Patient preferences for technical skills versus interpersonal skills in chiropractors and physiotherapists treating low back pain

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Received 11 June 2012; Revised 11 September 2012; Accepted 24 September 2012.

Background. Little is known about which characteristics of chiropractors and physiotherapists matter to patients and influence their preferences when seeking care.

Objective. To examine the impact of four factors (patient gender, practitioner gender, practitioner specialty—chiropractor or physiotherapist and practitioner reputation—technical ability or interpersonal skills) on patients’ choice of therapist to treat low back pain.

Methods. Questionnaire-based vignette study in which participants sampled from the general population rated the likelihood of consulting eight fictional therapists. Each fictional therapist represented a different combination of the three practitioner factors (e.g. male chiropractor with reputation for good technical ability). The study was administered as a postal survey to a simple random sample of residences in one postal town in England.

Results. Respondents (n = 657) consistently reported that they considered a practitioner’s qualifications and technical skills important when choosing either a physiotherapist or a chiropractor; and just less than a third thought it was important that a practitioner was a good listener. As hypothesized, female respondents preferred female practitioners and respondents had a general preference for physiotherapists over chiropractors. Contrary to our hypothesis, the practitioner’s reputation had the largest effect on respondents’ preferences and all practitioners with a reputation for technical ability were preferred over those with a reputation for interpersonal skills.

Conclusion. Similar factors are important to patients whether they are choosing an individual chiropractor or physiotherapist; patients particularly value information about technical competence. An awareness of these factors should help primary care providers to direct patients to relevant information and support their decision-making.

Keywords. Chiropractic, patient choice, physician characteristics, physiotherapy, primary care.

Introduction

Policy initiatives in the UK such as ‘Choose and Book’, ‘National Health Service (NHS) Choices’, and ‘Any Qualified Provider’ are designed to facilitate patient choice and this can have positive clinical outcomes for patients and enhance their satisfaction with care. According to the King’s Fund, patients can be involved in four choices with respect to their health care: choice of provider, appointment, treatment, and individual health professional. When choosing a primary care appointment, choice of individual doctor is more important to patients than factors such as appointment time and speed of access. This article focuses on how patients choose an individual health professional in the context of two therapies, chiropractic and physiotherapy. In the UK, chiropractic and physiotherapy are subject to statutory regulation by the General Chiropractic Council and the Health and Care Professions Council, respectively. Training is typically through a 4-year degree programme for chiropractors and a 3-year degree programme for physiotherapists. We chose to focus on chiropractic and physiotherapy as both are discussed in England’s Musculoskeletal Services Framework and current clinical guidelines for primary care of low back pain recommend manual therapy; but little is known about either how patients choose individual therapists or whether choices differ across
conventional and complementary/alternative medicine (CAM) contexts.

Previous studies on choice of individual practitioners suggest that, in general, female patients often but not always prefer female practitioners, especially for intimate health problems.\(^8\) Practitioner gender seems to be less important to male patients: although gender concordance preference is found in some men,\(^2\) other studies find that both men and women prefer female practitioners.\(^1\) Studies also report an ethnicity concordance effect,\(^1\) which is more important to some patients than gender concordance.\(^1\) Ethnicity and gender concordance effects might be driven by patients' beliefs that doctors of the same sex or ethnicity are easier to talk to, more empathic, and/or would make them feel more at ease during an intimate examination.\(^8\)\(^9\) Consistent with this, gender stereotypical expectations of general practitioner (GP) behaviour are related to patients' gender preferences.\(^1\)

Demographic factors seem to be less important to patients than more direct indicators of a practitioner's competence. While women are more likely to choose female than male obstetricians/gynaecologists when they only know the doctor's gender, when they are given additional information (such as competence indicators), gender preferences weaken.\(^16\)\(^17\) Similarly, when forced to choose, patients appear to prioritize a primary care doctor's technical competence over their interpersonal skills.\(^18\)\(^19\)

A few studies provide insight into how patients choose individual CAM practitioners. Consistent with the literature on lay referral networks in general,\(^20\) CAM users value information and personal recommendations from trusted friends and family members when choosing a therapy and practitioner.\(^21\)\(^22\) Patients value the empathetic therapeutic relationships they experience with CAM practitioners,\(^23\)\(^24\) suggesting they might prefer practitioners with a reputation for good interpersonal skills. A gender concordance preference has been shown for female patients choosing acupuncturists.\(^25\)

