Disability and Rehabilitation

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/idre20

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To cite this article: John Naylor, Clare Killingback & Angela Green (08 Feb 2024): An exploration of person-centredness among emergency department physiotherapists: a mixed methods study, Disability and Rehabilitation, DOI: 10.1080/09638288.2024.2310179

To link to this article: https://doi.org/10.1080/09638288.2024.2310179

Published online: 08 Feb 2024.

DISABILITY AND REHABILITATION
https://doi.org/10.1080/09638288.2024.2310179

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RESEARCH ARTICLE

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An exploration of person-centredness among emergency department physiotherapists: a mixed methods study

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ABSTRACT

Purpose: There is a growing number of primary contact physiotherapists based in United Kingdom emergency departments (ED) who are expected to deliver person-centred practices. Perceptions of physiotherapists working in these high-pressure environments on person-centredness are currently unknown. A mixed methods exploration of person-centredness among ED physiotherapists targeted this knowledge gap to inform future clinical practice.

Methods: Online survey and semi-structured interviews followed a convergent mixed methods design with sequential explanatory features. Data sets were analysed separately using descriptive statistics and thematic analysis, respectively, before merged analysis using joint display.

Results: Twenty-six surveys and 11 in-depth interviews were completed. The three overarching themes of ED patients, ED physiotherapists, and ED environment were generated. Themes were integrated and analysed alongside quantitative survey findings. This produced three novel contributions that further our understanding of person-centred practices among ED physiotherapists.

Conclusion: ED physiotherapists were mindful of an apparent, yet unspoken struggle between the competing philosophies of biomedicine and person-centredness. The results here support entering a patient's world as a person-centred approach to help navigate the line between what an ED attender wants and the clinical need of their visit.

IMPLICATIONS FOR REHABILITATION

- Most primary contact physiotherapists believe in the possibility of achieving person-centred practices within emergency departments (ED) and endorse attempts to deliver on this.
- Any idealised visions of delivering person-centred practice in ED must be adapted to local operational limitations and the acuity of the presenting case in question.
- ED physiotherapist could consider the notion of 'entering a patient's world' as a route to the meaning of a patient's problems *to them* by using a more narrative approach to assessment.
- A framework to support an *ED-specific version of person-centred practice* is currently lacking.

ARTICLE HISTORY
Received 31 March 2023
Revised 9 January 2024
Accepted 20 January 2024

KEYWORDS
Person-centred practice; patient-centred practice; physiotherapist; emergency department; mixed-method research design

Introduction

Person-centred practice (PCP) describes an individualised approach to healthcare that ensures people's preferences, needs, and values guide clinical decision-making through care that is respectful and responsive toward them [1]. Those in United Kingdom (UK) healthcare settings should be familiar with the concept of person-centredness due to its common use as well as its inclusion in documents ranging from key health policy [2,3] to professional practice frameworks [4,5]. The deceptively intuitive nature of the term, however, lends itself to misapprehension that risks its throwaway usage, possibly undervaluing its importance. Irrespective of its fashionable status, the prioritisation of a person-centred healthcare model – as one purposively tailored to a recipient's unique healthcare requirements – heralds a significant and timely shift away from a tradition of paternalism in healthcare far too important to be misunderstood [6].

Person-centredness is a multifaceted concept that presents interpretative and operational challenges to contemporary healthcare researchers and clinical practitioners alike. A host of positive patient outcomes have been attributed to the use of person-centred approaches, compared to usual care, such as recipient satisfaction, well-being, and self-management [7–9]. Empirical studies measuring its occurrence are challenged by the range of patient types and context-specificity of the person-centred activities under investigation [10]. The nebulous nature of what it means to be person-centred lends itself to different interpretations, reflected by the lack of a universally agreed definition [11].

The keen interest shown by health policymakers in person-centredness is seldom matched by explicit guidance of how to *do* person-centred practice on the shop floor. This supports previous notions of it still being an ambition rather than a health priority [12]. Clinicians themselves have reported difficulties incorporating person-centredness into their patient interactions [13–16]. Guidance to support the clinical implementation of person-centred practice, including person-centred frameworks, has been developed in areas of healthcare, particularly nursing [17–20]. Within the field of

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physiotherapy, interest in person-centred approaches is growing, with publications to support implementation with patients suffering from musculoskeletal pain, for example [21–23]. Those with a rehabilitative focus have attempted to conceptualise elements of person-centred practice via models and frameworks [24,25], with a more ambitious overarching person-centred physiotherapy framework based on the synthesis of all existing studies [26]. Due to the apparent context specificity of person-centred practice, the utility of any such frameworks, as these authors concede, requires empirical testing.

For the last decade, we have seen significant growth in the number of physiotherapists practising as primary contact clinicians within United Kingdom emergency departments (ED). Research into ED-based physiotherapy services has provided evidence of improved clinical outcomes that include reduced patient waiting times [27–32], reduced length of stay [28–30,32–35], reduced referral to specialties [36,37], reduced imaging [34–36,38] and positive patient experience [38–40]. There is also data to support ED physiotherapists' safety [35,41] alongside acceptance and positive perceptions by other ED staff [39,41–45].

Healthcare systems often draw from a biomedical model of care [46,47] which matches biological and physical failing in the body with appropriate biomedical solutions [48]. Management of musculoskeletal (MSK) injuries in ED might include, for example, administering medication for pain or application of the appropriate cast to immobilise a particular fracture. The standardising of such interventions is based on guidance on what is the best route or evidence-based approach. Despite a professional shift in healthcare towards more person-centred ways of working, the biomedical paradigm is foundational to MSK physiotherapy as well as the working reality in ED. The delivery of efficient and effective ED care via standardised processes based on evidence-based practice (EBP) may therefore conflict with the individualising, patient preference focus that underpins person-centred practice [49].

With the legitimacy of the emergency department physiotherapist role no longer in question [50], more nuanced knowledge on how ED physiotherapists perceive person-centred practices in such a service-centric and biomedical-oriented "macrosystem" [24] remain unexplored terrain. Fundamental tensions between standardisation of condition management (EBP) versus person-centredness [49] aside, the "structure" of ED at a system and organisational level might be such that it prioritises ways of working other than person-centred [24,51]. A mixed methods exploration of person-centredness among ED physiotherapists was therefore developed to fill this knowledge gap and ultimately inform future clinical practice. This study is grounded, and thus further justified, by the professional expectation, internationally, for all physiotherapists to enact person-centred practices for all their patients [52–54]. New knowledge here is important as it can add to the discourse and growing evidence base underpinning person-centred physiotherapy practice, particularly in areas of broadening professional scope. Output from the broader research project can be used to help the realisation of an already tricky model within the challenging and high-pressure arena of the emergency department. The explicit aim of the current research is therefore: *to explore the views of emergency department physiotherapists on person-centred practice and where they feel that they currently stand on implementing this* to fill the existing knowledge gap.

