PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Patient experiences with physiotherapy for knee osteoarthritis in Australia – a qualitative study
AUTHORS	Teo, Pek Ling; Bennell, Kim; Lawford, Belinda; Egerton, T; Dziedzic, Krysia; Hinman, Rana S.

VERSION 1 – REVIEW

REVIEWER	Lina Holm Ingelsrud Department of Orthopaedic Surgery, Copenhagen University Hospital Hvidovre, Denmark
REVIEW RETURNED	27-Oct-2020

GENERAL COMMENTS	I thank the editor for the opportunity to review this manuscript. The aim was to investigate patients' experiences with physiotherapy care for knee OA in Australia. The authors used a qualitative approach with semi-structured telephone interviews with 24 people who had received physiotherapy care within the past 6 months. Based on thematic analysis of these interviews, six themes were identified. The themes broadly covered OA diagnosis, access to physiotherapy, reasons to seek physiotherapy, type of physiotherapy received, satisfaction with physiotherapy and views on surgical intervention. Based on these six themes, the authors conclude that physiotherapy plays an important role in OA care in Australia and call for better funding models and pathways for accessing care. What is new in this study is that it explores the broad experience with physiotherapy OA care specifically, from a patient-perspective, in a country where physiotherapy is part of the primary-care pathway for OA management, and patients do not necessarily need referral to access physiotherapy care. The study therefore has the potential to clarify some of the challenges involved with physiotherapist-led care for knee OA, and that, despite there is an issue of possibly limited generalizability across other countries, I believe the findings are also relevant as hypothesis generating groundwork for future initiatives in other countries. I have some specific comments and questions outlined below. Methods: In general I find the methods section to be transparent and comprehensive. One detail I lack is in which time-period were the interviews performed? Results and discussion: The theme "perception of adequate OA knowledge" is, as exemplified with the three quotes, formed by the results from previous scans or radiographs, and previous consultations with other health-care professionals. Considering the theme "Belief that surgery is inevitable", it seems that patients in general, before even visiting the physiotherapist had a perception that any non-surgical intervention received could only have a temporary effect and that

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	they, despite any exercise, pain-relief strategies or weight management interventions, over time would experience functional decline and increasing pain that unavoidably would result in a need for surgical intervention. The authors did include a discussion about this matter on page 23. Did the authors consider whether the belief that surgery is inevitable; is in itself a detrimental viewpoint that may limit the effect of physiotherapy? Considering that the correlation between imaging findings and OA symptoms has been found highly varying and often poor (Bedson J, Croft P R. The discordance between clinical and radiographic knee osteoarthritis: A systematic search and summary of the literature. BMC Musculoskelet Disord 2008; 9: 116), and furthermore that nonoperative treatment that includes exercise reduces pain irrespective of radiographic severity (1) Skou ST, Derosche C, Andersen MM, Rathleff MS, Simonsen O. Nonoperative treatment improves pain irrespective of radiographic severity. Acta Orthop. 2015;86(4):1–6., and 2) Juhl C, Christensen R, Roos EM, Zhang W, Lund H. Impact of exercise type and dose on pain and disability in knee osteoarthritis: A systematic review and meta-regression analysis of randomized controlled trials. Arthritis Rheumatol. 2014;66(3):622–36.), and we know that primary care specialists sometimes have barriers to refer patients to physiotherapy because they either do not believe that exercise is effective, or, they do not believe that the care received at physiotherapist live up to clinical guidelines (Selten EMH, Vriezekolk JE, Nijhof MW, Schers HJ, Van Der Meulen-Dilling RG, Van Der Laan WH, Geenen R, Van Den Ende CHM. Barriers impeding the use of non-pharmacological, non-surgical care in hip and knee osteoarthritis: The views of general practitioners, physical therapists, and medical specialists. J Clin Rheumatol. 2017;23(8):405–10). The authors have partly discussed this on manuscript page 23, but my suggestion would be to strengthen the argumentation of why patients need improved access to physiotherapy, in the discussion by including some of the above points. Furthermore, I also consider it a relevant discussion that physiotherapists need to improve their focus on providing OA education. The identified theme five was “Happy and satisfied with physiotherapy”. From reading the report on pages 19-20 , it seems that the ability to provide personalised care was something that patients weighted highly, and therefore they found it disappointing when they did not perceive their received care was personalised. I would consider choosing another overall theme to better describe what patients valued with the care, more than whether most were satisfied or not, since there were examples of not so positive experiences with the delivered care also. I suggest to rephrase the overall theme “happy and satisfied” to something in the line of “ability to provide professional and personalized care”. As discussed on page 24, a strength of the qualitative design is that it gives the opportunity to explore interesting aspects emerging form the interviews further, such as the point that some patients received adjunctive treatments such as massage, acupuncture and electrotherapy. It would have been highly interesting, and also possible within this study to elaborate further on that specific choice of treatment and whether patients in fact requested these treatments themselves. Since there are previous reports on the usage of treatment interventions with limited evidence for knee OA (Hagen KB, Smedslund G, Østerås N, Jamtvedt G. Quality of Community-Based Osteoarthritis Care: A Systematic Review and Meta-Analysis. Arthritis Care Res. 2016;68(10):1443–52.), and since that fact that this usage in itself may be considered a barrier to refer to physiotherapy (Selten EMH, Vriezekolk JE, Nijhof MW, Schers HJ,

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	Van Der Meulen-Dilling RG, Van Der Laan WH, Geenen R, Van Den Ende CHM. Barriers impeding the use of non-pharmacological, non-surgical care in hip and knee osteoarthritis: The views of general practitioners, physical therapists, and medical specialists. J Clin Rheumatol. 2017;23(8):405–10), I believe that it is a shame that that aspect was not elaborated on during the interviews. Do the authors have any comments on whether it was a consideration not to explore that aspect further, or hypothetically, whether the interview guide was too structured in that it did not allow for other aspects to be explored, or whether the interviewer was not experienced enough to act on new information emerging during the interviews? I acknowledge that defining an interview guide is difficult and although I consider it rational to use the seven quality statements of the Australian government's OA of the Knee Clinical Care Standard as a framework, I wonder if the interview guide ended up being too strict, not allowing for other important aspects to be explored. From evaluating the six emerging themes, one thing that comes to my mind is that the emerging themes seem also (at least partly) to be formed by the aspects covered by the OA of the Knee Clinical Care Standard. I therefore consider it a limitation that patients were not involved in the interview guide preparation, as I believe that it could have helped to broaden the guide, since the aim of the study was broad; "to explore the experience of people receiving OA care in Australia". Aspects such as the process of deciding on treatment/shared-decision making, exploring barriers and facilitators of different treatment options within physiotherapy care, and experiences with treatment for OA in relation to possible other additional health-problems/diseases, could in my opinion have been interesting to have included in the interview guide.

