An Exploration of Person-Centred Practices among Emergency Department Physiotherapists

being a thesis submitted in partial fulfilment of the
requirements for the degree of

Doctor of

Philosophy of Health Studies

in the University of Hull

by

John Paul Naylor
BSc, Leeds Metropolitan University
MSc, York St John University

May 2024

Acknowledgements

This research would not have been possible without the *HUTH and University of Hull clinical academic careers collaborative research programme* scholarship.

At HUTH, I must give special thanks to my physiotherapy line manager, Sandy Wright, for her endless support and encouragement. I must also thank the ED physiotherapy team for their contributions to my research project, particularly my clinical colleagues, Mathew Nixon and Lawrence Grant. This gratitude extends to all physiotherapists and patients who participated in my research, including during patient and public involvement and engagement (PPIE) phases.

The deepest gratitude goes to my supervisors at the University or Hull, Dr Clare Killingback, and Dr Angela Green at the Trust, respectively. Clare was a consistent and impeccable mentor throughout my PhD journey, displaying remarkable faith in my ability to complete what was necessary at each stage. This, in turn, allowed me to believe in myself. Before meeting Clare, I was on a trajectory to complete quantitative research in which my heart was not truly invested; she opened my eyes to an exciting world of qualitative inquiry, from which I haven't looked back since. I thoroughly enjoyed our interactions and simply could not have done this without her - particularly her rapid responses to my communications. Aside of her ongoing support and supervision, Angela was instrumental in the developing a scholarship application and invaluable in obtaining PPIE approval and NHS ethics for the patient facing study. She, too, has been a most tremendous support throughout my research journey.

Finally, I am grateful to the patience and understanding of my wonderful wife, Michelle and our two loving children, Annabel, and Fred, who never complained when I shut my office door to get work done, but who would, after school, always pop in to check, "how's your PhD going, Daddy?" - I hope this inspires them to work hard and achieve their own goals in life.

Publications and Conferences

Lead author

Naylor, J., Killingback, C. & Green, A. (2023) What are the views of musculoskeletal physiotherapists and patients on person-centred practice? A systematic review of qualitative studies. *Disability and rehabilitation,* 45(6), 950-961.

Naylor, J., Killingback, C. & Green, A. (2024a) An exploration of person-centredness among emergency department physiotherapists: a mixed methods study, *Disability and Rehabilitation*, Available online DOI: 10.1080/09638288.2024.2310179

Naylor, J., Killingback, C. & Green, A. (2024b) The experiences of patients attending the emergency department who were managed by physiotherapists: A person-centred perspective, *Disability and Rehabilitation*, Available online DOI: 10.1080/09638288.2024.2382311

Co-author

Killingback, C., Green, A. & Naylor, J. (2022) Development of a framework for person-centred physiotherapy, *Physical Therapy Reviews*, 27:6, 414-429.

Killingback, C. & Naylor, J. (2024) Chapter 1: Emerging Technologies in Healthcare: Interpersonal and Client-Based Perspectives. In Hayre, C.M., Muller, D., Scherer, M., Hackett, P.M.W. & Gordley-Smith, A. (eds) *Emerging Technologies in Healthcare: Interpersonal and Client-Based Perspectives*. Boca Raton, FL: CRC Press, 1-14.

Conference

presentation

Naylor, J. (2023) A qualitative meta-synthesis of musculoskeletal physiotherapist and patient views on person-centredness. Chartered Society of Physiotherapy (CSP) Annual conference. Birmingham, 1 Nov 2023. Available online: https://csp2023.abstractserver.com/program/#/details/presentations/232 [Accessed 19/05/2024]

poster

Naylor J. (2023) How person-centred do UK emergency department (ED) physiotherapists consider their clinical practice to be? Chartered Society of Physiotherapy (CSP) Annual conference. Birmingham, 1 Nov 2023. Available online: https://csp2023.abstractserver.com/eposter/#/viewer/171 [Accessed 19/05/2024]

Abstract

Person-centred practice (PCP) constitutes an important, individualising approach that strives to confront a legacy of healthcare paternalism. The biomedical roots of physiotherapy, alongside context-specificity of PCP, hinder realisation of this humanistic model, particularly where research is lacking. This thesis explores how PCP is understood and experienced by patients and primary contact physiotherapists within emergency departments (ED) to address this identified research gap.

A qualitative systematic review of musculoskeletal physiotherapist and patient views on PCP informed subsequent mixed-methods exploration of ED physiotherapists', and qualitative exploration of ED patients', views of PCP. The systematic reviews' findings underscored the importance of person-centred traits, communication and empowerment when treating the unique person, generating novel contributions on how clinically brave ED physiotherapists might achieve empowerment through meaningful activity. The subsequent mixed-methods exploration of person-centredness among ED physiotherapists revealed a cognisance of their struggle between biomedicine and person-centredness, where entering a patient's world helped navigate the challenging line between ED attenders' wants and needs. Finally, a qualitative study exploring perceptions on the person-centredness of ED patients who had their care episode managed by a primary-contact physiotherapists, recognised the benefits of this ED physiotherapy model, through aspects of their connection, competence and time, while illustrating patients' experience of ED physical environment. Novel contributions from the patient perspective, here, reflected a cognisance of certain environment limitations to PCP, as well as institutional challenges to their personhood, with a suggestion that ED patients anticipated a validation of their visit and valued the educational aspects that the physiotherapists provided.

The combined findings produced common threads on the importance of therapists holding an empowering attitude toward, and listening, to patients as well as pursuing meaningful interaction with them. This shaped specific recommendations, with practical application, that are offered to assist ED physiotherapists PCP within the UK and beyond.

Contents

List of Figures

List of Tables

Abbreviations

ACP	Advanced Clinical Practitioner
AG	Angela Green (2nd supervisor)
BPS	Biopsychosocial
CASP	Critical Appraisal Skills Programme
CES	Cauda Equina Syndrome
CK	Clare Killingback (1st supervisor)
COREQ	Consolidated Criteria for Reporting Qualitative Research
EBP	Evidence Based Practice
ED	Emergency Department
ENTREQ	Enhanced Transparency in Reporting the Synthesis of Qualitative Research
FCP	First Contact Practitioner
HEE	Health Education England (now part of NHSE)
HRA	Health Research Authority
HUTH	Hull University Teaching Hospitals NHS Trust
ICE	Ideas Concerns and Expectations
IRAS	Integrated Research Application System
JD	Joint Display
JN	John Naylor
MECC	Making Every Contact Count
MMD	Mixed-Methods Design
MMR	Mixed-Methods Research
MSK	Musculoskeletal
NHS	National Health Service
NHSE	NHS England
PCC	Person-Centred Care
PCP	Person-Centred Practice
PPIE	Patient and Public Involvement and Engagement
RCEM	Royal College of Emergency Medicine
RCT	Randomised controlled trial
TQF	Total Quality Framework
UK	United Kingdom
WHO	World Health Organisation

Chapter 1 Introduction

1.1 Overview

This thesis sets out to explain how person-centred practice (PCP) is understood and experienced by patients and physiotherapists in the emergency department (ED). To achieve this aim, the researcher has chosen to focus specifically on primary contact physiotherapists and those individuals with musculoskeletal conditions that they manage in ED. Individualised person-centred approaches are important for ensuring that people's preferences, needs and values guide clinical decision-making through care that is respectful and responsive towards them (NHSE, 2024b). The wholesale acceptance of PCP as a core aspect of quality healthcare, supported by recommendations for health policy to enable this (Wolfe, 2001; The King's Fund, 2013; WHO, 2016), makes the search for new knowledge here an important one.

The Chartered Society of Physiotherapy (CSP) and other international physiotherapy governing bodies cite PCP as an essential aspect of members' practice (American Physical Therapy Association, 2018; Chartered Society of Physiotherapy, 2019; Physiotherapy Board of New Zealand, 2020). Despite this expectation to deliver on person-centredness, there remains a lack of clarity on how this might be operationalised, particularly in non-traditional musculoskeletal physiotherapist settings such as ED.

This chapter commences with an outline of the researcher's journey in deciding to explore this topic. The introduction then advances thought the historical origins and development of PCP, which outlines definitional challenges, PCP's interrelation with other models within musculoskeletal physiotherapy, and a consideration of ED physiotherapy and PCP. The chapter will then conclude with a summary of the thesis chapters to aid reader navigation.

1.2 The author's research journey

Within two years of qualifying as a physiotherapist I had opted to specialise in the management of patients with musculoskeletal conditions, as I had found this to be at the forefront of my clinical interests. Over the subsequent 16 or so years I gained extensive clinical experience in the field of musculoskeletal practice within both National Health Service (NHS) and private sectors, and across a diverse range of settings including physiotherapy, orthopaedics, and fracture clinic outpatient departments; trauma and elective orthopaedic wards; emergency and primary care.

All this clinical experience had, it seemed, by default, situated me within a quantitative research paradigm; something which became more apparent as I instinctively leant into a randomised controlled trial (RCT) protocol for the research module of my professional health and social care master's degree. But this was, after all, a time when I gave little thought to researcher positioning or paradigms but just knew that I felt comfortable in the safety of such empirical inquiry; that there existed an objective truth that could be revealed by careful investigation.

In applying for my PhD, this research view persisted and was again manifest in my rather positivist research proposal to develop and test a smartphone application for back pain management in ED. However, this apparent quantitative bent was all about to change during the first year of my doctoral studies, when I became cognisant of incongruity between the type of questions, i.e., about the human experience, that I was seeking to answer and an objectivist view of reality that I had thus far maintained.

Despite the acquisition of new clinical knowledge and skills, my approach as a physiotherapist had, it seemed, always centred around rapport-building, clear communication, and meaningful connection with patients – concerning myself more with the patients' subjective world than any objective truth. I believe that this is due, in part, to my personality type, but also my belief that such heart-felt connection is equally, if not more, important than the technical expertise demanded of the physiotherapist role. I reflected that some of most qualified and senior clinical colleagues did not necessarily get the outcomes they surely deserved, based on their extensive (and expensive) postgraduate training in technical manual therapies, for example. Furthermore, I made the anecdotal observation that simple, honest engagement with patients, sometimes without definitive treatment, still resulted in satisfactory patient reported outcomes. It had become clear to me that non-specific contextual factors might be as important as those proposed effects from certain manual techniques.

My own epiphany here appeared to correspond with the general movement in the physiotherapeutic profession away from outdated paternalistic views of our role as the expert clinician - holding all the power within the relationship with our patients, to more of a therapeutic partner. Under this newer interpretation, the therapist could still be an expert, but so too could the patient within their respective fields of assessment and management of musculoskeletal conditions and subjective lived experience of this condition.

Despite the strong historical alignment between musculoskeletal physiotherapy and orthopaedic medicine - based on biomedical orthodoxy and outdated attitudes such as the ‘clinician always knows best’, my continued attempts to form therapeutic relationships with patients meant that, without even knowing it I had, in a philosophical sense, already, one foot firmly anchored in the person-centred camp. Yet, person-centredness’ being all about the subjective and improving “the care of experience of individual patients” (Health Foundation, 2016:19) was more aligned with a qualitative paradigm; something which remained scary, uncharted territory for me as a potential researcher. This is when the penny finally dropped, and I realised the error in my dismissal of qualitative research.