We designed a study to test the impact of four factors (patient gender, practitioner gender, practitioner reputation and practitioner specialty) on patients' choice of practitioner to treat back pain. We hypothesized that

1. Female participants would prefer female physiotherapists and female chiropractors (as has been shown for other specialties).\(^8\)\(^11\)
2. Participants would prefer physiotherapists to chiropractors (as physiotherapy is established in conventional health care in England and chiropractic has received unfavourable press coverage in recent years concerning disputed claims about efficacy and safety).\(^26\)
3. Participants would prefer physiotherapists with a reputation for technical skills compared to those with a reputation for interpersonal skills (as has been shown for other conventional specialties).\(^18\)\(^19\) but they would prefer chiropractors with a reputation for interpersonal skills compared to those with a reputation for technical skills (consistent with the preference for caring therapeutic relationships among CAM users).\(^25\)\(^24\)

### Methods

Following Furnham et al.,\(^15\) we conducted a vignette-based questionnaire study with a mixed factorial design. Three within-subjects factors had two levels each: practitioner gender (male/female), practitioner type (physiotherapist/chiropractor) and practitioner reputation (technical ability/interpersonal skills). The between-subjects factor was respondent gender (male/female).

The questionnaire was adapted from a previous study.\(^25\) Participants were asked to imagine a scenario and answer three multiple-choice questions designed to check that they had read it (Box 1). Brief descriptions of eight fictional practitioners were presented, representing each combination of the practitioner factors (e.g. female physiotherapist with a reputation for being...

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**Box 1 Scenario for questionnaires**

Imagine that you have been suffering lower back pain recently. Your GP can’t offer you treatment, but does want to refer you on to a health centre for treatment from someone else. Both your doctor and a good friend recommend that you go to either a physiotherapist or a chiropractor.

Your doctor recommends two local NHS health centres, one a chiropractic centre and one a physiotherapy centre. Four practitioners work in each centre. They are all British and were born and raised in the UK. They all speak English as their first language. **All of the practitioners work in the NHS - you would not have to pay to see any of them.**

On the following page are the names of all eight practitioners and a brief sentence which sums up their reputation. The chiropractors are registered members of the General Chiropractic Council and the physiotherapists are registered members of the Health Professions Council. As members of these councils they are fully qualified and observe strict codes of practice.

Which symptom are you imagining while you do the questionnaire?

- Migraine
- Lower back pain
- Nasal congestion

Which professional body do all the chiropractors belong to?

- General Chiropractic Council
- Association of British Chiropractors
- British Chiropractic Society

Which professional body do all the physiotherapists belong to?

- General Medical Council
- British Physiotherapist Society
- Health Professional Council
easy to talk to). The dependent variable was the likelihood of consulting the practitioner (1 = never would make an appointment; 10 = certainly would make an appointment).

A checklist was used to identify which factors patients explicitly report as being important when choosing a practitioner. This checklist was designed to include all major factors that have been reported in the literature, namely, age, experience, ethnicity, safety record, qualifications, gender, clinician’s reputation as a good listener, clinician’s reputation as having good technical skills, proximity of clinic to home or place of work, ease of travel to the clinic, clinic appearance, convenient appointment times and length of wait to get an appointment. Half the respondents completed the checklist for both physiotherapists and chiropractors, and the remaining half was randomized to complete a checklist for either physiotherapists or chiropractors.

We recruited members of the general public, as most people will experience back pain in their lifetime and we wanted to avoid the possible biasing impact of recruiting through a health care setting—if invited by a practitioner, patients might be cued to focus on that practitioner’s characteristics when answering. We used a simple random sample of residential addresses in the Southampton postal area. The address database did not include names, ensuring complete anonymity but also meaning we could not address questionnaires to named individuals.

At power 0.8 and alpha 0.05, a sample size of 393 per group would allow us to detect a small between-groups effect; therefore, our target size was 786. We anticipated a 10% response rate because we were unable to re-contact non-responders or provide incentives. We randomly selected 10 000 residential addresses for screening against a mailing preferences list, after which study packs were sent to 8644 addresses. Packs contained the questionnaire, cover letter and free post reply envelope. The cover letter explained participants could answer an identical on-line version of the questionnaire if they preferred.

