Was erwarten Patienten,

die in die osteopathische Praxis kommen?

Eine qualitative Studie

Masterthesis zur Erlangung des Grades
Master of Science in Osteopathie

an der **Donau- Universität Krems**

niedergelegt

an der **Wiener Schule für Osteopathie**

von **Anja Meuser**

Esthal, Dezember 2008

Betreut von Mag. Katharina Musil und Mag. Heidi Clementi

Übersetzt von Lynda Oberfrank

Eidesstattliche Erklärung

Hiermit versichere ich, die vorgelegte Masterthese selbständig verfasst zu haben.

Alle Stellen, die wörtlich oder sinngemäss aus veröffentlichten oder nicht veröffentlichten Arbeiten anderer übernommen wurden, wurden als solche gekennzeichnet. Sämtliche Quellen und Hilfsmittel, die ich für die Arbeit genutzt habe, sind angegeben.

Die Arbeit hat mit gleichem Inhalt noch keiner anderen Prüfungsbehörde vorgelegen.

15.11.2008

Anja Meuser

Anja Meuser

What do patients expect who come to an osteopathic clinic?

ABSTRACT

This study deals with the issue of what patients expect in the osteopathic clinic. It is mainly a question of what the patients expect from the treatment and their expectations concerning the osteopaths. The reasons why a person decides to let her-/himself be treated by an osteopath and why patients choose an particular osteopath will also be discussed.

In a qualitative manner eight patients were interviewed using an interview guide. The results of the interviews were assigned to different categories.

The categories are about the way, the patients have been gone until they decide to choose osteopathic treatment, which criteria are important for the patient, when choosing an osteopath and the main question, their expectations regarding the osteopathic treatment.

The study shows that patients mainly seek out an osteopath which has been recommended by other people. They look for a gentle and constant solution for their problem, through osteopathic therapy and also advice on avoiding making mistakes in everyday life, so that they may be able to eliminate the cause of their problem.

In order to receive ideal treatment quality, patients expect their therapists to have a good education. They put less emphasis on brand names and titles of the osteopath.

The osteopaths' sympathy and friendliness are perceived as being important, and a friendly furnished treatment room is considered to be important, in order to relax whilst having treatment.

Key Words:

expectations, patients, qualitative study, satisfaction, motivation

Anja Meuser

Was erwarten Patienten, die in die osteopathische Praxis kommen?

ABSTRACT

Diese Studie beschäftigt sich mit dem Thema, was Patienten erwarten, die in die osteopathische Praxis kommen. Dabei geht es insbesondere darum, was sie von der osteopathischen Behandlung erwarten und welche Erwartungen sie bezüglich des Osteopathen/der Osteopathin haben.

Auch den Motivationsgründen wird nachgegangen, die die Patienten dazu bewegen, sich osteopathisch behandeln zu lassen und einen bestimmten Osteopathen oder eine bestimmte Osteopathin aufzusuchen.

Im qualitativen Stil wurden mittels leitfadengestützter Interviews acht Patienten befragt.

Die Ergebnisse der Interviews wurden verschiedenen Kategorien zugeordnet.

Die Kategorien beschäftigen sich damit, welchen Weg die Patienten gegangen sind bis sie zur osteopathischen Behandlung gekommen sind, welche Kriterien für die Patienten wichtig sind bei der Auswahl eines Osteopathen/ einer Osteopathin, bis hin zu den Kernfragen der Erwartungen, die sie an den Osteopathen/ die Osteopathin stellen und welche Erwartungen sie bezüglich der osteopathischen Behandlung haben.

Die Analyse zeigt, dass die Patienten hauptsächlich aufgrund von Empfehlungen durch andere Personen einen bestimmten Osteopathen/ eine bestimmte Osteopathin aufsuchen. Sie versprechen sich eine anhaltende Problemlösung auf sanfte Weise durch die osteopathische Behandlung, sowie eine Beratung zur Fehlervermeidung im Alltag, um die Ursachen ihrer Beschwerden ausschalten zu können.

Um eine optimale Behandlungsqualität zu erhalten, legen die Patienten Wert auf eine gute Ausbildung ihres Therapeuten. Sie legen jedoch weniger Wert auf Titel oder Markenbezeichnungen des Osteopathen/der Osteopathin.

Sympathie und Freundlichkeit des Osteopathen/der Osteopathin werden als wichtig empfunden. Auch ein freundlich eingerichtetes Behandlungszimmer empfinden die Patienten als wichtig, um sich während der Behandlung entspannen zu können.

Schlüsselwörter (keywords):

Erwartungen, Patienten, qualitative Studie, Zufriedenheit, Motivation

A big thank-you to…

...my parents, who by giving me their support, made my participation on the masters' course at all possible and who lovingly cared for my little son Noah whilst I was away.

…My dear husband Marko, who at the same time was in much greater stress than I was and was allowed to/ had to witness my many ups and downs.

…My little son Noah, who had to spend too much valuable time without his mother and whom I often missed.

… Nicole and Guido, who always managed to resolve my lap tops' technical problems and who also, supported me with their airport taxi services.

Concerning things which are not perceptible and concerning mortal things
Only the Gods have clarity,
but we as humans are only allowed to unlock.

Alcmaeon
(Greek Physician and Philosopher Scientist around 500 BC)

Foreword

The subject "patient expectations" was discussed in a psychology class, part of the master course for osteopathy at the Vienna School of Osteopathy. One can say that no one really had an answer to what patients expect from osteopaths. This left a big question mark in its place.

My interest on this subject was awakened and I decided to make it the subject of my master thesis.

Whilst doing my research I continued to find that most master theses concerned themselves with the effect of osteopathic therapy, clinical investigations of certain illnesses and questions concerning osteopathic techniques employed, but matters directly relating to the patient as the central person were hardly ever provided. Osteopathy with its claim of viewing everything in a holistic manner, should -as I mean-especially not lose sight of this aspect.

As one can see in the following study, patient expectations can be more or less of help whether they are satisfied with the treatment or not. The result of treatment can also be influenced through patient expectations.
These relationships are explained in the theoretical part of this study.

I hope that this master thesis will help osteopaths to have an listening ear for the expectations of their patients and that the findings herein will be used in a positive sense.

Index of Contents

1 Introduction

The subject "patient expectations" is a central issue in patient therapy. The literature research showed that there have been many studies preoccupied with this subject, most of which were in the orthodox medical area. Whereby the cohesion between patients' expectations and their satisfaction plays a role time and time again.

Several studies deal among other things with the issue patients-satisfaction in connection with fulfilled or unfulfilled expectations.
(Baker, 1998; Rao et al., 2000 ; Sigrell, 2001; Sigrell, 2002; Perron et al., 2003 ; Richardson, 2004; Zebiene et al., 2004)
Zebiene et al. (2004) examined this connection, in Lithuania, in the area of general medicine and determined, that a correlation exists between meeting patient expectations and higher satisfaction: *„ ...the results of our study demonstrate that the relationship between some of the expectations met and the satisfaction index actually exists. This supports our initial hypothesis that the more expectations are met, the more satisfied is the patient.* " (Zebiene et al., 2004, p.87-88)
Several studies continue to demonstrate, in turn, that patient satisfaction, significantly contributes to the outcome of the treatment. (Richardson, 2004; Perron et al., 2003; Licciardone et al., 2002; Ruiz-Moral et al., 2007)
This aspect was reason enough, to take the subject "patient expectations" seriously and to shed further light on the issue.

Patients have expectations concerning both the osteopaths and osteopathic therapy. Each patient comes to an osteopath with a different background history and previous experiences. This means that expectations vary individually.

Hrabal (2007) expresses, how important previous experiences can be in the "Doctor-Patient Relationship" as follows: *"The doctor-patient relationship is affected on the patients half, through anticipations which are a direct result of previous experiences with doctors. These form the basis for successful or unsuccessful doctor-patient relationships in the future and for cooperative or non-cooperative patient behaviour toward the doctor (compliance)''* (Hrabal, 2007, p.28-29)

Patient expectation is a subject which should be of interest to every practising osteopath, regardless of how long they have been practising or which kind of treatment they may use.

This study will endeavour to highlight how these expectations may have been created and out of which 'building blocks' they are composed. At the same time, interest also lies on the questions, where and how patients collected the information, which ultimately formed their expectations.

If expectations were discussed with the patients, they would be able to benefit from it. This view is underlined by Richardson (2004), who writes:

„Physicians´ understanding of patients´ expectations of complementary therapies will help patients make appropriate and realistic treatment choiches.“

(Richardson, 2004, p.1049)

Adequate and realistic decisions regarding therapy could help patients come a little closer to achieving their goals.

The outcome of therapy is considerably influenced by individual expectations:

„Because expectations of both practitioner and patient influence the outcome of an intervention, understanding the expectations and clarifying the limitation of treatment are important.“ (Richardson, 2004, p.1050)

Westhoff (1985) defines the expression 'expectation', as the idea which an individual has of a possible future event. At the same time, motivations that a person has are also expressed. He describes the fact, that expectations partially control human behaviour.

This study should shed light on what patients expect from therapy and from osteopaths, so that the therapist can consciously and more effectively, work together with the patient toward a defined goal.

This leads to following questions:

- What do patients expect from osteopathic treatment?
- What do patients expect from osteopaths?

2 „Expectations“ from a Sociological Point of View

Westhoff (1985) has extensively dealt with the importance of the expectation concept. He made a brief, concise definition of what an expectation is:

An individuals´ expectation is „*...an idea that one has of a possible future event.*“ (Westhoff, 1985, p.12)

Here the word „expectation“ tends to explain behaviour used, particularly as part of learnt, planned behaviour, as well as „ *...a necessary but not sufficient condition for a decision. Even if people can imagine a possible future event connected with a choice of an alternative, then they need help with the approach and process of making certain decisions.*“ (Westhoff, 1985, p.44)

Even motivation psychology deals with the causes and reasons for human behaviour and action. The concept of "motivation“ (lat. movere = to move) is closely related to the concept of expectation.

One of the first „motivation theorists“, the philosopher Epicurus (342-270 BC) assumed, „*...that we act in order to give ourselves pleasure and joy.*“

(Rudolph, 2007, p.2)

Therefore it would seem to be a fundamental human expectation that through ones actions, one gains positive experiences and avoids unpleasant ones.

This principle is also referred to, in philosophy, as „Hedonism“ or the „Pleasure-Pain-Principle“: „*We have expectations about the consequences of our actions, and these expectations control our actions. We behave according to Epicurus, so that expected consequences (the sum of possible positive and negative consequences) result in the most favourable outcome.*“ (Rudolph, 2007, p.2-3)

According to Westhoff (1985), expectations have different facets, based on the „proposed“ events: Assessment of subjective probability, temporal proximity, duration and importance.

These various facets according to Westhoff (1985) are explained and linked to the issue of patient expectation, in more detail below.

Assessment: A human goes through a process of evaluation regarding a possible future event; however the evaluation is still alterable.

This alteration may occur through an experience with this incidence, through information supplied from outside or influenced through ones own new associations.

In the case of a patient for example, the possible effects of therapy could be assessed. This assessment might be done through information received from outside or through other patients who one has been approached by, or even be influenced by various associations that one has. This means one combines a variety of information from which one then makes a certain image.

The event (e.g. the therapy) could eventually be differently evaluated with new information.

The assumption that targets in the evaluation process play a role brings with it that the evaluation may change if the individual gives other goals priority.

Control of human behaviour is seen as a function of individual assessment.

The evaluation ultimately shows whether an event is seen as positive or negative, an attractive or an unattractive option.

In order to accurately differentiate these classifications, humans go through a comparison process in which other previous events play a role.

These for example could be other therapies which the patient has already tried out or information which they have become through media or other people in their immediate environment.

The results of previous events are brought together from individuals and form a new evaluation.

Subjective probability: Expectation in literature is often the concept of ‚subjective probability'.

Temporal proximity: The future event can be more or less far into the future. The temporal proximity can, according to Westhoff (1985) have an influence on the assessment. Accordingly the same events which were more or less near in the future were evaluated differently. He however found contradictory statements in literature, which is why i will not go into this in depth.

Duration: The events duration can be more or less long.

Importance: The importance of an event is different for every human being. An individual will try to assess the importance for them self, by considering whether or not it can help in their target achievement or equates to their own values.

This even happens to patients who have to decide for themselves whether or not osteopathy can help bring them come closer to their own individual targets and whether the way in which this is done, accords to their own ideas.

„Disappointment" is encountered if this perception was incorrect and therefore led to expectations not being met.

The description of the different facets of the concept of expectation shows that a brief clarification of definitions is hardly feasible because of the many given factors.

A somewhat detailed description of the definition of expectation is given by Westhoff (1985): *"Expectations are mostly a subset use of cognition, ideas, thoughts, reflections, attitudes and sets. They are distinguished by targets, intentions, aims, beliefs, opinions, desires and standards. Expectations are listed as being parts of plans and in a lot of studies they are equalled to the concept of hypothesis."* (Westhoff, 1985, p.10)

To sum it up one could say that the concept of „expectation" describes the idea that a person has of a particular event, which may lay more or less in the future. The expectation follows a process of evaluation, through which a person behaves in a particular fashion in order to come to a decision. At the same time the importance, temporal proximity and duration of the event also play an important role. The expectations thus control the action, because a particular act in itself is the consequence of a certain target adopted.

2.1 The Advanced Cognitive Motivation Model according to Heckhausen

In the search for material concerning the role expectations play in the patients therapy process one find works in the psychological field which are about motivation.

The advanced cognitive motivation model is a general model which is usually mentioned when analyzing students learning motivation.

However as it is a general psychological model, it can also be transferred to address the patients´ situation.

The advanced cognitive motivation model describes the process which a person undergoes in order to attain a certain result. (Rheinberg, 2006)

It consists of four basic building blocks, through which the act can be predicted:

- The perceived situation
- Possible action
- Outcome of this action
- Consequences which are likely to result through this action

The assumption with which likelihood an action in a particular result ends is called Action- Result- Expectation. One could also say the „Probability of Success" a concept which comes from the area of achievement motivation. The assumption of how the situation may evolve without intrusive action is called Situation- Result- Expectation. (Rheinberg, 2006)

The outcomes attractiveness always depends on its consequences.

Transferred to patients one could say that the desired result in most cases is symptom relief. For those who have high situation-result-expectations the motivation to start an osteopathic treatment is very low, because through their current situation they already assume the expected outcome (possible reasons: other therapies, other measures which they practise at home themselves). A further therapy would be superfluous.

This would be different with the action- result- expectancy behaviour. The action would in this case be the osteopathic treatment. The patient believes that therapy has a significant influence on the outcome, namely alleviation of a complaint.

Thus motivation for therapy would be very high before treatment, in the action-result-expectancy category: *„The greater the action -result-expectancy the stronger the tendency to act. Whether or not this actually happens depends upon how important the outcome appears. This is determined by the consequences which result from the actors' point of view."* (Rheinberg, 2006, p.133)

Action-Result-Expectation should therefore be greater depending on the degree of suffering and how much the patients every day life is being restricted through his problem. Finally there is also the Result-Consequence-Expectancy, namely the expectation that a reached result will have a consequence. (Rheinberg, 2006)

In a patients case for example, this would mean the assumption that the outcome, namely symptom relief, will have a certain consequence. For instance that the patient may now be able to perform certain activities again due to symptom relief. *„The higher the Result Consequence Expectancy, the stronger the tendency to act."* (Rheinberg 2006, p.133)

A role is also played by the context of the incentive to Result-Consequence-Expectations.

The incentive of any consequence will firstly assess the probability; the question is whether the desired results are really established.

In the patients` case the attractiveness of the incentive would further enhance the motivation leading to action.

„...summarized this model says that a persons tendency to act becomes greater depending on how sure result consequences with a high incentive will follow, and even more so if the results are dependent on their own actions and not dependant on the course of things alone." (Rheinberg, 2006, p.133-134)

Based on patients this means that the incentive value must be very high, which in most cases means improvement of symptoms or maybe even freedom from them and includes active participation of the patient.

Summarizing one can say that the Action- Result- Expectancy describes the likelihood that an action (for example osteopathic treatment) leads to a certain outcome (e.g. pain relief).
If the outcome (e.g. pain relief.) is classified as very important and probable, and special consequences are expected (e.g. the possibility of being able to perform certain activities again) (= Result-Consequence-Expectation), incentive and motivation are probably very high for the action.

2.2 Perceived Self-Efficacy

Schwarzer (2004) describes the role of active participation in Banduras' social cognitive model. To explain this in further detail would certainly go too far in case of this study. But the notion of perceived self-efficacy which is contained therein should be more accurately studied.

The concept of perceived self-efficacy is defined as: *„ ...to be able to cope with new or difficult situations with a subjective certainty based on their own competence requirements. [...] The situation requirements are not tasks that are solved by a simple routine; effort and endurance are required for those whose degree of difficulty requires action in order to cope with the demand. [...] Then cognitive, motivational, emotional and actional processes can be controlled by subjective beliefs, especially by action-profit-expectations or outcome expectancies and perceived self-efficacy.* " (Schwarzer, 2004, p.12)
Difficult situations should therefore be tackled with active participation from the person itself. In order to solve a problem, complex processes are required, as we are talking about difficult situations, whereby perceived self-efficacy makes a positive contribution to performance results. (Schwarzer, 2004)
Therefore it makes sense to use patients' perceived self-efficacy in the situation between patient and therapist, in order to encourage active therapy participation. According to Schwarzer (2004) perceived self-efficacy is the fundamental requirement to be able to enforce new, creative ideas and stamina. This represents a fundamental requirement for high motivation and a high level of performance.

Four different sources can be used to build high self efficacy expectations. (Schwarzer, 2004):

- ***Measured success experience:*** One must convey achievements to the person involved, which can be attributed to his or her own efforts and abilities, this can be best done through goals which can be reached quickly and fostering coping strategies.
- ***Deputy experiences:*** Through observation of behaviour models, deputy experiences can be made and imitation is recommended.
- ***Persuasion:*** One tries to verbally convince someone that a certain thing can be achieved and this motivates them. Although the success of this is subject to the person who attempts this, art of conviction.
- ***Perception of ones own emotions:*** The perception of ones own emotions can provide information about ones own behaviour in critical situations.

This perceived self-efficacy model is a theoretical model, which has already been used in many areas, since it responds to basic behaviour and motivation in humans. (Schwarzer, 2004) If one built these ideas into the treatment situation between osteopath and patients it could positively affect the effectiveness and outcome of therapy.

An important factor would be for the patient to be actively involved in the treatment process and not just to be seen as a passive person who is being treated.

The osteopath could give the patient guiding tasks or strategies which required the patients own active involvement and would in turn help them to experience success attributed to their own power.

In this particular case, exercises which the patient carries out at home, nutrition tips which they must follow at home or other changes which they must build into their everday lives.

3 „Expectations“ in the Context of Patient-Therapist

The subject “expectations” in context patient-therapist is a central theme in this master thesis, since it contains essential aspects which are needed in order to answer important questions. Expectations can emerge and change through experiences which one has and the influences to which one is subjected. They develop during the course of ones life through faith and value concepts. A persons´ expectations are dependent on what ideas they have about what may happen. (Baker, 1998; Sigrell, 2001)
A patients´ personality even plays an essential role: age, education, ethnicity, health concern, vulnerability, experience, knowledge and the amount and nature of symptoms. The current health care system, the doctor and the relationship to the patient also plays a role. (Ruiz- Moral et al., 2007)
Patients´ satisfaction often depends on whether their own expectations are met or not. (Baker, 1998; Rao et al., 2000; Richardson, 2004;Sigrell, 2001; Sigrell, 2002; Perron et al., 2003; Zebiene et al., 2004)
Zebiene et al. (2004) investigated this relationship, in Lithuania, in the area of general medicine and found that there is a connection between meeting patients expectations associated with higher satisfaction: *„ ...the results of our study demonstrate that the relationship between some of the expectations met and the satisfaction index actually exists. This supports our initial hypothesis that the more expectations are met, the more satisfied is the patient. “*
(Zebiene et al., 2004, p.87-88)
In this study most patients expected “information”, “explanations and understanding“, „emotional support“ as well as „diagnosis and treatment“.
Sigrell (2001) stresses that the measurement of patient satisfaction is one possible way to be able to improve the quality of health care.
Even physical symptoms can be influenced by the expectations that an individual brings with them to the practise.
Kravitz et al (1996) investigated which factors influence expectations in the medical practice. In 74 % of cases it depended on the nature of the patients complaints (intensity, functional limitation, and seriousness of symptoms). Patients felt that it was important how big the susceptibility to illness was, depending on things like: age, previous diagnosis, family specific burdens and their lifestyles.

