The Tipping Point for Engagement in Professional Supervision by Physiotherapy Private Practitioners

Laura Holder *MHSc (Hons), PGDip, BSc (Hons)*
Physiovision, Auckland, New Zealand

Kiri Windross *BMS, GradDip (Psychology)*
Postgraduate student, University of Auckland, Auckland, New Zealand

Nicola M. Kayes *PhD, MSc (Hons), BSc*
Director, Centre for Person Centred Research, Auckland University of Technology, Auckland, New Zealand

ABSTRACT

The aim of this study was to explore the experience and perspectives of physiotherapists working in private practice in New Zealand regarding their decision to engage (or not) in professional supervision (PS). There is a scarcity of research on PS in the physiotherapy profession, despite recommendations by Physiotherapy New Zealand that all physiotherapists should engage in this professional development activity. Using a qualitative descriptive methodology, eight participants were interviewed who identified as either (1) having never experienced PS, or (2) previously but no longer engaged in PS, or (3) currently engaged in PS. Thematic analysis was used to analyse the data. Four themes were constructed: (1) PS and the capitalistic lens, (2) PS is not normal, (3) professional identity and vulnerability, and (4) the relationship in the supervisory context. The drive for increased productivity, cost-effectiveness, and, ultimately, profit continues to dictate practice habits. PS can require the practitioner to share uncertainties about practice, creating a tension in maintaining one's professional identity and credibility which can deter engagement. Balancing professional identity and vulnerability requires the supervisor to create a safe space for recipients to navigate these tensions and sustain their engagement in the process. A significant shift in practice habits and the value ascribed to PS would be required before PS is likely to be normalised as part of physiotherapy private practice culture.

Holder, L., Windross, K. & Kayes, N. M. (2020). The tipping point for engagement in professional supervision by physiotherapy private practitioners. *New Zealand Journal of Physiotherapy, 48*(1), 29–36. https://doi.org/10.15619/NZJP/48.1.04

Key Words: Professional Supervision, Private Practice, Thematic Analysis, Physiotherapy, New Zealand, Vulnerability, Professional Identity, Support

INTRODUCTION

Professional supervision (PS) is extensively used by those in the helping professions (Davys & Beddoe, 2010; Ducat & Kumar, 2015; Hawkins et al., 2012). PS is a collaborative process undertaken with a trusted colleague which uses protected time for the practitioner to explore their work reflectively, resulting in professional growth while ensuring consistency, quality, and safety of the service they provide to their patients (Physiotherapy New Zealand, 2012; Proctor, 2001). It has been shown to reduce workplace stress, increase job satisfaction, and assist work performance (Carroll & Gilbert, 2011; Erera & Lazar, 1995). For many health professions (i.e., occupational therapists, psychologists, and social workers), PS is mandatory, but this does not apply to physiotherapists. Nonetheless, Physiotherapy New Zealand (PNZ) recommends that all physiotherapists engage in PS regardless of their experience or work setting (Physiotherapy New Zealand, 2012), albeit on a voluntary basis.

Whilst PS is more commonly used by physiotherapists in a hospital-based setting (Wepa, 2007), the uptake by physiotherapists who work in private practice is less prevalent. It is thought that less than one-third of private practitioners engage in PS (Holder, 2014). Furthermore, there is an absence of literature focusing on PS in physiotherapy, with the exception of literature investigating clinical supervision with references to PS (Hall & Cox, 2009). This could in part be due to terminology and conflation of PS with clinical supervision. Butler and Thornley (2014) clearly identified the critical difference between clinical supervision and PS, and the need to separate these activities. Clinical supervision focuses on the needs of clients (not the physiotherapist) and is frequently delivered by a senior colleague associated with the supervisee's daily work (therefore not a neutral perspective) by teaching physical (not emotional) skills about client management. With a dearth of literature on PS, we have limited understanding of factors influencing the decision to take up PS by physiotherapy private practitioners in New Zealand.

The aim of this research was, therefore, to address this gap by exploring the experiences and perspectives of physiotherapists working in private practice in New Zealand regarding their decision to engage (or not) in PS.

