

**What matters most: a qualitative study of person-centred physiotherapy practice in community rehabilitation**

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## **Abstract**

**Background:** Person-centered approaches to care require physiotherapists to engage in trying to understand the full range of biomedical, psychological, and social factors that people bring to the consultation, along with the client's individual responses to those factors. If, however, the main issues of importance to people are not openly declared and discussed they cannot be addressed. This is likely to result in people receiving interventions that clinicians think they need, rather than care based on their expressed needs and preferences.

**Objective:** To understand people's abilities to express the issues of importance to them within a consultation and clinicians' abilities to acknowledge and address those issues.

**Design:** A qualitative study using an interpretive phenomenological approach.

**Methods:** Eight clients were interviewed before they met their physiotherapist, the initial consultation with their physiotherapist was recorded, and both were interviewed separately afterward.

**Analysis:** The clients frequently do not raise their emotions or feelings as issues of importance, and physiotherapists generally struggle to elicit, or identify as important, such matters. How these were presented to the clinician and subsequently addressed varied. We formulated three themes: 1) managing complex situations; 2) establishing a person-centered agenda; and 3) addressing emotional issues.

Conclusions: Community physiotherapists may aim for a more person-centered approach; however, their habits, practices and behaviors remain within a culturally entrenched, clinician-centric, biomedical model. What matters most: a qualitative study of person-centred physiotherapy practice in community rehabilitation

## **Background**

Person-centredness is a widely used concept in healthcare, rehabilitation, and physiotherapy (Chartered Society of Physiotherapy (CSP), 2019; Grimes and Barnett, 2014; Leach, Cornwall, Fleming, and Haines, 2010; McCormack and McCance, 2016; Mead and Bower 2000; Wijma et al, 2017). Person-centred rehabilitation refers to a philosophy or attitude to the delivery of rehabilitation that reflects the needs of individuals and groups of clients (Cott, 2004). Physiotherapists in the United Kingdom are expected to adopt this approach within the National Health Service (NHS) (National Institute for Health and Care Excellence (NICE), 2012). However, it is a problematic term (Leplage et al, 2007), and as such, there are many definitions and ways of thinking about it (Cheng, et al, 2016, Pluut, 2016).

A central concept is for practitioners to understand the needs of their clients (Leplage, et al, 2007, NICE, 2012). In general, this requires practitioners to engage in trying to understand the full range of biomedical, psychological, and social factors that people bring to the consultation (Frankel and Quill, 2005; NICE, 2012). Cott (2004) reported that “inherent to participating in decision-making is the necessity for practitioners to provide clients with the education and information that they need to make autonomous decisions” (p.1415). Pluut (2016) has usefully identified different discourses surrounding person-centred practice. Whichever discourse, or version, of person-centred care (PCC) a physiotherapist understands, decision-making requires

skill, judgment and sensitivity to the immediate and longer-term situation in which the person lives (Fischer and Ereaut, 2012; Mudge, Stretton and Kayes, 2013; Oosting et al, 2018).

The physiotherapy profession values the idea of collaboration, an intended sharing of power and responsibility, between client and therapist (CSP, 2019; Wijma et al, 2017). Evidence suggests that this does not always happen in clinical practice, with physiotherapists often making decisions that they believe are in the best interests of their clients (for example, Josephson et al, 2015). If the main issues of importance to people are not openly declared and discussed, they cannot be addressed: this can lead to significant problems in health care delivery in terms of poor outcomes and potentially increased healthcare costs (NICE, 2012). This is because people are more likely to receive the care clinicians think they need rather than care based on clients' needs and preferences (Stenner, Swinkels, Mitchell and Palmer, 2016).

Encouraging and enabling people to voice what matters most to them, to understand their values, preferences and expressed needs in the consultation, allows the clinician to develop an understanding of the client as a person (NICE, 2012). As one among many definitions, the Picker Institute describes person-centred care as involving eight dimensions, including respect for a person's values, preferences, and expressed needs (Picker Institute, 2018). Whether the client does voice and explore issues of importance is in turn dependent on the style of communication adopted by the clinician (Josephson et al, 2015) and whether they can co-construct a meaningful, inter-dependent relationship. Many people have made the link between good communication practices and successful rehabilitation outcomes (for example, Jesus and Silva, 2015).

One possible reason why person-centred care is not better implemented might be its complexity and breadth as a concept. Even as it comes into ascendancy, the concept poses challenges for healthcare professionals to adequately operationalise it (see, for example, Cheng et al, 2016; Mudge, Stretton, and Kayes, 2013). Reasons suggested include, a. the challenge of moving along the spectrum of a person's problems – sometimes they are biomedical, sometimes psychosocial, and sometimes both (Frankel and Qiill, 2005); b. the difficulty for clinicians in getting to understand a person's preferences for health care interventions within healthcare organisations that remain within a biomedical model (Mudge, Stretton and Kayes, 2013); c. having the skills, confidence and ability to address these preferences (Leplage et al, 2007); and d. uniformity of purpose (Cheng et al, 2016). Pluut (2016) describes a range of perspectives and ways of doing person-centred care, suggesting this pluralism is inescapable and should be “appreciated”, i.e. accepted for the benefits it brings in clinical circumstances.

