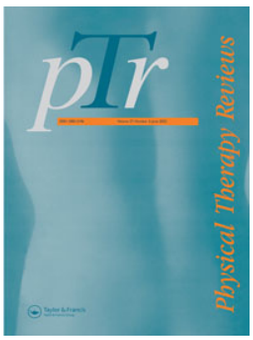

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Development of a framework for person-centred physiotherapy

Clare Killingback[a], Angela Green[b] and John Naylor[a,b]

[a]University of Hull, Hull, UK; [b]Hull University Teaching Hospitals NHS Trust, Hull, UK

ABSTRACT

Background: There is a growing call for healthcare to focus on person-centred practice. This can lead to improved outcomes for patients in terms of physical and psychological health. Challenges exist around how person-centredness is understood in physiotherapy. Having a physiotherapy framework would help support a shared understanding of the meaning of person-centred physiotherapy.

Aim: The aim of this study was to locate and synthesise studies which have a conceptualisation of person-centred physiotherapy practice. These were used to develop an overarching conceptual framework for person-centred physiotherapy practice.

Methods: The framework was developed through a systematic process involving a systematic literature search, screening studies against eligibility criteria, data extraction, data synthesis, naming and defining core constructs of person-centred physiotherapy practice, and generation of a pictorial representation of an overarching conceptual framework.

Results: The person-centred physiotherapy framework is comprised of four constructs: physiotherapist characteristics, which focuses on the knowledge and skills for clinical proficiency, attributes of the physiotherapist, reflection and self-awareness; person-physiotherapist interaction(s), which focuses on partnership, empowerment and self-management; the environment, which focuses on coordinated healthcare delivery, culture of the organisation and practice environment, and the physical environment; and the ongoing unique journey of the person and self-management. The relationships between the constructs reflect the complex nature of person-centred practice.

Conclusions: The framework presented can be used to better understand person-centred physiotherapy with a view to enhancing practice. The framework needs to be tested further through empirical research to establish its utility.

KEYWORDS
Physiotherapy; person-centred practice; patient-centred practice; framework

Introduction

From an international perspective, there is a growing call for healthcare to focus on person-centred practice [1–5]. Person-centredness refers to a philosophy of healthcare practice which reflects the needs, values, and preferences of the individual to optimise their experience of care [6]. When compared with usual care, a person-centred approach can lead to improved physical and psychological health as well as enhanced self-management [7].

Challenges exist around how the concept of person-centredness is defined, operationalised, and implemented with different professions focusing on different elements [8–10]. Moreover, whilst person-centredness is evident in healthcare policy, some argue that it is difficult to ascertain whether stakeholders are talking about the same thing without a shared language [11]. Variations in the terms are also evident in the published literature with terms such as person-centred care, patient-centred care, client centred etc. being used [9, 11]. Definitions of person-centred practice can be seen to be important in operationalising how services are delivered [9, 12]. However, others propose that we need to accept the 'fuzzy' nature of person-centredness [13] and instead focus on using a 'constellation' of multiple ideas which can be used to critically guide practice [14]. Despite the lack of consensus on an overarching definition of person-centredness, there appears to be some agreement on the core principles [8, 10, 11]. For example, Kitson and colleagues [8] identified consistency rather than divergence in the core principles of person-centredness across the medical, nursing, and healthcare policy literature. These include patient participation and involvement, the relationship between the patient and the professional, and the context in which care is delivered.

To better understand person-centredness in healthcare, a number of models and frameworks have been developed. These frameworks initially grew from medical and nursing contexts [15–17].

CONTACT Clare Killingback c.killingback@hull.ac.uk Faculty of Health Sciences, University of Hull, Cottingham Road, Hull, HU6 7RX, UK.

More recently, frameworks are being developed in a rehabilitation context [6], interprofessional practice [18], implementation frameworks [19], as well as frameworks which seek to be applicable across all healthcare settings [11, 20]. However, these conceptual frameworks developed from different contexts may not necessarily be applicable to all professions, including physiotherapy [21].

As a profession, physiotherapy has historically been aligned with biomedical models of practice [22]. The shift towards biopsychosocial models in physiotherapy challenged this historic model by offering a more holistic alternative [23, 24]. There is now a further shift in practice paradigms with an expectation from national physiotherapy bodies that their members practice in a person-centred manner [25–27]. Physiotherapists could be anywhere on a continuum from biomedical to biopsychosocial through to person-centred ways of working. Whilst the biopsychosocial model is more holistic in nature by including psychological and social aspects of a person's life, it would still be possible to practice within a biopsychosocial model and yet not be person-centred. For example, a therapist working with a person who has just undergone surgery could consider the biomedical implications of the surgical procedure, a person's past medical history, drug history, aspects of the psychological impact of the surgery and being in hospital alongside the social network and support the person may have. Yet they could fail to follow some of the key tenets of person-centredness such as fully involving the person's perspectives, needs, values, or preferences, considering the relationship between the person and the professional, and optimising the person's experience with care [6, 8].

Physiotherapists theoretically embrace the principles of person-centredness but can struggle to implement them in clinical practice [28–30]. Indeed, physiotherapists often believe themselves to be person-centred in their practice, yet when they are pushed to use more collaborative, coaching models of practice they can find it uncomfortable [29]. In some instances, physiotherapists will tend towards a more paternal manner, viewing themselves as the experts and struggle to relinquish control [31], thus limiting person-centred approaches which call on more equal relationships with the person [28, 29]. This challenge may be in part due to the understanding that physiotherapy practice and pre-qualifying training is still typically underpinned by a biomedical discourse [21, 29, 32–35]. There is a call for pre-qualifying physiotherapy curricula to draw on more embodied, person-centred approaches [36]. This would help ensure that the next generation of physiotherapy graduates have a greater sensitivity to person-centred practice [36]. A physiotherapy framework would help support a shared understanding of the meaning of person-centred physiotherapy. This is not to disregard frameworks from other healthcare contexts, but rather to provide a nuanced perspective of physiotherapy specific elements of person-centred practice which complement the wider person-centred healthcare conversation.

Several frameworks, theories, models, and associated constructs for person-centred practice in physiotherapy have been published to date, based on primary and secondary research [21, 37–43]. The aim of this study was to locate and synthesise studies which have evidence of constructs from a framework, theory, model, or conceptualisation of person-centred physiotherapy practice. These would be used to develop an overarching conceptual framework for person-centred physiotherapy practice. This can then be used to contribute to the wider person-centred healthcare conversation.

