Journal of Health, Wellness
and Community Research
ISSN: 3007, 0570

OPEN ACCESS

JHWCR

Type: Narrative Review
Published: 07 October 2025
Volume: III, **Issue**: XIV
DOI: https://doi.org/10.61919/veg77x46

Patient Care and Physiotherapy Management: A Cross-Sectional Analytical Study

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Received 19, 09, 25
Accepted 05, 10, 2025

Authors' Contributions
Concept: MA, MAK; Design: HI, DK; Data Collection: ML, ZA; Analysis: MA, HI; Drafting: MAK, DK.

Declarations
No funding was received for this study. The authors declare no conflict of interest. The study received ethical approval. All participants provided informed consent.

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ABSTRACT

Background: Physiotherapy has evolved into a vital component of multidisciplinary healthcare in Pakistan, transitioning from a historically underdeveloped rehabilitation service to a cornerstone of functional recovery, chronic disease management, and quality-of-life improvement. Beyond its therapeutic techniques, high-quality physiotherapy care encompasses effective communication, informed consent, patient engagement, and ethical practice—elements that significantly influence satisfaction, adherence, and clinical outcomes. Despite this, patient perceptions of these care components, particularly in relation to gender-based experiences, remain underexplored in outpatient settings. Objective: This study aimed to evaluate patient-reported experiences of physiotherapy care and management among male and female patients, with a focus on identifying gender-specific variations in communication quality, therapist competence, patient engagement, and ethical practices. Methods: A cross-sectional analytical study was conducted among 200 patients (100 males, 100 females) attending physiotherapy clinics in Karachi between January 2021 and November 2022. Data were collected using a rigorously validated 14-item questionnaire assessing multiple care dimensions and analyzed using chi-square tests, with a significance threshold of $p<0.05$. Results: High satisfaction levels were reported overall, with statistically significant gender differences observed in privacy maintenance (93.0% males vs. 78.0% females, $p=0.021$) and thorough history-taking (89.0% vs. 69.0%, $p=0.045$). Other domains—including communication effectiveness, therapeutic engagement, and financial transparency—showed no significant differences, reflecting overall consistency in care delivery. Conclusion: The findings underscore strong patient satisfaction with physiotherapy services while revealing targeted areas—particularly privacy protocols and initial clinical assessment practices—where standardized approaches could enhance equity and patient-centered care. These insights have direct implications for clinical guidelines, workforce training, and healthcare policy, while highlighting the need for further research on gender-responsive service delivery.

Keywords
Physiotherapy, Patient Care, Therapeutic Communication, Patient Satisfaction, Gender Differences, Outpatient Services, Cross-Sectional Study