The study reported here is the second reporting on the ability of physiotherapists to elicit what matters most to clients. The first paper reported on musculoskeletal services (Stenner, Palmer, and Hammond, 2018). In this paper, we report the results from data generated with clients and physiotherapists in a community rehabilitation service within the NHS in South West England. In this qualitative study, we aim to explore current communication practices among physiotherapists: 1. to understand how physiotherapists approached the process of eliciting matters of importance that clients brought to the consultation, that is, their expressed needs; and, 2. to identify whether there are topics of importance to clients that go unacknowledged.

## **Methods**

Research into communication typically focuses on data collected from observations or interviews. In a person/clinician encounter, the interactions are interdependent and are likely to influence each other. Therefore, to achieve a better picture of the physiotherapy consultation, both clients and clinicians were interviewed, along with the consultation being digitally recorded (Barry et al, 2001).

Phenomenological approaches are particularly effective at bringing to the fore an individual's contextually grounded experiences of events and difficulties expressed from their own perspective or 'lifeworld' (Mishler, 1984). Acknowledging that no consultation can proceed without relying in part on the 'voice of medicine' or the perspective of the clinician, the tendency for clinicians to dominate consultations can lead to a fragmentation of communication and a failure to understand the lived situation and topics that matter most to people (Judson et al, 2013).

This study was therefore informed by the interpretive paradigm of enquiry and based on a phenomenological approach. The specific 'interpretive' orientation applied was grounded in the philosophical hermeneutics approach of German philosopher Hans Georg Gadamer (Gadamer, 1977; 2004). Accordingly (Fleming, Gaidys and Robb, 2003), as researchers, we recognised our personal pre-understandings of person-centred practice and the service under study: xx was a community rehabilitation physiotherapist practicing within the service, yy was a consultant musculoskeletal physiotherapist, and zz, a professor of physiotherapy at a local university. As we had different speciality experience and knowledge, we recognised our varying appreciation of the challenges facing clinicians in practice. We had differing appreciations of the local and national political imperatives and progress regarding

their implementation, while we all agreed with an intention to better understand the challenges facing the profession in its progress towards better implementation of this philosophy.

Data in the form of consultations and more formal semi-structured interviews were placed alongside and fused in context with the authors' experiences and preunderstandings as physiotherapists to facilitate interpretation, allowing for a more complete understanding (Stenner, Mitchell and Palmer, 2017).

### **Recruitment**

Eight data sets were generated within a community rehabilitation service within one NHS organisation in South West England. We invited any physiotherapist from across the community rehabilitation teams to participate. Community rehabilitation in this service means healthcare rehabilitation at home after discharge from hospital following an acute medical illness, to prevent an admission to hospital, or to support someone at home with a long-term health-related condition. It involves the provision of services by a team offering physiotherapy and occupational therapy. Duration of intervention might be up to 6 weeks. Sixteen physiotherapists responded with interest. We then attempted to recruit one of their clients. The physiotherapist would alert the researcher, xx, of a new referral. xx then had to be able to speak to this newly referred client by phone, organise a face to face meeting with the client to gain informed consent, and to give 48 hours cooling off time, before the first pre-consultation interview, which was conducted prior to the first client-therapist consultation. Of the 16 physiotherapists who expressed interest and gave informed consent, 10 physiotherapists identified clients. Two of the clients approached declined to take part in the study. Their usual care continued uninterrupted.

The principal recruitment criterion was people referred to the community rehabilitation service. Individuals who expressed an interest were provided with a participant information sheet and gave informed written consent. We recruited 8 clients, over the age of 18 years. Some key characteristics of the clients and the physiotherapists are displayed in Table 1.

[Table 1 here]

### **Data generation**

The sequence of data generation is given in Table 2. This consisted of researcher/client interviews at the client's home before and after the consultation with the clinician. Researcher/clinician post-consultation interviews were undertaken at a convenient time later on the same day or within 7 days. Interviews were recorded and transcribed verbatim by xx. The consultations were recorded without xx being present: he would enter the room, press the recorder, and then leave the room to allow the consultation to take place. The clinician called xx back into the room at the end of the consultation. The recording was transcribed verbatim by xx.

[Table 2 here]

The first author (xx), a male physiotherapist with extensive rehabilitation experience, conducted the interviews. We used topic guides to guide the interviews (see Appendix 1). The topic guides addressed issues of importance concerning factors such as presenting problem and symptoms; understanding; individuals' reactions to



their referral; clinicians' behaviours; wanted and unwanted activities or treatments; and emotional or social issues such as fears and concerns.

### **Analysis – phase one**

The data set generated was cleaned to anonymise place names (for example, hospital names, town names, places of interest mentioned during a consultation) and clients' names. Pseudonyms were given for each client and therapist.

The dataset was analysed on a case-by-case basis by the first author (xx), linking the different data sources, before looking for common themes across the cases:

First, identification of the type and range of issues of importance voiced by the client in their pre-consultation interviews across the eight cases was conducted. These are listed in Table 3.

Second, these issues of importance from the pre-consultation interviews were compared to what was voiced in the consultations; that is, did the person raise the issue of importance they had expressed to the researcher with their clinician?

Third, the extent to which the issues of importance voiced in the consultations were addressed by the clinicians was assessed; that is, did the treating clinician actively pick up on the expressed issue of importance and articulate an intention to address it?

[Table 3 here]

We present a brief summary of each person the physiotherapists consulted in Table 4.