Patients also put previous experiences in immediate connection to their expectations as well as knowledge that had been passed on through: education, conversations with friends, relatives, other doctors and media.

The reason why it is important to study factors which affect patient expectations is explained by Kravitz et al. (1996) as follows: *„Obtaining a more thorough understanding of this process is important fort two reasons. First it may sensitize physicians to patients' concerns and facilitate more effective communication and clinical care; second, it could lead to strategies for helping patients form more consistently reasonable expectations in this era of limited medical resources."* (Kravitz et al., 1996, p.730)
Therefore it is of advantage for therapists to know their patients expectations in order to better understand their needs and to improve communication. Patients can thus be helped to have appropriate expectations.

Jackson and Kroenke (2001) studied in contrast, what patients unfulfilled expectations can lead to. This study was also in the general medicine area, specifically for patients with physical symptoms. Patients preferentially expected: diagnosis, prognosis, diagnostic tests, prescriptions and referral to specialists. Patients whose expectations had not been met during their visit to the clinic and which were still not fulfilled two weeks later were generally dissatisfied with the care. Giving diagnostic and prognostic information led to a reduction of serious disease concerns directly after the visit, fewer return visits, increased satisfaction and system relief.

Patients are guided by memories of previous experiences when they have to make decisions about therapy and its alternatives. Previous experiences which were not good have a negative impact on patients' cooperation and treatment results. (Baker, 1998) This is also confirmed by Rao et al. (2000) in their literature study on patients' expectations: *„Dissatisfied patients are less likely to comply with medical advice, to follow up with appointments, and to show symptom improvement, and they are more likely to change health care systems or physicians."* (Rao et al., 2000, p.1)
The therapist must therefore find out what his patients' expectations are, as the patient may not necessarily express their expectations by them self: *„ ...your patients*

may be dissatisfied because you have not lived up to their expectations, even though they haven't explicitly stated them to you. " (Baker, 1998, p.72)

To be able to perceive and respond to patients expectations as a therapist, can positively affect ones relationship to the patient: *„ Understanding how expectations are created, responding to those expectations, and influencing expectations are important factors in developing mutually beneficial relationships with your patients.* " (Baker, 1998, p.3)

Even the therapists´ ability to communicate can more or less contribute to patient satisfaction. The components which are meant here are things like the ability to address patients´ needs and expectations, ways of communication and human relationships in general. The therapists´ technical skills may also be of help. (Rao et al., 2000)

A study in Switzerland about patients expectations revealed precisely that therapists communication and perception skills are rather poorly trained: *„ Physicians had inaccurate perceptions of their patient´s expectations, regardless of patient´s origin.[...] However, physicians in our study were generally poor at identifying patients´ expectations...[...] Physicians both failed to identify patients´ expectations (underestimation) and erroneously identified expectations where they were absent (overestimation)"* (Perron et al., 2003,p.1-3)

Clinical decisions can also be influenced by the therapists´ perception of a patients´ expectations.

Cockburn and Pit (1997) found out that doctors tend to write prescriptions for medication for patients if they assessed a patient as wanting this than for patients who they assessed would not.

The study of Rao et al. (2000) demonstrates that patients often come to a practise with very specific ideas: *„ Several studies suggest that patients often have a specific agenda when they visit their physicians. This agenda includes the particular problems that the patients would like the physician to address; their concerns about the cause, seriousness, or prognosis of those problems, and their desire for specific actions. (ie, test ordering, prescription of medication, referral to a specialist, providing a work excuse)"* (Rao et al, 2000, p.2)

As one can see further above, expectations and patient satisfaction are directly related. Several studies show that patient satisfaction can significantly contribute to the outcome of treatment. (Richardson, 2003; Perron et al., 2003; Licciardone et al., 2002; Ruiz-Moral et al., 2007)

Ruiz-Moral et al (2007) come through their study to the statement, that fulfilling the expectations of treatment, has even more influence than other factors do. This study was conducted in Spain in the general medical field. Patients mainly expected:
"...the doctor showing interest and listening (30.5%), getting some information about the diagnosis (16.3%) and sharing problems and doubts (11.5%). "
(Ruiz-Moral et al, 2007, p.86)
They conclude that most expectations involve communication factors: *„ ...the main expectations of our patients had to do with communicative factors, and these are a part of the so-assessed perception of the communicative interaction and satisfaction, which was also related to the fulfillment of expectations. "*
(Ruiz-Moral et al, 2007, p.89-90)

A very different aspect is taken up by Mitchell Peck et al. (2004) regarding patient expectations: They find it important to study patient expectations in order to rearrange the health care system and save costs: *„ The more we know about patient expectations in a variety of settings, the better we will be able to design clinical delivery systems and educational programs to help health care providers meet patients´ needs in a cost- effective manner. "* (Mitchell Peck et al., 2004)
They also came to the conclusion that age and the level of education have an influence on satisfaction. Thus elderly patients are easier to satisfy than young and a lower educational level leads to higher satisfaction.
Ruiz- Moral et al. (2007) also found out that patient satisfaction is generally higher in older patients.

The study of Vieder et al (2002) concerns itself with the special needs of elderly patients in the osteopathic field.
They found out that elderly patients have a strong desire for personal interaction and a friendly therapist, since this triggers off comfort and confidence in them. Personal habits and appearance are also important for the patients in this case.

An overweight or unkempt therapist meant that the therapist could exercise less influence on the patient Another negative point was if the therapist invited a patient to ask questions but their body language signalized lack of interest and they didn't try to gain eye contact. Elderly patients also found it to be negative if the therapist didn't touch them or moved toward the door before the end of the conversation. Furthermore they were dissatisfied with their provided time and found that the therapist used too many foreign words. (Vieder et al., 2002)
It is surely worth mentioning that this study was carried out in the USA where osteopaths are active as doctors and therefore have a different framework to most osteopaths in Germany. For this reason one can only transfer the osteopathic studies done in the USA conditionally to the every day life of patients in German speaking countries or in Europe.

Expectations of patient and therapist do not always coincide. A study, which examines exactly this connection, exists in a discipline closely used to osteopathy: chiropractic. Sigrell (2001) came to the following results:

"Chiropractors and patients expected the chiropractor to find the problem and explain it to the patients, and they also expected patients to feel better and become free of symptoms. However, the following differences were revealed: patients had lower expectations of the chiropractic treatment than the chiropractors but higher expectations of being given advice and exercices than the chiropractors did. There was also a tendency for the patients to expect to get better faster than the chiropractors expected them to." (Sigrell,2001,p.300.)

It would seem that there is a communication problem and an exchange concerning expectations doesn't take place.

Tyreman (2001) goes even further when he says that therapist and patient have different interests, although both are working on improving patients´ health:

„It might (wrongly) be assumed that because patients and practitioners are both working to improve patients´ health they therefore have the same interests. Although there are some shared interests, such as removing pain or disability, these represent different kinds of interests. As the patient study demonstrated, patients´ interests are focused on activities in the world , such as being able to pick up a young child, while

practitioners´ interests are in explaining the illness in biological (and other) terms." (Tyreman, 2001, p.222)

Tyreman (2001) also says that the language which a patient uses to describe his symptoms is a different language to that of the practitioner when he explains the symptoms. The problems explanation doesn't refer to the patient's everyday life, but to biological mechanisms, whilst a patient refers to everyday things in his explanations. Tyreman (2001) says that this develops from the fact that patient and therapist have different experiences, interests and expectations: *„It also suggests descriptions of different worlds which relate to the different experiences, interests and expectations of patients and practitioners."* (Tyreman, 2001, p.118 f.)

To summarize, the following statements can be made:
The conclusion of patients expectations depends on different factors, such as: previous experiences, belief and moral concepts (attained by education), as well as personal characteristics such as age, education level and ethnic affiliation.
Expectations are also affected by the kind of the complaints which patients have, just as much as the known health system, the special therapist and the knowledge, which they possess through friends, relatives and the media.
As one can see by the multiple authors specified above, the connection between fulfilled patient expectations and their satisfaction was often confirmed with the treatment.
On the other hand dissatisfaction among patients leads to reduced compliance in the treatment, failure to attend doctor's appointments and a more frequent change in physician.
Patients concrete expectations, which are frequently described within this medical field are: information, explanations, understanding, empathy, emotional support, diagnosis and treatment, as well as giving a prognosis.
The therapists´ ability to find out and deal with patient expectations by using his communication talents can improve the relationship between patient and therapist and lead to better co-operation.

3.1 Model of Kravitz (2001)

Based on his own investigations and the results of his literature search, Kravitz (2001) provides a general model, which represents the relationships between patient's symptoms, their expectations and their evaluation of treatment.
He himself describes it as a „ ...*conceptual model relating patient symptoms, expectations, and evaluations.* " (Kravitz, 2001, p.882)
This model will be clarified in more depth, since it explains fundamental connections, in which patients expectations play a substantial role.

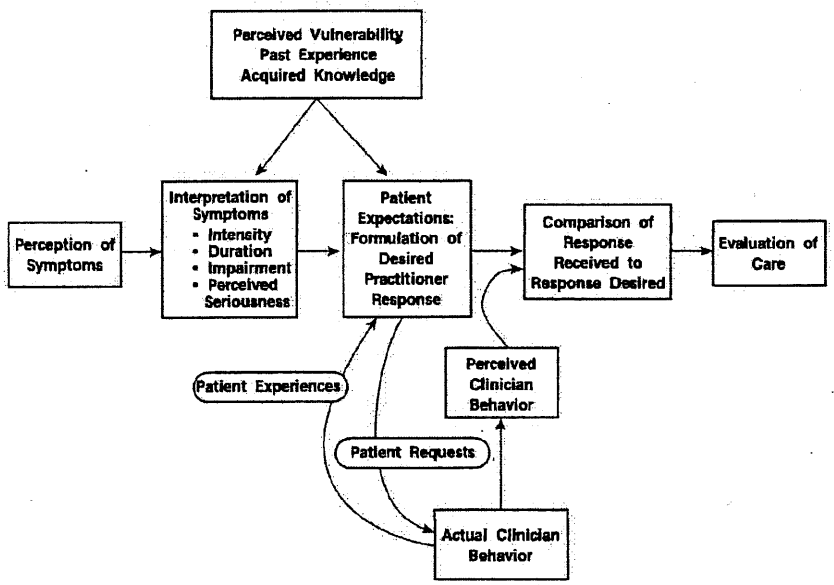


Figure 1: Conceptual model relating patient symptoms, expectations, and evaluations. ,Taken from „Measuring Patients' Expectations and Requests" (p.882) by R.L. Kravitz (2001), Ann Intern Med, 134: 881-888. Unchanged reproduction.

Patients have a certain perception of their symptoms. These symptoms are interpreted regarding intensity, duration, impairment and seriousness.
Interpretation of symptoms forms certain expectations, which the patient also takes to their therapist: they have a definite conception of how the therapist should react to them.
The interpretation of symptoms and the expectations regarding the therapists' reaction are shaped through past experience, acquired knowledge and the patients' perceived vulnerability.

The patient makes an evaluation of their visit to the therapist, this represents a complex process. This evaluation can be seen as a comparison process. The patient compares what he received as a reaction to his visit to the therapist with what he expected to receive there.

Through ones expectations, wishes or requests result which the patient then verbally communicates to his therapist. Kravitz (2001) differentiates between the terms „expectation" and „request": *„ ... `expectations' to mean desires, wishes or entitlements. Requests are explicit verbal expressions of expectations. "* (Kravitz, 2001, p.883)

The therapist reacts to this desire. The patient takes note of this in a certain way and builds this experience into their comparison. The evaluation of the welfare service finally develops from this complex process.

The evaluation is further affected by factors such as age, sex, ethnic affiliation and the patient's health status.

In his investigations, Kravitz (2001) also found out that the perception of symptoms is different between ethnic groups and that the socioeconomic status affects expectations on the health system. Patient satisfaction becomes lower the higher their income: *„ Culture and context play an important role in this model. For example, research has shown that the experience of symptoms varies among ethnic groups [...] that medical care expectations are affected by socioeconomic status [...], and that patient satisfaction declines modestly as income rises. "* (Kravitz, 2001, p.882)

3.2 Expectations and the Placebo-Effect

Patient expectations are seen as a component of the placebo-effect. (Di Blasi et al., 2001; Kaptchuk, 2002; Paterson und Dieppe, 2005; Hyong, 2005)

For this reason, this relationship should be further discussed at this point.

The placebo-effect is defined as: *„ ... `any therapeutic procedure which has an effect on a patient, symptom, syndrome or disease, but which is objectively without specific activity for the condition being treated' "* (Shapiro in Hyong, 2005, s.p.)

The placebo-effect is synonymous with the concept of „context effects" or the non-specific factors, which as therapy factors can influence the therapy result. They are differentiated from specific factors in therapy and studies.

(Paterson and Dieppe, 2005)

Paterson and Dieppe (2005) use the definition „incidental factors" synonymously. They also count patient expectations to the context effects: *„Incidental factors are the many other factors that have also been shown to affect outcome, such as the credibility of the intervention, patient expectations, the manner and consultation style of the practitioner, and the therapeutic setting."*

(Paterson und Dieppe, 2005, p.1203)

Di Blasi et al. (2001) also confirm this in their study:

"Nowadays, the influence of patients´ expectations and the power of suggestion tend to be controlled than rather investigated, and when noted, these effects are discounted as `non-specific´ or `placebo´ effects." (Di Blasi, 2001, p.757)

Kaptchuk (2002) counts, among other factors, how expectations influence the placebo-effect: *„The term* placebo effect *is taken to mean not only the narrow effect of a dummy intervention but also the broad array of nonspecific effects in the patient- physician relationship, including attention; compassionate care; and the modulation of expectations, anxiety, and self- awareness."* (Kaptchuk, 2002, p.817)

Hyong (2005) sets three factors which must be given, in order to trigger off a placebo-effect: *„...the placebo effect can last even up to a year or more if the three necessary elements are maintained: 1) beliefs and expectations of patients; 2) beliefs and expectations of doctors; and 3) a good relationship between them."* (Hyong, 2005, s.p.)

On the other hand, there are also indications that patient expectations not only participate as placebo effect, but also affect the effect of the treatment directly: *„However, evidence shows that patient expectations influence outcomes of both placebo and active treatment. Asthmatic patients who believe that an inert substance is a bronchodilatator or a bronchoconstrictor respond accordingly. [...]Patient expectancies also significantly change or even reverse the actions of many potent pharmaceutical agents."* (Kaptchuk, 2002, p.818)

The study of Di Blasi et al. (2001) about "context effects" shows how Leventhal describes the impact of context effects. His model states that a person who is treated because of certain clinical signs or symptoms, shows cognitive and emotional reactions.

The therapist can influence these reactions, by giving information, which affects the patients point of view: *„For example, sudden pain may cause an individual to feel anxious and so try to make sense of the situation by thinking about what it might be, what caused it, whether it is curable, what the consequences could be, and how long these symptoms might last. In consultations, health professionals can be instrumental in shaping the way patients think and feel about their illness or their treatment, through the information and reassurance they provide."* (Di Blasi et al., 2001, p.758)

The cognitive and emotional reactions can therefore be influenced by the therapist and can affect patient expectations: *"Cognitive care describes the ways by which practitioners can influence patients' beliefs about the effects of treatment or about the illness- eg, by giving a label to the condition or by giving a positive prognosis. Patients' expectations about a treatment can be made positive if they are told to expect the therapy to be `good', `safe', and `effective'; or negatively, if they are informed that the therapy they are about to receive is `dangerous', `unsafe', `ineffective', `limited', or has `potential side effects'. [...] The term `emotional care' is used to refer to ways through which health professionals can lower unhelpful emotions such as fear or anxiety by providing support, empathy, reassurance and warmth. Emotional and cognitive care are expected to enhance substantially the effectiveness of therapy or physical care."* (Di Blasi, 2001, p.758)

Here one also gets an impression, to what extent information, which patients have already got before they get into an osteopathic clinic, can affect their attitude and expectations concerning therapy.

Because before patients come to a therapy, they can have already received positive or negative information: *"We always meet the patient in here and now. They come from their past and are on the way into their future. Our meeting can therefore be positively coloured in anticipation or negatively burdened in expectation of unpleasant consequences."* (Kowarovsky, 2005, p.47)

4 Models of Relationships between Therapist and Patient

The nature of the relationship between therapist and patient in itself actually has an important therapeutic effect:

„Throughout history, doctor- patient relationships have been acknowledged as having an important therapeutic effect, irrespective of any prescribed drug or treatment.“ (Di Blasi et al., 2001, p. 757)

According to Di Blasi et al. (2001) this relationship can also be counted to the so called „context effects“ and/or the placebo effect in treatment. (see chapter 2.2)

That means that the relationship alone between therapist and patient can have an influence on the result of the treatment.

What kind of relationship or how one deals with patient expectations, can vary depending upon the patient. (Flynn et al., 2006)

Below various models will be presented, predominately concerning the relationship between therapist and patient.

This summary should give an insight into which relationship model patients might expect.

4.1 Paternalistic Model

In the paternalistic model, the therapist has the exclusive („paternal“) authority and the patient is regarded as a minor. The patient has to cooperate and do what he is told. (Büchi et al., 2000).

The patient must concur with the therapist's decision, whereby the therapist functions as the patient's protector and their interests are paramount.

(Klemperer, 2003, p.14)

This model probably has little meaning for the needs of today's „modern“ patients. However one should not forget that many older patients will accept this model and gladly leave the last decision for treatment up to the therapist.

Younger patients however have a greater need for participation and autonomy.

(Klemperer, 2003).

The therapist acts in the best interest of the patient but deprives him of his autonomy:
„Whoever decides to create their physician patients - relationship according to this model, strengthens the asymmetrical relationship to the patient. The patient must rely on the technical expertise of the doctor and leave out all factors which oppose therapy. In addition one does not take into account how the patient feels after diagnosis, in this extreme relationship model. They are emotionally abandoned. Confidence is presupposed and autonomy is low. "

(Schweickhardt and Fritzsche, 2007, p.27)

Progress in medicine and the general social development since the 1980s made changes to this model essential:

„The paternalistic model prevailed until the 1980s; its obvious inadequacies and the changed requirements of patients gave impetus for the development of various models in the physician patient interaction, which gave patients a larger and more appropriate leeway." (Klemperer, 2003, p.9)

As one can see from this quotation, the paternalistic model was the predominating model for a long time. The fact that the patient needs changed led to the further development of the predominating model, in order to correspond to these new needs.

4.2 Service Model (= Informative model)

The expectations of patients are now increasingly becoming a central issue in medicine. The therapist moves more and more into the role of „provider", whose central requirement is to satisfy the needs of his equal, his „customer ":
„The physician is the specialist in this model, however the full decision authority is assigned to the patient. The physician appears partly in the role of advisor and salesman, who offers a suitable product (medical service) to the patient. [...] The treatment decision is the patients alone. In the physician patient- discussion, the central theme is the satisfaction of the patient."

(Schweickhardt and Fritzsche, 2007,p.28)

In this model the patient demands, while the physician advises and on the patient`s wishes, enters into the context of the possibilities. The patient also renders her/his

decisions with the help of third parties, such as medical/therapeutic second opinions, information from the internet or from other available sources. (Büchi et al., 2000)

The patient selects for her/himself, what corresponds most to their desires and values, and the therapist supplies information. Consultation however does not take place as an interactive process. (Klemperer, 2003)

The service model could develop increasingly with the change of social standards:

„ The increased importance of patient-centred models of physician-patient interaction took place parallel to the increasing civil rights movement of the 1960s and the strong consumer movement in the 1970's " (Klemperer, 2003, p.14)

In this case one would also call the relationship „asymmetric ", however in the patients´ favor in whose hands the power of decision lies and who bears the consequences of all decisions.

