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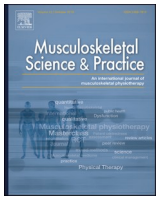

Original article

Exploring the business skills, experiences and preparedness of UK-based private physiotherapists when establishing and developing a physiotherapy business: A hermeneutic phenomenological study

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ABSTRACT

Aim: To explore the business skills, experiences and preparedness of UK-based private physiotherapists when establishing and developing a physiotherapy business.
Design: A hermeneutic phenomenological approach.
Participants: Six UK-based private physiotherapy practice owners were recruited via purposive and snowball sampling.
Methods: In-depth, semi-structured video interviews (n = 12) were audio-recorded and transcribed. Field notes, respondent validation and a reflexive diary were used. Data underwent line-by-line analysis, identifying codes and themes. Constant comparison of data, codes and themes occurred throughout. Peer review was utilised, and small sections of data and all emerging codes were independently reviewed.
Results: Knowledge acquisition: participants acquired business knowledge from training, external help, and trial-and-error approaches. Improved physiotherapy-related business training was requested. *Business skills:* Business plans were generally organic or lapsed with time. Success and timing of marketing strategies varied widely. The altruistic nature of many physiotherapists creates difficulties in requesting payments for services. *Clinical policies:* Lone working risks appeared more weighted towards protecting staff from physical abuse rather than allegations.
Conclusions: Improved physiotherapy-related business support and guidance may be beneficial. Focusing on word-of-mouth, website marketing, and establishing support networks may benefit practice owners. Greater consideration of the potentially negative implications of lone working, particularly accusations of inappropriate sexual behaviour, is recommended.

1. Introduction

In 2020 over 58,000 physiotherapists were registered with the UK Health and Care Professions Council (HCPC) (HCPC, 2020). Approximately 55% were employed within the NHS, leaving at least 45% working privately for independent providers, other employers or self-employed (CSP, 2019a; NHS Digital, 2020; NHS Education for Scotland, 2020). Developing a private physiotherapy practice typically involves balancing clinical knowledge with business skills and healthcare economics (Kapasi et al., 2016; Praestegaard et al., 2013). Insufficient business training can cause significant financial implications, impacting business success (Miron-Shatz et al., 2014).

In 2021 the Chartered Society of Physiotherapy (CSP) listed approximately 6500 private physiotherapy practices on their Physio2u site. Registration is voluntary and may not represent all private practices. The CSP advises new graduates to avoid private practice initially, and instead seek environments offering multiple specialities with structured learning and supervision (Physio First & Chartered Society of Physiotherapy, 2018). The KNOWBEST report (Minns Lowe et al., 2022) highlighted the importance of preparing graduates for additional career opportunities, including developing leadership skills. This raises questions regarding how, and at what stage in their career, physiotherapists acquire the business knowledge required for private practice ownership.

The same question can also be raised within other UK-based

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healthcare environments. Studies within the fields of osteopathy, dentistry and GPs all concluded that pre-professional training curricula required improvements in business management provisions (Freeth et al., 2012; Oliver et al., 2016; Sabey and Hardy, 2015).

Countries with different health structures offer alternative approaches to the acquisition of business knowledge. Eighty percent of Finish physiotherapy services are private. Physiotherapy training courses offer entrepreneurship modules covering leadership, organisational skills, healthcare management, and finances. From a survey of thirty Finish physiotherapy students, 80% viewed physiotherapy as a business-led environment (Laitinen and Pyoria, 2015).

In 2016 Emory University was one of a small number of American universities offering a combined physiotherapy and business administration degree. The course offers marketing, finance, management, quality, regulatory policies, and healthcare economics training (Kapasi et al., 2016; Kapasi and Davies, 2017). Emory University extrapolates successful business strategies from other industries, believing that interprofessional learning promotes innovation within healthcare (Kapasi et al., 2016; Kapasi and Davies, 2017). One example includes the adaptation of service industry lean business models, which strive to maximise value whilst minimising waste. A systematic review concluded that using lean business models within healthcare reduces costs, waste, and improves patient care (Ramori et al., 2021).

Within the UK, websites, guides, and books are available for physiotherapists opening a private practice (Butler and Champion, 2011; Co-Kinetic, 2018; Physio First & Chartered Society of Physiotherapy, 2018). However research exploring the various elements of establishing and running a private physiotherapy business is limited. Early research on expert opinion and single case studies is available regarding business planning within healthcare (Viney et al., 2000; Wassinger and Baxter, 2011). Marketing strategies within healthcare involving the use of social media has been more extensively researched through expert opinion, cross sectional, and mixed method qualitative studies (Ahmed et al., 2013; Knight et al., 2015; Pour and Jafari, 2019; Ventola, 2014; Zilber et al., 2019). Daugherty (2019) conducted the first qualitative study exploring marketing strategies within Florida-based physiotherapy clinics.