METHODS

Design

We drew on qualitative descriptive methodology (Sandelowski, 2010). This is a naturalistic approach to inquiry, which aims to develop insights into a phenomenon of interest (in this case, the decision to engage in PS) through seeking a rich description of events and accessing the meanings participants ascribe to those events. Three distinct groups of physiotherapists who worked in private practice were interviewed: (1) those who had never experienced PS; (2) those who had previously but are no longer engaged in PS, and (3) those who were currently engaged in PS. Data interpretation was underpinned by social constructionist epistemological assumptions (i.e., that people construct meaning through their interactions with the world and therefore that realities are multiple and varied, and both researchers and participants play a critical role in data construction and interpretation). The primary researcher (LH) is a physiotherapist with over 20 years of experience in private practice. LH is trained in and provides PS to physiotherapists in New Zealand. She believes in the inherent value of PS for physiotherapists, and this perspective was fundamental to her interest in this research topic. Ethics approval was gained through the Auckland University of Technology Ethics Committee (reference number 16/161) prior to commencement of the study.

Recruitment and sampling

Physiotherapists were eligible to take part if they self-identified as fitting into one of the three categories described above and were working in a private practice setting. Purposeful sampling was used to ensure the inclusion of people across all three categories and to capture diversity on key characteristics, such as gender, work experience, and cultural background. Participants were recruited using online platforms (e.g., LinkedIn and PNZ branch Facebook pages) and through professional networks (e.g., managers of physiotherapy practices and PNZ branch meetings). Advertisements invited people to participate in a study exploring views on PS from the perspective of physiotherapists working in private practice. Those interested in taking part were invited to contact the research team directly or provide their contact details to receive a full participant information sheet via email. They were then contacted to arrange a time for them to take part in an individual or focus group interview, depending on what was most logistically viable and the availability of others in the same category to make up a group.

Data collection

Data were collected using individual or focus group interviews held on the Auckland University of Technology North campus. The location was selected as it was convenient and regarded as a neutral location, independent from participant workplaces. Focus groups were used when a number of people in that same PS category were available. Focus groups are a useful method of data collection to explore collective perspectives of participants and illuminate agreement and inconsistencies among the group members (Gerrish & Lacey, 2010). Where a focus group was not viable, individual interviews were undertaken depending on participant availability.

Focus group and interviews were led by the third author (NK, who has extensive experience in qualitative and rehabilitation research, including skills in individual and focus group interviewing) following a semi-structured guide. As LH had a pre-existing supervisory relationship with some participants, it was thought that her involvement might influence their responses. A second independent person with experience in focus groups and PS with physiotherapists, provided support as co-facilitator, including taking note of any relevant group dynamics and non-verbal communication. The semi-structured guide helped to keep discussion focused on the phenomenon of interest, while being open enough to be responsive to discussion threads raised by participants. Discussion topics included clarifying understanding of what PS entails, its perceived value (or not), what helps or hinders engagement in PS, and reasons for taking up or withdrawing from PS. Example questions are included in Table 1. To generate a richer understanding of the research question, further questions were used to explore the answers given. The sessions were audio recorded and transcribed verbatim.

Table 1
Example Interview Questions

Topic	Interview questions/guideline
Understanding of PS	What do you understand by the term PS? What do you understand as to the purpose of PS? What is your understanding of how you would access PS? What kinds of topics could you imagine you would discuss in PS?
The value of PS	Who can benefit most from PS? What do you consider to be of value from engaging in PS? Can you think of some examples of how PS may impact your practice? What would help increase uptake of PS?
Barriers to PS	What are the reasons/barriers as to why physiotherapists maybe reluctant to engage in PS? What has stopped or prevented you from using PS currently?
Other	Is there anything else that you wanted to explore?

Note. PS = professional supervision.

