Exploring Physiotherapists' Participation in Peer Review in New Zealand

By

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ATTESTATION OF AUTHORSHIP

I hereby declare that this is my own work and that to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed: _____

Dated: _____

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ABSTRACT

This qualitative, descriptive study explored physiotherapists' experience of participating in peer review in public and private health services in New Zealand. Peer review is a professional activity where one health practitioner evaluates the practice of another. Accordingly, much professional effort has been expended on developing peer review systems and implementing review processes, yet the benefits of peer review are uncertain. A changing legislative environment where producing evidence of ongoing professional development is required, has provided impetus for this study given the limited research to support the use of peer review in this context. While the literature identifies competing focuses on professional development and accountability, there is lack of clarity about which model of peer review is being implemented in this country and which might serve the profession better. This study is a first step in clarifying the issues by identifying the personal, professional and organisational factors that influence health professionals' participation in peer review.

The methodology consisted of a qualitative descriptive approach situated within a post-positivist paradigm. Seven physiotherapists working in the New Zealand health system who had participated in a peer review process within the last 3 years participated in this study. Semi-structured interviews were conducted, guided by broad questions relating to central themes identified during an extensive literature review. Interviews were then audio taped and transcribed verbatim to form the data. Transcripts were analysed by assigning content labels to units of text that seemed to encapsulate one complete thought or idea. The labelled groups were analysed into sub-themes. Finally, the general themes that arose were described.

Findings indicate that while peer review systems have been developed and are carried out as prescribed, therapists lack clarity about the intended outcomes. While recognising the benefits of receiving feedback on practice, many manage the review process to maintain positive working relationships and ensure their practice is favourably reviewed. The strategies they employ and the consequences of managing peer review in these ways are described. Current peer review processes in New Zealand do not provide reliable information about competence to practice. Neither do they fully achieve their potential as a professional development tool. Therefore, the professional emphasis and effort on peer review needs to be revisited. The findings highlight the need for consultation amongst individual physiotherapists, physiotherapy managers, physiotherapy professional organisations, and the registration board, to negotiate whether regulatory or professional development needs will drive peer review processes in New Zealand in the future.

Chapter One: Introduction

This qualitative descriptive study explores the participation of physiotherapists in peer review, within the New Zealand context. A small sample of physiotherapists working in a range of environments, including both public and private practice settings, were interviewed and asked to describe their experience of the peer review process. The participants had all been involved in peer review, as both the reviewer and the person having their practice reviewed. As physiotherapists' participation in peer review seems to be increasing, examination of this professional pursuit warrants further study.

Focus of Inquiry

My research question was: What is the experience of physiotherapists' participating in peer review?

Aims of the Study

- To describe the experience of peer review through the voice of the participants in everyday terms.
- To identify factors and characteristics of the experience of peer review.
- To analyse whether these factors are helping or hindering the process of peer review as a developmental activity.

Peer review is a process traditionally used by professionals, where one member of the profession is asked to assess the work of another and then make comment on that

work. The term ‘peer review’ is often used synonymously with the terms ‘peer assessment’, ‘peer appraisal’ and ‘peer evaluation’. The term ‘peer’, in the context of this study is defined as another member of the same profession, as this seemed to be the connotation given to the word by participants.

A generic qualitative approach was selected for this study to explore the experience of seven registered physiotherapists currently practicing in the New Zealand healthcare environment. Although there has been considerable research into peer review internationally, there is limited local research of what physiotherapists in New Zealand actually do and what their experience of being reviewed and reviewing each other is. Therefore, a generic qualitative methodology was selected as an exploratory approach with which to begin examining this topic.

The sample selected included physiotherapists from public hospitals funded by the government who worked in both in-patient, out-patient and community-based settings, as well as those working in privately owned physiotherapy practices. All participants had been involved in peer review within the last 3 years. This timeframe aligned with the requirements of professional organisations and allowed participants to recall events and experiences with some accuracy.

Introducing Peer Review

A review of literature across many disciplines and countries shows that interest exists in how professional practice is evaluated, especially when that practice may be publicly funded as in health and education (Evans, Elwyn, & Edwards, 2004; Fedor, Bettenhausen, & Davis, 1999). Peer review is a professional tool intended to assure

quality of practice. Over the last few years, participation in peer review across many disciplines including physiotherapy seems to be increasing (Antonioni & Park, 2001; McLaughlin, 1998). The use of peers for evaluating practice has its benefits and costs. Peers are often the most frequent observers of practice, placing them in an ideal position to comment. However they are also in the position of being in a collegial relationship without organisational authority. It has also been suggested that peer review may suppress innovation in practice (Horrobin, 1990).

Peer review can be undertaken for a number of different purposes. These significantly affect the way in which participants both experience and accept the process (Fedor et al., 1999; Vuorinen, Tarkka, & Meretoja, 2000). Although scant literature exists regarding physiotherapists and peer review, there is considerable literature from other disciplines and particularly other health disciplines. In reviewing the literature, key issues influencing peer review were identified. These issues are clarity of purpose, validity and reliability, defining assessment criteria, training reviewers and reviewees, the impact of feedback, effects of interpersonal relationship and the influence of rater bias.

It is not clear how the current situation in New Zealand physiotherapy regarding peer review aligns with the international literature. Various models of peer review exist and seem to be used within different contexts to varying degrees. Two described models of peer review used by healthcare professionals include documentation in the clinical record alone as a basis for evaluating professional work, as well as the presentation of case studies. Models based on observation of practice predominate in the New Zealand setting however other models are also used. As a number of

different models of peer review exist and my intention in this study was to explore the current practices, I did not seek to define peer review when recruiting participants to the study. This allowed the participants to reveal their understandings and experiences of any and all the activities they regard as peer review.

In Chapter Two, the topic of peer review will be further explored, drawing on relevant international literature from a variety of fields, including the business, health, military and education sectors. This review of existing knowledge describes the complexities of the peer review process and the variety of purposes for which peer review is undertaken.

Terminology

The term 'peer review' refers to a formal process where the professional undertakings are examined by another person of that profession. This and other terminology associated with peer review is defined in Table 1 to help clarify frequently used terms in the data and findings, in particular the way they are understood in the New Zealand context.

Table 1: Definitions of Peer Review Terminology

Term	Definition
Criteria	the measurable key components of a standard. Criteria specify what is to be measured in a clinical audit (Ministry of Health (MOH), 2002)
Learning Culture	an organisational culture that places importance and value on learning rather than establishing blame.
Peer Review	an appraisal by professional co-workers of equal status of the way an individual physiotherapist or other health professional conducts practice, education or research. The appraisal uses accepted standards as measures against which performance is weighed (Mosby, 1998)
Peer Reviewee	the person who has their practice evaluated through observation and/or questioning by the peer reviewer
Peer Reviewer	the person who observes, evaluates and gives feedback on the practice of the reviewee (New Zealand College of Physiotherapy (NZCP), 2002)
Professional Development	activity that is undertaken to enhance the professional practice of an individual
Standard	a measurable statement about performance describing the quality of care to be achieved based on the best available evidence (MOH, 2002)
Template	a standardised document which contains the criteria and guidelines against which the peer review will be conducted and the results recorded

New Zealand Physiotherapy

Physiotherapists working in New Zealand are registered healthcare practitioners. As such, they are subject to various legislative and registration requirements in the New Zealand healthcare environment. In this context, professional demands and recent legislative changes have influenced peer review processes by encouraging a movement towards peer review in physiotherapy practice. However, at this point

there seem to be few studies describing the experience of participants in peer review (Evans et al., 2004). The implications for practice including ongoing professional development and quality assurance are complex. In particular, the question of how do physiotherapists' experience peer review remains unanswered. Further study in this area could help identify factors that influence physiotherapists' participation in peer review.

In New Zealand peer review is expected by the public, politicians, funding agencies and the New Zealand physiotherapy profession and the NZCP (McLaughlin, 1999; MOH, 2002; NZCP, 2002). An overview of the various influences will be provided, seeking to determine the impact of each of these separately.

Legislative influences.

With the introduction of the Health Practitioners Competence Assurance Act (New Zealand Government, 2003) into New Zealand law, there is a requirement for all health professionals to provide evidence of ongoing professional development and competence. The basic driver of this legislation is to protect the public by assuring the competence of health professionals, including physiotherapists. Peer review has been recognised by the Physiotherapy Board of New Zealand (PBNZ), the profession's regulatory authority, as an acceptable professional development activity and one way to demonstrate both competence and an intention to reflect on areas of practice which may require development (PBNZ, 1999, 2003). This recent change to the certification of the on-going competency of health practitioners introduced in New Zealand legislation during 2003, has required that all registered healthcare

practitioners participate in professional development activities and record evidence of this activity.

As well as establishing general expectations of ongoing activity to maintain competence, the PBNZ has defined the competencies required for practicing physiotherapy in New Zealand that have relevance to peer review. As competencies 9 and 10 detail indicators of meeting expectations when physiotherapists "Compare own performance to that of professional role models", "seek and accept evaluation from others" and "modify and adapt professional practice in response to evaluation" (PBNZ, 1999, p. 85-90). These competencies address developing individual professional growth and demonstrating accountability to the public and the profession. Peer review can provide evidence of meeting these competencies.

In New Zealand subsequent to this new legislation, professional registration boards have decided how they will assess competence for annual re-certification. For physiotherapy the activity of peer review is included in the category of 'work-based' professional development activities published by the governing body's, "New Zealand Physiotherapy Board Re-certification Guidelines" (PBNZ, 2005). They must also sign a self-declaration of competency. This seems to have influenced the uptake of peer review, as a professional development activity. In New Zealand, according to the MOH (2001):

> the peer review process is designed to foster individual accountability for professional development and practice, as well as group accountability for the overall quality of professional practice in a particular discipline or service. Peer review is considered to be a hall mark of professional practice. (p. 7)

Peer review is also a professional tool with multiple uses. It contributes to clinical audit which is defined as the systematic peer evaluation of an aspect of patient care (MOH, 2002), and other activities such as professional development, information for credentialing, service planning and evaluation. The overall purpose of peer review is to inform others about one's own practice in relation to that of the peer group (MOH, 2001).

Professional influences.

In New Zealand the professional association for physiotherapists is the New Zealand Society of Physiotherapists (NZSP). The role of this Society is as the professional body representing physiotherapists throughout New Zealand. In this role, the NZSP have developed standards for the practice of physiotherapy in New Zealand. Under Standard 12: "The physiotherapist has a duty to keep up to date with professional skills and knowledge." Criteria 12.8 states: "The physiotherapist participates in a peer review system appropriate to the work place" (NZSP, 2006, p. 19). Further more the NZSP's Code of Ethics: Section 2 Standards of Care – sub-section 2.4 advises "physiotherapists are encouraged to participate in peer review" (NZSP, 2003, p. 2).

The NZCP, an organisation associated with the professional body (NZSP), has as their mission: "To provide leadership in the promotion of competence and recognition of the highest standards of professional practice in all fields of physiotherapy" (NZCP, n.d.). This organisation is also pushing physiotherapists towards peer review. In order to maintain membership of this professional college,

physiotherapists are required to undergo regular peer review. This is required every three years and peer reviewers must be approved by the NZCP (Keals-Smith, 2002).

A sense of concern surrounds the effectiveness of the mechanism of feedback in peer review. The potential for using this mechanism of feedback to promote compliance with Recommended Best Practice Guidelines exists, but there are doubts as to how effectively this works if the optimum conditions for exchanging feedback are not established (Gopee, 2001).

Influences of the public.

An additional factor encouraging the profession towards peer review is public accountability. Peer review in New Zealand physiotherapy practice was highlighted in a high profile government inquiry into physiotherapy practices at National Women's Hospital (MOH, 1999) in regard to critiquing change in practice and innovation in practice. In this inquiry, the change to previous regimes in chest physiotherapy given to neonates was under critique, after a change in practice was introduced. The apparent increase in peer review may be attributable to some findings of this high profile inquiry. It is recommended by both the MOH and the Health and Disability Commissioner that health professionals participate in peer review to improve the quality of practice (MOH, 2001).

As this discussion demonstrates various political and professional drivers and the many different purposes of peer review are moving physiotherapists steadily in the direction of peer review. As the physiotherapy profession moves down this track, we need to know more about the issues surrounding the peer review process. For what specific purposes are we using peer review physiotherapy? What do we hope to

achieve through engaging in peer review? What characterises a successful peer review process?

Rationale for Current Study

Peer review has been used as a professional development strategy for many years. Research into peer review for physiotherapists is limited, particularly in the New Zealand context. However New Zealand health professionals are now required to participate in annual re-certification processes in the new HPCAA era. No longer will it be acceptable to rely on distant professional training as evidence of competence. In New Zealand from September 2004 and annually thereafter, registered health professionals can be asked to provide evidence of their ongoing competence before they will be issued with an annual practicing certificate.

Why Undertake Peer Review?

An increased understanding of peer review will have significance for all physiotherapists in this post-HCPAA era. Healthcare organisations are interested in finding ways to train and develop employees at lowest cost, without compromising the delivery of high quality service. Peer review is valued as a tool for auditing compliance with 'Best Practice' guidelines. These guidelines are published by professional organisations setting standards for the profession or groups of researchers promoting evidence-based practice (Hendriks et al., 2000). They can provide criteria for both self-evaluation and peer review. Feedback during peer review is seen as key to the success of this strategy of improving practice on an individual and national level.

Registration boards have decided how they will assess the health practitioners' competence including the evidence of peer review. This new focus setting peer review in a developmental framework may encourage continuous quality improvement as well as providing evidence of competency. For this to succeed there is a need to understand the influences on the peer review process as it is implemented in New Zealand, so that the experience of peer review is as conducive to learning as possible.

Giving and receiving feedback is part of the peer review process. Enabling this feedback exchange is a crucial factor in the success of peer review as a developmental activity. What is it that allows the giver and receiver to say and hear what needs to be said? What tensions exist between the two peers involved? Who else is in this equation? What is the true cost of giving feedback to your colleague? What are we risking and what are we gaining? Do we have enough opportunity to observe relevant behaviour? What is unspoken in these encounters? Once feedback is given, is that the end? How do we complete the loop? How are learning's evaluated and consolidated?

A lot is expected from peer review, particularly given the responsibility of maintaining and developing professional accountability, yet many questions remain unanswered regarding peer review. This study will not attempt to answer all these, but rather to begin finding out what is actually happening from the perspective of the people who participate in peer review. This information will then provide a foundation for determining the relevance and urgency of the other questions to inform physiotherapy practice in New Zealand. This study addresses the question of

'What is the experience of physiotherapists' when participating in peer review in New Zealand?'

As the above discussion shows, there are multiple influences and differing agendas regarding peer review for physiotherapists in New Zealand. This research study has significance for all physiotherapists, as well as other health professionals, who engage in peer review as a professional development activity in order to provide evidence to assist in establishing competency to practice as well as to address the demands and expectations of multiple stakeholders in peer review.

Role of the Researcher

As a physiotherapist myself, my aim was to describe the experience that other physiotherapists have when participating in a peer review process. My certainty that this is the place to start this inquiry stems from working over many years in a variety of settings and organisations both public and private. My experience has been that a number of different peer review processes exist in various organisations. Each place has its own way of undertaking review of practice. At times over my career as a physiotherapy supervisor, I have been charged with implementing peer review practices. It is my experience that some degree of resistance exists to the idea of participating in peer review amongst the physiotherapists encouraged to engage in this process, especially when colleagues are involved in reviewing each other. At various times over the years peer review has had more or less prominence in physiotherapy workplaces however, a growing emphasis has been placed by the physiotherapy profession on this process.

An analysis of the processes around safe and effective feedback in peer review could lead to an increased accountability and effectiveness in physiotherapy practice. Effective feedback in peer review is one of the key strategies used in New Zealand physiotherapy practice to ensure best service for consumers and continued professional growth of clinicians. Feedback during peer review has the potential to develop and maintain professional accountability. I have experienced that physiotherapists' participation in peer review can be used to provide evidence of continued professional development.

In any research there is an acknowledgement of potential influence from the researcher. In qualitative research it is readily acknowledged that the assumptions of the researcher may influence the research. By exposing these presuppositions, it is hoped to limit the effect of any bias. The assumptions I bring to this study are:

1. Peer review is a professional development activity.
2. Physiotherapists often need to continue in on-going collegial relationships with their partner in the peer review process.

From my experience coupled with discussions with other physiotherapy advisors, there are many different methods of peer review currently used in physiotherapy practice. These include one-on-one reviews through observation of practice and subsequent discussion, case presentations reviewed in a group and written case studies or clinical records submitted for critique. Therefore, experiences of the process of peer review may vary and be broader than those I have experienced and formed opinions about. This study provides further exploration of the physiotherapists' experience in participating in peer review, and adds to the knowledge about what the key issues are in the New Zealand context.

Summary

It is generally agreed that peer review contributes to quality improvement for both individuals and the profession (McLaughlin, 1998; MOH, 1999, 2001, 2002). Given the many factors influencing the process and outcome of peer review, few studies have investigated ways of addressing these issues (Evans et al., 2004). With the many legislative, regulatory and professional drivers steering New Zealand physiotherapists in the direction of peer review, further investigation into these issues seems warranted.

Structure of Thesis

In Chapter Two the existing knowledge regarding peer review is explored to identify what is already known and where the gaps in current knowledge exist. The approach to the literature review is examined and the need for further research discussed. In Chapter Three the methodology and methods used in this study are presented. Descriptions of the methods and the approach to data collection and analysis are discussed. The approach to rigor and the ethical considerations that influenced the research design and reporting are also offered.

Chapters Four and Five reveal the findings. These are arranged in two general themes. Firstly, 'Practice on Show' and secondly 'Managing the Performance.' These general themes are made up of several sub-themes which are described in each chapter. Finally in Chapter Six, the discussion of the findings takes place including the conclusions and relevance to practice. The strengths and limitations of this study are examined and areas for possible future research suggested.

Chapter Two: Literature Review

Recently the practice of peer review in a variety of disciplines including physiotherapy seems to be increasing (Antonioni & Park, 2001; Dannefer et al., 2005; McLaughlin, 1998). Therefore, the need to understand the experience of those health practitioners who participate in this process seems timely. In preparation for this study a review of literature was undertaken to identify the breadth of existing knowledge regarding peer review and to identify the gaps in this knowledge. Literature from a variety of disciplines and across many different settings was considered. For instance, how professional practice is evaluated in sectors such as health, education, business and the military has been of significant interest for researchers, especially when that practice may be publicly funded as in health and education (Evans et al., 2004; Fedor et al., 1999; Hofhuis, van der Ende, & De Bakker, 2006). Professional accountability is a responsibility of both the individuals and professional groups involved (Gopee, 2001). The approach taken to this literature review is described in the following section.

Approach to the Literature Review

A systematic search was undertaken for references to peer review processes in the world literature. This was limited to English and literature from 1970 until present. Early searches indicated that the search strategy needed to be a broad systematic approach as there was a large indexing to the term ‘peer-review’ meaning review of journal manuscripts by ‘peers’. This gave a large false positive hit rate relating to peer review of published literature. Terms used to assist with over coming this were, ‘peer-assessment,’ ‘peer-evaluation,’ ‘peer-appraisal,’ as well as ‘peer-review’ and then combining the searches. Included in the search were the terms ‘quality-

assurance' and 'quality-control' to gather literature describing peer-review with a quality improvement aim and also with the term 'professional-development'. Subsequently the meshed terms 'physiotherapy' and 'physical-therapy' were added to cover different terms used by the physiotherapy profession throughout the English-speaking world. Finally the term 'New-Zealand' was added to see what literature contained specific references to peer-review in the New Zealand context.

This broad search provided a wealth of literature from a variety of different perspectives and disciplines. Abstracts and citations were assessed then reviewed and literature identified that seemed to be relevant to the topic of peer review. Relevant literature was then sourced and categorised into priorities. Prioritised literature was read and critiqued. A grid was developed to record key details of each piece of literature reviewed including type, methodology and issues of relevance to peer review. In reviewing the literature on peer review, the terms peer-review, peer-assessment, peer-appraisal and peer-evaluation, have all been used by different authors to describe similar processes. Additionally the term, 'visitation' has arisen mainly in recent literature from northern Europe, to describe on-site visits to health professionals in practice by assessors who critique what they see according to a specific set of criteria. These various terms overlap in meaning and have been used synonymously in this paper. When referring to specific literature in this report, the terminology used by the original authors is retained.

Reading across the literature the following nine key factors were identified; clarity of purpose, validity and reliability, assessment criteria, training, time involved, feedback, interpersonal relationships, rater-bias and perceived fairness. Norcini

(2003) also found that a range of factors affected the quality of peer assessments including relationships, experience at performing peer assessments, whether the reviewer liked the reviewee, as well as for what purpose the assessment was being undertaken.

Systems of assessment and evaluation using professional colleagues, such as peer review help to define quality practice. However, any system of peers evaluating each other has its costs and benefits (Horrobin, 1990). The intentions of undertaking a peer review is not always clear to organisations or the people involved in the practice. Clarifying the purpose of peer review is important (Arnold, Shue, Kritt, Ginsburg & Stern, 2005). When the purpose of peer review is clear, those participating in the practice are more confident in their role, and have a better understanding of why they are assessing practice and the expectations placed on them. Participation in peer review practices can also be influenced by the experience of those involved and this may affect the acceptance of this process (Fedor et al., 1999; Lombarts, Klazinga, & Redekop, 2005; Vuorinen et al., 2000) by those expected to undergo peer review by employers and professional authorities.

In the New Zealand context, professional demands and recent legislative changes have influenced peer review processes by encouraging a movement towards peer review in physiotherapy practice (Skinner, 2004). However at this point there are few studies internationally describing the experience of participants in peer review (Evans et al., 2004) and the participation of physiotherapists in the New Zealand setting in particular (McLaughlin, 1998). The implications for practice including ongoing professional development and quality assurance are complex. In particular,

the question of what the physiotherapist's experience of peer review is like remains unanswered. Further study in this area could help identify issues which affect physiotherapists' participation in peer review.

In this literature review key issues were identified that may influence the effectiveness of peer review. The literature identifying these issues is discussed in the following sections.

What is Peer Review?

Peer review has been defined as "An encounter between persons equal to one another in professional education, qualifications and position, in which one person's professional pursuits are examined, discussed and critiqued" (Cheyne, McGinley, & Turnbull, 1996, p. 4). As this definition reveals, peer review is a process of evaluation of an individual's performance by members of the same profession whose status is similar to the status of those delivering the care. Peer review can also address the performance of groups of practitioners.

When examining the application and potential impact of peer review in physiotherapy practice, McLaughlin (1998) referred to the definition of peer review stated by the Health Funding Authority (1997): "An analysis of a clinician or other health care worker's practice by their equals (peers) that is based on an agreed, predetermined set of criteria or measures" (p. 16). As this and the previous definition reveal, a key component of peer review is the concept of the evaluation from the standpoint of a professional equal. Whether this refers to someone with the same professional qualification or clinical expertise is not explicit.

The peer review process may be formal or informal and can include any occasion in which practitioners are in learning situations with other colleagues. In the context of multidisciplinary teams, peer review can also incorporate feedback from 'peers' of other health professional disciplines, who are members of the healthcare team (MOH, 2002).

The process of peer review in physiotherapy varies markedly from place to place. The main forms of peer review are firstly clinical documentation audit, secondly direct observation of practice, thirdly patient and/or clinician interviews with written feedback (Hofhuis et al., 2006; McLaughlin, 1999), and lastly case review presentations (CMDHB, 2002). In New Zealand physiotherapy the most common forms of review currently described as 'peer review' seem to be direct observation of a sample of practice of one physiotherapist by a peer, or a verbal case presentation of a piece of work to a group of peers.

Purpose of Peer Review

Peer review has been used for a variety of purposes, regulatory and administrative, for quality assurance and to address developmental needs (Evans et al., 2004; Fedor et al., 1999; McLaughlin, 1999; MOH, 2001; Putzel, 2004). For the purpose of regulation governments, professional bodies, funding agencies and healthcare organisations often use peer review as a means of promoting compliance with legislation, membership requirements and contractual obligations (Accident Claims Corporation (ACC), 1998; HPCAA, 2003; NZCP, 2002). Governments are concerned with regulating who can deliver healthcare. Professional colleges can insist on regular peer review as a membership requirement. Funding agencies, such

as the government and health insurers for example the ACC, can use peer review as a quality control mechanism and restrict contracting to service providers who participate in peer review. These different organisations use peer review in a variety of ways to assist in benchmarking healthcare service providers against professional standards.

Administrative purposes include peer review being used as part of annual performance appraisals and criteria for performance (merit) rewards. From a quality assurance perspective, peer review can be used as one way to provide evidence of clinician competency. Peer review can be included in credentialing processes for assessing the scope of practice as well as competency of clinicians (MOH, 2001). Quality improvement cycles can include peer review in order to improve consistency of practice and highlight systems not meeting requirements (Vuorinen et al., 2000).

When the purpose of peer review is developmental, this can be a way of providing clinicians with information on which to base improvements in their practice. It can provide acknowledgement of what individuals do well and an opportunity to reflect on practice with a peer. As peer review can be a collaborative process, it has the potential to improve interpersonal relationships especially in learning organisations.

Clarity of purpose is one of the key factors influencing both the success (Horrobin, 1990) and the acceptance of the peer review process. By acknowledging the underlying purpose of peer review in any particular setting, those involved in the process will have greater understanding of the reason why they are performing this task. A clear awareness of the intended purpose of each peer review will assist those

involved to maximise the benefits of the process. If the purpose of peer review is not clear, participants may align their actions and critique in order to achieve desired outcomes for the perceived purpose rather than the intended purpose.