Materials and methods

Study design

The study was the second of a three-phase PhD exploration of person-centredness: the first being a qualitative systematic review of MSK physiotherapist and patient views on person-centred practice [55] and the last an ED patient-facing qualitative study (pending publication). The researchers adopted a mixed-methods approach within a pragmatist paradigm. This paradigm assumes an "existential reality" of different layers: some objective, some subjective, and some a mixture of the two [56]. With its real-world grounding and practical focus, namely to understand and improve emergency department patients' experience of physiotherapy interaction, the study is well matched to this philosophy.

Predominantly quantitative data were collected using online survey methods. Subsequent qualitative interviews were conducted to provide a greater depth of understanding. Analyses of qualitative and quantitative components were performed independently with a combined interpretation of results within the discussion as per convergent/parallel mixed method design [57] *(*Figure 1*.)*. The decision to conduct the survey first was based on its use as a sampling method and to inform the subsequent interviews, in-keeping with a quasi-sequential explanatory design. A Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was completed to ensure methodological rigour of the qualitative interview data collection methods [58].

Participant recruitment

Following university ethics board approval (REF FHS327), informed consent was received from all participants prior to their completion of the survey and interviews. A link to the online survey was shared widely on the Twitter social media platform, and via targeted emails to known emergency department physiotherapists to recruit a sample of convenience for the quantitative aspect of the study. These communications included a clear outline and rationale for the topic; explaining the goals for this doctoral research project alongside the intention to capture only those specialist physiotherapists responsible for assessing, diagnosing, and managing patients with MSK injuries at the first point of contact in ED. Survey participants and email recipients were encouraged to share the link with other appropriate colleagues in-keeping with a snowball sampling approach [59]. At the end of the survey there was an optional link to participate in a follow up interview.

Data collection

Survey

A 24-question online survey was developed for this study, with questions based on the wider person-centred literature, including work by the authors that would eventually constitute *development of a framework for person-centred physiotherapy* [26]. The survey included basic demographic data along with a mixture of open and closed questions on person-centred aspects that included: meanings, familiarity, interest, and training; as well as barriers, feasibility, importance, and perceived levels of person-centredness achieved in ED. A full version of the survey was initially piloted by a university academic librarian with extensive JISC online survey experience, as well as an ED physiotherapist prior to launch to test its functionality and content. The pilot data generated was assessed and found compatible with the proposed analysis. The only issues raised included repetitive nature of content, formatting of grid questions and the author being aware of possible chatbot issues, all of which were addressed before satisfactory retest by a different academic and physiotherapist respectively.

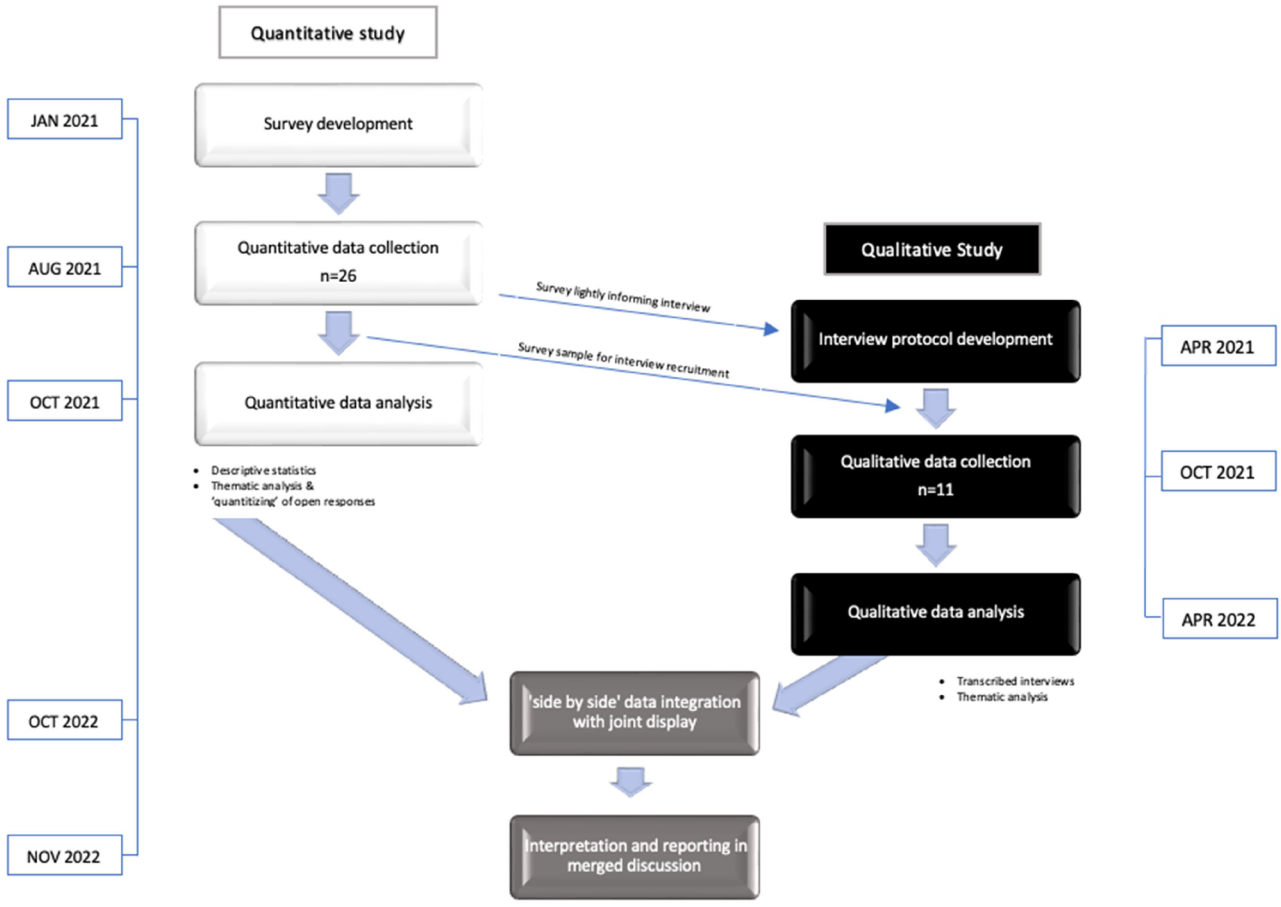

Figure 1. Procedural diagram of the convergent mixed method design used for this study.
A vertical timeline runs vertically downwards from January 2021 to November 2022. Two columns of three boxes: development, data collection, and analysis indicate the respective steps for two separate study arms. The third white box on the left, for the 'quantitative' study, shares a temporally overlap with the first of three black 'qualitative' boxes, on the right. Arrows from both columns converge centrally downwards to two grey boxes reflecting data integration and merged interpretation, respectively. Additional arrows cross from white to back boxes to indicate that the survey informed the interviews questions and recruitment.

Interviews

A semi-structured interview guide (*accessible from URL*) was developed through a consideration of the literature on person-centred physiotherapy practice alongside the research questions and overarching aim of the study. The survey results also informed the "building" of interview questions via interviewee responses to specific findings of interest [57]. The interview process was piloted with identified issues addressed. Interviews lasting approximately one hour were conducted by the main researcher (JN) via a web-based video platform with audio recording.