Since moving from musculoskeletal outpatients to ED in 2018, and later adding primary care to my work portfolio in 2021, my clinical focus had largely shifted to seeing patients at the point of first contact – that is, before, if at all, seeing a hospital doctor or general practitioner (GP). The responsibility of managing a caseload of undifferentiated musculoskeletal patients without the input of a doctor came with a new level of clinical uncertainty that I had not experienced before that is documented in the research literature (Ingram et al., 2023). The solution for managing such uncertainty in my case was to seek even stronger connections and understanding of my patients’ experience, beliefs, and expectations. My rationale here being to avoid missing something important in their narrative that might be of consequence to their clinical outcomes. I thus found myself beginning to prioritise receipt of the patient’s narrative, employing a more dialectical reasoning approach, and viewing the patient as being the expert in their own experience.

It was a master’s module in health coaching which sparked my first formal awareness and interest in PCP. This preceded the gradual shift from secondary to primary patient contact where I was experiencing, first-hand, the transformational effects of adopting soft skills in communication and person-centred tools such as therapeutic alliance, health coaching and ideas, concerns, and expectations (ICE) framework, and making every contact count (MECC) among many other person-centred approaches.

Having run the gauntlet of peer reviewers’ demands to publish my first article: a critical review based on my master’s dissertation, I felt that I had taken a big step to becoming the researcher-practitioner I had wanted. It was my thirst for doing further research and possibly a future career in teaching, coupled with my person-centred epiphany, that resulted in my grand ambition: to somehow unite this new researcher mindset, the healthcare model of PCP, and my current clinical practice in ED. The guiding vision here was a desire to help myself and my colleagues to deliver PCP within a primary contact ED setting, with the principal aim of improving patients' experience.

As I move to completion of my five-year, part-time PhD research apprenticeship, I can reflect on the benefits of maintaining my first-contact patient case load during the research period, as this has allowed me to continually enact, analyse, and reinterpret my approach through a widening lens of person-centredness. Furthermore, this has allowed me to look inward and to better understand the theoretical underpinnings of my approach as a person-centred first-contact physiotherapist.

I am keen to disseminate my academic output to assist others in development of their own more person-centred musculoskeletal practice, but in ED specifically.

1.3 Background to the study

1.3.1 History of person-centred practice

The origins of what we now refer to as PCP can be traced back to the client-centred counselling method developed in the mid-twentieth century by psychologist Carl Rogers (Rogers, 1951). Contemporary practitioners of a person-centred healthcare approach should recognise similarities in non-directive focus on an individual's experience of themselves, in place of an 'expert' telling them what to do (Yao and Kabir, 2024). The history of PCP development typically acknowledges the formative contributions of Edith Balint and her key assertion that each patient be 'understood as a unique human being' (Balint, 1969:269).

Some early influential work on PCP in relation to medicine was conducted by Canadian researcher Moira Stewart and colleagues, regarding PCP as a holistic concept of six interconnecting components: (1) exploring both the disease and the illness experience; (2) understanding the whole person; (3) finding common ground regarding management; (4) incorporating prevention and health promotion; (5) enhancing the doctor-patient relationship; (6) being realistic about personal limitations and issues such as the availability of time and resources (Stewart et al., 1995). Ian McWhinney, along with Stewart, made significant contributions to the PCP discourse in general medicine through development of a *Patient-Centred Clinical Method* based on the idea of entering a patient's world - to see the illness through their eyes (McWhinney, 1989).

Formative empirical research by Margaret Gerteis and colleagues, in an acute inpatient hospital setting in the US, produced a seven-dimensional model of PCP (Gerteis et al., 1993). Gerteis' work would prove foundational for the Picker institute and its conception of the so-called *Picker principles of person-centred care* (Picker, 2024).

In the UK, the first major exploration of patient-centredness was in the field of medicine and led by Mead and Bower. Their original framework, based on doctor-patient relations, presented PCP within five conceptual dimensions: 1) the biopsychosocial perspective; 2) patient-as-person; 3) sharing power and responsibility; 4) therapeutic alliance; 5) doctor-as-person (Mead and Bower, 2000).

Shortly after the turn of the millennium, PCP was brought to international prominence following publication of the *Crossing the quality chasm* report by the US Institute of Medicine (Wolfe, 2001). Underpinned by earlier research (Gerteis et al., 1993), this linked PCP to the idea of quality care and generated a particular focus on the potential of PCP for addressing the growing number of patients living with long term conditions.

Many significant contributions to the PCP discourse have subsequently followed, including a wide range of reviews and concept analyses (Holmström and Röing, 2010; Morgan and Yoder, 2012; Kitson et al., 2013; Scholl et al., 2014; Castro et al., 2016; Pluut, 2016) that have greatly improved our understanding of person-centredness, but without leading us to a single agreed definition (Nolte et al., 2020). Notable among contributions is that of McCormack and McCance, including their 'person-centred nursing framework' (McCormack and McCance, 2006), later revised and updated to a 'person-centred practice framework' applicable beyond their own nursing profession (McCance and McCormack, 2017). It was these same authors who highlighted 'context' as one of the biggest challenges for overcoming the disconnect between PCP policy and practice (McCance and McCormack, 2017; Janerka et al., 2023).

While acknowledging the challenges of realising PCP in an acute hospital setting, a recent meta-narrative review concluded PCP could be successfully implemented within this context and, what is more, improve care quality, patient and staff experiences, and care efficiencies (Janerka et al., 2023). At the same time as the endorsement and research interest in PCP across a range of health specialties grows, UK patient survey data points towards a continued deterioration in patient experience (Picker, 2024). The Picker Institute, particularly, have been closely involved in the evaluation and improvement of NHS patient experience. Their *principles* of *person-centred care*, "as a primary motivating force – not as a bolt on to an outdated biomedical model" (Picker, 2024:4) are enshrined in a *manifesto for a person-centred healthcare service* that offers a contemporary vision of how PCP within the NHS should look:

1. Fast access to reliable healthcare advice
2. Effective treatment by trusted professionals
3. Continuity of care and smooth transitions
4. Involvement of and support for family and carers
5. Clear information, communication, and support for self-care
6. Involvement in decisions and respect for preferences
7. Emotional support, empathy, and respect
8. Attention to physical and environmental needs

1.3.2 Person-centred vs. patient-centred and other synonyms

While PCP continues to be inconsistently prefixed, i.e., using ‘person’, ‘patient’, and ‘people’, among other synonyms, the former is preferred by many including the author. This is due to its consideration of the *whole* person and its upholding of personhood, as opposed to a narrow focusing on *condition* that is implied by ‘patient’, or a more population-level concern implied by ‘people’ (WHO, 2015). Using *person* to define PCP suitably safeguards an individual’s preferences, wellbeing, and wider social and cultural background (Health Foundation, 2016). Another possible semantic difference emerges when defining a *person-centred* goal in terms of living a meaningful life versus the *patient-centred* attention on functional wellbeing (Burgers et al., 2021).

Disambiguation between PCP and ‘personalised care’ is provided through the latter’s consideration as a social care model that builds on themes of PCP but with the choice and control over the support that is drawn, including health budgets (NHSE, 2024c). Whatever prefix is applied, be it *person-*, *patient-* or *people-*, *client-, user- etc*.... all would appear to uphold a Rogerian emphasis on relationships built on empathy, respect, and authenticity manifested through an ‘unconditional positive regard’ (Rogers, 1951). The terms have thus been considered interchangeably in this thesis as implying the same meaning.

While the lack of universal definition has, itself, been said to pose an implementation challenge for PCP (Holmström and Röing, 2010), the research focus appears to have shifted from conceptualisation to implementation (Janerka et al., 2023). Some have argued that the degree of indeterminacy and vagueness surrounding PCP should not be regarded as problematic and defend the idea of multiple accounts of person-centred practice that can vary across different contexts and groups (Mitchell et al., 2022). The Health Foundation offers a comprehensive and practical description of person-centredness through its utility to “support people to develop the knowledge, skills, and confidence they need to more effectively manage and make informed decisions about their own health and health care. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect” (Health Foundation, 2016:3).

1.3.3 Biopsychosocial and dialectical models with musculoskeletal person-centred physiotherapy practice

In response to perceived inadequacies of the prevailing western medicine’s separation of the mind and body; an enduring representation of Cartesian dualism - George Engel’s proposal of *the need for a new medical model: a challenge for biomedicine* (Engel, 1977) led to his biopsychosocial (BPS) model ultimately achieving acceptance within the physiotherapy profession (Sanders et al., 2013). The BPS perspective embeds patients within the world of work, family and social pressures and thus considers, for example, barriers such as the cost to the patient in terms of the time required for physiotherapy. The BPS perspective alone is, however, said to be insufficient to fully understand a patient’s problem and experience of illness (Toombs, 2013). If, as has been suggested, the BPS model lacks sufficient theoretical foundations, and is challenging to integrate (in terms of constituent -bio, -psycho, and -social) (Stilwell and Harman, 2019), then it is even more important that additional steps be taken to ensure care is more person-centred. BPS and PCP models appear compatible so far as to be able to characterise contemporary musculoskeletal physiotherapy in terms generally accepting of the BPS model, with an inclination towards being more person-centred, within consultations shaped by a predominantly biomedical approach.

As with a biomedical model of care, clinical reasoning is a fundamental component of musculoskeletal practice that traditionally takes a strong hypothetico-deductive bent. This differs from narrative reasoning which takes a more phenomenological, and by extension, person-centred approach. Narrative reasoning involves ‘the apprehension and understanding of patients' “stories”, illness experiences, meaning perspectives, contexts, beliefs, and cultures’ (Edwards et al., 2004:322).

The dialectical model combines and considers both clinical and narrative reasoning approaches and is defined as ‘reasoning that moves between those cognitive and decision-making processes required to optimally diagnose and manage patient presentations of physical disability (hypothetico-deductive) and those required to understand and engage with patients' experience of that disability (narrative reasoning)’ (Edwards et al., 2004:328). Dialectical reasoning appears compatible with a BPS model, and the PCP model that it underpins. As well their rejection of the biomedical model’s disease-centred ethic (Fuller, 2017), narrative and person-centred approaches hold in common an emphasis on the importance of entering a patient's individual world as a means to helping them.

PCPs is included within the educational standards for the *International Federation of Orthopaedic Manipulative Physical Therapists* (Rushton et al., 2016): an influential body that represents musculoskeletal specialists worldwide. A model more associated with 'softer' interpersonal skills being accepted by those from more passive, manual therapy background, demonstrates PCP's growing reach. Within the NHS, entire domains are now routinely turned over to 'person-centred approaches' for example, the *First Contact Practitioner and Advanced Practitioners in Primary Care: (*musculoskeletal*) A roadmap to practice* (HEE, 2021). Considering existing and anticipated musculoskeletal framework publications, PCP's position within NHS England's vision for accreditation of allied health professions appears secure. The expectation for musculoskeletal physiotherapists is, thus, not only in delivering PCP, but also evidencing that they are doing this as part of professional portfolios.

There is some specific guidance and recommendations for physiotherapists' attempting to accomplish PCP during the rehabilitation of patients suffering from musculoskeletal pain (Miciak et al., 2019; Caneiro et al., 2020; Lin et al., 2020b; Hutting et al., 2022; Jesus et al., 2022). Despite this, the unambiguous expectation for musculoskeletal practitioners to deliver PCP does not appear to be matched by the academic literature in which specific guidance on operationalisation PCP may be inadequate. PCP remains a nascent, yet under-researched area within musculoskeletal physiotherapy which is something important to address.