Analysis

Data were analysed thematically, drawing on Braun and Clarke's (2006) six-stage process. This process of analysis included familiarisation of the transcripts and audio recordings, coding at a semantic (descriptive) and latent (interpretive) level, identifying key ideas, creating candidate themes, refining candidate themes, and naming and defining final themes (Braun & Clarke, 2006). Theme construction and refinement was undertaken as a team (primarily by LH and KW). This was not designed to seek congruence or agreement of themes, given this would be inconsistent with Braun and Clarke's process. Rather, the diversity of perspectives across the team supported theme construction by helping to crystallise thinking, identifying patterned meanings in the data and ensuring the themes told a story of the data with reference back to the research question. The first and second author (who were trained in thematic analysis, involved in PS, and who have a background in physiotherapy private practice and counselling respectively) began by familiarising themselves with the data. This involved reading notes from the co-facilitator, listening to audio recordings, reading and re-reading the transcripts, and noting down first impressions of the data. Hard copies of transcripts were then coded manually, with LH and KW coming together regularly to discuss preliminary interpretations and construct initial candidate themes. Candidate themes were shared with NK to further develop and refine candidate themes, returning to the data and coding in a recursive manner before settling on final theme names and definitions. Quotes considered to best communicate the story of the data and final themes were identified to support reporting. Where text has been removed either to reduce the length of a quote or to enhance readability, we have inserted a bracketed ellipsis (i.e., […]). No text has been removed that would alter meaning of the comment.

RESULTS

A total of nine Auckland-based physiotherapy private practitioners initially volunteered for the research, with eight ultimately consenting to take part, as one volunteer decided they were unable to commit the time needed to participate.

Participants were urban-based and had 2 to 20 years of experience in private practice. Most were contractors and female, with an ethnicity mix of New Zealand European, Māori, and Pacifica. More details are provided in Table 2.

Our findings showed a distinct difference in the understanding of PS between the three groups interviewed. The degree of engagement in PS was determined by the perceived value of PS and how it contributed to practice enhancement, along with how the participants felt about asking for help within a supervisory relationship.

The four key themes generated were: (1) PS and the capitalistic lens, (2) PS is not "normal", (3) professional identity and vulnerability, and (4) the relationship in a supervisory context. Each theme is discussed below with supporting data extract examples. All participants have been given pseudonyms.

Theme 1: Professional supervision and the capitalistic lens

The degree to which participants viewed PS through a capitalistic lens appeared to influence its perceived value, with financial cost balanced against the perceived benefit of PS as a continuous professional development (CPD) activity. The choice of language here is deliberate, with a more capitalistic lens referring to a focus on generation of wealth, competition, and productivity of business.

PS competes with other forms of professional development when educational funds were allotted. When time and money were finite, choices needed to be rationalised. In addition to the direct cost of PS, participants referred to the hidden costs, viewing the time invested in PS as a loss of revenue-generating time.

> Yeah, I think time is money and if you work like a certain amount of hours that you get paid for all those patients that you see, people just don't have any extra time to build into their week, to do something that's unpaid. (Angela)

Another participant referred to the number of other costs associated with maintaining professional status in the context of limited resources:

Table 2
Participant demographics

Pseudonym	Gender	Age (years)	Ethnicity	Year qualified (years in private practice)	Experience of PS	Method of data collection	Location of work (employment status)
Angela	Female	35	NZ European	2003 (11)	Never	Focus group	Auckland (contractor)
Adam	Male	43	NZ European	1995 (20)	Never	Focus group	Auckland (contractor)
Alison	Female	45	NZ European	1992 (15)	Never	Focus group	Auckland (contractor)
Anne	Female	42	Māori/Samoan	2013 (4)	Never	Focus group	Auckland (practice owner)
Belinda	Female	41	Māori	2011 (6)	Previously	Interview 1	Auckland (contractor)
Bonny	Female	55	American	2013 (4)	Previously	Interview 1	Auckland (contractor)
Bea	Female	40	NZ European	1999 (15)	Previously	Interview 2	Auckland (contractor)
Caroline	Female	32	NZ European	2009 (2)	Currently	Interview 3	Auckland (contractor)

Note. NZ = New Zealand; PS = professional supervision.

> We have to pay so much for PNZ and so much for registration (a load of money) and then you have got to do CPD (a load of money) and at the end of the day we just don't make enough in private practice. (Bonny)

Furthermore, the costs are balanced with the perceived financial benefits of PS as a CPD activity. The benefits of CPD when viewed through a more capitalistic lens could entail gaining new technical skills to assist existing clients, attract new ones, or enhance business management and strategy, which were perceived to have immediate and direct financial return. The participants who had never engaged in PS appeared to have a more capitalistic view, valuing and prioritising professional development that supports technical skill development.

> The money that they have invested in that (PS) a few times a year could be potentially the same as a course or a seminar or something like that, so I think with people's limited budget or time you would weigh it up, it is seen more of a luxury than a necessity. (Caroline)

Angela, who had never engaged in PS, commented:

> [In] a musculoskeletal sports physiotherapy setting… it's probably not as necessary [to do PS] because you would be going to maybe conferences […] so you are always learning but you don't necessarily have to engage with [….] feelings which are evoked.