Sample size for interviews was guided by the concept of information power [60], with consideration of each of this model's "continuum" dimensions. The broad study aims, and multi-case analysis approach pointed towards requirement for a moderate to high sample. Conversely, high sample specificity, use of existing model/theory, and high quality of interview dialogue was suggestive of lower sample size requirements. The main author's relative inexperience as a researcher was offset by his specific clinical experience and insight as an ED physiotherapist and from prior publications on the topic of person-centred practice. High-level communication skills, allowing for rapport building with interviewees, and support from an experienced supervision team produced a tentative approximation for 10 to 15 interviews. The depth and quality of interview data, established from preliminary analysis after several interviews - allowing for the generation of analytical ideas, suggested a sample of around 10 would be sufficient. A final judgement was made after the 11th interview that sufficient data were collected for an analysis that could deliver on study aims.

Data analysis

Analyses of survey and interview data were initially carried out as independent processes as per simple parallel/convergent mixed method design [57] prior to merged analyses in the discussion via joint display of data sets.

Survey

Quantitative survey data were presented through descriptive summary statistics by the main researcher (JN). Qualitative survey data were thematically coded (JN) and "quantitized" by frequency of dichotomous response (i.e., response matching a category or not) [61]. "Quantitization" here allowed for merger and comparison of different data sources during explanatory analyses [62].

Interviews

Analysis followed the six stages of reflexive thematic analysis (RTA) of Braun and Clarke [63,64] with considerable analytical work

completed by the main researcher (JN) using verbatim interview transcripts in NVivo QRS. Coding carried out by the main researcher (JN) was checked for accuracy by one co-author (CK) with close involvement of both co-authors (CK, AG) from the generation of initial themes through to writing-up phases. An iterative collaborative approach provided different perspectives on the data, ensuring interesting analytical aspects were not missed [64]. The research team acknowledged their shared positioning as academic physiotherapists who strongly endorsed a person-centred model of care, within a "big Q" overarching research philosophy. While the main researcher had the final say, there was considerable contribution from the co-authors (CK/AG) with the refinement of themes and recursive draft-redrafting of final report.

A summary of themes was shared with all 11 interview participants via email after the research report was drafted. This included an invitation for any comments for consideration within a one-month window, after which the manuscript would be submitted. No constructive comments were forthcoming with only supportive replies on the research returned.

Joint analysis

The main "mixing" of analysis occurred within the discussion (conducted by JN) bringing the survey and interview findings together as per a parallel convergent mixed method design [57]. The joint analysis here followed Skamagki and colleagues' four-step approach to integrating two different data sets, namely: (1) creating joint display, (2) linking activity, (3) establishing relationships, and (4) interpreting and reporting [65] *(see extract* Figure 2.*)*.

Researcher position statement

The main researcher (JN) is a middle-aged, white, British male senior MSK physiotherapist (BSc; MSc) and doctoral researcher. While introduced to participants simply as an 'ED physiotherapy researcher' his clinical work in ED (for over a year prior to and throughout his PhD) provided an insider view of what it was to be a primary-contact ED physiotherapist. Experiencing the job satisfaction and positive impact from working with those attending ED was instrumental in the drive to explore the possibility of optimising his own person-centred philosophy within this dynamic and challenging environment; but also generating some novel research that could support team development.

The first author continued to practice in primary and secondary clinical settings while conducting the research. The second and third authors are also physiotherapists by background. CK was a community physiotherapist and an experienced qualitative, post-doctoral researcher who now works in pre-registration physiotherapy training. AG is a lead clinical research therapist at a large acute hospital trust and an experienced post-doctoral researcher with quantitative, qualitative, and mixed-methods expertise.

Results

Quantitative survey results

Demographics of survey participants

The online survey was completed by a total of 26 respondents (20 female, six male) who were based in an emergency

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*PC(P) = Person-centred (practice)

Overarching theme	Categories	Quantitative findings	Linking activity	Qualitative findings	Meta- inferences & interpretations
Emergency department patients	ST1.1 - Entering the patient' s world	**Q4.** 35% surveyees linked person-centredness with *consideration of patient's beliefs & goals as well as their needs* in open questioning. **Q11.3** - *seeing beyond the patient to the person* was extremely (81%) or very (19%) important **Q13.1** – *Unique journey of the patient* was seen as at least moderately important by 100% of surveyees (54% extremely, 35% very, 11.5% moderately)		*"He wasn't coping at home; he had a lot of psychological yellow flags as well going on that I think hadn't been addressed on previous attendances. I think they had literally, obviously from an A+E point of view, just looked at their 'right, red flags' you know 'this is it: pain management, functional, right you're off, you're out' and hence this gentleman just keeps bouncing back in and in again. And it just took, I think, you know, an extra 15-20 mins to identify those yellow flags all the psychosocial issues" (IV10 – female 30s)* *"The patients come to see you because they are concerned for whatever reason; you need to understand what that reason is in order for you to help them. You know, I think that question: 'what are your expectations of being here' or, you know, 'what are you hoping I can help you with' is far more important really than most of the other questions. And I think that means that you get an understanding of ...that's the accurate understanding of how you can help them." (IV2 – female 30s)* *"I do like open-ended questions, but I like to use a mixed approach and sometimes you know a lot of people particularly with MSK issues, your back pain patients for sure, do have a lengthy narrative to them" (IV10 female 30s)* "it's something a bit more serious or of concern about them I try my hardest not to just be typing while they're talking to me because I think sometimes you can then lose your patient and they maybe won't be as honest as I need to be." (IV6 female 20s)	Areas of **convergence** and **divergence** between the two phases include *consideration of patient's beliefs & goals as well as their needs* constituting the joint-highest 'quantitized' Q4. theme, epitomised by IV10 excerpt: *"The patients come to see you because they are concerned for whatever reason; you need to understand what that reason is in order for you to help them"*. Yet this only amounted to about a third of surveyees linking this with person-centredness when questioned openly, rather than closed options. Also seeing the person beyond patient was at least very important in Q11.3, yet an excerpt still uses **divergent** wording that seems to objectify/ reinforce person as 'patient' status. This was also an area of **expansion** on the survey, with one describing how they needed *"an extra 15-20 mins to identify those yellow flags all the psychosocial issues"* beyond normal ED approach of: *'right, red flags' you know 'this is it: pain management, functional, right you're off'*. Less emphatic (Q13.1) importance placed on *patient journey* demonstrated **complementarity** by IV10's allusion to inviting a narrative yet being wary of its potentially "lengthy" nature in ED.

Figure 2. Excerpt of joint display.
Left hand columns of a six-columned table are headed 'overarching themes' and 'categories' and populated accordingly. The third column presents several corresponding survey results. The fourth columns present variously tailed and orientated arrows that run from the quantitative findings of the previous column to indicative interview quotes in the sixth column. The type of linkage include convergence, divergence, expanding and complementing - denoted by arrow direction and type. The final column on the right explains the meta-inferences made.

department, or equivalent centre, and managing a caseload of patients at the point of first contact. A summary of participant demographics is presented in Table 1.

Experience and academic attainment. Ninety-two percent of respondents had over five years clinical experience. The estimated mean length of time of clinical experience was 15 years and mean time working in ED was six years. Three quarters of respondents had post-graduate qualifications (typically to MSc level).