Questionnaires were screened for correct answers to the multiple-choice comprehension questions and missing data on the practitioner ratings. Data were entered into SPSS version 19. A four-way mixed analysis of variance (ANOVA) examined the effect of each factor (practitioner gender, practitioner specialty, practitioner reputation and respondent gender) on patients’ preferences. Past experience of physiotherapy and chiropractic were included as additional between-subjects factors. Bonferroni-adjusted pairwise comparisons were used to explore interactions.

To compare the proportion of respondents who rated each checklist item as important for physiotherapists and chiropractors, we conducted chi-square tests for participants who were randomized to complete a checklist for chiropractors (n = 189) or physiotherapists (n = 149) and McNemar tests (for the 317 participants who filled in two checklists, one for each practitioner type). We adjusted for the number of significance tests, maintaining alpha at 0.01.

Results

Participants

Of the 899 questionnaires received (10.4% response rate), 221 were excluded for answering one or more multiple-choice questions incorrectly and 21 were excluded for having not rated one or more of the practitioners, leaving a final sample size of 657. A further 69 respondents did not report their gender and so were excluded from analyses that included participant gender.

Participants were aged between 18 and 91 years (mean = 50.8 years, standard deviation = 15.0). More women than men took part and participants had achieved a range of educational qualifications, with a substantial minority (31%) not completing secondary level education (Table 1). The majority of participants had experienced back pain, one-third had experienced chiropractic and just more than half had experienced physiotherapy. Respondents who were excluded were significantly older, less likely to have completed tertiary education and more likely to report chronic illness. However, they did not differ from participants in terms of gender, presence of activity-limiting illness or history of back pain, chiropractic therapy or physiotherapy (see Supplementary Material).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>170</td>
<td>25.9</td>
</tr>
<tr>
<td>Female</td>
<td>418</td>
<td>63.6</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed secondary school</td>
<td>454</td>
<td>69.1</td>
</tr>
<tr>
<td>Completed university degree</td>
<td>208</td>
<td>31.7</td>
</tr>
<tr>
<td>Completed postgraduate education</td>
<td>79</td>
<td>12.0</td>
</tr>
<tr>
<td>Currently studying at university</td>
<td>29</td>
<td>4.4</td>
</tr>
<tr>
<td>Other qualifications (e.g. at work or evening class)</td>
<td>328</td>
<td>49.9</td>
</tr>
<tr>
<td>Health status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic illness or disability</td>
<td>314</td>
<td>47.8</td>
</tr>
<tr>
<td>Activity-limiting illness or disability</td>
<td>194</td>
<td>29.5</td>
</tr>
<tr>
<td>Any history of back pain</td>
<td>483</td>
<td>73.5</td>
</tr>
<tr>
<td>Ever had chiropractic therapy</td>
<td>222</td>
<td>33.8</td>
</tr>
<tr>
<td>Ever had physiotherapy</td>
<td>357</td>
<td>54.3</td>
</tr>
</tbody>
</table>

aTotal frequency does not sum up to 657 because of missing data.
What factors influence preferences for practitioners?

Table 2 presents the ANOVA results; the mean ratings across all combinations of factors are available as Supplementary Material.

**Hypothesis 1: Gender concordance**

There was no main effect of participant gender, indicating that male and female respondents’ ratings were in general the same. Overall, participants demonstrated a small but significant preference for female practitioners over male practitioners, but this effect differed by participant gender: female participants had a statistically significant preference for female practitioners ($M = 7.15$, SEM = 0.08) to male practitioners ($M = 6.69$, SEM = 0.08), but male participants were not influenced by practitioner gender (female practitioners $M = 6.70$, SEM = 0.12; male practitioners $M = 6.64$, SEM = 0.12).

The effect of practitioner gender was also influenced by the practitioner’s reputation, as shown by a significant two-way interaction. For practitioners with a reputation for technical skills, there was a small but significant preference for male practitioners ($M = 8.48$, SEM = 0.08) over female practitioners ($M = 8.20$, SEM = 0.07). The opposite preference emerged for practitioners with a reputation for interpersonal skills; here, participants preferred female practitioners ($M = 5.65$, SEM = 0.10) to male practitioners ($M = 4.85$, SEM = 0.11).