Methods

Study design

These authors sought to develop an overarching conceptual framework made up of constructs which explain how they relate to the phenomenon of person-centred physiotherapy practice. For clarity, it is important to define how these authors are defining conceptual frameworks and constructs. A conceptual framework is a collection of defined, organised concepts or constructs with explanations of how they relate to a particular phenomenon [44]. McGregor [44] distinguishes between concepts and constructs based on their level of abstraction; for example, an object such as a table or chair is an observed fact and would therefore be called a concept. However, when an idea is inferred from what is observed it is called a construct (e.g. happiness, empowerment). Constructs are higher order abstractions which are more subjective in nature and are more difficult to measure or quantify [44]. This perhaps explains in part why person-centred practice has been difficult to define.

The conceptual framework was developed through an iterative process and involved a series of systematic steps with a view to combining existing frameworks, theories, models, or conceptualisations of person-centred physiotherapy practice. The systematic steps included: conducting a systematic search, screening studies against eligibility criteria, data extraction, data synthesis, naming and defining core constructs of person-centred physiotherapy practice, and generation of a pictorial representation of the overarching conceptual framework.

Table 1. Search terms.

Concept	Search	Boolean operator
Person-centredness	'Person cent*' OR 'patient cent*' [AB]	AND
Physiotherapy	Physiotherap* OR 'physical therap*' [AB]	AND
Framework	Framework or model* or conceptual or theor* or approach* or tool*	

Search strategy

The first step was to conduct a systematic search for existing frameworks, theories, models, or conceptualisations of person-centred physiotherapy practice. A systematic search was conducted across the following electronic bibliographic databases: CINAHL Complete; Medline; SPORTDiscus; and Academic search premier. No date limits were applied, and the final search was carried out in May 2021. Using a Boolean search strategy, key terms (person-centredness; physiotherapy; framework) and their alternatives (Table 1) were entered into the databases. The phenomenon of person-centredness is a complex one, thus selecting an exhaustive list of search terms is challenging, but given that the aim was to locate studies which had specifically examined person-centredness the authors chose to focus on the two key terms of person and patient-centredness. The authors appreciate that there is a distinction between these two terms with patient-centred focusing more on a functional life and person-centred taking the more preferred holistic approach to consider a meaningful life [45]. However, for pragmatic reasons the term patient centred was included as this is often used in healthcare literature [6, 16]. The search was limited to peer-reviewed papers published in English. Reference lists of eligible studies were hand searched. The authors of studies which met the inclusion criteria were contacted to see if they were aware of any further relevant studies.

Eligibility criteria and study selection

The authors sought to include studies which had evidence of constructs from a framework, theory, model, or conceptualisation of person-centred physiotherapy practice. The authors did not wish to limit articles based on methodological approach. As such, the synthesis was open to including studies using primary or secondary research methods.

It was challenging to determine from studies what constituted a framework, theory, model, and their associated constructs. After all, these terms often have multiple definitions or are used interchangeably [44]. Indeed, each qualitative study on person-centred physiotherapy could be said to have developed constructs related to person-centred practice through the analytical process. To guide decision making, the authors drew on work by Strauss and Corbin [46] with their view that themes from qualitative studies 'are more likely to be precise summaries of words taken directly from the data. There is little, if any, interpretation of data. Nor is there any attempt to relate the themes to form a conceptual scheme'. (p. 20). Therefore, if studies took a more interpretative approach and developed themes into a conceptual form then they would meet the inclusion criteria, whereas if data were only presented as themes, they would not meet the inclusion criteria. The full inclusion criteria are outlined in Table 2.

Articles identified by the database search were initially screened for eligibility based on their title and abstract. Full text screening was used where it was difficult to determine if an article met the inclusion criteria based on the title and abstract. Full text articles were independently reviewed by CK and AG. Discrepancies regarding eligibility for inclusion were resolved by discussion and consensus with JN. Search results were handled using an excel spread sheet to facilitate an audit trail of article screening.

Data extraction and synthesis

Each study which met the inclusion criteria was initially read and re-read to allow familiarisation. The frameworks, theories, models, and their associated constructs were then extracted by the first author into customised data extraction forms. These forms included information regarding the aims, study design, study setting, participant characteristics, constructs developed from the study findings, and pictorial or schematic representations of the individual study findings. These forms were used to assist the research team as they individually and collectively considered each study and their constructs.

The synthesis for this study was based on a three-stage process similar to thematic synthesis [47]. The findings sections of each study were imported verbatim into NVivo 12 data analysis software. This was drawn upon to help organise the findings of each included study and their subsequent constructs and to provide an audit trail. Each study was then coded in an initial phase of coding. Given that the studies were already made up of a number of constructs, the names of each construct were used as individual codes.

In the second stage, the codes were organised into related constructs, for example, codes related to the attributes of the physiotherapist, or the environment were grouped together. The third stage

Table 2. Inclusion/exclusion criteria.

Inclusion	Exclusion
Focus on patient or person-centred practice	Where the focus is on an intervention to enhance person-centredness rather than on developing an understanding of person-centredness as a construct
Focus on physiotherapy or physical therapy	Study protocols
Evidence of a framework, model, or theory of person-centred physiotherapy practice developed based on the study findings	Expert opinions and grey literature
Primary or secondary studies	
English language studies published in peer-review journals	

involved generating clear names and definitions for each construct to form the basis of the overarching framework. To provide transparency on this process a table with how the individual studies informed the development of the constructs which were core to person-centred physiotherapy are included in Table 4.

The authors had to consider what counted as an overarching construct in a similar way to which Braun and Clarke [48] considered what counts as a theme in qualitative data analysis. For example, does a theme or construct which has greater prevalence in terms of space within each study or across the entirety of studies mean that it is more critical? The authors would agree with Braun and Clarke that more instances of a construct within the individual studies does not necessarily mean it is more critical because 'keyness' is not dependent upon a quantifiable measure but rather if it captures something important in relation to the overarching aim of the study [48].