Geography of practice. The geographic spread captured responses from all the seven English NHS regions (East of England, London, Midlands, Northeast and Yorkshire, Northwest, Southeast & Southwest), plus one each from Wales and Northern Ireland, with Scotland alone unrepresented in this UK data sample.

Non-demographic survey findings

All respondents reported being familiar with the concept of person-centred practice. 54% reported receiving some related learning as part of pre-registration; 58% for post-registration training. A vast majority (89%) of participants were at least moderately interested in attending further training.

The most commonly reported aspects of person-centred practice by respondents were shared decision-making ($n = 9$); considering a patient's beliefs and goals as well as their needs ($n = 9$); and putting a central focus on the patient ($n = 9$) (see Table 2).

Table 1. Proportion and frequency of participant demographics for emergency department physiotherapists survey and interview participants ("-" denotes that data were not collected).

Demographic data	Characteristics	Frequency (%)	
		Survey participants	Interview participants
Gender	Woman	20 (76.9)	9 (81.8)
	Man	6 (23.1)	2 (18.2)
Age (years)	20-30	5 (19.2)	2 (18.2)
	31-40	14 (58.8)	7 (63.6)
	41-50	5 (19.2)	2 (18.2)
	51-60	2 (7.7)	–
Year of experience post-qualification	0-5	2 (7.7)	6 (54.5)
	6-10	7 (26.9)	3 (27.3)
	11-15	4 (15.4)	1 (9.1)
	16-20	8 (30.8)	1 (9.1)
	21-25	2 (7.7)	–
	25+	3 (11.5)	–
Academic attainment	Diploma	1 (3.8)	–
	BSc	6 (23.1)	–
	MSc	18 69.2)	–
	PhD	1 (3.8)	–
NHS region	London	2 (7.7)	1 (9.1)
	South West	5 (19.2)	3 (27.3)
	South East	3 (11.5)	1 (9.1)
	Midlands	1 (3.8)	1 (9.1)
	East of England	1 (3.8)	1 (9.1)
	North West	4 (15.4)	1 (9.1)
	North East and Yorkshire	8 (30.8)	3 (27.3)
	Wales	1 (3.8)	–
	Northern Ireland	1 (3.8)	–
Years working as first contact practitioner in an emergency department or equivalent centre	0-5	17 (65.4)	6 (54.5)
	6-10	4 (15.4)	3 (27.3)
	11-15	3 (11.5)	1 (9.1)
	16-20	1 (3.8)	1 (9.1)
	21+	1 (3.8)	–
NHS Banding	6	3 (11.5)	–
	7	12 (46.2)	–
	8	11 (42.3)	–

All respondents felt that person-centred practice was at least moderately possible within ED, with 96% also reported themselves to be practising in at least a moderately person-centred fashion. However, only 65% felt that their non-physiotherapist colleagues were working using person-centred principles.

The most commonly reported barriers to realising person-centred practice in ED were waiting time pressures and targets ($n = 24$); timely access to investigation, medicines, specialists, and other services ($n = 7$); and holistic clash of participants with biomedical-oriented ED service ($n = 6$) (see Table 3).

Qualitative results

Interviews included physiotherapists from EDs within all English NHS regions, so the journey for respective patients will have differed. However, it appeared typical for a patient to present at the ED reception before visiting the triage desk for "streaming" to the appropriate professional base on competency, be that ED medic, nurse, physiotherapist, or advanced clinical practitioner (ACP). In-keeping with the study's focus on MSK management, physiotherapists here were seeing patients ranging from traumatic injuries, such as hip fractures, through to non-traumatic MSK conditions like low back pain.

Thematic analysis of the qualitative data from 11 interviewed participants (two male; nine female, see Table 1) led to three overarching themes which were important from the perspective of physiotherapists working in emergency departments regarding person-centred practice: (1) the emergency department patients, (2) the emergency department physiotherapists and (3) the emergency department environment (see Table 4.).

Theme 1 - emergency department patients

This theme encompasses the views of UK ED physiotherapist on patients attending the emergency department. Four sub-themes are included as part of this overarching theme: entering the patient's world; reasons for ED attendances; patient characteristics, attitudes, and expectations; and involving the patient in decision-making.

ST1.1 – entering the patient's world. To achieve a level of patient interaction beyond a simple screen for pathology and injury, ED

Table 2. Frequency of responses from quantitisation of qualitative open question.

Regardless of formal definitions, what do you understand the terms patient or person centredness to mean?

Themes (Delineated by *relative surveyee frequency: high/medium/low*)	Total Frequency count	No. of 26 surveyed	(%)
shared decision-making	11	9	(35)
considering a patient's beliefs and goals as well as their needs	10	9	(35)
putting a central focus on the patient	9	9	(35)
tailoring-individualising care	8	7	(27)
holistic-BPS challenge to the biomedical model	7	7	(27)
providing options for an informed patient choice	5	5	(19)
involving family or carers	2	2	(8)
listening	2	2	(8)
multidisciplinary teamwork	1	1	(4)

Table 3. Frequency of responses from quantitisation of qualitative open question.

What potential barriers might make it difficult for a physiotherapist working within an emergency department to achieve a threshold of clinical practice that might be reasonably considered as being person-centred?			
Themes (Delineated by *relative surveyee frequency: high/ medium/low*)	Total Frequency count	No. of 26 surveyed (%)	
waiting time pressures and targets	28s	24	(92)
timely access to investigation, medicines, specialists, & other services	10	7	(27)
holistic clash of participants with biomedical-oriented ED service	9	6	(23)
patient mindset including unreasonable expectations	9	7	(27)
volume of patients to see	7	7	(27)
conventions of ED practice	5	5	(19)
dependency on the wider ED team	5	3	(12)
issues with pain management	4	4	(15)
space and privacy	4	4	(15)
poor GP referrals	1	1	(4)

Table 4. summary of themes from qualitative interviews.

Theme 1 - Emergency department patients
ST1.1 - Entering the patient's world
ST1.2 – Reasons for ED attendances
ST1.3 – Patient characteristics, attitudes, and expectations
ST1.4 – Involving the patient in decision-making.
Theme 2 – The emergency department physiotherapist
ST2.1 – Physiotherapist personality
ST2.2 – Physiotherapist skills
ST2.3 – Physiotherapist beliefs about person-centred practice.
Theme 3 – The emergency department environment
ST3.1 – The clash between biomedicine and person-centredness
ST3.2 – Issues of time, waiting and busyness
ST3.3 – Physiotherapists working with other ED team members

physiotherapists emphasised the importance of seeing each patient as something more than a presenting condition and sought to enter their world. A reductive focus on isolated structural problems, according to the participants, would be to neglect the myriad biopsychosocial contributing factors that must be considered as part of their preferred holistic approach. Therapists therefore appeared to place a value on understanding what the problems meant to their patients. An exploration of how this was impacting on a person's life and their ability to cope, for example, being key aspects of how they operated in a person-centred way.