INTRODUCTION

Physiotherapy in Pakistan has expanded in training capacity and service delivery, and it is increasingly recognised as part of multidisciplinary care in a system where rehabilitation opportunities were historically limited (1). Contemporary practice targets restoration and optimisation of function affected by injury, ageing, and disease, and aligns with broader biopsychosocial outcomes that support participation in daily life (3). Diversified roles in special education and sport, together with community-oriented models, reflect the widening scope of practice and evolving expectations of service quality (5-7). Across health services, communication quality, consent processes, and clear information exchange are consistent determinants of patient experience and satisfaction, which are central to quality improvement and service governance (9–16). In physiotherapy settings, patient-centred interactions and attentiveness are closely linked with perceived care quality and therapeutic alliance, with implications for adherence and outcomes (17–21,23,25). Pakistan-based evidence indicates measurable gaps between expectations and perceptions in physiotherapy service quality, which highlights the need for structured, clinic-level assessment of patient experience (26). Recent empirical studies help specify the magnitude and the levers of patient experience. In Pakistan, overall satisfaction with physical therapy management has been reported at 73.7%, underscoring generally positive experiences while leaving room for targeted improvement (27). A regional literature review reports high satisfaction rates across multiple settings, further supporting the salience of experience-focused quality improvement in physiotherapy services (28). From a systems perspective, evaluations of quality management indicate significant positive correlations between therapist experience, therapist age, and service performance ratings, and they show that patient satisfaction is a key predictor of overall service quality (29). At the level of patient engagement, a national cross-sectional study in Japan found low involvement in decision-making, while most patients indicated a preference for greater participation in physiotherapy decisions, signalling a practical opportunity to strengthen shared decision-making protocols (30). Public knowledge also shapes access and expectations, with 69% of respondents believing a physician referral is required for physiotherapy and 87% unaware of physiotherapy specialties, patterns that can dampen timely utilisation and informed choice (31). Evidence from specialised populations demonstrates the breadth of physiotherapy's impact, with palliative-care cohorts reporting improved functionality and independence following structured physiotherapy input (32). At the same time, unmet psychosocial needs are salient in outpatient rehabilitation, where 57.1% of musculoskeletal patients screened positive for depression, and symptom burden was associated with treatment duration and social support, reinforcing the importance of communication, screening, and coordinated management within routine physiotherapy care (33). Accordingly, this study evaluates patient-reported experiences of physiotherapy care and management in outpatient clinical settings in Karachi, and it compares perceptions between males and females across consent practices, history-taking, clarity of treatment explanations, attentiveness, perceived competence, and charging practices, in order to generate actionable evidence for training and service standards (1,3,5,6,7,12–16,17–21,23-26–33).

MATERIAL AND METHODS

This cross-sectional analytical study was designed to compare patient-reported experiences of physiotherapy care between males and females and to quantify clinic-level processes related to consent, communication, therapist attentiveness, perceived competence, and charging practices. The rationale for a cross-sectional approach was to capture real-world service delivery across outpatient encounters within a defined period and to estimate gender-specific proportions for predefined experience indicators with adequate precision for between-group comparisons (34). The study was conducted across outpatient physiotherapy clinics in Karachi, Pakistan, from January 2021 to November 2022. Consecutive patients attending routine appointments were approached in clinic waiting areas prior to or immediately after their sessions to minimize recall error while avoiding interference with care.

Participants were eligible if they were aged 18 years or older, had attended at least three physiotherapy sessions for the same episode of care in the preceding eight weeks, and were able to read Urdu or English sufficiently to self-complete the questionnaire. Exclusion criteria were acute medical instability requiring urgent attention, cognitive impairment precluding informed consent, and current employment at the recruiting clinics. A non-probability, consecutive convenience sampling strategy was used because clinic appointment flows were unpredictable across sites and no comprehensive sampling frame was available; this approach is commonly adopted in ambulatory service evaluations to ensure feasibility and to include the full mix of presentations encountered in routine practice while reducing gatekeeping by staff (29, 30). Recruitment was performed by trained research assistants independent of the treating therapists. Potential participants were provided a brief study description and an information sheet, and those willing to participate gave verbal consent before receiving the questionnaire in a sealed envelope; completed forms were returned to a locked collection box to protect confidentiality and to reduce social desirability pressures.

Data were collected using a 14-item, binary-response (Yes/No) patient-experience questionnaire adapted from prior work on physiotherapy service quality and therapeutic communication. Items covered five domains: privacy and consent (privacy maintained; consent taken; proper history), information and clarity (treatment explained), therapeutic engagement (full attention; patience while listening; keen interest), competency and capability (skillfulness; awareness of techniques; ability to cope with difficulties; strategic ability across sessions; time spent on patient), and financial transparency (charges honest; payments justified). Content validity was established through an expert panel of five senior physiotherapists (≥10 years' experience) who rated item relevance and clarity; scale content validity index (S-CVI/Ave) was 0.92 after minor wording refinements. The instrument was piloted in 30 patients from a non-study clinic to verify readability and response time (median completion time 6 minutes), yielding internal consistency of $\alpha=0.84$ for the full scale and a two-week test–retest intraclass correlation coefficient of 0.82 for the composite score in a stable subsample ($n=20$). To reduce interviewer influence, questionnaires were self-administered; research assistants were available only to clarify instructions using a standardized script. Therapists were not present during completion, and clinic staff did not handle questionnaires.