REVIEWER	Andrew Soundy School of Sport, Exercise and Rehabilitation Sciences University of Birmingham
REVIEW RETURNED	04-Nov-2020

GENERAL COMMENTS	General comments For me, I need to be convinced about the added value of this work. Introduction Line 20 you say currently very little is known about experiences of people receiving PT however from a quick search on scholar I noted the following as examples of what is known: The role of PT is considered within this study https://www.tandfonline.com/doi/abs/10.1080/09593980701588326 https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1391 https://onlinelibrary.wiley.com/doi/abs/10.1002/acr.24439 https://onlinelibrary.wiley.com/doi/full/10.1002/acr.20459 physiotherapy is also mentioned in general experience articles, from my experience of qualitative reviewing general experience articles of chronic illness often have a section on rehab e.g., https://www.tandfonline.com/doi/full/10.3402/qhw.v11.30193 Further review evidence is considered here https://link.springer.com/article/10.1007/s00296-013-2905-y there is also experiences of partaking in a PT intervention which may be relevant? https://www.sciencedirect.com/science/article/pii/S106345841831106

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	3 https://jech.bmj.com/content/55/2/132.short https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1382 https://www.tandfonline.com/doi/full/10.3109/09638288.2013.805257 I am not an expert in this area but I have concerns about how much has gone before and what is known and exactly what your study is adding. Also if you look at your interview guide you may need to consider the different areas of consideration. The reader needs to understand this. Line 27-52 When you consider the past review I think the reader needs to know the gaps more, but I think you need to go further and ensure other literature hasn't been done. From the above I think you need to be clear about the added value knowing experiences from the Australian health system if this is what makes your work unique. But also I think you need to consider the reader and identify conceptually if your work is telling us something that adds significant insight to this area? Methods You identify your paradigmatic view but not the methodology – can this be identified? Can you name a sampling method? Did you undertake a cognitive interview? Or pilot interview? Can you identify what you did to ensure quality? Can you identify an audit trail of evidence showing examples of each stage of analysis Results The interpretation and value of the results and discussion must be in context to the past literature. Until an updated rationale is given its hard to determine the value so I stopped at this point.

REVIEWER	Andrew Moore University of Bristol, Musculoskeletal Research Unit, Bristol Medical School. UK.
REVIEW RETURNED	16-Nov-2020

GENERAL COMMENTS	Thank you for the opportunity to review this manuscript which describes a qualitative study of people with knee OA and their experience of physiotherapy. Abstract: This is fine but the objective needs to state why the research is needed, i.e. what's the problem? (lack of evidence). The Results section appears to be a descriptive summary of the results rather than themes. The theme titles are not really titles but a descriptive summary of the findings. Consider revising these (also see my later comments on these which may help). Strengths and limitations key statements: the first bullet point does not appear to indicate whether or why the use of qualitative research is a strength or limitation. Main text. Introduction: The introduction covers the current literature around people's perceptions of physiotherapy well, and identifies the research aim, although the aim states it would identify patients' expectations about physiotherapy and I'm not sure that was achieved either in the approach or the results. Possibly revise the

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	aim slightly. Design: this requires a little more detail about the choice of approach. The mention of a constructivist paradigm is vague and possibly unnecessary. You could explain why qualitative methods are particularly useful when answering this particular type of research question, and backing this up with a few references which say the same sort of thing: https://pubmed.ncbi.nlm.nih.gov/11502338/ https://academic.oup.com/rheumatology/article/45/4/369/1785035 https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0842-9 There needs to be some discussion of why there was no patient and public involvement in this research. Participants were reimbursed for their time with a $50 gift card. Did they know this before they agreed to participate? The possibility that this could have had a bias effect on their perspective of physiotherapy needs to be discussed. The authors suggest that the principles of data saturation were used to determine sample size, but how was this managed? I imagine from facebook many hundreds of people might have responded tot he invitation, so how were responses managed? How many replies were received? How was the sample chosen? Was a framework used to ensure a balance of participant characteristics? I ask because I'm wondering why 75% of the sample were female, which suggest no framework was used to balance the sample. Were some participants turned away? More detail is required on these aspects if the study is to be repeatable. In some ways the study could be considered more deductive than inductive as the topic guide is based on the Care Standard criteria, and so the questions appear like a checklist rather than a more open semi-structured interview guide, which might ask more about people's views or feelings about their experience of physiotherapy. Why was the topic guide designed in this way? This may be one of the major reasons that the analysis appears to lack depth and is more descriptive than a truly inductive analysis. What is the process of inductive thematic analysis described by Morse? e.g. you could approach this by starting with "Following Morse et al's approach to inductive thematic analysis the researcher ... ". Why did two researchers conduct the analysis simultaneously? This is usually conducted by one researcher with input from the team later. Was it to reduce the risk of over-representation perhaps? The theme titles in the abstract appear to be very descriptive and more like a summary of the findings than themes. The titles are different in the results section. Consider revising the titles in the abstract. Overall I feel the analysis could be more conceptual as currently it is quite descriptive, and fails to really capture the essence of what's important about these participants' experiences. I've tried to give some suggestions for each theme.