As well as these organisational purposes, peer review can be seen as an indication of professionalism and public accountability. Peer review is considered to be a hallmark of professional practice (MOH, 2002; Vuorinen et al., 2000). The peer review process is designed not only as an organisational mechanism to ensure safe practice but also to place responsibility for safe practice onto individuals. This is a means of fostering individual accountability for professional development and practice, as well as group accountability for the overall quality of practice in a particular service or profession (Daniels & Magarey, 2000).

Factors Influencing the Uptake of Peer Review

The overall purpose of peer review is to inform others about ones own practice in relation to that of a peer group (MOH, 2002). The MOH have encouraged health practitioners towards this practice suggesting multidisciplinary teams focus on improving clinical outcomes and develop systematic review processes to examine the quality of practice through regular audit and peer review.

With the introduction of the HPCAA (New Zealand Government, 2003), there is a requirement for all health professionals in New Zealand to provide evidence of ongoing professional development and competence. As of the 18th of September 2003, in order to be granted an Annual Practicing Certificate (APC) physiotherapists in New Zealand have to provide the Registration Board, on request, with evidence of

their competence and on-going professional development. Peer review is one recognised way to demonstrate both competence and an intention to reflect on areas of practice which may require development.

In addition to the impetus provided by the HPCAA, the professional bodies also support the drive towards peer review for physiotherapists. Although the Physiotherapy Registration Board (PBNZ) does not define peer review, in the HPCAA the professional peer is defined as "a person who is registered with the same authority with which the health practitioner is registered" (New Zealand Government, 2003, p. 4).

The PBNZ defines the competencies required for practicing physiotherapy in New Zealand. Competence, as defined by Skinner (2002) is "a behaviour set at a threshold that will protect public health and safety and allow for continuous evolution of clinical practice, education and management roles" (p. 4). Although audit of continuing competence sits with regulatory bodies such as the PBNZ, the responsibility for continuing competence sits with the health practitioner and processes such as credentialing and peer review are encouraged (Skinner, 2006). Accordingly, the PBNZ's competencies 9 and 10 address individual professional growth and demonstrating accountability to the public and the profession, whereby physiotherapists are expected to seek and accept evaluation (PBNZ, 1999). Peer review can provide evidence of meeting these competencies.

One aspect of practice that might be expected to be addressed within any peer review process in New Zealand is the ability to practice in a culturally safe manner, which is

a key competency and expectation of physiotherapists practicing in this country (Main, McCallin, & Smith, 2006). At present the PBNZ has indicated that cultural competency as well as ethical conduct should be displayed throughout all dimensions of practice (PBNZ, 2004). Guidelines for cultural competence within physiotherapy in New Zealand have been developed by Taeora Tinana, the special interest group of Maori physiotherapists within NZSP, however as yet no specific competencies have been integrated into the registration requirements. The lack of explicit standards by which to assess cultural competence in physiotherapy practice, has been highlighted as an area that could be developed further to provide criteria to strengthen the assessment of these competencies (Ratima, Waetford, & Wikaire, 2006). There is a requirement placed on registration authorities such as the PBNZ to develop such standards by the HPCAA (New Zealand Government, 2003).

As well as the PBNZ and the NZSP, the NZCP is also pushing physiotherapists towards peer review. In order to maintain membership of this professional college, physiotherapists are required to undergo regular peer review. This is required every three years and peer reviewers must be approved by the college (NZCP, 2002). A final factor encouraging the profession towards peer review is public accountability, as highlighted in the inquiry into practices at National Women's Hospital (MOH, 1999). One aspect that is particularly relevant is what factors influence the experience of physiotherapists undertaking peer review with colleagues. In the next section, several factors key to the success of peer review as documented in the literature are discussed in greater depth. These are; clarity of purpose, validity and reliability, assessment criteria, training for different roles, feedback and interpersonal relationships in relation to peer review.

Key Factors

Clarity of purpose.

The importance of clearly stating the purpose of peer review has been mentioned repeatedly (Evans et al., 2004; Fedor et al., 1999; Horrobin, 1990; McLaughlin, 1998). If the purpose of peer review is developmental, as opposed to regulatory or administrative, the acceptance of peer review increases (Fedor et al., 1999). It has also been found that the clarity of purpose is essential because if clinicians are confused as to the true purpose of the peer review, the fear and anxiety of both reviewer and reviewee may increase (Putzel, 2004). This phenomenon is labelled 'peer fear' by Fedor et al.

Not only should the purpose of peer review be stated overtly by organisations, but it is also important to check with those involved in the process that their perception of the purpose is the same as that stated by the organisation (Zazanis, Zaccaro, & Kilcullen, 2001). Checking the perceptions of those involved may influence reviewers to construct an outcome that is politically congruent with the purpose they perceive (Antonioni & Park, 2001).

If the purpose of peer review is administrative and can be related to merit reward decisions, then studies have shown that the reviews tend to be more favourable and reviewers are more reluctant to give feedback concerning deficits in performance (Putzel, 2004; Zanzanis et al., 2001). One illustrative example comes from a study of peer evaluation with nurses in a hospital in Finland. Vuorinen et al. (2000) investigated the issues in peer evaluation with regard to professional development. Although these researchers described this study as a pilot for a qualitative study,

given the reasonably large sample size others might see this study as quite substantial. In total, 44 nurses working at a Finnish university hospital, aged from 20-60 years with between 1-13 years experience as nurses were involved. The study used a qualitative research approach developing a template of five questions based on concepts generated from a review of the literature. The researchers used content analysis to develop themes from the participants' essay-type answers.

The results found were that self-evaluation constitutes the basis for peer evaluation and that peer evaluation allows nurses to give and receive professional and personal support, for the purpose of professional development. Through professional support the opportunity for change in practice and alternative action is enhanced. Personal support requires peers to respect each other's equality and individual style and can decrease feelings of uncertainty related to the job.

These authors concluded that peer evaluation could be used as a method of promoting professional development in order to further on-the-job learning in collaboration with peers. Since these findings are from a single hospital this may limit the transferability of the research. Another substantial limitation of the study is that the participants had no practical experience of peer evaluation but had been only exposed to the concept. In the actual practice of peer review, the experience and the issues may differ to those anticipated by participants.

A second researcher not working in the same place was used in the study to improve reliability and researcher interpretation. There was also no indication given in the report that any member checking was undertaken to address any misinterpretations in

the data collection or analysis. However this study does illustrate that the clarity of purpose in peer review is a key factor to providing the support received from the peer evaluation process. Once the purpose of peer review is clear, the process for evaluating its validity and reliability can be more readily assessed.

Validity and reliability.

Validity is concerned with whether the process of peer review is actually measuring the qualities and competencies that organisations aim to measure, against specific professional standards. Local standards of practice and competencies exist to guide best practice in physiotherapy and it is these standards and competencies that are assessed by designing criteria which specify exactly what is to be measured. In peer review, the assessment criteria are critical to the validity of the process.

Given the complexity of designing criteria that accurately reflect professional standards, it is perhaps not surprising that the validity of peer reviews has in some studies been reported as very good (Goldman, 1992; Mumford, 1983) and in others reported as poor (Evans et al., 2004; Norcini, 2003). Using structured instruments with consistent criteria also improves the reliability of peer review (Goldman & Ciesco, 1996), as does the ability of the reviewer to assess the criteria.

The extent to which validity and reliability is achieved in practice is problematic however, with several authors recommending that any instruments designed for peer review need to have their validity and reliability measured prior to their use (Evans et al., 2004; Goldman, 1992; McLaughlin, 1998). Goldman subsequently undertook an extensive literature review regarding the inter-rater reliability of peer assessments of

the quality of care and found the reliability to be only slightly better than chance. He suggested several ways to improve the reliability of the peer assessment process, among them more objective assessment procedures, multiple reviewers, more effective reviewers, removing systematic rater-bias, outcome judgements and the use of standardised best practice guidelines (Goldman & Ciesco, 1996). However, there is disagreement with some of these suggestions. Masso (2004) voiced the contention that various biases are introduced such as hindsight and outcome bias, as well as attribution error. This is where poor outcomes are perceived to be due to the flaws of those involved rather than exploring whether other factors such as systematic factors, may have contributed significantly to the outcome. Masso also questioned the feasibility of multiple reviewers as Goldman recommends.

According to Putzel (2004), the ability of raters to make accurate assessments does not necessarily relate to their willingness to accurately report the judgements they have made. He also reports that no rules or procedures will stop the games raters play, but only a culture change to a learning culture will achieve this outcome. This assertion suggests that the low inter-rater reliability of peer review processes may reflect the complex nature of the contextual factors. Masso (2004) again queried the concept that peer review by group improves reliability and validity, but agreed with Goldman (1992) that averaging multiple independent reviews does improve reliability. Although not stated, these suggestions seem to be based on the thought that many heads are better than one. However, a group of reviewers discussing their judgements together has significant potential for the individual reviewers to be influenced by others. Additionally, how the reviewer feels about the purpose of the

review, their role in it and the reviewee has an affect on the inter-rater reliability (Antonioni & Park, 2001; Greguras et al., 2001).

Assessment criteria.

The process of peer review requires an evaluation of practice. By choosing the key components of any given practice to measure, a rating or measurement can be placed on whether practice is making the grade or meeting the standard. In order to achieve a consistent measurement of practice with different peer reviewers and different peer reviewees, Goldman (1992) suggested the use of structured assessment criteria. Assessment criteria specify what is to be measured in a clinical audit or peer review (MOH, 2002) and enable practice to be measured in a structured and formalised manner. At the same time as providing a measurement tool, criteria also provide a guide so that the expectation of the standard of practice is clear to all and consistent (Fedor et al., 1999; Gopee, 2001).

To increase the validity of peer review for physiotherapy practice, the development of appropriate assessment criteria is paramount. Further, the acceptance of peer assessment is enhanced if the criteria on which the assessment is based are developed collaboratively between all parties involved in the review process (Daniels & Magarey, 2000). Participants in peer review perceive the process as more just if they have had input into what is measured and how the different components of practice are to be assessed (Fedor et al., 1999). Where possible, criteria should be developed using evidence-based guidelines (Hendriks, et al., 2000). If these are not available an alternative consensus of best practice needs to be established against which to measure practice (McLaughlin, 1999).

One issue that has hindered the uptake of peer review is the lack of practice guidelines. Recently however, there has been an increase in the development and publication of these guidelines for physiotherapists to measure practice against. In a study undertaken to audit physiotherapy practice, Turner et al. (1999) found that physiotherapists often continued to practice in the methods they were taught as students and did not refer to current practice guidelines even when available. This extensive study involved the audit of 1254 physiotherapy patient records over a 2 year timeframe, selected from five different English hospitals and three different specialties. The consistent failure to meet minimum physiotherapy documentation standards throughout this wide variety of settings and across time was noted as the main finding. This study had also initially intended to evaluate the effectiveness of the care delivered but this was unable to be assessed as the standard of documentation was so poor.

Currently the United Kingdom's physiotherapy professional body, the Chartered Society of Physiotherapists (CSP) recommends peer review using the method of documentation audit and follow-up interview. If peer review is to be undertaken by documentation audit alone, then the apparently widespread failure to meet standards of documentation presents a severe limitation to this method of evaluating practice. Although not studied specifically in New Zealand, the standard of documentation may also pose a similar limitation when using this method of peer review. The question of how to prepare participants to get the most out of peer review is addressed in the next section.

Preparation for the role of reviewer and reviewee.

Traditionally the role of evaluating performance has rested with employers or supervisors. The recent change to also using peers to evaluate co-workers' practice represents a significant alteration in the expectations placed on employees (Fedor et al., 1999). In a peer review process peers must evaluate their co-workers and in turn be evaluated by peers themselves. These dual roles each provide their own challenges.

The task of peer review is one that many employees may not have experienced before. To be able to perform the task of peer review employees require information and skill development in preparation for undertaking the roles of both a peer reviewer and peer reviewee. These dual roles each require specific skills and at the same time an understanding and appreciation of the role of the other as well as how the outcome of a review will be used (Daniels & Magarey, 2000; Fedor et al., 1999; Wilkins, 1995). The above authors suggest that providing training to peer reviewers could improve the reliability and acceptance of peer review. However, Goldman (1992) expressed a different view. He suggested that a higher standard of peer review could be achieved by only using acknowledged experts. The concept of calling this process 'peer review' however is challenged by using 'experts' alone for review of practice and so may no longer represent the same phenomenon as 'peer' review.

To a lesser extent the model of peer review used by the NZCP, uses this idea, in that all 'peers' used for review should be associate members or members of the College. This recommendation of only using College members as reviewers represents an attempt to improve the quality of review processes. Another approach to improving

the quality of reviewers is reported by Sanzaro and Worth, who tested potential peer reviewers for consistency of their ratings and only used those with satisfactory results (as cited in Goldman, 1992).

Aspects of training suggested in the literature include firstly clarifying the purpose for the review (Fedor et al., 1999; Putzel, 2004). Secondly, developing skills in objectively assessing behaviours, interpersonal communication, as well as task performance (Evans et al., 2004) should be included in training. It appears that objective assessment criteria certainly assist in this process (Hendriks et al., 2000).

Of particular note, is the skill development required around giving and receiving feedback. The ability to construct, deliver and accept feedback that will assist the development of practice is an essential skill in the peer review process. For peers, this aspect of the review process holds considerable challenge as after the feedback process is complete, peers often need to return to being colleagues on a day-to-day basis. Although not highlighted in the literature, training around conflict resolution skills could assist in restoring relationships if the peer review process proves difficult. Furthermore, training to assist with the skill development of giving feedback may improve clinicians' ability to remain objective and to separate adequate performance from personal style (Strauss, Barrick, Murray, & Connerley, 2001). The role of feedback in peer review will be further discussed in the following section.

Feedback.

An integral part in the process of peer review is informing the peer being reviewed of the results. Once again the purpose of the review influences the willingness of

reviewers to give feedback. If the purpose of review is to fulfil an administrative requirement and potentially influence performance rewards such as pay or promotion, reviewers are more reluctant to give critical or negative feedback (Fedor et al., 1999). On the other hand, if the review is seen to have a developmental purpose the reviewers may be more willing to objectively critique practice (Putzel, 2004). In this latter situation reviewers may see themselves in the role of coach, rather than judge and feel more confident to address areas of practice where improvements could occur. To this end, the role of feedback is to inform, present an opportunity for self-reflection and, if required, the option of changing practice. Putzel (2004) suggested that by the mere introduction of a feedback instrument, behaviour change will be influenced.

Perhaps the most anxiety provoking issue with feedback is the effect it has on interpersonal relationships. In his social comparison theory, Mumford (1983) proposed that individuals want confirmation of their own abilities and opinions. He suggested individuals will choose peers who are similar but perform at a slightly lower level than themselves. This manipulation of the peer reviewer involved should result in more favourable feedback for the reviewee. To address this issue in some peer review systems, some or all of the peers selected to conduct the review are chosen by supervisors (Fedor et al., 1999).

One possible effect of this could be more reliable feedback with less positive bias. As previously stated clarifying the purpose and processes may support increased objectivity. The possible effect of this could be to raise the standard of practice expected and increase the consistency of review. Once again the clarification of the

purpose and the process of the review could lead to reviewers and reviewees being confident in their understanding and not necessarily wanting to favourably position themselves in relation to others, but rather to look for development opportunities.

Interpersonal relationships.

Interpersonal relationships during review contribute significantly to satisfaction with the peer review process (Arnold et al., 2005). These relationships in peer review are managed by individuals to gather both personal and professional support (Vuorinen, et al., 2000). Potential limitations identified in the literature include that when peers are working closely together they often develop relationships with each other and may become friends (Putzel, 2004). Consequently they do not want to cause friction within the work group and may therefore be unwilling to provide accurate ratings. Research into peer review often ignores these relationship factors however this reservation was not supported by Magin (2001) whose study found negligible bias resulting from friendships. In contrast Antonioni and Park (2001) found both positive and negative feelings from reviewers towards the people they are rating do affect the scores raters give.

Similar conclusions were reached when Greguras et al. (2001) used the social relations model proposed by Kenny (1999) to investigate the interdependencies of ratings associated with peer relationships. This small scale quantitative study involving 59 students showed that Sally's evaluation of John is likely to be dependent on John's evaluation of Sally. Although the numbers may appear small for a quantitative study, the specific group design was able to provide stable estimates with these numbers. As peers work closely together they develop interpersonal relationships which potentially affect the judgements co-workers are willing to make

about each other. Gregarus and colleagues (2001) suggested that the rating that a reviewer gives the reviewee, may be dependant on the rating the reviewer themself received. Peer evaluation research has often ignored this non-independence of data.

Dissatisfaction with the process of review by peers most commonly refers to concerns with rater bias, with concerns of whether the review is an accurate reflection of practice and not influenced by interpersonal relationships voiced (Fedor et al., 1999; McKinstry, Peacock, & Shaw, 2005). Although many studies, including those above support this concern, Magin (2001) found in his study that the actual level of reciprocity effects were negligible. Nonetheless the acceptance of peer review is decreased when the perception of rater bias is high.

In this chapter an overview of current understandings of peer review has been discussed. Peer review entails an examination of practice by a professional peer and is carried out in a variety of ways, including, clinical audit, observation of practice and case presentations. Health professionals engage in this process for many reasons such as for regulatory and administrative purposes, for quality assurance and to facilitate professional development. In New Zealand, there are several influences which have encouraged the uptake of peer review including various professional and political drivers. Several key factors influencing the peer review process have been identified including clarity of purpose, validity and reliability, assessment criteria, training, feedback and interpersonal relationships.

Support for a Study Arising from the Literature

The review of literature has revealed that research into peer review for physiotherapists is limited, particularly in the New Zealand context even though peer review has been used as a professional development strategy for many years. However New Zealand health professionals have entered into a new era with the introduction of the HPCAA (New Zealand Government, 2003). No longer will it be acceptable to solely rely on the training that students receive to become qualified as evidence of competence. A professional qualification alongside evidence of ongoing continuing professional development is now required. This has been articulated through a set of guidelines set within a developmental framework. Registration boards have decided how they will assess this competence. There are however, limitations to current knowledge about peer review. The existing literature is mainly focused on the process and its attributes. Within the literature discussing peer review in health, the majority of studies relate to the professions of nursing and medicine. There have been only a limited number of reports which studied peer review for physiotherapists. McLaughlin (1998) looked specifically at the implications of peer review for physiotherapists in New Zealand. No studies looked at the experience of participating in peer review.

As this discussion of the literature has shown, there are several key issues influencing peer review. Understanding clearly what the purpose of any particular peer review is and what each person and any organisation involved expect from it is important. The validity and reliability of peer review has been shown to be variable and establishing measurable criteria against professional standards is integral to improving both of these attributes. Preparing the people participating in the process

with adequate training is identified as helping to clarify their roles, develop feedback skills and support interpersonal relationships. Accordingly, the methodology and design of the study need to be broadly framed to enable any or all of these issues to surface. In the next chapter the methodology and the methods used to conduct this study are discussed.

Chapter Three: Methodology

Research Approach

For this study the methodology selected is a qualitative descriptive approach within the post positivist paradigm. In this worldview things exist as meaningful entities independent of consciousness and experience (Crotty, 1998) and these things can be described. Post positivism is a modified form of positivism that concedes that humans cannot fully understand reality, whereas with rigorous data collection and analysis, researchers can approach the truth. In positivism, "reality exists, there is a real world driven by real natural causes" (Polit & Hungler, 1997, p. 13), that out there a verifiable truth exists and this truth can be measured. However in a naturalistic paradigm the existence of multiple realities is acknowledged and this is constructed by individuals who form their own subjective view of what is 'reality'. Therefore the truth or not, of a viewpoint can never be ultimately decided but rather accepted as the best understanding presently available.

The post positive world view acknowledges many scientific approaches and that these are often competing. It holds that an understanding of 'reality' can be approached, but not reached, as this paradigm views the interaction of a researcher and participant as a construction. Influences of beliefs and values of participant and researcher, as well as the context will influence perceptions of 'truth' (Grant & Giddings, 2002). When using post positivist inquiry, researchers are engaging in an interactive process between researcher and participant, learning from each other. Rich data is produced based on individuals' personal experiences and their own perception of these experiences. This paradigm can be within qualitative research

(Grant & Giddings, 2002; Racher & Robinson, 2003), such as mixed method research and such qualitative methodologies as phenomenology. Research developed in the post positivist paradigm values varying approaches to achieve insights that are greater than just the measurable facts.

Qualitative descriptive studies are described as a fundamental type of qualitative research and aim to produce a comprehensive summary of the event under examination, which is in itself coherent and useful (Sandelowski, 2000). Qualitative studies using this generic approach do not have an explicit link to any of the traditional philosophical frameworks. Underpinned by broad understanding of the nature of truth, their focus is categorical description; they are less interpretive and not linked to theory (Caelli, Ray, & Mill, 2003).

This fundamental qualitative approach is used where a deep theoretical and methodological approach is not sought when investigating the research question. Accordingly, Caelli et al. (2003) describe generic qualitative research as those which:

> exhibit some or all of the characteristics of qualitative endeavor but rather than focusing the study through the lens of a known methodology they seek to do one of two things; either they combine several methodologies or approaches, or claim no particular methodological viewpoint at all. Generally the focus of the study is on understanding an experience or an event. (p. 3)

This particular methodology was chosen as providing a description of the experience of peer review that physiotherapists and other consumers of the research could relate to. Understandings were sought that would shed new light on the process of peer

review as an event which participants experienced from multiple perspectives. The aim of this study was to describe the event as participants believe it to be, using everyday terms, identifying how participants experience the peer review process.

According to Sandelowski (2000), qualitative description is less interpretative than grounded theory or phenomenology. In qualitative descriptive research such as the study described here, the researcher wants to capture the elements of the event and then describe what has been found in everyday language. This type of generic qualitative research is defined as one "which is not guided by an explicit or established set of philosophical assumptions in the form of one of the known qualitative methodologies" (Caelli et al., 2003, p. 19). Researchers conducting these studies seek descriptive validity or accurate accounting of events that most people (including researchers and participants) observing the same event would agree is accurate.

As previously stated, this study used a descriptive qualitative design to explore physiotherapists' participation in a peer review process. Descriptive studies are not concerned with relationships among variables. Their purpose is to observe, describe and document aspects of a situation. The design is non-emergent and the course of the research is pre-determined. This means that the plan of the research does not alter as a consequence of the findings or as a need to gather further data to support an emerging theme.

Role of the Researcher

In this type of research the role taken by the researcher has an influence on the research process. To clarify a researcher's position and how that might influence the study, a pre-suppositions interview was conducted with a research supervisor from Auckland University of Technology (AUT), prior to the collection of any data. The assumptions and presuppositions of the researcher were explored during the interview process. The interviewer directed questions aimed at uncovering my existing thoughts about peer review and what influence my ideas might have on the research project. These ideas may direct the research as well as the interpretation of data. During the interview several assumptions and presuppositions that as the researcher I held, were identified. These were:

- That the relationship between reviewer and reviewee can influence the outcome of peer review
- That the purpose of peer review is developmental

Husserl, as cited by Ashworth (1996) described one way of attending to subjective influence in interpretation is by bracketing the researcher's pre-existing ideas and putting them to one side in order to mitigate their influence. However, my experience is supported by Heidegger (1962) who suggested that there will always be an influence from the researcher whose subjectivity inevitably impacts on the interpretation of the research. Importantly, these influences should be acknowledged and steps taken to prevent my thoughts and ideas as the researcher driving the line of inquiry, as the intention of this research project is to hear the experience that participants have of the peer review process.

Ashworth (1996) argues that introducing the topic of research as peer review to participants imposes a common focus which brings with it cultural meaning. By being open to other perspectives and watchfully looking for alternative topics to arise as participants describe their own experiences some protection is provided against the focus to falling solely on aspects of the data, which align with my assumptions. To broaden the perspective taken during this research I have consulted with two supervisors from different professional backgrounds, nursing and occupational therapy. With new perspectives from these supervisors my efforts to understand and interpret the data can be guarded from my prior assumptions. By the testing of my tentative interpretations through challenge and being asked to articulate them in relation to the data, new insights and further reflection and interpretation were facilitated. Additional in-depth discussions with other colleagues from a variety of disciplines including social work, served to enhance reflection on the interpretation and credibility of the research findings.

Research Method

In this section the research methods used in this study will be discussed. This study aimed to describe in everyday terms the experience of physiotherapists' participating in peer review. In order to elicit this description semi-structured interviews were used to collect the data. The reasons why this data collection method was chosen along with the ethical considerations are explored in this section. How data was collected from the interviews and subsequently analysed are also described and discussed.

Approval for this study was granted by the ethics committee of Auckland University of Technology (AUTEC). Key ethical issues concerning this study were; informed consent, Treaty of Waitangi, power relationships and confidentiality/ anonymity. Each of these will now be discussed.

Informed consent.

All participants were fully informed through an information sheet (Refer to Appendix A) prior to being admitted to the study. Before the interviews commenced each participant's understanding of the information regarding the study and consent form (Refer to Appendix B) was confirmed and I was able to answer any questions participants had. Participants were advised that they were able to withdraw from the study up to the point where data analysis began.

Te Tiriti o Waitangi.

The principles of partnership, participation and protection must be upheld throughout any study. In the preliminary stages of this study, I consulted with both Taeora Tinana the special interest group for Maori physiotherapists, through their nominee the Maori Advisor in Home and Older Adults Service, as well as the research co-ordinator from the Maori Health Service at Waitemata District Health Board (DHB).