There has been no UK-based research and limited research focusing purely on private physiotherapy as opposed to general healthcare in relation to business strategies. There is a need for research into business planning, development, and marketing relating to private physiotherapy clinics, particularly within the UK. This study therefore aims to explore the business skills, experiences and preparedness of UK-based private physiotherapists when establishing and developing a physiotherapy business.

2. Methods

2.1. Design

The study adopted an interpretive paradigm using a hermeneutic phenomenological approach based on the work of Heidegger and Gadamer (Stenner et al., 2017). This approach focuses on experience and the ontological orientation of being-in-the-world, becoming hermeneutical when these experiences are interpreted (Ajjawi and Higgs, 2007; Crowther and Smythe, 2016; Stenner et al., 2017). Heidegger and Gadamer adopt a reflexive research approach, allowing the combined exploration of both the researcher's and participants' interpretations (Stenner et al., 2017). Identifying the researcher's pre-understandings is vital for a reflexive approach, see Table 1 (Stenner et al., 2017).

The University of Hertfordshire Health, Science, and Technology ECDA granted ethical approval (protocol number: HSK/PGT/UH/04122).

Table 1
Lead researcher pre-understandings.

Background	Physiotherapist Initial NHS working Moved to self-employed private practice under pressurised conditions in 2016 Established a private physiotherapy clinic under further pressurised conditions within a tight timeframe
Pre-understandings	Development of strong beliefs following negative experiences Insufficient business training available for physiotherapists Can be difficult to locate business-related resources offering sufficient specificity and depth Training available for staff management and leadership but physiotherapists lack preparedness regarding business management Marketing advice available for established clinics but lacking for brand-new clinics Trial-and-error approaches utilised frequently within clinics, often leading to financial losses

2.2. Sample

Sample size guidance within interview-based research lacks consensus and instead recommends focusing on gaining rich, in-depth data from a relatively homogenous group as opposed to frequencies (Guest et al., 2006; O'Reilly and Parker, 2013). It was estimated that six to eight participants would balance the practical limitations of a small study undertaken as part of a Masters degree with the requirement for rich data (Green and Thorogood, 2018; Guest et al., 2006).

Participants in phenomenological studies should have experience of the investigated phenomenon, promoting rich data set generation (Starks and Trinidad, 2007; Yuksel and Yildirim, 2015). Inclusion criteria were being an HCPC registered physiotherapist; being awarded an undergraduate or postgraduate physiotherapy-related degree from a UK-based university; and having established a UK-based private physiotherapy practice. Exclusion criteria included anyone known to the researcher; anyone not involved in the initial development of a practice.

The lead researcher (EW) identified potential participants via their practice websites, contacting them via email with a comprehensive study information sheet which did not include personal goals or background on the lead researcher. Potential participants were invited to invite others to participate (Bryman, 2016; Green and Thorogood, 2018).

Participants provided written informed consent prior to data collection. Recruitment occurred between April and November 2020. Data collection occurred between May 2020 and January 2021.

2.3. Interviews

Following a literature review, the lead researcher (EW) developed a semi-structured interview guide with input from their supervisor (CML) (Ramsook, 2018). The guide was arranged in a graphical format based on the A-scheme template as opposed to a vertical list (Aspers, 2009). This approach allowed the researcher to easily move between topics depending on participants' responses, maintaining awareness of topics still requiring attention (Aspers, 2009). Responses were probed to ensure adequate depth (Hermanowicz, 2002). The guide was piloted on the first two participants, see Table 2 for example questions. Interview feedback was provided by the supervisor (CML) based on transcripts of the first participant. Whilst the core content of each interview guide remained consistent, there was superficial tailoring to each guide depending on the participant's circumstances relating to clinic size/age/business partnerships.

Covid-19 restrictions meant interviews were conducted via video at a time convenient for the participant (Ramsook, 2018). Only the participant and lead researcher (EW) were present during interviews. Interviews were audio recorded and the anonymised data transcribed

Table 2
Interview question examples.

Interview Question
(Participants were able to introduce new topics or avenues of discussion at any time throughout the interview and conversational prompts were used when required to maintain flow)
Tell me about how you approached marketing your clinic? (follow-up questions to explore what went well/did not go well, website development and social media presence, and whether marketing strategies were self-researched or developed with help from external sources).
Tell me about how you developed the business plan for your clinic? (follow-up questions to explore when the business plan was developed and whether any external help was used to develop it).
Have you had any training related to business management? (follow-up questions to explore when, where, whether the training was received during a physiotherapy-related course and whether the training was adequate).
Looking back, do you feel there are any skills, experiences or training you would have benefitted from prior to opening your physiotherapy clinic?

verbatim by the lead researcher (EW) with the assistance of otter.ai software (Green and Thorogood, 2018). Field notes, memos and a reflexive journal were used, and the lead researcher's supervisor (CML) provided feedback on interview technique (Hermanowicz, 2002; Ramsook, 2018).