Following this three-stage process, the identified core constructs were then used to develop an overarching framework of person-centred physiotherapy practice with definitions for each construct and a pictorial representation. This process involved critical debate and dialogue within the research team to reach agreement and was iterative in nature taking place over a number of discussions to reach a consensus. The authors recognise that the framework will always be dynamic and may need to be revised according to new insights, comments, and literature [49].

The construction of the pictorial representation of the overarching framework was a highly visual process. A large whiteboard was used to highlight areas of commonalities, and uniqueness between the constructs. The original sources of the data were drawn upon to ensure there was shared clarity of the meaning of the key terms in the pictorial framework as it developed.

Results

Study selection

A total of 816 studies were identified through the search strategy with 33 undergoing full-text screening. Ten studies met the inclusion criteria (five qualitative, one mixed-methods, and four literature reviews). Figure 1 shows the process of study selection based on the Preferred Reporting Items for Systematic Reviews and Meta-Analysis [50].

Study characteristics

The included studies employed a range of research methods. The qualitative studies used content analysis [38, 41, 51], interpretive phenomenological framework analysis [21] or grounded theory [39]. The mixed-methods study used a literature review, focus groups, a Delphi survey, and interviews to establish domains for person-centred relationships [42]. Of the four literature reviews two used a mixed-methods approach [37, 40] and two used a qualitative approach [43, 52].

The primary research studies were carried out in The Netherlands [38], New Zealand [39], Canada [41, 51], Spain [42], and the United Kingdom [21]. The lead/corresponding authors of the literature review studies were located in the United Kingdom [37, 52], Sweden [40], or Belgium [43]. Table 3 provides an overview of the included studies.

Person-centred physiotherapy framework constructs with definitions

The following four core constructs have been identified and defined in the framework for person-centred physiotherapy: physiotherapist characteristics; person-physiotherapist interaction(s); environment; and ongoing unique journey of the person and self-management. The overarching framework is presented visually in Figure 2.

Physiotherapist characteristics

This construct reflects the characteristics of a physiotherapist who practices in a person-centred manner. To this end, three physiotherapist characteristics are described within the construct: knowledge and skills for clinical proficiency; attributes of the physiotherapist; reflection and self-awareness.

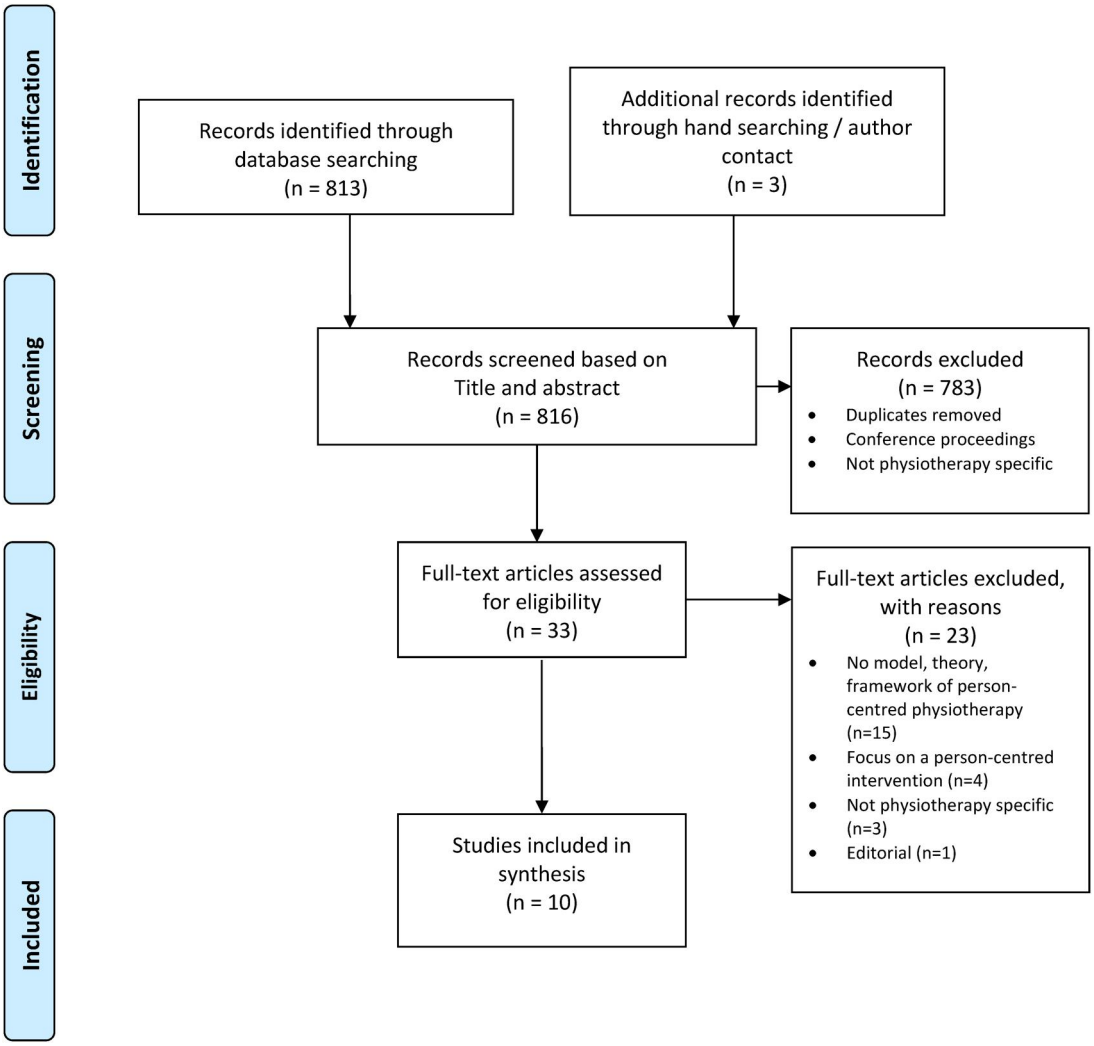

Figure 1. Flow chart of study selection. 816 records were identified through database and hand searching; 783 were excluded at the title and abstract screening stage due to removing duplicates, being conference proceedings or not physiotherapy specific; 33 articles were assessed at the full text stage—23 of these were excluded as they had no model, theory, or framework of person-centred physiotherapy (n = 15), the focus was on an intervention (n = 4), not physiotherapy specific (n = 3), or were an editorial. This left 10 articles which met the inclusion criteria and were included in the synthesis.