In the spirit of partnership, I sought to engage with Maori in designing the research process so that any benefits for Maori would be maximised and any special cultural considerations taken into account. From my initial consultation with the nominee of Taeora Tinana, the suggestion to include the issue of how competence in the areas of ethics and cultural competence are assessed was raised. During the interview process I responded to the participants' mention of terms relating to any aspect of culture or ethics by enquiring further. For example, one participant mentioned, *"Peer review is*

focussed on clinical aspects of things and not a lot around ethical and cultural issues." As I followed up on this statement, she went on to say, *"At the time of peer review, it wasn't always apparent, but outside that process there are people who react differently and respond to different cultures and different ethnicities in different ways."*

The intention to recruit Maori physiotherapists into the sample was considered when designing the recruitment process. This recruiting strategy was assisted by the opportunity provided through Taeora Tinana to disseminate the information about the study to Maori physiotherapists through their special interest group. From a New Zealand context it was advantageous to have the sample include Maori physiotherapists as it opened the possibility of uncovering unique cultural perspectives on peer review.

> *I think when I first became a physio in the hospital system, I felt that I had to shed all of that [Maori cultural style] and kind of acculturalise, so the process [of peer review] was OK because I could do that. But if I was to maintain that, my culture and being Maori, at that point yeah, it might have made a difference, it is hard to say because for me, it wasn't a safe place to be Maori in the hospital and so I wasn't.*

During interviews the aspect of difference in culture did arise in relation to interactions between reviewer and reviewee and also with therapist-patient interaction, these issues were explored.

Power relationships.

Power relationships exist between people in structured organisations and also within professional groups. This is also true of physiotherapists. In considering ethical implications for this study the potential for an unequal power relationship between the researcher and other physiotherapists in her place of work was thought to be

significant. As a supervisor and professional leader of physiotherapists within the Waitemata DHB, a government funded healthcare provider, actual and perceived imbalances in power do exist. This may influence what potential participants are prepared to say in an interview situation given the ongoing working and professional relationships required. Therefore all physiotherapists currently working in the same workplace as the researcher were excluded from the study.

Confidentiality and anonymity.

Various strategies were put in place to address concerns regarding confidentiality and anonymity of the data collected. This was addressed through the use of pseudonyms in transcripts and storing the hardcopies of transcripts and audio-tapes in a locked filing cabinet. Electronic copies of the transcripts were stored in a password protected computer situated in a restricted access office.

Consent forms were stored away from the data but also in a locked filing cabinet for the duration of the project and afterwards will be stored in the post-graduate office at AUT. The only person able to access this locked filing cabinet was myself, as the researcher.

The person transcribing the audiotapes signed a confidentiality agreement prior to commencing work on the project (Refer to Appendix C). Throughout the duration of the research project the data could only be accessed by myself and my research supervisors.

Identifying terms in the transcripts were removed or substituted so to preserve the confidentiality and anonymity of participants. Participants were asked not to name other people in their interviews. No identifying information has been used in this

report or will be used in any future presentations or publications arising from this study.

The use of pseudonyms when writing up the data was initially planned to protect the anonymity of participants. As the specific nature of the work environments described by participants evolved, the question of whether to continue the use of pseudonyms was raised by the researcher. The use of pseudonyms also allows the linking of quotes to one participant which may potentially decrease anonymity. As the writing up of data proceeded it became apparent that some threat to anonymity existed due to the small sample size and the work areas that participants came from and that this could lead to identification. After several discussions with the research supervisors the decision was made by the researcher not to use pseudonyms as this may lead to the potential identification of participants by readers familiar with the study context. As a consequence the pseudonyms were removed as was any language that could lead to the identification of the participants.

On completion of the project all final data collected will be stored in a locked filing cabinet at the researcher's residence for 6 years. An electronic record will be stored in AUT archives for a period of 6 years, in accordance with AUTEC guidelines. After 6 years all data and consent forms will be shredded or wiped.

Sampling

Purposive sampling was used to recruit New Zealand Registered Physiotherapists (NZRP) who had been involved in the process of peer review. Purposive sampling aims to select participants who represent a range of the larger population from which the participants are drawn (Seidman, 1998). This method of sampling was selected to

gain maximum variation in the group of physiotherapists interviewed. This provides an effective basic strategy for selecting of participants from a broad group and allows diverse variations. Purposive sampling allows the selection of information-rich cases which can be examined in depth. Different view points of the same event from several non-homogenous participants are likely to provide a more comprehensive picture of that event (Wengraf, 2001). The inclusion and exclusion criteria used when selecting participants were as follows.

Inclusions.

The study population from which the sample was selected included all NZRP who were working within the public health system at either Counties Manukau DHB or Auckland DHB. These particular government funded healthcare providers were selected for convenience. Additionally, NZRP working in the private sector were also considered for recruitment, once again for convenience from the Auckland area. In order to enable participants to recall events with reasonable accuracy a 3 year time limit was selected within which participants must have been involved in peer review to be included in the study sample. This timeframe also aligned with current expectations of the longest review frequency stated by professional organisations (NZCP, 2002).

Exclusions.

Physiotherapists working within the same DHB as the researcher were excluded from the study. This group of physiotherapists could possibly be seen to have a conflict of interest because of the potential power relationship existing between supervisors and supervisees. The time frame for exclusion on times longer than 3 years was based on participants being less likely to remember events accurately as the distance from the event increases.

Recruitment process.

The prospective participants for the study were NZRP who were working across a variety of settings in private and public health care environments. The public settings were those physiotherapists working in workplaces, which are not for profit and primarily funded by the New Zealand Government to provide free healthcare to all people with New Zealand residency status, such as public hospitals. Private settings were those that did not fall into this category and are primarily run as private enterprises, run for profit, such as private physiotherapy practices or private hospitals where patients, private health insurers or ACC pay for their treatment. The sampling strategy used in this research was intended to recruit participants who had experienced the peer review process from within a variety of settings for physiotherapy practice. The intention in seeking participants from a variety of different work environments was to capture situations where physiotherapists are working in isolated situations or in close proximity to each other, as it was anticipated that these could provide different experiences of peer review, as well as the potentially varying organisational expectations of the peer review process.

Recruitment of the participants was initiated through two strategies. Firstly, a call for participants was published in the professional association's (NZSP) monthly newsletter (Refer to Appendix D) in both the English and Maori languages, with information on how to contact the researcher.

Secondly, the researcher approached prospective participants through professional meetings held at their work place, described the research project and left participant

information packages with contact details for the physiotherapists to read. Physiotherapists interested in participating in the research project then contacted the researcher. Because the aim of this study was to obtain cases deemed information-rich and to explore the common and unique manifestations of peer review, the strategy of maximum variation sampling (Grbich, 1999) was used, visiting workplaces that use different models of peer review and across hospital-based and community-based settings.

Participants.

From these two approaches nine potential participants registered their interest and seven went on to participate in the research. It was not clear which approach these participants were recruited through, although the majority had attended professional meetings where the research project had been described. The eighth interested physiotherapist decided not to participate due to workload commitments and the ninth interested physiotherapist could not be contacted. Interview times were arranged and interviews conducted. Six out of the seven participants chose to be interviewed at their workplace, although they had been offered an interview venue away from their workplace as this might expose their involvement in the study. One participant preferred to be interviewed at home.

Of this sample six physiotherapists were currently working in the public health sector across a selection of different services and one was working in a private practice setting. The participants had a range of experience of participating in different settings including in-patient, outpatient and community-based provision of services, at times these were not necessarily where they were currently working. There was a range of age and experience represented in the sample varying from 7 years to more

than 10 years experience in physiotherapy practice. There were no newly graduated physiotherapists and all participants were women. All participants had been both reviewers of practice and had their own practice reviewed in a peer review process. In the sample of seven there was one physiotherapist who identified as 'Maori'. The remaining six identified themselves as from the 'other' category of ethnicity. For a copy of the demographic data form used to collate this information refer to Appendix E.

Method of Data Collection

A question template (refer to Appendix F) was developed based on themes that arose in the literature review. In this way the interviews were semi-structured and questioning was channeled to elicit responses from participants in line with the previously identified themes. The pre-prepared questions were used to initiate the interview and to follow through with identified theme topics in a consistent way. This approach aligns with the desire to approach the truth by heading in a determined direction. My intention was to ask questions' ranging from broad inquires such as "Tell me about the process of peer review you experienced," then to more specific questions such as "Did you prepare for your peer review, and what did you do?" These questions were designed to facilitate the participants' recall of peer review events, while allowing the scope for participants to select from a variety of events which held meaning for them.

Data was collected through seven semi-structured interviews of 40–60 minutes duration. Before the interviews started participants had the full process explained and were able to ask questions prior to consent being obtained. The interviews were

audio-taped using a tape recorder and the audio-tapes were then transcribed verbatim by a clerical support person.

The transcripts were sent back to participants for member checking. Participants were asked to check the transcript for accuracy and to advise the researcher if they wanted any comments changed or removed. The only replies received from participants were relating to some spelling inaccuracies. The transcripts formed the data of this study and this resulting data was analysed using content analysis.

Data Analysis

After the transcripts were generated they were printed out and read by the researcher. The accuracy of the transcripts was then checked against the tape-recorded interviews by the researcher to ensure the integrity of the data. Collecting the raw data from the transcripts of the interviews the data analysis began through content analysis as described by Pope and Ziebland (2000). This framework approach provides a systematic deduction of categories at the beginning or part way through the analysis. This approach is less often associated with qualitative research, however is being used increasingly and aligns more readily within the post-positive paradigm. This structured framework approach reflects the views and experiences of the participants themselves. It embraces a deductive fashion with more explicit analytical processes and is substantially informed by prior knowledge. Using a 5-stage framework approach, themes and categories were developed from the data. This framework involves the following stages: Familiarising, Identifying a thematic framework, Indexing, Charting and Mapping and Interpretation.

In the familiarisation stage the data was read several times before being coded using content analysis techniques. The approach used was to code each unit of text that seemed to encapsulate one idea or theme (Pope and Ziebland, 2000). Codes were then grouped into a number of different categories. The names of some of the themes changed as the analysis progressed. At times, data from one theme was moved to another as the meaning and context of the participants' words was re-analysed.

Once the initial content analysis was completed, another researcher was asked to view some of the transcripts and data analysis content and themes to compare with the researchers analysis. According to Pope and Ziebland (2000) there is some evidence that the use of more than one analyst can improve the consistency or reliability of analyses. Co-researchers reading the data on occasion did not arrive at the same interpretation of the data as the researcher. In these instances further discussion of the data concerned and the interpretation was undertaken until a consensus was reached or the different interpretations noted.

These categories were then organised into sub-themes and themes to inform the findings. The arrangement of sub-themes and themes changed throughout the course of analysing the data. Initially, three themes arose with three sub-themes in each. After considering the data further, several sub-themes were amalgamated as some of these seemed similar. For example the sub-theme entitled the 'process of peer review' and the sub-theme of 'tradition' became one. 'Expectations' and 'requirements' were another two sub-themes, which seem to be related and after further analysis were joined. With the collapsing of the sub-themes a decision was made to amalgamate the themes of 'Watching' and 'Practice on Show'. However, as analysis progressed the data was reconsidered and some themes, which appeared to

be one at first, were subsequently divided into two different themes once more. For example the theme of 'Practice on Show' was divided into Practice on Show and Requirements. This was a different grouping of the themes and sub-themes, which developed and changed and re-formed through out the data analysis process eventually remaining as one theme.

The interpretation of data was discussed with the supervisors of this study as it progressed and these discussions informed some of the reconsideration of the themes described above. The outcome of the study arrived at a comprehensive description of the data describing the experience of physiotherapists' participation in the peer review process within the New Zealand context.

The two main themes from analysing the data gathered in the interview process emerged as: Practice on Show and Managing the Performance. Multiple sub-themes arose from these two main themes. For the first major theme these sub-themes were; The Process of Peer Review, Watching, Demonstration, Expectations and Critique and for the second major theme; Setting the Scene, Protecting Relationships and Playing to the Audience. In Chapters Four and Five the findings are presented and interpreted within these groupings.

Rigour

In any research the quality of a study is often related to the degree of rigour which the study establishes and maintains. In quantitative research quality is frequently described in terms of validity, reliability and generalisability. Researchers working within the naturalistic paradigm have raised questions regarding the value of using these three criteria to demonstrate quality in naturalistic inquiry (Emden &

Sandelowski, 1998; Lincoln & Guba, 1985). Alternative concepts of rigour have been put forward by researchers in this paradigm against which this type of research can be measured (Caelli et al., 2003; Emden & Sandelowski, 1998; Krefting, 1991). Whilst suggesting different criteria be used to assess rigour in this qualitative research, literature suggests that this establishment of rigour is important and effort to make the processes used known is of value. In qualitative research rigour or trustworthiness can be assessed against four criteria put forward by Lincoln and Guba (1985). These are Credibility, Transferability, Dependibility and Confirmability. The approach taken in this study to rigour using these criteria is described in the following section.

The approach to rigour.

In this qualitative descriptive study the approach taken to establish rigour was similar to that proposed by Guba (1981) as described in Krefting (1991). Using a four stage framework, the criteria of credibility, transferability, dependablility and confirmability are assessed and discussed to establish rigour. This approach was chosen as an appropriate model to evaluate the merit of qualitative inquiry as models used to assess quantitative research look at criteria that are not relevant to qualitative endeavours. This approach was thought to be philosophically and methodologically congruent with the research design and the postpositive lens through which the researcher was approaching the data.

Credibility.

For a research study to establish credibility the level of confidence which participants have in truth of the data needs to be assessed (Polit & Hungler, 1997).

The credibility of a qualitative study can be related to internal validity in a quantitative study (Tuckett, 2005).

Researchers use different techniques and processes to enhance and establish the credibility of the data. The credibility of qualitative research can be increased by carrying out the research in such a way that the believability of the findings is enhanced. Prolonged engagement with the research process by investing sufficient time over the length of the study and persistent observation of the phenomenon under study is a technique that keeps the researcher focused on the aspects and characteristics of peer review and the conversations regarding peer review. As mentioned earlier member checks were carried out by sending the transcripts back to participants to confirm whether the data collected in the interview was accurately represented.

Having a variety of data sources supports the criterion of credibility. This was achieved in this study by interviewing multiple participants and also discussing the topic of peer review with health professionals from a variety of different disciplines. An in-depth literature review on peer review was carried out and this also contributed to the credibility of the by accessing existing knowledge and setting new knowledge within this context. In addition, investigator triangulation occurred with a second researcher checking the content analysis. The second researcher read through some of the transcripts and then reviewed the interpretation and themes arising from the data. This was then discussed and additional or differing understandings explored.

Peer debriefing, where colleagues experienced in peer review asked questions about the study and reviewed various aspects of the study was another technique. During this activity the aims and methods of the study were described to colleagues. They

would then discuss with the researcher their thoughts on both the topic of peer review and their experience with this process, as well as aspects of naturalistic inquiry such as methods and philosophical positions. This enabled me as the researcher to reflect on methods chosen, explore some emerging themes and assess initial credibility of the findings.

Content analysis involves a process to group, organise and interpret the qualitative data collected into developing ideas and themes (Polit & Hungler, 1997). The choice of content analysis to investigate the data generated in this study was made as this method allowed the words of participants to show themselves and influence the forming of categories derived from interpretation of that data. Sub-themes emerged as collections of categories or notions which were then grouped into the two main themes of Practice on Show and Managing the Performance.

With any qualitative research the researcher is used as a data collection instrument. To this end the credibility of the researcher themselves is relevant to the credibility of the findings. In this regard I have described my role as the researcher and my professional experience in physiotherapy and interaction with peer review processes in Chapter One. Additionally before commencing this study I participated in a pre-study interview to identify my assumptions, biases and prejudices. This was transcribed and retained. A journal was also kept of my thoughts and reflections throughout the research process.

When seeking to establish credibility in this research study I acknowledge the post positive paradigm from which I view the world, where truth or reality can be approached and the influence of the researcher on the research process acknowledged. Data was analysed through a lens coloured by my presuppositions

and theoretical position. By using research methods which align with the chosen methodology of qualitative description, strategies to establish rigour are enhanced.

Transferability.

The transferability of a study relates to whether the findings of any particular study can be transferred from one setting to another or from one group of participants to another. This criterion matches closely to generalisability in quantitative research but is not the same. In qualitative research the findings are philosophically tied to the reality of the particular participants of any one study and who are not assumed to be representative of populations. A thick description of the participants is given to provide the reader with enough information in order to make their own decision as to whether the findings are indeed transferable to other groups or settings (Krefting, 1991).

This study elicited data from a variety of settings and groups of physiotherapists using some different models of peer review. However, the predominant model described was of observation of practice. This may affect the transferability of the findings to other models of peer review. The local nature of the sample may also limit transferability, as does the New Zealand context, as peer review in other international physiotherapy environments may have different contextual drivers. Disseminating the finding through presentations and publications will also add to the transferability of the findings however the responsibility of deciding whether the results of this study can be transferred to another setting remains with the consumer of this research.

Dependability.

In qualitative studies dependability refers to the level of consistency or stability of data over time. This concept relates to reliability in quantitative studies, looking at whether these findings might be replicated if the research was conducted with another group of similar participants. Dependability of the findings in this study was enhanced by the match of research methods and methodology with the research question. This was achieved by a detailed description of both the methods and the research approach. As described, data was initially grouped into categories which were reviewed by research supervisors and collected into sub-themes and then the main themes which were reviewed again by supervisors. The decision making processes through out the data analysis were recorded. An audit trail regarding decision making is supported by supervision notes and the researcher's journal. Reporting of decisions made regarding theoretical, methodological and analytical issues are contained in the methods and discussion chapters this is the methods chapter, enabling consumers of the final research report to make a connection between the data collected and the interpretations given.

Confirmability.

Confirmability refers to the extent to which the data and the interpretations of the findings can be established as not imaginary. In quantitative studies confirmability is compared to objectivity or neutrality (Polit & Hungler, 1997). A key measure in confirmability is the extent to which the researcher declares their personal biases and presuppositions (Shenton, 2004). Keeping an audit trail of the raw data, analysis processes and results, notes from member checks, researcher's personal notes and reflections as well as drafts of the final reports, all enable the findings to be seen as

confirmable. Lincoln and Guba (1985) believe that when credibility, transferability and dependability are demonstrated, then confirmability is achieved.

Summary

Any research project requires a process to be followed to generate new knowledge. When designing research, there is a need to take into account basic philosophical assumptions and the meaning of truth. The paradigm of post positivism was used to acknowledge the existence of the multiple realities and perspectives of participants. Influence brought to the study by the researcher is acknowledged in this world view. The various ethical considerations were attended to when proposing this study particularly the partnership with Maori and the power dynamics of organisations where recruitment occurred. The confidentiality and anonymity of participants was specifically considered as any identifying information around work settings may expose participants. Sampling occurred to develop maximum variation and was purposeful.

The qualitative descriptive approach taken enabled the findings to be developed through an interaction between researcher and participants, and interpretations of the data were created amidst a social culture and within the specific context of physiotherapy in New Zealand. The methodology used needs to be congruent with the basic philosophical approach using methods which also align. The approach taken to gathering and interpreting the data in this study were by semi-structured interviews and a process of content analysis. The approach to rigour was described and included how credibility, transferability, dependability and confirmability are established.

As the interviews described above were transcribed more than 150 pages of transcripts, were generated. These formed the data that was analysed and interpreted through the research process. The findings are presented in the following two chapters, which are arranged in themes. Firstly, findings that support the theme of 'Practice on Show' are presented in Chapter Four.

Chapter 4: Practice on Show

This chapter and the next will present the findings of this study which set out to explore the participation of physiotherapists in the process of peer review in the New Zealand context. When analysing the data from the interviews two major themes arose: Practice on Show and Managing the Performance, along with several sub-themes.

Figure 1: Overview of Peer Review Process

In this chapter the theme of 'Practice on Show' is explored. Findings indicated that the participant physiotherapists had a consistent understanding of what constituted peer review processes. Physiotherapists hold an expectation of what the peer review process will involve and what the outcome will be used for. They also expected the

reviewers to be watchful and as reviewees, they consciously provided something for reviewers to watch. As such, amongst participants there existed an intention to place their practice 'on show' during the peer review process. Practice on Show has five sub-themes: Peer Review Process, Watching, Demonstration, Expectations and Critique. See Figure 2. The findings which support these sub-themes are presented and interpreted in this chapter.

Figure 2: Themes and Sub-themes of Practice on Show

Peer Review Process

In this section the process of peer review and the traditions which have influenced its development will be explored. Several models of peer review were described by participants with one model being consistently understood as an 'observation of practice'. This is the way in which participants expected to put their work 'on show'. In order to place their practice on show, physiotherapists often followed a set process which allowed others to watch. This presentation of their work and the resultant critique was something physiotherapists expected from peer review. Other models of

peer review are also described. Sub-themes of tradition, observation of practice and other models of peer review are discussed.

Traditions.

Health professionals have traditionally learnt their craft from each other. This type of teaching and learning is experienced as a student, as well as continuing after graduation and beginning to practise one's profession. This is also true of the physiotherapy profession.

As new graduates come into practice as registered physiotherapists this tradition of learning by observing the practice of others and having your practice observed continues. In the initial period of practice there is often a time of shadowing an experienced therapist assigned as the graduate's mentor, supervisor or senior. As such, having practice observed by others seemed expected and familiar to participants.

> *I think it [peer review] is not too far from my tradition of training, that there is always someone standing in the corner checking what I was doing, so it's not a foreign situation.*

After the initial period newly qualified physiotherapists take over the work and have their practice scrutinised by their supervisor through observation of their practice, a verbal case review or clinical documentation audit. This may also happen when physiotherapists begin work in a new area. As one participant explained, *"We had new people start work in that area and I was asked to do a [peer] review on their practice."* In this way the review process is sometimes used to assure quality of practice and competence in new work situations.

Growing out of this tradition of observing practice in order to transfer knowledge, formal processes of peer review have emerged. Participants referred to that tradition in their explanations of the peer review process: *"I consider the roots of that [peer review] are based around various histories in physiotherapy."* The tradition of watching practice is captured by what has been named, the 'peer review' process. In the following section participants describe the model of peer review based on observation.

Observation of practice.

When asked to outline her understanding of peer review this participant, like other participants, replied *"It would be an observation of practice."* Her response is consistent with my impression that while various models of peer review exist within physiotherapy, the dominant model used in New Zealand is observation of practice. That is, peer review is understood to be a process involving one physiotherapist (the reviewer) observing another physiotherapist (the reviewee) while he or she assesses and/or treats a patient. As described by one participant in this study, *"So the peer reviewing process in our physiotherapy team is that you are actually observed in assessing and treating a patient."* Because patients are necessarily part of the process, being subject to peer review entails physiotherapists explaining the process to the patient in that *"They [the reviewer] were going to be watching what we were doing…watching the therapist not the client."*

Therapists were clear in indicating that this process was about observing the therapist at work; however the condition of the patient is also crucial to the assessment and treatment plans developed and so requires consideration by the reviewer. Participants

described gathering information about the client as part of preparing for their role as reviewer.

> *I would have had a look at the notes prior to sitting in, so I would have an idea of what the patient is up to, what kind of treatment they have had and what the treatment plan looked like.*

In this way the patient with his or her specific condition influences what a reviewer would expect to observe, but is only one of various aspects that the therapist being reviewed considers. *"It was really organising time, client, explaining the process and then going through…or doing the client work and then discussing afterwards, the content of that."* As this participant indicated, discussion with the reviewer is part of the process. Another participant described the amount of time she spent discussing the peer review that had occurred. *"We sat down somewhere and discussed that for 20 minutes probably."* Asked what was discussed in this time the participant replied, *"She was giving me feedback about what she had observed."* Discussing the observations after the peer review was seen as part of the process and required specific time to be set aside.

The formal process of observing someone's practice was described by the participants as being called 'peer review' and consisted of some preparation, the actual work with the patient and a discussion afterwards between the two physiotherapists involved. Other models of peer review were also mentioned by participants as being different types of peer review and these are described in the next sub-theme.

Models of peer review.

Although peer review based on observation predominates, alternatives to the observation-based peer review model do exist. One participant described a clinical audit process by documentation review of a patient's clinical notes, as a form of peer review. In this situation, a group of physiotherapists were asked to *"Do it [a clinical review of notes] with the person next to you."*

Feedback in this model was via a written document on a prescribed form and was not discussed with the recipients of the feedback. One participant commented, *"I didn't hold that in high regard, that style of [peer] review."* The participant involved in this process felt being unable to discuss the results of the review with the reviewer, was a less valuable process.

Another participant described a process where she presented a case she had worked on to a group of physiotherapists. "*Another thing that we have done and I don't know if it falls under a peer review or not, is case presentations."* Asked if they were called peer reviews, this participant replied:

> *We don't call them that, but I did a case presentation last year and from a peer review point of view, I think I got much more out of that, than just a physio coming with me or me going with a physio.*

Presenting her assessment and treatment practice to a group of peers as a power point-based summary of the case, had provided this therapist with more of what she was looking for from peer review than the observation-based review of practice.

Yet another participant described several processes that she considered constituted 'peer review'.

> *Well, I think the first experience was really having another physiotherapist stand in the room with me and look at me instead of the patient and vice versa… We probably participate in peer reviews in many ways now, and as one of the clinical leaders in[this workplace], I would be involved with peer review, as looking at notes audits, giving a second opinion on a patient, usually with the treating physiotherapist observing. How else would we review? I guess performance appraisal is another form of peer review that I participate in.*

This participant highlights the view that several different processes can be considered a form of practice review which is carried out by peers. Her initial thoughts of peer review describe the observation of practice with the subtle difference being a changed focus from patient to therapist. She also indicates that as a clinical leader in her work setting she still would review practice as a 'peer' rather than as a senior or from a managerial perspective.