1.3.4 PCP and ED

Research into PCP has tended to vary across methodological approach, disciplinary perspective, clinical setting and patient population (Nolte et al., 2020). Aside of general philosophical principles, there appears to be a context-specificity to the clinical setting and patient *types* that will have a significant influence on exactly how PCP is operationalised in each situation. Areas such as medicine or nursing, general practice or acute hospital care have tended to dominate the extant research literature on PCP. While there exist numerous, generally positive, journal articles concerning physiotherapists' work within ED (Gill and Stella, 2013; de Gruchy et al., 2015; Sutton et al., 2015; Barrett and Terry, 2018; Ferreira et al., 2018; Davies et al., 2022), publications linking ED to PCP are few and limited to review or editorial articles (McConnell et al., 2016; Kennedy, 2017). The complete absence of specific literature linking ED physiotherapy with PCP is unsurprising given the relative novelty of this high stakes primary contact role, where a focus on delivery of safe and efficient care naturally precedes considerations pertaining to philosophy of practice.

For the purposes of this current research, it was therefore necessary to identify and focus on the closest proxy for that cohort of physiotherapists who manage musculoskeletal caseloads at the point of first contact within ED: the outpatient musculoskeletal physiotherapist. The justification here being that the pre-existing competence and confidence in managing musculoskeletal conditions has meant that it is musculoskeletal outpatient physiotherapists who move into primary contact physiotherapist ED roles. This is also relevant since the outpatient musculoskeletal model is formative to how physiotherapists go about assessing and treating patients with musculoskeletal conditions in ED. Through their adopting such a similar approach, it is anticipated that some of those interactional facilitators and barriers to operationalising PCP in outpatients will continue to have relevance within the ED setting.

The practice environment, relating to the context and culture in which the care is delivered, has been shown to impact on delivery of person-centred practice (McCormack and McCance, 2010; Killingback et al, 2022). The typical UK ED environment has, for the preceding decade or longer, been a challenging one to say the least. A testing sequence of political austerity, Brexit, COVID-19 pandemic, and unprecedented levels of industrial action on pay and conditions has left the NHS facing an existential crisis. Its workforce, with ED departments at the vanguard, has continued to fulfil its role operating at maximum capacity for so long as to degrade resilience and its ability to fully serve all patient needs. With patients continuing to attend ED in record numbers, the reports of excessive waits and poor experiences in ED are not surprising.

Asking healthcare staff to be more person-centred might seem like the last straw for a NHS already at breaking point, yet that is what health policy, and professional standards demand. While the challenging working conditions in ED might offer mitigation, this cannot be used as an excuse for ED physiotherapists' failure to (attempt to) deliver on a professional requirement for enacting PCP with their patients.

The stage is thus set for a fascinating exploration of perceptions of PCP among ED physiotherapists and their patients as a foundation for understanding and improving the ED patient experience.

1.4 Outline of the thesis

The thesis is divided into seven chapters (Figure 1.1). Chapter two describes the methodology as well as the rationale for the overall study design, methods of data collection and analysis along with the aim, research question and objectives. The systematic review of qualitative studies is presented in chapter three. This helped inform development of the survey and interview guides for subsequent studies. Chapter four presents the clinician-facing study: a mixed-method exploration of PCP among ED physiotherapists. This comprised an online survey and in-depth online interviews that were interpreted separately before merged analysis using joint display (Skamagki et al., 2022). The fifth chapter presents the patient-facing study which involved in-depth online interviews of ED patients who were managed by a primary contact physiotherapist. The sixth chapter brings together in synthesis the different studies with findings discussed in context of the extant literature. The seventh chapter is for the conclusion and provides an overview of key study findings, implications and recommendations for ED physiotherapy practice, as well as future horizons for research in this field. Finally, additional material relevant to the thesis is then presented in the appendix.

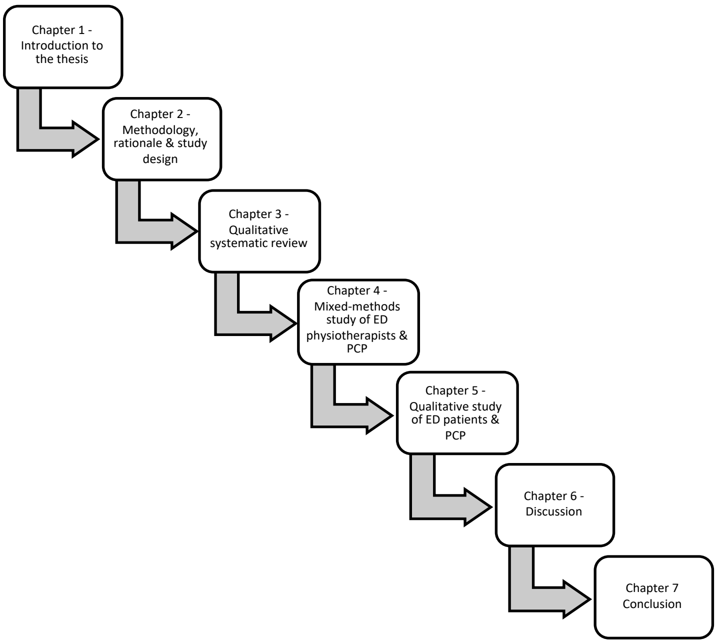


Figure 1.1 Overview of chapters and content of thesis

Chapter 2 Methodology, rationale and study design

2.1 Introduction

This chapter will outline the methodology, research design, and research methods employed for this broad exploration of person-centred practice (PCP) among UK emergency department (ED) physiotherapists from the perspective of those clinicians and patients receiving their care.

The chapter begins with an explanation of what the author understands by terms methodology, philosophy and paradigm and why these are relevant to research. This is followed by an introduction to the pragmatist's paradigm, with a discussion on how this pertains to the philosophical and methodological approach underpinning the thesis. A consideration of methods for respective studies is then followed by a brief discussion on ethics and data management, before a summary concludes the chapter.

2.2 Methodology, philosophy and paradigms

Where research methods specify the tools or "techniques" for collecting and analysing study data, *research methodology* clarifies the underlying assumptions, principles and procedures for that specific inquiry in terms of *how* we seek out the new research knowledge (Schwandt, 2015). *Research philosophy* describes the development of these research assumptions, its knowledge, and nature (Saunders et al., 2007), providing the researcher's thoughts from which new, reliable knowledge can be obtained (Žukauskas et al., 2018). The closely related term, *research paradigm* offers "a basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways" (Guba and Lincoln, 1994:105). Those ontological and epistemological considerations that, alongside methodology, constitute a research paradigm are, themselves, defined respectively here as "the philosophical study of the nature of existence, being, or reality" and "the study of the nature of knowledge and justification" (Schwandt, 2015:89, 108).

To demonstrate a logical congruence in decision-making, a researcher's methodological choices necessarily relate to the philosophical position that they take. As a clinician, on a research journey, without a background in philosophy, attaining such consistency poses certain challenges. To facilitate clarity of thought here, the author is assisted by considering research philosophy in terms of something *possessed by the researcher*; research paradigm as the philosophical *assumptions that they bring to the study*; and methodology as the *practical application of those philosophical principles* to the investigation.

The overarching philosophical lens embraced by the researcher here is that of pragmatism, chosen as one of the several commonly used paradigms of research (e.g., positivism, interpretivism). The pragmatist's paradigm, with its semantic allusions to all that which is considered practical, was chosen as one that prefers "action to philosophising" (Johnson and Onwuegbuzie, 2004:18), and is, thus, not overly burdened by the ideological stance taken. Premised, as it is, on using the best available methods to investigate real-world problems, pragmatism is not regarded as a methodology so much as a philosophy or, perhaps in some sense, even an "anti-philosophy" (Johnson and Onwuegbuzie, 2004:18). Before contextualising this thesis within the stated pragmatist worldview, the reader is provided with a brief discussion of its origins as a philosophy.

2.2.1 Pragmatism as a philosophy

The inspiration for development of pragmatism as a theoretical framing for modern research is rooted in a rich American pragmatic philosophical tradition, with Charles Sanders Peirce (1839–1914), William James (1842–1910), John Dewey (1859–1952) and Richard Rorty (1931–2007) among its notable proponents (Legg and Hookway, 2021). While pragmatism may have emerged as a big 'P' philosophy in the late 19th century, it was more contemporary contributors such as Rorty who established this approach as a wider research interest (Kaushik and Walsh, 2019). By directing attention to methodological matters, and dodging metaphysical concerns (Patton, 2005), the pragmatic approach addresses practical problems in the real world, rather than those related to the nature of reality and truth (Morgan, 2007).

Despite diverse scholarly backgrounds, there appears a shared belief from many proponents of scientific pragmatism in democratic contexts of its potential to improve society (Gillespie et al., 2024). Johnson and Onwuegbuzie go further here, stating pragmatism "takes an explicitly value-oriented approach to research that is derived from cultural values; specifically endorses shared values such as democracy, freedom, equality, and progress" (Johnson and Onwuegbuzie, 2004:18). In essence, the pragmatic philosophy views the world as determined by human actions with people, rather than external forces, shaping their experiences through action and intelligence that find meaning in consequences (Kaushik and Walsh, 2019).

It has been suggested that pragmatism's potential for conducting research has not been fully realised due to applications often being limited to a justification for carrying out mixed methods research (Gillespie et al., 2024). Pragmatism, however, attends to a broader action-oriented philosophical framework “regardless of whether that research uses qualitative, quantitative or mixed methods" (Morgan, 2014:1045). Other early career researchers’ attempts to reconcile traditional methodologies under an umbrella of ‘methodological pragmatism’ highlight the fresh perspective gained from working beyond and between the boundaries of traditional and pure methodological approaches (Clarke, 2021). By regarding the *research problem* as the most important determiner of research design (Giddings and Grant, 2007) pragmatism allows more comprehensive addressing of the research question by endorsing the use of disparate methods, (Shaw et al., 2010). Researchers must demonstrate a thorough consideration of the implications of this philosophy when designing their studies (Shaw et al., 2010) if they are “to find a middle ground between philosophical dogmatisms and scepticism and to find a workable solution” (Johnson and Onwuegbuzie, 2004:18).

Pragmatism views philosophical issues of ontology, epistemology and methodology in vastly different ways than other common paradigms (Creswell and Plano Clark, 2018). Pragmatism, as a big ‘P’ philosophy - adapted as a paradigm, assumes a diverse ontological position with all individuals having their own unique interpretations of reality (Kivunja and Kuyini, 2017). This assumes an ‘existential reality’ of different layers: some objective, some subjective, and some a mixture of the two (Dewey, 1958). A pragmatist’s epistemology is a relational one, determined by what a researcher deems appropriate to their study (Kivunja and Kuyini, 2017).

Pragmatism, according to Greene (2008), offers a realist take on the physical world, in combination with a constructivist view of the social world, allowing for the qualitative and quantitative integrated inquiry. Johnson and Onwuegbuzie (2004:18) similarly contend that “knowledge is viewed as being both constructed and based on the reality of the world we experience and live in”. Pragmatism is said to avoid the ontological concepts of truth and reality by accepting the existence of single or multiple realties (Cresswell and Plano Clark, 2011; Kaushik and Walsh, 2019). A pragmatist epistemology does not view knowledge as reality (Rorty, 1980) but constructed to manage existence and to take part in the world (Goldkuhl, 2012). It is through such interpretations that reality, and the world, are considered as more dynamic.

Having introduced pragmatism, the author now moves to justify his choice of pragmatic framework as a “practical and outcome-oriented method of inquiry that is based on action” (Johnson and Onwuegbuzie, 2004:17) to address a research question that explores PCP in the novel ED physiotherapeutic context.