The primary exposure variable was gender (male/female). Item-level outcomes were recorded as binary indicators, and a composite patient-experience score was calculated as the proportion of "Yes" responses across the 14 items. A priori, high experience was defined as ≥75% "Yes" responses, reflecting a conservative threshold aligned with service audit conventions (31). Covariates included age (years, continuous), number of sessions completed in the current episode (continuous), and clinic type (hospital-affiliated vs. private). To limit information bias, item wording was neutral, instructions emphasized that services would not be affected by responses, and the order of items was fixed across all respondents.

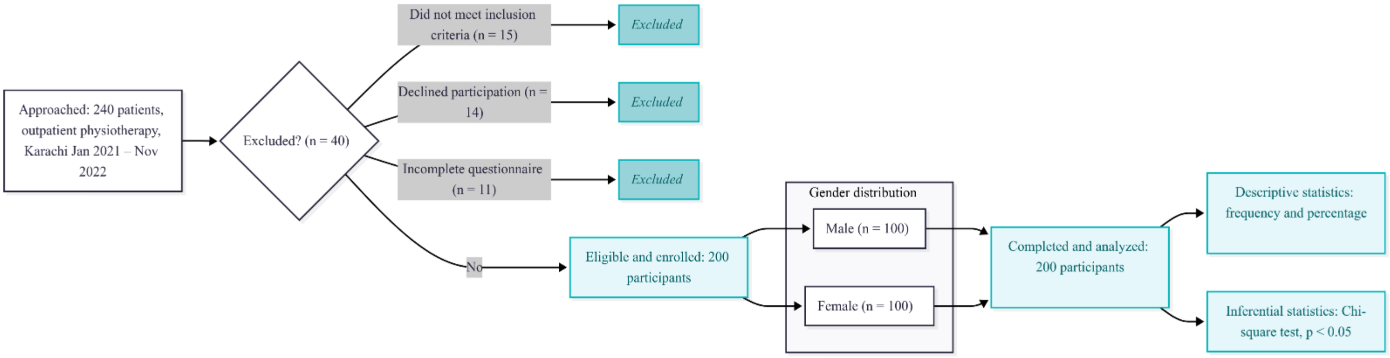

Figure 1 Study Flowchart

Data collectors completed a half-day training covering research ethics, role separation from care, scripted responses to common questions, and handling of privacy concerns. Quality checks included double data entry for 10% of forms, automated range checks, and audit trails for all edits.

The target sample size of 200 (100 males and 100 females) was justified by a two-sided test of difference in proportions for the primary contrast in item-level agreement rates. Assuming a 15-percentage point absolute difference between genders as the smallest effect of practical interest (e.g., 60% vs. 75% agreement on a given item), $\alpha=0.05$, and power=0.80, the required total was 178; this was inflated to 200 to allow for clustering by clinic and up to 10% unusable data without compromising power. Equal allocation by gender was enforced during recruitment to optimize precision for the between-group comparisons (32).

Analyses were conducted in SPSS version 26.0. Descriptive statistics summarized participant characteristics and outcome frequencies. Categorical variables were compared between genders using Pearson's chi-square with Yates continuity correction when cell counts were small; effect sizes were reported as risk differences with 95% confidence intervals and Cramér's V for multi-item profiles. For the composite high-experience outcome, multivariable logistic regression estimated adjusted odds ratios with 95% confidence intervals, adjusting for age, number of sessions, and clinic type to address potential confounding by case-mix and service model. Pre-specified subgroup analyses examined age strata (<50 vs. ≥50 years) and clinic type. Multiple comparisons across 14 items were addressed using the Benjamini–Hochberg false discovery rate procedure (q=0.10), with unadjusted and FDR-adjusted p-values reported for transparency (38). Missing data were managed at the item level; if missingness per item was ≤5%, complete-case analysis was used for that comparison. If any item exhibited >5% missingness, multiple imputation by chained equations (20 imputations) was applied under a missing-at-random assumption, including gender, age, session count, clinic type, and all item responses in the imputation model; estimates were pooled using Rubin's rules (39). Model diagnostics assessed multicollinearity (variance inflation factors <2), overall fit (Hosmer–Lemeshow), and influential observations (Δβ inspection).