As physiotherapists often accept the process of being watched as something of a tradition in the discipline, some organisations have captured this process to attend to performance development. This developmental approach was described by one participant:

> *It was a formal process where it was to be done every six months and there was the form and you went with the other person and watched them treat a patient or help them with it and then later on, you filled out a form and ticked boxes or made some comments and then had a look at their notes and then you met up with them later and went over it with them and tried to come up with some little thing they could improve on, or some things to work on.*

The approach described by this therapist of *'trying to come up with some little thing … to improve on'* speaks to a manufactured interest in conforming to the process of peer review as developmental. It also assumes an expectation by the organisation or individual who is receiving the information from the review, that there will be something to "*work on*".

Aligning with this expectation of identifying some aspect of practice to improve, participants had some ideas about who they regarded should be reviewing who. They often referred to the experience or seniority of colleagues when discussing the reviewer's role and in keeping with the cultural norms of physiotherapy practice, tending to equate seniority or years of practice in the profession with knowledge and skill. However, participants did have varying views.

> *In some areas, those years of experience and people who have vast experience in a specialist area can think 'Oh, you know, there's nothing [a less experienced peer reviewer] you can teach me', but yeah, I think I have come to appreciate that you can learn something from everybody and that needs to be valued.*

This participant proposed that the opportunity to learn from others in a peer review situation does not need to depend on clinical experience or expertise. Rather, other physiotherapists of all levels have a role to play in peer review. The view that you can learn from younger as well as senior colleagues was discussed by several participants. Some felt *"You can learn from the juniors because they have a fresh set of eyes and they are asking all these questions and I am thinking 'Why didn't I ever ask that kind of thing?'"* As physiotherapy practice evolves the current perspectives of newer graduates can provide challenge for existing practitioners.

To maximise learning provided by peer review the concept of including the patient's view was suggested by one participant. However this participant was not sure if that fitted with her understanding of the currently-used model.

> *I always wondered whether peer review should have, I don't know if it fits in with peer review, but whether the patients should have some comment, because you don't know really, how well a physio is performing, until you ask the person [patient].*

This possibility raises the question of whether the view point of a physiotherapist is sufficient to generate feedback on practice. However as indicated, the idea of feedback from patients was raised by only one participant.

Summary.

This initial presentation of findings has shown that traditional ways of teaching and learning in healthcare settings have relied on watching each other work and this is true of the physiotherapy profession. The process named 'peer review' is recognised by physiotherapists as one way to gather feedback and critique of one's professional practice. Although there exist various ways of undertaking a peer review of a colleague's practice, most physiotherapists in New Zealand would equate the term 'peer review' with the process of one physiotherapist watching the practice of another and then commenting on what they had observed. In the next section the concept of 'watching' and what this means to the observer as well as those being watched is explored further.

Watching

To watch someone is in a literal sense, to observe what that person is doing. Dictionary definitions however, hold specific connotations of how one 'watches', including the "state of alert or constant observation or attention" (Burchfield, 1994). The verb to 'watch' suggests vigilance or looking attentively. Watching, therefore, means looking at or observing closely or attentively (Collins, 1982). In the following sections the theme of watching is further divided into sub-themes of Being Watched, Silent Observer and Opportunities to Observe.

As discussed, watching the practice of others is a traditional approach to training and mentorship in the discipline of physiotherapy. Students would learn by observing practice and then by being observed practicing. "*It is a strong style within physiotherapy… in my student days there was always someone standing over you, watching what you were doing."* Teachers watch students, students watch teachers and students watch each other. Educational institutions training physiotherapists have traditionally used this model of teaching, setting the stage for the process of peer review.

Even decades after completion of their initial training therapists beginning work in an unfamiliar area are often faced with new protocols and procedures. In this circumstance peer review was described as a tool which may be used as an opportunity to check up on people, to see if they are using a certain protocol in the correct manner or are able to implement a new physiotherapy technique correctly. *"It is quite a specific programme, they needed to follow."* The peer review process enables adherence to guidelines or protocols to be assessed from a clinical, professional, as well as an organisational point of view.

As the intent of watching is to give feedback, watching can bring learning. Participants also spoke of using peer review as an opportunity to experience different ways of practicing and approaching clinical situations.

> *I was so used to seeing people with just a normal bed. I hadn't thought about using his bed to help stand him up, getting him in his wheelchair and raising the height of his bed. So, it was really good to get someone else's perspective and look at things in a different way. I think it is a helpful process to do a peer review.*

As this quote suggests, watching practice and providing feedback for clinicians on their practice may result in a different clinical outcome for the patient as a consequence of the peer review. Additionally, exposing therapists to different practice styles allows both reviewer and reviewee to reflect on why they practice in a certain way. "*Someone else's view point, like if they practice in a completely different way than you, can be really helpful."* Watching provides opportunity for learning.

Alternatively an unintended consequence of watching each other was the view of one participant, was that there is a risk when people work together within one organisation with certain ways of doing things, of becoming *"clones of each other."* This participant also thought, *"it's hard to look at things with a fresh pair of eyes,"* suggesting that review from people outside of the same workplace might be valuable. This was particularly the case when referring to highly specialised areas of practice such as burns units.

Continuing into professional practice, the roles of watcher and watched are frequently swapped as physiotherapists develop their knowledge and expand their practice into different specialties. Learning new skills by watching, being watched by others and then passing on knowledge by allowing others to watch, physiotherapists alternate their position. This is also true in the process of peer review, which requires both a reviewer and a reviewee. Familiar with the role of being watched and also that of the observer, participants describe in the following sections their experiences with these differing perspectives.

Being watched.

Therapists generally recognised the benefits of having a peer watch their practice and described this watching as an activity they thought would help critique their practice, making them more aware of things they might have missed or affirming things they did very well. The peer reviewer is thought of as bringing a new perspective to the assessment and treatment sessions that they are observing:

> *I would like to know that what I am doing is up to date. That I am safe with the client, and that the client is happy with my performance and with somebody new coming in, who doesn't know the client, I think that is a good opportunity to look at that.*

In the role of reviewee, participants understood they would be observed and some reflected on their feelings about 'being watched'. One participant reported therapists at her workplace being comfortable with the peer review process, *"people were quite sort of laid back and relaxed about the process."* Another added, "*I am reasonably relaxed about anybody coming with me [to review me],"* indicating that any other physiotherapist would be acceptable to her as a reviewer. For these participants peer review is just part of the job and they infer that they are unconcerned about the process. However both statements *'reasonably relaxed'* and *'quite laid back'* indicate that these participants may still have some reservations or anxieties around the peer review process.

Some physiotherapists find peer review a positive experience: "*I quite enjoy going out with another physio and looking at my practice and the other way around"* and *"I haven't had any bad experiences with peer review."* Both these participants also indicate that each role, reviewee and reviewer, was enjoyable or at least not negative.

Set against such experiences, the idea of being watched seemed a normal part of practice for physiotherapists particularly in a hospital setting, as described by one participant:

> *Well, I suppose, like most people who have worked in hospitals,…people would watch me all the time. The relatives were watching and the nursing staff or doctors were often watching you when they walk down the corridor, so I am used to people watching me.*

This participant was used to being observed and even being under constant surveillance in the hospital setting, which may have influenced her behaviour. Always being watched by everybody has been discussed by many in relation to power and control and surveillance. These issues have been linked to lack of choice. However as the participant goes on to describe, when in a practice setting where there are no other health professionals watching, such as when delivering physiotherapy in people's own homes (community-based physiotherapy), her behaviour might be different to what she would do if she felt she was being watched.

> *I guess, in the community there would be things that I would perhaps do that, if I was felt there was more observance [I wouldn't do]. I think you get into a few slack ways and it's not picked up on.*

This participant indicates that the 'picking up' or uncovering of 'slack' practice is something that is more likely to occur in practice settings where there is more 'watching' of one practitioner by others, and that choosing to do the correct thing might be a result of whether or not you are 'watched'.

Daily informal review occurs when therapists work within sight or hearing of each other. *"So I think it's harder for people that work in isolation on a normal day-to-day basis to be peer reviewed, than someone who works in close proximity to other therapists."* This seems to desensitize practitioners to the peer review process and make it less daunting. One suggestion to help improve the system of peer review was

to use informal review processes more frequently to familiarise practitioners with the process.

> *I think two per year is not very much and perhaps, what we do is have two formal peer reviews per year and that on a few other occasions during the year, it's very informal – so that people get quite used to the process.*

De-formalising the peer review process seemed to be one way used to normalise peer review for physiotherapists.

Part of being watched involves being evaluated or critiqued. A feeling of being assessed or 'on trial' often accompanies physiotherapists during the process of peer review. Some participants described anticipating this event: *"I do remember a week in advance, being nervous before a peer review coming up… counting down the days to it."* Here some degree of anxiety was exhibited. *"It's silly because it shouldn't be a scary process and it shouldn't be nerve wracking, but it's still a formal process, where someone is watching you."*

The experience also seemed frightening for some participants. It seemed to generate anxiety or fear with anticipation of the process leading to feelings of intimidation or anxiety. *"A very daunting experience for people who are new to it."* This therapist later expressed the view that participating in more reviews, may lead to greater confidence. On occasion participants commented that being nervous and watched, may lead to feelings of misrepresentation of their 'usual practice' in a formal peer review situation.

> *When I worked on a ward and I was a little bit more isolated, there were sometimes situations where you felt that the snapshot that person got of you, was an unfair representation of what you are normally like, especially because you are nervous at the time.*

Here, this participant alludes to the difference of being isolated in practice, as opposed to being regularly watched by others even though informally. This may put therapists in a situation where normal practice is judged by the single observed session. The inference here is that more than the single session observed may be taken into account when reviewing someone that you work in sight of regularly.

In summary being watched during the peer review process has different connotations for different people. Some participants welcomed the opportunity and were comfortable; others were nervous and even frightened of this situation. As the reviewee, the reality of being critiqued or evaluated was acknowledged as part of the process. Some therapists thought of the peer review as only able to reveal a 'snapshot' of practice and suggested this problem may be exaggerated between practice in isolation and in regular view of others where informal observation occurs. Accordingly it seems that whether therapists are being watched at any particular time or feel that they might be observed may influence their behaviour, not just during the review but in everyday practice. Alongside these reservations, the process of review exposed therapists to different ways of doing things and allowed their competence in applying certain protocols to be assessed. Allowing therapists to reflect on their own practice and the feedback they receive from the perspective of another physiotherapist are benefits participants recognised of 'being watched'. In the following section the position of 'the watcher' is explored.

Silent observer.

Consistent with dictionary definitions of watching most physiotherapists emphasised that peer reviewers simply watched. That is, many positioned themselves so that their

presence did not directly affect what the physiotherapist was doing but they were nonetheless watchful. "*You have someone who is a lot more experienced than you, coming to watch you, sitting in the corner of the room, with their eyes fixed on whatever you are doing."* Reviewers with their years of experience at hand often take a back seat, but also focus attention deliberately on what the therapist is saying and doing with the patient.

The idea of a 'silent observer' was described by various participants: *"I just sat back again and let her do what she does. And then we discussed the client afterwards"* and *"The reviewer stays out of the whole treatment process and just sits as a quiet observer, during the whole time."* Just observing, keeping quiet and not speaking were often anticipated behaviours of the reviewer. That reviewers are in fact expected by some participants to be 'silent' is also reflected in the comments above.

The silence maintained by some reviewers was talked about by participants as being purposeful, *"I probably would tend not to ask so many questions during the visit, ask questions afterwards."* This participant described that her role as reviewer was to keep her questions until after the interaction with the patient had been completed. The role of being a non-participant observer was described by some physiotherapists when asked what the role of the reviewer was:

> *The supervisor just followed me through to whichever room I was in, in their house and then the client went back to where he normally sits and we just finished up and I made another appointment to go and see him again later on. We left the house and then found a nice sunny spot to sit somewhere else, the supervisor and myself, and we just talked through what happened.*

This idea of pure observation and non-interaction was a common theme with the generally accepted view that reviewers are present purely to make an observation on

which to base their critique of the physiotherapist's practice. Other reviewers seemed to prefer to occupy a 'front row seat'

> *I would sit along side them, like the physio would be here, the patient would be there, across the table for the session, usually, and I would sit along side the physio and just observe and not make comment and just make notes as you go.*

The physical position of this reviewer seemed to facilitate the watching, however still allowed the 'silent' role to be maintained.

When acting as a reviewer physiotherapists also emphasised their non-participation in the physiotherapy session. For example one therapist described her actions as *"I am usually a wall hugger, really, I just sit in a corner and watch and so I am not involved in any of the client-therapist relationship and management, unless I am asked to be."* This role of a non-participant observer is discussed by Adler and Adler (1994) and relates to the role peer reviewers may choose to adopt by limiting interaction and involvement. However although many therapists expected to be silent while conducting a review, this was not always the case. Some participants took an active role in the therapist-patient process by questioning, directing and also redirecting the process of the assessment or treatment throughout the review session.

> *We gained the consent of the patient for us to perform a peer review session with her and the assessment was led by the physiotherapist and at points, she would ask me whether I had any comments, or whether I would have any more information, or whether I would do any other testing. At which point, I would then offer some information or help her with a demonstration of a test. At the conclusion of the assessment, we stopped and discussed the analysis with the patient and then discussed what the plan of management (was) we would take.*

This approach describes an interactive session, with reviewer and reviewee each taking a significant role in the session and with the direction given by the reviewer potentially altering the course of the assessment and treatment. In this instance the

role of coaching the reviewee has been integrated into the peer review process. The experience of being the watcher was described one participant:

> *I feel quite comfortable in the position of the reviewer, because I've had, I've done it quite a few times now and mostly the people that I review are people that are within my immediate team, so I'm really familiar with them and we have respected each other and you know, value each other's opinions and so mostly my experience as a reviewer has been quite positive.*

The 'watcher' role was one this participant felt at ease with and she describes several reasons for this. Firstly, she has participated in the process several times; secondly, knowing the people she will review very well; thirdly, sharing a mutual respect for each other in a professional sense and finally, finding the opinions of others useful within this team setting. While finding this role a comfortable one, this participant also alludes to the fact that this has not always been the case. In the last part of the quote she indicates this with the words 'mostly' and 'quite' positive.

Taking on the role of reviewer was something participants did with some consideration. When asked about what they did to prepare for the peer review one participant talked about her dual roles.

> *As a reviewer, I prepare my self by making sure that I've blocked out adequate time to be with that therapist and observe them and I prepare by printing out the templates and just re-familiarising myself with the key areas that I am required to look at …and I usually sit down with the therapist beforehand and discuss the things that I am going to be looking at.*
>
> *As the reviewee, … probably the same, re-familiarise myself with the template to just remind myself about what exactly they're interested in looking at, while they're watching what I'm doing.*

Being organised, having adequate time set aside and knowing what the criteria against which the reviewee would be measured were all things considered as key tasks. This participant also sought a shared understanding of what she would be assessing in her role as reviewer. However another participant when asked if as

reviewer and reviewee they talked to each other about what they expected during the process replied *"We tee up the time, go out and then afterwards have a chat about it, not beforehand."* For this participant mutual expectations were not discussed prior to the peer review process occurring.

As a reviewer another participant also described her preparation as, *"I just read the form beforehand, so that when I went in, I knew the sort of things to look out for and that I would have to record."* This approach seemed to indicate a more one-sided approach to the preparation. Yet another participant commented that they did not do anything much to prepare *"Thinking back, I probably didn't prepare a lot"* but then added:

> *I would let the person know, who I was going to review, that it was today and it would be at this appointment time. And I would come and sit with them. I would give them a look at the sheet, just to remind them what we are going to go over.*

This explanation indicates that some choice had been made about which patient would be involved in the review process, by the reviewer's choice of time and that the reviewer had wanted to make clear what was on the template, that would be used in assessing the reviewee's performance.

In preparing for a peer review the same participant described reading the client's notes. This was to ensure familiarity with any clinical considerations this particular case would require, as far as protocols and stage of treatment were concerned and that the reviewing therapist could then take over the treatment if required.

> *Normally, I would have had a look at the notes prior to sitting in, so I would have an idea of what the patient is up to, what kind of treatment they have had and what the treatment plan looked like. So that when I sat down, I was kind of, up to speed and probably could have taken over the treatment myself, if need be.*

With this comment it is not clear what the participant's intent is in being able to take over the treatment. This may be to do with knowing exactly what should be happening at this point in time with the patient's treatment or that if safety issues arose that the reviewer would be in a position to intervene. Another participant also described reading the notes in advance as something she liked to do. *"I do like to read the notes before hand, so I have got an idea of the context."* It seemed important to many of the participants to be clinically informed about the particular patient's current status prior to commencing the review.

Although not often referred to as having occurred, one other participant described a peer review situation where the reviewer did take over the treatment and then did not wish to complete the peer review process by filling in the template or giving feedback.

> *Probably, the time that I did ask someone to review me and because of being so pregnant and also looking for someone to hand this client on to, I didn't actually end up… she didn't complete the form …she felt that it wasn't appropriate to do that, but she didn't really go into why. I assumed it related mainly to her having taken over the treatment and that, but I wasn't entirely sure. It was the end of the day and she was in her last week of working for us, that particular time and so I was left feeling a little bit uncertain, as to why she hadn't put anything onto paper. I wondered if there was something that she thought I hadn't done very well.*

This resulted in confusion for the reviewee as she was unsure as to why the reviewer had not completed the process. Her understanding of the contract between reviewer and reviewee had not been fulfilled.

Two participants mentioned that it would depend on why they had been asked to review someone as to whether they would prepare or not for their role as reviewer. It

appeared that if they had been asked specifically to review a particular person, then they might do some preparation.

> *Now, I probably have developed another step, where I do actually try to determine what the process is for,… so I might meet you and say beforehand, what is going on, rather than just saying, 'Oh well, we'll do the peer review and here's the form'.*

Here clarifying the purpose of the review with the other person seemed particularly important under these specific conditions. Another participant added:

> *If it was someone that I had been asked to review…if that person was a lot more senior than me, and there might be some problems in me giving them feedback, then I might just think a bit more about what my approach might be.*

These participants indicate that the purpose for undertaking the review is a factor influencing what they do as preparation, including contemplating how they might approach giving feedback about the outcome.

Another factor considered was regarding the practice setting the person being reviewed was currently working in as discussed by this participant:

> *When you are working in isolation and you're being reviewed, it really is just a snapshot of that moment in time. Of what you were like with that patient, at that moment. Whereas, when you work in an area where it's open plan, and you get that informal review on a daily basis, I think you've got a much fuller picture of what that person's strengths and weaknesses are. And perhaps, in your peer reviews, you can focus more on the things that you know about that person already.*

She indicates the possible implications of seeing only a small slice of practice when reviewing others who practice in isolation. However having regular daily exposure to the practice of the person being reviewed, in some settings may influence the emphasis in a review session. This participant described taking the opportunity to direct the review, to explore those pre-suppositions or assumptions.

> *If issues come up, they are issues that people talk about it, whether it is a cultural issue or something, because being the most senior physio, they kind*

> *of come to you and say "this has happened" and it wasn't always those kind of issues that come up, but then it makes you wonder, if they are not coming up, because we are overseeing them or... there has to be a little bit more, because our peer review is really focused on clinical aspects of things and not a lot around ethical and cultural issues.*

The issues that come up around practice for particular therapists may be discussed and known about within that work group. As this participant suggests, peer review then provides an opportunity to investigate these issues further by directing the review and expanding the scope from just clinical to involve other aspects of practice such as cultural competency and ethical issues. The participant also raises the question as to whether issues do not get raised or come up, because of who is oversight of practice.

Considering the person who was being reviewed was something physiotherapists mentioned. When in the role of the reviewer participants also acknowledged that they might take into account the nervousness of the reviewee and allow for that in their appraisal of the session. *"I remember being very aware, that the people I was reviewing, were also quite nervous about the process and you know, it was built up in advance…there was a bit of apprehension."* Taking into account the emotional state of therapists undergoing review allows for the performance of therapists to be seen in the context of a pressurised or exam-type situation. By the use of the word *'also'* this participant alludes to the notion that it is not only the reviewee who might be nervous, but also the person taking the role of reviewer. Any anxieties the patients might have were not mentioned directly by participants.

While practicing physiotherapy, observing and judging the practice of others happens both intentionally and unintendedly. At times proximity of practice environments

enables frequent observation of others as they work, however physiotherapists often practice in isolation. The degree to which people are watched or are watching varies amongst settings and is explored in the following section.

Opportunities to observe.

Participants have described the way observing others' practice happens in their work area.

> *I noticed a big difference when I moved into this area compared to an area where I was working in a lot more isolation. Being the only therapist on a ward, for example, means that you don't have other physio's watching what you're doing or just doing informal review of what you're doing.*

Being isolated in an area of practice not observed frequently by other physiotherapists, leads to less opportunity for informal review. This participant went on to explain the difference in an area where several physiotherapists practice within sight of each other on a daily basis.

> *Then, when I moved into this area, because it's a very open plan layout, it meant that you were overheard by other therapists all day long. You're overhearing other people talking to their patients. You're observing people you know, treating. It means you get quite a lot of affirmation for what you're doing, because you basically see that your practice is similar or, you know, even better than other people's practice, sometimes and that can be quite, quite good feedback, even though it's quite informal.*

Working in close proximity is seen as an added value by this participant, in the setting where daily practice is constantly exposed to observation and informal peer review. The intimate knowledge of peer practice can also be used to direct the formal process of peer review.

The role of reviewer was frequently described by participants as one that was silent and also of being a non-participant observer. However at times interaction between

reviewer and reviewee and sometimes reviewer and patient, did occur during a peer review process. Expectations of the reviewer's role were sometimes discussed beforehand, but often not. They are literally silent, including being silent about their expectations. Gaining sufficient knowledge of the case was seen by some as a task to be completed prior to commencing a review. So although outwardly silent, the watching is done from a perspective of being informed, watching with intent and unspoken expectations. The purpose of peer review also influenced what preparation was undertaken for the role of reviewer, if anything was prepared and how feedback would be delivered after the review. The anxiety and anticipation of the reviewees was considered by some reviewers and taken into account in their own minds, when making the assessment of performance. As reviewers prepared and focussed on their observation role, those who would be watched also contemplated their task. Therapists being reviewed were anxious to present their practice in a good light. In the next section, various strategies and approaches to this are explored.

Demonstration

As with any performance, watchers need something to watch. They may be looking for a show. Participants described the idea of wanting to put on a show for the watchers by demonstrating their skills and knowledge. They discussed including in their performance as many of the things that the watchers would be looking for as they could. This theme and its sub-themes: consent, review templates and clinical documentation and formality are explored.

Knowing that they would be watched, participants described ways they would prepare for the peer review. Before the session *"I re-familiarise myself with the*

template, to just remind myself about exactly what they're interested in looking at." During the session, normal practice may not be followed in an attempt to show case the therapist's skills and knowledge, focussing on aspects the therapist believed reviewers wanted to see.

> *Often your treatment turns into this really lengthy process, because you want to demonstrate all of the points on the marking sheet to the reviewer... Just because you think you have to be extra thorough to please the person that's reviewing you.*

Being extra thorough in order to demonstrate all that therapists believe is expected from criteria on a marking sheet, may direct the practice displayed. Wanting to please reviewers with their individual likes and dislikes potentially moves physiotherapists away from demonstrating the way they practice everyday when unobserved. This concept of 'showing off' your 'best' practice is at variance with the notion of peer review, being to allow the reviewer to witness a 'snapshot of ordinary practice'. *"Trying to keep it as close to your normal practice as possible, is better because you really want that person to get a snapshot of how you really practice."* The expectation to see everyday practice demonstrated in a peer review process did not seem to be discussed between reviewers and reviewees.

Altering your usual practice to "show off" may not actually be the case, but may be suspected by the reviewer.

> *He commented that, that [telling the client about research which had shown the treatment to be effective] was obviously a bit for show and I told him that it wasn't. I don't think he believed me, actually that, that was the way I always saw clients.*

The suspicion from the reviewer seemed to upset this therapist and may continue to influence their ongoing relationship, if unresolved.

Consent.

The demonstration of aspects of practice was anticipated by reviewers. Part of preparing for this demonstration is making sure the other participants in the peer review process, such as the client, know what is going on. An essential element in the process was described by participants as the requirement to obtain consent from the patient for the process of peer review to occur prior to or during their assessment or treatment session. Physiotherapists may want to demonstrate this consent process to the reviewer or make sure they 'know' it has already been completed. Putting the consent process 'on show', was described:

> *I always ring the client first, and have a conversation with them and say 'Is it alright with you if so and so comes? They are one of my colleagues and they are coming to look and see how I practice.'*

At times therapists mentioned giving the patient an option to be involved in the review process or not. *"You ask the client if that is okay, for the other person to come with you…making sure that the client is always comfortable and if they want to say no, that is fine."* Therapists gaining consent from patients for a colleague to conduct the peer review was often achieved prior to the appointment time. However this was not always the case.

> *So you remind the person [physiotherapist] that it was today and that you are going to fill out the form [review their practice using a template] and then at the time when the patient would come in, then we would, I would get the physio to tell the patient, 'Is it ok, if a person sits and watches the way that I practice today?' Take a few minutes and get their consent.*

Here obtaining consent is seen by this participant, acting as a reviewer, as something that needed to be done before the peer review process could commence. She describes requiring the therapist under review to 'tell the patient' and then describes 'asking' for consent. The 'asking' for consent is not indicated by the word 'tell'. However, even the process described for obtaining consent may, with the reviewer

and reviewee present, result in patients feeling reluctant to decline. Participants often mentioned gaining consent and were keen to demonstrate this. However it was not always clear what patients were consenting to, the peer review process taking place or the physiotherapy assessment and treatment.