4.3 Cooperative model (= Calculated model)

In this model there is a cooperative collaboration between therapist and patient. The physician remains the medical expert. The patient is however included and considered in his entirety. In this model the patient is the expert on her/his own values and life circumstances, these play an important role and are inquired about during the therapists´ consultation. This relationship model is the most equal one so far. It leads to participative decision making (shared decision making = SDM): *„Two basically equal people come to a shared decision. In order to achieve this joint decision, both must first be willing to share relevant information and be able to make and accept a decision. "*.(Schweickhardt and Fritzsche, 2007, p.33)
„Shared decision making " (SDM) is the cooperative model which is currently most used in the USA and in Germany (Geisler, 2004) as it takes into account our current ethical conceptions in the therapist-patient relationship.: *„In order to achieve a shared decision, physician and patient must mutually communicate their knowledge and moral concepts. An important aspect of the medical consultation in shared decision making consists of helping the patient to define and articulate their moral concepts, preferences and desires. The physician in turn informs the patient in an appropriate manner, about the technical background. The physician remains the knowledge expert, and the patient is acknowledged as expert for his own preferences.*

Therapy is a decision by agreement between two „experts", who have sought and found a consensus and in addition, the responsibility is divided. Thus the traditional division of responsibility is overcome in the physician-patient relationship."

(Geisler, 2004, p.4)

Osteopaths should give this model the most attention because the expectations of most patients show that they are most likely to want the cooperative model. (Schweickhardt and Fritzsche, 2007) It is the one amongst the models, which sees patients in their entirety, as it also contains the basic osteopathic principles.

There is evidence that patients do not prefer all the components of „shared decision making". Flynn et al. (2006) mention a total of three components in SDM:
„ ...information exchange, deliberation, and decisional control. "

(Flynn et al., 2006, p.1159)

Flynn et al. (2006) describe that patients predominantly want extensive information from their practitioner, which however does not necessarily mean that they would like to make a common decision about treatment.

„ It is well established that patients want to receive informations from their physicians almost universally... [...] Preferences for deliberation (i.e., formal discussion about options) and preferences for decisional control (i.e., power over the final selection of treatment) are known to differ substantially among patients... "
(Flynn et al., 2006, p. 1159)

That means that not all patients want to discuss the various options and are not interested in a common decision in the end.

4.4 Patient orientated Model

The patient-orientated model is not a totally independent model, but refers to therapists´ attempts to find and use the most suitable and favourable model for the patient. So the therapist tries to „meet the patient halfway"
(Schweickhardt and Fritzsche, 2007)

This attitude is based on the idea that different patients with different personalities also need different models, in order to be cared for optimally: *„Depending on the patient this can lead to a paternalistic, service orientated or cooperative relationship."* (Schweickhardt and Fritzsche, 2007)

Here the different expectations and perceptions of each patient play a role. Accordingly the therapist must first identify these, in order to be able to optimally deal with the patient.

5 Expectations in Customer Service

Over a period of time it emerged for Karten (2004), a consultant for large companies, that there are three major problem areas related to expectations in customer services or in the services sector in general.
In the medical field patients are not directly thought of as 'customers' but in reality they are. For this reason a closer look is needed as how to deal with "customers" expectations.
A further reason why expectations are compiled, described and dealt with here, as Karten (2004) did, is that in literature, despite the large number of authors who have dealt with the subject of patient expectations the approach employed hardly begins to describe how to find concrete expectations and how to react to them.
The three areas which Karten (2004) judged to be particularly important are: communication, gathering information, and developing strategies and procedures in dealing with expectations.

Communication.

In this area Karten (2004) deemed it important to set goals and not to give impossible promises or contradictory messages. That means: What one says, one does without changing anything one previously said.
In communication with the customer one should speak their „language ". This means that complicated technical terms should be avoided, to better communicate on the same level with the customer. Using too many technical words can be a communication obstacle.
It is deemed as important to involve the customer and consider her/his opinions:
„ One point is particularly important when it comes to the question of whether or not a customer's expectations are fulfilled or not: their participation. If customers have the feeling that their opinions have been sufficiently considered, they are even more satisfied with their achievement. For many customers, consultation and assessment of their opinions and position is sufficient participation already in reaching a common goal. " (Karten, 2004, p.75)

Even the manner of listening can affect communication. Convincing listening can contribute to receiving important information. This in turn can help to understand the

customers´ expectations. Techniques of good listening are: eye contact, giving confirmation (e.g. with expressions such as „okay" or „aha"), placing intermediate questions and paraphrasing (repeating what the customer says), making notes and avoiding distractions.

Last but not least one should only make conclusions when one has all relevant information, in order to retain objectivity: *„Hasty conclusions block you for the possibility of objectively determining the needs of your customers and reduce ones ability to fulfil the expectations expected of you"* (Karten, 2004, p.86)

Gathering information. Karten (2004) is of the opinion that one cannot deal with expectations of customers, if one does not know, what they want.

The communication method (see above) on the one hand helps find out what their needs are and in addition on the other hand special strategies can help to get relevant information. These will be dealt with below.

It can be of help to support the customer in describing their needs. When collecting information one should also analyze it and have a certain degree of scepticism, since the customer unintentionally, possibly doesn`t say what they really mean:

„This scepticism is not appropriate; because one fears that customers intentionally lead one behind the light because they possibly don´t say what they mean. If you do not succeed in finding out, what your customers really need, you won`t completely fulfil the expectations set in you." (Karten, 2004, p.108)

In order to find out what the customer really means, one should develop a „ basic questioning attitude ", and also ask about things which one already believes that one knows:

"Ask a lot of questions, not only about things you don`t yet know. Also analyze all the things which you believe you already know about your customers and the problems which you want to solve. [...] ...You learn more, if you don't appear to be the absolute expert. If you ask your customers to put information at your disposal you will find out more than they realise" (Karten, 2004, p.108)

Strategies and procedures. Customers may react differently to services and possibly not as one would expect them to. Perception and expectations are closely linked and affect each other mutually: *„ Nevertheless perception flows into the expectations and demands, which are addressed to you. And these perceptions are often the origin of*

expectations, which you regard as inadequate. A vicious circle develops: What a customer perceives, influences in turn their interpretation of the perceived. "
(Karten, 2004, p.155)

Surveys and interviews would be one strategy which could be carried out in order to learn customers´ perception and to come nearer to individual expectations. One would get feedback, how customers see services and whether they correspond to their expectations.

A further point, which can help customers develop more realistic expectations ,would be to let them participate in ones own efforts and to give them responsibility.

Karten (2004) considers it to be important, not to rely on the fact that customers are content just because they don't complain. From her view, this could also mean that the customer has capitulated a little: *„It can be a risky venture to regard the absence of complaints as a yardstick with which to measure customer satisfaction. Worse than that, it could be a fatal error, especially if it concerns services, which are also offered by other competitors. Rather than to suggest that 'everything's going well', silence can also mean that the customers simply see no more sense in bringing out their complaints.* " (Karten, 2004, p.175)

In the opinion of Karten (2004) one shouldn't leave customers in the dark as to what they should expect. This results, in her opinion, in discontent and uncertainty: *„A person who doesn't know to what he must adjust himself experiences an unnecessary stress situation, which incidentally is one of the most common causes of dissatisfaction among customers.* " (Karten, 2004, p.179)

Karten (2004) mentions that through all service-orientations, there are certain limits which we should consider. Expectations are created by the supplier acting. The customer will expect the supplier to behave in exactly the same way the next time. So depending on the supplier's behaviour it is possible to increase expectations:

„There is a close connection between what you do and which expectations you thereby wake: Each time you react to a request, you reaffirm the customer to ask again. Every time you respond within seconds to a cry of help, the customers´ expectations are aroused and they expect the same response, regardless of whether a quick response is needed or not.

And every time you rescue a customer from a situation which happened due to her/him violating rules, you are nourishing the expectation that you are willing to take over the responsibility for their irresponsibility. " (Karten, 2004, p.198)

6 Methodological Part

„One designates methodology as the doctrine of methods, which gives information about how one can investigate an interesting section of the world, i.e., which steps have to be taken and how the steps should be done.“ (Gläser and Laudel, 2006,p.26)

Therefore for each question there is a selection of methods under which one can find out which is most suitable.

In the following two sections, I would like to explain why the qualitative method is the best choice for the formulation of the question in this study.

6.1 Selection of Methods

The theme of this thesis already states which category of research it concerns namely a study in the field of empirical social research.

„Empirical social research is investigations which observe a certain section of the social world; these observations contribute to the development of theories. Even if this research processes is referred to as empirical, i.e. based on experience, they emanate from known theories and also contribute to them. They do this by observing the social reality theories and drawing theoretical conclusions from observations.“ (Gläser and Laudel, 2006, p.22)

A closer explanation why the qualitative method was selected can be found in chapter 6.2.

In order to find out, which expectations patients have in the osteopathic field, it was obvious that they should be asked directly in interviews, since they are the experts, who can give information about the topic of their expectations.

„Experts are people who have special knowledge on social issues, and expert interviews are one way to tap this knowledge.“ (Gläser and Laudel, 2006, p.10)

In order to have a „central theme“ for the interview, a guide with open questions was developed. Depending upon how the interview developed, additional questions were inserted, in order to gain more information.

More detailed information on interview and guide can be found in the following chapters.

6.2 The Qualitative Issue

My first choice at the beginning of my considerations was the quantitative method. I imagined developing a questionnaire and distributing this to as many patients as possible.

However, whilst searching for literature, it turned out that virtually no study on patient expectations in the osteopathic context existed. The nearest such study had been taken with chiropractic patients.

Since however for an area which has hardly been explored the qualitative approach is most suitable, I had to distance myself from my idea of a questionnaire, in order to once more intensively question the fundamental possibilities of this topic.

„Both types of methods have specific pro and cons, and it primarily depends on the subject and goal of the investigation, which methods can be used. "

(Gläser and Laudel, 2006, p.24)

The subject of investigation would probably have been applicable for a quantitative study too. But the fact that fundamental facts had to a large extent not yet been investigated, pointed towards the qualitative method. Before the occurrence frequency of certain characteristics can be examined, the characteristics themselves should first be investigated.

„In method levels there is a substantial difference between quantitative methods and non-quantitative methods. Quantitative methods are based on an interpretation of social facts, which results in the description of these facts being shown by numbers. Either the characteristics of the facts or the occurrence frequency of the characteristics are described by numbers. This procedure implies a reduction of social complexity and a standardisation: Part of the observed social diversity is illustrated on scales, and the occurrence frequency of characteristic developments is operated on. Qualitative methods are based on the interpretation of social facts, which result in a verbal description of these facts. "

(Gläser and Laudel, 2006, p.24)

The missing data had therefore to be found first. The second step was to produce a questionnaire which would for example be further used as the theme of a master thesis and which results could be used as a study to quantify i.e. to statistically evaluate numbers.

„The reasoning of statistic relationships between cause and effect, presupposes the application of quantitative methods, and the empirical identification of relations between cause and effect and there following generalization suggests the application of qualitative methods.“ (Gläser and Laudel, 2006, p.25)

The method resulted from the given situation, the lack of data, particularly within the osteopathic field. Step one had to be made before step two was taken and not vice versa.

First of all I had to take a step back and thus find out which expectations existed at all in the osteopathic context.

In order to achieve this goal a more qualitative method moved into the foreground.

So I decided to interview my patients as experts of their expectations.

The master thesis supervising tutors, Katharina Musil and Heidi Clementi also advised me to choose the interview-style in this context.

6.3 The Interview-The Development of the Questions

The interview guide mainly consists of open questions. If further topics or new, interesting aspects came up during the interview, then further questions were added, in order to give the interview greater depth and widen the scope of the topic. The initial guide gave me a kind „scaffold“ for questioning and guaranteed that I could inquire about similar information in each interview, without forgetting the main aspects.

„Part of the understanding interview is a flexible guideline assistant. Once it has been created it rarely occurs that the interviewer just reads off questions, one after the other in sequence. The interview guide is merely an assistant, in order to bring the informants to talk about certain topic, and ideally a dynamic discussion forms,

which if it remains on the topic, can develop into a more valuable discussion than just simple answers to questions. " (Kaufmann, 1999, p.65)

The individual questions arose through my literature research. They are a combination of all relevant issues, which already arose in similar studies and were then transferred to the field of osteopathy.

The questions were arranged in such a way that content related issues were dealt with successively.

The guide begins with less complex issues and goes on to questions of more depth.

„One can begin with some simple and easy to answer questions, in order to simply break the ice. But one should also not place too many such questions, because otherwise the informant adjusts themselves to a superficial answer style. "
(Kaufmann, 1999, p.66)

6.4 The Interview Guide

- How did you first hear about osteopathy? (TV, radio…..)
- What prompted you to visit an osteopath, what did you expect from them?
- Did you first seek more exact information about osteopathy? (If so, where?)→ books, internet etc.
- What complaints led you to an osteopath?
- When did your complaints start?
- Have you already tried different therapies regarding your complaints?
- Did they help you?
- Which criteria are important to you when selecting an osteopath? (Local proximity, training, experience, recommendation of friends/acquaintances, list of therapists)
- What do you think about titles e.g. (like D.O.,M.R.O., MSc etc.), which an osteopath can have?
- Would you prefer your osteopath to be a man or a woman?
- What do you expect from an osteopath?

a) Do you want to know the facts about the background to your complaints? (e.g., how these could have developed, what particular osteopathic explanations there could be for it …)

b) Would you like the treatment approach to be explained ? (e.g. the individual treatment steps)

c) Do you expect a prognosis?

d) Do you expect cooperation with other therapists?

- Try in your words to describe what happens in your view, in a osteopathic treatment.
- What do you expect from the osteopathic treatment?

(Alleviation of complaints, freedom from complaints, clarification of causes, advice, exercise program, wellness and general relaxation …)

- Over which health topics do you expect advice /consultation with your osteopath?

(nutrition, food supplements, healthy lifestyle, book tips…)

- How many treatments are necessary in your opinion, in order to cause a clear improvement of your problem?
- What in your opinion does osteopathy offer you which other therapies don't?
- Would you say that your expectations concerning osteopathy have changed with time? (retrospective of your first treatment-today)
- Have your expectations concerning osteopathy been met so far?
- What do you find important concerning the consulting rooms in an osteopathic clinic? (The premises, ambience, treatment room)
- Which clothing do you find appropriate for an osteopath?
- Which person would you trust the most? (photos see appendix)

6.5 Selection of Interviewees

The choice of interview partners was accomplished according to the criteria specified below, in order to obtain a selection as representative as possible, although the number of interviews, which are possible in the context of a master thesis are limited.

„The drawing of samples is rightfully one of the masterpieces of the standardised interview. It must either be representative, and/or the representativeness must come as close as possible or the basis be defined by precise categories."

(Kaufmann, 1999, p.60)

I selected the interview partners according to the following criteria:

Gender: Approximately the same number of men and women were questioned, in order to obtain the views of both genders. More precisely from the eight people questioned, five were women and three men. As generally speaking more women than men attend therapy an extra women was questioned. Licciardone et al. (2002) confirmed in their study about patient satisfaction that 76,2% of the patients in the USA are women.

Age: In order to highlight the aspects of different age groups, older and younger patients were interviewed.

Educational level/Occupation: The interviewees have very diverse school records and professions. Thus the housewife without qualification was interviewed alongside the university graduate.

Anderson et al. (1993) found, amongst other things in their study, that there is a correlation between the education of patients and the measure of satisfaction. Those with higher education levels showed a lower satisfaction level.
Regarding alternative therapies, Astin (1998) found that patients who prefer alternative medicine, exhibit higher education levels. This was the most striking socio-demographic factor in this study.

Location of clinic: Since I work in various osteopathic clinics, I could use the opportunity and interview patients from different places, who also knew the inside of different clinics. This extended the spectrum of views.

6.6 Implementation of the Interviews

Before turning the recording equipment, the meaning and purpose of the interviews was once again explained to the patients.

It was also explained to them that the interview would be recorded but that their data, names and locations would be kept anonymous. They were also encouraged to feel free, if necessary even pause for reflection and not to feel under time pressure through the recording equipment. Six of the interviewees combined their date of interview with a therapy appointment. Seven of the interviews took place in the clinic and one at the home of patient.

6.7 Transcription of the Interviews

The interviews were recorded with an Apple iPod and were transcribed in full. The transcripts were made anonymous. That means that all people and places named were replaced, as well as the names of the interviewees.
The transcripts were made as detailed as possible in order to become the best accurate presentation for analysis.
The following rules were used:

- Existing dialects were not amended
- Comments such as „um“ or „hm“ have been taken over
- Short breaks of a few seconds have been marked with dots …
- Long pauses are shown with the time in brackets, for example.: (10 sec. pause)
- Laughter or smiles was named in brackets after the statement: (laughs), (smiles)
- Emphasis was written LARGE
- Interruptions in the interviews, for example by a phone ringing or other persons have been identified
- The interviews and interviewees are named with letters. There are interviews A to H and patients A to H.

The interviews have page numbers, as well as line numberings on each side, sequential in each case, so that individual passages in the text can be exactly designated as quotations.

Number of words of all 8 transcripts: 33.598
Number of pages of all 8 transcripts: 78

6.8 Qualitative content analysis according to Mayring

First of all the transcriptions which were to be evaluated were handled individually. The different topics in the texts were divided into categories. *„The category system is the central tool of the analysis. They make it possible for other people to reconstruct the intersubjectivity of the analysis."* (Mayring, 2007, p. 43)
The categories are linked to topic areas of the questions in the interviews. Nevertheless the categories differ from interview to interview, since for the questioned individuals, different ranges of topics were of importance or new aspects arose during the discussions. After the texts had been divided into categories the relevant text passages were extracted:
„Extraction is to read and decide which information contained in the text is relevant for the investigation. " (Gläser and Laudel, 2006, p.194)
Thus relevant information was collected from the text. *„With the qualitative content analysis one creates various information basis' from the original texts, which only include information relevant to the questions in the interview. "*
(Gläser and Laudel, 2006, p.194)
This is a preparation step for the evaluation. Headings in the result part are formed as far as possible from these categories. Whilst creating the category system and extracting the relevant passages, as much objectivity as possible was tried to be kept, although it is impossible to do this step without interpreting the text: *„The extraction is a crucial step in the interpretation: In order to determine whether relevant information is contained in a text, it must be interpreted. The allocation to a category and the verbal description of information contents are based in each case on text interpretations. This means at the same time that in spite of the rules used to make*

the extraction, the understanding process of the respective scientist is also individually characterized. " (Gläser and Laudel, 2006, p.195)

Subsequently, the extracted statements were summarized in the result part under the different categories. The source of information was also always provided, in order to be able to check later, whether the substantive statements were well built in to make them as comprehensible as possible from the original text.

In the pooling of information similarities and contradictions will be shown and people's different views and perspectives surveyed and displayed.

The result of this unification represents an answer to the empirical question that was made with this work, and the editing represents a part of the interpretation process:

„ Whether information is considered redundant and/or contradictory, is a question of individual understanding. " (Gläser and Laudel, 2006, p.196)

Results from scientific studies or literature have been incorporated in the result part, in order to point out further aspects of the issue.

7 Results

7.1 Data of the Interviewees

The patients were selected according to the criteria stated in section 6.5. The names of the interview partners were kept anonymous by means of letters from A to H. The following table points out as is described in section 6.5 that special emphasis was put on receiving a broad spectrum within all ranges. That meant asking patients with as many differences as possible in age, education and learned occupation in order to get different perspectives represented within interviews.