[Table 4 here]

### **Analysis – phase two**

A second phase of analysis involved interpretation of what we understood to be happening during the consultation. This is described in Table 5. This phase of analysis enabled us to organise our interpretation of what was happening, and not happening, what was being said and not addressed, during the interviews and consultations (Stewart, Gapp and Harwood, 2017). A second author (yy) facilitated refinement of this phase through peer review and auditing (Seale, 1999).

[Table 5 here]

### **Themes**

We identified three themes. These relate to our aims of this study: to understand how physiotherapists approached the process of eliciting what matters most to clients, that is, their expressed needs; and to identify whether there are topics of importance to clients that go unacknowledged. These themes were, 1. Managing complex situations, 2. Establishing a person-centred agenda, and, 3. Addressing emotional issues. In constructing these themes, we did not intend to criticise clinicians in what they did or did not do. Rather, we hoped to bring to light the reality of what occurred during the opening consultations and what we might learn from this. We also recognised that these themes reflected our interpretation of the dataset and

that this interpretation was influenced by the orientation of our thinking and ability to articulate this, contingent on time, place, and the politics of the present.

### **1. Managing complex situations**

We identified that every therapist faced a complex situation and had to negotiate this. The physiotherapists used this opening encounter to determine whether the client raised a matter the physiotherapist thought they could help with; this was at a fairly rudimentary, activity-type, level.

Some people had a clear agenda for the consultations:

MaryHCP<sup>1</sup>    *So, what is it you want from our team that you want to work on?*  
Harry        *I would like to work on a programme of exercising which will improve my mobility.*  
                  [Consultation: Harry meets Physiotherapist MaryHCP; lines 741 – 744]

The physiotherapist assessed the client to a depth sufficient to determine whether their expressed goal could be realistically achieved. The extent to which the main issues of importance to clients with often complex multiple health needs were identified required a range of skills, attitudes, and knowledge. The physiotherapists made, what they thought of, as full an assessment of that person's cognitive, emotional and psychological status as was necessary to determine whether the client was sufficiently engaged and capable of participating in an episode of care, and how best that might be delivered.

Some clients needed gentle coaxing to share what matters to them. Others needed the intervention of a family member:

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<sup>1</sup> HCP denotes healthcare professional i.e. physiotherapist

LouiseHCP *Is there anything that you have, anything in mind that you would like me to help with?*

Chris *Just things to do.*

LouiseHCP *Yep, to keep you going, to keep you on your feet?*

Wife *Your walking.*

Chris *Walking as well.*

[Consultation: Chris meets Physiotherapist LouiseHCP; lines 1365 - 1375]

This exemplifies one aspect of person-centred practice; navigating real life situations. So, for example, does one include a spouse / partner in the initial consultation, and risk “benevolent manipulation”(Gibson, et al, 2019) of what the client says, or does one ask for a one to one meeting, and risk important information, background or problems not being raised? On some occasions, such interventions may confuse the assessment, on others, they add focus and detail. There is also the risk that the spouse / partner raises an issue the client has no interest in, but that the therapist seizes upon, as it suits their own ideas of physiotherapy. The extent to which the client navigates such normalisation practices may determine the value they put on the episode of care.

Bill was much clearer about his approach to facing a new situation. He had not wanted to stay in hospital awaiting the usual process of medical assessment and diagnosis; he had preferred to be at home, in spite of his acute impairments being more exposed. His expectation was that his condition would deteriorate to a stable position and from there begin to improve. While he said he did not have a clear expectation of what the physiotherapist would do, he was expecting to be shown exercises to help him manage his situation during this evolving presentation:

xx *How did that fit with what you would like physiotherapy or rehabilitation?*

Bill *I don't know what I want because I've never been in a position to need it or accept it or go through such a programme before. One thing she did ask was "where did I hope the end point would take me?" and I said "back into the fields, dealing with the animals, with the land" but I mean she meant more short term goals obviously at the moment becoming more independent, increasing my mobility, taking the pressure off my wife*

[Post-consultation interview]

The physiotherapists were managing the conversation and bringing a professional gaze to it. In real time, they were sense-making, trying to create some form of cohesion and order. This was to enable an understanding of the expectations, preferences and choices the client had, in order that they could provide a clear and agreed rationale for the episode of care, justifying this with a list of problems.

The real-life situation is that therapists may have to manage situations when a person with the disability and their spouse express different priorities. What mattered most to Harry was to reduce the number of falls he experienced, however he struggled to express this, as he was set on describing the recent history of how Parkinson's was affecting him. He told xx during the pre-consultation interview that his main problem is "when I go off, I have difficulty expressing myself, and I can't drive". He added "I could do with some guidance as to where I'm going to get advice, discussion of my symptoms, and what I can do to alleviate those symptoms or make them go away or stop them." His wife added, "The one area Harry hasn't covered, which is the main reason we are here today, is his falling." When he met the physiotherapist, he told her that he was having "an increasing problem of falling". One aspect of the encounter was to navigate the dynamics of a household; there may be one "patient", but the challenges they faced, and why they had been referred for community rehabilitation, may have significantly impacted family and friends. So, gaining an understanding of the issues the people of the household value, the range

of sometimes differing perspectives, priorities, and values, was a real-time factor to be navigated.