Review templates.

The demonstration itself was shaped by peer review templates or forms outlining the peer review process and setting out marking criteria. These were often described as being organisation-specific. Each organisation had developed its own way of managing the peer review process. The process of peer review was described in guidelines at some workplaces and not in others. *"The client was my choice, using forms that we have here as the guidelines, a map to go through the process and then a discussion afterwards."*

Some workplaces had developed their guidelines based on the format which the NZCP had produced. When asked about the peer review process one participant stated, *"I did one peer review when I was actually doing a research project…and we used the college forms for that"* and added *"The college [peer review process] seems to be a better format, there is more to think about, look at, do, than what it is for the hospital."*

While some participants did not refer to any guidelines or how the process of peer review developed, others described the creation and development of a form or template on which to record the results of peer review.

> *That was developed within our organisation. Taken off bits, it has been quite standard for the last, just about ever since I have been there. I have been there 9 years, but it did change in the very beginning, so it has probably been at least 5 years, the same form, that I have worked with.*

The development of these templates was brought about by different processes. One participant described the template used as arising from an external accreditation process.

> *It has arisen out of the template that the accreditation auditors have used and while we had [it] just because it comments on things like whether the records are legible or whether there is a sound history and whether there is apparent objective information and testing. Whether there is analysis, diagnosis, planning and all that sort of stuff and we have converted it together, [to a] sort of rating. So we found that the general feedback was valuable. Physiotherapists are probably, what we felt was even more valuable was to see themselves as physios benchmarked across the [organisation].*

From this organisation's process, a rating score has been developed which reflects the need in this setting, for some quantitative data according to the participant concerned. This could measure whether a certain level of compliance was reached. This type of data was also required to enable benchmarking across a large number of practice settings within one organisation. A rating or score was used to match or measure physiotherapists, against one another.

> *So that has been quoted as a score, so we can then benchmark across the [organisation] and also standardise, so that if a certain percentage which we expect you have to reach in order to fulfil the job description, that needs to be a bit more quantitative for us.*

In this particular work setting the participant felt qualitative measures alone would not facilitate standardisation of work practices which is why this organisation developed a way of quantifying the peer review. This could be an attempt to use subjective feedback to standardise practice by quantifying it using a rating which is then compared across the organisation. In adapting the template from various sources, the process can be aligned with individual organisational purposes, as well

as to meet professional development needs. This change occurred over time and with time became described as 'standard'.

Some type of template was frequently described by participants as being used to document the observations made, as well as the reviewer's commentary on the practice under review. This template contained criteria or a marking schedule as mentioned by this participant. *"The first context [peer review process] had a list of criteria and had documentation, draft documentation to go with it, a skeleton form to go through the processes."* Guiding the process of peer review, these criteria formed a basis for post-review discussion. *"Ah, yes, yes, basically, because we have a formalised template in front of us. We basically, go through each of the points on the template and discuss the pros and the cons about each one."*

Completing documentation was described as taking some time to write after the review session and was usually not completed until after the patient's notes, written by the reviewee, had been read by the reviewer. Often a time delay in the peer review process occurred at this stage before feedback was given to the reviewee. However participants agreed that the sooner this was done the better, in order to complete the process.

One further aspect of physiotherapy practice participants identified as being scrutinised within the process of peer review, is that of cultural competence.

> *That it [peer review] encompasses more than just the clinical function. That it becomes that everyone has the skills to be able to comment on cultural and ethical issues, because I think that is perhaps why we don't always comment on those things, because we are not quite sure where it is we are at ourselves, with those issues.*

With current templates used to record the observation of peer review, participants mentioned that aspects like cultural competence, ethical issues and communication issues are not always clearly identified as criteria to be assessed. This may not meet the current requirements under the HPCAA (New Zealand Government, 2003) to demonstrate that therapists meet all practice competencies including these competencies, which the NZPB have stated should be demonstrated throughout all aspects of clinical practice.

Clinical documentation.

In the process of peer review all aspects of practice are on show, including written records. The documentation of the assessment, care plan and treatment that a physiotherapist provides for a patient forms the clinical record or notes, as do subsequent progress notes.

> *I just knew that when they as a reviewer, someone coming to review my own work, that they would be looking at my notes [clinical documentation] and they would be looking at my practice and I suppose, I would try and keep my notes really good for the weeks leading up, so that it would reflect really good practice.*

Spending time before reviews were due to make sure documentation was up to scratch was a common theme. Some participants discussed how they would make a concerted effort leading up to the review to ensure the documentation that would be put on display was a good as possible and would be a reflection of their good practice. Another participant described how the gaze of a reviewer would be directed towards notes that *"I know are good."* In this way the normal everyday documentation is not necessarily put on show, perhaps suggesting that substandard notes are hidden from the reviewer's eyes.

Preparing for peer review participants considered ways of demonstrating all that they believed reviewers wanted to see. Providing evidence of consent seemed important. The clinical documentation formed part of the evidence reviewers wanted to view. Aware of this, participants included this in their preparation. Using templates and guidelines, both individuals and organisations pushed peer review towards meeting the expectations they had of the process. These expectations were many and varied. In the following section some of the requirements and expectations placed on peer review and those that participate in it are discussed.

Expectations

This theme has several sub-themes which are the Purpose of Peer Review, The HPCA Act and Who is a Peer. Over time the process of peer review has become embedded within physiotherapy practice. The historic traditions of training models and guiding newcomers into practice have supported this. In New Zealand, various influences have encouraged the profession to continue and even promote the use of peer review as both a quality assurance method and a professional development tool. Participants in this study frequently referred to using peer review to meet different requirements or expectations of themselves as both professionals and employees. Frequently participants mentioned that it was compulsory within their organisation. *"Why we are doing peer review, was part of what we have to do for our job"* and *"Well, here at the hospital, of course, it is something that you have to do."*

The timeframes and the number of peer reviews expected were different for individual organisations. This participant detailed specific frequencies that peer reviews had to be completed within according to the organisation she worked for.

"We are required, within our workplace, to have at least two peer reviews per year." One participant also described the role the NZCP played in promoting peer review within New Zealand, by establishing peer review as a requirement for college membership. *"The college brought in this process that peer review was required."* Another participant reflected on her involvement in peer review as a student, but that as a practicing physiotherapist she was not involved as much until the professional organisation (NZCP) developed a formal peer review process, which is mandatory for all of its members every three years.

> *As an undergraduate and then as a post graduate, I was involved in peer review processes, but outside the educational system until the College facilitated the peer review process and developed a form and encouraged its members to do that, once every three years, at that point, we probably didn't do very much [peer review] at all.*

The peer review process while used frequently in training as students may not always be carried over into practice by qualified physiotherapists without some professional incentive, as this participant indicated. Participants referred to the pivotal role that the NZCP played in introducing the process of peer review into professional practice in New Zealand.

Purpose.

The purpose of peer review was clear to some participants, *"We want to make sure we are providing excellent service and that we are providing, you know, a safe service and we are providing an effective service."* It was less clear to others, as reflected in this participant's questions.

> *It is one of these things that I wonder 'Why we do peer reviews, because on the whole, why do we do them? What do we want the outcome to be?*

Others could identify several purposes but were still not clear, as this participant describes when asked about the purpose of peer review:

> *I have been thinking about that and I am not sure that, that is very clear. I guess the College (NZCP), makes it a little bit clearer, because it looks at so many different areas about the client's safety, what the physio's doing, but also the surroundings in the practice and how the practice is laid out and what that is like. The hospital, that [the process] is a bit more simple. When I look back and think about it, I am not 100% sure why we do peer review. How deep we are going into it and it is something we do, but I am not sure how good it is.*

This participant felt confused as to the purpose of peer review although she felt that the purpose of one organisation's peer review was a little clearer than the other. The multiple purposes as explained by participants, may be contributing to this confusion.

> *I think it's got two purposes. I think the first one is that it helps us to grow as professionals, but I think the second purpose is to make sure that we are fit to do our jobs. And it's, it's a quality assurance method within our organization and it reassures our professional leaders and also the clinical board [within the organisation] that we are practicising at a certain standard and that we are safe in our practice.*

These are different purposes; one developmental and the other to check competency as a form of quality assurance. Each has its own set of desired outcomes influences how therapists will play to the audience, to achieve the outcome they want from the process.

Another purpose referred to by one participant was the art of teaching the reviewer, through demonstration of 'good practice'.

> *For instance, one example was a client that was my last visit and so I was going over my objective measures again, to demonstrate how I did those and that particular one, there was a bit of it. I like things where there is more than one purpose. It was also for the other therapist to see how I assessed, and reassessed, as well.*

Asked if she considered that she was teaching the participant replied, "*Yes.*" The intended audience was still the reviewer, but the intentions were not to have the

practice reviewed as ‘good’; but to the have the reviewer become aware of, or appreciate what good practice is.

Clearly what the information gained in peer review is to be used for, and who sees it, is perceived by participants to influence the information collected and specifically, what is documented.

> *So, there are two elements to it. So, I guess if you were to make peer review a completely anonymous thing, that it is really just between the two therapists, you would get a lot different and more information out of it, than if it was used for audit purposes.*

As this therapist suggests, the recording of the results of a peer review session in a formal written document that could be used for audit and viewed by others [outside the two therapists concerned], may influence the actual commentary and critique.

Quality assurance was a common notion when discussing the purpose of peer review with participants:

> *I think it is just another of those things, you know, the quality assurance, we relied on a quality assurance person at the last place or two or a committee and they would make sure that certain things happened through the year and it is just a lot of work for everybody, all this extra paper work, we are having to go and tick boxes, but I think it’s got to be done because in the past I have known there were therapists who train and they just go and they memorise a book and they don’t do a thing and they just get into some bad habits on their own.*

This participant infers that although the process does involve a lot of extra work for many people, it is something she regards as essential to assure the quality of physiotherapy being practiced. She also refers to her experience of physiotherapists who, after qualifying, perhaps use books alone to update their knowledge without reference to any colleagues and that this, in this participant’s opinion, can lead to ‘bad habits’ or less than optimal or maybe even incompetent practice.

Reasons given by participants for getting involved in peer review differed but were consistently around the idea of being required to be involved in the process rather than choosing to be part of a peer review process. *"I would say that management, just management told us we were to do it, just part of the policy, we were given six monthly time, we would just [say] 'here's your forms folks, find someone to do it with'."*

Addressing safety concerns was cited as a reason for needing peer reviews, as this participant mentions: *"If there is a safety concern, be it with the client or the physiotherapist, because things can wrong with us too…, we need peer reviews, they are good for that."* With this thought in mind, one might expect the opportunity to uncover 'substandard or 'unsafe' practice be anticipated in the peer review process, but this was disputed by participants. *"Everybody is always on their best behaviour"* and *"I suspect that if a physio is unsafe, that one will see that around at work anyway."* This infers that informal review (for example in-office discussions) on a day-to-day basis is likely to alert others to unsafe practice and that being 'on show' during a peer review has the potential to disguise 'usual practice' as the participants in the review process are putting their 'best practice' on display for the reviewer to see.

The expectations of the review process were sometimes clearer than at other times and some reviewer - reviewee pairs would meet prior to the peer review to discuss what the process was to be and what they expected of each other.

> *Yeah, its basically the marking guide, if you like, it's also got some information about the process attached to it, so that both the reviewee and the reviewer are very clear about what's going to happen and that the expectation is the same on both sides.*

Some therapists vary from viewing the peer review process as something that 'has to be done' from a personal and professional development point of view, to seeing the peer review process as something that is 'useful' to the organisation. For instance, one stated: *"It is a useful process from an organisational perspective to ensure that everyone is practicing at a safe and competent standard."* Similarly, another participant held that: *"They know that they are doing what they should be doing, that they are meeting the organisation's requirements, that they are meeting professional requirements."*

Participants generally accepted that peer review processes were useful to the professional leadership. *"Basically we are required within our workplace to have at least two peer reviews per year… for a credentialing type process… usually the professional leader is involved in ensuring that that happens."* This participant went on to add:

> *You've also got aspects of mechanisms to make sure requirements are met, and moving into consequences – the outcomes from these requirements. Our peer review forms are part of our credentialing process, that tell the board [Hospital Clinical Board] whether we are fit to do our work. [This process] reassures our professional leaders and clinical board within the organisation that we are practicing at a certain standard and that we are safe in our practice.*

Through professional leadership, organisations use peer review to assure themselves of professional competence in their employees. The systems in place in this organisation ensure that peer reviews take place and that appropriate actions result from the outcome of the peer review process. The systems that ensure reviews take place as scheduled also assist individuals to ensure professional development, make sure they are meeting standards and check their practice is up to date and has not

slipped into bad habits: *"It makes you think at the time, really hard, what you are doing and you try and be as good as possible."*

Organisational roles often took responsibility for ensuring the process occurred rather than leaving it to individual physiotherapists.

> *Someone else did actually say to you 'Hey it is time to do it now.' Generally we were all doing it, the whole department, everybody like, 'Can you see if you can get this done, next month?'*

When I asked one participant if someone in the department would be organising the process and checking that everybody was participating in it, the response was *"Yes."* This answer indicates the driving force for peer review was sitting with the organisation rather than with individuals. Again this points to a quality assurance purpose rather than a developmental purpose. Another physiotherapist recalled how their organisation managed to ensure the process occurred regularly:

> *Most recently I was the most senior physio and so, I would make a note every six months or when it needed to come up again, and so, I would flag to myself that we needed to do it and then delegate it to one of the senior staff members to get it all organised, the nuts and bolts of the process. So, a senior staff member would get the form that we used, she would photocopy those off, she would photocopy the instructions of how to do it. This would be the kind of basic sheet that we have to kind of remind us of what we need to do.*

Frequently it seemed within organisations the peer review process was driven by organisational leadership with organisational purposes in mind. Physiotherapists in senior positions saw this as their responsibility and would organise the process or delegate this task to others but still ensure that the organisational requirement was met.

The NZCP have set a minimum requirement for regular peer reviews as one of the conditions of ongoing membership. For those participants that were college members, this was clearly something they were very aware of. Participants mentioned the college by name and referred to this requirement, as a reason for undertaking the process of peer review *"For the college it is a requirement that you do, once every three years."* Participants have chosen to undertake different processes using different forms to meet the needs of different organisations, as described by this participant. *"The context of one [peer review] was for professional competency for physiotherapy external agencies [college] and then for the internal one [employer]."* It was unclear whether this participant considered both reviews were to establish professional competency or whether just the College one was concerned with this.

Another reason mentioned as a requirement for peer review was to do with particular funding contracts with ACC, a government-run accident insurance scheme, which prescribes peer review as necessary within certain time-frames. In this situation the organisational requirement was for more frequent peer review than what was required by ACC.

> *At our organisation, we do peer review. I think we say to do it, every six months. I worked in the a particular area, where we tried to do it every six months because that was what the organisation stipulated, but also a lot of us were working within a specific ACC contract and within that, they have a stipulation that you do it [peer review] once every 12 months. So it met both needs.*

In this instance, it was clear that the peer review process was meeting two sets of requirements. Those expected by different organisations, the employer and the funding agency.

Participants shared their views on the purpose of peer review and what they expected of it dependant on its purpose. Sometimes this purpose was clear at other times it was not. According to participants' expectations of the process, their view of who they considered a peer was variable. Some of the views on who they expected to be classed as a peer are presented in the following section.

Who is a 'peer'?

The question of who is a peer was raised during the interview process.

> *So normally, peer review is with a peer, or somebody who's a higher. So somebody who is a higher level than you in terms of more experience or is more senior or in a more senior position. So it would be very unusual for a junior therapist to give feedback to a more senior therapist, or for a health care assistant to do a peer review with a therapist. So usually juniors would do peer reviews with, sometimes with other juniors or generally it's a peer review with juniors and with health care assistants, who have just started doing peer reviews. It really was just a pure peer thing, so they just chose somebody, the same level, and asked them to be reviewing them.*

To this participant peer seems to mean another physiotherapist at the same level or higher. Interestingly, she also mentions health care assistants who are not professionals, as participating in the practice of peer review. Another participant when asked to think about a particular instance of peer review went on to describe a time when she had asked her supervisor to review her:

> *This gentleman in the community that we visited, my supervisor came with [me], well we ended up going to the house in separate cars. We teed up the time. The client knew and his wife knew that we were both coming in. I made the appointment and went in to see the client. At that stage, I did not realise that my supervisor had already known this client beforehand. So, we went in, I did what I normally do, sat down introduced the supervisor and the client was happy, everyone was happy and I just carried on with my follow through. It was not a first assessment. Just a follow through.*

In this context it seemed participants considered their supervisor to be a 'peer'. However some participants felt that there was a difference if the supervisor or manager was conducting the review, but would still call the process as 'peer review'.

The notion of being on one's best behaviour was a common thread when in the presence of a supervisor, *"If it's my supervisor coming with me I'm going to be a good girl no matter what"* and even with a peer who is not the therapist's supervisor *"You're still good, because you are treating clients and you have to have a certain standard."* Wanting to be seen as competent and 'good at your job' and achieving a standard were ideals described. In contrast, reviewing the practice of their manager was identified as a dilemma for one participant:

> *I think that it then, really puts the reviewer in a very awkward position, because they are kind of torn, where they want to give honest feedback about your performance, but I think in another sense, they're also very aware that I'm their manager and they want to, I don't know, I guess, they don't want to be seen in a bad light, and they're reluctant to give feedback, that perhaps, isn't so good.*

The opinions and expectations of peers seemed important to these participants and impressing the reviewer was a carefully considered task. This seemed to take on more significance when it involved supervisors or managers of physiotherapy practice, with one participant acknowledging the difference in role and purpose she took on when reviewing people she supervised. *"Here as supervisor…so it would probably be more, because of my senior role, it would be more related to looking at performance level."* From her position as reviewer, this therapist saw her role as changed because she was a supervisor, focussing more on benchmarking the practice of one physiotherapist against another.

The term ‘peer’ was used by participants to apply to ‘other’ physiotherapists. At times these ‘peers’ may be colleagues practicing at the same level, but the term was equally applied to the role a supervisor would take in a peer review situation. Having more or less experience or skill as a physiotherapist did not seem to affect one’s standing as a ‘peer’.

In sum, the tradition of peer review in physiotherapy has contributed to various expectations regarding this process. Professional organisations, employers, funders and the Registration Board have all developed expectations around the participation of physiotherapists in peer review. Physiotherapists themselves have expectations of what is required, both as a reviewer and as a reviewee. Often their past experience has influenced this view. In 2004, new requirements imposed on New Zealand physiotherapists by legislation were designed to assure the public of competent health practitioners. Participants described a renewed interest in peer review to provide evidence of competency in order to meet some of these requirements. This legislation and its apparent impact on peer review is explored in the next section.

HPCA Act.

The new HPCA Act (New Zealand Government, 2003) requires New Zealand health practitioners to be re-certified by their Registration Board each year, as able to meet their registration competencies. Continuous professional development (CPD) must be undertaken by each physiotherapist to a minimum level each year. Recording of the hours spent in various CPD activities approved by the Registration Board is collated in a professional development portfolio by each physiotherapist. To this end, the documentation of peer reviews were seen by participants as evidence of an

acceptable professional development activity that could be used as one of the components to meet the new re-certification requirements. *"It was useful to have now, useful for portfolios."*

The 'portfolio' referred to is a compilation of evidence of CPD into a folder as a written record, as required by the new re-certification requirements. *It [documentation of the review] got stuck in your portfolio."* Prior to September 2004, New Zealand physiotherapists were not required to keep professional development portfolios and participants indicated that this, by the use of the term 'now'. *"I get a copy of it (peer review form), I make sure I get a copy of it now, because it goes in my portfolio."* Collecting evidence of peer review seemed of more importance to many participants since the change in legislation.

Copies of the documentation of peer review sessions where held by the person undergoing the review, but at times participants expected that others may also hold a copy or view the results. *"So we keep the original documents."* Furthermore *"So the information (documentation of peer review) goes to our professional leader at some point in time. So it's shared with them."* Sharing the information contained in peer review was something that was expected by some participants. Asked in her experience 'Where do the forms actually end up, who would see them and would that influence what is documented,' One participant replied: *"In our department all the forms come back to the senior physio in the area… the results go off to the professional leader,"* and then expressed the thought *"I had never considered that people would think 'I wonder who is having to read that?'"*

The sharing of this information with nominated seniors and leaders of the service seemed to be anticipated by this participant. The idea that reviewers would consider who would be reading the information contained in a review and that this might influence what is written, seemed new. This sharing of peer review documents was something mentioned by participants with regards to peer reviews undertaken to meet workplace expectations. Not all participants were clear as to where the documents would be held.

> *I get a copy of it. I make sure I get a copy of it, now, because it goes in my portfolio, so it is very important. Where the rest of it goes, I don't know. I guess it is, one of us keeps a copy it…No, I am not quite sure, I guess it might end up on the manager's desk, I have no idea.*

Again for some participants it was clear who owned the information gained in peer review and where the documents would be stored, but for others this was less clear. Clarification of this was sometimes sought before the start of a review:

> *Both from a reviewer and a reviewee, I think it is important to say [at the beginning] how it is going to be used in the end, who owns the information in the end. Is it something that goes on a file as part of a performance appraisal? And therefore, it has an extended sort of role in determining someone's future career prospects or salary or whatever, as opposed to someone wanting to know that they are safe.*

This participant infers the life and influence of a peer review document could be far greater than in the immediate circumstance, if it is to 'go on file' in someone's personnel records as suggested here. In turn what might be recorded on such a document of considerable influence might also differ, according to that perceived end use, or 'life'. Despite some awareness that reviews are filed, assumptions of confidentiality in the peer review process were often made by participants: *"No-one is going to go around saying 'Oh, so and so didn't even do such and such.' Well, you would hope not. It should be confidential."* This participant went on to say:

> *There can be a lot of gossip within physiotherapy circles and people can fall out, say. But I think there is an assumption of confidentiality, but really it*

> *should be, there probably should be [something] signed, perhaps it should be a contract.*

This participant felt strongly there should be a clear confidentiality agreement between the two parties in the peer review relationship. Unlike work-based documents, the college-based peer review guideline clearly states that the documentation and results of the peer review process will remain confidential to the two physiotherapists concerned, reviewer and reviewee.

The expectations physiotherapists held of the peer review process varied. Organisations also seemed to hold expectations of this process which may be different to those held by the physiotherapists involved. A sense of obligation or compulsion often accompanied the organisationally imposed peer review requirements, as opposed to those which had a developmental focus. However for many participants the purpose they were undertaking review remained unclear. The commentary on practice resulting from a peer review formed part of the process and was expected to be used as evidence by many, of both competence and additionally an evidence for the portfolio of CPD to meet physiotherapy board requirements under the HPCA Act. This commentary involves critique and in the next theme, participants discuss what the role of this critique maybe.

Critique

The act of seeking peer review is one that invites a critical appraisal or evaluation of one's work or performance. Physiotherapists are advised by professional bodies and the registration board (PBNZ) and professional organisations in the *Standards of Physiotherapy* (NZSP) to open one's practice up for evaluation. Peer review is a

commonly accepted process for achieving this. Under the theme of Critique several sub themes emerged. These were: Organisational Audit, Standards and Criteria, Protected Time, Open to Feedback.

In this study, peer review was frequently described by participants as a method to assess the competency of a physiotherapist. This presumably involved the reviewee meeting certain standards of practice and demonstrating registration competencies although participants did not express a direct link with any specific document containing standards of practice or competencies by name. One participant identified the purpose of the critique as: *"Determining practice competency or determining bench-marking for practice."* This participant describes two different outcomes of the evaluation gained in peer review. One is assessing whether some minimum level of competency is achieved, the other, a levelling against some ideal practice standard. In the following section, what guides this evaluation and the resultant critique are discussed by participants.

Organisational audit.

In some organisations peer review was viewed as part of the human resource management process, providing evidence that employees met certain standards or benchmarks or were practicing to a 'safe' standard. In others it was viewed by participants as "a tick box process", with the content of the review, at times remaining confidential between the two participants.

> *The supervisor would check that off and then basically, when you had your annual review, you didn't have to bring it in to that, your performance appraisal, but obviously if you were asking for… or well, they would want to see that it was there or… the details of it. I'm not sure exactly.*

That physiotherapists had completed their peer review seemed to be what was important and not the content of what had been documented. If you were asking for something perhaps a salary review, then maybe the detail would be used as evidence to support some type of merit reward. However in the context of annual performance appraisals, usually just the mere acknowledgement that the peer review had been completed was sufficient.

Irrespective of issues of confidentiality, a generalised awareness of the expected standard of practice can be shared through the peer review process. Participants described their organisation's use of this process as a type of audit to check that all physiotherapists are meeting a basic standard.

> *So, I pointed out to her that you're not meeting the requirements….and she was most surprised. She said she is always picking it up on other people but never realised she was doing it herself and she was grateful for me pointing it out to her.*

It was felt that some practitioners may be completely unaware that they had been practicing at a level considered 'below standard.' *"And they'd be absolutely horrified if they realised that, so having some review that should help alleviate that."* In such cases, the process of peer review might help increase therapists' awareness of current best practice. What the standards of practice were or where they were defined, was not mentioned by participants. Although not detailed specifically, a general understanding of these standards and what that represented seemed assumed.

Standards and criteria.

Aligning practice with documented standards of practice enables measurement using specific criteria. Participants described peer review being used by organisations to measure standards of practice:

> *Well, I just think it just shows that we have got standards and we can work to them. And that we meet the requirements and we are not scared of authority, if we had to do that twice a year, doesn't bother me. We will do this and show that we are up there and…as a profession that we are not shy of being reviewed.*

This participant described the use of peer review not only to demonstrate to physiotherapists that standards of practice are met, but also to others outside the discipline of physiotherapy that the profession can withstand scrutiny.