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	Theme 1: I'm struggling to see what's different about these quotes from those in theme 2 which also describe seeking care. When describing "The perception of adequate OA knowledge" in the results the authors state that (p16, L38) "Participants tended not to seek validation or confirmation of their knowledge about OA from their physiotherapist, nor seek further education." Is this supported by a quotation? This is an important claim as it suggests something could possibly be missed if physiotherapists don't check patients perceptions about their knee OA (we know wear and tear, bone on bone, degenerative etc are not always constructive ways to think about OA and can affect how patients manage it). This issue is however, nicely covered in the discussion. Theme 2: "Varying models of physiotherapy care" to me doesn't really capture what's described in the quotes or the description. Is there something here about a wide variation in access and provision of physiotherapy care? Theme 3: Consider revising the title as "varied reasons for seeking care" does not really capture the essence of what is described. People seem to be seeking care for pain and functional limitations. Did you get any sense that this was in preference to seeking care from a doctor, or to avoid prescription for pain medications? Theme 5: You describe issues of trust, confidence, therapeutic relationships, personalised care, tailoring etc. There is more going on here than is suggested by the title and it possibly requires splitting into more than one theme. The authors also state: "When care was not personalised, participants expressed a sense of disappointment, describing the treatment received as a 'sausage factory', 'supermarket shelf', or being a 'one size fits all program". How many participants suggested this was the case, and was this their experience of physiotherapy or their suggestion that this is what it might feel like if it wasn't personalised? There are no quotes to back this up in the table. Theme 6: While participants may have believed surgery to be inevitable this belief appears to be based on what their doctor said, not the physiotherapist. They were using the physio to postpone or prepare for surgery, so perhaps the title could better reflect that. Also consider whether the quotations accurately reflect what is described in the results section. Discussion: The discussion could be more critical about the results and their importance and there is a danger that the results are over-generalised. For example, it could be taken that the authors are suggesting that because that all 24 people were generally "happy and satisfied", and therefore we can generalise that all is well with physiotherapy for knee OA in Australia. It is stated that participants "appreciated the personalised care that most physiotherapists tended to provide" but can the authors really claim that most physiotherapists provide personalised care based on these findings? Physiotherapists would also need to be interviewed to provide further evidence of this. The authors state the "findings suggest that Australian physiotherapists work in a patient-centred way..." Again this is possibly overstated, and would require physiotherapists' views as well. It might be more accurate to say that the findings suggest that patients within this study perceived physiotherapists to be patient-centred etc. The rest of the discussion covers many of the issues raised in the results nicely and sets these findings against

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	current literature. The strengths and findings section also covers important aspects of the study and potential future research with people from more diverse backgrounds, and also research in low to middle income countries. However, there should be some coverage of the potential bias introduced by the offer of $50 recompense for involvement.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1

1. **Methods: In general I find the methods section to be transparent and comprehensive. One detail I lack is in which time-period were the interviews performed?**

   We have now included the time-period as to when the interviews were performed in the Methods section, under "Participants":

   Page 8, line 166: *"Interviews were conducted between December 2019 and January 2020."*

2. **Results and discussion: The theme "perception of adequate OA knowledge" is, as exemplified with the three quotes, formed by the results from previous scans or radiographs, and previous consultations with other health-care professionals. Considering the theme "Belief that surgery is inevitable", it seems that patients in general, before even visiting the physiotherapist had a perception that any non-surgical intervention received could only have a temporary effect and that they, despite any exercise, pain-relief strategies or weight management interventions, over time would experience functional decline and increasing pain that unavoidably would result in a need for surgical intervention. The authors did include a discussion about this matter on page 23. Did the authors consider whether the belief that surgery is inevitable; is in itself a detrimental viewpoint that may limit the effect of physiotherapy? Considering that the correlation between imaging findings and OA symptoms has been found highly varying and often poor (Bedson J, Croft P R. The discordance between clinical and radiographic knee osteoarthritis: A systematic search and summary of the literature. BMC Musculoskelet Disord 2008; 9: 116), and furthermore that nonoperative treatment that includes exercise reduces pain irrespective of radiographic severity (1) Skou ST, Derosche C, Andersen MM, Rathleff MS, Simonsen O. Nonoperative treatment improves pain irrespective of radiographic severity. Acta Orthop. 2015;86(4):1–6., and 2) Juhl C, Christensen R, Roos EM, Zhang W, Lund H. Impact of exercise type and dose on pain and disability in knee osteoarthritis: A systematic review and meta-regression analysis of randomized controlled trials. Arthritis Rheumatol. 2014;66(3):622–36.), and we know that primary care specialists sometimes have barriers to refer patients to physiotherapy because they either do not believe that exercise is effective, or, they do not believe that the care received at physiotherapist live up to clinical guidelines (Selten EMH, Vriezekolk JE, Nijhof MW, Schers HJ, Van Der Meulen-Dilling RG, Van Der Laan WH, Geenen R, Van Den Ende CHM. Barriers impeding the use of non-pharmacological, non-surgical care in hip and knee osteoarthritis: The views of general practitioners, physical therapists, and medical specialists. J Clin Rheumatol. 2017;23(8):405–10). The authors have partly discussed this on manuscript page 23, but my suggestion would be to strengthen the argumentation of why patients need improved access to physiotherapy, in the discussion by including some of the above points.**

   It was not the aim of this study to determine whether patient beliefs impact outcomes from physiotherapy, indeed a quantitative longitudinal study design (ideally a moderation analyses within a randomised controlled trial) is required to robustly answer such a question. However, as

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suggested by the reviewer, we have expanded our discussion of the points raised by the reviewer:

Page 29, line 436: *"Such perceptions and beliefs about OA are detrimental considering there is often a mismatch between imaging findings and OA symptoms (46, 47) and that conservative management such as exercise can reduce pain irrespective of radiographic severity.(48, 49) In addition, as some primary care specialists are hesitant to refer patients with OA to physiotherapy because they either perceive exercise to be ineffective or lack trust in physiotherapists to provide evidence-based care,(50) patients may not necessarily have been well-informed about the benefits of exercises during their specialist consultation.(51) In order to maximise success with exercise interventions, these findings suggest that physiotherapists could consider reframing their conversations to actively invite the patient to share their pre-existing knowledge about OA so that any perceptions may be subtly corrected, and evidence-based educational resources shared.*"

3. **Furthermore, I also consider it a relevant discussion that physiotherapists need to improve their focus on providing OA education.**
   Thank you for this suggestion. We have also added the following points to the Discussion section:
   Page 30, line 442: *"In order to maximise success with exercise interventions, these findings suggest that physiotherapists could consider reframing their conversations to actively invite the patient to share their pre-existing knowledge about OA so that any perceptions may be subtly corrected, and evidence-based educational resources shared. Physiotherapists should consider the language they use when discussing OA (i.e. avoid biomedical terms such as 'wear and tear' or 'degenerative') so that they are not contributing to patient misinformation (i.e. joint surgery is inevitable; OA symptoms will worsen over time), and instead provide a sense of hope and optimism for prognosis with conservative care."*

4. **The identified theme five was "Happy and satisfied with physiotherapy". From reading the report on pages 19-20 , it seems that the ability to provide personalised care was something that patients weighted highly, and therefore they found it disappointing when they did not perceive their received care was personalised. I would consider choosing another overall theme to better describe what patients valued with the care, more than whether most were satisfied or not, since there were examples of not so positive experiences with the delivered care also. I suggest to rephrase the overall theme "happy and satisfied" to something in the line of "ability to provide professional and personalized care".**
   Thank you for this suggestion. We have changed Theme 5: "Happy and satisfied with physiotherapy' to "Professional and personalized care". This has been amended in the Abstract and Results sections and Table 3.