**Table 2**  
ANOVA of main effects and significant interactions showing influence of practitioner and participant factors on participants’ preferences

<table>
<thead>
<tr>
<th></th>
<th>$F$</th>
<th>$P$</th>
<th>Partial $\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All main effects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant gender</td>
<td>3.48</td>
<td>0.06</td>
<td>0.01</td>
</tr>
<tr>
<td>Previous experience of chiropractic</td>
<td>0.71</td>
<td>0.40</td>
<td>0.00</td>
</tr>
<tr>
<td>Previous experience of physiotherapy</td>
<td>2.11</td>
<td>0.15</td>
<td>0.00</td>
</tr>
<tr>
<td>Practitioner gender</td>
<td>42.07*</td>
<td>&lt;0.001</td>
<td>0.069</td>
</tr>
<tr>
<td>Speciality</td>
<td>32.69*</td>
<td>&lt;0.001</td>
<td>0.055</td>
</tr>
<tr>
<td>Reputation</td>
<td>800.23*</td>
<td>&lt;0.001</td>
<td>0.585</td>
</tr>
<tr>
<td><strong>Significant two-way interactions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner gender × Participant gender</td>
<td>23.93*</td>
<td>&lt;0.001</td>
<td>0.040</td>
</tr>
<tr>
<td>Male participants, effect of practitioner gender</td>
<td>0.90</td>
<td>0.34</td>
<td>0.002</td>
</tr>
<tr>
<td>Female participants, effect of practitioner gender</td>
<td>110.16*</td>
<td>&lt;0.001</td>
<td>0.163</td>
</tr>
<tr>
<td>Practitioner gender × Reputaion</td>
<td>19739*</td>
<td>&lt;0.001</td>
<td>0.258</td>
</tr>
<tr>
<td>Technical skills, effect of practitioner gender</td>
<td>29.58*</td>
<td>&lt;0.001</td>
<td>0.050</td>
</tr>
<tr>
<td>Interpersonal skills, effect of practitioner gender</td>
<td>173.07*</td>
<td>&lt;0.001</td>
<td>0.234</td>
</tr>
<tr>
<td>Practitioner gender × Speciality</td>
<td>6.62</td>
<td>0.01</td>
<td>0.012</td>
</tr>
<tr>
<td>Male practitioners, effect of specialty</td>
<td>39.86*</td>
<td>&lt;0.001</td>
<td>0.066</td>
</tr>
<tr>
<td>Female practitioners, effect of specialty</td>
<td>19.49*</td>
<td>&lt;0.001</td>
<td>0.033</td>
</tr>
<tr>
<td>Speciality × Participant gender</td>
<td>4.58</td>
<td>0.03</td>
<td>0.008</td>
</tr>
<tr>
<td>Chiropractors, effect of participant gender</td>
<td>5.41</td>
<td>0.02</td>
<td>0.009</td>
</tr>
<tr>
<td>Physiotherapists, effect of participant gender</td>
<td>0.52</td>
<td>0.47</td>
<td>0.001</td>
</tr>
<tr>
<td>Speciality × Previous physiotherapy</td>
<td>12.02*</td>
<td>&lt;0.001</td>
<td>0.021</td>
</tr>
<tr>
<td>No previous physiotherapy, effect of specialty</td>
<td>2.13</td>
<td>0.15</td>
<td>0.004</td>
</tr>
<tr>
<td>Previous physiotherapy, effect of specialty</td>
<td>51.93*</td>
<td>&lt;0.001</td>
<td>0.084</td>
</tr>
<tr>
<td>Speciality × Previous chiropractic</td>
<td>4.83</td>
<td>0.03</td>
<td>0.008</td>
</tr>
<tr>
<td>No previous chiropractic, effect of specialty</td>
<td>46.7*</td>
<td>&lt;0.001</td>
<td>0.076</td>
</tr>
<tr>
<td>Previous chiropractic, effect of specialty</td>
<td>4.68</td>
<td>0.03</td>
<td>0.008</td>
</tr>
<tr>
<td>Speciality × Reputaion</td>
<td>123.90*</td>
<td>&lt;0.001</td>
<td>0.179</td>
</tr>
<tr>
<td>Technical skills, effect of specialty</td>
<td>9744*</td>
<td>&lt;0.001</td>
<td>0.147</td>
</tr>
<tr>
<td>Interpersonal skills, effect of specialty</td>
<td>0.22</td>
<td>0.636</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Significant three-way interactions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner gender × Speciality × Participant gender</td>
<td>4.45</td>
<td>0.04</td>
<td>0.008</td>
</tr>
<tr>
<td>Male participants, effect of specialty</td>
<td>20.40*</td>
<td>&lt;0.001</td>
<td>0.035</td>
</tr>
<tr>
<td>Female participants, effect of specialty</td>
<td>18.01*</td>
<td>&lt;0.001</td>
<td>0.031</td>
</tr>
<tr>
<td>Female practitioners, effect of specialty</td>
<td>21.58*</td>
<td>&lt;0.001</td>
<td>0.037</td>
</tr>
<tr>
<td>Female practitioners, effect of specialty</td>
<td>2.45</td>
<td>0.12</td>
<td>0.004</td>
</tr>
<tr>
<td>Reputation × Speciality × Previous chiropractic</td>
<td>5.17</td>
<td>0.02</td>
<td>0.009</td>
</tr>
<tr>
<td>No previous chiropractic, technical reputation, effect of specialty</td>
<td>120.14*</td>
<td>&lt;0.001</td>
<td>0.175</td>
</tr>
<tr>
<td>No previous chiropractic, interpersonal reputation, effect of specialty</td>
<td>0.11</td>
<td>0.74</td>
<td>0.000</td>
</tr>
<tr>
<td>Previous chiropractic, technical reputation, effect of specialty</td>
<td>18.52*</td>
<td>&lt;0.001</td>
<td>0.032</td>
</tr>
<tr>
<td>Previous chiropractic, interpersonal reputation, effect of specialty</td>
<td>0.67</td>
<td>0.41</td>
<td>0.001</td>
</tr>
</tbody>
</table>