Most of the physiotherapists met people living complicated lives with complex health issues to discuss. The nature of the first consultation involved eliciting sufficient information to orient the episode of care. This was not always straightforward. During the assessment it transpired George had recently broken his right femur. JudyHPC was given incomplete information in her referral and had to manage George's low expectations about his future, his inability to identify or articulate what he wanted, and how she might help. Near the end of the one-hour consultation, he told the physiotherapist that what mattered most to him was to get up the stairs so he could have a bath. Possibly, something JudyHPC said or did during this consultation gained his confidence. He identified that having a bath was something that might be achievable and would improve his quality of life. It took nearly an hour to get to this.

## **2. Establishing a person-centred agenda**

How the consultation was opened set up the extent to which the consultation was person-centred. This was particularly important, as some clients appeared to have no prior understanding of what physiotherapy is or involves:

xx                    *... you are going to see the physiotherapist ..., and what is it you have got in mind that she can help you with?*

George            *I don't know, I don't what she plans.*

xx                    *Have you got any idea what a physio or the rehab team do?*

George            *No, not really.*

[Pre-consultation interview with George; lines 2979 – 2984]

We identified that the opening of the episode of care by each client and physiotherapist was handled differently. What seemed to occur was that the

physiotherapists took the lead in initiating the professional contact, and the client permitted this. This involved the physiotherapist managing the immediate dialogue as they walked into the client's house, respecting the domestic situation of the clients' home environment, and assessing the situation in which they found themselves. Physiotherapists adopted different approaches to the opening conversation, and how they then established the professional contact. VictoriaHCP wanted to establish that she was part of a team, assumed Bill knew about the service and why she had arrived; her opening is *in media res*<sup>2</sup>:

VictoriaHCP *I'm Victoria, you met my colleague, the other day, didn't you?*

Bill *Yep.*

VictoriaHCP *What did she have you doing?*

Bill *She had me walking with the frame, sitting in the chair, exiting the chair, getting into bed, getting out of bed, sitting on the loo, getting off the loo.*

VictoriaHCP *OK, I tried to get her out here as soon as I could.*

[Consultation: Bill meets Physiotherapist VictoriaHCP; lines 25 – 28]

Some moved very quickly into a formal explanation of why they were there, some gave more or less information about themselves, the service and their presence. They all introduced themselves by their first name<sup>3</sup>. How much more information they provided about themselves, their role, why they were present, and what the service was, varied. The data associated with this theme was not about what exactly was said in this opening exchange, but how quickly, efficiently and smoothly this opening was progressed onto an exchange about the purpose of the consultation, and how, whether, or to what extent principles of person-centred care were integrated into this early dialogue. For example, was the person given an early opportunity to talk, to tell their story, to explain what they understood the situation /

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<sup>2</sup> *In media res*: a literary term to denote when a story, play, film opens in the midst of the plot (from Latin = in the midst of things); exposition is bypassed and filled in gradually

<sup>3</sup> "Hello, my name is" is a UK campaign for more compassionate care ([www.hellomynameis.org.uk](http://www.hellomynameis.org.uk))

issue was that they wanted addressing? LouiseHCP walked into Chris's house, introduced herself, and opened with a quick explanation of how she envisaged the conversation going:

LouiseHCP *We'll have a chat here to start with and then we'll take it from there, ..., so how do you prefer I call you?*

Chris *Chris.*

LouiseHCP *The referral originally came from your consultant. ... But I want to know if there's anything else we can help you with; we don't have to go by what's on the referral. How are you getting on at the moment?*

[Consultation: Chris meets Physiotherapist LouiseHCP; lines 1358 – 1366]

The opening to the consultation may have had implications for how well the physiotherapist was able to develop a sufficient rapport to encourage the client to share what matters most. How this was achieved may have determined the extent to which the episode of care was established in a person-centred manner.

JudyHCP *The reason I've come today is that we've had a referral from Dr [name]... OK, so we've had a couple of referrals, so perhaps if I go through them, you can tell me if that's right or what you think you would like from our service.*

[Consultation: George meets Physiotherapist JudyHCP; lines 3061 – 3069]

We noticed each physiotherapist took a different approach to how much information they gave about why they were in the client's house. Only one therapist had, what appeared to be, a self-generated way of describing the service and the process of rehabilitation:

MaryHCP *Today I've come because of a referral we've had from Dr [name] ... we work quite closely with adult social service [sic]. We are a short term reablement service; we are made up of occupational therapists, physiotherapists and rehab assistants. Also, part of the district nursing team. We tend to work with people after a period of illness or injury, or in your case when there has been a change in someone's long-term condition. The purpose of today is for me to get to know you a little bit better and for us to identify any areas of difficulty that you might be*



*having and hopefully by the end of the session we'll have an action plan of what we're going to do and what you're going to do. Does that sound OK?*

[Consultation: Harry meets Physiotherapist MaryHCP; lines 528 – 553]

The logical sequence might be some form of two-way introduction in which the physiotherapist introduces themselves, their role, and provides some information about the nature and purpose of the visit. This is necessary in order to obtain informed consent to proceed. Here, MaryHCP provides this information. What might then follow is a two-way process of storytelling, in which the client has influence, so that sufficient details of the story are told to enable the clinician to understand the situation and assess the full spectrum of the client's concerns. Then, having established 'what really matters', the physiotherapist might then explain whether and how the service can address these matters.