Gadamer believed that a participant's understanding of the topic changes over time, requiring two or three interviews with each participant (Fleming et al., 2003). Participants underwent two interviews. First interviews lasted between 39 and 73-min, with a mean of 55-min. The second occurred between three-seven-weeks later, lasting between 23 and 40-min long, with a mean of 28-min. (Fleming et al., 2003; Hermanowicz, 2002). Following the second interview there was the option of further clarification via email, to assist in both the participants' and lead researcher's (EW) development of understanding (Fleming et al., 2003). No email clarification was required.

Table 2 is part of a larger interview guide also containing questions relating to establishing and running a private physiotherapy clinic which will be reported elsewhere in due course.

2.4. Data analysis

Hermeneutic inquiry involves moving between parts of the text and the whole text. The lead researcher (EW) progressed through cycles of thinking, writing, and reading, combining data interpretations with their own experiences to develop new perspectives (Crowther and Smythe, 2016; Crowther et al., 2017). This cyclical pattern is termed the hermeneutic circle and the resultant shared understandings creates a fusion of horizons between the experiences of both the researcher and participants (Crowther et al., 2017; Suddick et al., 2020). Horizons are open-ended, making fusion ongoing and evolving with endless variations, meaning the truth can never be fully revealed (Crowther et al., 2017; Spence, 2017). The lead researcher (EW) instead aimed to reveal insights into the phenomenon (Ajjawi and Higgs, 2007; Crowther et al., 2017).

Table 3 outlines the data analysis process. The iterative and reflexive nature of hermeneutic data analysis meant that sampling, data collection and initial descriptive coding occurred concurrently. Principal analyses helped guide subsequent sampling decisions regarding the aim for maximum participant variation (Busetto et al., 2020; Moser and Korstjens, 2018). Participant availability influenced the timing of data collection and analysis. Participants 1–3 were interviewed and coded first, then participants 4–5, then participant 6. Initial coding for first interviews occurred prior to conducting each corresponding second interview. Follow-up interview guides were therefore unique to each participant, allowing further probing into initial findings. Following the principles of hermeneutic cycling, this strategy also allowed initial findings to be discussed within second interviews, promoting a deeper shared understanding (Ajjawi and Higgs, 2007; Fleming et al., 2003). None of the participants contested the provided summary and most felt it was a useful refresher owing to the gap of three to seven weeks between interviews.

Table 3
Data analysis (Ajjawi and Higgs, 2007; Fleming et al., 2003; Ho et al., 2017; Linneberg and Korsgaard, 2019).

Step	Actions	Reasons
1	Familiarisation of all data by the researcher: Audio recordings listened to. Transcriptions read. Audio recordings transcribed verbatim.	To gain an initial understanding of the whole text. To maximise accuracy and reliability. To assist with interview technique reflection and improvement. Data emersion assisted the researcher in moving beyond the transcription words to uncover deeper meanings.
2	Initial coding using an inductive coding approach: Every sentence was investigated to explore their meanings. Transcripts were annotated descriptively with individual words or short summaries to capture the essence of each segment.	To help capture the data's complexity and diversity. Not constrained by pre-existing theoretical frameworks. Driven by the data, allowing the researcher to better explore the ontological possibilities. Point of note: prior experiences means that coding can never be completely inductive, there will always be a small element of deductive.
3	Second coding: Initial descriptive codes refined and organised into code categories based on their content and meaning. The researcher explored emerging patterns, grouping conceptually similar codes to create sub-themes with the assistance of NVIVO 12 Pro Software. oA total of 83 initial code categories were identified.	Owing to the volume of data, initial code categories were divided into two journal articles covering different result topics.
4	Initial theme development: Identified from the code categories pertaining to the current article.	To develop a rich and detailed understanding of the investigated phenomenon (see Fig. 1).
5	Returning to the text: Constant movement between the whole text, parts of the text, codes and categories occurred throughout, following the hermeneutic cycle.	Relating every sentence to the meaning of the whole text expanded the sense of the whole text, and in turn the meaning of each part.
6	Identification of quotes: Quotes representing the shared understanding of both the researcher and participants were identified.	To provide the reader with insights into the discussed phenomenon.

Strategies promoting rigour included a reflexive journal, peer review, field notes, respondent validation, a code-recode audit on one transcript, and constant comparison of data, codes, and themes (Barbour, 2001; Koch, 2006; Ramsook, 2018; Stenner et al., 2017). The researcher's supervisor (CML) independently reviewed small sections of data and all emerging codes (Barbour, 2001). Upon submission and completion of her Masters degree (EW) the supervisor (CML) read all transcripts to provide further nuance and insight, and discussed findings.