PATIENT	*GENDER*	*AGE*	*EDUCATIONAL LEVEL*	*OCCUPATION*	*SURGERY*
A	*f*	*41 Y*	*A-level*	*Banker*	*1*
B	*m*	*36 Y*	*Elementary school*	*Electrician, tech.buisness economist*	*2*
C	*f*	*51 Y*	*Elementary school*	*Industrial clerk*	*1*
D	*f*	*75 Y*	*Elementary school*	*none*	*1*
E	*f*	*44 Y*	*O-level*	*Laboratory assistant*	*1*
F	*f*	*55 Y*	*A-level*	*Primary school teacher*	*3*
G	*m*	*43 Y*	*Vocational Diploma*	*Mechanical engineering technician, Paramedic, Ayurveda- massage-therapist*	*3*
H	*m*	*29 Y*	*A-level*	*Process engineer.*	*2*

Table 1: Data of the Interviewees.

At the time of the interview all eight patients were in osteopathic care with me, although four of them had also previously been treated by other osteopaths
The patients were selected from three different clinics in which I was active at the time of the survey.

In the table the surgeries are named 1, 2 und 3.

All three surgeries are located in the area of Rheinland-Pfalz, Germany.

7.2 The Path to Osteopathy

7.2.1 Who or what brought the patients to osteopathy?

This section explains through who or what patients came to osteopathy.

Expectations which patients bring with them often arise in advance of treatment by talking to friends, relatives or other persons who recommend them a certain method of treatment. (Kravitz et al., 1996)

To get an insight into what origin these expectations have, it is relevant to know by whom or what the patient found their way to an osteopathic clinic.

Six patients opted for a certain osteopath based on the recommendation of another person who had already had a positive experience with the respective therapist.
The people who gave the recommendations are:

- Pat. A: An aquaintance
- Pat. B: Midwife and chief physician in the children's clinic
- Pat. C: Fellow worker and Physiotherapist
- Pat. D: Daughter and the attending Physiotherapist is an osteopath
- Pat. E: Chiropodist
- Pat. F: Midwife

The two remaining patients chose their osteopaths, because a friend is osteopath (Pat. G) or an acquaintance of the mother is osteopath (Pat. H). Therefore there was a direct connection to an osteopath through friends or acquaintances.
It is clear to see that in almost all cases the recommendation was the reason for a specific choice of osteopath.

In her master thesis "How did you come to us" Wagner-Scheidel (2006) actually comes to the result that 77% of the people asked (in this case 157 of 204 people) selected their osteopaths due to a recommendation. In most cases (in this case 109) these were friends. (Wagner- Scheidel, 2006, p.26)

From this fact one can conclude that a significant part of expectations which patients bring into the practice with them, are formed through stories of recommending persons.

The people recommended in the case of the interview partners were mainly acquaintances or people from an immediate social environment.

7.2.2 Complaints

To provide a better insight into which patient clienteele has been questioned in the interviews, the table below shows with which symptoms patients came to osteopathy. The symptoms are shown in the way the patient named it.

Patient	***Symptoms***
A	Back problems
B	Back problems
C	Problems with the sacroiliac joint after a fall
D	Problems with the cervical spine, back, intervertebral disks and feet after a fall
E	Lumbar spine problems with radiating pain, headache
F	Backache, intervertebral disk problems
G	Problems with knees and spinal column with radiating pain
H	Back ache

Table 2: Patients and their symptoms

7.2.3 Prior Therapy Types

From the table below you can read which forms of therapy the patients had already applied or therapist they had already visited before they came to osteopathic therapy.

Pat.	Ph	Chiro.	Mass.	Cs	Orthop.	Ctm	Shiatsu	Bt	Injections
A	▲						▲		
B	▲					▲			
C		▲	▲	▲					
D	▲		▲						
E		▲						▲	▲
F					▲				
G		▲	▲						
H	▲	▲							

Table 3: Patients and their prior therapies

Ph= Physiotherapy

Mass.= Massage

Chiro.= Chiropractic

Cs= Cranio- sacral therapy

Orthop.= Orthopaedist

Ctm= Connective tissue massage

Bt= Back training

From the table it is evident that all respondents have already been treated by at least one, but usually have had several therapies and/or have visited different specialists before they have gone to osteopathic treatment. In most interviews it became clear that previous treatments had not brought the desired results. This for example was reported by Mr. B: *„ ...but I would say with hindsight that they brought no relief, or not to the extent which I expected." (IB/2/34-35)*

In interview A it becomes clear that previous therapies did not actually solve the problem. *„ ...and I was prescribed time and again physiotherapy or massage, but the problem that my neck became stiff again and again, and/or the nerve tweaked, was never really solved." (IA/2/1-3)*

Mrs A. makes this clear in a further statement. Ease was reached but no lasting solution:

„That has not really solved the problem, although it has eased me, but not, if for example now my neck hurts, because it's twisted or because a nerve is trapped, then its no help if one pulls on an arm or loosens it somehow, then it has to be ..sorted."

(IA/3/1-4)

Mr. G. also reports the same of his therapies. He found them pleasant, but a permanent problem solution was missing:

„Only chiropractic..and massages. They were good too, but they did not treat or solve the problem."(IG/2/29-30)

Mrs E. also missed a permanent improvement through previous applications: *„I originally went to my family doctor, and he set my back right. Then I went to back-training in order to build up my back muscles. I had injections too, but nothing helped permanently." (IE/2/17-19)* Ease of pain through tablets was not perceived by her as a permanent solution: *„Yes, and then it came back. And that was very...severe, and I didn't want to live from tablets alone." (IE/2/23-24)*

Mrs F. makes clear that she had experienced previous treatment as a violent intrusion: *„As far as orthopaedic care is concerned, that was almost like going to the dentist for me, a horror vision, when someone knees on me and tries to bring my spine back into position by force. "(IF/1/45-47)* She reported that although the treatment ultimately helped, she perceived it to be a violent interference.

„In retrospect it helped but just the thought of going back there and to experience the forcible access in the body..or to the body, that is not very pleasant." (IF/2/50-3/2)

Interviewee G also mentioned this aspect: a certain amount of relief was achieved through treatment but it was perceived as an intervention by force: *„... I had problems with my spine and went to a chiropractor and they wounded and twisted me till I ended up nearly vomiting, it crashed about inside so that I thought they'd broken more than was good. Even if you are freed afterwards the brutality of this method didn't assure me at all." (IG/1/22-26)*

The sustainable complaint improvement could not be reached by Mr H through treatments already completed: *„I always went to a chiropractic that set me straight,*

3 or 4 of them, all different ones. That helped but it always came back nevertheless. " (IH/1/36-38)

The statement that previous therapies didn't bring about the success desired is heard repeatedly again. In most cases the centre of attention was based on conventional methods, from which patients were disappointed, especially if it promised long term improvement.

Richardson (2004) also observed this in her study. In her study osteopathy was represented by 30% of the patients, 50% of the patients had acupuncture and 20% homeopathy: "*Patients' comments indicate a failure of conventional medicine to alleviate some of their problems, an important finding for public health because it suggests an area of unmet health needs that some complementary therapies might support.*" (Richardson, 2004, p.5)

Here it is assumed that patients believe they will be helped by complementary methods.

7.2.3.1 Summary

All interviewees have already tried various other kinds of therapy before they tried osteopathy. The previous most common types of therapy, i.e. therapies, which were used before the patients went into osteopathic treatment, were: Physiotherapy, chiropractic and massage. Additionally: craniosacral therapy, connective-tissue massage, shiatsu, back training, injections and orthopaedic treatment. Which injections were given and which exact treatment the orthopaedist used, was not specified.

A central theme runs through almost all interviews, that previous therapies hadn't brought the results desired or if there was any then only for a short period, whereupon the patients concluded that „the actual problem was not resolved ".

In particular, chiropractic was found to be done with too much force and therefore unpleasant.

To sum it up in one sentence, one can conclude from the above statements that the people asked are disappointed by previous therapies because they didn't have a lasting effect and only brought temporary relief.

7.2.4 Motivational Reasons

As already described in chapter 2, motivation and expectations are closely linked. This is why it is important to regard the patient's motivational reasons more closely.

Pat. A wants to try osteopathy in order to avoid something unpleasant, like an operation in this particular case for her son. She sees osteopathy as a non-invasive therapy: *„ ...it simply takes the pain away without using classical medicine and/or without needing greater operations. Because first we were told that he had to be operated on and that he needed to have a stomach, umm, an endoscopy and that he had to be treated and I didn't want that to happen." (IA/1/43-47)*
A further motivational reason for her is the fact that previous therapies hadn't brought the desired success: *„In my case physiotherapy or massage was prescribed time and time again, but the problem that my neck became stiff again, and/or the nerve tweaked, was never really solved.." (IA/2/1-3)*

Pat. B describes exactly the same reason as motivation for osteopathic therapy. Previous therapies and advice about changes in behaviour were likewise ineffective. This was the reason why he wanted to try out osteopathy:
„I think it had to do with the fact that...previous therapies hadn't dealt with my symptoms or my complaints. In the past things like, physiotherapy and sentences like `You simply need to do more sport´, hadn't helped me. I found that even if I did sport, including things which were good for my back like breast-trainer and Nordic-walking they didn't bring me any nearer to my goal, which was relieving my symptoms. That's why I decided to try out osteopathy and I simply went to an osteopath for treatment." (IB/1/43-50)
In the literature found there are different opinions as to whether patients prefer alternative therapy forms because they are disappointed in conventional medicine or not.

Wapf and Busato (2007) and Richardson (2004) found that discontent with conventional medicine is one factor why patients prefer to use complementary medicine. Other important factors according to Wapf and Busato (2007) include recommendations from friends and family, the desire for a certain path of procedure and the holistic approach.

Astin (1998) assigns discontent with conventional medicine a subordinated role. In contrast Mrs. C. had had positive experiences with craniosacral therapy and was motivated by this fact: *„I wanted to find a method like I had had with craniosacral." (IC/5/33-34)*

A further motivational reason was the fact that osteopathy is a holistic method and she was searching for such a therapy:

„So in brief I actually came to osteopathy because I was looking for something which incorporates the entire body, just like if you go to an alternative practitioner who sees things holistically. That's just what I was looking for, but for my bones." (IC/2/10-13)

In the study of Richardson (2004), this aspect is also expressed by the interviewees: *„Several patients expressed a desire for `an individual approach to be seen as a whole person'. This holistic approach was defined through the process of engagement that the patient expected to undergo with a practitioner. [...] There was an expectation among patients generally that this holistic approach would address the cause of the problem as the individual was treated..."* (Richardson 2004, p.1052)

Here patients see a direct connection between the holistic approach and finding the cause of their problems.

Licciardone et al. (2001) also stress osteopathy's holistic approach, making it unique: *„Two frequently cited aspects of osteopathic medicine that contribute to its uniqueness are the holistic or patient–centred approach, with an emphasis on preventive care, and the use of osteopathic manipulative treatment (OMT) as part of the overall therapeutic approach."* (Licciardone et al., 2001, p.374)

It was motivation enough for Pat. D, that her daughter had already gained positive experiences with osteopathy:

„My daughter, she went to an osteopath in R.. She had an accident once and it helped her a lot. She had problems with her neck vertebrae and she even had problems seeing properly. They wanted to operate on her and then she went to an osteopath and was helped so much, that was really great. [...] and because of her I actually had the idea that I should try it too..." (ID/1/21-30)

Different studies stress the fact that many patients decided on a particular therapy or therapist through recommendations they had received from relatives or friends. (Wapf and Busato, 2007; Kravitz, 2001)

In osteopathy Mrs E. sees a possible chance of getting to grips with her recurring complaints without taking a lot of pain tablets. She also lacked sustained success with her previous therapies and hoped to find this in osteopathy. These are the reasons which motivated her to try osteopathic treatment:

„ Yes, and then it came back. And that was very...severe, and I didn't want to feed myself on tablets alone." (IE/2/23-24)

She too is disappointed by previous therapies and hopes for the sustainability of osteopathy:

„ ...Yes, the other therapies which I've tried up to now, weren't successful in the long run. And with osteopathy I already promised myself that I can leave out the tablets and ...that I will be able to sleep properly again...without pain...over a longer period of time."

(IE/5/26-29)

Disappointment over conventional therapies is always an issue in the interviews, including Mrs F, whose motivation for seeking an osteopath mainly lies in previous therapies failure to help.

AM: „ Umm, so it was actually your disappointment over conventional methods which led you here. "

Mrs F: „ which actually brought no relief for ages. " (IF/2/4-7)

She personally is more and more reluctant to have conventional therapy which in this case meant chiropractic therapy on her spine: *„ ...I can no longer go along with these conventional and abrupt methods." (IF/2/12-14)*

However, in her case the immense suffering pressure has always been high. For this reason she simply tried everything out which might alleviate the pain:

„ ...for me the pain threshold was so high that I tried out everything which might alleviate the pain .That was my reason for coming here. " (IF/1/.28-30)

The same became clear in interview F, as in the conversation with Mrs. E, taking (pain) medication is not the desired long-term solution.

In Richardson's study (2004) this is one reason for choosing complementary therapy:

„For some patients, allopathic treatment was not working. [...] Concerns about taking medications (particularly on a long-term- basis) and about their potential side-effects were highlighted reasons to obtain complementary therapy."
(Richardson, 2004, p.1052)

Another motivating aspect of osteopathy for Mrs F is, the reference to self healing powers which osteopathy offers:
„It is also very important to me concerning which osteopath or which osteopathic surgery one goes to: that I can work around swallowing so many tablets. I mean that...how should I say ...the self healing powers can be activated or at least encouraged." (IF/6/35-38)

Pat. G also found the chiropractic therapy an unpleasant and forceful interference. He feels that osteopathy is a gentler method which corresponds better to his nature, which is why he finally started osteopathic treatment: *„The initial reason was, I had problems with my spine and went to a chiropractor and they wounded and twisted me till I ended up nearly vomiting, it crashed about inside so that I thought they'd broken more than was good. Even if you are freed afterwards, the brutality of this method didn't assure me at all. Then I heard through a friend, that osteopathy is a different and more gentle method, and that is much more my thing. Then I tried it out and it worked. That was the first approach for me." (IG/1/22-29)*

Astin (1998) also stated in his study, that many patients used alternative therapies, because their own philosophy and personal values agreed more with these forms of therapy:
„ ...they find these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward health and life."
(Astin, 1998, p.2)
Wapf and Busato (2007) also stated this connection: *„CAM therapies are attractive because they are perceived as more congruent with patients´ spiritual/religious values, beliefs or philosophy regarding the nature and meaning of health and illness."* (Wapf and Busato, 2007, p.5)
Astin (1998) also deducted, that a holistic view on the issue of health, motivated a lot of patients for alternative therapies: *„ ...and to hold a philosophical orientation*

toward health that can be described as holistic (i.e., they believe in the importance of body, mind and spirit in health). They are more likely to have had some type of transformational experience that has changed their worldview in some significant way... " (Astin, 1998, p.9)

Recurring problems were the reason why Pat H decided to test osteopathy. He reported that the various chiropractic treatments had helped him but only temporarily: *„I often had problems with my back, so I went there to try it out. I always went to a chiropractic that set me straight, three or four of them, all different ones. That helped, but it always came back nevertheless." (IH/1/35-38)*

7.2.4.1 Summary

The motivational reason which is most frequently spoken about is that previous therapies hadn't brought about the desired long term success. In particular, chiropractic operations were repeatedly perceived as being too brutal.
For several of the interviewees this was the reason for seeking out osteopathic therapy.
The holistic benefits of osteopathy and the encouragement of self healing powers are also particular decision criteria.
Furthermore in several cases, a motivational reason was that medical school methods such as pain medication wanted to be avoided.
Most of the interviewees expect a continuous solution to their problems through osteopathic treatment in a „more gentle" manner. They often have experienced, that pure symptom fighting didn't bring any success. Osteopathy with its holistic claim promises them more than mere symptom control.

7.2.5 The Need for Information about Osteopathy

Specific expectations of patients can result among other things from information, which patients get from their environment. This may include information, which they receive from their personal environment, i.e. through friends or relatives, or through information, which they receive through media, i.e. radio, television, literature, as well as the Internet. (Kravitz et al., 1996)

The third Bremen survey report HEALTH! (2006) reported that 56 % of patients seek additional information parallel to visiting a medical surgery. In 33 % of these cases this took place before they visited a doctor, in order to be better prepared and in 48 % of the cases to be more accurately informed. The following reasons were given: *„Searching for information is found to be especially helpful regarding better understanding and/or contributing to their own behaviour concerning recovery-a critical attitude towards the physician plays a lesser role."*
(N.N.,BIPS- Bremen Institute for Social Research and Social Medicine, 2006, p.17)

The wealth of information on the Internet is especially difficult to overlook. (N.N.,BIPS, 2006; Murray et al., 2003). In addition apart from the excess quantity offered the quality is a little doubtful since it is never checked. Younger and middle-aged people especially like to draw on information from the internet. People with higher levels of education use it more frequently. (N.N.,BIPS, 2006)

In interview E the patient reports that she was overwhelmed by the wealth of information about osteopathy on the Internet. Her reaction was to break off her search and to simply try out for herself whether osteopathy could help her:
„Yes, I once had a look on the internet to find out what it is. But then there was so much to read, that I thought I might as well just try it out." (IE/1/41-42)
Many of the patients looking for information on the Internet also seem to have difficulty finding relevant information, since their input or search strategy is flawed:
„One quarter of respondents who looked for health information on the Internet were unable to find relevant information. Because this was not related to educational status, it is unlikely to be due to problems with spelling or literacy levels. Thus additional strategies are needed to help people locate pertinent information once they are online." (Murray et al, 2003, p.6)
In the above mentioned study by Murray et al.(2003), 3209 patients were interviewed about their success in searching for information regarding health information on the Internet.
31% said, they had used it to search for information in this area in the last 12 months, 16% found relevant information for themselves and 8% took the information to their doctor, in most cases in order to listen to her/his opinion on it. Most physicians reacted positively, if they had adequate communication skills:

„The effect of taking information to the physician on the physician- patient relationship was likely to be positive as long as the physician had adequate communication skills, and did not appear challenged by the patient bringing in information." (Murray et al, 2003, p.1)
The patients in the study saw a great many advantages in searching the Internet. Most said that they were more self-confident in the physician consultation, had gained a better view of their situation and were therefore more encouraged to follow the physicians´ advice.

Pat. A, C and D obtained no information before they came for treatment because they fully trusted the person who had recommended them to osteopathy.
Pat. B. said that he had informed himself through flyers which were displayed in the waiting room but that he had not completely understood all the connections yet and was sure that although he was a long term patient, the need for further information still existed:
Mr B: "I think it is important and a question whose answer I'm still looking for is: Where does osteopathy actually begin and where does it end? I believe that I've still not quite penetrated the whole issue of osteopathy's possibilities. Maybe many things could be treated, and osteopathic treatment applied, which I don't know about. And I just think that a lot of other people have the same problem, who don't yet know about osteopathy, or perhaps confuse osteopaths with `new physiotherapists.´"

AM: „Okay, that means that there is simply more...need for education concerning what effect osteopathy can have on everything, or where it would be useful."

Mr B:" When I consider how long we have confronted this issue, and acknowledge what I already know, then reflect on others, who up till now have had nothing to do with osteopathy or know even less, then I think there is a big knowledge gap." (IB/7/30-44)

Here one can see that the patient, although he has been a patient for some time and fully informed, still doesn't feel that the information is sufficient.
In his opinion, a huge knowledge deficit still exists about osteopathy.

Even for patient F, there is still need of information about osteopathy. She personally has great interest in learning more about osteopathy and its possibilities:
„ ...it would really interest me to know what exactly happens in the therapy, then I would have a better complete overview, as to what an osteopath really is, which factors play a role.[...]...because at the doctors' you already know that there are syringes standing around and in an emergency you'll get one or a prescription is filled out or you somehow have to wait, so that's clear. The doctor's image is clear. Depending on what problems one has you already know how to act. But with osteopaths it's still uncharted territory." (IF/12/49- 13/17)
In this case one can see that the approach in osteopathic therapy is still unclear and that the patient would like to know more about what she can expect, to which problem, from the therapist.