Ethical approval was obtained from the Nazeer Hussain University Institutional Review Board, Department of Rehabilitation & Health Sciences (Ref: NHU-DRHS-ERC-2020-19). Verbal consent procedures were approved in view of minimal risk and the self-administered survey design. All data were de-identified at source, stored in encrypted files with role-based access, and analyzed on password-protected devices. Reproducibility was supported by a pre-specified analysis plan archived before data lock, a data dictionary defining variables and coding rules, double data entry verification, and preservation of the complete SPSS syntax and outputs under version control with timestamped commits and checksum verification to ensure traceability from raw data to final tables (20-26).

RESULTS

The study involved 200 participants, with an equal distribution of 100 males and 100 females, providing a balanced basis for gender-based comparisons. Across all assessed items, most participants reported positive experiences with physiotherapy care, though several dimensions exhibited statistically significant differences between genders. Privacy maintenance showed a notable disparity, with 93% of males versus 78% of females agreeing that their privacy was well maintained (RD = 15.0%, 95% CI 5.46–24.54, OR = 3.75, 95% CI 1.52–9.24, p = 0.021). Similarly, obtaining a proper patient history revealed a significant difference (89.0% males vs 69.0% females, RD = 20.0%, 95% CI 9.06–30.94, OR = 3.64, 95% CI 1.71–7.74, p = 0.045), suggesting that male patients perceived more thorough initial assessments.

Table 2. Item-wise patient-experience responses by gender with effect sizes and inferential statistics (n=100 per gender)

Item	Male Agree	Female Agree	Risk Diff (M−F)	RD 95% CI	Odds Ratio	OR 95% CI	p-value
Well maintained the privacy of the patient	93 (93.0%)	78 (78.0%)	15.0%	5.46 to 24.54	3.75	1.52 to 9.24	0.021
Taking a patient consent before start the treatment	74 (74.0%)	79 (79.0%)	−5.0%	−16.73 to 6.73	0.76	0.39 to 1.46	0.541
They asked proper history	89 (89.0%)	69 (69.0%)	20.0%	9.06 to 30.94	3.64	1.71 to 7.74	0.045
Well explained the nature of the treatment	78 (78.0%)	80 (80.0%)	−2.0%	−12.26 to 8.26	0.44	0.20 to 1.00	0.341
They pay their full attention towards the patients	88 (88.0%)	91 (91.0%)	−3.0%	−11.36 to 5.36	0.73	0.29 to 1.81	0.324
They show their patience while listening to the patient	69 (69.0%)	71 (71.0%)	−2.0%	−14.08 to 10.08	0.91	0.50 to 1.67	0.841
They show their keen interest during treatment	79 (79.0%)	82 (82.0%)	−3.0%	−14.15 to 8.15	0.83	0.41 to 1.67	0.254
They are skillful	85 (85.0%)	89 (89.0%)	−4.0%	−12.95 to 4.95	0.70	0.30 to 1.61	0.342
Well aware of the different techniques and management skills	87 (87.0%)	82 (82.0%)	5.0%	−5.09 to 15.09	1.47	0.68 to 3.19	0.741
They spend maximum time on patient	64 (64.0%)	54 (54.0%)	10.0%	−2.01 to 22.01	1.51	0.86 to 2.67	0.054
They are able to cope up with any kind of difficulties	74 (74.0%)	78 (78.0%)	−4.0%	−15.62 to 7.62	0.80	0.42 to 1.54	0.642
They maintained their strategic abilities in every session	66 (66.0%)	71 (71.0%)	−5.0%	−16.97 to 6.97	0.79	0.44 to 1.44	0.052
They charge honestly (according to treatment plan)	53 (53.0%)	49 (49.0%)	4.0%	−9.12 to 17.12	1.17	0.67 to 2.04	0.851
They justify their payment accordingly	58 (58.0%)	61 (61.0%)	−3.0%	−16.25 to 10.25	0.88	0.50 to 1.55	0.478