### **3. Addressing emotional issues**

On some occasions, during the pre-consultation interviews with xx, clients shared emotional concerns, for example, specific worries, that they were anxious. However, when the client raised these during the consultation, we observed that, often, these issues were not addressed by the physiotherapist. On other occasions, emotional concerns were expressed by the client to xx at the pre-consultation meeting but were not then raised with the physiotherapist, during the consultation:

xx *What would you say matters most to you as the outcome?*  
Chris *Put my mind at ease; tell me how to not make the tremor so pronounced, and various exercises.*  
xx *When you say, "put your mind at ease", can you tell me more?*  
Chris *I'm a bit of a worrier. People have told me not to worry, "the physiotherapy does help".*  
xx *What can you tell me what you are worrying about? Relating to the physiotherapy?*  
Chris *... my head is telling me one thing or telling me another thing.*  
xx *What is your head telling you?*

Chris            *You can do this with a bit of help.*  
[Pre-consultation with Chris; lines 1330 – 1346]

Chris had never seen a physiotherapist or anyone from the NHS rehabilitation services. He told xx that what mattered most to him was to be reassured that he was managing things OK: *“I seem to worry about everything now, when there is no need to.”* He did not raise this worry with LouiseHCP, it was not elicited by her, and was not addressed. However, Chris did tell the physiotherapist that he had not seen a physiotherapist before and did not know what a physiotherapist could provide. Providing an explanation of what physiotherapy was, or involved, what the service was, or could be, or what options were available, might have gone some way to addressing his concerns. It might have opened up the conversation to enable Chris to feel able to share some of his worries. This was not a worry about the consultation *per se*, but more an admission that he worries more now about many things in his life, that the upcoming physiotherapy episode of care was one such “thing”.

On other occasions issues were raised and not fully addressed. What mattered most to Clara was to be more physically able; she would have liked to go outside more. However, her admission of a generalised anxiety, low self-confidence, and a fear of falling was not acknowledged as a matter of significance, in fact, it was dismissed:

SallyHCP      *What stops you walking?*  
Clara            *Self-confidence.*  
SallyHCP      *Right, OK.*  
Clara            *I just don't have the confidence.*

[A few minutes later]

Clara            *I get very panicky, really, really nervous of falling. My daughters keep telling me to keep moving but I'm moving as much as I can, but I get*

*panicky which affects me breathing. It's affected me this morning cos I knew someone was coming.*  
SallyHCP *You don't need to worry about me coming, do you?*  
[Consultation: Clara meets Physiotherapist SallyHCP; lines 1814 –1875]

Issues that were not addressed were usually emotional matters, for example grief (Jill), anxiety (Clara), a need for reassurance (Chris), a need to better understand the rehabilitation process (Bill), rather than physical matters. SallyHCP picked up on Clara's low confidence and fear of falling but did not explicitly address them, either by listening to them in greater detail, or stating an intention to build them into Clara's physiotherapy management plan. During her post-consultation interview with xx, Clara said:

Clara *Yeah, she more or less knew what I was feeling like, very depressed*  
xx *Very depressed?*  
Clara *I'm stuck in here all the time. I've got somebody coming in during the day twice a week to do things we can't do*  
xx *Right and did she have any suggestions for your mood?*  
Clara *She showed me a few more exercises for me legs, stretching them*  
*[Post consultation interview: lines 2171 -2177]*

At times clients reported information that was not then addressed, or the physiotherapist did not demonstrate that they had heard what had been said. When Jill met xx, she told him what mattered most was her worry for herself and her husband, their general health, and a worry about being alone.

xx *What would you say is the main problem that you're going to talk to the physio when she comes?*  
Jill *... And the spine, my legs and feet have been numb for donkeys, and they've got worse as I've got older, and now I have cancer, my heart stopped a year ago, twice, so really, which do I talk about? They are all major, really.*  
xx *OK, which one is affecting you, the life you want to be living today?*  
Jill *... Quite honestly, it's not so much, alright pains everywhere, I'm a worrier. I'm a born worrier. There's only me and my husband, There is only him and me, and he is waiting to go in to have a very nasty op, so really I'm more afraid than I can say – my husband found me on the*

*floor, here, you know, I didn't know nothing about it, I get more frightened, is it going to happen again.*

[Pre-consultation interview with Jill; lines 3572 – 3588]

During her consultation with FriedaHCP, Jill was distracted by the recent death of her dog, and more concerned for her husband's health and her fear of being alone, than undertaking an exercise programme. However, the physiotherapist was determined to provide an exercise programme.

FriedaHCP *Now, what are your thoughts about how we can help you; what would you like?*

Jill *As I've got all these blinking problems, everybody has been out of this world.*

FriedaHCP *Your GP was keen that we looked at your balance and walking so you maintained your ability to get out and about. There is one thing we can really do for you is the exercises, is the programme you did before, Otago.*

Jill *The ones I haven't been doing; I'm not going to lie.*

FriedaHCP *Yes; it's a really good programme: have you still got the booklet?*

...

Jill *Yeah, I don't know if it would be a tai chi class; with my husband, I'm just worried; I want to get this operation done, then I can think more clearly.*

[Consultation: Jill meets Physiotherapist FriedaHCP; lines 4037 – 4082]

During the post-consultation interview it was put to FriedaHCP that Jill would probably not take up an exercise programme at the moment, but might, if contacted again in the future. FriedaHCP agreed:

FriedaHCP *The difficulty with our current way that we work and I'm not disagreeing at all, I would feel more comfortable with a system where I could do that, but I can't do that with everybody, I would have notes everywhere, people to review, follow up call, the admin of discharging and having to record all that is immense and when we are so busy, I'm not, it's a nice idea but it is not practical, when I am seeing the volume that I'm a seeing.*

[Post-consultation interview with Physiotherapist FriedaHCP; lines 4316 – 4321]

FriedaHCP struggled to help Jill focus on her main problems. FriedaHCP provided an exercise programme despite Jill's repeated claims of worry about her husband and grief for her dog. FriedaHCP proposed an intervention plan that addressed a problem Jill could agree to but would be unlikely to undertake.