Participants highlighted the risks to person-centredness of allowing patients to feel as though they were not being listened to. Assumptions about what was needed from their ED visit were often at odds with a patient's expectations, thus requiring a *"listening to the … person's reason for attendance…. their concerns and expectations and addressing both" (Participant#3-female;30s;0-5 yea rs in ED).* Exploration, it appears, of individual patient ideas, concerns, and expectations (ICEs), via open questions such as *"what's brought you in today?" and "What is it you are expecting me to do for you?" (Participant#10-female;30s;6-10 years in ED)* facilitated co-construction of the patient narrative so vital to achieving person-centred ED physiotherapy practice.

While accepting the necessity for some closed questioning, when screening for cauda equina syndrome for example, the preference of ED physiotherapists for asking open questions aligned with their vision of what constituted a person-centred approach.

> *"I do like open-ended questions, but I like to use a mixed approach and sometimes you know a lot of people particularly with MSK issues, your back pain patients for sure, do have a lengthy narrative to them" (Participant#10-female;30s;6-10 years in ED)*

ST1.2 – reasons for ED attendances. Participants were cognisant of the manifold reasons that a patient might visit their ED. An important facet of person-centredness within this ED context was that participants appeared non-judgemental of these reasons, even in clearly "non-emergency" cases. Frustration regarding patients appearing to *play the system* notwithstanding, judging the "correctness" of a person's decision to attend was not seen as being part of the ED physiotherapist's role. Showing empathy for the absolute desperation that brought some individuals to ED, too, was important. With ED not *"somewhere that you necessarily choose to go" (Participant#2-female;30s; 0–5 years in ED),* the more person-centred thing from participants' perspective here was to explore the reasons for the patient's attendance.

> *"It's like they've come because they just can't take it anymore. So, they're in a bad state anyway. It's not like 'oh, I've banged my leg. I'm in a really good headspace', A lot of it is 'I've had this back pain for weeks, for months. I'm not getting any help'. They're in a low place; it's a cry for help sometimes. Or it's an emergency for them. So, being as patient-centred as you can is important because they are going to take on that information of what you say, they are going to feel listened to" (Participant#11–male;30s;6-10 years in ED)*

Accepting, as well as not judging, a person's reasons for attending ED too was important to person-centred ED practice; particularly due to the perceived culture among medical and nursing colleagues that some patients' attendances constituted a waste the ED staff's time.

The widely held view that unaddressed patient concerns resulted in a subsequent reattendance underpinned the practical, as well as person-centred motivations to ensure individual patient needs were met by participating physiotherapists:

> *"You're addressing their reason to attend because, if not, invariably, they'll bounce back a few days later. So, I think if you can find out what their worries are, or why they are there, you can answer that in the end, I think." (Participant#1–male;40s;6-10 years in ED)*

ST1.3 – patient characteristics, attitudes, and expectations. Aside of the clinical presentation, individual patient characteristics such as the culture, generation and level of education were regarded as influencing ED physiotherapists' ability to deliver person-centred practice. Older patients, for example, were linked with compliance and respect for medical opinion, whereas younger patients appeared happier to make decisions about management. This was related by some participants to patients having better health literacy; those with a lower health literacy required more explanation and education. Helplessness and high passivity were also clear barriers here. Different ethnicities were associated with varying coping strategies and perceived responsiveness to person-centred approaches:

> *"In certain cultures when you say… 'what do you think is wrong with you today?' they sort of look at you sometimes as though 'well that's why I've come to see you.' or will actually say that. But sometimes it can be useful asking those questions and other times they just look at you as if you're incompetent." (Participant#9–female;30s;0-5 years in ED)*

ST1.4 – involving the patient in decision-making. Participants were unified in endorsing their patients' involvement in management decisions that forwarded their individual goals. Shared decision-making (SDM) is considered an essential aspect of ED physiotherapists' person-centred practice:

> *"I suppose that the indication that the patient is at the focus of all of the care, so they make the decision or they are very much involved in the decision-making process. And that it's targeted towards goals that they want to achieve really, I suppose rather than goals that we might want to achieve with them." (Participant#2–female;30s;0-5 years in ED)*

Most participants felt it was good to be able to offer patient choice since patients were deemed to be more receptive, and ultimately more empowered having considered (the pros and cons of) all options available for their management. Conversely, participants acknowledged that some patients want to be told what to do, deferring to a person that they consider the professional or expert.

Participants used phrases such as 'getting the patient on-board' or 'patient buy-in' to indicate the importance of engaging the patient such that they can be more involved in their own decision making. This involved seeking to understand the patient, developing a rapport, and providing explanations, reassurance and education serving to increase patient understanding and acceptance. With patient engagement, in this iteration, still contingent on understanding patient needs, this alternative appears both consistent and perhaps more in-keeping with what it is to be person-centred.

> *"I mean they need to be involved, they need to accept it and they need to have understood…that's my job to help them to understand what they need to do to get the best out of their situation…They need to be on board with it otherwise the whole thing is a bit of a waste of time really; they're just going to turn up two days later and go through the same thing again with somebody else." (Participant#2-female;30s;0-5 years in ED)*

Theme 2 – the emergency department physiotherapist

Three sub-themes encompassing the views of UK ED physiotherapist on themselves feature as part of the overarching theme of the emergency department physiotherapist: physiotherapist personality; physiotherapist skills; and physiotherapist beliefs about person-centred practice.

ST2.1 – physiotherapist personality. Participants discussed certain personality traits that, they proposed, facilitated delivery of person-centredness such as empathy, courtesy, and confidence. Most highlighted the importance of an empathy that was facilitated by recalling their own experiences as a patient or, framed through what they would wish for friends or family. Such empathy here related to caring and kindness and was manifested in such simple acts as making a patient a cup of tea, thus allowing a patient to see them as a real person. Displaying good manners like being respectful and making simple gestures, such as apologising for any waits or properly introducing yourself, were other ways through which participants felt courtesy facilitated person-centredness.

> *"you do get frustrated, and you do get tired, and I try to think about the reason that people have come here rather than sort of dismissing them as not working the system correctly or not understanding the system or just jumping the queue or things like that. People are usually there because they really, really want help and as a person I try to remember that." (Participant#2-female;30s;0-5 years in ED)*

ST2.2 – physiotherapist skills. In terms of a physiotherapist's skills, communication, in its broadest sense, was consistently highlighted as vital to achieving person-centredness in ED. This required self-awareness of their own body language, such as an open posture, face-to-face positioning at the same level, eye contact, and affirmative nods to convey their listening.

Participants were unanimous in their view that ED physiotherapists required active listening skills as this resulted in manifold benefits including enhanced engagement, better understanding of the patient, rapport building and not missing subtle clinical symptoms. Despite some considering it impractical, most participants supported the receipt of an uninterrupted narrative as *"important because it sometimes presents you something you weren't expecting." (Participant#4-female;30s;0-5 years in ED*) and might not have otherwise learnt. Interruption was associated with inexperience and, except for certain patients, an uninterrupted open narrative approach, even in the maelstrom of ED, was considered more person-centred and more efficient than closed questioning:

> *"what's also really interesting is when you start looking into kind of time efficiency. letting someone speak for a minute they probably tell you more than you asking them 12 questions in the following minute. So, I think that there is a perception that things need to be short and snappy, and you just need to get the important information out. But the reality of it is probably giving people the chance to talk is a much better option." (Participant#3-female;30s;0-5 years in ED)*

A more nuanced slant on communication here relates to an ED physiotherapist's social dexterity, typically attributed by participants to their life experience. Such soft social skills reportedly facilitated conversations that open doors into patients' personal lives. The process of getting to know patients equated to a kind of social disarming that humanised the therapist, placing the patient at ease and at the centre of the consultation. This disarming was underpinned by an ability to convey empathy which reappears as a conditional skill that is required by person-centred ED physiotherapists.