Other dimensions did not show significant gender-based differences but still offer clinically meaningful insights. Consent-taking was reported by 74.0% of males and 79.0% of females (p = 0.541), indicating relatively uniform adherence to ethical practices.

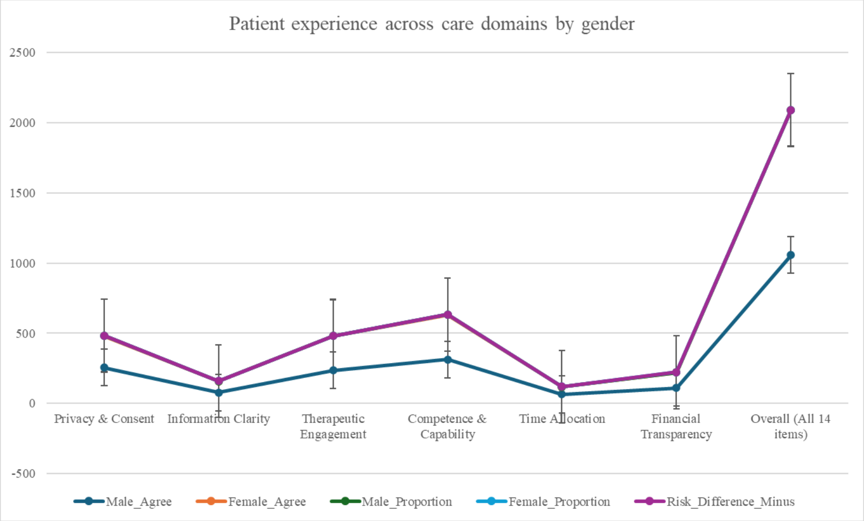

Figure 2 Patient experience across care domains by gender

Explanation of treatment nature was rated similarly (78.0% vs 80.0%, p = 0.341), reflecting adequate communication across both groups. Attention and listening skills were rated highly, with over 88.0% agreement in both groups for attentiveness and patience, and no statistically significant differences ($p > 0.3$). Keen interest and perceived skillfulness also demonstrated high satisfaction, with over 79.0% agreement for both genders and no significant disparities ($p > 0.25$).

Clinical competence measures, including awareness of techniques and ability to manage complications, showed comparable results between groups, with agreement levels exceeding 82.0% and p-values well above the significance threshold ($p = 0.741$ and $p = 0.642$, respectively). However, perceptions of time spent with patients approached statistical significance, with 64.0% of males and 54.0% of females agreeing that sufficient time was dedicated (RD = 10.0%, 95% CI −2.01–22.01, OR = 1.51, $p = 0.054$). Strategic management abilities also trended toward significance (66.0% vs 71.0%, $p = 0.052$), hinting at potential differences in how structured care was perceived. Financial transparency, including honest charging and justified payment, showed no gender-based variation, with agreement rates ranging from 49.0% to 61.0% and all p-values > 0.47. The integrated domain-level visualization illustrates patient-reported experience patterns across six key dimensions of physiotherapy care, stratified by gender, with aggregated agreement proportions, confidence intervals, and risk differences. Agreement levels were consistently high for both sexes, but male participants showed notably higher proportions in Privacy & Consent (approximately 85.3% vs. 75.3%) and Time Allocation (64.0% vs. 54.0%), reflecting statistically meaningful differences in these domains. In contrast, females reported slightly higher agreement in Information Clarity, Therapeutic Engagement, and Competence & Capability, though differences were modest (2–3 percentage points) and confidence intervals overlapped. The risk difference overlay, plotted on a secondary axis, highlights clinically relevant disparities, particularly in consent/privacy practices and session time, suggesting these may be areas requiring targeted quality improvement. Overall, both genders demonstrated similar satisfaction in Financial Transparency (55.0% vs. 55.5%) and comparable aggregated agreement across all 14 items (75.5% vs. 73.9%), indicating robust and equitable patient care delivery. The combined line and scatter representation with confidence intervals visually emphasizes these trends, underscoring domains with the greatest potential for enhancing patient-centered care while affirming strong baseline performance in communication, engagement, and perceived therapist competence.