2.2.2 Philosophical assumptions for this thesis

Having presented pragmatism from philosophical and paradigmatic angles, the reader is briefly introduced to the backdrop of the current research project, for the purposes of gaining a better understanding of why this philosophical lens matches this context.

The longstanding and ongoing issues faced by UK emergency departments in terms of the mismatch of capacity and demand are well documented (Illman, 2022; The King’s Fund, 2022; NHSE, 2023). Considering the effects of overcrowding and long waits (The King’s Fund, 2022), for example, when frontline NHS services like ED are so stretched then the quality of patient experience will naturally suffer (Hillman, 2014; Walsh et al., 2022). With no resolution anticipated anytime soon, it falls to clinicians on the ground, such as those physiotherapists who interact with ED attenders, to do what they can to improve their experience. As a physiotherapist, based in ED, the researcher and his team have an orientation towards making every contact count for their patients, manifested through a person-centred model of care. Whether this approach is shared by other UK ED physiotherapists, how they might define PCP and how their patient experience this are all unknowns.

While ED constitutes a non-traditional workplace for primary contact ED physiotherapists, they face an additional existential and philosophical challenge of practising in a setting that is steeped in a biomedical culture, that stands in contrast to a person-centred approach (Naylor et al., 2024a). Given this realpolitik and uniqueness of this challenge, the authors desire to help and improve experience calls for a slightly different, more patient-oriented approach to research, taking in the views of patients as well as the physiotherapists on PCP. This is important as “although the ED environment presents unique challenges, including patient-centeredness can help to create a better environment for providers and patients” (Walsh et al., 2022:10).

As outlined in the previous section, pragmatism’s action orientation (Kaushik and Walsh, 2019) makes it an appropriate paradigmatic/philosophical approach for research focused on ED patient experience of physiotherapy. The current exploration of PCP among ED physiotherapists from both physiotherapist and patient perspectives for respective inquiries did, however, throw up some paradigmatic challenges.

The researcher’s positioning as an ED practitioner, seeking to explore and possibly realise changes at the clinical practice level, identified the utility for a mixed methods design. As the findings from the systematic review, alongside extant literature on PCP, were used to inform this initial primary study design, the researcher’s open-minded and flexible approach in answering the overarching research question appeared well-matched to this philosophy of pragmatism. Furthermore, use of a mixed methods design within a pragmatic framework allowed the researcher to choose the most appropriate methods with which to answer the question without needing to commit to any specific methodology framework (such as grounded theory or phenomenology, etc.). The paradigmatic lens’ enduring focus on what was the best and most practical method to answer the research question, eschewing prescriptive and inflexible methodologies such as grounded theory, remained a persistent feature that was justifiable by adoption of this pragmatist stance.

The quantity and quality (in terms of person-centredness, specifically) of ED physiotherapists for this inquiry was an unknown. The inaccessibility in terms of geographical spread, and in terms of barriers to normal clinical access during a global pandemic, led the pragmatic decision-making to conduct the initial quantitative survey. To understand how ED physiotherapists experienced PCP in their practice, the research would also demand the use of qualitative methods, in this case semi-structured in-depth online interviews. Collection of quantitative survey data that was followed by, and could inform, subsequent qualitative data collection offered several practical benefits including: 1) provision of a purposive sampling method; 2) the ability to address the complexity of something like person-centredness and physiotherapy in this unique and challenging ED arena and; 3) addressing the risk of building a survey, predominantly informed by the findings of a systematic review that was itself based on something as nebulous and disputed as PCP. Since PCP has many interpretations, any errors brought in from the review to the survey might subsequently be amplified if data collection was limited to survey data alone. The qualitative interviews that followed therefore allowed cross-checking of data sources and thus reduced the risk of errors associated with a closed questioned approach alone.

Given the rich insights gleaned from clinicians from the mixed method inquiry, during planning for the subsequent primary study, the researcher realised it would be essential that any exploration of PCP must also necessarily capture the voice of the *person* at the centre of PCP’s perspective, namely the ED patient. It followed that the most practical, pragmatic thing to do would be a similar use of qualitative semi-structured in-depth online interview methods but this time with ED patients. For methodological consistency, the pragmatic paradigmatic assumptions were carried over to the third study, despite it lacking a quantitative pairing this time. Here, the researcher could exploit his unfettered access to an unlimited sample of the population of ED patients being managed by primary contact ED physiotherapist on his doorstep.

The reflexive thematic analytical methods of Braun and Clarke (2021) that were applied to the interview data in the mixed methods and qualitative studies, respectively, are considered as relatively theoretically flexible and thus unaligned to any single specific methodologically. The pragmatic approach to thematic analysis adopted was consistent with the author's methodological standpoint of pragmatism carried across all studies.

The researcher felt the need to further justify his continued use of a pragmatic theoretical lens for the qualitative data collection methods in the second primary study, with this now uncoupled from a mixed method design. While interpretivism may be the most common paradigmatic lens of qualitative inquiry, it is not necessarily synonymous with an interpretive paradigmatic approach (Goldkuhl, 2012). Foster offers additional support for this researcher positioning, by stating that "methodological pragmatism makes no prior commitment to the superiority of mixed methods; rather, whether or not to use qualitative, quantitative or mixed methods is a matter to be determined purely pragmatically, based solely on the needs of the research" (2024:5). Moreover, it is pragmatism's concern for action and change and the interplay between knowledge and action that makes it appropriate for any research approaches that intervene, as opposed to merely observing the world, (Goldkuhl, 2012) as this thesis attempts to do. Pragmatism also "recognizes the existence and importance of the natural or physical world as well as the emergent social and psychological world that includes language, culture, human institutions, and subjective thoughts" (Johnson and Onwuegbuzie, 2004:18). Pragmatism's consistency with analytical thematic analytical methods used for the qualitative arm of the mixed methods inquiry provided another reason not to change the researcher's philosophical stance. Thus, varying the methodological position away from pragmatism for the final study was deemed an unnecessary step to capture and bring together these different viewpoints from physiotherapy and patient participant groups while maintaining paradigmatic coherence.

This thesis was, thus, constituted by a multi-study design based on systematic review, mixed method - survey and interviews, and qualitative interview methods approaches respectively. In this way the three studies comprising the thesis were planned and executed in a flexible fashion through a pragmatic research lens.

Physiotherapy's roots in a biomedical model of care, driven by the push for evidence-based practice, has meant a philosophy underpinned by a positivist paradigm which fails to capture "the context, complexity and patient centredness that characterise expertise in physiotherapy services" (Shaw et al., 2010:514). As physiotherapy practice does not fit into traditional positivist, constructivist or critical paradigms, it has been characterised as a multi-paradigmatic science (Parry, 1997). Shaw and colleagues' contention that practice-oriented research should be conducted outside these traditions, and proposal of pragmatism as the solution to this issue (Shaw et al., 2010), further support the philosophical decision-making in the current research. The use of interviews and thematic analysis methods are closely linked with interpretivist tradition, and associated with ontological reality that is socially constructed. Yet, Pragmatism's non-committal to any one philosophical system/reality afforded the author the opportunity and freedom to choose the approach best serving the aims and purpose.

2.3 Ethics

Ethics and health and safety considerations are an important part of any research, with special attention required when dealing with human participants. The approval for studies that comprise the thesis and was sought from the appropriate respective bodies is now outlined.

For the systematic review no formal ethics approval was required as the study method involved synthesising pre-published secondary data. The review did, however, follow best practice by drafting and submitting a systematic review protocol (PROSPERO registration number: CRD42020170762) that was closely followed and updated upon completion.

For the mixed method study, the researcher sought and received university research ethics board approval (REF FHS327 – see appendix 2). This included submission of this study's patient information sheets, survey and interview questions, consent forms and data management plan. Informed consent here was received from all participants prior to collecting their data. The first page of the online survey (see appendix 6) required a formal consent box to be ticked before proceeding. This was supported by linked patient information sheets written in plain English. At the end of the survey was the option to participate in follow up interviews by clicking on a link to a second survey. The reason for this separation was to ensure division between anonymous main survey data and personally identifiable data on the mini survey. On this additional mini survey (see appendix 6) was a limited number of necessary demographic and contact questions to allow later contact for arranging the online interview. Those that wished to be interviewed were emailed consent forms and the information sheets. When the signed consent forms were received, an online interview invitation was sent. The recorded interview data was, itself, stored and transcribed from university secure servers, from which point the transcript was only identifiable by the participant code – the key for which remained only on university secure servers so there was no way to identify the participant's words. In this way participant anonymity was protected, with subsequent indicative quotes associated with their interview code, plus age and years of experience, provided in the demographic mini survey.

For the final ED patient-facing study, it was necessary for the researcher to go through a challenging and time-consuming process to obtain formal ethical approval for this study. This required completion of an extensive ethics application form through the online IRAS portal. After the form was approved, the researcher was then required to face an online Health Research Authority (HRA) panel before finally receiving formal approval by the Yorkshire & The Humber - Leeds East Research Ethics Committee (IRAS Project ID: 317609; REC reference 22/YH/0260 – see appendix 13). The research was also granted sponsorship by Hull University Teaching Hospitals NHS Trust (HUTH) with the Trust's 'capability and capacity' to conduct the study confirmed prior to commencing data collection (R2847).

Anonymity and confidentiality of patient participants and their data for this study was always respected, underpinned by an ethics-approved data protection plan and an informed consent process. This time, those patients expressing an interest in being interviewed, on their experience of being managed by an ED physiotherapist when this was offered at the conclusion of this interaction, were provided with a patient information sheet and provided their preferred contact method. The minimal amount of information which included preferred name, contact, condition and date was then sent by encrypted NHS email, from the ED physiotherapist who treated them, directly to the researcher. They were then contacted as soon as possible, but after at least a day, to discuss their involvement in the study. Here they were formally screened using the study inclusion/exclusion criteria and asked to complete a consent form when they confirmed that they had read the information sheet and were happy to be interviewed. A date convenient to them was then set for online interview. When conducting the recorded interviews, the data was stored and transcribed from university secure servers. After transcription the data was only identifiable by a participant code – the key for which was also stored on university secure servers so there was no way to identify the participant's words. In this way participant anonymity was protected, with subsequent indicative quotes associated with their interview code, gender, decade of life and condition.

Health and safety assessments were completed as part of the respective university and IRAS ethics applications procedures to ensure any foreseeable risk to anyone's health and safety that might occur because of involvement in the study was addressed.

2.4 Data management

For both primary studies, the respective ethic committees required completion of a full data management plan as part of their approval processes. The fact that ethical approval was granted attests to this being suitably addressed. However, any data that could lead to the identification of participants was stored on university secure servers meaning that there was no one, at any time, other than the researcher and his supervisory team, who could access or identify this data as belonging to individual participants. Completed consent forms were assigned a participant code and stored with audio interview data on university secure servers. Transcribed audio interviews were anonymous except for this code requiring access to the online stored 'key' to identify the transcripts. For the survey, additional steps were taken to separate the actual survey data from the demographic and contact data for those who completed the survey and chose to be interviewed as discussed in the ethics.