7.2.5.1 Summary

The surveyed patients reported in most cases that due to positive stories people, who had recommended them osteopathy, had told them, they just tried osteopathy as the next step.
Only one patient searched the Internet for specific information about osteopathy, but however, felt overwhelmed by the large range of information, so she stopped the search and convinced herself by going to an osteopathic clinic.
In two other cases, it became clear that there is increased demand for information about the general approach in the treatment and application areas of osteopathy.

7.3 Selecting an Osteopath

7.3.1 Selection Criteria of Patients looking for an Osteopath

For Pat A, the most important selection criteria is that she became the recommendation to go to a certain osteopaths from a friend:
"*It was important that the person who had said I should go so far-said that I'll only find it there ...*" *(IA/3/10-11)*
Even for Mr. B the recommendation was a crucial reason for deciding on a particular therapist: *„ The first step was the recommendation and the second step was the personal realization and the recommendation, which we would pass on at any time, yes.“ (IB/3/20-21)*
It seems to him that an osteopathic team can have a good reputation and that one can gladly fall back on one person from this team:
„ ...the second decisive reason was simply due to the mouth propaganda we were given , whereabouts the good osteopaths' are and that if one becomes one who belongs to this team, then of course one's twice as happy.“ (IB/3/1-4)
Mrs F chose a certain therapist due to a recommendation from her midwife, who also assured her that the therapist had had good training: *„ The midwife told me Mr P was someone who had had a very good training. And osteopathy-well I mean, I'm sure that there are plenty of practices but he was recommended to me as a capacity and that was the reason why I selected that particular practice.“ (IF/2/35-38)*

Pat. H would likewise rely on recommendations from the circle of acquaintances. The recommendation is important for Pat. G too, but not the decisive reason to remain with a therapist. In his opinion not every therapist fits to each patient and vice versa: *„ That would be important to me, but not decisive. Because the picture I finally make can only be made by myself. Someone can tell me anything they want, but there are simply patients who don't fit to the therapist and vice versa. That happens. I know that too. From my own practice.“ (IG/3/11-14)*

In the studies of Wapf and Busato (2007) and Richardson (2004), the recommendation of relatives and friends could be likewise deducted as important criteria during the patients´ decision making for a certain therapist:

„Adult CAM[1] patients gave the following reasons for choosing their complementary physician: relying on recommendations of their family and friends... "
(Wapf and Busato , 2007, p.4)

The first important thing for Pat C, is that the osteopath is sympathetic as a person. If this wasn't the case, she would stop the treatment and try other therapists:
„ ...I like the person who is there, if not I mean: my God if he/she is unsympathetic then I can still look and see what happens in the hour that I'm there and then I can leave, that's all. And then I can look for another one, can't I? That's how I go about it." (IC/3/11)
Another important issue for her is the proximity of the practice:
„If it had been nearer then I would have gone back again. But I had to drive there and that was too far for me, so I looked for someone who was nearer..." (IC/5/35-36)
She also feels that it isn't pleasant to drive a long distance if one isn't feeling well:
„ ...if you're not feeling good, driving doesn't really do you good either and one doesn't want to drive so far." (IC/5/43-44)
Mrs F is of the same opinion. For her it's important that there are parking spaces in direct proximity of the practice: *„With my back ache and my not always foreseeable constitution, the geographical proximity is important to me. So I don't need to drive far and can find a parking lot in the near. If I'm feeling really bad, I can't drive or walk far. So to that extent a practice in my near is very pleasant. (IF/2/46-50)*
For Mrs C the practice should also be well attainable, by means of public transport:
„ ...that one can still get there by public transport. That's important to me. " (IC/6/2-3)
For Pat. G the local proximity doesn't play such a role, he finds a longer journey acceptable*: „That wouldn't be important to me if the therapy was successful. " (IG/3/18)*
Pat. H, said it would be good if the practice was within 15-20 minutes driving distance. He considers this distance as „feasible".
Mrs E says that the local proximity of the practice and sympathy are a bonus:
„Now I just thought I'll try it out, because it's just around the corner as it were and I thought, if I'm not content or I think I need a bit more sympathy, so that...um that

[1] CAM=complementary and alternative medicine (Wapf and Busato, 2007)

one can get along with the osteopath, just like it is at the doctors. If that hadn't been the case then... I would have tried it somewhere else. " (IE/2/37-41)
Sympathy also plays a substantial role for Mr.H: *„Sympathy plays a great role. The way in which someone presents itself and whether one can get along with one and other or not." (IH/3/.6-7)*

Mrs E came to the practice ultimately because she saw the practice sign whilst randomly driving past*: „... whilst driving home from work...I saw the sign outside and I thought... because I didn't even know where such a clinic was ...and I thought, I'll give them a ring." (IE/2/29-31)*
The therapists´ good training is for Pat. F important, because in her opinion, her condition is so bad that she can't just let any therapist treat her: *„I wouldn't let anyone, who didn't have some kind of idea, experiment on my back a little. That would be too risky. The fear of landing in a wheelchair is too great. "(IF/3/9-11)*
For Pat. G the therapists´ training, is also primarily important in selecting an osteopath: *"At the moment it would be important to me, whereabouts he/she had completed their training what kind of training they had done and how much they had already practiced. How much experience they had already collected and if they had, where it had been collected." (IG/2/37-39)*
Mr. G also makes it clear that he mainly feels that the quality of education is important. It makes no difference to him whether the therapist has taken his final exam or has acquired titles or additional designations. He would ask about the therapists´ level of training and whether she/he specializes in certain disciplines before he made an appointment. Another criteria point is the question of whether treatment is billable over the insurance:
„How can I pay when I go there? That's obviously a criteria point for me. Yes. Can I pay or is it billable or not? The question of training includes a lot for me, yes ..." (IG/3/3-5)
A further issue that he mentions is the charisma of the therapist and that she/he stands behind what she/he does and lives in this way:
„ ...the personal charisma would be important to me, how he arranges his environment and that he also stands behind what he does and lives his life that way. Yes. And not that he

sells a product called osteopathy, but that he really stands behind the matter. I think that is felt relatively quickly. But only then when one has been there." (IG/3/26-30)
It is clear from this statement, that how the osteopath lives her/his life and whether shw/he follows the advice, which they give to their patients is obviously very important to Mr G.

McNerney et al. (2007) asked osteopathic physicians in the USA about their health behaviour. Key points therein were: „Lifestyle" (how much holiday does one take?, free time, how much sport does one regularly do?), risk factors (smoking and consumption of alcohol) and physical examinations and medical screening (routine examinations and regular testing of cholesterol and blood pressure) It was found that the interviewed DOs do not differ from their patients in health behaviour :
„In terms of their personal health behaviours, DOs resemble the stereotypical patient. They are healthy overall, and they carry out some physician instructions- but not others. Losing weight and getting more exercise, in particular, are two areas in which DOs need to 'walk the talk' and follow the advice they give to patients regarding making consistently healthy lifestyle choices. Controlling weight and getting regular exercise are problems for DOs regardless of age, sex, or practice type." (McNerney et al., 2007, p.545)

7.3.1.1 Summary

The most relevant point in selecting an osteopath was for all interviewees the recommendation through people of trust.
Whether one feels sympathy for the osteopath, is another important criteria point for the interviewees, although one can only tell this, once one has visited the therapist. Lack of sympathy would be a reason, for some, to switch therapists.
In most cases, the proximity of the practice decides upon whether treatment comes in question there or not. Several of the interviewees can't imagine travelling long distances due to their pain. Only one interviewee said that distance didn't play a role. Parking in practice proximity and accessibility by public transport, to a good practice is also a selection criterion.

Furthermore, it is important that the osteopath has enjoyed a good education. The interviewees who deem this as important, would inform themselves about the osteopaths´ status of training before making an appointment.

.

7.3.2 The Relevance of added Titles and Names

In the previous chapter it was already mentioned that therapists´ training is an important point of criteria for some of the interviewees. This chapter will try to put light on whether it is relevant for patients, that their osteopaths have additional titles and designations (such as MSc or D.O.) and whether they expect them to have.

For Pat. A, additional titles and designations are totally unimportant. She has found her osteopath, is happy there and it doesn't interest her: „ *...Oh! I don't think about those things [...]I don't want to try out anything else, I'm happy here and I don't really want to know, what...so quite frankly I don't care about titles.* " *(IA/3/32-35)*
For Pat C, D and E additional titles and designations are irrelevant: "*No. They don't have to have a doctorate or anything. The important thing is the treatment and the person.* " *(ID/3/49-50)*
For Mr. B additional titles and designations are "secondary". For him, recommendation and personal assessment must be correct. He is aware that additional titles and designations show a "qualification", but their significance is unclear to him: "*Well, my first impulse is: `Now what does that mean and what's the meaning behind it?'[...] Doesn't help me any further, if I don't actually know what it means.* "*(IB/3/27-31)*
Pat. F is open for the importance of additional titles and designations an osteopath can have. From her side there is interest to learn more about it: "*Yeah, I don't know what they mean. I've just read them on the sign downstairs and I asked myself what they mean. So it would be quite nice to know.* " *(IF/3/16-18)*
On the other hand she says that if the osteopath carries out good work, they have no meaning for her. However, she also sees additional titles and designations as a quality criterion:
„... *if he works with me and it's good, then the abbreviations and designations don't interest me, but I imagine they must be acquired somewhere, in order to be a good osteopath.* " *(IF/3/23-25)*

ForPat. G. the importance of additional titles and designations is just as unclear as for Pat. B and F: *"... I've no idea what that all means ..."(IG/4/7)*
He thinks that such designations are generally given too much emphasis: *"I think it is a social criteria, which the population and people in general overestimate and that it ultimately depends upon the person and not what is written on the sign.."*
(IG/3/41-43)

Mr. H likewise attaches no importance to titles and additional designations and has never concerned himself with them: „ *If I'm to be honest: I've never looked at it. [...] That's all the same to me. I don't know, what's written on the sign downstairs. [...] Particularly since I don't know, what such abbreviations mean. And what the meaning is behind them." (IH/3/25-31)*
In the course of the interview, it turned out however, that a little interest exists to find out more: *"If such abbreviations are written on it ... maybe it's not a bad thing to know what they mean." (IH/3/39-40)*

7.3.2.1 Summary

All of the surveyed patients came to the statement that additional titles and designations play no role, or if then only a very minor role, in the selection of the osteopaths. It was emphasized that the quality of work and the therapist as a person are more important.
For most of the interviewees, the importance of additional titles and designations is unclear. Nevertheless, they believe that it must be a quality feature.
Some of the interviewees are generally interested in learning more about the importance, others are not interested.
One can say that the interviewees have eventually perceived the abbreviations of titles and additional designations (e.g. sign on the practice), but usually no further attention or interest was given to them, although their significance is unclear.
Basically they don't expect their osteopath to have a title or additional designation. Therefore it would be no selection criterion in their search for an osteopath.

7.3.3 The Role played by the Osteopaths Gender

According to research, it is quite possible that the therapist selection is affected by the gender of the therapist:

„Among the factors that influence patient's choice of doctor are the sex and ethnic origin of the doctor. The doctor's own sex may influence attitudes towards male and female patients and patients' perceptions of the doctor." (Ahmad et al., 1991, p.330)

Since so far there are no investigations within the osteopathic field, it was interesting to pass this question on to the interviewees, in order to see whether there are possible expectations on the patients' side, which can be fulfilled either by a male or by a female therapist.

Pat. A finds it „very good", that she is currently being treated by a woman. She has also been treated by a man whom she also found in order: *„It's very...good, but I would have stayed with her husband, if... that wasn't...even further away. But its okay, I like it when I am tended to by a woman." (IA/3/40-42)*

For Mr. B the center of his attention is the quality of the work, no matter whether this is carried out from a female osteopath or a male osteopath: *„Here the qualification clearly counts, I make no difference and in this particular case I have no fear of contact or prejudices. It's all the same to me." (IB/3/38-40)*

For Mrs E, F and Mr H it doesn't matter whether the therapist is male or female. Mrs C comments: *„Two legs, two hands (laughs) [...] I'm totally impartial, totally. [...] The main thing is... good!" (IC/7/27-35)*

Mrs F stresses that it has much more to do with the good quality of work and the interpersonal relationship with the osteopath: *„On that I wouldn't have any problems, I don't really care, and the quality of work is what counts, and whether we understand each other well. A woman can be just as cool as a man. So I think it depends on the interaction between the person and me." (IF/4/37-40)*

Pat.G is the only one among the interviewees who's view is somewhat differentiated on this issue. He doesn't principally prefer to be treated by a man or a woman, but he finds it good, if he has the choice between the two genders. He believes that both "energies" are important for the patients, according to their current state: *„... nice if there are both. Because I think that both are important sources of energy for someone who is being treated. Sometimes it's good, if one is treated by a woman and*

sometimes it is simply good and right, if one is treated by a man. Whereby, I cannot fasten that to one particular criterion. That is more of a feeling." (IF/4/21-25)

Graffy (1990) conducted a study in a London clinic, which investigated to what extent patients rather select a male/female physician. The patients could freely decide which of the four colleagues they would thereby prefer.
He came to the conclusion that 48% of women chose a female doctor and, in contrast, only 27% of men sought out a female doctor. However, only 29% of the women had explicitly selected because of the female gender.
The study by Ahmad et al. (1991) showed that compared to Asian patients the doctors´ gender played a bigger role for non-Asian patients. The Asian patients generally opted for an Asian doctor, whether man or woman. In this case it is made clear that the ethnicity also plays an important role and in many cases the doctors´ gender becomes super ordinate.

Anderson et al. (1993) found out that the sex of the therapist stands in no relation to patient satisfaction. Overall, factors such as age, education level, ethnicity of the patient, as well as professional experience and sex of the therapist were investigated against patient satisfaction. The only factor influencing this was the educational level of patients.
Patients with higher levels of education were more demanding and more difficult to satisfy.

7.3.3.1 Summary

With one exception, all interviewees indicated that the gender didn't matter to them in their choice of osteopaths and made no significance in their choice of therapist. It was repeatedly stressed that qualities such as the quality of work or the qualifications of the therapist and also the personal relationship between patient and therapist played a greater role.
In one case, it was positively evaluated, if there was a choice between male and female osteopaths.
The interviewees expressed no particular expectations, which focused more on one of the two sexes.

Only one of the interviewees felt it was positive to have the choice, according to the current needs, of being treated by a man or a woman.

7.4 Patient Expectations

7.4.1 The Amount of Counceling needed

In many studies dealing with the issue of patient expectations it is clear that a large proportion of patients have a need for information and advice. (Sigrell, 2000 ; Sigrell 2002; Rao et al., 2000; Richardson, 2004; Zebiene et al. 2004 ; Ruiz- Moral et al., 2007)

In the study from Zebiene et al.(2004), which refers to the general medical field, patients need for information and advice is the first point among the criteria which patients expect:
„The principal components analysis showed that patients mostly expected `information' and `explanation and understanding' items... " (Zebiene et al., 2004, p.87)

In the opinion of Pat. A, the osteopath on his part doesn't need to give so much information. She prefers to inquire purposefully, if she wants to know something: *„No, I don't expect that. So...I specifically ask what I want to know and I don't think that I forget anything. The things which are important to me, I ask, but whether someone needs to tell all of that ... I don't know. I don't think so." (IA/4/8-10)*
This approach is satisfactory for her: *"... if I ask, I get a great explanation, answer, and so I'm really very happy." (IA/4/1-2)*

Mr B finds information on specific therapy situations very important in order to better understand things for himself and prevent any disruptive factors: *„This is really important, because now I think if you know the reason behind your problems, then you can perhaps, on the one hand better understand things regarding therapy and on the other hand maybe one can turn off any interferences, if they still exist." (IB/3/49-4/1)*

Pat E is of the same opinion. The information is important for her in order to enable her to change things in her everyday life: *„ ...out of interest and whether maybe there is something which I can change in my daily life or should do so in the future." (IE/3/19-20)*

She finds it just as important as Mrs A, that if one has a question, one should receive an answer.

Mrs. F also says that counselling and explanation are important in order to positively change something in one's own actual condition:

„...if one wants to change or improve one's condition then it's important to receive clear statements about where the cause might lie..." (IF/4/47-49)

At her doctors, she discovered that there was no time for a detailed discussion. She finds counselling and explanation of therapy important for her personal development: *„ ...at least one has an idea of what the causes might be or may possibly be related. I find that interesting. If you can't come up with the reasons yourself, because of emotions or whatever, it's good to have a bit of help from outside. I find that very important, yes. Since if it was like that at my family practitioners or my orthopaedists ...one doesn't have these kinds of talks there, out of lack of time. It's never actually been mentioned. It's only symptoms, control and Bye. [...] So I find this very informative and profitable for me and any action I might take myself." (IF/5/12-21)*

Mr. H is included in the list of those who are happy to be advised, so that they can adjust their daily lives in order to improve their problem: *„In order to know where this comes from and how I can avoid the complaints. If they are avoidable. Or what I can change in my lifestyle so that these complaints go away." (IH/3/10-12)*

Mrs F stressed that she finds it particularly important, to get more detailed explanations during the first treatment, because the bond of trust between patient and osteopath has to be developed first: *„Especially when someone is touched in such a way for the first time, that it's explained: What's happening there [...]before it gets to the intimate contact stage, skin contact, I think it's important to at least ask people: `Would you like to know what I'm doing now or plan to do? That way barriers or blockades are broken and trust is built."*

(IF/5/30-37)

Mrs. F is of the opinion that in the course of further treatment, maybe a little less detailed explanations are needed, than in the first treatment. She would rather ask if she still wanted to know something specific: *„And if I felt like it, then following treatment, I would ask: ` What did you do today?´ Or `How did it go, or how did my body react, could you comment on it?´" (IF/6/1-4)*

Mr. G finds the consultation as already mentioned several times above, important, in order to find a solution to his problem: *„Yes, in order to understand that, I mean... if I know where something comes from, then maybe I can change things in my everyday life so that my symptoms no longer happen or that they get better or that they change for the better." (IG/4/44-46)*

He finds the explanation of individual grasps or treatment steps less important. If he was interested in something particular, then he would ask about it: *„There are simply treatments, where it's good if one can be quiet, let it happen, and then there are treatments where one thinks: `Oh! What's that?´ Then perhaps one gets an answer to a question or to a comment, but not a running commentary about what he/she is just doing and what's going to happen next and so on." (IG/5/8-12)*

For Pat. G the consultation also includes getting hints about what one can do as self-help, for example, exercises, nutrition tips and ergonomic office equipment: *„...in the event that I have a problem with my bones, I also get shown exercises or a different posture is recommended or something like that. Or if I work in an office, then he/she gives me tips about...Yes exactly, about how I can better setup my work place, or if they don't know, then they know somebody who can help setting up such a work place. So that the monitor and keyboard are in the right place, the correct height and so on. Or if it's organic... if my pancreas doesn't work properly, then I will get nutrition tips..." (IF/6/14-21)*

Pat. C also esteems the importance of explanations in treatment*: „...so I gladly ask about things or obtain explanations, where what comes from." (IC/7/49-50)*
The given information should not be too detailed and in addition not too scarce either*: „...so as not to talk about a sacroiliac joint for three hours but also not to just say: `sacroiliac joint!´." (IC/8/11-12)*

Pat. B would only like brief information about the approach in treatment: *„ ...because it's interesting to know what's being done, but to give it a name, would be enough for me. I think it's not relevant for me to experience each point, or each step now. I think it's more important to get brief information." (IB/4/11-14)*

Pat. D would on the one hand, gladly like information: *„ Yes, I would like information about the background." (ID/4/16-17)* On the other hand she doesn't necessarily want to have every step of the treatment explained: *„ ...what they do is very good, and I don't need to have it explained. I tell them my symptoms and then they treat it." (ID/4/38-40)*

Pat H doesn't often feel in a position to lead profound discussions during treatment: *" With some treatments, one is just completely gone, mentally and at that moment, its less important to me what's just being done, because it's so relaxing that I'm no longer in a position to have ... able to follow... a serious conversation." (IH/3/ 24-27)*

For some of the interviewees it is important that the osteopath gives them a prognosis regarding their complaints.
Pat A, for example, finds it reassuring to get a prognosis: *„ ...I've always asked about the indication, that was a little reassuring. It was important for me to know for reassurance sake. To roughly know." (IA/4/41-43)*
Pat.C also attaches importance to a prognosis: *„ ...I like to know where I stand." (IC/10/38-39)* She says that she can better adjust to treatment if she knows that it might take longer till improvement sets in: *„ ...you can cope better somehow. If you now know that it's something which is going to be a bit lengthy. At least, I'm like that: I can simply cope better, than when I go around thinking: `Oh that's nothing'. Or maybe I go there two or three times and it hasn't helped, and nothing's happened in that time, then one often gets afraid or bad tempered because one thinks: `Maybe it won't help.' But if I know from the beginning, it will take time, depending on how long it has already persisted, I can't assume that one application, and everything will be better. I find it very good to simply be told the truth." (IC/10/1-10)*

Mrs. D finds the prognosis good, in order to get a realistic view: *„And I actually find it good that everything's explained to one in such a way, because one grasps at every straw. But one knows that it will never completely go away." (ID/5/5-6)*
For Pat. E the prognosis is important in order to know *„ ...whether you must simply accept that it is, as it is." (IE/3/51)*
However Mrs F apparently wants to hear a positive prognosis, she would prefer avoiding a negative one: *„ ... if they still do this and that, then they at least see a chance to stabilize things, I would like to hear a prognosis then. But if someone said to me: `it's hopeless', then I would say: `Oh! yes, well thank you'" (IF/6/25-27)*
Pat H sees the sense in a prognosis in that he can better assess how often he must still come into the practice: *„ Whether it will take longer until the problem is eliminated to some extent and whether one needs 3 or 4 treatments or whether one can't correctly get an estimate, or whether one must come again and again at regular intervals because of this problem." (IH/4/46-49)*

7.4.1.1 Summary

Generally, each of the interviewees is interested in counselling and explanation. Most of them want information, in order to help them avoid making mistakes in their everyday lives, where the cause of their problem might be.
When it comes to explaining processes or relationships in the treatment, a brief explanation is enough for most of them. If they were interested in further explanations, most of them would then ask, in order to get a detailed statement.
Most of the interviewees found a prognosis useful for different reasons: Reassurance, in order to know „where one stands", to assess how often one needs treatment or even to get a realistic assessment of the situation.
Overall the interviewees expect sometimes more and sometimes less explanation and counselling depending upon the specific treatment situation. It is important to most that they get a detailed explanation on demand.