3. Findings

Of the 114 physiotherapists invited into the study, ten offered to participate. Four withdrew prior to the first interview due to Covid-19 time-constraints. Six participants were recruited, see Table 4 for

Table 4
Demographics.

Participant (P)	Male/ Female	Age	Prior Career	Location	Undergraduate Degree	Postgraduate Degree	Practice Opening	Experience Prior to Opening	Sole Physiotherapist	Rooms	Admin Staff	Business Training
1	Male	43	None	City	Physiotherapy BSc Hons Ireland 1998	Sports and Exercise Medicine MSc UK 2003	2004	6 years	No	4	Yes	No
2	Female	51	None	Rural	Physiotherapy BSc Hons UK 1990	None	2017	27 years	Yes	1	No	No
3	Female	50	Dancer	City	Physiotherapy BSc Hons UK 1996	Polestar Pilates Instructor 2003, 3 x Physiotherapy MSc modules UK 2013–2015	2003	7 years	No	3	Yes	No
4	Male	32	None	City	Physiotherapy BSc Hons UK 2009	None	2018	10 years	No	3	No	A-level
5	Female	63	None	Rural	Physiotherapy UK 1979	Sports Medicine MSc UK 1998	1989/ 2009	6 years	No	3	Yes	No
6	Female	53	Typist	City	Physiotherapy BSc Hons UK 2004	1 x Physiotherapy MSc module UK 2019	2009	5 years	Yes	1	No	B-tech business studies 1985

demographic details.

Analysis revealed three connecting themes, see Fig. 1. The business knowledge participants acquired directly influenced the development and execution of business skills and clinical policies. Topic findings are presented below with supporting quotations (example Q1) found in Table 5. Each quotation lists the corresponding participant followed by either 'a' indicating the first interview or 'b' from their follow-up interview.

3.1. Knowledge acquisition

Adequate business knowledge is essential for establishing a successful physiotherapy clinic (Wassinger and Baxter, 2011). Participants acquired business knowledge from three sources.

3.1.1. Business training

Only two participants reported official business training, instead relying on local business-related courses, which five participants found to be beneficial. However, courses generally targeted product-related instead of service-related businesses, necessitating the extrapolation of information to physiotherapy environments (Q1).

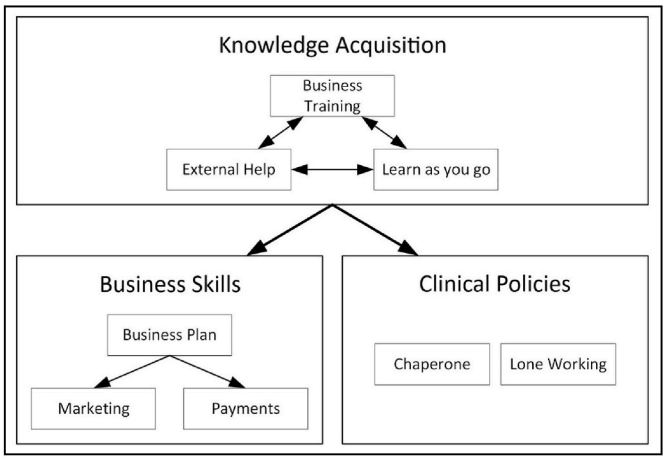

Fig. 1. Theme relationships.

Four participants struggled to locate sufficient information, reporting a *"lack of available resources"* (P4a), *"there is no … here's the book and you've got to tick this box and* that *box"* (P1b). Everyone except participant six expressed a desire for additional physiotherapy-related business training *"I wish that … as part of our training … there was a business module"* (P4b), (Q2-Q5).

However, training may not translate into skill, and participants reported a lack of business experience (Q6). Experience was key for all participants, including knowledge of task delegation and *"knowing who to call"* (P5a).

Four participants struggled balancing physiotherapy and business roles: *"I'm a physio before I'm a businessperson"* (P6a), whilst one participant highlighted the ethical challenges, suggesting an alternative solution (Q7).

3.1.2. External help

The benefit of business advice from professional organisations was viewed as variable by participants. Two participants felt *"X (organisation) have given advice where we've needed it"* (P5a), however others commented more negatively *"X (a private provider/organisation) … actually wasn't worth paying into"* (P6a), (Q8-Q9).

Task delegation was a necessity. Everyone employed accountants to *"make sure it's done properly"* (P1b), and outsourced websites. Four participants *"employ somebody"* (P5a) to manage their website, the others enlisted help from *"a friend"* (P1a) or family. Learning website skills appealed to three participants, who now *"upgrade* [the website] *ourselves"* (P3a). The others felt *"I … could have done it myself … it's not something I have … any interest in"* (P6b).