2.5 The lens of person-centredness

Paradigmatic considerations aside, another influence on the current research came from its broad focus on perspectives of person-centredness. However, with ongoing conceptual debates attempting to determine exactly what constitutes person-centredness, PCP remains a poorly theorised model (Giusti et al., 2020); lacking in a universally agreed definition (Byrne et al., 2020); and has a context-specificity to its research (Health Foundation, 2016). The interpretations of this systematic review, considered alongside the broader extant literature on PCP, including a concurrently developed physiotherapy PCP framework (Killingback et al., 2022b), constituted points where PCP influenced the research process. In this manner, PCP constituted an overarching lens that specifically informed the survey and interview question-development for subsequent studies. The person-centred model therefore shaped the research design as well as orientated the analysis of the findings and synthesis in the discussion thesis. Due to the primary research aspects of this project being spread over separate studies, each has its own section on methodology and researcher positioning. The discussion, too, houses an extensive section on researcher reflexivity that considers insider/outsider positioning, for example.

2.6 Summary of methodology chapter

This chapter has presented the overarching philosophical and methodological approach taken for this study. Further depth is provided within the respective study and discussion chapters, commencing with the systematic review (study 1) in the following chapter.

2.7 Aims and research question and research objectives

The **aim** of this thesis was to explore PCP in ED from the perspectives of primary contact ED physiotherapists and their patients.

The main **research question** was:

> How is person-centred practice understood and experienced by patients and physiotherapists within the emergency department?

This overarching PhD research question was operationalised through three respective studies:

1. Systematic review of musculoskeletal physiotherapists and patients views on PCP

2. Mixed-method exploration of how PCP is understood and interpreted by ED physiotherapists

3. Qualitative inquiry of how PCP is experienced by ED patients managed by ED physiotherapists

The main **objectives** of the research were to:

1. Explore and discover how and to what extent primary contact ED physiotherapists understand and interpret PCP.
2. Explore and discover how ED patients experience primary contact ED physiotherapists as being person-centred.
3. Use the study data to make recommendations on how primary contact ED physiotherapists might become more person-centred in their clinical practice.

Chapter 3 – The systematic review (study 1)

3.1 Introduction

This chapter will present a systematic review of the views of musculoskeletal physiotherapists and their patients on person-centred practice (PCP). The review was undertaken to gain a better understanding of what is known about PCP within the ED physiotherapy proxy setting of musculoskeletal outpatients. The findings and interpretations here influenced significantly the studies presented in later chapters.

The chapter commences by discussing the utility of systematic reviews, which includes the reasoning for qualitative metasynthesis as well as the use of a musculoskeletal proxy group for this current study. This review is then contextualised by a brief overview of PCP's relevance to contemporary healthcare and musculoskeletal practice, specifically. After this will follow the methods, results and discussion sections. The chapter will then conclude by presenting the overall aims, research question and objectives for the thesis.

3.2 Systematic reviews

Systematic review is a type of research where the findings of multiple related studies are synthesised to answer a specific research question. These are conducted in such a way as to minimise bias and random errors (Cook et al., 1997). In a similar fashion to their primary study counterparts, quantitative systematic reviews can be used for hypothesis testing, while qualitative reviews answer more open-ended questions and explore concepts or experiences that provide new theory or understandings (Tenny et al., 2024). While the quantitative systematic review method is, by now, well-established, the qualitative metasynthesis, pioneered by Noblit and Hare (1988), is a more recent development that continues to evolve (Seers, 2015). Despite systematic approaches being taken, a key difference between quantitative and qualitative systematic reviews surrounds the interpretive aspects of the latter, where overlapping or different findings can result. The lack of reproducibility that this implies is not, however, regarded as weakness. Rigour, here, is maintained through transparency of reporting at all stages of the process as well as by the provision of clarity on the reviewer's stance (Bearman and Dawson, 2013). The qualitative systematic review, according to Clark (2016:2) thus:

> "provides a vital means to know and tune into the past conversation in your topic area that allows the researcher to position themselves and their work substantively, ontologically, theoretically, and methodologically in this landscape."

A qualitative systematic, rather than narrative literature review was chosen for this current research; a decision based on several reasons including the lack of a universally agreement definition of PCP; the context-specificity of PCP; and the dearth of specific qualitative evidence linking ED, PCP and physiotherapy. The first two reasons necessitated operationalisation of this concept based on a review of the closest evidence to this specific setting and way of working. As a previously unexplored field, it was the latter reason that necessitated selection of a closest proxy context for ED where at least some literature existed. Pre-existing competence and confidence in managing musculoskeletal conditions has meant that it is by default, predominantly musculoskeletal outpatient physiotherapists who perform this primary contact physiotherapist role in ED. It was the *musculoskeletal physiotherapy proxy setting,* therefore, that was selected as constituting the closest available alternative for that cohort of physiotherapists who manage musculoskeletal caseload at the point of first contact within ED. The specific meta synthesis approach taken followed that described by Thomas and Harden (2008), discussed further in the methods section.

While there are qualitative systematic reviews on PCP, to the best knowledge of the researcher there are none exploring the views of on PCP of musculoskeletal physiotherapists and their patients. With subjective views at the heart of this enquiry, the choice of this topic and research question was, thus: what are the views of musculoskeletal physiotherapists and patients on person-centred practice?

3.3 Background of PCP

3.3.1 Background of PCP in healthcare generally

There is a growing interest internationally for healthcare to focus on person-centred practice (Miles and Asbridge, 2017; Dickson et al., 2020; PCP-ICoP, 2024). The movement towards person-centredness embodies a general philosophical departure from clinician-centric to a more patient-focused approach with individual patient preferences at the heart of any decisions that are made about the care received (Richardson et al., 2001). A seemingly inexorable rise in the use of this term is indicative of its broad appeal across a wide range of healthcare areas, from health policy to patient advocacy (Department of Health, 2000; Wanless, 2002; Darzi, 2008; Department of Health, 2013; Francis, 2013; National Voices, 2014; Patient's Association, 2017). Despite a growing body of evidence to support person-centred practice, these findings are mixed and consistent with this being an "ambition, but not yet a priority" (Redding and Hutchinson, 2017:5). Person-centred practice has therefore yet to be established as widespread practice but remains strategically important internationally (Edgar et al., 2020).

In the United Kingdom (UK), this shift of power to patients should be taken in the context of the "patient-centred" visions for change defined in Government reports that include *High-quality care for all (Darzi, 2008)*. Furthermore, the importance of patient experience in the UK is now enshrined within legislation following publication of *The Health and Social Care Act* (2012). The importance of a hospital's "patient-centred culture" has also emerged in responses to revelations of sub-standard care seen in such critical reports as the *Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis, 2013). Overall, this has led to an increased attention being placed on the patient perspective and patient experience; exemplified by the existence of advocacy organisations such as National Voices, Healthwatch and entities such as the Patient Experience Library (National Voices, 2014; Healthwatch, 2019; Patient Experience Library, 2021).

The formative 'person-centred nursing framework' (McCormack and McCance, 2006) was recently revised to a broader 'practice framework' (McCance and and McCormack, 2017) with applications beyond nursing. Despite their obvious utility, it is unclear whether such broad scope models are applicable to the particularities of disparate areas of healthcare practice (Jesus et al., 2016). While most of the academic research on the implementation of person-centred practice has been associated with medicine or nursing, its adoption within physiotherapy research has been described as 'embryonic' (Dukhu et al., 2018). Physiotherapy governing boards internationally are calling for members to adopt a person-centred approach (American Physical Therapy Association, 2018; Chartered Society of Physiotherapy, 2019; Physiotherapy Board of New Zealand, 2020; Physiotherapy Board of Australia, 2021). This expectation is arguably constrained by an inadequate evidence base with which to explain exactly how person-centredness might be achieved in a variety of different healthcare settings (Dukhu et al., 2018). A disconnect between a strong promotion of person-centredness in the literature and the lack of interactional data to support whether physiotherapists are willing or able to achieve this has also been highlighted (Cowell et al., 2019).

3.3.2 Background of PCP in musculoskeletal specifically

Clinical guidelines on the management of musculoskeletal (MSK) conditions consistently recommend employment of a person-centred approach (Lin et al., 2020b). However, operational differences have been noted between musculoskeletal outpatients and more acute medical settings on which some of the existing person-centred practice models are based (Cooper et al., 2008). Furthermore, different professional groups and contexts tend to focus on different aspects of person-centredness (Gillespie et al., 2004). Since physiotherapists manage a range of patient types across different settings, the specificity of context and patient groups under investigation may therefore require models based on data from more homogenous cohorts.

Optimistic expectations that result from such unanimous endorsement of person-centred practice appear to gloss over the difficulties faced by clinicians in their attempts to integrate these principles into practice (Hutting et al., 2022). It is not unreasonable for those less familiar with person-centred practice to anticipate this taking more time to deliver when time constraints have been reported as a barrier to adopting psychological, over purely biomedical, aspects to their practice (Driver et al., 2017). Furthermore, training to support and promote psychosocial aspects of person-centredness, addressing the lack of knowledge and role clarity should be a requirement at preregistration level and as part of a physiotherapist's continuous professional development (Alexanders and Douglas, 2016; Driver et al., 2017; Driver et al., 2021). If physiotherapy communication is poor, then this will constitute a barrier to the cornerstone of person-centred practice (Lin et al., 2020a) for which core training will be essential. Patient barriers, on the other hand, include low health literacy levels (Altin and Stock, 2016), negative attitudes to recovery and inappropriate expectations (Morera-Balaguer et al., 2019) among other factors. A dogged pursuit of person-centredness in the face of patient resistance to the 'activated' roles required by this model i.e., where paternalism is preferred to shared decision-making, could lead to a 'person-centred paradox'.

3.3.3 Previous related reviews and the research 'gap'

A systematic review by O'Keeffe and colleagues reported 'individualized patient-centered care' as one of four themes that were perceived by musculoskeletal patients' and physical therapists' to influence patient-therapist interactions (2016). Further research of therapists' awareness and enhancement of interactional factors, such as 'patient-centered care', the authors concluded, had the potential to improve patient interactions and treatment outcomes. A systematic review by Wijma et al (2017) took a broad approach to understanding what patient-centredness in physiotherapy entailed but without focusing on a single clinical specialty. In seeking to build on this previous work (O'Keeffe et al., 2016; Wijma et al., 2017) the aim of the current review was to explore systematically physiotherapist and patients' views on person-centred practice within a musculoskeletal, rather than general, physiotherapy setting. This is important because person-centredness in musculoskeletal remains an under-researched area within physiotherapy.

3.4 Methods

3.4.1 Information sources and search strategy

This review followed a systematic review protocol (PROSPERO registration number: CRD42020170762). The PRISMA guidelines (Moher et al., 2009) and “enhancing transparency in reporting the synthesis of qualitative research” (ENTREQ) checklist (Tong et al., 2012) were used to ensure transparency in reporting and enhance the rigour of this review.

A search was carried out on the following electronic bibliographic databases: Academic Search Premier, CINAHL Complete, MEDLINE, APA PsycINFO, SPORTDiscus. No date limits were applied, and the final search was carried out in September 2021. Reference lists of eligible studies were hand searched as well as forward citation searching using the Web of Science database. A Boolean search strategy was employed (Figure 3.1) to search the databases using key concepts and their alternatives (Physiotherap* OR “physical therap*” AND Person-cent* OR “person cent*” OR patient-cent* OR “patient cent*”).