5. **As discussed on page 24, a strength of the qualitative design is that it gives the opportunity to explore interesting aspects emerging form the interviews further, such as the point that some patients received adjunctive treatments such as massage, acupuncture and electrotherapy. It would have been highly interesting, and also possible within this study to elaborate further on that specific choice of treatment and whether patients in fact requested these treatments themselves. Since there are previous reports on the usage of treatment interventions with limited evidence for knee OA (Hagen KB, Smedslund G, Østerås N, Jamtvedt G. Quality of Community-Based Osteoarthritis Care: A Systematic Review and Meta-Analysis. Arthritis Care Res. 2016;68(10):1443–52.), and since that fact that this usage in itself may be considered a barrier to refer to physiotherapy (Selten EMH, Vriezekolk JE, Nijhof MW, Schers HJ, Van Der Meulen-Dilling RG, Van Der Laan WH, Geenen R, Van Den Ende CHM. Barriers impeding the use of non-pharmacological, non-surgical care in hip and knee osteoarthritis: The views of general practitioners, physical therapists, and medical specialists. J Clin Rheumatol. 2017;23(8):405–10), I believe that it is a shame that that aspect was not elaborated on during the interviews. Do the authors have any comments on whether it was a consideration not to explore that aspect further, or hypothetically, whether the interview guide was too structured in that it did not allow for other aspects to be explored, or**

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whether the interviewer was not experienced enough to act on new information emerging during the interviews?

It was not the aim of this study to explore drivers for treatment decisions. In looking at our original submission, we realise the aim of our study was not articulated specifically enough and thus it was not clear to the reviewer why our interview guide was structured the way it was. To clarify, our aim in this study was to explore how the experiences of people receiving physiotherapy care for their knee OA in Australia aligned with the national Clinical Care Standard for knee OA. This study is complementary to our earlier work which explored quality of care from the physiotherapist perspective (reference #7 in the manuscript). We know from our previous study that physiotherapists were aware of the lack of evidence supporting manual therapy for knee OA management but they sometimes chose to use such treatments anyway as an adjunct to exercise and for short-term pain relief.(7)

We acknowledge that the original aim for this study was not specific to the national Clinical Care Standard and may thus have been somewhat vague or misleading. Therefore, we have made the following changes to Abstract section:

Page 2, line 26: *"This study aimed to explore the experiences of people who had recently received physiotherapy care for their knee OA in Australia and how these experiences aligned with the national Clinical Care Standard for knee OA."*

Page 2, line 29: *"Qualitative study using semi-structured individual telephone interviews and thematic analysis, where themes/subthemes were inductively derived. Questions were informed by seven quality statements of the ~~Australian government's~~ OA of the Knee Clinical Care Standard. Interview data were also deductively analysed according to the Standard."*

The following change was made to the Introduction section:

Page 6, line 116: *"This study is complementary to our previous similar qualitative study with physiotherapists as participants.(7) In the present study, we aim to explore the experiences of Australians who had recently received physiotherapy care for their knee OA and how these experiences aligned with the national Clinical Care Standard."*

The following change was made to the Method section under 'Data analysis':

Page 10, line 195: *"The interview data were also deductively analysed according to the national Clinical Care Standard for knee OA."*

The following change was made to the Discussion section:

Page 26, line 354: *"This qualitative study explored experiences of people who had received physiotherapy care for their knee OA in Australia and how they aligned with the national Clinical Care Standard for knee OA.(8)"*

6. **I acknowledge that defining an interview guide is difficult and although I consider it rational to use the seven quality statements of the Australian government's OA of the Knee Clinical Care Standard as a framework, I wonder if the interview guide ended up being too strict, not allowing for other important aspects to be explored. From evaluating the six emerging themes, one thing that comes to my mind is that the emerging themes seem also (at least partly) to be formed by the aspects covered by the OA of the Knee Clinical Care Standard. I therefore consider it a limitation that patients were not involved in the interview guide preparation, as I believe that it could have helped to broaden the guide, since the aim of the study was broad; "to explore the experience of people receiving OA care in Australia". Aspects such as the process of deciding on treatment/shared-decision making, exploring barriers and facilitators of different treatment options within physiotherapy care, and experiences with treatment for OA in relation to possible other additional health-**

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problems/diseases, could in my opinion have been interesting to have included in the interview guide.

Please see response to comment #5 above - where we have clarified that our aim was to specifically explore how experiences with physiotherapy care aligned with the Clinical Care Standard. We trust the changes made (detailed at comment #5 above) have now addressed this comment and highlighted why the points the reviewer has raised were outside of the scope of this study and not relevant to our specific aim.

Reviewer 2

1. **General comments: For me, I need to be convinced about the added value of this work.**
As described under Reviewer 1 comment #5 above, in hindsight we see that our aim was not clearly articulated in our original submission. We have now revised our manuscript to more clearly articulate that our aim was to explore how the experiences of people receiving physiotherapy care for their knee OA in Australia aligned with the national Clinical Care Standard for knee OA. This is novel work and yields important new knowledge about the quality of physiotherapy care for Australians living with knee OA, as no prior study has explored how patient experiences align with the National Clinical Care Standard for knee OA. This study is complementary to our prior study which explored how care aligned with the Standard from the *physiotherapist* perspective (reference #7 in the manuscript). Please see our changes to Reviewer 1 comment #5 above to see how we have revised the manuscript to make the novelty of our study clearer. In addition, we have completely re-written the Introduction section to align this study more clearly with previous research and to highlight the unique knowledge gaps that this study aims to address:

Page 5, line 95: *"To date, there are indications that physiotherapy care provided to people with knee OA may not necessarily align with evidence-based care standards. We recently conducted a qualitative study to explore the experiences of Australian physiotherapists delivering care for people with knee OA and how their experiences aligned with the national Clinical Care Standard.(7) The Clinical Care Standard for knee OA defines seven key aspects of care that people with knee OA should expect to receive in Australia.(8) We found physiotherapists tended to rely on biomedically-oriented assessment and would often provide treatment (such as manual therapy) and self-management strategies that aimed to address the 'mechanical' aspects of knee OA. The primary focus for physiotherapists was to provide goal-orientated personalised exercise. Surgery was perceived as a last resort, and patient comorbidity, adherence, and desire for a 'quick fix' were the main clinical challenges experienced. Physiotherapists also described a mismatch between what they knew and what they did when it came to imaging, weight management and manual therapy. Weight loss, medication and surgical advice were perceived to be outside of their scope of practice. Nevertheless, physiotherapists' reported experiences were mostly consistent with the quality care standard.(7) Findings from this study provide useful information about physiotherapy management of people with knee OA but it can be argued that a patient's perspective of their physiotherapy care experiences may not necessarily be similar to that of the therapist.*

Several qualitative studies have explored patient experiences of receiving care for their knee OA from either a multidisciplinary team which included physiotherapists (9-14) or solely from physiotherapists.(15-19) However, none of these studies have specifically explored patient experiences receiving physiotherapy assessment, diagnosis, treatment options and follow-up appointments for their knee OA. This study is a complementary paper to the previous qualitative study with physiotherapists as participants.(7) In the present study, we aim to explore the experiences of Australians who had recently received physiotherapy care for their knee OA and how these experiences aligned with the national Clinical Care Standard for knee OA. Such information will help enhance our understanding of patient experiences ~~about~~ with physiotherapy care for their condition and may help inform strategies to improve future care and service delivery."