In contrast, the participant who remained actively engaged in PS still had a desire to develop marketable technical skill and knowledge, but it was not their only focus: "I break up my supervision in different categories so I have got a clinical question, I have got challenging situations, and then I do professional development" (Caroline).

When PS was valued as a long-term investment, the financial gain was in keeping the practitioner working effectively and efficiently to earn a living. The focus was on supporting self-development through maintaining the practitioner's mental well-being, addressing stress in the workplace, processing the emotional aspects of practice, and/or as a method of quality control: "I think it's vital to my development as a person but also as a therapist and it gives me perspective and clarity in situations that I cannot go through myself" (Caroline).

Another capitalistic view of PS was accountability and its ability to advance a career pathway. All participants appreciated how the accountability of PS had tangible and potentially immediate benefits. Belinda commented in the sense of accountability derived through the supervision process: "It can hold you accountable to goals that you might have or decisions that you are making or […] someone to talk to if you have got issues particularly in moving forward in your own clinical practice."

For those participants who had previously engaged in but not sustained PS, commencement coincided with a critical point in their career and was seen as a remedial service to help keep accountability to the profession.

> Yeah, my main (reason) was career direction. You know I have been doing it a long time and my littlest had just gone off to school and I was at that road of, do I want to keep doing physiotherapy? (Bea)

Despite PS being seen by all participants as a mechanism for providing accountability, the benefits of this appeared to be insufficient to initiate or sustain engagement in PS in the context of competing priorities where there existed more tangible, immediate gratification. In contrast, PS was more likely and sustainable when recognised as a long-term investment in self.

Theme 2: Professional supervision is not "normal"

It was clear that all participants viewed PS as neither "normal" nor a routine part of practice. This appeared to be influenced by past practice experiences and current workplace behaviour, which was formative to their knowledge and understanding regarding the place of PS in physiotherapy.

Past experience, mainly undergraduate clinical training, strongly influenced their understanding of PS, even though some of the participants qualified 20 years ago. The experience of clinical supervision as a physiotherapy student usually carried negative feelings, and this was then generalised to any form of supervision and reflective practice thereafter:

> Being supervised as a student always made me feel really nervous and like, on edge, as if I was always being watched and I was going to be judged on whatever I did, I really hated it. […] So just like, even just the word PS makes me feel a bit nervous. (Anne)

Participants who had never received PS frequently blurred the lines between clinical supervision and PS. This highlighted a confusion in their understanding regarding the unique and specific characteristics and purpose of PS, and the value it could hold, compared to clinical supervision.

Once participants had commenced working as a physiotherapist, practice habits appeared to be influenced by those around them. It was recognised that physiotherapists working for a District Health Board (DHB) participate in PS because it is expected in that setting. However, that was not the case in private practice, and in that context, engagement was more likely when it was normalised by the employer. Caroline, who was receiving ongoing PS, negotiated this arrangement directly with her manager, who was fully supportive of the process. Bea, however, had two contrasting experiences across work settings: "I went back to my boss and said, 'I want someone to talk to for my own reason', and he was really supportive which was good".

In contrast to:

> My new boss, I did tell him when I took on the new job. I said, 'Look, I have found this really valuable', and at the time [he] went, 'Oh, I should look into this for the staff', but that's as far as it went.

Bea also referred to the impact of unsupportive colleagues:

> I had conversations with some physios that I'd worked with when I was doing professional supervision and they were like, 'Oh, I would never do that, why would you do that?' You know they just thought that was such a ridiculous thing to do.

What was considered "normal" by all participants were the informal corridor conversations, although the degree to which they were seen as a form of support or supervision

was interpreted differently. Those participants with no prior experience of PS viewed these meetings as an adequate substitution for formal supervision.

> We do a lot of informal supervision. Like this week, I had a 15-year-old that tried to kill himself and so there's another physio who is going to work with him and a personal trainer. So, you go and talk to them about suicide. (Anne)

In this instance, the absence of PS has the potential for both the physiotherapist's and client's personal or emotional needs being left unaddressed.