Knowledge and skills for clinical proficiency

The focus of this characteristic is on the knowledge and skills required by physiotherapists to be clinically proficient [38, 39, 42, 43]. Knowledge needed to be disease specific, have a familiarity with the range of possible dysfunctions, and incorporate the person's perspective [43].

Attributes of the physiotherapist

The attributes of the physiotherapist focuses on key interpersonal skills for person-centred practice. Although not an exhaustive list, several key attributes were noted as being central to person-centred practice. These include the personal characteristics and attitudes of being conscientious, present, genuine, receptive, empathetic, and compassionate [38, 39, 41–43, 52]; to be concerned about people, to take them seriously, to respond and adapt, to be culturally sensitive and able to make people feel safe and accepted such that they feel able to share relevant information [38, 40, 42, 43, 51, 52]. Importantly, person-centred physiotherapists dialogue and communicate authentically and effectively [39, 40, 42, 43, 51, 52]. They have well developed verbal and non-verbal interactions that promote confidence and trust for the person [39, 42, 43, 51, 52]. The attribute of being an active listener is central to person-centred practice so that the person feels heard and understood [38–43, 52].

Reflection and self-awareness

The focus of this characteristic is on the role that reflection and self-awareness play in supporting person-centred physiotherapy practice. Reflective physiotherapists seek to continually improve practice [40]. They are mindful of the persons experience and the role that physiotherapists play in their

Table 3. Core constructs in relation to the individual studies.

Physiotherapist characteristics	
Knowledge and skills for clinical proficiency	• Technically skilled: Competent; communicative skilled; goal and process oriented; positive [38] • Knowledge and expertise [39] • Professional aspects: Skill, competence, technical experience and knowledge; Professionality; Physiotherapist as educator; Follow-up of home prescriptions [42] • Knowledge and skills [43]
Attributes of the physiotherapist	• Conscientious: act morally in clinical decision making; act morally on commercial / financial level; in control [38] • Compassionate: concerned; personal contact; take patients seriously [38] • Responsive: adapt to the patient; continuity of care; aware of vulnerability / dependency; respect the patient boundaries; culturally sensitive; make patients feel safe [38] • Communication [37] • Ability to communicate [39] • Understanding people and able to relate [39] • Confidence [39] • Transparent focus on progress and outcomes [39] • Giving of self (inside the interaction, outside the interaction) [41] • Personal characteristics of the professional: Motivating and encouraging the involvement of the patient in the process based on a positive attitude; Perception of security, trust in oneself; The physiotherapist shows empathy towards the patient; Authenticity of the physiotherapist towards the patient; Unconditional acceptance [42] • Communication capacities of the professional: Congruence between verbal and non-verbal communication; Non-verbal communication; Active listening skills; Verbal communication; Assertiveness [42] • Seeing the person—individualized care, person over pathology, equality, unique individual, world view, values and beliefs, acceptance (Giving of self—something more, teamwork, self-disclosure) [52] • Communication—attention to the narrative, verbal and non-verbal, empathy, active listening, language [52] • Therapeutic space—safety, time, physical space (Physiotherapist characteristics matter—personal attributes, socio-cultural, competence, age) [52] • Fostering autonomy—shared decision-making, self-awareness, self-reflection, self-efficacy, behaviour change, self-management, responsibility (Interpersonal collaboration—trust, motivation, agreement) [52] • Confidence [43] • Social characteristics [43]
Reflection and self-awareness	• To refine physiotherapy interaction skills (responsiveness can be enhanced by self-awareness, reflection, and education) [40] • Developing skills by experiences and education [40] • Changing interaction and reflective practice [40]
Person-physiotherapist interaction(s)	
Partnership	• Partnership: Equality; cooperation and creating space; take the lead [38] • Decision making [37] • Information sharing [37] • Active partnership [39] • Establish good relationship [39] • Therapist's expertise and self-confidence creates a confident patient [39] • To seek mutual understanding of what is meaningful to the patient [40] • Understanding goals that are meaningful to the patients [40] • Setting goals in collaboration [40] • Conditions of engagement in therapeutic relationship: Committed, Genuine, Receptive, Present [41] • Acknowledging the individual (meeting as an equal, validating the patient's experiences, individualizing the treatment approach) [41] • Relational aspects: Affinity with the physiotherapist; Care; warmth (sensitive, kind, affectionate); Close attitude; Displaying interest and involvement in the patient's problem; Emotional support [42] • Partnership: Mutual trust and respect; Collaboration/active involvement [42] • Seeing the person—individualized care, person over pathology, equality, unique individual, world view, values and beliefs, acceptance (Giving of self—something more, teamwork, self-disclosure) (Søndena˚ et al. 2020) • Sharing the journey—role change, holistic, behaviour change (Legitimising the experience—their story, legitimising the biological, therapeutic touch) (Søndena˚ et al. 2020) • Patient expectations [21] • Finding out what matters to the patient [21] • Collaboration influences [21] • Informed decision making [21] • Choices (freedom to make choices throughout the journey) [21] • Patient engagement [21] • Shared decision making [21]
Empowerment and self-management	• Empowerment: empowerment; support self-control [38] • Therapeutic relationship [37] • Individualisation [37]

(*continued*)

Table 3. Continued.