> *"your personality traits and how you communicate; they're all kind of quite instinctive, natural things which, yes, can be developed and improved, but ultimately…I'm fairly sociable, I'm happy to talk to people from various walks of life; I find people interesting more than things, maybe." (Participant#8–female;20s;0-5 years in ED)*

ST2.3 – physiotherapist beliefs about person-centred practice. Participants had strong beliefs about the importance of person-centred practice. There was a sense that this approach brought about the best outcomes for patients and that there was no excuse for not being person-centred. However, the feeling that growing pressures within ED, exacerbated by the pandemic, had brought real challenges to being able to practice in a person-centred manner; ED physiotherapy had become more akin to a firefight than the idealised care associated with person-centred practice. In facing such clinical pressures, and as the patients back up in the waiting room, a creeping pragmatism necessarily encroaches on a genuinely best interest focus on patients:

> *"I'd like to say that every single person that I work with has the patient in the best interest and would be patient centred. And I'm sure, I don't think that you'd work in healthcare if you didn't. I think the pressures in ED change that a little bit and that's the difficulty." (Participant#6-female;20s;0-5 years in ED)*

The point was made that person-centredness was about wanting the best outcome for patients and again, underpinned by a certain empathy by treating patients as you would your own friends or family. However, this wasn't entirely selfless, since being person-centred made clinicians feel positive about themselves

because they were doing things to help people. A certain righteousness also came across from one participant not caring what colleagues said about their version of person-centred practice taking too long as she knew it was the right thing to do:

> *"I am like, you know what: I don't care because I will stand up. I'll happily put my neck on the line…Inside, internally that's why I'm here and I want to do. and it is a balance, it is a fine balance; you can't spend an hour with every patient." (Participant#5–female;30s;11-15 years in ED)*

Theme 3 – the emergency department environment

This theme encompasses ED physiotherapists' views on the challenges of being person-centred while working as part of an interdisciplinary team within the physical space and cultural reality of a UK emergency department. Three sub-themes are included as part of this overarching theme: the clash between biomedicine and person-centredness; issues of time, waiting and busyness; and physiotherapists working with other ED team members.

ST3.1 – the clash between biomedicine and person-centredness. The prioritisation of treatment numbers over patient experience more than anything here epitomised the existential struggle faced by avowedly person-centred physiotherapists working in ED. Additional challenges of sub-optimal physical workspaces, as well as the emphasis on checklist screening over a more biopsychosocial focus, present the reality through which participants found ED culture and environment poorly disposed to delivering person-centred practices.

Firstly, according to participants, the physicality of the ED environment was itself poorly suited for enacting person-centred practices. The limitations in terms of physical space, characterised by awkward doors and linking corridors, meant challenges to accommodate numerous patients in cramped and chaotic waiting areas. The lack of patient privacy when working behind curtains or in shared rooms was seen as a barrier to person-centredness, exemplified by one participant's explanation that *"there is no way you are going to get a 100% truthful answer out of a patient on a taboo subject if they've just got a set of curtains pulled round them." (Participant#10–female;30s;6-10 years in ED*).

Secondly, the checklist-type screening expected of, and by, non-physiotherapy colleagues drew particular opprobrium from some participants. This was due in part to a belief that this approach resulted in patients being discharged from ED without sufficient insight regarding their condition beyond an understanding that no treatment was needed; a decidedly non-individualised and non-person-centred approach.

> *"But I think sometimes we are far too, maybe, drawn into 'this is my assessment and these are the questions I have to ask', 'these are the boxes that I have to tick', 'this is what I need to document' and maybe people just forget. They forget that actually, yes things need to be documented, however, I'm allowed to stray from it. there's nothing to say you can't stray from that program." (Participant#10–female;30s;6-10 years in ED)*

Thirdly, participants appeared to define their role through an interest in the psychosocial aspects of how a patient manages *after* discharge; a fundamental difference to some of their colleagues. There was a sense here that participants felt aspects of a patient's social situation were not always fully considered once medical tasks were completed within the ED system. In one participant's clear delineation, *"what they [the patient] want is more psychosocial - about how they are managing things and how their symptoms are interfering with their life - and what we give them in ED is a biomedical view …. like, you've broken your leg so therefore this happens… but how does that impact on their life?" (Participant#1–male;40s;6-10 years in ED).*

Participants reacted to the culture clash in ED between the palpably biomedical model of care and their preferred holistic person-centred approach in several ways. There was a resigned acceptance that physiotherapists lacked influence at the executive level to change how ED operated. Participants also believed that patients expected (and deserved) more from the service than remedial care alone.

This notion of a certain physiotherapist exceptionalism was manifested by participants continuing to act as *therapists* and doing things their own way, despite potential collegial disapproval. This included ED physiotherapists disregarding numbers of patient they treat and being prepared to take more time with individual patients, even when this placed them at odds with colleagues. The burden of fulfilling expected quotas, however, was ever-present and meant therapists finding a balance for their own situation while maintaining their acceptance as part of the ED team.

> *"My colleagues don't like it; they say I'm taking too long, they've said that's not the sort of information we need to be providing in the ED, it's not emergency care, this is not a rehab environment and all these sorts of thing and actually it's not understood, I don't think, that that's what we're maybe best at… and getting that balance which is tricky. And getting that balance for it to actually be person-centred, I don't think we have achieved that yet" (Participant#2–female;30s;0-5 years in ED)*

ST3.2 – issues of time, waiting and busyness. Participants agreed that time was a barrier to person-centredness in ED. However, they pushed back against this narrative and justified expending this extra time, as well as accepting any breeches incurred, through their belief in delivering quality over quantity. In fact, doing everything possible as part of a person-centred consultation was variously associated by participants with reduction in admissions, reattendances and complaints. This goes some way to explain one participant's bafflement of an ED manager's suggestion that time was being wasted on patient details when this was, after all, a key aspect of person-centredness: highlighting the existence of system and organisational level challenges to realising person-centred physiotherapeutic approaches in ED:

> *[The senior hospital manager]"was like: 'we needed to overcome the fact that so many of our junior doctors wanted to know all about their past medical history and they wanted to know all about their drug history and how this other condition; how it might relate' and I was going: 'this sounds good' and she was like: 'this just isn't the right time or place for this' and I couldn't actually believe that was kind of where she felt there was too much time being taken up: people asking questions and trying to find out more." (Participant#3–female;30s;0-5 years in ED)*

Despite being both anticipated and typical, the busyness of ED and a wait of many hours for patients was a real challenge. Participants expressed an understandable frustration and feeling of being almost disadvantaged when beginning a patient's care after they had already been waiting for so long. This was further compounded by waits for blood results, investigations, or specialists which they might then require. More worryingly, several participants associated longer waits with patients' aggression towards them and other staff; something that would surely limit an attending physiotherapist's person-centredness:

> *"Even from the patients themselves, you know, that the longer they wait… so where I work violence and aggression is a huge issue. Every day I work I will get shouted at least once or would be called a pretty awful name. so, I'm very aware that the longer the patients are waiting the more*

aggressive the environment's going to get so that's another pressure." (Participant#9–female;30s;0-5 years in ED)

With one participant reporting regularly starting shifts facing an existing eight-hour backlog, a person-centred deficit would appear priced into their ED reality; offering a real challenge to fulfilling any aim of delivering person-centred practice. There is clearly a gulf between ideals of person-centred ED practice and the reality of waiting up to 12-h before seeing a physiotherapist, simply to be told it was just simple back pain and that they should go home.

