenda of concerns</td>
<td>PT questions set an unconstraining action agenda for the PAT</td>
<td></td>
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</tr>
</tbody>
</table>

### Patient agenda

<table>
<thead>
<tr>
<th>Interactional consequence</th>
<th>Extract 1</th>
<th>Extract 2</th>
<th>Extract 3</th>
<th>Extract 4</th>
<th>Extract 5</th>
<th>Extract 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAT orients to the constraints of the questions restricting the PAT’S action</td>
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</tbody>
</table>

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1 Yes/No (Y/N) questions are often used to seek confirmation or denial from an answerer WANG, J. 2006. Questions and the exercise of power. *Discourse & Society*, 17, 529–548.


3 Yes/No declarative (YND) is a yes-no question, which merely invites confirmation of known information from the recipient, who is projected as an authoritative source.

4 *Wh*-question (*WH*-Q) are questions using words such as ‘what’, ‘why’, ‘when’, ‘who’, ‘where’ and ‘how’

5 The third-turn follows a question-answer pair and provides a space for feedback or evaluation.


7 Action agenda – refers to how turns of talk shape and constrain next turns of talk and refers to the kind of responsive action required of a respondent.

8 Topical agenda - refers to the topical content to which that responsive action should be addressed.
| PT pursues PAT’s work status in preference to developing the PAT’S emotional concerns | PT pursues PAT’s plans to have more children in preference to PAT’s solicited attribution concerns | PT pursues symptom behaviour in preference to developing the PAT’S emotional concerns | PAT pursues her concerns about causation beliefs making it conditionally relevant for the PT to re-engage, both verbally and non-verbally | PT actively develops the PAT’S concerns about bending his spine and the distress of having persistent pain | PT actively develops the PAT’S attribution concerns |

*PT = Physiotherapist
**PAT = Patient


Figure 1. Physiotherapist turns away from patient and starts recording and patient looks towards the chart (the arrows denote eye gaze).

Figure 2. The physiotherapist disengages with the patient’s concerns and records in the chart.
Figure 3. Physiotherapist turns away from patient and starts writing in the chart

Figure 4. Physiotherapist turns gaze back to the patient (the arrows denote eye gaze and the patient using her arm to attract the physiotherapist’s attention)
Figure 5. Physiotherapist’s open hand gesture and maintaining eye contact invites the patient to continue
Figure 6. Physiotherapist’s body orientation and eye gaze towards the patient