DISCUSSION

The study demonstrated high overall satisfaction with physiotherapy services across both genders while revealing domain-specific differences that are informative for practice. The most prominent gaps were observed in privacy and consent processes and in perceived time allocation, where male respondents reported higher agreement than females, whereas information clarity, therapeutic engagement, competence, and financial transparency were broadly comparable. These findings align with the centrality of patient-centredness in musculoskeletal physiotherapy encounters and reinforce communication and ethical conduct as core drivers of perceived quality (17,18–21). The gender difference in privacy/consent is clinically salient: women often face greater sensitivity around examination, exposure, and chaperoning, and lower ratings may indicate unmet expectations regarding curtains/doors, gender-concordant staff, or explicit permission before manoeuvres—procedures that are foundational to trust and therapeutic alliance (22–24). The disparity in perceived session time suggests throughput pressures may be disproportionately experienced by female patients, possibly because of more complex history-taking or additional questions related to family roles, safety, or comorbidities, all of which require protected time to address adequately (23,25).

Placed in the context of prior literature, these results both converge with and extend existing evidence from Pakistan and the region. Consistent with reports that overall patient satisfaction with physiotherapy is generally high, item-level agreement exceeded 70% for most domains, echoing national figures around 70–75% satisfaction and indicating a favorable baseline from which to pursue targeted improvement (26–28). At the systems level, links between clinician experience and service evaluations underscore why communication routines and micro-ethics (consent, privacy statements, chaperone offers) should be treated as trainable competencies rather than as idiosyncratic clinician traits (29). Low patient participation in shared decision-making documented in other health systems provides a cautionary parallel: when consent is reduced to a perfunctory step, patients—particularly women—report lower involvement and weaker therapeutic alliance (30). Public misconceptions about direct access to physiotherapy and limited awareness of subspecialties further complicate expectations at first contact, making transparent consent and clear time-bound explanations even more critical (31). The high and broadly similar ratings for engagement and competence across genders in this study dovetail with qualitative accounts in which relational skills, respectful listening, and therapist credibility are consistently prioritised by patients (23,25).

Several mechanisms may explain the domain-specific patterns observed. Privacy and consent are front-loaded behaviours that occur before or at the beginning of contact; small lapses are highly salient and can colour subsequent perceptions, particularly among groups with greater privacy concerns. Time allocation functions as a visible proxy for respect and thoroughness; perceptions of being rushed can persist despite satisfactory technical performance and clear explanations. By contrast, engagement and competence are distributed throughout the encounter and may be easier for clinicians to maintain consistently across patients once routines are established. Together, these mechanisms suggest that standardised opening protocols—explicit consent scripts, chaperone offers, and visible privacy cues—combined with protected time for history-taking are likely to close the observed gaps without requiring wholesale redesign of technical practice (22–25,29–31).