ST3.3 – physiotherapists working with other ED team members. Working with non-physiotherapy colleagues within ED teams posed unique challenges for those physiotherapists aiming to promote and deliver a person-centred experience for patients. A patient attending ED typically interacts with multiple health professionals creating many points at which patient care is transferred. A poorly communicated handover could result in a change to the planned care a patient receives, particularly in the situation where somebody misunderstands the original concern. If continuity of care is precarious, it follows that continuity of person-centredness will be even more so, explaining this participant's call for clear documentation and handover reflecting person-centred, as well as clinical, aspects. Poor interprofessional communication also reportedly risks frustrating and unnecessary waits, caricaturised by a patient sat in the department unsure of what they are waiting for:

"[they might be sent] straight for an x-ray. You've not even seen them, but you can tell from the assessment clerking what it's likely to be and that sometimes helps the flow. But then they'll come back from the x-ray and sit back in the waiting room for another hour, not say anything why they went for an x-ray or what the outcome was and so things like that happen all the time." (Participant#9–female;30s;0-5 years in ED)

A key challenge to person-centredness, according to participants, relates to the contrasting approaches that some non-physiotherapy team members adopt. An abrupt or poorly handled patient interaction upon entering ED, for example, can undermine person-centredness before they have even met the physiotherapist. The same is true for continuation of care by others after the physiotherapist, where great efforts to fulfil person-centred approaches can be swiftly undone. Interactions with any ED team member that is not person-centred therefore holds the potential to negate the prior efforts of others.

I feel we need a lot more training for all the staff to have that holistic approach because if I as a clinician am giving patient-centred care if the nurse isn't on board and isn't kind of pushing the same drivers for that individual, then we're not kind of all on the same page. (Participant#10–female;30s;6-10 years in ED)

Proposed explanations as to why other non-physiotherapy team members were considered less person-centred highlighted their specialised focus or lack of clinical interest outside the ED bubble, rendering them insensitive to the wider patient health journey. The lack of training in person-centredness provided for ED staff was also defended in the terms of ED's necessary medical focus on *"what the patient needs rather than what the patient wants" (Participant#10–female;30s;6-10 years in ED)*. Other explanations here include desensitisation and the lack of quality time that ED treatment nurses can expend on individual patients.

"I think the clinicians who work in ED/A + E as their full-time job I think often get desensitised to the trauma that the patients are going through. So, it almost becomes quite normalised, and they get…. quite at ease with some quite major lifechanging events for some patients and like there is some flippant comments" (Participant#8–female;20s;0-5 years in ED)

Results from joint analysis of survey and interview data

The merged analysis was achieved using the qualitative themes as headings with cross tabulation of relevant quantitative survey findings within a joint display [65]. The resulting mixed interpretations offered a general theoretical underpinning for the discussion, but also reinforced the several specific analytical points discussed. For example, the initial analytical discussion point presenting a struggle between the competing philosophies of biomedicine and person-centredness: while notably informed by the qualitative theme of a *clash between biomedicine and person-centredness*, this was also influenced by a convergence between survey finding on the feasibility of achieving person-centred practice in ED and interviewees' allusions to being able to "*stray from the program*", "*take more time*", or stand apart from those "*that aren't prioritising*" this model. Furthermore, open survey responses regarding barriers to person-centred practice revealing both "*conventions of ED practice*" and *"clash with biomedical environment"* converged with interview participants' reference to ED as "not a rehab environment" and rather a place of "boxes that I have to tick" – corresponding to a "different healthcare model, basically". As such, the separate data sets were merged, and the interpretations used to support key discussion points for the study.

Discussion

The aim of this study was to explore the views of emergency department physiotherapists on person-centred practices. This knowledge is important due to the professional expectation for *all* physiotherapists to deliver person-centred practices with their patients [53].

The qualitative themes were integrated and analysed alongside quantitative survey findings as part of the joint display. This led to the generation of three novel contributions that further understanding of the person-centred practices of ED physiotherapists which are discussed here.

The first new knowledge here was that ED physiotherapists were mindful of an apparent, yet unspoken, struggle between the competing philosophies of biomedicine and person-centredness. With EDs set up to manage life-threatening medical emergencies [66], the hierarchical nature of these consultant-led units reinforces a positivist-influenced biomedical model of care. The growing interest in philosophical perspectives underpinning physiotherapy practice, on the other hand, reflects a divergence from the profession's own biomedical origins [16,67]. No longer pursuing purely structural explanations based on the existence of a single diagnostic reality or truth, a greater importance is now being placed by physiotherapy on lived experience [68,69]; something more aligned with a person-centred philosophy. Contemporary physiotherapists, including those in ED, have thus tended to adopt a more flexible person-centred attitude to those in receipt of their care: one informed by values that challenge reductive and structural biomedical conceptualisations of pain [70]. The findings of this study highlight how physiotherapists working in ED struggle with the apparent schism between contemporary physiotherapy philosophy and the presiding biomedical culture of ED. The ED physiotherapist is torn between competing demands of personal/professional philosophy and the presiding ED culture that prioritises the quantitative over qualitative. A struggle epitomised by pervasive feelings that, instead of being a consequence of their

more holistic approach, the typically lower number of patients treated by physiotherapists over their shift were perceived by ED colleagues as them not pulling their weight. In reality, this appears to be more of a clash of practice paradigms.

Part of the biomedical pressures of ED was evident in the way that physiotherapists sensed an ever-present and oppressive expectation to work faster to achieve high treatment numbers, within an overriding screen and discharge culture. With total ED attendances in December 2022 recorded in England at 2,283,000 – the highest since collection began [71] – this goes some way to explaining this attitude. Participants, however, appeared more concerned with ED reattendance rates than treatment numbers as quality indicators of their effective clinical intervention. Effectiveness in this domain is supported by data suggesting MSK physiotherapists in ED can reduce avoidable patient re-attendances [72]. Despite the perceived risks from rushing patients, participants taking more time to pursue the individual's needs, through their person-centred philosophy, placed them at odds with the more pragmatic 'department-focused' ethos of the broader ED team. Decompartmentalising the person from their whole, with reduction down to their biomedical presenting condition in the name of swift processing, was an anathema to the person-centred instincts of ED physiotherapists. Despite these pressures, physiotherapists contrived to uphold as many person-centred aspects as possible that remained within their power.