Support structure was vital, with all participants drawing on family *"husband … is a lawyer"* (P5a), *"partner's dad is a businessman"* (P4a), and friends/colleagues *"I have a lot of people who are entrepreneurial"* (P1a) to further their business knowledge.

3.1.3. Learn as you go

The third knowledge acquisition method was *"learning … as we go"* (P4a). Learning was an ongoing and unpredictable process with a trial-and-error quality *"some surprises and I'm still learning"* (P2a), (Q10-Q12). Every participant relied on self-directed research: *"I did it myself"* (P5a), *"you have to figure out for yourself"* (P1b).

Previous private work provided business insights for most participants "I*'ve learnt … from being in … other practices"* (P2a), and being a

Table 5
Interview quotations to reflect the study codes.

Topic	Quotations
Business Training	Q1 *"They weren't geared up to … what I was doing … they were more aimed at people that … had a product or … made things … but it did actually give me the confidence"* (P6a) Q2 *"Even at undergraduate level, to put in just a module … Everything is predicable … how businesses react to things, and all the various rules of economies … And if we knew some of those things going in … you would be better prepared for what's in front of you"* (P1a) Q3 *"I would have liked it … if the CSP were running a course on how to run your business … to have business training from a very recognised source* (P2a) Q4 *"Perhaps a marketing weekend … and a finance weekend"* (P3a) Q5 *"I sometimes regret not having looked at doing an MBA … that would have … perhaps made me … more business orientated"* (P5b) Q6 *"We … had zero business management experience other than just speaking to people … who own their own businesses"* (P4a) Q7 *"This … ethical dilemma of being a clinician … and then … running a business. It would be good to … have a businessperson run the business … I can take care of the clinical side of things and be involved in some business decision making, but I would want this MA … person behind it who is … comfortable with making … the harder decisions. They're not unethical, but you … think I shouldn't be out there blowing my own trumpet because that's unethical"* (P1a)
External Help	Q8 *"I contacted X (a professional organisation) … they were reluctant to give me anything verbally"* (P2a) Q9 *"X (a professional organisation) were lacking in the private practice world environment. X (A private provider/organisation) were a bit better but still maybe not as best as they could have been"* (P4a)
Learn As You Go	Q10 *"Having some planning is ideal, but … sometimes learning on the job is ok too"* (P3a) Q11 *"it's a leap of faith, trying to make it happen, and then learning by your mistakes along the way"* (P1a) Q12 *"Every day's a school day … it's stressful, but it's fun …* [I've] *obviously made some mistakes … and I'm learning from that"* (P4a) Q13 *"You start spending money on things you* ***think*** *you should be spending money on, with no real evidence to back it up … You just think … this is what other businesses are doing, therefore I should be doing this"* (P1a)
Business Plan	Q14 *"In the early years, we did try to do it, but it always seemed to change anyway. And then we … slipped a bit … I know it's not very professional"* (P5a)
Marketing	Q15 *"Leaflet drops … was written off by a lot of people … but actually it worked really … well"* (P4a) Q16 *"What you would perceive to be the referrers, the GPs, and the consultants, …they're not the majority … they're referring into the NHS"* (P1a) Q17 "[patients are] *coming from within 2 miles of where you … work, they come because you are convenient, that's where they spread the word-of-mouth"* (P1a)
Payments	Q18 *"They … started to get ridiculous in the things that they were asking for"* (P2a) Q19 *"Their terms … changed, they were wanting to negotiate prices more"* (P3a) Q20 *"Probably the hardest bit of private practice … is initially getting over that … fear of going 'can you pay me now?'"* (P4a) Q21 *"there's still this … feeling that if you've got the knowledge to help somebody you should … be able to give it to them for free, which is ridiculous … because it's not free in the NHS, we just pay for it in a roundabout way"* (P3b) Q22 *"Despite me doing this for very many years … I can't always ask, so I am still … a bit ridiculous at times"* (P3a) Q23 *"People either have to get their head around, or if you have a receptionist that can do it … it's a little bit more comfortable for everybody"* (P1a)
Chaperone	Q24 *"When they're young … the parent wants to be in … when they're a little bit older, the parent might feel that the younger person wants the privacy. We've just always said we expect you to be in the building" (P3a)* Q25 *"Clinically vulnerable adults … we do make sure that they can … come with somebody who is able to support them"* (P4a) Q26 *"It was just a question of them telling us what they needed for it to be right for them"* (P2a)
Lone Working	Q27 *"If they* [female physiotherapists] *are here on their own … they have the opportunity to not let somebody in, they have access to calls, they have access to getting out of the building"* (P1a) Q28 *"When I've had patients who have … become … more volatile, I feel I can de-escalate that quite nicely"* (P4a) Q29 *"it's trying to get … physios to understand that these patients … are often … feeling vulnerable … they can … come across … more hostile than is the case"* (P1a) Q30 *"I … let somebody know where I'm going and when I'm going to be back … I'd always have my mobile phone"* (P2a) Q31 *"a male … physio colleague, was accused of touching a patient. He professed he was innocent and then he took his own life … there's always that at the back of my mind"* (P5b)

self-employed associate was *"a good route in … because … you … get an idea of what's required … to run a business"* (P6a). However one participant highlighted the false economy of copying others without appropriate research (Q13).