In contrast, those participants with experience of PS all engaged in informal discussions with colleagues, but viewed the value of these opportunistic conversations as different to PS:

> I have got lots of physio friends and colleagues and you can talk about things with them, but then it feels like a moan session. Whereas with someone who is just there to be very objective and does actually throws [*sic*] back questions at you, [it] was quite useful. (Bea)

Similarly:

> You are sitting there finishing notes and you are having a conversation with a colleague going, 'Hey, I have got this issue' and often they are more emotional conversations because you are really fired up about something. They are quite biased conversations. Whereas when I sit with my supervisor, they are often unbiased. (Caroline)

Theme 3: Professional identity and vulnerability

Participants perceived PS to have the potential to expose their vulnerabilities, potentially threatening their professional identity as being a rehabilitation expert. The medical model tends to position practitioners as experts, that is, as someone possessing a great amount of knowledge and skill. However, it was recognised that PS would be most authentic and effective when the supervisees discuss their uncertainties and concerns relevant to their practice. Being both vulnerable and an expert created tensions for some, and there was concern that seeking PS may infer self-doubt or incompetence.

All participants acknowledged the need to be honest and open in PS, and that vulnerability could be threatening. Additionally, it was recognised that physiotherapists working in private practice were cautious about being vulnerable (or being perceived that way) and valued self-sufficiency. As such, acknowledging weaknesses or asking for help was seen in a negative light, especially by participants who had never used PS:

> Physios generally have to come across as quite confident. They have to be confident in front of their clients so they do build up a bit of a wall. And so when you go to a course for the weekend you are learning your moves you have got to be confident too and you have got to kind of, you know you are with your peers, there's no safe area. (Adam)

In contrast, those who had experienced PS viewed it as a relief to "open-up" or "get it off their chest", and saw being vulnerable as an important part of the process:

> One thing that you realise is that it's OK for me to look like I don't look perfect and I think that's OK, so I don't have to hide myself or put up a wall. And I go, I have done this, I can actually just be honest, and I think because I am honest, I get more out of it. (Caroline)

Theme 4: The relationship in a supervisory context

Participants placed paramount importance on the skills and characteristics of the supervisor, in particular the extent to which they created a trusting and safe relationship. This was perceived as particularly important given the vulnerability inherent in PS, as described above. Participants expressed the need to feel confident to negotiate the supervisory process and, where necessary and timely, to cease the supervisory relationship if expectations were not met.

Participants outlined the desirable attributes of a professional supervisor as trustworthy, impartial, non-judgemental, a good listener, neutral, and empowering. A supervisor with these attributes appeared to reduce the perceived risk of feeling vulnerable or being seen as incompetent. Those with experience of PS felt the relationship worked well when the power imbalance was minimal, mutual respect existed, and when they could relate to their supervisor both personally and professionally. Bea commented:

> I felt quite comfortable because I thought we were of [a] similar age, we had kids, I looked up to her from a career perspective because she had done a lot of study and that, I saw that as a real value for me to talk about the things I wanted to talk about […] I don't think I felt like I was a junior versus a senior, I felt quite at ease.

Similarly, Alison noted: "I would choose someone that I respected and someone that I felt comfortable chatting with who I knew would give me honest feedback".

In contrast, all participants appreciated that an undesirable relationship with a supervisor could be detrimental. For example, "If you did get someone who was judgmental and said. 'Oh I wouldn't have done that', or you know, something like that. So, I think there would be skills that would help supervisors be better supervisors" (Alison).

While issues could arise around having an undesirable supervisor, it was also problematic if the supervisor had a dual role (i.e., was an existing work colleague). While it may be more convenient to use someone at work, the participants were cognisant of the potential conflict and tensions that could arise if being supervised by someone who was involved in their daily practice. For example, Bea provided supervision to a work colleague and commented:

> We were colleagues so I don't know if our relationship worked so well […] it just felt it wasn't as objective. It was harder to be objective possibly, from my point of view, and I did struggle sometimes not to give solutions.

Similarly, Caroline noted: "When I was doing supervision at the hospital it would never be with my direct boss so it was always someone who was slightly sideways because that would have a direct impact in terms of my employment".