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2. **Introduction: Line 20 you say currently very little is known about experiences of people receiving PT however from a quick search on scholar I noted the following as examples of what is known:**

   The role of PT is considered within this study

   https://www.tandfonline.com/doi/abs/10.1080/09593980701588326

   https://onlinelibrary.wiley.com/doi/abs/10.1002/acr.24439

   https://onlinelibrary.wiley.com/doi/full/10.1002/acr.20459

   Physiotherapy is also mentioned in general experience articles, from my experience of qualitative reviewing general experience articles of chronic illness often have a section on rehab e.g.,

   https://www.tandfonline.com/doi/full/10.3402/qhw.v11.30193

   Further review evidence is considered here

   https://link.springer.com/article/10.1007/s00296-013-2905-y

   There is also experiences of partaking in a PT intervention which may be relevant?

   https://www.sciencedirect.com/science/article/pii/S1063458418311063

   https://onlinelibrary.wiley.com/doi/abs/10.1002/msc.1382

   https://www.tandfonline.com/doi/full/10.3109/09638288.2013.805257

   Thank you for your advice. In keeping with Reviewer 2's previous comment (see above), we have re-written the introduction and that sentence no longer exists in the revised version. We have also framed the introduction to better summarise the work that has preceded ours (including citing the references highlighted by the Reviewer) and to better articulate the knowledge gap that this study aims to fill:

   Page 6, line 112: *"Several qualitative studies have explored patient experiences of receiving care for their knee OA either from a multidisciplinary team which included physiotherapists (9-14) or solely from physiotherapists.(15-19) However, none of these studies have specifically explored patient experiences receiving physiotherapy assessment, diagnosis, treatment options and follow-up appointments for their knee OA."*

3. **I am not an expert in this area but I have concerns about how much has gone before and what is known and exactly what your study is adding. Also if you look at your interview guide you may need to consider the different areas of consideration. The reader needs to understand this.**
   We have addressed this issue under Reviewer 2 comment #1.

4. **Line 27-52 When you consider the past review I think the reader needs to know the gaps more, but I think you need to go further and ensure other literature hasn't been done.**
   We have addressed this issue under Reviewer 2 comment #1.

5. **From the above I think you need to be clear about the added value knowing experiences from the Australian health system if this is what makes your work unique. But also I think you need to consider the reader and identify conceptually if your work is telling us something that adds significant insight to this area?**

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Thank you for pointing this out. Please also see our response to Reviewer 2 comment #1 above as that addresses this direct issue. In order to ensure that our work is unique and relevant, we have added the following to the Introduction section:

Page 6, line 116: *"This study is a complementary paper to the previous qualitative study with physiotherapists as participants.(7) In the present study, we aim to explore the experiences of Australians who had recently received physiotherapy care for their knee OA and how these experiences aligned with the national Clinical Care Standard for knee OA. Such information will help enhance our understanding of patient experiences ~~about~~ with physiotherapy care for their condition and may help inform strategies to improve future care and service delivery."*

Given that the aim of this study was specifically to explore how the experiences of people receiving physiotherapy care for their knee OA in Australia aligned with the national Clinical Care Standard for knee OA, we have made some changes to the Results and Discussion sections. The following were added to the Results section:

Page 24, line 347: *"**Alignment with Clinical Care Standard for knee osteoarthritis:** Deductive analysis was used to generate Table 4, which summarises how participant experiences of physiotherapy care for knee OA aligned with the Clinical Care Standard."* (Note that Table 4 is a new table that has been included in the revised manuscript)

The following was added to the Abstract under 'Conclusion':

Page 3, line 57: *"~~These results provide evidence from the patients' perspectives about the important role physiotherapists play in the care of Australians with knee OA. Improved funding models and pathways for accessing physiotherapy care appear to be needed.~~ Patients' experiences with receiving physiotherapy care for their knee OA were partly aligned with the Clinical Care Standard, particularly regarding comprehensive assessment, self-management, and exercise."*

The following was added to the Discussion section:

Page 26, line 365: *"Our findings suggest that, generally, patients within this study perceived Australian physiotherapists to work in a patient-centred way to ensure that patients' treatment expectations, needs and preferences are respected. Such care aligned with the Clinical Care Standard relating to self-management, where patients received management plan that suited their needs and preferences. These findings were also similar to our previous study with physiotherapists,(7) who described offering an individualised self-management plan based on knee symptoms and signs, functional ability and goals."*

Page 28, line 397: *"Our findings highlight the importance of funding mechanisms for physiotherapy services to relieve the financial burden that people experience when accessing necessary care for knee OA. Therefore, it remains unclear if patients were offered regular reviews by their physiotherapist, as recommended by the Clinical Care Standard, due to lack of funding being a potential barrier to regular reviews."*

Page 29, line 415: *"Similarly, physiotherapists themselves also perceived exercise and physical activity to be their main role in the management of people with knee OA(7, 20) and are confident to prescribe exercises to improve knee strength and range of movement.(21) However, inconsistent with the Clinical Care Standard, it appeared that patients were predominantly assessed by their physiotherapist for their knee symptoms and functional limitations, with little consideration of psychosocial factors. In addition, the management plan provided by the physiotherapist tended to overlook strategies specifically related to weight loss/maintenance. Our patient findings are also similar to our previous study with physiotherapists,(7) who tended to focus on biomedical assessment and management of knee OA. Regarding weight loss advice,*

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they generally provided education about the importance of weight loss rather than advice about strategies to lose weight."