3.2. Business skills

Business knowledge influenced business plan creation, in turn influencing marketing and payment strategies.

3.2.1. Business plan

Business plans were generally seen as an inconvenience. Four participants created plans, however two were *"developed primarily because the bank was asking for it"* (P3a). Only one participant commented positively and felt the process *"gave us an understanding of how businesses run"* (P4a). Plans were otherwise *"organic … with some logic"* (P1b) or had *"not been particularly documented and stuck to. It's … morphed more than planned"* (P3a). One participant highlighted their lapsed good intentions (Q14).

The two without official plans commented *"I didn't … have a massive plan"* (P6b), or that they had *"an idea of a target number of patients to see per week"* (P2a) but no plan for achieving this.

3.2.2. Marketing

Successful marketing strategies varied, however everyone reported two key methods. The first was *"word-of-mouth"* (P5a), which many attributed to physiotherapy being *"so personal"* (P2a), *"focus on delivering the care, let the patient be your advocate"* (P1a). The second was *"the website"* (P2a).

Other successful strategies included Google Ads *"to make … physios busier if they're … quiet"* (P1a), newsletters *"it's a reminder that … you exist"* (P3b), merchandise *"I've got a sweatshirt with my brand on"* (P2a), *"visual awareness of the clinic"* (P3a), and networking *"I had … connections through rugby and tennis"* (P5a). However, *leaflet* drop, magazine, local directory, and GP advertising provoked mixed responses *"I don't do any paper advertising; I think it's a complete … waste of time"* (P1a), *"If doctors trust you … they'll refer to you"* (P5a), (Q15-Q16). Marketing location was a fundamental factor for some participants (Q17).

Marketing attitudes varied. Two participants outsourced marketing: *"we are physiotherapists … not marketing gurus"* (P4b). The others adopted trial-and-error approaches *"I … fell into lots of traps of advertising"* (P6a), *"made the classic mistakes"* (P1a); or described their marketing as *"poorly"* (P3a) or *"lazy"* (P2a) due to *"time factor"* (P2a), and *"not … knowing … what would be effective … worrying … about financial outlay and it … not bringing in … patients"* (P3a).

On *reflection*, five participants felt their website required more input. One participant highlighted the evolving nature of websites: *"still pictures don't … work anymore. Everyone's moving to moving picture"* (P4b). They believed staff and clinic videos promoted *"familiarity"*, allowing patients to *"relax into that environment straightaway"* (P4b). Three participants felt they should utilise *"more social media"* (P2b). However

some commented *"the amount of advertising … I … haven't had to do surprised me"* (P2a) but reflected *"I … would have done more advertising at the start to get it going faster" (P2a)*.

3.2.3. Payments

Payments were taken via insurance companies or directly from patients, where *"the majority of people pay by card"* (P3a). One participant avoided cheques *"because they're such a pain"* (P2a). Most participants used insurance companies initially because it *"felt like … a good way to build the practice"* (P3a). However five participants have since reduced or *"phased them all out"* (P6a) owing to issues with payments and paperwork *"they are just very … bad payers"* (P6a), (Q18-Q19).

The difficulties physiotherapists experience taking payments was highlighted by everyone *"most people are not very good at talking about money"* (P2a), (Q20) and ascribed to training gaps *"we're never taught in all … our studies"* (P4a). Participants reported *"always feeling guilty"* (P5a) and felt it was *"a big problem with physios who … don't always value their service within the private sector"* (P1a). Working within an NHS environment fostered this mindset (Q21). Whilst some improved *"now I'm … matter of fact about it"* (P6a), others maintained their dislike (Q22), employing receptionists as a solution (Q23).

3.3. Clinic policies

The CSP recommend private practices develop various policies, of which chaperone and lone working are two (CSP 2013).

3.3.1. Chaperone

Chaperoning was used by all participants for paediatrics *"I would never see a child on their own"* (P6a). However, flexibility was employed for older children depending on competency (Q24). Uptake by adults was more varied. Two participants commented *"I don't think I've ever had an issue where it's* [adult chaperoning] *come up"* (P5a). Others reported uptake by clinically vulnerable adults (Q25) or for cultural reasons (Q26).