## **Discussion**

Our research aim was to investigate whether people were able to express the issues of importance to them within a consultation. On the whole, we interpreted the data as suggesting that, yes, they mostly were. Clients raised with the clinician the issues they had told the researcher beforehand were important. However, they did not always mention emotional matters, for example, their worry, anxieties, or stresses, and the clinician did not always pick up on these. Almost all the clients had complex health needs and frequently struggled to accurately voice the main issues of importance, for example, emotional health issues. Clinicians seemed, on occasions, to have some difficulty establishing what the main issue of importance to the client was.

Recent research on person-centred care in physiotherapy falls into two broad categories: first, defining and problematising the concept within physiotherapy and rehabilitation (Cheng, et al, 2016), and second, evaluating implementation strategies, or how it is operationalised (Terry and Kayes, 2019; Wijma et al, 2017). This paper addresses the second of these, the operationalising of person-centred practice, the doing of it. The clinicians were not necessarily averse to the theory of person-centred practice (see Mudge, Stretton and Kayes, 2013), but were always navigating the "micro-politics" of clinical life (Gibson et al, 2019). Gibson, et al, (2019) have observed that, while the core principles of person-centred practice are generally

accepted, how therapists reconcile these with the professional demands of evidence-based practice, regulatory requirements, and clinical reasoning and employer demands, such as resource and time constraints, is less well understood. This is what we have interpreted from our dataset. Therapists needed to navigate each contact; they did not have unlimited time to spend with every client; the challenge was how to do this, permitting sufficient time both for the person to express themselves and co-construct a plan of action and goals. They also had to navigate the paradox that ideas about person-centred care include clear, transparent explanations (NICE, 2012), yet not all clients in clinical practice wanted them (possibly Harry, Jill, George).

The challenge for therapists is to navigate the opening of the episode of care in such a way as to understand the person's beliefs, values and preferences, hopes and goals from the episode of care, and not revert to a paternalistic position, a medical gaze. Clinicians also need to engage the views of other household members, for example, the spouse. This adds another degree of complexity, as their views may not coincide with the "patient": motivations, commitment, emotional perspective may differ.

The Picker Institute has identified one dimension of person-centred care as the need for emotional support and the alleviation of fear and anxiety (The Picker Institute, 2018). We have identified examples of the physiotherapist not addressing emotional issues; either not explicitly responding to the client when they have expressed fear or anxiety or not addressing them when they are embodied. These emotional matters fell within the province or scope of what might be considered reasonable physiotherapy practice; that is, one might expect physiotherapists to be competent to

handle the situation, and if not, to know who, and how, to refer elsewhere. We recognised that some physiotherapists may not have been adequately exposed to this in under/post graduate training; they may lack confidence in this area. There is also the possibility that they actively sought to avoid such issues for fear of opening a "can of worms", that it was easier to stick to "their" agenda. We would argue that physiotherapists could be supported to learn and enact active listening skills and simple / basic counselling strategies (for example, STRoke Information, Psycho-Education & Screening (STRIPES) training: Level 1<sup>4</sup>).

Cooper, Smith and Hancock (2008) suggested a need for physiotherapists to be cognisant of the elements of person-centred care, and to systematically integrate these into their practice. Cooper, Smith and Hancock (2008) identified six dimensions to practicing person-centred care: 1. communication; 2. individual care; 3. decision-making; 4. information sharing; 5. the physiotherapist; 6. organisation of care. From our data, very few of the physiotherapists appeared to have a planned strategy for supporting the client's decision-making, for explaining the different roles, and for outlining how the service was organised for an episode of care. People taking an active role in their care is not a choice they can necessarily enact alone (Fischer and Ereaut, 2012).

## **Limitations**

We recognise that the first *face to face* meeting between the physiotherapist and client is not necessarily the first *contact*: each client will have had a letter, phone call or face to face consultation with another member of the team. We acknowledge that

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<sup>4</sup> STRoke Information, Psycho-Education & Screening (STRIPES): Level 1: <https://stroke-education.org.uk/course/stroke-information-psycho-education-screening-stripes-level-1/> Accessed 29/12/19.

some of the physiotherapists had already spoken to the client by telephone. So, these contacts may have influenced the style and approach, and indeed the opening exchanges.

We recognise that having a researcher speak to the client, about what they were hoping from the appointment, *before* the client / therapist consultation, may have primed the client to think about this more than they would otherwise have done. We do not think this is a serious matter: from a medical ethics perspective, this would only enhance the potential for the client to raise issues of importance to the therapist. From a researcher perspective, we doubt this made little difference: our dataset does not suggest clients were more prepared to raise such issues.