Furthermore, the ability to influence the supervisory process formed a key point of difference between those who are currently or have had PS compared to those who had never taken it up. Those who had never experienced PS were clear on how they would like sessions to be structured, such as being supervisee led. However, they appeared to not know that this was within their control. Knowing how to discontinue the relationship if it was not meeting the needs of the supervisee was also a key concern.

> You have to really invite that person in quite deeply to what it is you are doing, so once they become entrenched, then how do you un-trench them without, I don't know, upsetting their feelings? […] I think it's the downside […] It is such a personal relationship. (Belinda)

In contrast, those with experience of PS felt fully empowered to determine the terms and conditions of PS, and choose their own supervisor.

DISCUSSION

Engagement in PS appeared to be influenced by a complex set of interacting factors related to the perceived value of PS in the context of capitalistic values, what constitutes "normal" practice by peers and employers, the importance of sustaining one's professional identity as an expert, and the need to be confident in developing a supervisory relationship tailored to individual needs and preferences. This is the first study that we are aware of to examine experiences and perspectives of PS in the physiotherapy profession, and specifically for those working in a private practice setting.

The themes identified in this research are consistent with what is already recognised about some of the practice habits of physiotherapists. There is acknowledgement that the majority of physiotherapists have less focus on the development of interpersonal skills and self, and preferentially invest in the advancement of technical skills for the improved management of conditions (Williams, 2018). However, there is a growing body of evidence that emphasises the importance of a humanistic, client-centred approach to care, and the necessity of being a reflexive practitioner (Kayes & McPherson, 2012; Potter et al., 2003; Resnik & Jensen, 2003). Furthermore, from a client-centred perspective, the important skills a physiotherapist needs include effective communication (Potter et al., 2003), being a collaborative problem solver, empowering clients through education, cultivating a trusting client-practitioner relationship, and possessing good self-reflection skills (Kayes & McPherson, 2012; Resnik & Jensen, 2003). While PS aims to develop some of these skills through reflective practice, engagement in PS by physiotherapy private practitioners remains limited. The drive for increased productivity, cost-effectiveness, and, ultimately, profit continues to dictate practice habits (Brun-Cottan et al., 2018).

Low uptake of PS by physiotherapists may be explained by the profession evolving from the biomedical model of health care, where there is a depersonalising approach to care, giving little attention to the social determinants of health and well-being (Nicholls & Gibson, 2010; Stewart & Haswell, 2007). As a result, physiotherapists' own feelings for, and recognising the feelings of, their clients is unacknowledged and deemed inconsequential (Nicholls & Gibson, 2010).

The biomedical paradigm used by physiotherapists may also help to explain why participants who had never engaged in PS expressed hesitancy or felt no need to seek support. How practitioners support their clients may well be reflected in how they wish to support themselves. Norris and Kilbride (2014) highlighted how practitioners work with a paternalistic view and feel they possess the solutions to all client issues. It has also been highlighted how physiotherapists struggle with the tension of moving from being the biomedical expert to working wholeheartedly collaboratively (Mudge et al., 2014). The core principle of PS focusses on the supervisee's desire to learn how to do their work better (Carroll & Gilbert, 2011), which implies that their work was not already perfect. Therefore, PS could be perceived as a threat to the professional identity of the supervisee, which may deter people from entering into it.

A dearth of research on nonmandatory PS for health workers means a comparison is not possible. However, it is widely acknowledged that when a supervisee feels threatened in PS (normally through a misuse of power), learning ceases and PS has negative connotations (Hawkins et al., 2012; Sparks, 2014).

Another significant barrier to engagement in PS was the extent to which uptake of PS was normalised (or not) in the workplace culture. All the participants highlighted PS as not "normal" in private practice. Other research examining engagement in work-based learning has found that the culture of learning comes from the leadership within an organisation (Attenborough et al., 2019; Thurgate, 2018) and that good leadership can transform the workplace culture around seeking support and further education. This may explain the apparent and striking difference in engagement in PS between physiotherapists who have the support of their employer (and view PS as "normal") compared to those that do not. For sustained engagement in learning, it has also been argued that leaders in the organisation need to model behaviour, not just provide consent for others to participate (Attenborough et al., 2019; Thurgate, 2018).