Page 30, line 458: *"Regarding knee surgery, patients mainly sought physiotherapy care to postpone or prepare for knee surgery. Our patient findings are similar to our previous study with physiotherapists,(7) who had also felt that surgical advice was outside the scope of practice of physiotherapy care. However, some physiotherapists described their role as preparing patients for knee surgery when they were referred for physiotherapy."*

Page 32, line 500: *"Overall, patients' experiences with receiving physiotherapy care for their knee OA were partly aligned with the Clinical Care Standard, particularly regarding comprehensive assessment, self-management, and exercise."*

6. Methods: You identify your paradigmatic view but not the methodology – can this be identified?

The following wordings have been added to the Method section, under "Design":

Page 7, line 146: "*This qualitative study used semi-structured interviews and was based on a constructivist paradigm, where knowledge is built through active experience and interpretation.(22)*"

7. Can you name a sampling method?

The following wordings have been added to the Method section, under "Participants":

Page 8, line 156: "A *convenience sample of ~~People~~ adults who had sought physiotherapy care to manage their knee OA were recruited from around Australia via Facebook and our research volunteer database."*

8. Did you undertake a cognitive interview? Or pilot interview?

We did not undertake a cognitive or pilot interview. However, the interview questions were further refined following the first three phone interviews to improve clarity for participants based on experience from the initial interviews. The refinement also helped to enhance/expand the prompts to ensure rich information were collected from the participants. The following wordings have been added to the Method section, under "Interviews":

Page 10, line 179: "*Interview questions were refined following the first three phone interviews to improve clarity for participants based on experience from the initial interviews. The refinement also helped to enhance/expand the prompts to ensure rich information were collected from the participants.*"

9. Can you identify what you did to ensure quality?

In order to ensure quality of reporting, we were guided at the outset by, and reported our study according to the Standards for Reporting Qualitative Research checklist. The following sentence has been modified in the Methods section, under "Design" to reflect this:

Page 7, line 150: *"~~The Consolidated Criteria for Reporting Qualitative Research~~ The Standards for Reporting Qualitative Research checklist was used to ensure explicit and comprehensive reporting of this study.(26)*"

We also ensured quality by i) establishing the eligibility criteria for participants so that we were recruiting suitable participants; ii) using a semi-structured interview guide to facilitate open-ended responses from participants to collect more in-depth information; iii) conducting telephone

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interviews to promote a perception of anonymity in interviewees to allow participants to feel comfortable to share; iv) having the same researcher conduct all interviews to ensure quality/consistent interviewing style; v) to minimise over-representation, two researchers (instead of one) individually read, re-read, and inductively coded each transcript before comparing their codes and grouping similar topics/ideas into categories, themes, and sub-themes; and vi) the senior researcher also read all transcripts prior to discussion to ensure data credibility and confirmability. Most of this information was included in the methods of the original submission, however we have now added the following wording to the Methods section, under "Data analysis":

Page 10, line 186: *"An inductive thematic approach was used initially (29). In order to minimise over-representation, two researchers conducted the data analysis simultaneously."*

10. **Can you identify an audit trail of evidence showing examples of each stage of analysis?**
An audit trail of evidence showing examples of each stage of the data analysis has been included as a supplementary file and written as below:

Page 14, line 224: *"Six themes emerged following the inductive thematic analysis (29). ~~Which~~ An audit trail of evidence showing examples of each stage of the data analysis is presented in Supplementary file 1. The six themes identified are outlined in Table 3 and described below."*

11. **Results: The interpretation and value of the results and discussion must be in context to the past literature. Until an updated rationale is given its hard to determine the value so I stopped at this point.**
Thank you for your advice. As discussed above, we believe the aim of our study is now more specific and all the changes we have made to the Results and Discussion sections per our responses to Reviewer 2 comment #1 have strengthened our rationale for this study.

Reviewer 3

1. **Abstract: This is fine but the objective needs to state why the research is needed, i.e. what's the problem? (lack of evidence).**

Thank you for pointing this out. We have made the changes in the Abstract section under "Objective" as below:
Page 2, line 24: *"Physiotherapists commonly provide non-surgical care for people with knee osteoarthritis (OA). It is unknown if patients are receiving high-quality physiotherapy care for their knee OA. This study aimed to explore the experiences of people who had recently received physiotherapy care for their knee OA in Australia and how these experiences aligned with the national Clinical Care Standard."*

2. **The Results section appears to be a descriptive summary of the results rather than themes. The theme titles are not really titles but a descriptive summary of the findings. Consider revising these (also see my later comments on these which may help).**

Thank you for your advice. We have made changes to the Abstract section under "Results":

Page 2, line 41: *"Results: Six themes emerged: 1) Presented with a pre-existing osteoarthritis diagnosis (prior OA care from other health professionals; perception of adequate OA knowledge); 2) Wide variation in access and provision of physiotherapy care (referral pathways; funding models; individual vs group sessions); 3) Seeking physiotherapy care for pain and functional limitations (knee symptoms; functional problems; 4) Physiotherapist management focussed on function and exercise (assessment of function; various types of exercises prescribed; surgery, medications, and injections are for doctors; adjunctive treatments); 5) Professional and personalized care (trust and/or confidence; personalized care); 6) Physiotherapy to postpone or prepare for surgery."*

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We have also revised the theme titles as per your suggestion. Please see Reviewer 3 comment #12.

3. **Strengths and limitations key statements: the first bullet point does not appear to indicate whether or why the use of qualitative research is a strength or limitation.**

   Thank you for pointing this out. We have made the changes to the Abstract section under "Strengths and limitations of this study":

   Page 4, line 68: *"A strength of this study was using a ~~Qualitative~~ qualitative ~~research was used~~ design to explore how the experiences of people receiving physiotherapy care for knee OA in Australia aligned with the national Clinical Care Standard.*"

4. **Main text: Introduction: The introduction covers the current literature around people's perceptions of physiotherapy well, and identifies the research aim, although the aim states it would identify patients' expectations about physiotherapy and I'm not sure that was achieved either in the approach or the results. Possibly revise the aim slightly.**
   We have addressed this issue under Reviewer 2 comment #1.

5. **Design: this requires a little more detail about the choice of approach. The mention of a constructivist paradigm is vague and possibly unnecessary. You could explain why qualitative methods are particularly useful when answering this particular type of research question, and backing this up with a few references which say the same sort of thing:**

   https://pubmed.ncbi.nlm.nih.gov/11502338/

   https://academic.oup.com/rheumatology/article/45/4/369/1785035

   https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0842-9

   Thank you for pointing this out. Reviewer 2 was happy for us to identify our paradigmatic view, so we elected not to remove it. However, we agree that an explanation of the usefulness of qualitative methods can add more details to our qualitative approach. Therefore, the following points have been added to the Method section, under "Design":

   Page 7, line 147: *"Qualitative methods allow for in-depth examination of the attitudes, experiences, and behaviours of individuals in their natural context and can contribute to a broader understanding of medical research.(23-25).*"

6. **There needs to be some discussion of why there was no patient and public involvement in this research.**

   In Australia, although patient and public involvement in research is increasingly valued, it is not standard practice to involve patients or public in the design of qualitative research such as this.