The second new knowledge moves deeper into understanding how ED physiotherapists actualise person-centred practice within a biomedical domain. It was through holistic attitudes here that participants searched beyond presenting conditions to discover what a problem means to a given person. At its core, this was about the importance that ED physiotherapists placed on entering a patient's world.

The importance of establishing meaningful connections with patients is well documented in the literature [25,73]. However, when seeking to establish such meaningful connection with their patients in ED, physiotherapists intentionally drew on the consideration of broader psychosocial drivers including issues with loneliness, relationships, or an inability to cope. Acknowledging often-challenging personal issues was, according to ED physiotherapists, a means to establish holistic co-constructed narratives; providing meaningful connection as well as an understanding of what the problem means to the person. Additionally, participants were mindful of the future re-attendance risk if this important step was missed, exemplifying the long view taken by ED physiotherapist in terms of getting to the root of the issue rather than just getting someone out of the door.

If the first discussion point attends to the "what" and "why" of person-centred ED physiotherapist paradigms of practice, then this second point speaks to "how" this therapeutic alliance could be cultivated by such tools as open questioning, effective listening, and minimal interruptions. For example, this idea of 'entering the patient's world' to understand the meaning of the problem for the person aligns well with other person-centred communication frameworks such as the 'ICE' acronym: An approach based on establishing patients' ideas, concerns, and expectations [74]. The assumption that ICE can provide helpful diagnostic clues and deeper insight into the reasons for patient encounters [75] only serves to strengthen its application in this context. 'Entering the patient's world' echoes broader narrative-based practices [76–78] that emerged in response to perceived shortcomings of the biomedical approach [79]. A recent review of musculoskeletal physiotherapists and patients' views on person-centred practice, found offering patients sufficient time and encouragement to speak about "everything" was considered an important part of person-centred practice by both parties [55]. In contrast to the review's non-emergency setting, 'entering the patient's world' here speaks to a specific application within ED, rendering this new contribution a novelty of *context* rather than concept.

The rationale for physiotherapists seeking to understand what a problem means to a person appeared to stem from a physiotherapist viewpoint that ED is often a last resort for many people presenting. This links to the third contribution based on the findings of this study of ED physiotherapists.

The final knowledge here relates to a theoretical line between perceptions about what an ED patient needs versus what they want from their visit; or to put it another way, where ED clinicians prioritised their focus. While the broader ED team's priorities clearly fell on the side of clinical necessity, the person-centred physiotherapist considered both sides of this line.

Despite its clear remit for major trauma and medical emergencies [66], certain patients continue to make 'inappropriate' visits to ED [80]. The well-publicised persistent and worsening pressures faced by emergency services has not, it seems, deterred non-emergency attenders [81,82]. With the post-pandemic NHS landscape leaving many, often more vulnerable patients, unable to secure timely attention elsewhere, many non-emergency decisions to attend ED might thus be rendered as technically legitimate. Considering challenges that affect everyone, but particularly the most vulnerable, a person-centred ED physiotherapist might be forgiven for wondering *'if I don't help them with this problem, then who will?'* for which a clear understanding of their world becomes a necessary step to be able to move forward.

Study participants acknowledged that judgements on appropriateness were being routinely made by healthcare professionals within the ED team. Other studies have alluded to related judgements by ED clinicians' in terms of themes of 'legitimacy' [83] and patient "worthiness" [84,85]. Judging worthiness was not something regarded by person-centred physiotherapists as appropriate or part of their role.

Shortcomings in other areas of the UK National Health Service, particularly within primary and social care, has hampered the natural flow of patients through ED; reflected by increased demand at the front door and, particularly, transferring patients to hospital wards at the other end. This study's focus on person-centred interactions of physiotherapists with these "minor" MSK cases evidenced patients having their own host of reasons for attending. One contentious reason was unacceptable waits to see a GP [86], be it for a subacute conditions or exacerbation of a chronic problem. Consequently, ED physiotherapists were effectively seeing patients who technically shouldn't be there but had little other recourse to medical attention. Faced with genuine patient desperation, participants conveyed a righteousness in helping those patients whose problems were exacerbated by the health service's shortcomings. It is most unfortunate but understandable given service pressures, that perceived interprofessional tensions could result from physiotherapists taking longer to unpick these complex and now chronic biopsychosocial issues, but such an example reignites the clash in ED between biomedicine and person-centredness. The biomedical dichotomy of 'it's either an emergency or it can be discharged for the GP to sort out' so antithetical to a person-centred model of care, thus exposes a more fluid and uncertain boundary between what a patient wants and what they need from ED.

Implications for practice

Despite the encouraging signs that the physiotherapists in this study already subscribe to and are enacting person-centredness

in ED, this discussion cannot ignore inevitable questions about the sustainability of ED physiotherapists' attempts to realise person-centredness in the face of such strong practical and cultural headwinds. While arguments have been made which range from patients' rights to professional physiotherapy standards and philosophies, the realpolitik ultimately necessitates a rejection by clinicians working in ED of any idealised visions of person-centredness. While its delivery is clearly not impossible, given the current climate it is challenging to say the least. One solution the authors can offer here is a conceptualisation of a specific *ED version of person-centred practice*: one that is dynamically adapted to the presenting case and operational limitations. ED physiotherapists' focus should be to facilitate a dialogue based on open questioning and active listening - which is both welcoming and non-judgemental, but crucially establishes why patients have come; how it is affecting their life; what are they worried about; and what they feel needs to happen. Armed with this information the physiotherapist will be best placed to offer individualised choices that empowered a patient's self-management, reducing the likelihood of reattendances. While in-keeping with, and at the high end of, conceptualisations of a continuum scale of person-centredness [16], given the practical situation in ED, a framework to support this is currently lacking.

Limitations and conclusions

Strengths and limitations

Survey

While the number of primary contact physiotherapists practising within UK emergency departments was unknown, this survey sample was presumably small, constituting a limiting factor to generalisability. Furthermore, the use of percentages to present findings with small samples can be problematic [87]. However, the mixing of methods and subsequent merged analysis here meant that the authors were not relying on numbers alone to tell the whole story. The geographic spread captured responses from all the seven English NHS regions, plus one each from Wales and Northern Ireland, provided a broad picture of UK ED physiotherapists' practice. The lack of representation from Scotland, however, limited the extent to which authors can claim a truly UK-wide perspective.

Interview

Interviewed participants from only NHS English regions limited the extent to which authors can claim a truly UK-wide perspective. Interview participants were likely to constitute a more person-centred group of physiotherapists introducing selection bias.

Conclusion

This study offers three novel contributions that further our understanding of the person-centred practices of ED physiotherapists. Firstly, that ED physiotherapists were mindful of an apparent, yet unspoken struggle between the competing philosophies of biomedicine and person-centredness. Secondly, that 'entering a patient's world' was an acceptable route to achieving person-centred practice in ED. Finally, that there exists a difference of professional focus in ED for delivering what a patient wants versus their clinical need.

Given the current context, there has never been a more pressing need for guidance on how to operationalise person-centred practice in ED if the profession is to continue its progress away from biomedical roots for the benefit of all its patients. Further research exploring the patient perspective of ED physiotherapist practices is needed.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

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