Physiotherapist characteristics	
	• Goal setting [37] • Ongoing care [37] • Goal achievement [37] • Self-efficacy [37] • Self-management [37] • Patient engaged in therapeutic process—becomes self-directed [39] • Using the body as a pivot point (clarifying physical problems and solutions, facilitating the patient's connection to the body, using touch to bridge a gap) [41] • Fostering autonomy—shared decision-making, self-awareness, self-reflection, self-efficacy, behaviour change, self-management, responsibility (Interpersonal collaboration—trust, motivation, agreement) [52] • Patient-physiotherapist interactions [43] • Individuality [43] • Support [43] • Goal setting [43] • Education [43] • Communication [43] • Self-management [21] • Balance of power and control [21] • Education to empower [21]
Environment	
Coordinated healthcare delivery	• Continuation of care [21] • Service structure [21] • Time to care [21] • Perception of coordination in the communication between the physiotherapist and other professionals; Perception of the physiotherapist as having professional autonomy [42] • Therapeutic space—safety, time, physical space (Physiotherapist characteristics matter—personal attributes, socio-cultural, competence, age) [52]
Philosophy of the organisation and practice environment	• Patient-centred culture [21] • Service structure [21]
Physical environment	• Physical space allowing privacy [42] • Safety and dignity [38] • Therapeutic space—safety, time, physical space (Physiotherapist characteristics matter—personal attributes, socio-cultural, competence, age) [52]
Ongoing unique journey of the person and self-management	• Uniqueness: a unique individual; a deep understanding; holistic vision [38] • Autonomy: right to decide; independence [38] • Responsive: adapt to the patient; continuity of care; aware of vulnerability / dependency; respect the patient boundaries; culturally sensitive; make patients feel safe [38] • Individualisation [37] • Goal achievement [37] • Self-efficacy [37] • Self-management [37] • To seek mutual understanding of what is meaningful to the patient [40] • Acknowledging the individual (meeting as an equal, validating the patient's experiences, individualizing the treatment approach) [41] • Personalized therapy: Psycho-social-cultural sensitivity; Sensitivity to changes in the patient's status [42] • Sharing the journey—role change, holistic, behaviour change (Legitimising the experience—their story, legitimising the biological, therapeutic touch) [52] • Fostering autonomy—shared decision-making, self-awareness, self-reflection, self-efficacy, behaviour change, self-management, responsibility (Interpersonal collaboration—trust, motivation, agreement) [52] • Patient expectations [21] • Finding out what matters to the patient [21] • Self-management [21]

journey [40]. Part of the product of this reflective behaviour is a self-awareness of the impact that the physiotherapist has on people within physiotherapy services [40].

Person-physiotherapist interaction(s)

This construct reflects the role that person-physiotherapist interaction(s) play in person-centred practice and includes two key aspects: partnership, and empowerment and self-management.

Partnership

The process of partnership working is one in which there is an understanding of shared expertise [38]. This is where the person is the expert of themselves, and the physiotherapist brings their skills, knowledge, and attributes to work collaboratively [38, 40, 42, 43, 51]. This involves the physiotherapist being non-judgemental and seeking to empathetically understand and accept the lived context of the person including their personal environment, life choices, social context, and psychological factors which can impact on health [40,

Table 4. Study characteristics.

Study	Aims	Study design	Setting and participants	Original constructs from the individual study findings
Bastemeijer et al. 2021	To describe the aspects of physiotherapy practice that people with musculoskeletal pain value in high-quality care to develop a taxonomy of patient values in healthcare.	Qualitative design Content analysis	Setting: The Netherlands Participants: 17 adults (nine female, eight male) with chronic or recurrent musculoskeletal pain Aged between 33–79 years old (average of 57 years)	• Values about oneself (uniqueness and autonomy) • Values regarding actions of the professional (technically skilled professional, conscientious professional, compassionate professional, responsive professional) • Values regarding interactions between patients and the professionals (partnership and empowerment)
Dukhu et al. 2018	To critically review evidence for barriers to, and facilitators of, person-centred care in adults living with long-term conditions in a physiotherapy context and identify its components and outcomes in practice.	Critical review Synthesis of eight articles (three qualitative, four quantitative, one mixed methods)	Setting: Studies were from Canada, Australia, or United Kingdom Participants: 439 adults with long-term conditions who experienced physiotherapy in hospital or the community	• Patients and physiotherapists were key stakeholders • Communication and individualisation influence outcomes • Outcomes include comprehensive care, goal achievement, self-efficacy, therapeutic relationship • Components of person-centred care were identified as self-management, ongoing care, decision making, individualisation, information sharing and goal setting • These relationships take place within the wider context of care
Kidd et al. 2011	To determine patients' perspectives of components of patient-centred physiotherapy and its essential elements.	Qualitative design Grounded theory	Setting: New Zealand, musculoskeletal outpatient physiotherapy department Participants: 8 individuals who recently received physiotherapy (4 male, 4 female) Age 20–68 years	• Ability to communicate • Confidence • Knowledge and expertise • An understanding of people and an ability to relate • Transparency of progress and outcome
Melin et al. 2021	To analyse definitions and related requirements, processes, and operationalization of person-centred goal setting in the physiotherapy research literature	Literature review A synthesis of 21 studies Content analysis	Geographical location of studies not included. 12 studies included data from both patients and physiotherapists; three studies included data from only patients five studies from physiotherapists only; one perspective paper did not include any generated data.	• Understanding goals that are meaningful to the patients • Setting goals in collaboration • Facing challenges with person-centred goal setting • Developing skills by experiences and education • Changing interaction and reflective practice. These categories were abstracted into two higher-ordered interlaced themes: • To seek mutual understanding of what is meaningful to the patient; and • To refine physiotherapy interaction skills, which we suggest would be useful for further conceptualization.
Miciak et al. 2018	To identify and provide in-depth descriptions of the necessary conditions of engagement of the therapeutic relationship between physiotherapists and patients.	Interpretive descriptive study Qualitative Semi-structured interviews Content analysis	Setting: Private practice clinics in Edmonton, Canada. Participants: 11 physiotherapists with a minimum 5 years of clinical experience and seven adult patients with musculoskeletal disorders. Age not included.	Conditions identified for established a therapeutic relationship for a person-centred approach: • present • receptive • genuine • committed
Miciak et al. 2019	To identify the various ways that physiotherapists establish meaningful connections with their patients	Interpretive descriptive study Qualitative Semi-structured interviews Content analysis	Setting: Private practice clinics in Edmonton, Canada. Participants: 11 physiotherapists with a minimum 5 years of clinical experience and seven adult patients with musculoskeletal disorders. Age not included.	• Acknowledging the individual (meeting as an equal, validating the patient's experiences, individualizing the treatment approach) • Giving of self (inside the interaction, outside the interaction) • Using the body as a pivot point (clarifying physical problems and solutions, facilitating the patient's connection to the body, using touch to bridge a gap)

(*continued*)

Table 4. Continued.