   We have added a sentence acknowledging this as a limitation in the Discussion section:

   Page 31, line 476: *"There was no patient and public involvement in the design of this research."*

7. **Participants were reimbursed for their time with a $50 gift card. Did they know this before they agreed to participate? The possibility that this could have had a bias effect on their perspective of physiotherapy needs to be discussed.**

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Participants were aware that they would be reimbursed for their time with a $50 gift card. To ensure that we have acknowledged any potential bias, we have added the following points to the Discussion section:

Page 31, line 480: *"Participants were reimbursed for their time with a $50 gift card so they might have responded to interview questions in a socially desirable manner. Efforts were made to reduce this effect by informing participants at the beginning of the interview that there were no right or wrong answers to the questions asked."*

8. **The authors suggest that the principles of data saturation were used to determine sample size, but how was this managed? I imagine from facebook many hundreds of people might have responded to the invitation, so how were responses managed? How many replies were received? How was the sample chosen? Was a framework used to ensure a balance of participant characteristics? I ask because I'm wondering why 75% of the sample were female, which suggest no framework was used to balance the sample. Were some participants turned away? More detail is required on these aspects if the study is to be repeatable.**

A convenience sampling method was used to recruit participants for this study. 76 responded to the interview invitation but only 31 participants fulfilled the eligibility criteria. Of the 31 participants, 24 were female. Of the 31 participants, 24 completed the interview while the remaining either declined participation or were not contactable. None of the eligible participants were turned away from the interview. Using this sampling method, we also managed to recruit a range of participants, including males and females of differing age, occupational status and geographical location across Australia as described in the Results section.

In order to improve transparency of this study, the following wordings have been added to the Method section, under "Participants":

Page 8, line 156: "A *convenience sample of ~~People~~ adults who had sought physiotherapy care to manage their knee OA were recruited from around Australia via Facebook and our research volunteer database."*

The following wordings have also been added to the Results section:

Page 11, line 201: "*Seventy-six participants responded to the interview invitation but only 31 fulfilled the eligibility criteria for this study. Of the 31 eligible participants, 24 completed the interview while the remaining either declined participation or were not contactable."*

We also acknowledged that having 75% of the sample as female is a limitation, so we have added the following to the Discussion section:

Page 31, line 479: "*There were many more females than males in the sample which may reflect the social media approach to recruitment."*

9. **In some ways the study could be considered more deductive than inductive as the topic guide is based on the Care Standard criteria, and so the questions appear like a checklist rather than a more open semi-structured interview guide, which might ask more about people's views or feelings about their experience of physiotherapy. Why was the topic guide designed in this way? This may be one of the major reasons that the analysis appears to lack depth and is more descriptive than a truly inductive analysis.**

In looking at our original submission, we realise the aim of our study was not articulated specifically enough and thus it was not clear to the reviewer why our interview guide was structured the way it was. To clarify, our aim in this study was to explore how the experiences of people receiving physiotherapy care for their knee OA in Australia aligned with the national Clinical Care Standard for knee OA. This study is complementary to our earlier work which

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explored quality of care from the physiotherapist perspective (reference #7 in the manuscript), which also used a similar inductive and deductive approach to analyses. In the revised manuscript, and in light of the Reviewer's comment, we have now framed our analysis as both inductive and deductive, and added some extra (deductive) results into the revised manuscript.

The following changes have been made to Abstract section under 'Design':

Page 2, line 29: *"Qualitative study using semi-structured individual telephone interviews and thematic analysis, where themes/subthemes were inductively derived. Questions were informed by seven quality statements of the ~~Australian government's~~ OA of the Knee Clinical Care Standard. Interview data were also deductively analysed according to the Standard."*

The following changes have been made to Method section under 'Data analysis':

Page 10, line 195: "*The interview data were also deductively analysed according to the national Clinical Care Standard for knee OA."*

The following changes have been made to Results section:

Page 24, line 347: *"**Alignment with Clinical Care Standard for knee osteoarthritis:** Deductive analysis was used to generate Table 4, which summarises how participant experiences of physiotherapy care for knee OA aligned with the Clinical Care Standard."* (Table 4 is a new table that has been included in the manuscript)

10. **What is the process of inductive thematic analysis described by Morse? e.g. you could approach this by starting with "Following Morse et al's approach to inductive thematic analysis the researcher ... ".**

Thank you for the suggestion. The following sentence in the Method section under "Data analysis" has been modified as below:

Page 10, line 187: *"Following Morse et al's approach to inductive thematic analysis (which advocates for four steps: 1) read and re-read interview transcripts; 2) step back and reflect on interviews as a whole; 3) identify ideas of similar nature 4) group ideas into themes)(29), firstly, ~~First,~~ the student researcher (PLT) and another post-doctoral researcher (BJL) with expertise in qualitative methodologies (and who is not a physiotherapist) individually read each transcript*."

11. **Why did two researchers conduct the analysis simultaneously? This is usually conducted by one researcher with input from the team later. Was it to reduce the risk of over-representation perhaps?**

Yes, two researchers conducted the analysis simultaneously to minimise risk of over-representation. To reflect this, the following wording has been added to the Methods section, under "Data analysis":

Page 10, line 186: *"An inductive thematic approach was used initially.(29) In order to minimise over-representation, two researchers conducted the data analysis simultaneously.*"

12. **Overall I feel the analysis could be more conceptual as currently it is quite descriptive, and fails to really capture the essence of what's important about these participants' experiences. I've tried to give some suggestions for each theme.**
    a) **Theme 1: I'm struggling to see what's different about these quotes from those in theme 2 which also describe seeking care. When describing "The perception of adequate OA knowledge" in the results the authors state that (p16, L38) "Participants tended not to seek validation or confirmation of their knowledge about OA from their physiotherapist, nor seek further education." Is this supported by a quotation? This is an important claim as it suggests something could possibly be missed if**

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physiotherapists don't check patients perceptions about their knee OA (we know wear and tear, bone on bone, degenerative etc are not always constructive ways to think about OA and can affect how patients manage it). This issue is however, nicely covered in the discussion.