Criteria are defined as accepted standards used in making decisions or judgements about something (Collins, 1982). Consistent with such definitions, participants talked about the criteria contained on the various templates they used to guide what they were looking for when observing performance. Many aspects of clinical practice were being assessed in the peer review process, as described by this participant:

> *It's not all about clinical skill in the peer review process. We're also looking at their ability to communicate with the patient and, you know, whether they are being culturally aware of that patient. So, it's not all to do with the clinical skill.*

For this participant, assessment of practice included examining interpersonal skills as well as clinical skills. However another participant felt the focus of peer review remained clinical: "*Our peer review is really focussed on clinical aspects of things and not a lot around ethical and cultural issues."* Whether this narrow focus meets the competency assessment criteria, as defined by the New Zealand Registration Board remains unanswered.

'Tick- box' type forms or templates with black and white (yes / no) marking criteria were commonly described by participants:

> *From memory the form is whether, 'yes' you performed or 'no', not, no there was some other word, but it was pretty much 'yes / no', black and white. And so if there were areas that I thought the person hadn't quite performed within the treatment session or there wasn't the opportunity to kind of demonstrate those skills, then I would probably question them around that.*

At the same time, there was some scope for writing comments. *"Later on you filled out a form and tick boxes or made some comments."* Forms or templates would guide the review and seemed in some participants' views, to allow or disallow comment on certain aspects of what was observed or not observed during a treatment session or assessment.

> *There used to be a question, I think there is a question, around cultural issues, cultural aspects, finding out about that kind of thing and I felt within our whole team, that kind of is a "Oh, tick the box. We know you are ok, like that." But I thought, there could have been a little bit more emphasis on that.*

For this participant, being able to comment on such things a cultural awareness and sensitivity was superseded by just putting a "tick in the box", due to the structure of the form. This allows cultural competency to be assessed by a single tick, with little detail as to what that means.

Another participant commented that it was easier to give feedback on some areas of practice than others:

> *It's easier to give feedback about those types of points, like for example, their documentation afterwards, than discussing with them or pointing out to them areas of their clinical reasoning that you perhaps don't agree with, or want to challenge them on.*

There are assessment requirements on reviewer and reviewee, which are structured into the process itself. At times the forms would direct reviewers to comment on things that they did not think were relevant to the review process. However they felt

that a tick box process was being engaged in to fulfil the needs of the organisation or management:

> *Sometimes the forms, the things you have to comment on, (were not so helpful) but then if they are not applicable, you can just write 'not applicable'. Sometimes things are done because management higher up has to do [it] as part of their [management] review…. And that doesn't help us – a lot of people can see that straight away, "We are only doing this because so and so's got to do a report," and it doesn't actually help our patients.*

This participant clearly linked the outcome of peer review to helping the patient. Others see it more as helping themselves to maintain their registration or useful to fulfil various management functions and organisational requirements. Also the notion of using peer review as a quality assurance tool was mentioned by participants:

> *It's really seen, I guess, as a bit of a quality assurance, and probably a little bit of clinical audit as well as to make sure that people are capable of doing their jobs and therefore identifying any areas where they might need help.*

Peer review is seen here to be performing dual roles; measuring the quality of physiotherapy, as well as checking that clinical practice is meeting the standard.

Participants did not mention by name standards that the criteria used in peer review were derived from. Existing templates and guidelines channelled participants to measure practice in a certain way, against the criteria detailed on the template. The observations and resultant commentary were then shared with the person under review. This necessitated considerable time for both physiotherapists involved. Participants discussed how they managed this aspect of the process.

Protected time.

The expectation of protecting time for the process of peer review has been raised in relation to the time required to observe the practice, to develop a critique, feedback results of the review and to action any follow up required.

> *And then, at the end of the appointment or when I thought the appointment had finished, then I would probably walk off and take my form and complete the form and then try and catch up with the physio, within the next couple of days, to give them feedback. If possible that day, soon after, but it didn't tend to happen that way. So, it was usually within the same week, that we would sit down for feedback.*

Preference was given to completing their commentary and giving feedback as soon as possible after the observed session; however participants acknowledged this was not always the case.

> *You would be doing well, if you sat for a whole half an hour. Ideally, we would book an hour but depending on caseload, you would more likely go to 20 minutes, just because of the volume of people [patients to be treated] coming through.*

Discussing the review and the reviewer's thoughts on the session could take considerable time and this was not always available. In discussion with the physiotherapist reviewed, one participant described giving the opportunity to elaborate on why aspects of practice were present or not:

> *Say, if I notice that they missed out on some elements that I felt should have been on the, in the session, then I'd point that out to them, and discuss with them, you know, why they missed it or you know, why they did it the way they did. Usually, they've got really good rationale for what they did, and sometimes just [the reviewer] having that rationale, makes it a lot easier to understand.*

Allowing physiotherapists to explain their clinical reasoning and rationale for their practice was an integral part of the process. When asked what could be done differently with peer review in the future, one physiotherapist responded:

> *I think it [peer review feedback] needs the time, the valuable time to be put aside for it, because it is one of the things that always gets cast aside or chunked down to 20 mins instead of an hour, which you would really love to have had, to be able to discuss.*

This post-review discussion can provide an opportunity to build professional and personal relationships, explore other perspectives and learn from the practice of others. Allowing time for reflection on the session, including questions the reviewer might want to ask, as well as any discussion took considerable time out of the physiotherapists' busy day, however was seen as a valuable component of the process.

How participants viewed the role of feedback from reviewers is discussed in the following section.

Open to feedback.

By engaging in peer review, an expectation develops that practice is displayed in order to be critiqued. One participant commented that if you ask for peer review, you are likely to be 'open to' and 'accepting of' the feedback generated by this process. *"If I ask for peer review, then I am open to hearing something that needs to happen."* It may be that the reverse is true, that if the process is compulsory, that infers a less open-minded approach to the feedback generated.

Some aspects of practice such as clinical reasoning were not able to be observed and so would be raised by reviews in the discussion time afterwards.

> *Usually they're asked about the decision making process behind the treatment, because often when you're with a patient, some of that is explained to the patient, in your conversation with the patient, but a lot of the thinking behind what you're doing, is just in that therapist's head. So, it's quite nice afterwards, to be able to sit down with the person and just discuss exactly what their reasoning was, behind their assessment and how*

> *they translated that into treatment. And also ask them how they perceived the patient's reaction to their treatment and how they felt their session went, in terms of their rapport with their patient and whether they think that, the patient understood what went on, in the treatment session.*

Those thought processes that the physiotherapist used in her assessment and treatment were also evaluated as part of the review process. Additionally this participant described a situation where at the end of a review, specific technical knowledge was challenged:

> *She actually used the feedback session at the end, to probe the depth of my clinical knowledge, so she asked me some specific questions about anatomy and physiology and theory. That really challenged me, at the end of the process and it was a bit awkward at the time, but you do come away with it, thinking or knowing more and also challenging yourself more.*

This participant could see the value in the challenges presented to her, through the reviewer's questioning. It seemed that the formality of any review situation can influence the critique formed and its delivery. Participants often referred to the degree of formality when discussing peer review. When considering the formality of feedback the issue of whether the comments were written down or given verbally seemed to be a guide as to what would be 'on record' and even in a formal review situation, verbal comments were seen to be less formal than those written on the template or form.

> *I think if you put it down on paper, it becomes very formal. There's a record of it and perhaps she would feel that I would be offended by it. That I would have it on my record, because our peer review forms, you know, are seen by our professional leader. So, I think she is really worried that I would be offended, if she had written something in that box.*

Writing comments down on paper seemed to formalise the critique. These comments were now 'on record' and participants thought they might be unacceptable to the recipient, maybe causing offence.

In addition to these procedural variations participants were concerned that for some cultures, giving feedback to those older in age, posed significant challenge. In these cultures, a lot of respect is given to elders; this is also true of Maori. Asked if she felt this might provide a barrier to giving feedback to people older than herself, one participant replied:

> *Yeah, it might be. I just remember, it wasn't a therapist, but one of our assistants was an older Maori woman and I had recently become the most senior physio and just sitting giving her feedback, I felt really uncomfortable. Just for the fact that she was an older Maori woman, with all this wealth of experience and it took us a while to kind of, find the basis to talk to each other about those kinds of things.*

The consequences of a difference in cultural attitude to feedback and the relationship with elders, was also described by other participants. Asked what had enabled this particular participant to give feedback to an elder in this situation, she went on to say:

> *We got to know each other quite well and so I knew that in her whanau [extended family group], that she was, kind of right up there. She was the wealth of knowledge and she was really knowledgeable in that area of her life and in the work environment, that was my area of expertise and so kind of recognising those two differences, it became 'ok' for me, with being a specialist in that kind of work environment, to give some advice and direction.*

Then adding: "*It took us a while to work out what the heck was going on, or for me anyway, and she was thinking 'You little upstart'* (laughing)*"* Although this situation was not one of professional peer review, it alludes to the fact that time spent getting to know each other can assist in the acceptability of giving and receiving feedback, and how a difference in age can influence relationships both from a cultural and professional perspective. Finding out about each other, getting to know each other and respecting each others area of expertise, contributed to the awkwardness of giving feedback to those with seniority. At times, this seemed also to apply to the culture of physiotherapy.

Another participant also acknowledged a consequence of introducing the peer review concept to healthcare assistants in one organisation as described above. With this being a relatively new process for this group of health workers, little information was available but anecdotally reports indicate that the marking of colleagues in this group is always at high levels, almost always scoring 5/5 and documenting little feedback that would challenge the way healthcare assistants were working. One participant commented on this phenomenon:

> *I've seen recently, having the peer review process introduced to our health care assistant staff, and they are very, very new to the process. And, it was very clear, at the end of that process, that they had all given each other wonderful, wonderful feedback. And absolutely no feedback, that would challenge their practice or give them something to take away and work on. And I think that's just a reflection of that being a very new process to them and… not wanting to offend each other.*

The peer review process may take time to become effective. The primary goal of taking away something to work on, a developmental focus, was not achieved in this group of healthcare assistants who were experiencing peer review for the first time. Concern for each others' feelings seemed to disallow constructive critique. This may also be true of physiotherapists in some cases. Further investigation into the phenomenon of giving perfect scores with no room for improvement is one that could reveal insights into why this occurs and in which groups, with which relationship dynamics.

Summary

The process of peer review has developed from traditional ways of transferring knowledge and skill used by the physiotherapy profession. This way of learning begins as undergraduates and continues throughout the professional life of physiotherapists. Although many different models of peer review exist, the

predominant model described by participants was one based on observation of practice.

Physiotherapists involved in this model of peer review adopted one of two roles. They would become the watcher or the subject of the watching. During the process of review, participants seemed interested in demonstrating as many aspects of practice as they could, particularly those they thought the reviewer would be looking for. The observations of the watcher were documented on various templates or forms and the criteria held within these directed the reviewer's gaze.

Physiotherapists held certain expectations of the peer review process; however clarity around the purpose of peer review was not always present. Recent legislation introduced to assure competence of health practitioners in New Zealand was mentioned frequently by participants when discussing what the documentation from peer review was used for.

The peer review process resulted in a critique of individual practice which was used for organisational audit and benchmarking, as well as for development of practice. Protecting the time required for peer review was seen as priority in order to get the most out of this professional development activity.

In the next chapter, the findings are presented to support the second theme of Managing the Performance. Participants describe, in sub-themes, how they used various strategies to set the scene, protect relationships and play to an audience during the peer review process.

Chapter 5: Managing the Performance

Peer review in all its forms is designed to expose a particular piece of a physiotherapist's work and open it up for scrutiny by other physiotherapists (NZSP, 2006). When the things people do are opened up for scrutiny they are put on show, becoming a piece of performance art with actors, a script, an audience and even props. Naturally the performers want to show their work in its 'best' light and to be seen as someone who delivers care in the 'best' way. Participants described many and varied ways they use to achieve this. By managing the performance they may influence the outcome of the peer review process itself. In this chapter the second major theme, Managing the Performance is examined. This theme is made up of three sub-themes, Setting the Scene, Protecting Relationships and Playing to the Audience.

Figure 3: Themes and Sub-themes of Managing the Performance

Setting the Scene

Like any play, a set of scenery and props helps to provide the setting against which the actors can play. To a certain degree in the peer review process this is the part

taken by the patient and their 'condition'. Patients with their issue or problem provide the backdrop against which the physiotherapist's skills are displayed. The unpredictable nature of working with a patient who does not know the script, poses both challenges and opportunities for the players in the peer review process.

Choice of patient.

One way of setting the scene used by participants was to carefully select the patients that the review was to focus on.

> *They [the reviewee] organise a new patient and have an hour or so that an assessment takes, maybe half an hour, 40 minutes and then there is a period of discussion and then we follow, well, we used the College standard peer review form.*

In some cases, the 'organising' or selecting of a patient was left to the reviewee. The ability to choose which new patient or follow-up patient to be reviewed with, allows the therapist to select a patient or condition they are comfortable treating, one that is within their skill level and comfort zone. In other cases the selection of the patient for review was random and chosen by the reviewer.

> *We would make it that the reviewer would put a time in their slot [block out a time in the reviewer's own diary to do the peer review] so that you [the reviewee] wouldn't know which patient they would come and observe you with, so it was on their discretion as to who they would sit in with. You kind of had no [idea], kind of like an exam situation like the students do. We thought that was quite a good way of doing it.*

In this situation the institution has imposed rules to block the therapist from setting the scene by choosing the patient. In other situations the reviewer would randomly select a time slot but then alter it if the patient selected might not produce enough of a challenge for a senior physiotherapist:

> *[When I was doing a review] I would go for random and if I picked one out that I thought 'Oh no, this is going to be too easy' I would put it back. So I suppose I wanted to have a test of the person's range of skills and abilities.*

> *If it was going to be just a walk in the park, I would put it back and find another one…Especially when we are looking at the senior practitioners. They are working at a senior level and you want to know that they are working at that level.*

This approach manipulates the background against which a therapist would display their skills and takes this as an opportunity to extend the assessment of their skills to their limits. This was particularly the case with therapists expected to have advanced skills, such as those designated as 'seniors'. This process of selecting the patient is used as one strategy to manage the potential challenges in the peer review.

Selection of reviewer.

The issue of how reviewers and reviewee were selected was often mentioned by participants. There seemed to be two different practices in place. One way of selecting who would review who was that the therapist would, *"have the choice of who you are going to ask, who will be the one who reviews you."* The other option was a randomly chosen review pairing. "*We would pick names out of a hat to decide who would review who, and at that point, within the next couple of weeks everybody would review each other*."

Whether chosen or random, the practice of pairing up with a colleague draws attention to the notion of 'peer' and what is meant by this term. Is 'peer review' truly seeking critique from a fellow therapist practicing at the same level, or in the same role, or with the same number of years of clinical experience in a particular area, or just any other physiotherapist? The peer chosen as reviewer is one way the institution 'sets the scene' by dictating who will review whom or allowing the person under review to have a greater influence on the process by selecting their own peer. Some

workplaces had made a conscious decision around who is classed as a peer and who it was appropriate to do a review with.

> *We had had discussion previously about whether the seniors should review seniors and the juniors review the juniors, which we stuck to for the seniors, but we felt that it would be 'ok' for the junior rotational staff to review each other if the work load was such that a senior member couldn't do it.*

In this way the organisation or the team of physiotherapists concerned created their own rules to govern the selection of review pairs. In this situation it is interesting that there appeared to be rules or norms as to what constitutes a 'peer' suitable to perform review and how this may be changeable at times when workload is high. This set of rules seems to imply that the preference in this workplace is for a senior to review a junior. As a secondary option, a junior could review a junior, but seniors would review seniors.

Alternatively some participants described how they would have a preference as to whom they would choose as the 'peer' to review their practice.

> *Basically what we do is we identify somebody who we would like to do our peer review, somebody that we think would provide valuable feedback about our practice and that has some knowledge in the area that we are practicing in.*

This choice of reviewer might be made for a variety of reasons and was often made with the apparent intention of influencing the outcome of a review. That is, participants set the scene in their favour.

One participant observed that the policy in her place of work ensured that once a year a peer review was undertaken, and that it is the physiotherapists who would identify which person they wanted as their reviewer. "*The policy and practice is that everybody undergoes a formal peer review once a year and we just, each of the*

physios, identify who they would like to have as the reviewer and then they select them." Another participant described how she makes her choice of reviewer: "*So you would pick someone you know you are working well with."* This participant also stated: *"We only pick people to review us who are going to give us a reasonable review. We are not going to pick people who, we know, like things done in a different way completely, or have a sharp tongue."* It seems this participant has made an overt choice based on achieving the outcome of a 'reasonable' review.

A key selection criteria in choice of reviewer mentioned by participants was the similarity in ideas of 'what works' and in the 'way we were trained', meaning what people were taught as undergraduates.

> *There are some people I would not like to review me, because they might have quite different ideas to mine about how things should be done. Especially like, I've been graduated over 30 years and the way I was trained is quite different to the way some new grads have been trained, but even people out 10 years. And they might think some things are important and I don't, so we have just got different ideas about things.*

This participant indicates she has made a conscious choice over who she would 'not like' and by default 'like' to review her practice. This decision is described as being influenced by what this physiotherapist believes to be 'ideas about how things are done' or which may reflect philosophies and methods of practice. She explicitly links this with years since graduation, inferring that recently graduated therapists may have ideas about practice that are at odds with her own. Surprisingly, she does not make any connection to evidence-based practice or what is currently regarded as best practice. This may indicate what she is referring to is a practice style.

Similarly, when asked if she thought people are careful about whom they pick for a reviewer, given that it is a formal document and it will go into their portfolio, one participant responded:

> *Oh, not only are they doing that, yes, they will pick a good reviewer, but also, they are going to pick a good patient and usually, you know that May is 'review' month and you write all your notes really well and also you just say, "Here are two names of two people," or three and say, "Go and look in their notes", because you know that you have written those up well.*

Here, distinct mechanisms to set the scene and direct the gaze of reviewers are identified: selecting 'good' participants and, very specifically in this case, pointing to documentation that is 'written up well', which was perhaps not typical of someone's work. Participants perceived that allowing physiotherapists to choose their own reviewer may influence the outcome of the review process.

> *And then there are people as well you know, people are quite different and there are different personalities as well, and so, some people you might sort of, barely tolerate, and others you really like, so I wouldn't pick a person who I didn't actually like.*

This participant points to some of her selection criteria for choosing a reviewer. Liking seems to be high on her list. Asked whether she believed the relationship between reviewer and reviewee influences what happens, this participant replied:

> *I would say so. I would say it puts it at even more than 'peer', it's almost like a 'friend'- review in a way. Whereas if it was just like a 'peer', like …some physio, from another hospital, comes and does it, it is quite different to me, picking [a colleague, I would call a friend].*

She then went on to say, "*It is different, so that is a different standard of reviewing then. If it was a true 'peer', it would be a bit harder. I wouldn't get so many ticks."*

In this comment the therapist alludes to different standards of review occurring with external versus internal reviewers. She also infers that if your 'friend is completing your review, a different standard of review could result, one where the outcome

might be more favourable'. Another participant described how in her workplace the organisation could deter therapists from choosing their friends, but did not state how this could be achieved. "*And you sort of discourage, probably, buddies reviewing each other, a little, but that, as it turns out generally, that hasn't been a problem."*

Allowing choice of reviewer, so that therapists are able to pick a peer that they like and agree with, someone who has the same ideas, had the same training and may be your 'friend', enables the scene to be set in a way that enhances the outcome of the review process. Having an outsider or external reviewer might be more challenging and result in a less favourable outcome. Knowing what particular reviewers like to ask about and preparing for that, was another way participants described that the process could be influenced. *"They probably knew it was coming, because I always asked people, so whether they had pre-thought about what they answered, that kind of thing."* The likes and dislikes of individual reviewers might be known and acted upon. In the same light, preferred answers and ways of acting during the review were pre-prepared.

Staging for challenge.

Another way in which some physiotherapists may choose to set the scene so that the peer review process will be challenging, is through the selection of both client and reviewer. Choosing a client whose assessment and treatment is expected to be complex is one way senior therapists described to achieve this.

> *Recently I've tried to challenge myself a little bit more and gone with new patients that I haven't seen or treated before. Just so it becomes a little bit more of a real situation, where I'm confronted with clinical reasoning challenges. Having to communicate with a new patient that I haven't met before, so that it's a bit more of a reflection of what I am truly like, with a new patient.*

When therapists undertake to challenge themselves through their choices in setting up the peer review, they may be disclosing their intention to use the peer review process as an opportunity for development, for pushing the boundaries rather than playing it safe, in order to elicit a good review. Additionally, these participants appeared to be seeking to open up their practice for more critique of clinical reasoning. A clinician who is choosing to set the scene in this way is taking a risk for the reward of constructive critique.

Yet another strategy participants used was managing the choice of reviewer rather than patient, in order to provide challenge. Seeking a peer with as much or more clinical experience as themselves often provided what was seen as greater insight into their own practice.

> *The two peer reviews were entirely different. The therapist that was a lot more experienced than I was, I found that a much more valuable process because they could really hone in on areas that I could work on and you know, challenge myself on further.*

This strategy reveals the desire by some therapists to use the peer review process to extend skills and have that practice evaluated by their peers or even their seniors, by choice. This approach distinguishes the 'play it safe and get a good review' from the approach of 'how can this process be used to develop practice further?'

In addition, some participants would ask for particular aspects of practice to be examined *"There are specific things that I want them to look at."* This may be a way of directing critique and feedback in order to challenge senior practitioners more specifically in areas they have self-identified for development, rather than a basic review of an assessment or treatment session. Alternatively it might be a strategy for

directing the gaze of a reviewer towards certain aspects of practice, so that their gaze does not fall or is less likely to fall on other things.

Another way institutions set the scene was to have an expectation that a follow-up treatment session would be observed rather than a new assessment. However in some organisations reviewees were free to choose the type of session it was to be.

> *It tended to be a follow-up, because the new patients in this practice area, may be just a very quick safety, new patient assessment and wasn't always meeting all the criteria of our review, so we decided that's probably not the best way to capture the information.*

In this case this participant indicated that the type of conditions seen in her area of practice meant that a full assessment was not carried out at the initial appointment, so 'all the criteria' [of peer review] could not be met or demonstrated during a first assessment.

The peer review process also provides an opportunity to assess the physiotherapist's interactions with clients from a different culture than their own. Assessment of this competency could be achieved through deliberate choice of a patient from a different culture rather than this randomly occurring, as suggested by one of the participants. *"Make it so you are reviewing with them [the physio being reviewed] other cultures and to make it happen rather than be by chance, so that you can see them working with different cultures."* In this way, this participant proposed a type of selection criteria could be developed for choosing the patients who would be part of the review process, adding challenge with specific competency areas in mind.

To some extent the desired review outcome is driving the process of setting the scene. The purpose of the review be it developmental or quality assurance, also

influences how the players set the scene. All players can take a role in organising the background and the props used in a peer review. The reviewer, the reviewee, but also the organisation can lead this process to achieve their own ends.

In summary, setting the scene for peer review was managed in various ways. Choices made by participants were purposeful at times and at others random selections. Some participants had definite preferences when selecting reviewers and patients. The purpose and desired outcomes of peer review clearly influenced these choices. Ideas on criteria for selecting patients and reviewers were exposed but these were often not formalised. Participants were conscious of the challenges inherent in the peer review process and sought to manage the inherent risks. In the next section strategies to protect various relationships throughout the peer review process are described.

Protecting Relationships

The notion of protection indicates the presence of risk of some kind, be that perceived or real. Feeling a need to protect something is also about valuing the thing you want to protect. Many relationships exist in the peer review process. These include the relationship between peers, between the therapist and the patient, the employer and employee and also between the profession and the public. This section examines these relationships and the influence they may have on the process and outcome of peer review.

To begin with, there is the relationship between the two people undertaking the peer review together. They have a professional relationship relating as peers; as two physiotherapists, members of the same profession. This pair of physiotherapists also

have a relationship based on seniority or years of clinical experience, which may relate directly to years in the job, position in the organisation or degree of clinical expertise. This relationship may also be based purely on relative age or be based on level of respect and has different meanings in different cultures. How this relationship of 'peers' is currently viewed by each person, may affect the review process itself and its purpose, as this participant explained: "*Because of my senior role, it [peer review] would be more related to looking at performance level."* That is, this senior therapist saw her role as one of benchmarking the therapists she reviewed, of comparing one against another and rating the level of their performance.

In many situations there also exists a collegial relationship which stems from working with a person everyday, usually with a symbiotic connection of offering and receiving support, especially in times of high workload or complex clinical situations. Colleagues may at times develop a personal relationship of friendship inside and perhaps, outside of the workplace. Colleagues may also develop a dislike or distrust of each other. They may experience feelings of difference from a personal or professional point of view. At certain times personal relationships may influence professional relationships. Working through difficulties or uneasiness in relationships can take time and is not always a comfortable process.

In addition there is the relationship between a physiotherapist and a person they are assessing and treating. This relationship may already be established and the physiotherapist will have developed some degree of rapport with the client. Alternatively, this might be the first time of meeting and in this case, a new relationship with the patient is formed as the peer review process begins.

Review pairs.

The interpersonal relationship between reviewer and reviewee can be affected by the process of peer review. The complexities of these professional relationships flow into the peer review process. Feedback about the performance is given and received. For example when one participant first interacted with the therapist assigned as her peer reviewer, she candidly reported initially thinking, "*you cheeky little upstart"*. Nonetheless, feedback from different perspectives was thought to improve the working relationship as was acknowledging others 'areas of expertise'.