Study	Aims	Study design	Setting and participants	Original constructs from the individual study findings
Rodriguez et al. 2020	To develop a tool for evaluating person-centred therapeutic relationships within physiotherapy services	Mixed-methods study in three phases: 1. literature review and focus groups with patients and PTs 2. e-Delphi survey 3. Interviews to evaluate the items	Thirty-one items were generated based on seven domains identified after the analysis of four focus groups of physiotherapists and four patient focus groups. Nine experts participated in the e-Delphi survey. Fifty-five patients participated in the two rounds of the cognitive pre-tests.	**Personal characteristics of the professional** • Motivating and encouraging the involvement of the patient in the process based on a positive attitude • Perception of security, trust in oneself • The physiotherapist shows empathy towards the patient • Authenticity of the physiotherapist towards the patient • Unconditional acceptance **Communication capacities of the professional** • Congruence between verbal and non-verbal communication • Non-verbal communication • Active listening skills • Verbal communication • Assertiveness **Professional aspects** • Skill, competence, technical experience, and knowledge • Professionality • Physiotherapist as educator • Follow-up of home prescriptions **Relational aspects** • Affinity with the physiotherapist • Care • Warmth (sensitive, kind, affectionate) • Close attitude • Displaying interest and involvement in the patient's problem • Emotional support **Personalized therapy** • Psycho-social-cultural sensitivity • Sensitivity to changes in the patient's status **Partnership** • Mutual trust • Mutual respect • Collaboration/active involvement **Environment** • Perception of coordination in the communication between the physiotherapist and other professionals • Perception of the physiotherapist as having professional autonomy • Physical space allowing privacy
Søndena* et al. 2020	To present a concept analysis of therapeutic alliance	Literature review 14 literature reviews and qualitative studies included Concept analysis	Characteristics in terms of settings and participants of studies not included	Master attributes relating to the concept: • Seeing the person—individualized care, person over pathology, equality, unique individual, world view, values and beliefs, acceptance (Giving of self—something more, teamwork, self-disclosure) • Sharing the journey—role change, holistic, behaviour change (Legitimising the experience—their story, legitimising the biological, therapeutic touch) • Communication—attention to the narrative, verbal and non-verbal, empathy, active listening, language • Therapeutic space—safety, time, physical space (Physiotherapist characteristics matter—personal

(*continued*)

Table 4. Continued.

Study	Aims	Study design	Setting and participants	Original constructs from the individual study findings
				attributes, socio-cultural, competence, age) • Fostering autonomy—shared decision-making, self-awareness, self-reflection, self-efficacy, behaviour change, self-management, responsibility (Interpersonal collaboration—trust, motivation, agreement)
Ward et al. 2018	To explore perceptions of person-centred practice and how it can be enacted	Qualitative online focus group was undertaken through an international tweet chat within the existing social media communities Interpretive phenomenological framework analysis	Tweets from 23 physiotherapists were analysed	• Service structure • Patient expectations • Finding out what matters to the patient **Collaboration influences** • Balance of power and control • Education to empower • Informed decision making • Choices • Patient engagement **Leads to** • Shared decision making • Person-centred practice • Self-management
Wijma et al. 2017	To summarise themes related to person-centredness in physiotherapy and construct a proposed conceptual framework for utilization within physiotherapy	Qualitative systematic review 14 articles	Combined number of participants = 231 Seven studies included views of physiotherapists; five included patients two included both Age range: 18–84 years	**Patient-physiotherapist interactions** • Individuality • Support • Goal setting • Education • Communication **Physiotherapist characteristics** • Social characteristics • Confidence • Knowledge and skills

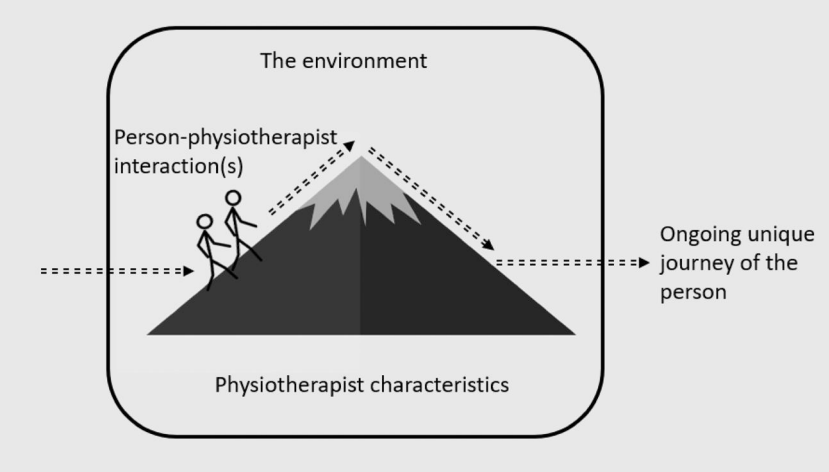

Figure 2. Person-centred physiotherapy framework. Two stick persons are in the centre of the framework to represent the construct of person-physiotherapist interaction(s) and are climbing up the left-hand side of a mountain. The construct of the environment is at the top of the mountain and the construct of physiotherapist characteristics below. The mountain and constructs are surrounded by a box. A dashed arrow enters the box from the left, moves up the left-hand side of the mountain, down the right-hand side of the mountain and then continues outside the box with the construct of the ongoing unique journey of the person.

42, 43, 51, 52]. The physiotherapist can then incorporate that understanding into goals and treatment [40].

For partnership working there is a need for a strong relational aspect to be present to promote shared decision making and informed choices [21, 37, 38, 51, 52]. This builds upon the interpersonal skills, attributes, and attitudes of the therapist such that there is a care, warmth, interest, and involvement in the person's situation and emotional support from the physiotherapist [42, 52]. This also considers an individual person's uniqueness, beliefs,

values, goals, and experiences as part of therapeutic interactions promoting mutual trust and respect [38, 40, 42, 43, 51, 52].

One of the challenges of partnership working is in situations where a person expects the practitioner to make decisions for them reflecting the concern about how involved a person may wish to be in their care [21]. Thus, people may choose to be active or passive within interactions [40].

Empowerment and self-management

In therapeutic interactions, physiotherapists play a role in motivating and encouraging the involvement of the person they are working with (with the inclusion of significant others as appropriate) to seek mutual understanding of what is meaningful, i.e. what matters [21, 38, 39]. This means the physiotherapist should seek to promote the agency and autonomy of the person and engage and empower them in the therapeutic process with a view to supporting them in continuing in what is meaningful to them [38, 40, 52]. This may include the physiotherapist helping the person examine their beliefs about their health conditions and grow in their knowledge (such as through education), skills, confidence, self-management, and prevention [21, 38, 39, 43, 51, 52].