We trust that the inclusion of the deductive analysis, that aligns participant experiences with the expected domains of care outlined by the Clinical Care Standard, addresses the Reviewer's concern that a more conceptual analysis is needed.

For Theme 1, we are referring to patients seeking OA care from other health professionals other than physiotherapists. This differs to Theme 2, which looks at receiving care specifically from physiotherapists. To avoid confusion, we have changed the sub-theme "History of seeking care for OA elsewhere" to "Prior OA care from other health professionals". This has been reflected in Table 3 and the Abstract section.

We agree that the statement relating to "Participants tended not to seek validation or confirmation of their knowledge about OA from their physiotherapist, nor seek further education" in the Results section sounds like a strong claim. This was the general sense we had when analysing the interview transcript however, there was no direct quote to reflect this. Therefore, we have removed this statement from the Results section. We have also made the following change in the Discussion section to reflect this:

Page 29, line 426: *"Interestingly, participants tended to have an OA diagnosis already made prior to their physiotherapy consultation. They also believed that they already had adequate knowledge and understanding about their knee OA ~~and did not seek further information from their physiotherapist~~."*

b) Theme 2: "Varying models of physiotherapy care" to me doesn't really capture what's described in the quotes or the description. Is there something here about a wide variation in access and provision of physiotherapy care?

Theme 2 has been changed to 'Wide variation in access and provision of physiotherapy care". This has been reflected in the Abstract section, Table 3, and the Result section.

c) Theme 3: Consider revising the title as "varied reasons for seeking care" does not really capture the essence of what is described. People seem to be seeking care for pain and functional limitations. Did you get any sense that this was in preference to seeking care from a doctor, or to avoid prescription for pain medications?

Theme 3 has been changed to "Seeking physiotherapy care for pain and functional limitations". This has been reflected in the Abstract section, Table 3, and the Result section.

We did not get any sense that this was in preference to seeking care from a doctor or to avoid pain medications as these aspects of care were not explored within this study.

d) Theme 5: You describe issues of trust, confidence, therapeutic relationships, personalised care, tailoring etc. There is more going on here than is suggested by the title and it possibly requires splitting into more than one theme. The authors also state: "When care was not personalised, participants expressed a sense of disappointment, describing the treatment received as a 'sausage factory', 'supermarket shelf', or being a 'one size fits all program". How many participants suggested this was the case, and was this their experience of physiotherapy or their suggestion that this is what it might feel like if it wasn't personalised? There are no quotes to back this up in the table.

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Reviewer 1 expressed a similar comment about this theme, and Theme 5 has been revised as per Reviewer 1's suggestion to "Professional and personalized care". This has been reflected in the Abstract section, Table 3, and the Result section.

An additional quote has been added to Table 3 under 'personalized care' sub-theme.

All of the quotes provided in Table 3 for this sub-theme clearly imply that these relate to the actual patient experience with physiotherapy care, instead of their belief about what it would feel like if they did not receive personalised care.

e) **Theme 6: While participants may have believed surgery to be inevitable this belief appears to be based on what their doctor said, not the physiotherapist. They were using the physio to postpone or prepare for surgery, so perhaps the title could better reflect that. Also consider whether the quotations accurately reflect what is described in the results section.**

This theme has been changed to "Physiotherapy to postpone or prepare for surgery". This has been reflected in the Abstract section, Table 3, and the Result section. We have also revised the quotations for this theme to reflect further.

13. **Discussion:**

a) **The discussion could be more critical about the results and their importance and there is a danger that the results are over-generalised. For example, it could be taken that the authors are suggesting that because that all 24 people were generally "happy and satisfied", and therefore we can generalise that all is well with physiotherapy for knee OA in Australia.**
Numerous revisions have been made to the discussion that have already been outlined in our responses to Reviewer 1 (comment #2 & 3) and Reviewer 2 (comment #5). In addition, we agree that the above statement may be over-generalised. Therefore, we have made changes to the Discussion section:

Page 26, line 357: *"Participants within this study valued physiotherapists' ability to provide professional and personalized care ~~were generally happy and satisfied with their physiotherapy care~~ and described having a strong sense of trust and/or confidence in their physiotherapist. They also felt that physiotherapists understood their problems. ~~and they appreciated being offered the personalised care that most physiotherapists tended to provide~~."*

b) **It is stated that participants "appreciated the personalised care that most physiotherapists tended to provide" but can the authors really claim that most physiotherapists provide personalised care based on these findings? Physiotherapists would also need to be interviewed to provide further evidence of this.**
We agree that we cannot claim that most physiotherapists provide personalised care based on the findings from this study. The sentence "appreciated the personalised care that most physiotherapists tended to provide" has been removed.

c) **The authors state the "findings suggest that Australian physiotherapists work in a patient-centred way..." Again this is possibly overstated, and would require physiotherapists' views as well. It might be more accurate to say that the findings suggest that patients within this study perceived physiotherapists to be patient-centred etc.**
We agree this statement is possibly overstated so we have made the changes as below in the Discussion section:

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Page 26, line 365: *"Our findings suggest that, generally, patients within this study perceived Australian physiotherapists to work in a patient-centred way to ensure that patients' treatment expectations, needs and preferences are respected."*

d) The rest of the discussion covers many of the issues raised in the results nicely and sets these findings against current literature. The strengths and findings section also covers important aspects of the study and potential future research with people from more diverse backgrounds, and also research in low to middle income countries. However, there should be some coverage of the potential bias introduced by the offer of $50 recompense for involvement.

As stated earlier, to ensure that we have captured any potential bias due to $50 reimbursement to participants, we have added the following points to the Discussion section:

Page 31, line 480: *"Participants were reimbursed for their time with a $50 gift card so they might have responded to interview questions in a socially desirable manner. Efforts were made to reduce this effect by informing participants at the beginning of the interview that there were no right or wrong answers to the questions asked."*

VERSION 2 – REVIEW

REVIEWER	Lina Holm Ingelsrud Department of Orthopaedic Surgery, Copenhagen University Hospital Hvidovre, Denmark
REVIEW RETURNED	21-Dec-2020

GENERAL COMMENTS	I believe the authors have addressed the concerns i had with the submitted first version of this work and have adequately clarified the points I raised. I have no additional concerns.

REVIEWER	Andrew Moore University of Bristol, Musculoskeletal Research Unit, Bristol Medical School, UK
REVIEW RETURNED	16-Dec-2020

GENERAL COMMENTS	The authors have addressed all of my suggestions and I have no further concerns about the manuscript. It reads a lot better, and it adds clear value to the literature. Well done.

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