7.4.2 Expectations concerning the Osteopath

This chapter deals with, what particular human and therapeutic abilities patients expect of osteopaths.

For Ms. C the osteopath is also a confidant with whom she can also imagine talking about things which are particularly emotional. She expects the therapist to have a certain amount of sensitivity which would be a signal for her that one can talk about confidential matters:

„Well, what is most important, looking at it from a human point of view, is whether I feel that there is empathy. And one can feel that. That it's there. And that you also have the feeling that if something was bothering me, I could talk to her/him about it [...] I think that's important too." (IC/19/39-42)

For her it's very important to have confidence in one's osteopath in order to be able to relax: *" That confidence has to be there. That is very important. Because without it, I don't think one can't let oneself go"* (IC/19/47-48)

Pat D says that human interaction, things like sympathy and friendliness of the therapists are important to her: *"... that the osteopaths themselves were sympathetic and friendly, that's important to me." (ID/7/39-40)*

For Mr G human relations are also important, that social interaction between his therapist and him is good and that he can use this fact to his advantage: *„For me it's important that the relationship between therapist and patient is agreeable and that it brings a certain amount of success or insight, in any form whatsoever. And that was often the case." (IG/10/22-25)*

For Pat B, it is also an important criterion that the osteopath has an overview of how the treatment will develop, in relation to the treatment success. He wants to leave it up to the osteopath to realistically assess how much treatment is necessary in order to get to grips with the problem and that the osteopath also works to that end. He expects the osteopath to look at the whole situation and make clear to him as a patient what he should do:

„At the beginning we had a situation, where we took our son ... to an osteopath, who had been recommended to us, but I experienced that the problem didn't become effectively better and the simple assessment of the local osteopath differed from the one we had. In this particular case, I mean that he felt that after one or two treatments everything would be fine and therapy would be completed. Our son and I later realised otherwise, it was better, but the sustainability was lacking.

Therefore it was important for me to find an osteopath who had an over view, pursued things and made control appointments in order to maybe find that NOTHING was left overlooked. And who doesn't rely on me or that I don't have to rely on myself: ` Is something still there, do I go again now or am I still within the estimated time?' "(IB/2/39-50)

An assessment of the situation and its consequences are also for Mrs. F something she expects from her osteopath: *„I want to know where I stand at this moment and what could still happen in a positive sense." (IF/6/44-45)*

The atmosphere created by the team of therapists in a practice, also plays a big role for her. This situation helps her to decide whether she will be comfortable there as a patient or not: *„Another thing which is important for me is the feeling that it's a good team, although I've never been to another therapist apart from here. That the team work productively together, that there is no tension and no competitive thinking within the team. I find that very important. If you heard: `Oh, you'd prefer the colleague' and then a face was pulled or so... then you have the feeling that this clinic here has a good partnership or well-functioning team." (IF/10/39-45)*

Mrs E expects her osteopath to inform her about innovative possibilities which she/he may have learnt through training etc. For her it is one way, in relation to her complaints, to perhaps take a step further: Mrs. E: *"... if I don't know whether some things can be done with osteopathy or that there are new ideas, new treatments, just something new. [...] ... and that one speaks to the patient about them.[...] ... If one has learnt something and now could perhaps apply it, or offer it to the patient, talk to them about it and tell them that there is something new." (IE/8/7-20)*

In literature, there are indications that the therapist can be influenced in his clinical decisions, depending on what expectations he suspects the patient to have. In the study by Cockburn and Pit (1997) patients were increasingly prescribed medication when the doctor thought that the patient expected this from him: *„When the patient did not expect a medication the practitioner's judgement agreed in 80% of cases and when the patient did expect a medication the practitioner's judgement agreed in 65 % of cases. When the patient did not know in about half the cases the practitioner considered that the patient did not want a medication. However, for all categories of patient's expectation, patients were more likely to receive a medication when the*

practitioner judged that they wanted medication than when the practitioner judged they did not." (Cockburn and Pit, 1997, p.521)
Therefore, it can be seen that the physicians´ perception of what the patient requires, can influence her/his decision.

7.4.2.1 Summary

The interviewees make it clear that a good interpersonal relationship with osteopaths is an essential and important issue for them. Another big role played is the patients´ confidence in their therapist and rapport felt for her/him.
It was also mentioned that friendliness is expected of the osteopaths and that they should possess the ability to review the patients´ situation and to give an overview and sensibly control the course of the treatment in order to result in a good and satisfactory outcome.
It is considered as beneficial, if the osteopath has newly acquired knowledge which can be used in connection with patients' complaints and that he/she includes it in the treatment process and tells the patient about it.
A good team spirit in the practice is appreciated and helps ensure that the patient is comfortable.
One can say that the patients´ criteria above is expected and that each person "checks" for themselves whether these basic criteria are available between therapist and patient.

7.4.3 Expectations concerning the Osteopathic Treatment

In the previous chapter expectations regarding human relationships between patient and osteopath were discussed among other things.
In this section the question is asked, what expectations the patients bring with them regarding osteopathic treatment.

Richardson (2004) sees it as important that the therapist knows about patients' expectations regarding alternative therapies, because this understanding in turn, contributes to his/her patient assessment and ensures that it remains reasonable and realistic:

„Physicians´ understanding of patients´ expectations of complementary therapies will help patients make appropriate and realistic treatment choices.“ (Richardson, 2004, p.1049)

This issue represents a central theme of this study and should therefore be looked at in more depth.

Mrs A expects the osteopathic treatment to eliminate pain without invasive intervention: *„ ...that the pain simply goes away, without any ... classical medicine, or without major interference.“ (IA/1/43-45)*

She hoped that the existing symptoms would disappear with the treatment: *„I promised myself that it would go away, hopefully, and it did. “ (IA/2/7)*

She mentioned that at the beginning of the therapy, she had hoped for success and that meanwhile she expects success: *„The first time I just hoped, because I didn't know whether it would really help and now I have the expectation that when I come here, afterwards I will feel well. “ (IA/7/13-15)*

Mrs C has the same expectations as Mrs A of osteopathic treatment. She too, expects symptom improvement, complete freedom would be ideal: *“Yes, improvement in any case, from the physical discomfort that I have. [...] And at best, of course, elimination of complaints, if that's at all possible. It is of course, it just depends on what it is, and how long it is has already been there. But in any case an improvement.“ (IC/11/39-45)*

Pat D´s expectation of osteopathy is no different. She expects:

”An improvement. An improvement!” (ID/5/40)

The main expectation of Pat E is pain relief: *“Yes, I promised myself pain relief. Because I had this bad back pain and I hoped to get help.“ (IE/1/31-32)*

Pat B also expects an improvement in his complaints, if not even complete freedom. Furthermore, in the osteopathic therapy, he would also like to know what he can do himself in order to achieve an improvement: *„ ...I go there expecting symptom relief, I'd be particularly happy to gain complete freedom from symptoms, but also of course for advice: ` What can I do myself ?´ Well, of course, I would like the `Complete package´ “(IB/4/43-46)*

The question if "complete package" meant advice on areas such as nutrition, food supplements and healthy way of living was answered: *„Absolutely! If there are things which I can do myself, then I naturally like to receive advice.“ (IB/5/1-2)*

Mrs F primarily expects pain relief. Moreover, she hopes to get her "system" back into balance in a gentle way by means of osteopathy. She expects osteopathy to deal more with the human being as a whole: *„ ...that my pain gets a little better and that my whole situation or my whole system is brought back into more harmony, with this lighter method and not the brutal conventional treatment. So that was what I hoped, because I thought about the conventional method with abrupt manoeuvring of my spine, syringes and medication, and I wanted to try the method based holistically on the human being. And find out what's mentally behind it." (IF/1/34-40)*
She also hopes to get a better relationship with her own body again, through the treatment. It's a positive feeling for her that someone is tending to her. She sees the treatment as an interaction between patient and therapist and feels more involved as a human in the treatment process, than she's used to with conventional medicine.:
„ ...simply that I feel better, more comfortable. In myself, with myself and with my body. That I can find a bit more body feeling again for me, with this form of treatment. Now, with this treatment, it's a feeling that I can let go, now someone's there tending to me. Who tends to my body, but there is obviously the danger that we let ourselves totally fall and think: `Oh! How nice, I'll go there again, because there I'll be cuddled a little'. No, I really see it as an interaction between the therapist and me, even if it's a passive interaction. I don't do much. I let do. But it's different to when a doctor does something to one, then sends you away, here there is sustainable impact. That's how I feel. That I'm not closing the door and that's it, but that I follow the advice I'm given, drink more and rest after treatment. So that the effect continues and that one doesn't carry on under one's normal stress. That one thinks: `Now, I've been to the osteopaths, now I have to do this and that and then I'll go home.´ That's not so. So one has a lasting sense of what has been done." (IF/1/34-2/15)
From this section it is clear that osteopathic treatment penetrates into their lives to a certain depth. After treatment, their routine is still different to the usual everyday routine and one pays more attention to oneself and doing things slower.

Pat. G expects as most of the other interviewees that his "problem" will be solved. Moreover, he expects an insight into the causes of it. Only then can one go about curing it and doing so permanently: *„...that the problem which I have is solved and that one finds out what causes it. In order to not just be treated for the symptoms but that the cause is researched on the whole, so as to prevent things happening again in*

the future. Because if you don't find the reason behind it then it will probably come back again and again." (IG/6/4-9)

Mr H has principally got the same expectations on osteopathic treatment: *"That the pain goes away.[...] Maybe that it never comes back, yes, that would be really good." (IH/1/40-47)*

In the study of Richardson (2004), patients who had acupuncture (50%) and homeopathy (29%) were questioned along side osteopathic patients (30%) Richardson (2004) came to the conclusion that patients expect the following: symptom relief, a holistic approach to treatment, improvement in the quality of life, information provided by the therapists, reduction of the need to use allopathic medicine and tips on how to help oneself. Patients also desired a better availability of complementary medicine in their health care system.
Interestingly enough nearly all of these factors are expressed in the interviews

7.4.3.1 Summary

All interviewees agree upon one particular expectation issue which they have about osteopathic treatment, all of them expect system relief and most hope, in the optimal case, for freedom of symptoms. In two cases it was also stressed that emphasis should be placed on lasting improvement or even a „cure". To achieve this one should also seek the cause of the symptoms which could stand in the way of a cure. It is clear that a mere combat of symptoms is not sufficient, in order to achieve the goal of sustainable improvement or even a cure.
It was often said that osteopathy can achieve this in a gentle manner and that this is expected and encouraged.
The desire for a „complete package" of health advice was also mentioned. This could include advice on nutrition, food supplements or even tips about a healthy life.

7.4.4 Cooperation with other Therapists

In this chapter the question is examined on whether the interviewees expect the osteopath to cooperate or exchange information with other specialized therapists who are also treating the patients.

Mr B finds collaboration with other specialists makes sense, whereby therapies shouldn't be contrary to one and other. For this reason he informed his therapist about which other therapies he is taking. From his experience, therapists are seldom active on their own initiative. This however would be desirable: *„I would certainly welcome that, if that was the case...experience has shown that the individual specialists tend to do nothing. They occasionally write a letter to one and other, but I've experienced lately that the patient has to sort the coordination out them self. And that's the reason why I always tell other therapists clearly who else is going to see my reports and which other therapies I'm taking. [...] It is important that one doesn't do conflicting things and I would obviously welcome it if the specialists would share and exchange information in their own jargon." (IB/4/26-36)*

Pat. H is the same opinion as Pat. B, that cooperation is a positive thing, so that therapists don't work against one and other. However he also says that this is mostly just theory and often difficult to implement in the practice: *„...in this case it would be helpful if one was having treatment by several different therapists that they told each other what had been done, so that they don't work against each other. [...] So it would be good if they told each other what they had done, but that's probably not feasible. It means that I need to know exactly what's been done in order to be able to tell the next therapist." (IH/5/6-17)*

Mrs C also finds collaboration between therapists useful but she doesn't exactly expect it.

„If it was necessary, why not? Not a bad thing!" (IC/11/19)

Pat. F also finds that collaboration makes sense, especially since her own experience has shown that treatment is then more than effective. In her opinion it gives a better overall picture of her as a patient: *„...If the other therapists agreed then it would be all right. I've already noticed for example that it's helpful through the cooperation between my local practitioner and my dentist or my psychotherapist and my local practitioner, it doesn't help anyone to get the complete picture of me as a person or as a patient if I go around and tell a bit here and a bit there. I think that it is important that each of them knows about the others and that some kind of exchange takes place between them in order to optimise treatment. If they take it seriously." (IF/7/21-28)*

However she also realises that therapists have a time problem in the practice: *„Well if people had the time, but no one has that any more.." (IF/7/49)*
Pat. G sees advantages in cooperation but he doesn't expect it: *„I wouldn't mind an exchange taking place. It's clear that that can only be beneficial. [...] But I don't expect it, I have absolutely no expectations but it would be ok for me, because if a specialist has the desire to exchange details with an other specialist that would be of benefit to everyone.." (IG/5/39-49)*

7.4.4.1 Summary

Generally, the interviewees find, that cooperation between their osteopaths and other therapists is sensible and see advantages in it. They see that therapy can be optimized for them and also that it can prevent various therapies which they are using, working against each other.
Basically, respondents find cooperation positive, but you can almost read "between the lines" that this cooperation is not common, not on the agenda, and ultimately in everyday practice, difficult to implement for lack of time.

7.4.5 Patients imagined Idea of what Osteopathy is

What expectations patients have depends among other things, on what idea they have of what will happen. As already described in Chapter 2, the expectation of an individual is: „*...an idea that one has of a possible future event.* " (Westhoff, 1985, p.12)

For this reason, it is important to accurately consider the idea which patients have about osteopathy.

Mrs A is of the idea that osteopathy will resolve "the problem" without violent interference. She believes that osteopathy provides a sustainability which can not be achieved by other known treatments: *„ ... I think that osteopathy...in my case especially my back, solves the problem, if the spine isn't where it should be, it will probably be somehow pushed into place without being pulled and cracked, and without it being set straight like at the... chiropractic...or if one goes to*

physiotherapy, or massage, only tissue is eased or stretched... but the fact that one's vertebrae are not in the right place is not resolved." (IA/5/41-47)

Osteopathy brings her relief in the form of muscle relaxation and she also talks about the fact, that after the treatment she has a "different attitude towards life". All that she perceives during treatment is that the therapists´ fingers make slight movements which trigger of a major reaction: *„ ...I always try to listen inside myself and think, how...does it work? Because actually from the beginning I couldn't really believe that when I get off the table, it really is easier and the muscles are loose and that there's just another feeling there. That's really a different feeling, because if you can't look straight ahead for weeks without pain and then suddenly you can turn your head...that's just a great feeling, but I must say it is...I don't sense...hardly anything. I feel the fingers, sort of itchy and that they...such slight movements but so much reacts in my body... it's fantastic to me" (laughs) (IA/5/13-21)*

Mr B believes that osteopathy is more than just an „alternative" and that it has different ways of going about things.: *„I think...or my feeling is, that it is more like an alternative. I think that it just existed some when and my experience is that it is a gentle alternative medicine method...Which means that one can treat a lot of things in a different way from the methods used so far and I regret that it is not yet very well known. That it is still an unknown method..." (IB/5/28-33)*

Mrs C thinks that osteopathy can help her without tablets… *„ ...that I can be helped without having to take pills and chemicals..." (IC/12/23-24)*…and that osteopathy positively influences inner organs as well as bones and muscles: *„ ...that it doesn't just help my bones, my muscles and everything around them, but also my inner organs, because that also helps me to detoxify" (IC/13/27-29)*

Just like Mrs A she says that she can feel slight movement: *„ ...what one really feels is...that is actually very fascinating, these very slight, really there just like feather movements." (IC/17/37-39)*

Furthermore, she finds that one can relax during osteopathy although some things in the treatment are a little unpleasant. She senses a sort of 'getting softer' sensation through the treatment and has the feeling that her blood circulation is better afterwards:

„ ...how one becomes more and more relaxed. I can feel that it's just right, how I can let my shoulders hang. I mean hang in a positive sense. That I can feel inwardly relaxed. I'm often even tired, sometimes I could just fall asleep under their hands.