From discussing the process of peer review, it seemed that some participants when reviewing their colleagues, would protect the various relationships present. This was described by several participants:

> *It is a good chance for someone to pick up something that they have been doing incorrectly... Say, if a certain test is done a certain way and then you find you let them hold on to something and they shouldn't have been holding on. So, it is good to get that sort of feedback, because we all make little mistakes along the way and there are things that we can improve on. And I think I would also try and leave on a positive note like to say 'another time that you are doing that you probably, might be better to just remember to check the brakes on the bed or something, but overall it was a very good treatment' and leave her in a pleasant mood.*

> *I think that perhaps the main thing that might make a difference is if you had a personal friendship with somebody and I think if you have a personal friendship with somebody, I think it would be difficult to be objective in the peer review process and you'd be aware of not wanting to hurt somebody's feelings.*

When discussing the level of questioning that goes on in reviews and if this is different depending on who the review is with, another participant revealed: "*Yeah, and if you have got a matey thing going on, yeah, we will just tick the box and say*

we did it, kind of thing." Being careful of interpersonal relationships was something participants considered as they engaged in peer review.

Protecting the recipient of feedback from the personal opinion of the reviewer was described by one participant:

> *I would try and make it like 'this is the way things are done here at this hospital, it's not my idea that everyone has to write notes in a certain way, but this is the way that it is done here so while you are working here, that is how we have to do it'. So it is sort of out there or up there, it is not coming from me, it's not my opinion.*

By describing certain protocols as 'the way it's done here', reviewers are able to distance themselves from committing to the one-way approach and owning the feedback. This approach infers that 'it's not my idea, but we have to do it this way.'

One participant clarified further how she positions herself as not responsible for the criteria used in the critique:

> *I think that helps my relationship with the person as well, because I've got to keep working this person. So, I don't want them thinking 'Oh, she picked me up on this and she is a stickler for notes being done the right way.' When it is not actually me, it's just the rules of the organisation.*

Care was taken by this participant to look after the collegial relationship by distancing herself from the responsibility of the critique. In this way the organisation is blamed for any discomfort caused when criticism of a colleague's practice is drawn. This participant also felt that critique from peers was more acceptable than critique from those in more powerful positions like perhaps, supervisors or managers, as she goes on to describe: *"She would rather get it [constructive feedback] from me, than from someone higher up, ticking her off for that."* Protecting colleagues from

the criticism of others in the organisation, such as supervisors or managers, was seen to be desirable.

While looking after their collegial relationships was important to participants, so was the relationship between the therapist being reviewed and the patient. Perceived risks to this relationship and how they were addressed are discussed next.

Therapist and patient.

The explanation of why another therapist might be 'watching' reveals the risk or threat perceived by therapists to their professionalism, from exposing the examination of their practice by a peer to the patients. The positioning of peer review within a quality assurance framework provided some protection for the professionalism of the reviewee. This need for protection indicates some perceived risk or threat to one's professionalism. The purpose of peer review was described to the clients by participants from one workplace, as part of a quality assurance process.

> *I always ring the client first and have a conversation with them and say, 'Is it alright with you if so and so comes? They are one of my colleagues and they are coming to have a look and see how I practice. And there may be some conversation around what we are doing, but they are here to watch me, not you and it is just part of our practice.' It is not, I wouldn't exactly say, 'not that I have done anything wrong', but it depends on the client, but 'not that I had been a bad physio or anything'.*

The risks perceived by physiotherapists undergoing review related to the view held by patients regarding the reviewee's professionalism and possible competence. This reflects the regard in which the patient holds the physiotherapist. One participant commented that a careful explanation to the patient was required to avoid a situation

where *"The client might think you were a more junior physio or something because you had someone come in and watch you."*

The review process was managed to minimise these perceived risks. The opinion formed by patients, colleagues or employers, about the physiotherapist undergoing review was one outcome of the review process that concerned participants. "*You don't really want to question too much what the person is doing while they are in front of the client."*

Accordingly, some participants described a process which was intended to protect therapists' relationship with patients, by explaining why the peer review was happening.

> *How do you explain it to the client, without the client suddenly thinking, 'Why does she need someone to check on her?' So, we sort of try and phase it into part of the quality processes of the organisation and physiotherapy. So, that in effect, it is giving the client confidence that there is always someone that people are always learning. So that is the first step getting in the door.*

Therapists explained that peer review is part of a quality process designed to protect the client and that both their employer and the profession itself supported this quality assurance process is paramount. Another participant who was concerned about what clients might think, described how she explained the process to patients.

> *So, we basically just arranged with the client, saying that we were bringing another physio with us and that they were going to be watching what we were doing.*

This therapist went on to describe how limiting the questioning within a review session might protect the level of confidence a patient has in their physiotherapist.

> *I think it depends on the type of conversations you are having with the client, but in general I think it is more useful not to perhaps, engage in a lot of conversation around the client, because you don't want, sort of, I am aware sometimes that the client may think that you are being assessed or that you are 'on trial' for some reason and that they might not have as much confidence in you, as a physio. So, if there were lots of questions going on in front of the client that might sort of encourage them [the client] to think not so highly of you.*

Interestingly this participant describes the concept of being 'on trial' and if this was so, that the confidence the patient had in the physiotherapist's abilities would decrease. However, not all participants felt this way. Another participant revealed that in the setting she worked in the questioning of the reviewee and the reviewer making suggestions throughout the review session was common place:

> *We gained the consent of the patient for us to perform a peer review session with her. And the assessment was led by the physiotherapist and at points she would ask me [as reviewer] whether I had any comments or whether I would have any more information or whether I would do any other testing. At which point, I would then offer some information or offer a demonstration of a test. At the conclusion of the assessment, we stopped and discussed the analysis with the patient and then discussed whether, what sort of plan of management we would take.*

Integrated into this review process was an expectation that coaching would occur along the way. Patients were included in the discussions and treatment plans made collaboratively. This is a very different approach to the one of limiting questioning in front of the patient.

In upholding the position of the physiotherapist as a competent health professional in front of the patient, participants took steps to explain the purpose of peer review to the patient involved and to protect the relationships present. Considering the existing hierarchy of professional relationships amongst physiotherapists, participants took steps to respect these customary levels of seniority within the process of peer review.

Hierarchy.

When contemplating the cultural norms of physiotherapy practice regarding seniority or years of practice in the profession and its relationship to knowledge and skill, participants had varying views.

> *In some areas, that those years of experience and people who have vast experience in a specialist area can think 'Oh, you know nothing', but yeah, I think I have come to appreciate that you can learn something from everybody and that needs to be valued.*

Acknowledging the contribution that all physiotherapists have to make in assessing clinical practice as part of a peer review process, whatever their level of skill and experience was not universally agreed:

> *I guess it's because if you're reviewing someone with less clinical skill than you, you feel that you have a lot to contribute and you have a lot to offer that person. Whereas if you're reviewing somebody with more clinical skill or with a longer length of time in that area, you feel that perhaps you have less to offer them, because they have been around for longer and perhaps, they know more than you do. Having said that, though, it's not all about clinical skill in the peer review process. We're also looking at their ability to communicate with the patient and you know, whether they are being culturally aware of that patient. So, it's not all to do with the clinical skill.*

As this participant points out, the full range of competencies including communication skills and cultural competence are also being assessed during the peer review process.

Protecting the natural hierarchy of relationships and levels of respect customary to physiotherapy teams seemed to show itself in references to seniority, years of experience or specialist knowledge.

> *The other most senior physiotherapist and I, so she is a Master of Physiotherapy, she and I, would lead a lot of the clinical initiatives between us. So, generally people feel, I mean, we are the most likely people to be asked to review. But on occasion, you know, people have chosen just a 'peer' that they thought had a particular speciality that they would value using, in reviewing a particular type of client.*

In this workplace, there seemed an expectation that the most senior and qualified therapists would be preferred as reviewers.

Another concept that arose was that less experienced physiotherapists might be reluctant to judge the performance of more senior colleagues: "*I got the feeling from her that she felt it probably wasn't her place to tell me I could have done better, because I've more experience than she did."* This brings up the notion of someone's right to critique or judge practice and who decides this. What makes it 'her place' to provide suggestions for improving performance or assessing when practice meets the standard? Does the act of taking on the role of reviewer also assume the right to critique, regardless of relationship?

The view that you can also learn from younger colleagues was discussed by several participants. Some felt *"You can learn from the juniors because they have a fresh set of eyes and they are asking all these questions and I am thinking 'Why didn't I ever ask that kind of thing."* Some participants valued the new perspectives of younger colleagues and appreciated the challenge they can bring.

When in a junior rotational post, therapists were often peer reviewed by their supervisor. Whether this would be classed as a 'peer review' is a question that needs further discussion but this process was referred to frequently by participants as 'peer review'. In many situations, a physiotherapist seen as a senior in a supervisory or management role would be classed as a 'peer', suitable to engage in the peer review process with juniors, supervisees or direct reports. This brings into question the influence of the power dynamics of these unequal organisational relationships and the degree to which this influences performance and feedback in the review process.

> *I think as a junior, like, I never had a say as to when it [peer review] was going to happen, but you knew that once every rotation that you would be peer reviewed, which was really good at that stage for your development. Knowing that you are either on the right track, or you are completely, need a bit more work to do on whatever area it is.*

In this situation review seemed a very natural part of the learning and development process that was just expected and would enable colleagues to know if they were achieving competence or needed to develop further skills. *"It tended to be the person who was supervising me, so usually a senior."* The role of reviewer was most often taken on by the senior therapists, who held overall responsibility for clinical practice in that area. The usual structure of physiotherapy groups involves some form of hierarchy. The order of the physiotherapists within the group was referred to by participants as being related to seniority, qualifications, specialist knowledge and years of experience or age. However it was also recognised that more junior physiotherapists sometimes had more up to date knowledge and could bring fresh insights to practice. There seemed to be an expectation that therapists in senior roles would be most suitable to become reviewers of more junior staff, and if this role was reversed that giving feedback on performance was more of a risk. How therapists managed the risks inherent in peer review is explored in the next section.

Risk taking.

At times participants described consciously taking risks with relationships when giving feedback during peer review:

> *I noticed that during the course of the treatment her, her eye contact well, was basically – she made very little eye contact with the patient and her eyes were kind of, darting around the room to see what else was going on.*

The participant went on to explain what impact she thought this had on the patient, and how she felt about giving this feedback:

> *But I felt that because of her body language and lack of eye contact in that case, that she was losing the patient's interest in what was going on and that the patient felt that she wasn't the most important person there, in that session, at that time. So, I felt quite awkward giving that feedback to the therapist.*

Developing confidence in giving both positive and negative feedback was something that occurred with risk-taking, as this participant further describes:

> *I think someone's just got to have the confidence to start off saying, 'Actually, there was something that I felt you could have done differently,' and the other person will think, "Gosh, if she can give me feedback about that, I'm sure I can point out a thing or two, too."*

The outcome of testing these collegial relationships with challenging feedback can have a lasting effect on workplace dynamics and participants did mitigate these risks, at times choosing not to criticise: *"Oh, you would never criticise in front of a patient; in fact, you would be very sensitive about even criticising at all."* In this participant's experience, encouraging the physiotherapist to reflect on the session rather than directly criticising leads to better outcomes. In some respects, this is mixing reflective practice into the process of peer review. Asking the physiotherapist what they thought went well, and what they would do differently, were questions sometimes asked at the end of a review to allow self-reflection and self-critique. This approach will assist practice development to some degree but may still require a frank critique of what was observed in order to lead to practice improvement, as the person under review may not be aware of practice deficiencies or strengths. The theme of looking after relationships was laced throughout the participants' stories. Much care and thought has been spent on tending to the relationships, so that ongoing working situations would not be compromised and that respect and trust are developed and maintained.

Many participants perceived an imminent risk to their relationships as a result of the peer review process and took steps to minimise these. Participants altered their approach depending on who was involved, how much choice they had in the process, what the purpose of the review was or who the intended audience was. Manoeuvring their performance to achieve a certain purpose and impress the target audience was another way that participants managed the performance. In the next section ways of achieving this are discussed.

Playing to the Audience

When undertaking a peer review process, the reviewee and reviewer have in mind what is required and who will be looking at the results of any peer review process. This may vary between organisations and between individuals. Depending on who the perceived audience was, participants described a wish to highlight certain things for reviewers that they knew liked this or that. If the purpose of the review was clear, they would seek to demonstrate or move towards that goal. The ultimate audience of any particular peer review might be a variety of people or groups; for example, the peer reviewers (who may or may not be a colleague), the assessors who would review the therapist's professional development portfolio as part of meeting HPCA requirements, the senior therapists asked to assess new or advanced skills in a specific area or supervisors and managers, as part of an annual performance appraisal process. In this next section, the assumed purposes of the various processes are examined and the range of potential audiences for peer review documents is discussed. Participants describe ways they perceive different audiences may influence the execution of peer review.

Multiple audiences.

Participants referred to a number of potential audiences who they thought might view their performance or the record of it. Firstly, there would be the physiotherapist taking the role of reviewer.

> *The person reviewing me sits back and has their forms, pieces of paper and basically sits in the background, while I am with the client for my half an hour or hour, depending on what it is that I am doing. So, their role is mostly depending on the questions on the piece of paper, I think. Then, it is just to look at my performance with the client.*

Initially the reviewer would form the primary audience, although participants were cognisant of the existence of further audiences who may view the outcome of what was observed, described and critiqued. Some reviewers saw themselves as the primary audience and were reported as candidly saying *"That was obviously for show."* However the therapist being reviewed in this case emphatically informed the reviewer *"It wasn't."*

Secondly, the client themselves is a member of the audience watching the show that unfolds. As discussed previously, at times therapists concerned themselves as to what the patients would make of the review process. *"There may be some conversation around the process, while we were with the client and that it wasn't that they were watching the client at all, it was all about the therapist."* Never the less, clients were necessarily present, alerted to the performance and positioned to watch the show.

Thirdly, supervisors, managers and professional leaders may become viewers of the documents describing and representing the performance. Whether these audiences viewed the show itself, documents containing the critique of the performance or just the information that the review had been completed, was at times unclear.

> *In our department the forms all come back to the most senior physio. This person kind of, collates the percentage of how well we are doing and lets everybody know and then the forms just sit in the filing cabinet. And the results go off to the Professional Leader. Yeah, I had never considered that people would think 'I wonder who is having to read that.'*

Finally, various organisations also become audiences to peer review, as they use the documents for processes to assess competency, validate credentials and demonstrate requirements for professional association memberships. Workplaces, clinical boards, Registration Boards and professional organisations were all mentioned by participants as having access to the evidence that peer review had taken place.

Interestingly one participant suggested that the practitioner under review is also an audience:

> *Probably, some of it, is for your own benefit, in that you are seeking to, not to reassure yourself, but see how you are practising, if it is an area of special interest or an area you are trying to up-skill into. And then obviously there are the other ones that you have to do for your requirements for the job.*

Being for 'your own benefit' and 'not seeking to reassure yourself' places this process in a developmental framework aimed at increasing awareness and skill as does desiring confirmation from the audience of their level of practice in the eyes of others participants were able to restore their confidence in their own abilities .

The different audiences are varied, often according to the purpose of the review. Situations where peer review was taking place were often described as formal or informal. The formality of the process was seen by participants as being more or less, often depending, on the purpose. In the next section, the differences between formal and informal processes and their impact on the audience are explored.

Formality.

The requirement for physiotherapists to participate in peer review may produce a formal process or may result in a much more informal process. Peer review was often described as such by participants. The relationship between the requirement to participate in peer review and the formality of the process was attributed to a variety of influences. Some participants have described their experience of peer review as a formal process.

> *Peer review is quite a formalised process within our workplace, especially within the physiotherapy team and it's been a process that I have been involved in for the last 5-6 years of my career. It's really become a very normal feature of our practice and we are required within our workplace, to have at least two peer reviews, per year and it's a formalised document that everyone has access to.*

> *With the peer review, the policy and practice is that everybody undergoes a formal peer review, once a year and we just, each of the physios identify which, who they would like to have as their reviewee, reviewer and then they select them.*

Organisational documents seemed to dictate the process and the intended audience. In this case, the formality of peer review was linked to purpose. To meet organisational or administration requirements the formal and written approach was taken. Once documented formally on a standard template, various organisational roles were able to view the document and the number of the audiences increased.

Another reason for increased formality in a peer review process was linked to the use of supervisors as peer reviewers. This particular audience has organisational and professional status. With this audience reviewees were aware of the potential use of the information gained in peer review to gauge their competence, level of practice, developmental needs or even scope of practice. When asked about the difference it

might make to the process if a manager or supervisor was doing the peer review, one participant responded:

> *I think it would probably depend on the manager, but you would probably be a bit more aware of how they may, or may not use the information, but that there seems to be a bit more at stake, when it is the supervisor than when it is just a colleague. It is more likely to be because of that difference, between a supervisor and supervisee, you are probably more likely to be engaging in that review process for a more formal thing and so you probably are aware that what comes out of it may be used to demonstrate or look at the level of your competence, or to say that you can do this or you can't do this or we think you need to do more of this, or learning in this particular area. It's around what is at stake.*

Managers and supervisors reviewing practice added a sense of formality and an increased sense of consequence to the interaction, which was attributed to the audience. However if participants wanted purely developmental feedback or other ideas for a difficult case, an informal approach was often taken, as described by this participant:

> *I like to see us do more things like, if we have really difficult clients and we don't know what to do, then we grab each other and say "come with me and help" and that is what I would personally do. I haven't needed to, but now that I have been here for a little while, that is what I would do. At the same time, you can say 'let's make it into a peer review,' but that would be a possibility.*

Dispensing with the formality and making a decision later to record the joint sessions as a 'peer review' seemed an option to increase the attractiveness and frequency of peer review to this participant. Although this participant states that she has not used this approach yet at this workplace, she clearly sees the potential benefit of performing for this informal audience. Another degree of informality was described with a follow-up patient:

> *For instance, I sat with one of the younger physios to look at a shoulder assessment and I will come in and look, at a subsequent follow up [treatment] with the, another one of the younger members of staff, who I am sure, having seen him [the patient] once or twice whether [or not] her diagnosis is correct. So was that, it is just a question of, you know, tapping*

> *one of your old colleagues, on her shoulder and saying, 'Are you available to come with me?'*

This describes a type of informal peer review which is accessed by physiotherapists who work alongside each other as colleagues, seemingly as part of their normal daily practice. This type of review is rarely documented and uses a collaborative process to gain learning and develop skill.

If concerns about practice were identified in the peer review process, ideas about what was done with the information obtained were varied. Some participants admitted:

> *I have no idea. I know what is done with the pieces of paper… [they] are collected and for annual reviews, I guess they are really there for the manager to look at. If a problem comes up and it needs to be passed on, there's is a way of doing that.*

Others were very clear about who the information goes to; "*We are required to submit two peer reviews for a credentialing type of process, for each year. So, the information goes to our professional leader at some point in time, so it's shared with them."* Although not discussed explicitly by this participant, presumably any concerns documented would be followed up by the professional leader mentioned.

Some concern regarding the actions of various audiences in response to peer review documents was expressed by one participant:

> *What's going to happen anyway, if there is no money for further education or [no] time, its got to be followed through, to be followed through, so if its (that) we are always going to carry on next week, the same as we did before, despite the review, well, it might as well not take place, if no changes can be made.*

This participant harboured some doubt as to whether reviewees, audiences or organisations would follow up areas identified in the review process that require

further training. This brings into question the value of peer review if outcomes are not reviewed and acted upon. Having identified education or training needs for specific individuals, this participant felt that access to this knowledge and skill development may not be available due to lack of organisational resources.

Sharing information with the professional leader has implications for the confidentiality of the information written down. Who has access to this documentation might also affect what is recorded.

> *So, I guess if you were to make peer review a completely anonymous thing, that it is really between the two therapists, you would get a lot different or more information out of it, than if it was used for audit purposes.*

According to this therapist, the perceived audience of any peer review process would significantly alter the commentary produced. Restricting the audience to the reviewer and reviewee may provide increased critique.

The audience and purpose will influence the formality of the process of peer review. Participants described different audiences they thought might view their performance and how formally or not they might act. In turn, the audience may react differently according to how they perceive their role as critic. Whether others might also view the performance, second hand, through formal review documents was taken into consideration by reviewers, when constructing the critique. Informality seemed to allow more information to be shared between performer and audience and also appeared to some participants to be more attractive.

Not all audiences were perceived in the same way and different organisational status was one identifier which seemed to make a difference to the participants. Another

factor which participants mentioned might influence how they would play to the audience was that of culture. The culture of those watching and playing was considered by participants, including that of the patient. The influence of cultural considerations is discussed in the following section.

Cultural mix.

Each person involved in peer review has their own cultural background, both physiotherapists and patients. Participants commented on how their own particular culture and the expectations this brings might impact on the process itself and how they acted within it:

> *I think that culture has a big point to play, because I'm From a european country and in that culture, and they're pretty upfront and they give pretty honest feedback about things and she's Asian culture and she's not a very forthright person, in terms of giving really honest feedback or giving negative feedback. So I, I don't know, I think that probably was an element that plays in it as well, it's not in her culture to give somebody with more experience, negative feedback.*

Cultural norms around giving feedback and respect of seniority can influence the process where physiotherapists from different cultures interact. Both audience and performer are affected by their cultural expectations.

For when asked how the peer review process fits with the Maori culture for Maori physiotherapists like herself, reflected:

> *My initial thought is that it's all a bit formal. But then, within Maori culture, there are a lot of formal things like the powhiri [traditional welcome ceremony] and all that kind of stuff. I think that's a hard question to answer.*

Another participant reflected on the difficulties in communication and expectations, amongst those from different cultures who do not share a common first language or up bringing.

> *Coming from a different, though Pakeha [non-Maori] culture, myself and my training having been in Europe and not here[in New Zealand], it has taken me a long time to become more 'ok', with 'the New Zealand way' and 'New Zealand' culture and how things happen. And sometimes I still wonder where I am coming from or where other people are coming from. Maybe, that is where my clarity of purpose could be my understanding and not, English understanding. It's a language [thing] and it can also be 'Hey I didn't grow up in this society, so I don't have the grounding that people in this society have.'*

Asked if she thought there is any misinterpretation sometimes over language and colloquialisms, this participant went on to say: "*That happens at home too. And that's life for me. It's called 'Denglish'. Yes, it does happen."*

The culture of the particular work environment/area was also commented on specifically by one participant:

> *I think that in the culture of this specialty area, I would hope and it would, yeah, and it would be my impression that because it is such a learning environment, that most things are quite open about being commented on. Not necessarily written on the form, of course, but it would definitely be more than informal feedback level and the stuff, that was quite open.*

Having a culture in this physiotherapy area of openness and support was thought to encourage feedback. The learning culture in this workplace enabled feedback to be given in an informal manner, not written down but still regarded seriously.

The peer review process also provides an opportunity to assess the physiotherapist's interactions with patients from a different culture than their own. One participant discussed how this had impacted on her review and what she had learned from this.

> *It was a learning thing for me. It was a gentleman who was a Middle Eastern gentleman, who I was discussing around, he had a stroke and I was discussing around his personal cares and things and the difficulty was, why he didn't use his hand to do part of his personal cares and the person interviewing [reviewer asking questions after the review] me, realised that this was a cultural component, that I hadn't picked up on and she asked me "Did you realise this?" So, that was one of the things that I learnt.*

The discussion after this encounter with a patient from an unfamiliar culture, allowed the therapist involved to reflect on significant cultural practices such as those involved in personal hygiene and to consider the implications for her physiotherapy approach. Taking these opportunities, aspects of cultural competency can be assessed during peer review. This aspect of practice is one of the competencies expected by the Registration Board. This could be achieved through the deliberate choice of a client from a different culture as suggested by one of the participants. *"Make it so you are reviewing with them [the physio being reviewed] other cultures and to make it happen rather than be of chance, so that you can see them working with different cultures."* In this way, this participant proposed a type of selection criteria could be developed for choosing the patients who would be part of the review process, in order to assess various aspects of practice.

Cultural competence is something that New Zealand physiotherapists are expected to display. Physiotherapists engaged in peer review may find they are of a different cultural background to their patients and their reviewers. This may impact on the peer review process and how feedback is delivered and received. At times, this difference may compromise the feedback message.

Not having English as a first language, may also impact on the communication between therapists and with the patient. The culture of physiotherapy itself and how

various workplaces position the process of peer review in relation to a learning culture, will affect the experience of participating in peer review. Becoming more familiar, learning about other cultures were ways participants suggested to assist developing confidence in this aspect of practice. Tailoring the physiotherapy session to meet the cultural needs of the audience was something that was considered by some participants and not others.

Participants were conscious of displaying as many aspects of practice as possible to meet expectations of the audience. Providing proof of their participation in peer review seemed important and evidence of this activity was gathered by both reviewees and reviewers.

Preparing evidence.

Collecting evidence that could be placed in their portfolios, was frequently mentioned by participants:

> *Keep a copy each, to put in our portfolios and I think each person then takes it to their one-on-one, for appraisal. So they don't go into a manager's folder or anything like that. They are our property, each person, each one would keep a copy.*

This participant expected both reviewer and reviewee to have a copy of the review documents, which they would keep.

Another concept is that in the view of participants, the peer review process is a two-way process and that teaching and learning occurs for both people involved in the peer review. Further evidence of this as a development activity for both parties was indicated by the following comments: *"And put them in your own portfolios to say that you have done it…You have either been the reviewer or reviewee."* This

supported the view that playing the role of reviewer as well as having subjected yourself to review, is a professional responsibility.