Another tipping point for engagement in PS relates to the supervisory relationship itself. It is almost unanimously agreed within PS literature that the supervisory relationship is a critical component for optimal PS (Beddoe, 2012; Carroll & Gilbert, 2011). Arguably, vulnerability may create the context for reflexivity, thereby supporting personal growth and development. However, this is complex, sitting alongside a co-existing need to sustain one's professional identity and credibility as an expert. Given this complexity, it is clear the supervisory relationship needs to create a safe space for recipients to navigate this tension and sustain their engagement in the process. Molloy and Bearman (2019) describe balancing vulnerability and credibility as intellectual candour and a transformative practice to allow the practitioner to access different ways of knowing.

This study has provided a first look at experiences and perspectives regarding the tipping point for engagement in PS for physiotherapists working in private practice. In order to

further understand the use of PS by physiotherapists, future research should aim to capture the opinion of physiotherapists who work in an environment where PS is mandated and is part of the workplace culture, such as in a DHB setting. This would deepen current understanding. Capturing the opinion of stakeholders (clients, funders, and professional bodies) would also be worthwhile to understand the role PS could have within the physiotherapy profession in New Zealand.

Although this study has provided some insight into the tipping points for engagement in PS by physiotherapy private practitioners, there were limitations. In particular, the diversity of our sample was limited. For example, there was only one male and only one person who had sustained engagement in PS. Further, all participants were exclusively from urban practices and are likely to have different experiences and perspectives compared to those working in rural and remote locations. Future work exploring perspectives not already captured in the current study would further enhance the understanding of factors that help or hinder uptake of PS in private practice.

CONCLUSION

The use of PS by physiotherapists in private practice appears to be unusual despite PS being strongly recommended as a "core component of physiotherapy practice" (Physiotherapy New Zealand, 2012). There is minimal focus on the development of interpersonal skills and self, where investment in the advancement of technical skills dominates. While a lack of understanding of what PS can offer limits engagement, the perceived threat it poses to self and professional identity also appear to be a key factor limiting uptake. When PS is seen as a long-term investment in self-care, engagement appears more likely to be sustained.

KEY POINTS

1. There is a dearth of literature on the use of PS in the physiotherapy profession, particularly in the private practice setting in New Zealand.
2. The drive for increased productivity, cost-effectiveness, and, ultimately, profit continues to dictate practice habits.
3. PS is not seen as a normal part of physiotherapy private practice culture.
4. To engage in PS, the practitioner needs to balance the tension between professional identity and credibility with being able to be vulnerable about practice deficiencies.
5. The supervisory relationship needs to create a safe space for recipients to sustain engagement in the process of PS.
6. When PS is seen as a long-term investment in self-care, engagement is more likely to be sustained.

ACKNOWLEDGEMENTS

The authors acknowledge funding from the Physiotherapy New Zealand Scholarship Trust Fund, which supported this research. They also thank those physiotherapists who generously gave their time to attend the focus group or interviews, and Mrs Lisa Blaikie, who assisted with facilitation of the focus group.

DISCLOSURES

There are no conflicts of interest which may be perceived to interfere with or bias this study.

PERMISSIONS

Ethical approval was obtained from the Auckland University of Technology Ethics Committee (reference number 16/161). Written, informed consent was obtained from all participants.

ADDRESS FOR CORRESPONDENCE

Laura Holder, PhysioVision, 27 Acmena Lane, Pakuranga, Auckland 2010, New Zealand.

Email: lauraholder.supervision@gmail.com

REFERENCES

Attenborough, J., Abbott, S., Brook, J., & Knight, R.-A. (2019). Everywhere and nowhere: Work-based learning in healthcare education. *Nurse Education in Practice, 36*, 132-138. https://doi.org/10.1016/j.nepr.2019.03.004

Beddoe, L. (2012). External supervision in social work: Power, space, risk, and the search for safety. *Australian Social Work, 65*(2), 197-213. https://doi.org/10.1080/0312407X.2011.591187

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brun-Cottan, N., McMillian, D., & Hastings, J. (2018). Defending the art of physical therapy: Expanding inquiry and crafting culture in support of therapeutic alliance. *Physiotherapy Theory And Practice*. Advance online publication. https://doi.org/10.1080/09593985.2018.1492656

Butler, S., & Thornley, L. (2014). Presenting the case for all physiotherapists in New Zealand to be in professional supervision. *New Zealand Journal of Physiotherapy, 42*(1), 42-46.