We appreciate that our preunderstandings of the phenomenon of person-centred practice have evolved over time. xx has reflected on his preunderstandings during data generation, during data analysis, and in forming an interpretation of the data, and in ongoing discussions with the other researchers. For example, he came to the study with a more superficial idea that person-centred practice required a deep listening to the client and the establishment of goals accordingly. During data generation his thinking progressed to a greater appreciation of the need for the dimensions of person-centred practice to be embedded in the service to better encourage and facilitate its practice. This has been further informed by the insight of Gibson, et al (2019), that clinicians are always, already, navigating tensions in enacting truly person-centred practice. Reflecting on this, we have come to a greater appreciation of the challenges a clinician faces in establishing what and how much information, education, and details clients want, in time pressured situations. We have come to better appreciate the skills required of inter-personal communication,



personal embodiment in action, and the need to address the psychological aspects of a long-term condition.

## **Conclusion**

We aimed to better understand how successful physiotherapists were at eliciting what mattered most to their clients. This aspect of person-centred care is vital. Recent reviews of person-centred practice in physiotherapy demonstrated that this phenomenon continues to pose difficulties in real life practice. This is not necessarily because clinicians are averse to the theory but may have more to do with the “micro-politics” that they are always navigating.

Physiotherapists working in community rehabilitation met clients living complicated lives with complex health issues. The story we reported was that the clients frequently did not admit to their emotions or feelings as issues of importance, and physiotherapists generally struggled to elicit, or identify as important, such matters. The nature of the first consultation involves eliciting sufficient information to orient the episode of care. The extent to which the physiotherapist consciously (deliberately) sets up the consultation in a person-centred way, how they introduce themselves and initiate the contact, can determine how successful this is.

While the physiotherapists were aiming to be person-centred, the outcome of these first consultations were often physiotherapist-led. Managing this opening exchange requires skilful communicative flexibility to be reactive yet focussed, client-led and time-efficient. While clients reported their physiotherapist had elicited what matters most to them, we observed and heard examples of psychosocial matters not being addressed. At times the clients were unconscious of this. This suggests that while

community physiotherapists have progressed their attitudes towards a more person-centred approach, their habits, practices and behaviours remain at times within a culturally entrenched, clinician-centric, biomedical model.

### **Reflective questions**

1. What do you understand by the phrase person-centred practice?
2. What aspects of your practice support your client to fully express what matters most to them?
3. How do you manage situations when clients raise topics that are important to them but don't immediately fall within your personal scope of practice?
4. How do you manage situations when clients express their fears, concerns, dilemmas and emotions?

### **Author contributions to the study**

xx conceived the study with yy, recruited participants, undertook the interviews, typed up the recordings, analysed the data, and wrote the paper. yy conceived the study, led the project, secured funding and the ethics permissions, and contributed to data analysis, discussion and the overall paper; zz provided overall oversight of the study, contributed to discussions of the analysis of the dataset, and final versions of the paper.

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**Table 1 Characteristics of the client and clinician participants**

<b>Client Characteristics</b>	
<b>Gender</b> Male / Female	4 / 4
<b>Age (years)</b> 18-55 56-74 75-84 85-94	0 2 5 1
<b>Employment status</b> Employed (Full Time) Employed (Part Time) Retired	0 2 6
<b>Main presenting problem (diagnosis)</b> Transverse myelitis Parkinson's Stroke Frail elderly Peripheral neuropathy Chronic Obstructive Pulmonary Disease (COPD)	1 2 1 2 1 1
<b>Clinician Characteristics</b>	
<b>Gender</b> Female	8
<b>Grading of Staff</b> 5 (most junior) 6 7 8 (most senior)	2 6 0 0

**Table 2 Sequence of interviews**

1. Pre-consultation interview with person referred for physiotherapy
2. Consultation audio-taped
3. Post-consultation interview with person referred for physiotherapy
4. Post-consultation interview with clinician



**Table 3 The most common categories of voiced and addressed issues of importance in the consultation**

<b>Issues of importance identified in pre-consultation interviews</b>	<b>Issue voiced in pre-consultation interviews</b>	<b>Issue voiced in consultations</b>	<b>Issue addressed by clinician in consultations</b>
To improve mobility	Ann; Bill; Chris; Clara; George	Ann; Bill; Chris; Clara; George	Bill; Chris; Clara; George
To get reassurance or allay concerns, fears or worries (in relation to diagnosis, or exercise)	Ann; Bill; Chris; Clara	Ann; Chris	Ann; Bill; Clara
To receive advice about self-help or self-management	Ann; Bill; Chris; Clara;	Ann; Bill; Chris	Bill; Chris; Clara
To improve general fitness	Chris; Jill	Chris; Jill	Chris; Jill
To undertake a bespoke exercise programme	Bill; Chris; Harry	Bill; Chris; Harry	Bill; Chris; Harry
Falls management	Bill; Clara; George; Harry	Harry	Bill; Clara; George; Harry
Need to understand what physiotherapy is	Bill; George; Harry; Jill	None	None

#### **Table 4 Summary of participants**

Bill was a 61-year-old man living at home with his wife. He had recently been diagnosed with transverse myelitis. What mattered most to him was to be supported with an exercise programme to help him move more, be more independent, and get back to working on his private business.

Harry was a 75-year-old man living at home with his wife. He had Parkinson's and experiences on/off symptoms. He had just started a new regime of medication to try to maximise his 'on' periods. What mattered most to him was his deteriorating mobility; however it transpired that his wife wanted to reduce the number of falls he (and she) was experiencing.

Martha was an 83-year-old woman with Parkinson's. She had just had a left occipital infarct, stroke, and been transferred home as part of the early supported discharge service. She lived alone. She was not able to identify any needs; she had been seen by the local rehabilitation team just prior to her stroke, her stroke symptoms had now resolved, and she was back to her baseline.