Who decides what evidence of peer review is viewed by the audience, often depends of how things are measured, who does the measuring and what the intended outcome or purpose is. As well as the individuals involved in the process, the organisation might also influence what is put on show, by the selection of and sanction of the particular model of peer review used. Organisations may also dictate the process and format of peer review it chooses to use and therefore, who sees the results. Issues of confidentiality and who will see the documents relating to completed peer reviews was often unclear to participants.

Evidence of peer review was collected with purpose in mind by the participants. Many particularly mentioned the impetus created by the HPCA Act and the need to compile a portfolio to attest to their competence and on-going professional development. This evidence provides a lasting record of the activity of peer review and represents a snap shot of the practice of the physiotherapists involved.

Summary

The stage is set for peer review in a multitude of ways. Through choosing the patient the review will focus on and who will review the practice, those involved can manage the performance and direct the spotlight. Relationships between actors, the audience and even with the props are also managed during the performance. Protecting professionalism, collegial relationships and valuing the client-therapist relationship throughout the process of peer review is key to the long-term outcome of

this professional undertaking. After the peer review is complete life goes on and participants positioned themselves to minimise risk to these on-going relationships. The audience itself is not consistent in the process of peer review. Multiple audiences are looking for a show, a display of skill and knowledge. The purpose of each peer review changes who will view the show and what skills the therapist is wanting to display. Further discussion of the findings in this study will be presented in the next chapter including the implications for practice and the limitations of this research and suggested areas for future investigation.

Chapter 6: Discussion

Introduction

In this qualitative, descriptive study I set out to explore the participation of physiotherapists in the peer review process, within the New Zealand context. The focus of my inquiry was the research question: What is the experience of physiotherapists' participating in peer review? In this chapter I relate the study findings to previous knowledge and interpret the themes. I then go on to discuss the significance of the study findings and relevance to practice, above all what this means for health professionals participating in peer review.

I was particularly interested in uncovering aspects of the experience that make peer review more or less worthwhile from a professional developmental point of view apart from the function of providing evidence of competency. By describing the physiotherapists' experience of participating in the peer review process, I have identified factors and characteristics of the experience that may help or hinder the process in terms of being a professional development activity. The themes that emerged from this study reveal the intention of physiotherapists to display practice and show this practice in the best light during the process of peer review.

Synopsis of Findings

The physiotherapists who participate in the peer review process are involved in opening up practice for examination. In this way, the practice concerned is put 'on show' where professional knowledge and skill is laid out for others to see. Although other processes were mentioned as contributing to ways in which performance was examined, peer review by observation was the dominant model described. Reviewing

a peer through observation involves directly viewing practical skills, but was also understood to include discussion and questioning, to elicit clinical reasoning, as well as review of documentation. The traditions of peer review go deep into the history of physiotherapy and how it is taught. Like other health professions, physiotherapists learn from one another the practice of their profession. Peer review reinforces this model of learning and evaluation.

Observing the action of others, participants in this study were watchful. As they developed more skill and experience, their role often changed from the watcher to one being watched. Participants' perspectives changed as they took on these alternate roles in peer review processes.

Physiotherapists could appreciate the value of displaying practice to colleagues who see practice from a different viewpoint, seeing benefit in the evaluation of their practice and the opportunity for self-reflection. Feeling watched was frequently described and some therapists were comfortable with this, it seemed almost expected as part of daily practice. Being under surveillance when working in hospital situations was assumed by some as the norm however, others were not at ease with being watched. Some participants described feeling anxious prior to a formal peer view for some time before the event, while others felt that everyday informal review of practice occurred, as physiotherapists worked with patients, within sight of each other.

Most peer reviewers saw their role as simply to observe the practice on display. This silent stance promoted the flow of what therapists would expect the practice would

be if the observer was not present at all, creating a ‘snapshot’ of usual practice for the observer to critique.

Performing for the reviewers was something the participants described. The observers needed something to watch and physiotherapists were interested in providing the show. Displaying their skills and knowledge was something the physiotherapists aimed to do within the time with the patient but also afterwards in the discussion that usually followed. An awareness of what reviewers would be looking for was present in the minds of many physiotherapists during the review. Attempting to demonstrate all aspects of practice expected by others became a focus for many. The selection of reviewer, reviewee and patient are rarely a naive choice. Therapists set up a background against which to display their skills. Choice of patient, reviewer and the degree of challenge they were seeking set the scene for the performance.

As all aspects of practice are on display in peer review, documentation is also examined. Paying attention to keeping documentation up to date before a review was due was described by several therapists in anticipation of the gaze of the reviewer. Documents referred to as peer review forms or templates were used to guide the watchers as they watched. These provided criteria by which to measure or mark the display of practice. With the knowledge of what was contained in these documents, therapists often provided a demonstration with these criteria in mind. These criteria were often not explicit and reviewers felt less able to comment on aspects of practice they felt important constrained by the templates.

Peer review has become something that is used by individuals and organisations to meet various expectations and requirements. In New Zealand, recent influences have promoted the expectation that peer review be used for both quality assurance and professional development. Some of these expectations held were overt and some were less so. The steady move towards peer review had been encouraged as professional organisations developed guidelines that promoted peer review and employers shifted to align with this raised expectation. The NZCP had played a leading role in this development.

Clarification of the intent and a mutual understanding of why peer review was taking place were not always present. The question of 'Why do we do peer review?' was frequently asked by participants, as if peer review is just something we do as physiotherapists without consciously knowing why. Others could describe the reasons they engaged in peer review and why organisations demanded it. The main two reasons for peer review were for professional growth and also to ensure that physiotherapists were able to do their jobs, that they were competent to practice and able to meet organisational requirements. These dual purposes of practice development and quality assurance were at times, in conflict. This clouded the perceived purpose of the review for some participants and at times led to a reticence from reviewers to form critique. The notion that in some circumstances the documentation of a peer review could be applied for a different purpose influenced the commentary.

By inviting peer review of your practice, you also open yourself to critique. This evaluation is strongly supported by both the registration authority and the

professional organisations interested in upholding the standards of the profession. Determining minimum levels of competency as well as bench marking individuals against one another were perceived as possible outcomes from the critique developed.

There is real risk in the peer review process to the relationships within it. Therapists expressed the need to protect the various relationships present. Relationships exist between the two therapist involved and the patient, but also between the therapists and the organisation they work for. The relationship between the public and the profession is also represented through the process of peer review.

Therapists report guarding their relationships with peers and the review process poses it own challenges around this. Interpersonal relationships are complex and the critiquing of practice can be seen as a personal rather than professional commentary. When peer review is taking place internally within one workplace or organisation the risk to relationships seems to be increased. Several participants suggested external review might generate very different results with increased objectivity. Review between friends was mentioned by several therapists as something that was preferred, but also acknowledged as probably of a less critical nature. It was readily conceded that this would provide less benefit to the person being reviewed. Not owning the critique that is formed and blaming the organisation for the standard set, was one way participants tried to protect their relationship from harm.

Therapists were often aware of what was required in peer review and what watchers expected to see. This primary audience was often the first audience considered and

sometimes the only one perceived. However, various audiences exist in the process of peer review and as therapists become conscious of them, they have designed ways of playing to them. Potential audiences for peer review of practice, extend past the reviewer and onto the patient, employers, funders, professional organisations, registration boards and finally the public. Depending on the purpose of the review and the desired outcome therapists would play to that end, with that audience in mind. Actively managing this performance, physiotherapists positioned their practice with the intention of achieving a favourable review or to provide professional challenge.

Relationship Between the Findings and the Literature

At a local level Skinner (2004) suggested recent legislation HPCA Act (New Zealand Government, 2003) and existing professional standards have increasingly encouraged peer review of practice, for physiotherapists in New Zealand. This has indeed, been the response from physiotherapists in this study, using peer review to meet professional CPD requirements.

Consistent with Horrobin (1990), who found that understanding the purpose of the review lead to greater acceptance and maximised the benefits, this study showed that when the purpose was not clear much of the potential benefit was lost as physiotherapists consciously employed a range of strategies to reduce the risk of having their competence questioned or harming relationships with colleagues. Many scholars agree that peer review is used for a variety of purposes and this was also the case in the New Zealand setting (Evans et al., 2004; Fedor et al., 1999; McLaughlin, 1999; MOH, 2001; Putzel, 2004) where at times, practice development was the aim

and others, to meet organisational requirements. The desired outcome seemed predetermined and physiotherapists managed the process to that end.

Magin's (2001) assertion that liking and familiarity had no significant effect on the rater bias was not supported by these findings. They did, however, align with the findings of Putzel (2004) and Antonoioni and Park (2001) whose studies supported the contention that friendships and dislike, influence the way peers review each other.

The relationships within the process of peer review held significant importance and physiotherapists in this study put considerable thought into protecting them. As Putzel (2004) suggests, the willingness to objectively critique practice is greater when the purpose of review is developmental. The findings reveal the purpose was not always clear and when fulfilling organisational requirements was the perceived aim, less than objective assessment directed at this goal was the result and this was consistent with Fedor et al (1999).

Preparation for the roles within peer review was limited and although training and skill development are seen by Daniels and Magarey (2002) as essential, this was not identified as a prerequisite by participants in this study. In addition, the criteria against which, physiotherapists measured practice, seemed ill defined in many situations and not connected with best practice guidelines or competency documents and specifically cultural competence, as noted by Ratima et al. (2006).

User acceptance of peer review as described by McKinstry, Peacock and Shaw (2005) decreases when perceived rater bias is high. Although this may be the case, I found this risk seemed be managed by physiotherapists themselves through their ability to select reviewers to increase the utility and acceptance of the feedback gathered in peer review. This is also supported by Mumford (1983), social comparison theory, which suggests that individuals want reassurance regarding their own abilities and will select peers who perform at a similar or slightly lower level. Additionally, the assertion by Goldman (1992) that an increased standard of peer review may be achieved by using experts was supported by the choice of more advanced practitioners when the focus of practice development was the aim.

Perspectives Arising from the Study

As discussed in the findings, being watched is something physiotherapists are used to throughout their training and early practice. Never the less, this 'being watched', generated some anxiety and nervousness in physiotherapists contemplating an upcoming review. Anxious to be seen in a 'good light' and to be able to demonstrate 'all that was being looked for', resulted in overly long treatment sessions and a sense of nervousness that what was observed might be considered normal everyday practice. This was a dilemma for both reviewers and reviewees as some thought that what they saw was a specially put on show for the reviewer's benefit whilst others felt that their practice was not representative because they were so nervous. It seemed throughout the study that caution was taken to present oneself in the best light and objective steps were taken to enhance the view of practice exposed to a reviewer's gaze.

The formality of peer review seems to directly influence how reviewer feels about peer review. Informal peer review was more accepted by physiotherapists as a developmental forum where practice was reviewed discussed and different ideas shared. Whereas as once a formal documented review process was undertaken the evaluation of practice and the written commentary attached was viewed to have a life of its own. Extending frequently, past the two physiotherapists directly involved in the peer review process. What reviewers are prepared to write down in black and white often depends on the perceived purpose of the review and expectations around this varied greatly.

If seen as an organisational focussed document, one of prime importance to the organisation to demonstrate that the physiotherapist concerned was meeting certain requirements, then reviewers and reviewees would both set up the environment of the peer review to achieve the desired result. Both the choice of reviewer and the choice of patient were often selected to facilitate the required outcome. Pre-planning was involved in presenting yourself and therapists would frequently ensure that documentation that was to be reviewed was exemplary. This was sometimes achieved by only allowing access to the notes that therapists knew they had written up well. This finding begs the question of what physiotherapists themselves, their employers and professional and legislative bodies are interested in seeing in peer review? Is it that we want to know that a therapist is competent, meets the standards of current best practice, can demonstrate the appropriate practical skills and documentation also meets a prescribed standard? Do we want to know that the therapist can do this in a ideal situation or do we want to know that they do this at

any given time? Is peer review a development opportunity, where we want therapists to 'bare all' so that gaps can be identified, and then, remedied?

What happens to the practice that is identified as not meeting the standard was very unclear. Some presumptions were made that higher up the chain someone might look at it and the appropriate safety nets were in place. This was not obvious however and begs the question of what can and should be done if gaps in knowledge and skill are identified and how areas of expertise might be acknowledged. Of critical concern in this regard, is that the possibility of sharing knowledge and consequent group development may be lost without planned followed up after analysing the results of peer review.

Recommendations

For individual therapists.

Peer review provides an opportunity for individuals to measure their performance. Taking either the role of reviewer or reviewee, allows practice to be exposed to a different perspective. From this reflection, practice development can occur and competency can be assessed. Each time a physiotherapist takes part in a peer review, knowing why they are performing the review, will influence the outcome. Physiotherapists in this study were not always clear as to whether the purpose of any particular review was to develop their practice, or to show that they were meeting a competency benchmark which was often ill defined. Giving and receiving critical feedback carries significant risk and when this is with colleagues, the perceived risks may outweigh the perceived benefits. Individual therapists need to clearly identify why they are asking for their practice to be reviewed.

Many reviewers saw their role as a non-participant observer but others were willing to be an integral part of the treatment or assessment session by interacting with both reviewee and patient. If this occurred the focus was decidedly shifted towards a developmental activity rather than a more evaluative one. Once the purpose of the review is clear, the expectations of the role the reviewer adopts will be apparent. Individuals need to clarify expectations of each other in the review process. This mutual understanding will allow the focus of development or alternatively quality assurance to become an agreed goal.

The role of reviewer was generally a comfortable one for physiotherapists to take on. The power associated with this position may well contribute to this sense of ease. One reservation however was that of the ability to give critique that was acceptable to the person being reviewed. This was especially so if the person receiving the feedback was considered more experienced. Couching feedback in acceptable terms and appropriate style was something the participants discussed. Their concern with balancing the feedback to be not too heavily weighted in the negative direction was evident. Even if there were many areas requiring development, some of these may be held back and discussed later so as not to overwhelm the recipient.

Individuals need to develop skills in constructing feedback based on specific, objective behaviour-based criteria. Clarifying the reviewee's intent to receive feedback will also give reviewers permission to reveal all that they discover in peer review. Acknowledging strengths in practice should be included in every critique as well as areas for development.

For organisations.

Organisations have placed considerable faith in peer review processes. The results are often used to justify claims of competency and credentialing of health practitioners. If individual therapists use this process to meet organisational requirements, their own practice development may take a back seat. Aligning practice with objective criteria derived from practice standards and registration criteria may improve the reliability and validity of peer review. Being clear as to the purpose of peer review will assist organisations to meet their goal of peer review, be that developmental or as quality assurance.

The idea of being under constant gaze or surveillance was generated by the discrepancies of the therapists who work within sight of each other daily and those who generally practice in isolation. Those frequently exposed to the gaze of other seemed less fearful of the process of peer review. Familiarity with the process and receiving feedback more frequently would be one way of desensitising therapists to critique and observation by others. Organisations need to decide how frequently reviews need to occur and how formality will assist or constrain the willingness of physiotherapists to engage in this process. Organisations stating the purpose of each type of peer review will give therapists increased confidence to move towards that aim. Employees' understanding of the organisational purpose needs to be verified.

For the profession.

Maintaining the reputation of physiotherapists as health professionals is paramount. The regard with which the physiotherapists are held is significant to its success and longevity. Peer review is seen as a professional responsibility as the actions and

reputation of one reflects on all. Development of skills and expertise in an era of evidence-based practice is crucial to the advancement of physiotherapists. Their professional standing amongst the healthcare community is dependent on measures such as peer review for on-going confirmation of this. To this end, the profession, College and Society need to ensure the process of peer review preserves the intent and that the purpose is clear, whether that be quality assurance or practice development.

Interpersonal relationships seemed to be something that therapists were very conscious of throughout the peer review process. They were aware that after the review, they would frequently be in an ongoing collegial relationship, with their review partner, and both reviewer and reviewee took steps to preserve this .To some extent this risk was mitigated in many areas by the reviewee having the choice of who would review them. This allowed them to choose a colleague who has similar ideas or styles of practice to minimise the potential conflict, but with the risk of minimising critical feedback and professional development. Organisations and professional bodies need to be aware of this risk and find ways to work with therapists to address the issues.

For the public.

Confidence in the competency of health practitioners is of prime importance to the public. Since the introduction of the HPCA Act (New Zealand Government, 2003), the accountability for demonstrating that competence, now falls upon the shoulders of each practitioner. As a self-declaration of competence is now annually required physiotherapists using peer review as evidence of this, therapists need to be confident

this process is robust, as do the public. Assurance of the quality of physiotherapy is what the public expect, particularly when that service is publicly funded. This is a process which previously has been voluntary and now is often required by employers and organisations. The registration board is directly influencing the uptake of peer review through its re-certification guidelines. However, there are no mechanisms in place to learn whether the actual practice is robust and able to ensure ongoing competence. Guidelines to assist in the implementation of peer review should be developed to attend to any conflicts of interest that exist between reviewer and reviewee. With all the complexities of practice, quality is difficult to define. The development of clear specific assessment criteria is required. This includes the assessment of cultural and ethical competence.

Strengths and Limitations

I believe this study, which explored what the experience of physiotherapists engaging in peer review is like, contributes to the body of knowledge about peer review. This was a question that no one else has looked at before, uncovering factors which influence physiotherapists' participation in this process. Confidence in these findings rests in part on a sense that the interview process was successful in eliciting a true account and that things that were not anticipated were discovered. In addition, the aim of this study was to create a description of the event of peer review using the voices of participants. This was achieved through a qualitative descriptive approach, which gave a thick description of the experiences of the participants.

In this study I believe the process for analysis used to be rigorous and is grounded in the words of participants. The step-by-step research process is described and transparency maintained.

Any qualitative research is a construction built between researcher and researched and I acknowledge that the personal influence of researcher cannot be separate entirely from the process or the findings. Potential bias and pre-suppositions of the researcher were mitigated by allowing scrutiny of the process by others including supervisors, peers, conference presentations and colleagues from various professions. These processes have strengthened the research approach and allowed worthwhile learning opportunities.

Nonetheless, each piece of research has its limitations and this study is no different. Although this study had small numbers, a range of physiotherapy settings were represented, but there was only one participant from a private practice setting. Undoubtedly, a larger scale study might uncover deeper meanings than were elicited in the semi structured interviews undertaken. Additionally focus groups could have lead to greater shared understandings but would have exposed the participants to the very reticence around peers discovered in this study.

As with all research this study has answered some questions and generated others. Future research into the training support needed by physiotherapists in their role during peer review and objective assessment criteria that are linked to standards of practice is required. The study of other groups of physiotherapists and other health

professions could also add to the understanding of the professional development potential of peer review.

Conclusion

I began this research project with the belief that the developmental potential of peer review is significant and that the relationships of colleagues influence what is said throughout the process. The findings in this study have not confirmed that peer review is used as a developmental tool universally, but rather that in many instances the organisational and professional requirements drive the participation in peer review. Additionally the findings indicate that physiotherapists actively manage peer review process to achieve their intended purpose of being positively appraised. The influence of collegial relationships has a substantial effect on the outcome of peer review and concerted effort and thought goes into preserving these.

These findings have implications for therapists themselves, their employing organisations and professional and regulatory bodies if the money and time committed to peer review processes is to make a worthwhile contribution to professional competence and safety of the public.

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APPENDICES

Appendix A: Participant Information

Participant Information Sheet

Project Title
Physiotherapists' experience of participating in Peer Review in New Zealand: A qualitative descriptive study.

Invitation
You are invited to participate in my study which is part of the Masters of Health Science qualification within Auckland University of Technology, Auckland. I am interested in the experience of peer review and would like to interview physiotherapists who have participated in the peer review process.

What is the purpose of the study?
To describe the experiences of physiotherapists who have participated in a peer review process and to identify factors and characteristics of the experience that may influence the process.

How are people chosen to be asked to be part of the study?
Physiotherapists will be invited to join the study at various professional meetings within their workplace and given information packs about the study. If you choose to join the study, you will contact the researcher and if you meet the selection criteria, interview times will be set up.

What are the selection criteria?
To join the study you need to: Be a New Zealand Registered Physiotherapist
Be currently working in either CMDHB or ADHB or private practice.
Have participated in a peer review process within the last 3 years.

What happens in the study?
I will interview selected physiotherapists at a convenient time and place. With permission, I will audiotape each interview. The interview will last approximately 90 mins. The interview will be transcribed verbatim and you will receive a copy of the transcription. You will be able to check this transcription and then return it to me. I will then analyse all the interviews for content and themes that emerge from the interviews. A 20 minute follow-up phone call may be requested for clarification with selected participants. Finally, I will describe the characteristics of peer review as related to me by all the participants and identify factors or characteristics which may influence this process.

What are the discomforts and risks?
As you will be talking about personal experiences in your life, you may feel strong emotions. During the interview you may tell me things which you later regret. You have the right to instruct me to delete these or any part of your story. It is up to you which parts of your experience you do or don't describe to me. If any evidence of non-competence or deceitful practices is uncovered during this study then I will

adhere to the professional (NZSP) code of ethics. If you feel you need support after the interview there is one free counselling session available through AUT.

What are the benefits?
This study will describe the characteristics of peer review, as it is enacted by physiotherapists in New Zealand and identify factors that influence the experience of participating in a peer review. In studying this process I hope to highlight the factors that characterise and influence the process. It is important for organisations using peer review as a professional development tool to nurture quality in professional practice to understand what helps and hinders the process.

How is my privacy protected?
Your privacy will be protected by the use of pseudonyms in the transcripts. Your taped interviews and transcripts will be kept in a locked filing cabinet. Identifying details will not be used in the research. You will be asked to choose a place and a time for the interview that allows you to protect your privacy.

Costs of participating
The cost to you of participating in the study is your time. I would like to interview you in a place that is quiet and convenient for you, that may be your home or another quiet and comfortable place that you would prefer. If you chose to be interviewed away from your home I will reimburse you for your reasonable travel costs to and from the alternative place.

Opportunity to consider invitation
I would like to give you an opportunity to consider this invitation. If after reading this information sheet you would like to participate in this study please contact me on the numbers or e-mail listed below. If you require further information about this study to assist you in deciding whether or not to participate, please do not hesitate to contact me.

Concerns regarding this research project
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. Concerns regarding the conduct of this research should be notified to the Executive Secretary AUTEC, Madeline Banda, madeline.banda@aut.ac.nz, Ph. 09 921 9999 ext 8044

Researcher Contact details:

Ta-Mera Rolland
Ph. Wk 09 4868920 ext 3769 or Mob 021 2489965
Email ta-mera.rolland@waitematadhb.govt.nz

Project Supervisor Contact details:
Clare Hocking
Ph. 09 921 9999 ext 7120
Email clare.hocking@aut.ac.nz

Approval by the Auckland Regional Ethics Committee:

Version 2: 21-11-2005 Approval: 05/228

Appendix B: Consent Form

Consent to Participation in Research

Title of Project:	Exploring physiotherapists' participation in peer review in New Zealand.
Project Supervisors:	Clare Hocking and Marion Jones
Researcher:	Ta-Mera Rolland

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to the completion of data collection without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.

Participant signature:.....

Participant name:……

Date:……

Project Supervisor Contact Details:
Clare Hocking
Ph 09 921 9999 ext 7120
Email clare.hocking@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee
Date: 21-11-2005
AUTEC Reference Number: 05 / 228

Appendix C: Typist Confidentiality Form

Typist Confidentiality Agreement

Title of Project: **Exploring physiotherapists' participation in peer review in New Zealand.**

Project Supervisor: **Clare Hocking and Marion Jones**

Researcher(s): **Ta-Mera Rolland**

I understand that all the material I will be asked to transcribe is confidential. I understand that the contents of the tapes can only be discussed with the researchers. I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Typist's signature: .....

Typist's name: .....

Typist's Contact Details: .....

.....

.....

Date: .....

Project Supervisor Contact Details:
Clare Hocking
Ph 09 9219999
Email: clare.hocking@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee
Date: 21-11-2005
AUTEC Reference number 05/228

Appendix D: Advertisement

Factors Influencing Peer Review

- **Have you participated in a peer review within the last 3 years?**

- **Would you be willing to describe your experience of peer review?**

This would involve a 90 minute face to face interview and may include a follow up phone call to clarify anything.

If you are interested in being involved in this research please contact:

Ta-Mera Rolland
Phone: 09 4868920 ext 3769
Mobile: 0212489965
E-mail: ta-mera.rolland@waitematadhb.govt.nz

Appendix E: Demographic Data

Prospective Participant Demographic Data

Name _____

Contact details

Email:

Phone:

Mobile:

Please circle as appropriate

Gender M / F

Ethnicity NZ Maori

Other_____

Please circle as appropriate

Years working as a physiotherapist Less than 1 1-3 4-6 7-9 10+

Registration with NZ Physiotherapy Board Yes No

Peer Review Experience Participated in a peer review

As a reviewee approx date: _____

As a reviewer approx date: _____

How many experiences with peer review

Only one two multiple

Please circle as appropriate

Did the reviewee have much more/ less / same years of experience as reviewer?

Employed in Public Sector

Private Sector

Appendix F: Interview Schedule

Likely Interview Questions

Tell me about the process of peer review you experienced?

How did you get involved in doing a peer review?

Did you prepare for your peer review? What did you do?

Please describe what happened when you were doing the review?

What sorts of things were asked/ did you ask?

Can you tell me about giving/ receiving feedback?

Do you think that the relationship between the reviewer and the person being reviewed influences what happens? Can you tell me about that?

Are there things that are helpful or not helpful in the way peer review is conducted?

In the future is there anything that you'd like to be different?

Probing Questions

Can you tell me more about that?

How did you respond to that?

How was that helpful

How did you feel about that?