Environment

This construct focuses on the role of the environment (i.e. the context in which the therapeutic encounter takes place—be that a hospital, clinic, person's home, or online consultation) in supporting person-centred practice and has three parts: coordinated healthcare delivery; culture of the organisation and practice environment; physical environment.

Coordinated healthcare delivery

Physiotherapy services do not happen in isolation but can be one part of a range of healthcare encounters and episodes. As such, for person-centred practice to take place, there needs to be an appropriate interprofessional combination of staff with necessary staffing levels and time available to provide a quality service [21, 52]. Interpersonal connections within the healthcare team need to be strong, along with a commitment to work collaboratively and inclusively to support people in their services in realising the best mutually agreed outcomes [21, 42]. This then supports collaborative healthcare and support planning that can be coordinated such that from the person's perspective, services appear seamless across episodes, particularly when transitioning between services such as acute to community [21].

Culture of the organisation and practice environment

Person-centred cultures and systems at an organisation and service structure level are important in enabling person-centred values to be enacted in the day-to-day practice environment [21]. Involving those who have experience of their services and patient organisations in meaningful engagement in the co-production of local healthcare policy and decision making is important [21]. This would help ensure a continuity of care such that healthcare services are designed with the person at the centre throughout the entirety of their healthcare journey from initial contact to discharge [21].

Physical environment

The physical space of the environment is one in which the space has been designed with consideration to those accessing the services in which dignity, privacy, and safety are promoted [38, 42, 52].

Ongoing unique journey of the person and self-management

This final construct reflects the fact that at some point, people's lives may intersect with healthcare services as part of their unique journey. As such, person-centred physiotherapy needs to be contextualised within the past, present, and the expectations and hope of the future journey [38]. One of the outcomes of person-centred physiotherapy practice is that people have the self-efficacy required not just to achieve their immediate goals but to continue in the self-management of the limitation that is stopping them from living a meaningful and fulfilled life [21, 37, 40, 52]. At times this may mean helping the person accept some of the limitations and adapt accordingly [40]. An understanding of the persons lived context, including psychosocial and cultural factors must be considered as part of their uniqueness [21, 38, 42, 43, 51, 52].

Discussion

The aim of this study was to develop a conceptual framework for person-centred physiotherapy practice. This is important in providing a nuanced perspective of physiotherapy specific elements of person-centred practice which complement the wider person-centred healthcare conversation.

The core principles of person-centredness reported in a synthesis of the nursing, medicine, and health policy literature include aspects of patient participation and involvement, the relationship between the patient, and the context [8]. Similarly, the most recent iteration of a broader person-centred healthcare framework for all healthcare practitioners includes core aspects of prerequisites, the practice environment, person-centred processes, and person-centred outcomes [11]. These core principles are reflected in this physiotherapy framework through the constructs of the physiotherapist characteristics, person-physiotherapist interaction(s), and the environment. Thus, there are many similarities with this physiotherapy framework and previous person-centred frameworks highlighting consistency in the core principles of person-centredness [8]. What this current physiotherapy framework adds is an emphasis of the key role that the promotion of self-management plays and highlighting the unique journey of the person within the context of a particular healthcare episode. This is not to say that these elements are omitted from frameworks from other disciplines, but rather this framework brings to the fore the key role that some of these more nuanced aspects play in physiotherapeutic encounters.

In reality, person-centredness in healthcare practice is a complex phenomenon which cannot be reduced to a discrete set of constructs. However, the aspects noted in the framework serve to illuminate the complicated, intricate nature of person-centredness in physiotherapy practice. The constructs are represented pictorially in Figure 2.

To summarise the pictorial representation, the characteristics of the physiotherapist are situated at the base of the framework to emphasise the foundational nature that knowledge and skills for clinical proficiency, attributes, and reflection and self-awareness play in supporting person-centred encounters. Without these fundamentals, person-centred physiotherapy is not possible.

The centrality of the person-physiotherapist interaction(s) in the framework indicates the way that strong therapeutic relationships, through partnership, empowerment and self-management are at the heart of person-centred practice. The environment (i.e. the context in which the therapeutic encounter takes place—be that a hospital, clinic, person's home, or online consultation) is situated at the top of the framework to indicate the overarching role it plays in person-centred practice. As noted by McCormack and McCance [15], some of the challenges around implementation of person-centredness are beyond the scope of individual practitioners. For example, physiotherapists with strong characteristics and good partnership working, empowerment and self-management skills which facilitate person-centred encounters may be limited in their ability to be person-centred due to the influence of the environment. After all, some organisational level changes may be needed to realise a truly person-centred environment [21], but this does not necessarily prohibit the physiotherapist from enacting some aspects of person-centred practice. Thus, whilst the environment is an important construct, it is only one of the constructs.

Furthermore, there are calls to re-frame practice from a dichotomous perspective of either biomedical *or* person-centred and embrace practice as being on a continuum [53, 54]. If a continuum approach were adopted for each construct, then it could empower physiotherapists to edge closer to aspects of person-centred practice which are within their scope to influence. For example, whilst the context of practice may be in a positivist healthcare setting which is more biomedical in its approach, the individual physiotherapist or physiotherapy team could still approach person-physiotherapist interactions from a viewpoint of partnership and empowerment. This view encourages physiotherapists to make small, incremental changes within biomedical environments towards more person-centred encounters [31]. The continuum perspective also provides an opportunity for therapists to build their own self-efficacy in finding opportunities for person-centredness. As an example, a shift towards more partnership ways of work could be evident in adopting a narrative approach to assessments to empower people. Narrative-based approaches call on therapists to use more open questioning styles to adopt a mutual search for meaning and sense-making of the persons whole story [55–59]. This narrative approach would be in contrast to a more biomedical diagnostic approach. With the latter view, little partnership is needed, with the former narrative view, partnership is essential.

In the pictorial representation of the framework, the therapeutic encounter is surrounded by a box representing the fact that this is an episode in the life of the person accessing physiotherapy services. The dashed line and mountain represent the ups and downs of health and life and the ongoing unique journey of the person. The outcome of the person-centred interactions would be the continuation of that journey in which people are able to carry out the activities which are meaningful to them. The uniqueness of that person can only be understood in the entirety of their journey (past, present, and future) and their lived context including an awareness of psychosocial and cultural factors [40, 42, 60].