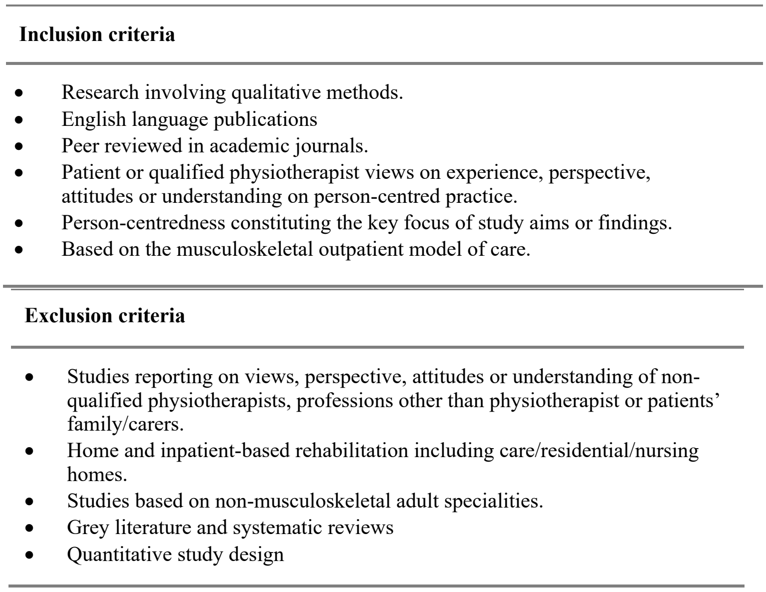
PIC search parameters **Population:** Musculoskeletal physiotherapists and their patients **Interest:** Person-centred (and synonym) approaches to physiotherapy practice **Context**: Musculoskeletal (MSK) physiotherapy outpatient settings
Databases searched: Academic search premier CINAHL complete MEDLINE APA PsycInfo SPORTDiscus with Full Text
Search parameter #1 **Person-cent* or “person cent*” OR patient-cent* or “patient cent*”** [select a field]* **(default author, subject, keywords, title info, all abstract (or first 150 words if no abstract)*
Search parameter #2 **Physiotherap* or “physical therap*”** [All text]
limits Combined search parameter #1 and #2 = 5756 Limit to English, academic journal, and removed duplications = 3250

Figure 3.1 PIC search strategy.

3.4.2 Eligibility criteria and study selection

Studies were included if they involved qualitative methods and were published in an English language peer-reviewed academic journal, as defined and indexed by EBSCOhost interface (Table 3.1). The views sought were those of the experiences, perspectives, attitudes or understanding of qualified musculoskeletal physiotherapists, and their patients, on the topic of person-centredness. It was deemed necessary that person-centredness constituted the key focus of the study aims or findings sections and that this was within a predominantly musculoskeletal outpatient-type setting.

Table 3.1 Inclusion and exclusion criteria.



Inclusion criteria
• Research involving qualitative methods. • English language publications • Peer reviewed in academic journals. • Patient or qualified physiotherapist views on experience, perspective, attitudes or understanding on person-centred practice. • Person-centredness constituting the key focus of study aims or findings. • Based on the musculoskeletal outpatient model of care.

Exclusion criteria
• Studies reporting on views, perspective, attitudes or understanding of non-qualified physiotherapists, professions other than physiotherapist or patients' family/carers. • Home and inpatient-based rehabilitation including care/residential/nursing homes. • Studies based on non-musculoskeletal adult specialities. • Grey literature and systematic reviews • Quantitative study design

Papers were initially screened for eligibility by JN using their title and abstract. Full text articles were independently screened by JN and CK. Any disagreements on individual judgement were resolved by discussion and consensus with the review team.

Included studies were critically appraised using the Critical Appraisal Skills Programme checklist for qualitative research (CASP, 2018). While the value of critical appraisal for qualitative research remains a contested area, this is typically used to evaluate whether or not a study adequately addresses questions of meaning, process and context in relation to the review outcomes (Hannes, 2011). Discrepancies were resolved by discussion and consensus among all three researchers (JN; CK; AG).

3.4.3 Data extraction and synthesis

A data extraction form was used to extract characteristics of participants, year of publication, country, study settings and study design including aims, method, and methodology plus any other special features of the studies. The lead reviewer (JN) was responsible for data extraction, but this process was checked by the second reviewer (CK), with any disagreement on individual judgement being resolved by discussion with the third reviewer (AG).

Qualitative metasynthesis broadly describes the interpretive integration of qualitative findings from primary research into an interpretive synthesis of the data (Sandelowski and

Barroso, 2007). Formative demonstrations of qualitative research synthesis, based on ethnographic studies (Noblit et al., 1988), have led its wider application beyond this so-called meta-ethnography. Such other qualitative metasynthesis approaches include meta-study, critical interpretive analysis, meta-narrative and thematic synthesis (Holopainen et al., 2020). In keeping with other recent physiotherapy studies (Wijma et al., 2017; Unger et al., 2019; Holopainen et al., 2020), the synthesis here followed the methods of thematic synthesis described by Thomas and Harden (2008).

The thematic synthesis method itself, in brief, can be summarised by the following steps: initial line-by-line coding of text; development of descriptive themes close to the primary data, and interpretative development of analytical themes to generate the new explanations (Thomas and Harden, 2008). Before thematic synthesis was commenced, the data from the findings or results section of eligible studies were imported verbatim into QSR International NVivo 12 software program. Data were coded line-by-line in the first open coding phase. Once coding of the first study was complete, codes from the next study were added to code 'bank' or new code developed as necessary, constituting a start to the synthesis (Thomas and Harden, 2008). The second stage of synthesis involved the organisation of these 'free codes' into related areas to construct 'descriptive' themes. In the third stage, analytical themes were generated. This was where novel interpretations based on the individual findings of primary studies occurred. Data were initially coded by JN before other members of the review team (CK and AG) independently cross-checked sections.

3.5 Results

3.5.1 Included articles

3.5.1.1 Study selection

The search strategy identified 5756 articles. Figure 3.2 shows the process of study selection based on a PRISMA diagram (Moher et al., 2009). A total of nine qualitative studies met the inclusion criteria.

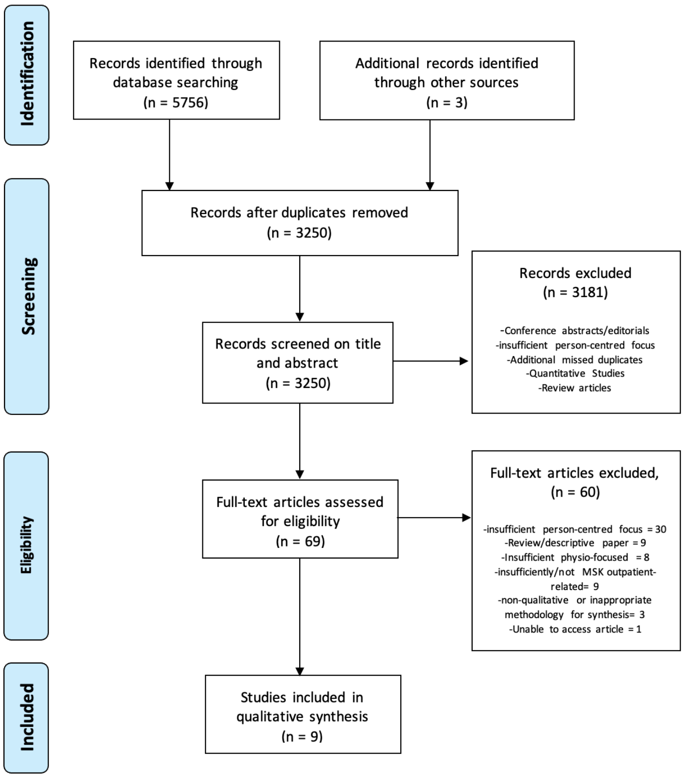


Figure 3.2 PRISMA diagram for the systematic review.

3.5.1.2 Quality of included studies

Study quality was assessed using the CASP qualitative appraisal checklist. The claim that the CASP tool has utility for addressing most of the principles and assumptions supporting qualitative research (Holopainen et al., 2020) is supported by its use in several recent qualitative systematic reviews in physiotherapy (O'Keeffe et al., 2016; Elvén and Dean, 2017; Holopainen et al., 2020). All nine studies were deemed to be of very high quality. The only consistent shortcoming in five of the included articles (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Cowell et al., 2019; Morera-Balaguer et al., 2019) was a lack of reporting on researcher *reflexivity* and/or researcher positionality. This is no small matter considering qualitative researchers' status as *an instrument of data collection* with the consequence that any data, and subsequent interpretations, cannot be fully accepted without a disclosure of their interests and positioning of 'self' within their study (Sutton and Austin, 2015). Reflexivity, too, provides an opportunity to evaluate the researcher as an active participant in the process of meaning creation (Hertz, 1997) and thus, makes it possible for the reader to legitimise and validate what is being reported. The absence of clarity on these details in some of the aforementioned articles may have therefore limited the conclusions drawn by the review.

3.5.1.3 Study Characteristics

A range of qualitative methods/methodological approaches were used (Table 3.2) including narrative enquiry (Ahlsen et al., 2020); framework analysis (Cooper et al., 2008); conversation analysis (Cowell et al., 2019); interpretive descriptive methodology (Ibsen et al., 2019); grounded theory (Kidd et al., 2011); thematic analysis (Meerhoff et al., 2019); modified grounded theory (Morera-Balaguer et al., 2018); constant comparison (central to grounded theory) (Morera-Balaguer et al., 2019); and interpretive phenomenological analysis (Sullivan et al., 2019). Data collection methods included: Semi-structured interviews N=5; semi-structured focus groups N=3 and observations N=1.

Study sample size ranged from 5-31, with a total number of participants across all studies of 153 (41 physiotherapists: 25 males and 16 females; and 112 patients: 37 males and 75 females). Three studies involved data collected from physiotherapists; five studies involved data collected from patients and one study included data collection from both via observation of a physiotherapist-patient interaction. The geographical spread of studies included: UK (Cooper et al., 2008; Cowell et al., 2019; Sullivan et al., 2019) Spain (Morera-Balaguer et al., 2018; Morera-Balaguer et al., 2019), Holland (Meerhoff et al., 2019), Denmark (Ibsen et al., 2019), New Zealand (Kidd et al., 2011) and Norway (Ahlsen et al., 2020).