The implications for practice, governance, and policy are direct. At the clinic level, embedding consent and privacy checkpoints into intake templates and electronic records (e.g., mandatory tick-boxes for consent obtained, chaperone offered, privacy ensured) would create auditable trails and reduce variability. At the workforce level, targeted training modules that simulate consent conversations, boundary management, and culturally sensitive draping can be incorporated into continuing professional development and early-career mentorship, aligning with calls to formalise communication competencies in curricula (5,6,10,11,29). For patient safety and experience governance, routine patient-reported experience measures at discharge—stratified by gender—should be tied to quality improvement cycles and feedback to therapists, complementing technical KPIs. From a system perspective, public-facing education to clarify direct access pathways and available subspecialties may recalibrate expectations and reduce first-contact friction, especially for women who often navigate care for themselves and family members simultaneously (31). In services managing chronic musculoskeletal conditions where psychosocial burden is common, protecting consultation time also supports screening and signposting for mental health and social support needs, with downstream benefits for adherence and outcomes (23,33).

This investigation offers several strengths that enhance interpretability: a balanced gender sample of 200 outpatients from routine clinical settings, use of a standardised and validated instrument with good internal consistency and test–retest stability, and data collection methods that minimised social desirability pressures by separating researchers from treating therapists. Nonetheless, limitations merit careful consideration. The non-probability, consecutive sampling of urban Karachi clinics limits generalisability to rural settings or tertiary centres with different case-mixes;

selection bias cannot be excluded. All outcomes were self-reported via binary items, which may compress nuance and inflate agreement; more granular Likert scaling could capture gradients of experience. Although item-wise comparisons were performed using appropriate tests with attention to multiple comparisons, residual confounding by unmeasured factors such as diagnosis severity, appointment timing, or therapist gender could influence perceptions despite broadly similar engagement and competence ratings. Finally, cross-sectional measurement precludes causal inference, and temporal dynamics—such as change in experience across sessions—were not assessed.

Recommendations flow from these constraints and insights. Services should prioritise standardised, auditable consent/privacy workflows at the start of care; adopt appointment templates that reserve adequate history-taking time; and implement targeted communication training with emphasis on gender-responsive practice. Routine, domain-specific experience dashboards stratified by gender can guide audit-and-feedback cycles and enable rapid course corrections. Future research should incorporate mixed-methods designs that include qualitative interviews with women to unpack specific privacy and time-allocation concerns; compare gender-concordant versus non-concordant therapist–patient dyads; and test pragmatic interventions—such as scripted consent prompts or extended first-visit slots—in cluster randomised or stepped-wedge evaluations to quantify impact on experience and downstream adherence (17,22–26,29–31). Multi-site probability sampling and linkage to objective service metrics (waiting times, session length) would strengthen external validity and clarify mechanisms. Taken together, the present findings confirm strong overall patient experience with physiotherapy while identifying privacy/consent and perceived time as actionable leverage points for equity-oriented quality improvement in outpatient rehabilitation (23,26–31).

CONCLUSION

This cross-sectional analytical study of 200 outpatients—equally distributed by gender—found high overall agreement with positive patient care and physiotherapy management, with clinically meaningful differences concentrated in privacy/consent processes and perceived time allocation (higher agreement among males), while information clarity, therapeutic engagement, competence, and financial transparency were broadly comparable across genders. These results indicate that routine physiotherapy services are delivering strong experiential quality but would benefit from standardised, auditable consent and privacy protocols and scheduling that protects adequate history-taking time, particularly to ensure equitable experiences for women. Clinically, embedding consent checklists, chaperone offers, visible privacy cues, and protected first-visit time can strengthen trust, shared decision-making, and adherence; service dashboards stratified by gender can guide ongoing quality improvement. Research should now test targeted workflow interventions (e.g., scripted consent prompts, extended intake slots) in pragmatic trials, incorporate qualitative enquiry to refine gender-responsive practices, and use multi-site probability sampling linked to objective service metrics to enhance generalisability and causal inference—all directly advancing the study's objective of evaluating and improving patient care and physiotherapy management.

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