*For all tests, degrees of freedom, df = 1, 567.

* $P < 0.01$. 
Hypothesis 2: Practitioner specialty
There was a small but significant effect of specialty: in general, participants were more likely to consult physiotherapists than chiropractors. However, this was influenced by gender, the participant’s previous experience of physical therapies and the practitioner’s reputation. There was a significant three-way interaction among participant gender, practitioner gender and practitioner specialty: practitioner gender was more important than specialty for female participants, but practitioner specialty was more important than gender to male participants (see Supplementary Material for means).

The interactions among specialty, previous experiences of therapies and practitioners’ reputation revealed additional circumstances influencing the general preference for physiotherapists over chiropractors. Among practitioners with a reputation for technical skills, physiotherapists were preferred to chiropractors and this preference was stronger among participants who had not previously experienced chiropractic. However, the preference for physiotherapists over chiropractors was not found for practitioners with a reputation for interpersonal skills or among participants who had not experienced physiotherapy before.

Hypothesis 3: Practitioner reputation and specialty
Practitioner reputation had a moderate to strong effect29 on patients’ preferences: in general, participants were more likely to consult practitioners with a reputation for technical expertise (M = 8.34, SEM = 0.07) compared to those with a reputation for interpersonal skills (M = 5.25, SEM = 0.10). Contrary to our hypothesis, this effect held across both chiropractors and physiotherapists.

What factors do people report considering when choosing practitioners?
A similar proportion of respondents rated each factor as important when considering physiotherapists compared to chiropractors. The only significant difference was among respondents who completed checklists for both chiropractors and physiotherapists, slightly more of whom rated experience as important for physiotherapists (93%) than chiropractors (86%). Overall, practitioners’ experience and technical skills were most commonly rated as important (by >80% of respondents), being a good listener was rated as important by approximately one-third of respondents and practitioners’ personal characteristics (gender, age and ethnicity) were thought to be important by <10% of respondents.

Discussion
Summary of main findings
Consistent with Hypothesis 1, female respondents preferred female practitioners. However, practitioner gender had no effect on male respondents’ preferences and, although statistically significant, the effect of practitioner gender was small even among the female participants. Furthermore, only a small minority of respondents explicitly stated that gender was important when choosing a physiotherapist or chiropractor. Consistent with Hypothesis 2, respondents had a general preference for physiotherapists over chiropractors. This was stronger among men than women and among people who had previously experienced physiotherapy. Overall, however, these effects were small. Hypothesis 3 received mixed support. The practitioner’s reputation had a large effect on respondents’ preferences and practitioners with a reputation for technical skills were strongly preferred over those with a reputation for interpersonal skills. Surprisingly, this was true for both physiotherapists and chiropractors; similarly, respondents consistently reported that they considered a practitioner’s qualifications and technical skills important and only just less than a third thought it important that a practitioner was a good listener.