3.3.2. Lone working

Participants raised three areas of concern regarding lone working. Every participant discussed the risk of physical harm, with most highlighting female staff safety (Q27). Precautions included *"cameras"* (P6a), *"video entry system"* (P3a), *"panic button"* (P5b), colleague support, and *"gut feeling"* (P2a). Generally, participants had *"not had problems with violence or intimidation"* (P3b) and felt able to prevent escalation (Q28). One participant believed staff education was key to managing difficult situations (Q29).

Those lone working from home relied on family *"my husband works from home"* (P6a), and neighbours *"nothing moves that my neighbours don't see"* (P2a), although one participant expressed concern that *"everybody knows where you live"* (P6b). Home visits were deemed *"more worrying"* (P2a) by some, prompting additional safety measures *"I won't do a home visit to someone … capable of getting a taxi"* (P6B), (Q30).

Two female participants discussed the risk of patient accusations against practitioner behaviour, rating concerns for male staff highest *"I've felt that I've particularly needed to take care of the male physios"* (P3b). One recalled a difficult experience in a previous clinic (Q31).

Another participant expressed concerns over patient safety relating to *"the knowledge aspects"* (P4a) of junior staff lone working, feeling staff may lack adequate experience to independently deal with complex presentations or *"spinal red flags"* (P4a).

4. Discussion

This study explored the business skills, experiences and preparedness of private physiotherapists establishing and developing a physiotherapy business. Business plans, marketing strategies, taking payments, and clinical policies are four of the key areas Physio First recommend practitioners address when establishing a physiotherapy business (Physio First & Chartered Society of Physiotherapy, 2018). This study explored how participants acquired business knowledge and how this knowledge impacted their ability to address the aforementioned areas. Five out of six participants felt additional physiotherapy-related business training would be beneficial. Every participant felt confident discussing clinical policies, however their preparedness to address business plans, marketing and payments varied.

This is the first UK-based study exploring the business skills and experiences of private physiotherapy clinic owners. Research in other countries is also limited. In a qualitative case-study design involving sixteen participants over three focus groups, Davies et al. (2016) highlighted that Australian physiotherapists with under five-years experience lacked adequate business training to deal with matters such as finances, administration and marketing. Despite between five- and twenty-seven-years experience prior to establishing their clinics, current participants reported difficulties addressing these areas. Lear et al. (2016) surveyed 273 American practitioners from five health professions, including practice owners (numbers unspecified). Of these, 66% worked within small private practices. Although physiotherapists were not surveyed, 87% of participants felt that additional business knowledge would be beneficial. Current results suggest a requirement for further physiotherapy-related business training. When combined, results imply that suboptimal business training may extend to other health professionals and countries.

The KNOWBEST Report (Minns Lowe et al., 2022) highlighted the need for the professional body to work with independent providers and private practitioners for the provision of student placements to alleviate the growing demand for NHS placements. Increased provision of placements within these areas could provide valuable opportunities for students to acquire business skills and knowledge of best practices.

Barring participant four, the development and maintenance of structured business plans beyond securing financial support was not prioritised. Plans generally adopted an 'organic' format. Business plan and performance relationship evidence is variable. Brinchmann et al. (2010) conducted a comprehensive meta-analysis of 46 studies investigating business planning within small firms. The study concluded that business plans were more beneficial for established than new firms, proposing that basic plans might suffice initially. Fernandez-Guerrero et al. (2012) analysed data from 2401 Spanish service companies. Eight percent were grouped within health, veterinary, or social care (details unspecified). The study determined that business plan quality did not predict success or survival rate, and experience did not significantly increase survival predictability. Osiyevskyy et al. (2013) conducted a cross sectional empirical study using secondary data from an electronic businessowner survey of 393 small or medium businesses, of which 3% were UK-based and 7% healthcare (details unspecified). This study instead concluded that combining an inspiring business vision and marketing plan showed positive correlations with growth rates, reporting a 42.9% compared with a 17% growth rate with/without these factors respectively. Current study participants had successful clinics; however it is unknown how many clinics fail to survive. The research therefore raises questions regarding the optimum level, style, and timing of business planning for private physiotherapy clinics.

Every participant felt unprepared to address marketing strategies during clinic development. Participants wasted resources via trial-and-error, lacked marketing to prevent possible losses, or outsourced marketing. Successful strategies varied, however every participant felt word-of-mouth and websites were key. Results align with Daugherty (2019) who listed these as two of the five key marketing strategies utilised by five small Florida physiotherapy business owners. Many studies have highlighted word-of-mouth importance, particularly electronic advertising, and suggest that brand awareness, service quality and customer loyalty can positively influence word-of-mouth (Daugherty, 2019; Godey et al., 2016; Krishnamurthy and Kumar, 2018; Mohtasham et al., 2017; Yaman, 2018; Zilber et al., 2019). Daugherty (2019)

discussed the marketing focus shift from referral sources to managing current patient relationships once businesses became established. Current participants echoed this finding, reporting reduced requirements for active marketing with established reputations. This implies that physiotherapy-specific marketing-strategy guidance may be most beneficial during early clinic development.