Carroll, M., & Gilbert, M. (2011). *On being a supervisee: creating learning partnerships* (2nd ed.). PsychOz Publications.

Davys, A., & Beddoe, L. (2010). *Best practice in professional supervision: a guide for the helping professions*. Jessica Kingsley Publishers.

Ducat, W. H., & Kumar, S. (2015). A systematic review of professional supervision experiences and effects for allied health practitioners working in non-metropolitan health care settings. *Journal of Multidisciplinary Healthcare, 8*, 397-407. https://doi.org/10.2147/JMDH.S84557

Erera, I. P., & Lazar, A. (1995). The administrative and educational functions in supervision: Indications of incompatibility. *The Clinical Supervisor, 12*(2), 39-56. https://doi.org/10.1300/J001v12n02_04

Gerrish, K., & Lacey, A. (Eds). (2010). *The research process in nursing* (6th ed.) Wiley-Blackwell.

Hall, T., & Cox, D. (2009). Clinical supervision: An appropriate term for physiotherapists? *Learning in Health and Social Care, 8*(4), 282-291. https://doi.org/10.1111/j.1473-6861.2009.00226.x

Hawkins, P., Shohet, R., Ryde, J., & Wilmot, J. (2012). *Supervision in the helping professions* (4th ed.). Open University Press.

Holder, L. (2014, December 1). Do we understand and use professional supervision? A private practice perspective. *Physio Matters,* 21.

Kayes, N. M., & McPherson, K. M. (2012). Human technologies in rehabilitation: 'Who' and 'how' we are with our clients. *Disability and Rehabilitation, 34*(22), 1907-1911. https://www.tandfonline.com/doi/full/10.3109/09638288.2012.670044

Molloy, E., & Bearman, M. (2019). Embracing the tension between vulnerability and credibility: 'Intellectual candour' in health professions education. *Medical Education, 53*(1), 32-41. https://doi.org/10.1111/medu.13649

Mudge, S., Stretton, C., & Kayes, N. (2014). Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disability & Rehabilitation, 36*(6), 457-463. https://doi.org/10.3109/09638288.2013.797515

Nicholls, D. A., & Gibson, B. E. (2010). The body and physiotherapy. *Physiotherapy Theory & Practice, 26*(8), 497-509. https://doi.org/10.3109/09593981003710316

Norris, M., & Kilbride, C. (2014). From dictatorship to a reluctant democracy: Stroke therapists talking about self-management. *Disability & Rehabilitation, 36*(1), 32-38. https://doi.org/10.3109/09638288.2013.776645

Physiotherapy New Zealand. (2012). Supervision in physiotherapy practice. Retrieved 26 March, 2014 from https://pnz.org.nz

Potter, M., Gordon, S., & Hamer, P. (2003). The physiotherapy experience in private practice: The patients' perspective. *Australian Journal of Physiotherapy, 49*(3), 195-202. https://doi.org/10.1016/S0004-9514(14)60239-7

Proctor, B. (2001). Training for the supervision alliance attitude, skills and intention. In J. R. Cutcliffe, T. Butterworth, & B. Proctor (Eds.), *Fundamental themes in clinical supervision.* Routledge.

Resnik, L., & Jensen, G. M. (2003). Using clinical outcomes to explore the theory of expert practice in physical therapy. *Physical Therapy, 83*(12), 1090-1106.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health, 33*(1), 77-84. https://doi.org/10.1002/nur.20362

Sparks, J. (2014). Negotiating power relations on the threshold of supervision. *Journal of Systemic Therapies, 33*(1), 16-29. https://doi.org/10.1521/jsyt.2014.33.1.16

Stewart, J., & Haswell, K. (2007). Primary health care in Aotearoa, New Zealand: Challenges and opportunities for physiotherapists. *New Zealand Journal of Physiotherapy, 35*(2), 48-53.

Thurgate, C. (2018). Supporting those who work and learn: A phenomenological research study. *Nurse Education Today, 61*, 83-88. https://doi.org/10.1016/j.nedt.2017.11.010

Wepa, D. (2007). *Clinical supervision in Aotearoa/New Zealand: A health perspective*. Pearson Education New Zealand.

Williams, B. (2018, October 1). Putting person and whānau centred care into practice. *Physio Matters,* 16-19. https://pnz.org.nz/Attachment?Action=Download&Attachment_id=1046