Table 3.2 Overview of studies included in the systematic review

Study	**Context**	**Methodology**	**Primary aims**	**Data collection**	**Strengths**	**limitations**
Ahlsen et al, 2020	Setting: Multidisciplinary rehabilitation clinic, Norway Common conditions: Chronic musculoskeletal (MSK) Perspective: 5 Physios - Gender: 2 Males, 3 Females	Narrative inquiry	Examine therapists' understanding of patient-as-a-self in patient-centred practice (PCP)	Semi-structured interviews	Clear theoretic framework; clarity on positionality	Only six interviews; single location; no patient perspective
Cooper et al, 2008	Setting: Seven physiotherapy departments, Scotland Common conditions: Chronic non-specific recurrent low back pain (LBP) (within the previous 6 months) Perspective: 25 Patients - Gender: 5 Males, 20 Females	Qualitative study	Define patient-centredness from the patient's perspective in the context of physiotherapy for chronic LBP	Semi-structured interviews	Detailed inquiry of PCP; high number of physio participants (25)	Lack of researcher positionality or reflexivity; risk from self-selected sample
Cowell et al, 2019	Setting: two primary care outpatient depts, London, UK Common conditions: Initial exam, non-specific chronic LBP Perspective: filmed observations Gender: 10 physios (7 Males, 3 Females) & 20 patients (9 Males, 11 Females).	Conversation analysis - qualitative observational method	How physios solicit & respond to the agenda of concerns that patients with non-specific chronic LBP bring to initial encounters.	Video-recording initial physiotherapy consultations	Includes patients as well as physios; provides practical implementation on PCP.	Lack of researcher positionality or reflexivity; observer effects of researcher and video recorder
Ibsen et al, 2019	Setting: Spine centre, Denmark Common conditions: LBP Perspective: 7 patients - Gender: 3 Males, 4 Females	Interpretive descriptive methodology	Explore patients' perspective & preferences new LBP patient reported outcome instrument	Semi-structured focus groups	Clear theoretic framework; full COREQ included	Only seven patients; risk from capturing 'healthier' patients.
Kidd et al, 2011	Setting: Hospital physio outpatient depts, New Zealand Common conditions: MSK Perspective: 8 patients recently received physio Gender: 4 Males, 4 Females	Grounded theory (GT)	To determine patients' perspectives of components of patient-centred physiotherapy and its essential elements	Semi-structured interviews	Rigorous (GT) methodology; focus on patient perspective	Only eight patients; lack of researcher positionality or reflexivity.
Meerhoff et al, 2019	Setting: primary care physio two regional networks, Holland Common conditions: MSK problem Perspective: 21 patients - Gender: 6 Males, 15 Females	Qualitative thematic analysis (Braun and Clarke, 2006)	Explore patient perspective in MSK issues - patient reported outcome measures for quality improvement in primary care physio practice & determine what barriers/facilitators	Semi-structured interviews	high no. of patient participants (21); clear researcher positionality outlined.	Risk in participating physios selecting the patient sample e.g. wrong exclusion of illiterate patients
Morera-Balaguer et al, 2018	Setting: Outpatient rehabilitation health centres, Spain Common conditions: Neuromusculoskeletal Perspective: 21 physios >1 year working same place Gender: 5 Males, 16 Females	Qualitative study	Explore physio perceptions & experiences regarding barriers & facilitators of therapeutic patient-centred relationships in outpatient rehabilitation settings	Focus groups (FG)	high no. physio participants (21); recruiting across multiple varying sites.	Lack of researcher positionality or reflexivity; risk of influential/dominant voices within FGs
Morera-Balaguer et al, 2019	Setting: Physio unit in primary care & hospitals, Spain Common conditions: Neuro MSK Perspective: 31 patients - Gender: 10 Males, 21 Females	thematic analysis constant comparison	Explore the barriers and facilitators for the establishment of a person-centred relationship, based on the experience of physio patients	Focus groups	high no. patient participants (31); recruitment across multiple sites	Lack researcher positionality or reflexivity; sampling physio also treating
Sullivan et al, 2019	Setting: UK Common conditions: Chronic non-specific recurrent LBP Perspective: 5 physios - Gender: 2 Males, 3 Females	Interpretative phenomenological (IPA) analysis	Explore participants' lived experiences of communicating the diagnosis chronic non-specific LBP to patients during MSK physio practice	Interviews	Clear researcher positionality & reflexivity; theoretic framework	challenge on reader judge transferability due to nuanced nature of IPA study.

3.5.2 Qualitative synthesis

Thematic synthesis of the included studies led to development of four themes that summarised musculoskeletal physiotherapists and patients views of person-centred practice: 1. Treating each patient as a unique person; 2. Importance of communication for achieving a therapeutic alliance; 3. Necessary physiotherapist traits for person-centredness; and 4. Supporting patient empowerment. Themes will be presented with direct quotes from the original studies with a representative thematic schema presented in Figure 3.3.

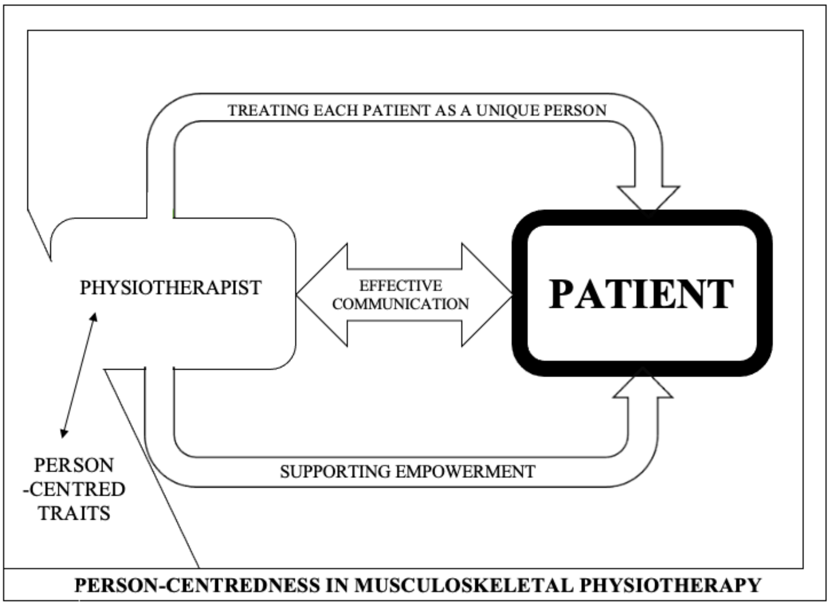


Figure 3.3 Schema representing review findings.

3.5.2.1 Theme 1. Treating each patient as a unique person

For a musculoskeletal outpatients' therapeutic approach to be considered as person-centred, the clinicians and their patients both acknowledged that physiotherapists should recognise each patient as a unique person. The importance of *treating each patient as a unique person* was evident by the prevalence of this theme in all but one study (Meerhoff et al., 2019). Patient participants appeared to appreciate, or feel entitled to receive, an individualised approach. This included choosing a style of care reflective and adjusted for their needs (Cooper et al., 2008; Ibsen et al., 2019; Morera-Balaguer et al., 2019).

Acknowledgment of the uniqueness of patients as people was apparent in the way that some therapists sought to understand what was meaningful to their patients. This included a focus on aspects of their hobbies, interests or on something enjoyable or familiar, rather than simply what the therapist wanted for them (Ahlsen et al., 2020). Physiotherapists who practiced in this way saw the potential for reimagining treatment, from the perspective of the unique patient in question, by tailoring therapy into something personally meaningful to them. Physiotherapists saw this tailoring as a way to promote engagement with treatments by relating this to the real world and being relevant to the patient (Sullivan et al., 2019).

> If you can show them something that they can see themselves ... and allow them to relate it to the real world, it ... it gets them on board ... they've already linked that in their mind to having some relevance to ... to them (Sullivan et al., 2019).

From the patients' perspective, the ability to engage meaningfully with a given therapeutic approach (e.g., specific exercises for back pain) required a patient's belief in the treatment's effectiveness for their own unique situation (Cooper et al., 2008; Kidd et al., 2011). For the approach to achieve a certain level of person-centredness, however also required there to be a 'fit' of treatment with individual patients' lifestyles. For example, one patient with back pain could not envisage himself doing a particular exercise despite acknowledging that the exercise was relevant to his back pain (Cooper et al., 2008). When treatment activities were meaningful to the patients, they felt that their needs were being addressed as unique people (Cooper et al., 2008). If, for example, the exercises were viewed as boring or too easy, and thus not meaningful, then they were more likely to disengage (Cooper et al., 2008; Kidd et al., 2011).

The idea of paying careful attention to individual patient stories diverges from a traditional physiotherapist role that prioritises the diagnosis and management of physical impairments. Willingness on the part of a physiotherapist to get to know the singular patient and tune into their individual needs and interests underlined an important role for the co-construction of patient narratives (Ahlsen et al., 2020). In the view of some physiotherapists, an approach tailored to the unique patient narrative or perspective allowed patients to use their own voice in construction and development of new meanings for their concerns (Cowell et al., 2019; Sullivan et al., 2019; Ahlsen et al., 2020). The addition of open-text boxes on a patient reported outcome measures was one such example that, patients felt, enabled them to provide more details on their individual needs and functioning (Ibsen et al., 2019). Patients expressed the desire to receive personalised explanations on diagnosis and treatment, with an emphasis on this being in a form of clear and easy to follow information to help them develop their understanding of their condition (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2019). This helped them feel like they were being seen as a unique person since the information was tailored to their own situation (Cooper et al., 2008; Kidd et al., 2011). Similarly, the use of overly technical language was recognised as a barrier to developing individual patient understanding and resulted in patient disengagement (Cooper et al., 2008; Sullivan et al., 2019).

> You know not everybody knows medical speak (. . .) But, if you have a good understanding in layman's terms. . .Ever since then I've a clear understanding of what exactly is happening to my back when it goes out, what needs to be done, and how to get back on track (Cooper et al., 2008).

As such, physiotherapists described their attempts to individualise understanding by deploying everyday analogies and metaphors (Sullivan et al., 2019; Ahlsen et al., 2020). For patients, the quality of the personalised explanations from the physiotherapist was helpful in building a trusting relationship with their therapist (Kidd et al., 2011). The importance of these individualised explanations was seen by both patients and physiotherapists as being part of a process which varies between individual patients and can take time, therefore should be 'layered', as opposed to delivered all at once (Cooper et al., 2008; Kidd et al., 2011; Sullivan et al., 2019). This tailoring of information thus ultimately facilitated a stronger patient-therapist collaboration (Morera-Balaguer et al., 2018; Sullivan et al., 2019).

3.5.2.2 Theme 2. The importance of communication for achieving therapeutic alliance

This theme embodies the various aspects of communication relevant for achieving a level of person-centred musculoskeletal outpatient practise. Communication was notable in four key areas: clarity of communication that addressed expectations, facilitation of an open dialogue, listening, and non-verbal communication.

Firstly, clarity of communication was viewed by some patients as essential in the delivery of person-centred practice as it helped address their expectations of what was realistic in terms of therapeutic outcomes (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Morera-Balaguer et al., 2019). Clear therapist communication was valued and constituted a source of satisfaction and trust in the therapeutic relationship (Kidd et al., 2011; Morera-Balaguer et al., 2019; Sullivan et al., 2019).

> She told me what I had, what she was going to do and why, and what we expected to achieve, then you know how you are going to progress and you see the improvement. The clarity and way she expressed herself was important (Morera-Balaguer et al., 2019).

When patient expectations were not met and they were disappointed with progress there was a tendency to blame the therapist for their unclear communication on expected improvements or prognosis (Cooper et al., 2008; Morera-Balaguer et al., 2019):

> I think by the middle or the end of my treatment I would have expected to know what was going on, what was wrong with my back. . .Yeah. I think, if it's curable or if it's not. If it's just going to be a long-term thing. I would like to have found out (Cooper et al., 2008).

Thus, patient expectations were viewed as a burden by some physiotherapists (Sullivan et al., 2019). From the perspective of the therapist, they felt that patients needed to be more realistic with their expectation of being 'fixed', cautioning the communication of misplaced hope to avoid perceptions of their ineffectiveness later (Morera-Balaguer et al., 2018; Sullivan et al., 2019; Ahlsen et al., 2020).

Secondly, clinicians and patients acknowledged the utility of open dialogue to achieve a mutually developed treatment approach (Ibsen et al., 2019; Sullivan et al., 2019; Ahlsen et al., 2020). Patients being offered sufficient time and encouragement to speak about 'everything' was seen as being important for person-centred practice by both patients and clinicians alike (Cooper et al., 2008; Ahlsen et al., 2020). Rejoinders such as 'do you think', for example, were indicative of therapist attempts to reach a deeper understanding of patient perceptions and encourage development of their concerns (Cowell et al., 2019). Supporting patients to communicate their beliefs and values in narrative form, therefore, appeared to enrich physiotherapist-patient relationships, furthering the aim of building therapeutic alliance.