And I think that is a very positive occurrence. Well sometimes it does hurt, oh! yes, but sometimes that can't be helped.
But actually it's this sensation of `getting softer', which one feels. And afterwards this feeling of having a better blood circulation." (IC/18/1-10)
Mrs D shares the idea of an improved blood circulation with her: *„ Well I think that it has to do with certain grips...so I can't describe it properly...I can't...it's sort of...how should I say? That the circulation...that one's blood runs better...that's what I imagine. But I can't really describe it. Just that afterwards the whole feeling... that I feel better after these grips. That's what I try to explain to people who don't know anything about osteopathy, but one can't really tell them much. I say: They do special grips on you which help the blood to better circulate." (ID/5/23-30)*
Mrs D sees osteopathy as a treatment method without any side effects: *„ ...If for example I go to an orthopaedist, she/he will give me an injection, but that has side effects which the osteopathy doesn't. So osteopathy doesn't have any side effects and I find that better." (ID/6/13-15)*
When Mrs F came to her first treatment all that she knew was*„ ...that one's bones are compressed a bit and the organs. I didn't know any more than that. That it was a gentle method, healing method." (IF/1/12-14)*
She imagines osteopathy to be a treatment method which is pleasant and not painful. The exact definition in public use isn't clear to her. She also makes the statement that she doesn't think that an orthopaedist would recommend an osteopath to a patient as they are practically rivals: *„ Under osteopathy one understands as layman, it is something which doesn't hurt, which is pleasant and brings your body something. And under orthopaedist are things which everyone can imagine, methods of setting things straight, injections, tablets and x ray machines. But I think the job ,osteopath' isn't clearly defined for the general public. It's more of a mouth to mouth propaganda and I can't imagine an orthopaedist recommending someone to go to an osteopath. That would perhaps be a loss for them." (laughs)*
(IF/4/22-29)
For her, trust in her therapist is essential in osteopathic treatment. She thinks that an osteopath listens to the patients statements and tests their whole body system, in doing so the osteopath finds particular parts of the body where her/his hands dwell longer : *„ I think that an essential factor for osteopathic treatment is that one goes to*

the practice with confidence and when treatment happens, if I'm being treated, then I can lie down and relax and give indications about what my problem is and then I know he will direct his attention to these things, puts his finger on it. But at the same time check over the whole system. So he says: ` Wait a minute' or he feels that something is wrong and that it is appropriate to take a closer look and he stays on that place a little longer. This is very pleasant for me." (IF/8/4-12)

Mrs F has a concrete idea of how osteopathy works. Her conception is that the osteopath works with „movements "and/or „frequencies "and that thereby an interaction is given in the body. In her opinion the therapist promotes these „movements" and harmonizes thereby the organs: *„ ...that the therapist simply gets on to the persons energy circle, and then they can feel the movements, frequencies. And what they then explained to me was that they adjust themselves as it were to the movement or the interaction of the organs amongst themselves. And by using their hand movements, they then as it were, push back this frequency and bring the organs back into consonance." (IF/8/38-44)*

She sees this procedure as an „interaction" between osteopath and patient, since she is more included into the whole procedure as a patient. For example after the treatment she still obeys behaviour advice, in order to support the effect of the treatment*: „ ...but I really see it as an interaction between the therapist and me, even if it's a passive interaction. I don't do much. I let do. But it's different to when a doctor does something to one, then sends you away, here there is sustainable impact. That's how I feel. That I'm not closing the door and that's it, but that I follow the advice I'm given, drink more and rest after treatment. So that the effect continues and that one doesn't carry on under one's normal stress. That one thinks: `Now, I've been to the osteopaths, now I have to do this and that and then I'll go home.' That's not so. So one has a lasting sense of what has been done." (IF/9/5-15)*

She also sees that a lot of background knowledge is evidently taught in an osteopaths training and that they must develop great sensitivity: *„ ...there is more behind it than just a bit of pushing and poking. I think there is a very big background potential... in this training ... that a very fine feeling for the patient must be developed, otherwise it has no sense. [...] I think there must be a lot of psychological training behind it.." (IF/10/4-12)*

For Pat G, osteopathy offers a special, holistic way of seeing things. For him, this is a peculiarity of osteopathy, which he misses in conventional medicine: *„ The way I got*

to know osteopathy...it offers me a different view of things. A holistic approach, where not only symptoms are viewed, but I as a whole, with my surroundings, my social environment, my hygiene, diet and so on. That's the way I got to know it. And nothing else offers that. I haven't found anything like that in normal medicine." (IG/6/26-31)

On the question what in his opinion osteopathy offers him which other treatments don't, he replied: *„ ...sustainability. [...] ... that symptoms are really relieved. That the pain goes away, that a misalignment is then gone. On one's foot, the knee, I don't know what. And the gentleness, no one else offers that." (IG/6/39-48)*

Osteopathy also offers him sustainability in the sense that the effect of treatment doesn't stop within a certain time, but is lasting. And also that it is reached in a gentle way.

Pat. H knows osteopathy to be not without its side-effects because it happened that he had slight orientation problems after treatment. Other people have even told him that symptoms may even first get worse after treatment: *„I've only heard stories, that after treatment one first feels worse and that you don't know where you are and have slight orientation difficulties and that one patient had himself put into hospital the next day, because he was feeling so bad afterwards. I didn't really feel bad, but I didn't know where my car was." (IH/2/1-5)*

7.4.5.1 Summary

The interviewees' ideas of what osteopathy is describe, what they perceive during the treatment, what they imagine osteopathy to cause, what osteopathy can accomplish and how it might work in their imagination.

Some of the interviewees perceive that during treatment slight hand movements are made by the osteopaths.

Several times the opinion is held that the effect of osteopathy is lasting and that in osteopathic treatment, problems will be solved, i.e. complaints do not return.

There is also the idea that osteopathy is a "different approach" without explaining this precisely and that during osteopathic treatment, bones, muscles and organs are affected and this leads to an improved blood flow.

However, what an osteopath does during treatment seems to be elusive and is circumscribed.

Osteopathy is viewed as a gentle method, which encourages the interaction of the organs and brings them back into unison. Osteopathy is also described as having no side effects, on the other hand, there are voices which say that after treatment a temporary deterioration may occur.

7.4.4 Expectations concerning Clinic Organisation

Expectations in clinic organization should be discussed, as this aspect emerged during the course of the interviews and for two of the patients surveyed, this also played a role in their expectations.

Mr G values not having to wait a long time in the clinic: *"That one has a reasonable amount of waiting time. That I don't have to sit around for two hours until it's my turn. Because nowadays, we can't all just stop and wait around for an hour or two. Where they make an appointment for three and it's your turn at six. " (IG/10/35-38)*
He feels that a waiting period of up to half an hour is in order.
Mrs E is keen on the practice being well organized so that one isn't disturbed through someone coming in or the phone constantly ringing during therapy:
„ ...that one simply feels well and that one is... not disturbed, that it's peaceful and that the phone doesn't ring continuously or the door be opened." (IE/6/15-16)
For Mr H appropriate waiting periods are also important criteria in clinic organisation. He feels that a waiting period of 15 minutes is ok:
"It's very important to me that I don't have to wait long. If I make an appointment ... well, of course, you can't always be dead bang on the minute, but so that it's not more than a quarter of an hour later. Yes, that's very important to me. I also think that that's a very big shortcoming in doctors. One has already made an appointment, and even there you sometimes have to wait a long time. So waiting for over an hour till it's your turn, no, that's not ok." (IH/7/36-41)

7.4.5 Clothing worn by the Osteopath

Several studies have examined what concept patients have about therapists´ clothes and what they would prefer. (McKinstry and Wang, 1991; Rehman et al., 2005; Lill and Wilkinson, 2005; Newman Turner et al., 2006)

McKinstry and Wang (1991) came amongst others things, to the conclusion that 64% of patients considered it important or very important as to how their doctor was clothed. 82% of the people questioned by Rehman et al. (2005) indicated that the therapists´ clothing was important.

The two last mentioned studies were both made in the physicians´ area. This is definitely not a 1:1 representation for osteopaths. Therefore it is only briefly mentioned here, that patients preferred the white lab coat most of all, in both studies. However it could still be interesting for osteopaths as the results vary in different age groups, social layers, between men and women, depending on ethnic affiliation and also from practice to practice.

Elderly patients for example, prefer a white lab coat and African-American patients generally place more value on the doctors´ clothes. (Rehman et al, 2005; McKinstry and Wang, 1991)

The study in New Zealand which was carried out by Lill and Wilkinson (2005), came to the conclusion that older patients generally tend more toward white lab coats and favour conservative clothing on their doctor. However, overall a rather half-formal dress was preferred, meaning conservative, but not necessarily the classic white coat. The elder people who were questioned also assessed it as negative if female physicians had facial piercing, short tops, dyed blonde hair, training shoes, sandals, open hair, short skirts, long earrings, and multiple rings or wore sleeveless clothes. With male doctors, the following points were evaluated negatively by elderly patients: facial piercing, dyed blond hair, earrings, T-shirts, training shoes, long hair, several rings, a tie with a cartoon character and no tie.

The study from Newman Turner et al. (2006) examined the aspect of therapists clothing, in the complementary medicine field. 45% of the people questioned were osteopathic patients. The study was carried out in Britain, whereby all parts of the country were included. It was found that the white coat is preferred over ordinary clothes. Different regions varied: depending on the region, it varied between 15-90% who preferred the white coat. Relatively old and relatively young patients mainly opted for it and especially osteopathic patients:

„The majority preferred practitioners to wear a white coat (65%) rather than casual dress. [...] However, the result relating to the white coat was puzzling, being very variable between sub- groups. In a univariate analysis, white coat preference was highly significantly related to area of residence [...] and ranged from 80% to 90% in

East Anglia, Midlands and Scotland to only 15 % in the North East. The preference was highest in the youngest (20-29) and oldest (70+) age groups [...] and in those receiving osteopathic treatment."
(Newman Turner et al., 2006, p.104-105)

To get an idea about which clothes osteopathic patients find appropriate for osteopaths and what ideas they have on this subject, the question was integrated into the interview guide.
First of all the interviewees were asked which clothes they would find adequate for an osteopath.
Mrs A puts, just as in previous issues, less emphasis on outward appearances. She says:
„I think it should be...casual." (IA/8/5)
Mr B also takes the view that clothing is less important, he puts the therapist's qualifications in the foreground:
"... if the osteopath is qualified, then that is completely ... I don't care whether they are wearing jeans, Bermuda shorts or running around in a bikini because the qualifications count for me and.. clothing is more than secondary to me." (IB/6/26-28)
Mrs C pleads likewise for a more casual kind of clothing. She finds white „physician garb" inappropriate:
„Completely casual. COMPLETELY run of the mill. That would be best. I don't really like it when alternative practitioner's run around in white physician's garb. I really think its ok if their dressed in spa trousers or a spa suit, they often wear jeans. I wouldn't want it differently." (IC/15/27-30)
Pat. D can't imagine osteopaths in white coats and thinks that a kind of casual clothing is most fitting:
„...casual...and not tarted up. More conventional, I would say. Simple. [...] ... can't imagine an osteopath running around in a white coat. Casual clothing and nothing else..."
(ID/7/46-8/8)
Mrs E basically takes the same view. The way in which doctors dress is not appropriate for osteopaths, simply „normal"clothing:

„... now, if he was dressed like a doctor, completely in white, I wouldn't find that...so appealing. Just normal clothing. (IE/6/38-39)

The most important thing for Mrs F is that the osteopath feels comfortable in the clothing he/she is wearing:

„The clothes in which they feel comfortable. Well, I think a green gown or billowing robe would be somewhat aloof. That wouldn't be good. Because I think an osteopath doesn't need a uniform in order to show his/her ability. And I also think that a therapist should wear clothing in which they can move and feel comfortable. Then they can work their best."(IF/11/12-16)

In her opinion, clothes should support the essence of the person wearing them, otherwise the therapist would seem unnatural to her:

"I really think someone should dress in such a way as they feel best, and not as is expected of them. That sort of person is consistent for me when they run around in an outfit in which they feel good. If however I notice that it's put on, then there's an obligation behind it, which I don't find good." (IF/12/2-6)

She believes that it would have a negative impact on treatment if the osteopath felt uncomfortable in his/her clothes:

"Well, I think osteopaths come across better when they dress so as they think fit, leaving it up to them about how they want to dress. And that has to do with the person and not... I think someone feels comfortable when they feel well with them self and then they can deal with things better. That's my opinion." (IF/12/39-43)

Pat. G thinks that the first priority in osteopaths clothing should be that it is comfortable. It should rather not be white and nevertheless differ a little from normal street clothes. He makes it clear that the clothing issue is less significant for him:

„Comfortable clothes. They can even be colourful too. Yes. But it should still stand out against that what is generally worn on the street. That would be good. [...] There are simply people for whom it is very, very important, what one wears, for me, it's basically not important what one wears. For me it's nice if someone doesn't run around in sterile-white, I find that really bad, I don't like that at doctors too, or else where. I just think the person who's there should be authentic." (IG/8/40-9/4)

Mr H finds normal everyday clothes appropriate for osteopaths, it is important for him as well that the therapist feels comfortable in his/her clothes:

"I would say .... just normal everyday clothes. Just what the osteopath feels is good. The osteopath wouldn't really seem credible if he sat there with a suit and tie on. I

don't think that would be a good idea. I mean, he works with people and not with paper, and not with a computer and then it's actually quite normal, T-shirt, jeans, shirt, trousers ... should be comfortable for him." (IH/8/31-36)

7.4.5.1 Summary

On the question which clothing is considered reasonable for an osteopath, the opinions of the interviewees are very similar. The therapist's clothing should be casual and comfortable and she/he should feel comfortable in the clothes worn. They are of the opinion that an osteopath who feels comfortable in his/her clothing is more authentic and credible for patients and that this positively affects their work.
The only discrepancy is, that there are voices which say that clothes should be as "normal", as in everyday life, on the other hand the opinion that the afore mentioned criteria should be fulfilled but that one should be able to distinguish from normal "street clothes".
A consensus is found, that white clothes, as are usual for doctors, are not desired on osteopaths.

7.4.6 Clothing worn by the Osteopath and Trust

In literature, there are indications that the way in which a therapist dresses, has influence on whether patients have more or less confidence in the therapists abilities. McKinstry and Wang (1991) found: *„Given that 41 % of the patients said they would have more confidence in the ability of one of the doctors based on their appearance it would seem logical for doctors to dress in a way that inspires confidence."* (McKinstry and Wang, 1991, p.275)

In a study from Rehman et al. (2005) patients indicated that they tend to discuss confidential problems with a doctor, whose clothes they prefer, which in this case is the professional outfit: the white lab coat: *„Respondents also answered that they were significantly more willing to share their social, sexual, and psychological problems with the physician who is professionally dressed."* (Rehman et al., 2005, p.1283)

In order to get an idea about what priorities osteopathic patients have regarding dress of osteopaths, when they see real pictures, following experiment was conducted: The interviewees were shown four photos of a female osteopath and four photos of a male osteopath wearing different clothing styles. They should look at them and decide which osteopath they would most likely trust on hand of his/her clothes. Factors such as sympathy and facial expression should be ignored and only the clothes judged.

The photos can be found in the appendix of this master thesis.

Female osteopath.

Picture ***Wa*** is the only one which is favoured from all of the interviewees: *„ ...this is a more pleasant direction. " (IA/8/22)*

Everyone also finds photo ***Wb*** good. Mr B thinks, ***Wb*** is *„ ...open and innovative" (IB/7/13)*

Photo ***Wc*** arouses less confidence in the interviewees. Mrs A finds this outfit *„terribly formal." (IA/8/17)* Mr B feels it is too buttoned up and hardly innovative at all.

The white lab coat is generally rejected by everyone.

Mrs C thinks that the photo ***Wc*** looks to strict. She thinks, just like Pat. D and H, that the white lab coat is too *„doctor-like"* and that it is inappropriate in alternative medicine:

„I think that in alternative medicine, there's no..no one needs it." (IC/16/25-26)

Pat. F also finds photo ***Wc*** as inappropriate: *„ ...I find it too buttoned up and too closed." (IG/9/38)*

Contrary to the previous photo, photo ***Wd*** is judged as too lax. Mr B feels that the person in this outfit is not recognizable as a therapist:

"... now I don't know who I have in front of me. Now, purely related to optics, I would walk in and be uncertain whether it was the lady from the reception, or even another patient in front of me." (IB/7/14-17)

Mrs D feels that the outfit is *„to sporty, that doesn't look like she's in the clinic." (IF/12/16)* Mr G also feels that these clothes are too casual for an osteopath:

„For me she looks a bit like : `I've just come from jogging and I'll do a bit of therapy quickly and then I'll be off again.´" (IG/9/38-40)

Mr H joins the above opinions. For him ***Wd*** is *„ too casual"*

Male osteopath.

Photo ***Ma*** was unanimously rejected from the interviewees. Pat. B feels reminded, through this kind of clothing, of a salesman: *„Now that only radiates seriousness but not competence, a little bit salesman. " (IA/7/1-3)*

Mr H is reminded more of someone in an office: *„ ...looks likes, a... clerk." (IH 8/46)*

Pat. D. judges the clothes as *„ too fine" (ID/8/21),* exactly the same as Pat. E: *„to fine." (IE/7/20)*

Pat. F believes that she can tell that the person doesn't feel happy in the clothes he's wearing: *„Well he obviously doesn't feel happy in the other outfit. [...]...that's absolutely, it doesn't fit at all." (IF/11/36-40)*

Mr G feels that the osteopaths' clothes on photo ***Ma*** are useless and too reserved: *"Because a tie wearer is far too aloof for the job. To work on people with such a tie and a nice jacket, somehow that's useless in my view." (IG/9/25-26)*

Mrs A finds photo ***Mb*** as *„ terribly formal " (IA/7/17).*

Pat. C on the other hand, feels that the outfit reminds her to much of a doctor*:*

„He looks so 'doctor-like', I wouldn't like that." (IC/16/21)

Mrs D also thinks that this osteopath looks more like a doctor: *„No. That's more like a doctor." (ID/8/26)*

Mrs E is the same opinion. For Mrs F the photo looks to buttoned-up: *„ ...that's to tight for him up there." (IF/11/44-45)*

Mr H feels reminded through the white lab coat of a hospital:

„ ... that looks awfully like hospital." (IH/8/46)

Pat. B is the only one who prefers photo ***Mb***: *„ ...for me it radiates seriousness and competence" (IB/7/1-2)*

The photo of ***Mc*** is approved by everyone. Mrs A finds ***Mc*** *„ok"*. The other interviewees evaluate the photo as good and suitable, whereby this photo becomes the least detailed commentary. Everyone thinks it is in order and has nothing negative to say about it.

Md is picked out by a few as first choice. Mrs A favours it because it is casual. She can also well imagine the clothes on the photo of ***Mc***, but finds ***Md*** better*: „ Yes, that direction. C is ok, D is better." (IA/8/41)*

Mrs C most likely trusts someone who is dressed casually: *"I like it very, very casual. Something like that is what I really like (pointing to D, in dark shirt)". (IC/16/34-35)*

She finds that osteopaths should basically dress in "plain clothes".

„ ...very casual, just like one would dress oneself for a normal day. That's how my alternative practitioner dresses. I've never seen one in a suit. Honestly not." (laughs) (IC/16/45-47)

Pat. F, G and H also support the casual variant worn by ***Md***. Emphasis is put on the fact that the therapist should feel comfortable in his clothes.

7.4.6.1 Summary

The white lab coat was unanimously rejected for female osteopaths. It was generally regarded as too formal, rigorous, doctor-like and evaluated as too secretive. The people questioned considered the casual hooded jacket as too easy going and casual. In their opinion, this person is not recognizable as a therapist.

The white blouse, as well as the beige cord blouse were favoured and rated as pleasant, open and innovative.

Interestingly, the photographs, which were negatively assessed, were commented on much more extensively than the photos which were rated as good.

For male osteopaths the outfit with jacket and tie is considered too fine, salesman-like, and too office-like and is seen as being distanced.

The white lab coat is rejected just the same as the female osteopath, because this outfit has the effect of being to formal and doctor-like.

The white shirt and dark casual top were rated as pleasant and were most favoured.

8 Discussion

8.1 Summary of Results and Comments

This work represents the attempt to find out what patients expect from osteopaths and osteopathic treatment when they come to an osteopathic practice, using qualitative methods.

The theoretical part of this master thesis deals with the term expectation in the social sciences field and in the context of patient-therapist.
In the methodological part the qualitative method is presented and the interviews and their analysis using qualitative content analysis are explained.

By the selection of interviewees emphasis was laid on becoming as large a spectrum as possible regarding gender, age, education and clinic location in order to be able to listen to different opinions and views.

In the result part at the end of most chapters there is a summary of the respective results. For this reason no complete summary of results will be given here. Nevertheless, the most important points are summarized again here, in order to unite the many individual questions and quintessential points of the study.

Motivation to try out this method of treatment (osteopathy) was found by most of the interviewees, through favourable stories that they heard from people in their immediate environment. Due to these recommendations, the next step was to simply „try it out "and the recommended practice was visited.
Disappointment over various other methods, which had not brought about permanent success and were partially felt to be brutal, also led patients to look for alternative possibilities.
In particular the holistic requirement of osteopathy and the possibility of being able to achieve continuous symptom relief in a gentle manner, motivated most of the interviewees to visit an osteopath.
Need for information about osteopathy still generally exists, treatment approach and in which areas osteopathy can be applied, were particularly mentioned.