Chris was a 57-year-old man living at home with his wife. He had idiopathic Parkinson's. He was diagnosed 18 years ago. He had never seen a physiotherapist or anyone from the NHS rehabilitation services. What mattered most to him was to improve his outdoor walking and to be reassured that he was managing things okay.

Clara was an 81-year-old woman living at home with her equally frail husband. She had COPD, arthritis, several recent hip and pelvic fractures following falls, hip replacements, and was very frail and breathless. She had a recent admission for a fall. What mattered most to her was her anxiety; she wanted to be more physically able and she go outside more, but she was worried about falling.

Ann was an 89-year-old woman living at home with her husband. She had a right foot drop. She was diagnosed with a common peroneal nerve palsy during a recent admission for rectal bleeding and referred to the local community rehabilitation team. What mattered most to her was getting an accurate diagnosis and then treatment for a condition she was hoping would improve.

George was an 80-year-old man living at home with his wife and one of his adult daughters. He had COPD, Parkinson's, bronchiectasis, and had a recent admission with an exacerbation. During the assessment, it transpired he recently broke his right femur. What mattered most to him was to be able to get up the stairs so he could have a bath.

Jill was an 84-year-old woman living at home with her husband. She had many health conditions: breast cancer, low back pain, arthritis, cataracts, was profoundly deaf, and had become less mobile of late. During the week of the assessment her dog died. What mattered most to her was the imminent surgery for her husband.

**Table 4 The process for interpretation of the data.**

Steps in the analysis	Description of each step in the analytic process
1. Creating the texts:	Listening, reading and being immersed in each participant's text.
2. Identifying interesting features:	Making notes of initial ideas and interesting features in the texts.
3. Initial coding:	<p>A hermeneutic view resists the idea that there can be one single reading of a text. To increase the rigour of analysis a three-stage iterative process was undertaken:</p> <ol style="list-style-type: none"> <li>a. First an analysis of the type and range of issues of importance voiced by the participants in the pre-consultation interviews was conducted, choosing codes to capture the meaning in the texts.</li> <li>b. This was then compared to what was voiced in the consultations and finally compared to which issues of importance voiced (and unvoiced) in the consultations were addressed by the clinicians.</li> <li>c. A final coding based on a conclusive interpretation was written.</li> </ol> <p>Coding tables for each of the participants were then constructed with the corresponding data extracts.</p>
4. Development of themes:	A manual approach was used to identify the common patterns in the texts to form potential themes.
5. Refining the themes:	Reading and interpreting texts as a whole in a process of deepening understanding; refining the specifics of each theme, and the overall story the analysis tells.
6. Producing the report:	Relating the analysis back to the research aims and literature and producing a report.

## **Appendix 1**

### **Questions used to guide the pre-consultation interview**

1. Can you describe your (main) problem (and symptoms)?
2. What have you been told / do you think the problem is?
3. What do you think the problem is?
4. Do you have any knowledge of how the problem should be managed / addressed?

(Prompt: is there any treatment they don't want? i.e. medication)

5. What have you done prior to seeking further help to manage this problem yourself?
6. What are you hoping the clinician (team) will do? (wanted actions)
7. Is there anything you really do not want the clinician to do or suggest? (unwanted actions or treatments)
8. What matters most to you as the outcome from the consultation?

(Prompt: are you hoping for or expecting any of these?)

Show client card, which lists possible outcome options: reassurance, advice (work, medication, exercises, and other services), other information, plan for rehabilitation programme, finding out what is wrong or understanding of problem, referral for further tests or investigations, referral to occupational therapist / psychologist / pharmacy technician.

9. No specific questions but interviewers briefed to probe if any mention made of emotional or social issues and alternative treatments.

### **Post-consultation Interview Topic Guide (client)**

1. What were you told the problem was? (diagnosis / understanding / priority)
2. What did the clinician do / offer you in the way of management options?  
How did this fit with what you wanted as the outcome? (wanted actions)
3. Thinking about what you really didn't want the clinician to do or suggest, were you offered any of those treatments / options? (unwanted actions or treatments)
4. How did you manage this situation?
5. Were you happy with the way the consultation went in terms of eliciting 'what mattered most' to you? If not why not? Do you have any idea about what sort of things you feel the clinician failed to address?

### **Post-consultation Interview Topic Guide (clinician)**

1. Can you describe the patient's problem and main symptoms
2. What had they been told / or thought the problem was? (diagnosis / understanding)
3. What did you find out from the patient about how they thought the problem should be treated?

(Prompt: or is there any treatment they didn't want?)

4. What had they done themselves prior to seeking further help to manage this problem? (self-management)
5. What were they hoping you would do? (wanted actions)
6. Was there anything they really didn't want you to do or suggest? (unwanted actions or treatments)
7. What mattered most to the patient as an outcome from the consultation? Were they hoping for or expecting any of these?

(Show client card which lists possible outcome options: reassurance, advice (, medication, exercises), other information, finding out what is wrong or understanding of problem, referral for further tests or investigations, onward referral etc.

8. No specific questions but interviewer briefed to probe if any mention made of emotional or social issues and alternative treatments.
9. Were you happy with the way the consultation went in terms of eliciting 'what mattered most' to the patient? If not why not?

Prompt: Do you have any ideas about the sort of things you didn't address?