Strengths and limitations of the study
The study suffered from a very low response rate, which questions the extent to which our sample represents the general population; compared to census data, women and older adults were over-represented in our study; compared to national figures, which suggest 60% of community-dwelling adults report chronic illness,30 adults without a chronic illness were slightly over-represented in our study. Further analysis suggested that, within our sample, older people and those without chronic illness had small but statistically significant tendencies to rate all practitioners slightly lower. This suggests that, compared to the general population, we might have slightly underestimated the likelihood of consulting. Sampling directly from the general population and not using any follow-up mailings or incentives probably contributed to the low response rate and these points should be addressed in future studies.31 Overall, we obtained a large sample size and screened responses to ensure only those who comprehended the vignette-based scenario were included in the analyses. We tested hypotheses about possible multiple influences on choice of individual practitioner using an experimental design in the context of musculoskeletal primary health care.

Comparison with existing literature
In general, our findings are broadly consistent with previous literature and provide new evidence regarding the factors that influence patients’ choice of individual practitioners of conventional and CAM therapies. The gender concordance preference that we found for female respondents is consistent with that reported for other practitioners including primary care doctors.8–11 The general preference for physiotherapists over chiropractors is consistent with the survey evidence that although CAM modalities such as chiropractic are
popular, they are used by a minority of the general public.\textsuperscript{32} The finding that patients preferred physiotherapists and chiropractors with technical skills over those with a reputation for good interpersonal skills is slightly surprising, given the emphasis on patient–practitioner relationships in surveys of satisfaction with chiropractic therapy\textsuperscript{33,34} and the broader CAM literature.\textsuperscript{18,19} However, it is consistent with more directly comparable studies in conventional medicine\textsuperscript{18,19} and might be related to misperceptions of chiropractic as a risky therapy.\textsuperscript{35} Overall, we found that similar factors were considered important by patients choosing an individual practitioner, whether a conventional (physiotherapist) or a CAM practitioner (chiropractor). This contrasts with a qualitative study of chronic rheumatology patients, in which decision-making processes regarding treatment selection differed across three groups of patients, those who use conventional medicine, those who use complementary medicine, and those who use both conventional and complementary medicine.\textsuperscript{22} This difference may be a function of the musculoskeletal context of our study, as some patients see musculoskeletal CAM therapies as more akin to conventional medicine than other CAM therapies.\textsuperscript{35} It might also be because we described our fictional chiropractors and physiotherapists as working in the NHS, whereas previous studies of CAM use have often, but not always, occurred in the private sector.\textsuperscript{36}

**Implications for future research and clinical practice**

Primary care providers should provide the sort of information that patients find relevant to support them when choosing an individual physiotherapist or chiropractor. Musculoskeletal practitioners could consider highlighting their qualifications and technical expertise in materials for potential patients, e.g. by describing their training and depth and breadth of professional experience (while of course remaining within professional codes of conduct). Our findings suggest that similar factors are important to patients. Whether they are choosing an individual chiropractor or physiotherapist, patients most value information about a practitioner’s level of technical competence, but patients are also influenced by their gender and specialty. An awareness of these factors should help providers support patients in choosing individual chiropractors and physiotherapists.

**Supplementary material**

Supplementary material is available at *Family Practice* online.

**Acknowledgements**

We would like to thank the participants and Gemma Fitzsimmons and Lucy Cousins for research assistance. This study was completed in partial fulfilment of RS’s BMedSci degree.

**Declaration**

Funding: University of Southampton School of Medicine and the Primary Care and Population Sciences unit. FLB’s post was supported by Arthritis Research UK (Career Development Fellowship 18099). GTL’s post was supported by a grant from the Rufford Maurice Laing Foundation.

Ethical approval: Ethics approval was granted by the University of Southampton’s School of Medicine Ethics Committee (SOMSEC081.10).

Conflict of interest: none.

**References**