The view of uniqueness is not new in the context of person-centred practice. A focus on the values and preferences of the person and being mindful of the individual's perspective is central to being person-centred [6, 20, 60]. However, what this framework seeks to highlight is that for physiotherapy practice to be person-centred, it needs to be contextualised within the unique past, present, and the expectations and hope of a future journey of the individual. Framing practice in this way is important from the viewpoint of working with those accessing physiotherapy services to empower them to develop the self-efficacy needed to continue in what is meaningful to them [37, 38, 40, 60]. To phrase this another way, it is to say that considering the unique journey of the person supports meaningful goal setting beyond the immediate healthcare encounter and into the longer-term view of helping the person self-manage whatever limitations are stopping them in continuing in what is meaningful to them.

Person-centred practice is a complex phenomenon [11]. This framework has sought to distill some of this complexity into more tangible constructs. However, given the complexity it is important to ask the question of the utility of such a framework. The authors propose that the framework could be used in the following ways. Firstly, similar to early nursing frameworks [15], this framework can be used as a tool to benchmark existing practices and highlight areas for changes based on principles of person-centred physiotherapy practice. Secondly, it helps provide a shared understanding and common language in describing person-centred practice [61]. This is important because there is said to be a dearth of conceptual papers on person-centredness in physiotherapy [62]. Thirdly, it could be used to structure learning around person-centred practice for pre-qualifying physiotherapy students. This would be important in preparing the future physiotherapy workforce to practice in a person-centred manner [36]. Fourthly, it could be used as a tool for reflection and continuing professional development for qualified physiotherapists. For example, each construct could be used to frame reflective questions such as, 'where in my practice am I empowering patients in the ongoing self-management of their long-term conditions?', or 'do I consider the unique journey and lived context of each patient I work with and how can I be more considered of this in developing collaborative goals which are meaningful?'. These types of reflective questions would be important because although self-management was highlighted in this framework, it does not mean that it comes easily to physiotherapists. Indeed, literature suggests that physiotherapists need to further develop their skills in supporting self-management [31, 63].

Finally, the framework can be used to further operationalise person-centred practice. Research into person-centred practice in physiotherapy has been said to fall into two categories: 1) defining the concept within physiotherapy; and 2) how it is understood, implemented, and operationalised. This study falls into the former category with a view to bridging the gap by providing a framework from which to implement and operationalise person-centred physiotherapy practice.

Strengths and limitations

The strength of this study is that it sought to develop a framework for person-centred physiotherapy practice by synthesising a number of existing frameworks. This framework serves to bring to the fore some of the more nuanced aspects of person-centred practice within physiotherapy. The included studies were from The Netherlands, New Zealand, the United Kingdom, Canada, Spain, Sweden, and Belgium offering an international perspective on person-centred practice.

Limitations include the challenge that any framework is going to be an oversimplification of reality. This is particularly difficult given the wide range of areas that physiotherapists work in; it is challenging to provide a framework which will be transferrable across the full gamut of areas of physiotherapy practice. For example, further consideration would need to be paid to situations where the person is lacking capacity or unconscious such as in an intensive care setting or indeed in Emergency Department settings where different practice pressures may apply.

Whilst the authors attempted to carry out a comprehensive and rigorous search strategy there is always a risk that not all relevant studies were located. In addition, the studies included in the synthesis were limited to those published in English and grey literature was not included. This may have led to the exclusion of some relevant studies. Furthermore, the heterogeneity of the study design made the inclusion of quality assessment problematic and as such the authors recognise this as a limitation of the synthesis.

Conclusion

The study has developed an overarching conceptual framework which can be used to better understand person-centred physiotherapy. Four core constructs have been identified and defined: 1) physiotherapist characteristics, which focuses on the knowledge and skills for clinical proficiency, attributes, reflection

and self-awareness; 2) person-physiotherapist interaction(s), which focuses on partnership, empowerment and self-management; 3) the environment, which focuses on coordinated healthcare delivery, culture of the organisation and practice environment, and the physical environment; and 4) the ongoing unique journey of the person and self-management. The relationships between the constructs reflect the complex nature of person-centred practice. The framework needs to be tested further through empirical research to establish its utility in physiotherapy practice. Frameworks will always be dynamic and as further insights are unearthed and new research is presented this framework will need to be revised.

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Notes on contributors

Clare Killingback graduated as a physiotherapist from the University of Nottingham (1999), since then he has worked in various NHS trusts and most recently in the area of community rehabilitation. Clare spent 10-years working internationally as a physiotherapist with 4-years in Northern Iraq seeking to develop physiotherapy services. Her PhD (awarded in 2016) focused on the role of community-based group exercise programmes in supporting physical activity in older people. In 2019 Clare set up the BSc (Hons) Physiotherapy programme at the University of Hull which she now leads as a senior lecturer. Her current research interests lie in person-centred practice, self-management, and pedagogy. She is passionate about helping the next generation of physiotherapists become excellent in utilising evidence-informed practice.

Angela Green graduated as a physiotherapist in 1987 and specialised in neurological rehabilitation (children and adults) in both acute and community NHS Trusts. She now supports people with cancer related fatigue. Angela's PhD (awarded in 2008), focussed on patient involvement in physiotherapeutic consultations. She has been a fellow of the National Institute for Health and Care Excellence. She has also worked in the Yorkshire and Humber region to increase Allied Health Professional engagement in research, in conjunction with the NIHR Yorkshire clinical research network, and as a hub lead for the Council for Allied Health Professional Research (CAHPR) network. Her current research interests lie in person-centred practice and rehabilitation, particularly in relation to long COVID. Angela is passionate about increasing the visibility of Allied Health Professionals (AHPs) at system level and increasing AHP engagement in research.

John Naylor currently works at Hull University Teaching Hospitals NHS Trust and is studying for a PhD within the Faculty of Health Sciences, University of Hull. John's research interests lie in Low Back Pain, Physiotherapy and Emergency Medicine. His current project is around person-centred physiotherapy practice in emergency departments.

ORCID

Clare Killingback http://orcid.org/0000-0003-1564-2156

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