The current study touches on the altruistic nature of physiotherapists and the difficulties regarding taking payments for services. The CSP lists altruism, through prioritising the interests of individuals, as an underpinning value members should demonstrate (CSP, 2019b). Whilst participants felt NHS employment fostered this mindset, they later struggled transitioning into private practice and charging for services. One participant commented that many physiotherapists do not value their service within private practice. Tolan (2016) surveyed 184 NHS physiotherapists to investigate value. Business expenditure costs were rated as lowest priority by 65%, whilst 55% ranked clinical effectiveness as highest priority. Results indicate that physiotherapists are more concerned with clinical outcome, trending towards altruism. However, the low priority of business expenditure could negatively impact service sustainability (Tolan, 2016). Current study participants highlighted their preference for further training regarding taking payments.

Chaperoning was discussed from the patient perspective and lone working from preventing physical violence against staff. Only two female participants discussed the risks of patient accusations against lone working practitioners. The CSP classifies lone working and male physiotherapists treating female patients as higher-risk situations (CSP, 2013). The HCPC received 74 complaints against physiotherapists between 2019 and 2020, with 32 progressing to full hearing. All 32 allegations were against male physiotherapists (M. Noel, personal communication, May 19, 2021). The CSP has highlighted the increasing risks all physiotherapists are facing from allegations caused by a move towards a compensation culture (CSP, 2013). The CSP particularly emphasised the increased vulnerability of private-practice male physiotherapists, providing guidance on chaperone provision, especially during first appointments (CSP, 2013). However further research may be required into how physiotherapists are perceiving and addressing this threat in practice.

The lead researcher's (EW) pre-understandings developed throughout the study. The researcher (EW) still believes there is scope to improve physiotherapy-related business training, but appreciates that experience is vital, and adequate training might not translate into skill or experience. Whilst learning on the job is acceptable, the study demonstrated considerable trial-and-error tendencies which the researcher believes may reduce with improved training. Whilst insufficient business training did not prevent participants establishing successful businesses, the researcher (EW) believes that improved resources could establish clinics faster and minimise the financial implications of failed trial-and-error approaches.

4.1. Limitations

Covid-19 restrictions impacted data collection and prevented face-to-face interviews. Virtual interviews created technical issues. One participant took delivery of a package during the interview, another felt uncomfortable using video, and three interviews were briefly interrupted by video/audio-feed failures. Participants repeated inaudible sections; however, the interview flow was disrupted and sections were not repeated word-for-word, implying that participants had paraphrased or altered answers. The impact interrupted flow has on rapport varies amongst studies; some report negatively whilst others reported that overcoming technical issues creates a positive bonding effect (Krouwel et al., 2019; Seitz, 2016; Weller, 2017). Rapport did not appear adversely affected in the current study.

Recruitment took considerably longer than expected owing to Covid-19. Physiotherapists stated pandemic-related time implications when declining participation. Low recruitment uptake weakened the intended purposive nature of sampling. Later recruitment moved towards convenience sampling to obtain enough participants. Despite the unpredictability of convenience sampling, the study achieved a wide range of participant demographics and rich data (Etikan et al., 2016). However, the self-selecting nature of participants means the sample may not be typical of all physiotherapy practice owners (Sharma, 2017). In addition, views from these self-selected participants may differ significantly from the views of the professional organisations being discussed, who have not had their view explored and reported to date. This study does not contain viewpoints from all relevant stakeholders. A larger sample size, or expanding the project, was unachievable within an unpaid project constrained to the limited timeframe of a Masters degree program, with the addition of Covid-19 restrictions. Research including the views of professional organisations would provide a more nuanced picture than this project alone.

Finally, the lead researcher's (EW) qualitative inexperience may have impacted the quality of data collection and analysis. However the substantial qualitative experience of the researcher's supervisor (CML) aimed to minimise this impact.

5. Conclusion

This research suggests that improved physiotherapy-related business support and guidance may be beneficial for physiotherapists. Focusing on word-of-mouth, website marketing, and establishing support networks may benefit practice owners. Greater consideration of the potentially negative implications of lone working, particularly accusations of inappropriate sexual behaviour, is important. Areas identified for future research include exploring the transferability of the study findings, research to find out how and when UK-based physiotherapists would prefer to access business training, what such training should consist of to be considered effective and the optimum style and timing of private physiotherapy business plans.

Declaration of competing interest

The authors report there are no competing interests. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.msksp.2022.102694.

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