The interviewees are also interested in becoming advice, apart from therapy, about how mistakes in everyday life can be avoided in order to locate the cause of complaints.
Most of the interviewees only want a rough explanation about the treatment process. If certain processes are more interesting, they would then like to be given a more detailed explanation on demand, however, they see no need, on the therapist's part, to exactly explain everything.
In order to better assess their situation, patients are interested in a prognosis.

The treatment goal for all interviewees is to attain relief of at least one complaint and optimally to even become symptom free, through osteopathic treatment, in gentle manner. It is also judged as meaningful to search for the cause in order to find out from where the problem comes and to make corresponding changes in ones everyday life which lead to a solution of the respective problem.
The interviewees also gladly listened to tips concerning their behaviour with nutrition, food supplements and a healthy lifestyle, insofar that they were related to their problems.
The patients surveyed emphasize found it important for their osteopath to have been educated well, so that they could expect good treatment quality.
They placed no great value on titles and additional names (like MSc. or DO), especially since it was unclear to all of them what these abbreviations actually meant.

The main focus points are quality of treatment, sympathy toward the osteopaths and friendliness on the part of the therapist to the patient. Even a good team spirit in the practice is also an important point which was spoken about. In most cases, the therapist's gender plays no role for the patients. Reasonable clothes for an osteopath are considered to be a rather casual and comfortable therapist-style.

Pleasant, warm colours and a certain degree of comfort and cosiness are desired in the treatment rooms. No disturbing noises or other disturbances should be present during treatment if possible.
Other desired factors are respected privacy about information given and conditions of visibility for other patients.

Furthermore, through practice organisation, there should only be short waiting periods.

This study should point out which aspects in patient expectations can flow into the osteopathic field.
The information which the patients surveyed in the interviews have given should give osteopaths an insight into patients thoughts and actions in order to be able to ultimately respond to their needs and ideas.
The issue patient expectations in the osteopathic field could only be touched upon with this study because the fundamental goal was to get a small selection of views from as many different patients as possible.
This his study may be a basis for further research h in this field. The results could, for example, be helpful for further quantitative research (questionnaire) on patients' expectations.

8.2 Critical Reflection on the Study

In this master thesis some studies were used which examine the issue of patient expectations or satisfaction within the medical range. However the conventional medical field is definitely not representative of osteopathic medicine, as practiced in Europe. For this reason only statements and results were used from these studies, which can be transferred to the osteopathic field.
The osteopathic studies from the United States are also less than 100% representative of the European area since the osteopaths there work as doctors.

9 Literature

Ahmad, W.; Kernohan, E. and Baker, M. (1991): Patients` choice of general practitioner: importance of patients` and doctors` sex and ethnicity. British Journal of General Practice. Vol.41; 330-331.

Anderson, L.A. and Zimmermann, M.A. (1993): Patient and physician perceptions of their relationship and patient satisfaction: A study of chronic disease management. Patient Education and counselling, Vol.20, 27-36.

Astin, J.A. (1998): Why patients use alternative medicine- Results of a national study. JAMA, Vol.279, No.19, 1548-1553.

Baker, S. K. (1998): Managing patient expectations. The art of finding and keeping loyal patients. San Francisco: Jossey- Bass Publishers.

Büchi, M.; Bachmann, L.M.; Fischer,J.E.; Peltenburg, M. und Steurer, J. (2000): Alle Macht den Patienten? Vom ärztlichen Paternalismus zum Shared Decision Making. Schweizerische Ärztezeitung, 81,Nr.49; 776-2780.

Cockburn, J. and Pit, S. (1997): Prescribing behaviour in clinical practice: patients´ expectations and doctors´ perceptions of patients´ expectations- a questionnaire study. BMJ Vol. 315; 520-523.

Di Blasi, Z., Harkness, E.; Ernst, E. Georgiou, and Kleijnen,J. (2001): Influence of context effects on health outcomes: a systematic review. The Lancet, Vol. 357, 757-762.

Flynn, K.E.; Smith, M.A. and Vanness, D. (2006): A typology of preferences for participation in healthcare decision making. Soc Sci Med; Vol.63,No.5, 1158-1169.

Geisler, L. (2004): Bedarfsgerechtigkeit im Gesundheitssystem? „Konkordanter Bedarf" als unverzichtbare Voraussetzung. Die Rolle des Arzt- Patient- Dialogs.

Referat, Berlin. http://www.linus-geisler.de/vortraege/0409bedarfsgerechtigkeit.html [01.08.2008]

Gläser, J. und Laudel, G. (2006): Experteninterviews und qualitative Inhaltsanalyse.2. durchgesehene Auflage, Wiesbaden: VS Verlag für Sozialwissenschaften.

Graffy, J. (1990): Patient choice in a practice with men and women general practitioners. British Journal of General Practice. Vol.40; 13-15.

Hrabal, V. (2007): Erwartungen der Patienten an die Arzt- Patient- Beziehung und Zufriedenheit mit Ärzten unter dem Gesichtspunkt ihrer Krankheitstheorien und des Krankheitsverhaltens vor Inanspruchnahme des medizinischen Systems. Lengerich: Pabst Science Publishers.

Hyong, J.C. (2005): Reviving the old sermon with the placebo effect. Rev. Bras. Psiquiatr., Vol. 27, No.4, s.p.

Jackson, J.L. and Kroenke, K. (2001): The effect of unmet expectations among adults presenting with physical symptoms. Ann Intern Med. Vol. 134, No.9 (Part 2); 889-897.

Kaptchuk, T.J. (2002): The placebo effect in alternative medicine: Can the performance of a healing ritual have clinical significance? Ann Intern Med, Vol. 136, No.11, 817-825.

Karten, N. (2004): Vom Umgang mit Erwartungen. Wie man Kunden begegnet, die alles wollen und das besser, schneller, sofort! Bonn: mitp-Verlag.

Kaufmann, J.-C. (1999): Das verstehende Interview-Theorie und Praxis. (Edition discours; Bd. 14) Konstanz: UVK- Univ. Verl. Konstanz.

Klemperer, D. (2003): Wie Ärzte und Patienten Entscheidungen treffen–Konzepte der Arzt- Patienten- Kommunikation. Veröffentlichungsreihe der

Arbeitsgemeinschaft Public Health. Berlin: Wissenschaftszentrum für Sozialforschung (WZB).
http://skylla.wz-berlin.de/pdf/2003/i03-302.pdf [20.08.2008]

Kowarowsky, G. (2005): Der schwierige Patient-Kommunikation und Patienteninteraktion im Praxisalltag. Stuttgart:Verlag W. Kohlhammer.

Kravitz, R. (2001): Measuring patients´ expectations and requests. Ann Int Med. Vol. 134, 881-888.

Kravitz, R.; Callahan, E. J.; Paterniti, D.; Antonius, D.; Dunham, M. and Lewis, C. (1996): Prevalence and sources of patients´ unmet expectations for care. Ann Intern Med, Vol. 125 (9), 730-737.

Licciardone, J.; Gamber, R.; Cardarelli, K. (2002): Patient satisfaction and clinical outcomes associated with osteopathic manipulative treatment. JAOA, Vol 102. No 1, 13-20.

Licciardone, John C. and Herron, Kathryn M. (2001): Characteristics, satisfaction and perceptions of patients receiving ambulatory healthcare from osteopathic physicians: a comparative national survey. JAOA, Vol. 101, No 7, 374-385.

Lill, M.M. and Wilkinson, T.J. (2005): Judging a book by its cover: descriptive survey of patients´ preferences for doctors´ appearance and mode of address. BMJ, Vol. 331, 1524-27.

Mayring, P. (2007): Qualitative Inhaltsanalyse- Grundlagen und Techniken. Weinheim und Basel: Beltz Verlag.

McKinstry, B. and Wang, J. (1991): Putting on the style: what patients think of the way their doctor dresses. British Journal of General Practice. Vol. 41, 275-278.

McNerney , J.P.; Andes,S. and Blackwell, D.L. (2007): Self- reported behaviors of osteopathic physicians. JAOA, Vol.107, No.12, 537-546

Mitchell Peck, B.; Ubel, P. A.; Roter, D. L.; Dorr Goold, S.; Asch, D. A.; Jeffreys, A. S.; Grambow, S. C. and Tulsky, J. A. (2004): Do unmet expectations for specific tests, referrals and new medications reduce patients´ satisfaction? Journal of General Internal Medicine, Vol.19(11); 1080-1087.

Murray, E.; Lo, B.; Pollack, L.; Donelan, K.; Catania, J.; White, M.; Zapert; K. and Turner, R. (2003): The impact of health information on the Internet on the physician-patient relationship-Patient perceptions. Arch Int Med. Vol.163, 1727-1734.

Newman Turner, R.; Leach, J.; Robinson, D. (2007): First impressions in complementary practice: The importance of environment, dress and address to the therapeutic relationship. Complementary Therapies in Clinical Practice. 13,102-109.

N.N. (BIPS-Bremer Institut für Präventionsforschung und Sozialmedizin) (2006): Gesundheitliche Information und Beratung aus Sicht der Bremer Bevölkerung (Kurzfassung) -Dritter Ergebnisbericht der Bremer Umfrage GESUNDHEIT ! http://www.soziales.bremen.de/sixcms/media.php/13/BerichtgesundheitlicheInfo.pdf [25.10.2008]

Paterson, C. and Dieppe, P. (2005): Education and debate: Characteristic and incidental (placebo) effects in complex interventions such as acupuncture. BMJ, Vol.330, 1202-1205.

Perron, N. J.; Secretan, F.; Vannotti, M.; Pecoud, A. and Favrat, B. (2003): Patient expectations at a multicultural out-patient clinic in Switzerland. Family Practice, Vol.20, No.4, 428-433.

Rao, J. K.; Weinberger, M.; Kroenke, K. (2000): Visit-specific expectations and patient-centered outcomes. Archive of Family Medicine. Vol.9; 1148-1155.

Rehman, S. U.; Nietert, P. J.; Cope, D.W. and Osborne Kilpatrick, Anne (2005): What to wear today ? Effect of doctors´attire on the trust and confidence of patients. The American Journal of Medicine. 118;1279-1286.

Rheinberg, F. (2006):Motivation-Grundriss der Psychologie, Band 6. 6.überarbeitete und erweiterte Auflage, Stuttgart: Verlag W. Kohlhammer.

Richardson, J. (2004): What patients expect from complementary therapy: a qualitative study. American Journal of Public Health, Vol.94, No. 6, 1049-1053.

Rudolph, U. (2007): Motivationspsychologie-Workbook.2.vollständig überarbeitete Auflage, Basel: Beltz Verlag.

Ruiz- Moral, R.; Pérula de Torres, L. Á. and Jaramillo- Martin, I. (2007): The effect of patients` met expectations on consultation outcomes. A study with family medicine residents. Society of General Internal Medicine, Vol. 22, 86-91.

Schwarzer, R. (2004): Psychologie des Gesundheitsverhaltens-Einführung in die Gesundheitspsychologie. 3. überarbeitete Auflage, Göttingen: Hogrefe Verlag.

Schweickhardt, F und Fritzsche,K. (2007): Kursbuch ärztliche Kommunikation. Grundlagen und Fallbeispiele aus Klinik und Praxis. Köln: Deutscher Ärzte–Verlag.

Sigrell, Håkan (2001): Expectations of chiropractic patients: The construction of a questionnaire. Journal of Manipulative and Physiological Therapeutics, Vol. 24, Number 7, 440-444.

Sigrell, Håkan (2002): Expectations of chiropractic treatment: What are the expectations of new patients consulting a chiropractor, and do chiropractors and patients have similar expectations? Journal of Manipulative and Physiological Therapeutics, Vol. 25, Number 5,300-305.

Tyreman, S. (2001): The concept of function in osteopathy and conventional medicine : a comparative study. London: Dissertation. British School of Osteopathy.

Vieder, J. N.; Krafchick, M. A.; Kovach, A. C.; Galuzzi, K. E. (2002): Physician-patient interaction: What do elders want? JAOA, Vol. 102, No 2, 73-78.

Wahrig- Burfeind, R. (2007): Wahrig- Fremdwörterlexikon. Gütersloh/München: Wissen Media Verlag GmbH.

Wagner-Scheidel, B. (2006): Wie kommen sie eigentlich zu uns ? Wien: Masterthesis. WSO - Wiener Schule für Osteopathie.

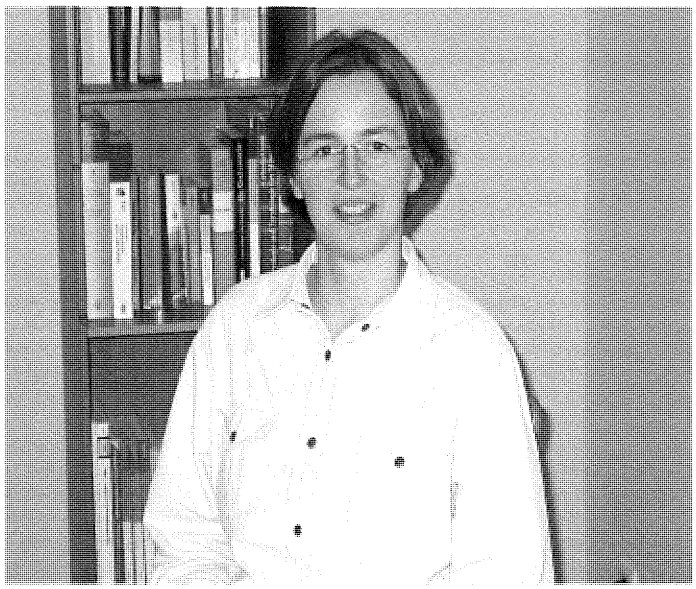
Wapf, V and Busato, A. (2007): Patients´ motives for choosing a physician: comparison between conventional and complementary medicine in Swiss primary care. BMC- Complementary and Alternative Medicine, 7:41 http://www.biomedcentral.com/1472-6882/7/41 [02.08.2008]

Westhoff, K. (1985): Erwartungen und Entscheidungen. Heidelberg: Springer-Verlag.

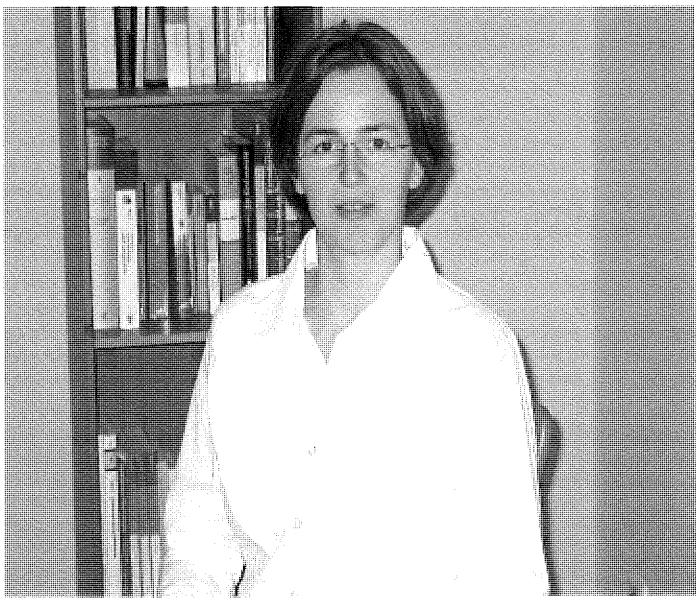
Zebiene, E.; Razgauskas E.; Basys, V.; Baubiniene,A.; Gurevicius,R.; Padaiga, Z. and Svab, I. (2004): Meeting patients´ expectations in primary care in Lithuania. International Journal for Quality in Health Care, Vol.16, No 1, 83-89.

10 Appendix

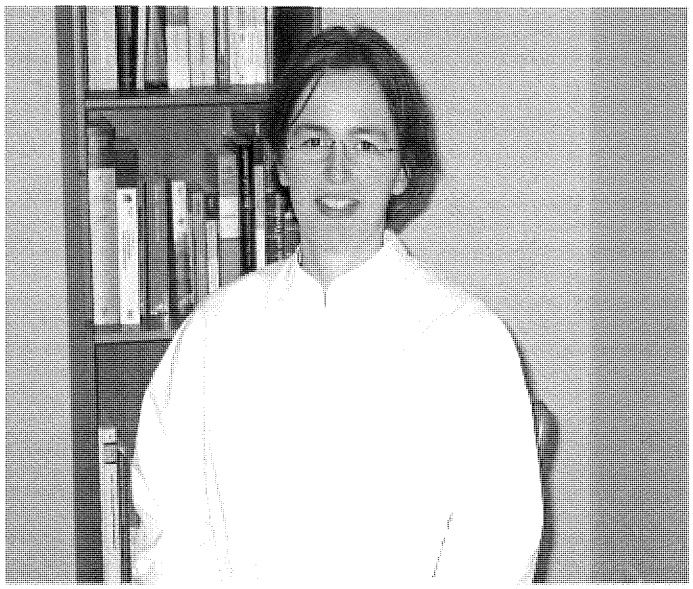
10.1 Female Osteopath



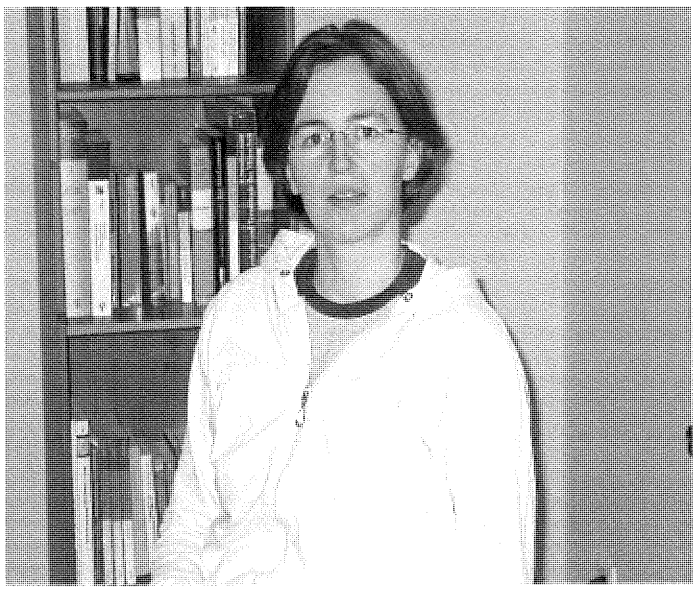
Picture Wa



Picture Wb



Picture Wc



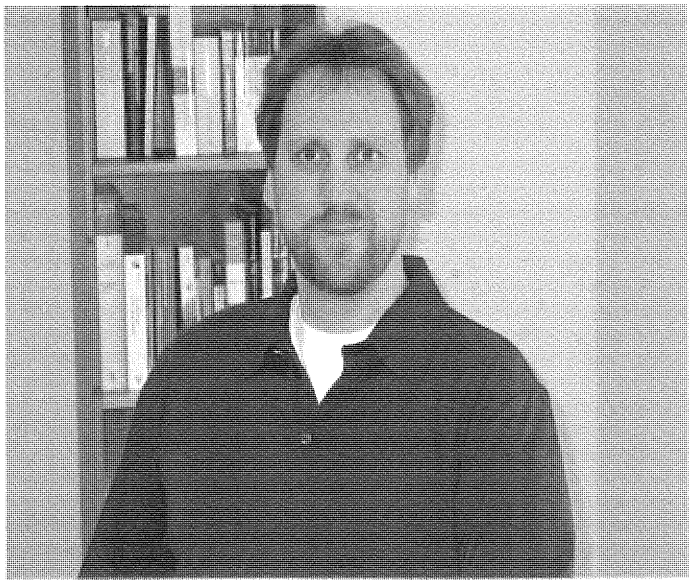
Picture Wd

10.2 Male Osteopath

Picture Ma

Picture Mb

Picture Mc



Picture Md