Thirdly, for a musculoskeletal outpatient consultation to be perceived as person-centred, both patients and therapists agreed on the importance of a physiotherapist's listening skills (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Cowell et al., 2019; Morera-Balaguer et al., 2019; Sullivan et al., 2019; Ahlsen et al., 2020). Listening was linked to maintaining focus on patient concerns (Cowell et al., 2019) with an additional emphasis being placed by patients on the therapists not appearing to "judge" when hearing a patient's account (Morera-Balaguer et al., 2019). For the initial stages of consultation with a new client, active listening and questioning were of particular significance to therapists seeking to interact in a person-centred manner (Sullivan et al., 2019).

> I don't know if I did anything in the first assessment ... I'd listened to her, I'd listened to all the story ... I just listened to all of the, the things that were going around in her head (Sullivan et al., 2019).

Finally, the body language of clinicians was a further key aspect of communication central to promoting a therapeutic relationship with patients. In some instances, body language was deliberately deployed by physiotherapists to engage or relax patients. This included a proactive focus on patient gaze, use of open upper limb gestures or deliberately placing notes down as a signifier of their full attention (Cowell et al., 2019; Sullivan et al., 2019). Non-verbal continuers backed up with empathic nods were interpreted as an invitation for the patient to explain what they mean. Conversely, body language was employed in a less person-centred fashion to close a conversation (Cowell et al., 2019). Patients were generally aware when therapists were not engaged by interpreting aspects of the physiotherapist's body language. This included a failure to look patients in the eye or physiotherapists turning away to focus on something else (Cowell et al., 2019). This resulted in patient disengagement and a feeling of belittlement and was damaging to therapeutic relationships (Cowell et al., 2019; Morera-Balaguer et al., 2019).

3.5.2.3 Theme 3. Necessary physiotherapist traits for person-centredness

This theme reflects the views of patients and physiotherapists regarding key traits required by the therapist for musculoskeletal encounters to be perceived as person-centred. These traits include: a level of technical expertise; emotional intelligence and personality; confidence and clinical bravery.

The first trait required by a physiotherapist for person-centred practice was the importance of technical expertise; clinical competence and knowledge (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Morera-Balaguer et al., 2019; Sullivan et al., 2019). Patient and physiotherapy participants across a range of studies hinted towards the therapist being an 'expert' trained to know what is best for the patient (Cooper et al., 2008; Kidd et al., 2011; Cowell et al., 2019; Morera-Balaguer et al., 2019; Sullivan et al., 2019; Ahlsen et al., 2020).

The second trait which was perceived to be important for person-centred practice in a musculoskeletal context was the role of emotional intelligence on behalf of the physiotherapist. Aspects of emotional intelligence, namely: self-awareness, self-regulation, motivation, empathy and social skills, were referenced to some extent by patients or therapists, demonstrating the essential relationship between an outpatient physiotherapist's levels of emotional intelligence and the delivery of person-centredness (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Cowell et al., 2019; Morera-Balaguer et al., 2019; Sullivan et al., 2019; Ahlsen et al., 2020). The clear expectations from one patient provides their own checklist of therapist attributes for person-centredness (Kidd et al., 2011):

> An understanding of the pain, . . . and a feeling that I matter and that I'm a real person. . . .And then probably most important is the . . .the knowledge that she shares and put[s] into practice and then the encouragement to do the

> exercises, because what she does is only part of it. You know, there's that thing to get you doing the rest. . . . and . . . part of that encouragement is actually the ability . . . [to] answer questions and . . . I think it's. . .about taking the person seriously. . . .it was respecting the questions and being prepared to answer them and . . . that gives you, that confidence. . . .it's ability to inspire confidence (Kidd et al., 2011).

Traits such as niceness or competence alone were not sufficient. There appears a complex mixture of idiosyncratic factors, including the physiotherapist's persona, that combine to shape this (Cooper et al., 2008).

Patients' perception of negative therapist personality traits, that included abruptness or angry faces, led to poor levels of person-centredness. Instances where patients revealed a dislike for their therapist unquestionably constituted a barrier to realising person-centred relationships (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2019):

> there are people who, in my own experience, you take a dislike to from the very start, and, I know I shouldn't judge like this, they may be able to do miracles but... (Morera-Balaguer et al., 2019).

Thirdly, for physiotherapy encounters to be person-centred there was an expectation from patients that they needed to feel confident in their therapist (Kidd et al., 2011; Morera-Balaguer et al., 2019). Similarly, therapists perceived their self-confidence to be important in supporting patients (Morera-Balaguer et al., 2018; Sullivan et al., 2019).

The final trait which was perceived to be important from a person-centred perspective was the role of clinical bravery. This reflects the fact that, at times, therapists need to be willing to step out of their comfort zone, even perhaps, beyond their perception of the traditional physiotherapy role, in order to truly achieve person-centredness (Sullivan et al., 2019; Ahlsen et al., 2020). Clinical bravery is characterised by a musculoskeletal physiotherapist accepting the principle of going where the patient needed to take them, even venturing into areas concerning psychological distress or resulting in emotional reaction or conflict with patients:

> I learnt that maybe one should risk going, for example, into conversations with patients; dare joining the patients in their frustration; not being afraid and stop thinking this is not my field of competence, but daring joining the patients in these talks, I think that is important (Ahlsen et al., 2020).

3.5.2.4 Theme 4. Supporting patient empowerment

This theme reflects the view from some physiotherapists that an attitude of empowerment was necessary to practice in a person-centred manner (Ahlsen et al., 2020). When attempts to achieve patient empowerment were unsuccessful, or neglected, this had the potential to result in patient disempowerment (Morera-Balaguer et al., 2018; Cowell et al., 2019). The strong focus on empowerment being evident in only one therapist-facing article was itself noteworthy.

For more complex musculoskeletal patients, empowerment meant negotiating acceptable levels of pain tolerance, while building body awareness and patient confidence. Comforting patients and proposing alternative ways to move, adjusted to their individual tolerance levels, allowed patients to have new experiences, strengthening the patient's sense of self (Ahlsen et al., 2020). For other physiotherapists, empowerment centred on patient self-management aimed at helping the patients to help themselves:

> We teach them what they need, give them the insight they need and the training experience they need, the confidence. Then, when they are finished here, they can continue with the work and I think that is really a lifelong perspective (Ahlsen et al., 2020).

Clinicians' views regarding opportunities and barriers for achieving patient empowerment were present in several studies (Morera-Balaguer et al., 2018; Cowell et al., 2019; Ahlsen et al., 2020). A traditional musculoskeletal physiotherapy assessment format constitutes a significant barrier hampering patient empowerment. In a possibly typical scenario, a therapist turns away to write their notes, signifying that they are moving on with their assessment, however, the patient has not yet finished and therefore feels it is necessary, appropriate and possible to draw the therapist's attention back (Cowell et al., 2019). The patient's apparent disregard for the physiotherapy assessment structure, via an active demonstration of self-empowerment in this example, highlights the impact that patient empowerment can have on therapeutic relationship dynamics.

Physiotherapists were aware of the importance of empowerment to support patients but perceived that some patients preferred to have the therapist lead the management of their condition (Morera-Balaguer et al., 2018). Indeed, from the patient perspective, some exhibited a dependence on the therapist, preferring to defer decision making to the physiotherapist (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2019). The therapeutic management of a patient in possession of low self-efficacy was deemed to require more professional and personal effort (Morera-Balaguer et al., 2018).

The level of patient self-awareness regarding their current musculoskeletal issues emerged as a person-centred practice-relevant concept that was linked to empowerment in patient and physiotherapist studies (Meerhoff et al., 2019; Ahlsen et al., 2020). For example, patient reported outcome measures were considered by some patients as a useful tool for improving self-awareness and empowerment to manage of their condition (Ibsen et al., 2019; Meerhoff et al., 2019). This is because the detailed questions about health problems made them more aware of their musculoskeletal health challenges such as when pain is actually present on any given week. It also gave them a clearer picture of their overall health by empowering patients to understand the nature and severity of their own health issues.

3.6 Discussion

The aim of this review was to explore the views of musculoskeletal physiotherapists and patients on person-centredness. This is important because musculoskeletal outpatient physiotherapy may have its own unique barriers to operationalising person-centred practice. This review found that in an outpatient musculoskeletal context, physiotherapists needed to treat each patient as a unique person, requiring core traits and strong communication skills as well as promoting empowerment. These themes are commonly reported in the wider literature of person-centred practice (Morgan and Yoder, 2012; Scholl et al., 2014; Castro et al., 2016; Pluut, 2016; Wijma et al., 2017; Santana et al., 2018; Eklund et al., 2019; Byrne et al., 2020). However, what this review adds is that, within the well-reported principles of person-centredness, there are some nuanced differences which are of relevance specifically in a physiotherapeutic musculoskeletal context.

Firstly, in the current review, empowerment was clearly noted in some studies, but its presence was noticeably lacking as a consistent theme across most studies. This lack of consistent reporting of empowerment from a musculoskeletal context may therefore be suggestive of empowerment being a challenging concept for musculoskeletal physiotherapists to master. Empowerment is conceptually evident within person-centred models from acute and post-acute settings (Morgan and Yoder, 2012; Scholl et al., 2014). Within physiotherapy more generally, empowerment was central to person-centred practice, where it was defined by its aims of encouraging patient autonomy, self-confidence and a personal feeling of responsibility and power (Wijma et al., 2017). One proposed link between patient-centredness and empowerment, although not physiotherapy-specific, positioned patient-centredness as antecedent, and possibly prerequisite, to patient empowerment (Castro et al., 2016). This is important because it suggests that patient empowerment may not be possible without physiotherapists adopting a person-centred approach. Despite being established as central to person-centredness within the wider literature, these highlighted issues with empowerment might constitute a specific barrier to operationalising person-centredness in an outpatient context.

One of the reasons that makes empowerment a challenging concept for musculoskeletal physiotherapists may relate to adopted models of clinical practice. Despite a longstanding acceptance of the biopsychosocial approach, much of physiotherapy practice remains firmly underpinned by a biomedical model; one that typically provides clinicians with control over an assessment that aims to solve patient problems (Engel, 1977; Mudge et al., 2014; Fuller, 2017). Focusing on a structured, checklist-style approach might tackle physical deficits, but fail to elicit and address the individual patient needs, with direct consequences for patient empowerment. If the shift to person-centredness constitutes a holistic approach beyond biomedical and biopsychosocial models, then musculoskeletal outpatient practice's siloed focus on individual body regions may leave it lagging some way behind (Caneiro et al., 2020). One possible way to achieve this desired shift might be through adoption of the narrative approach modelled by Ahlsen and colleagues (2020) who sought to empower patients. Narrative-based practice, like person-centred practice, emerged as a response to the perceived shortcomings of the biomedical approach (Zaharias, 2018). A critical area of narrative-based practice is in the sharing of power between clinician and patient (Low, 2018), requiring a willingness on the physiotherapist's part to get to know their patient and tune into their specific needs and interests through hearing their full narrative. More open questioning and a mutual search for meaning and sense-making holds the patient's story as central and is therefore more likely to strengthen the physiotherapist-patient relationship. A proposal from this review echoes the opinion of others (Greenhalgh and Hurwitz, 1999; Charon, 2009; Launer, 2018; Low, 2018; Zaharias, 2018; Ahlsen et al., 2020) regarding the need to shift to a more narrative approach to consultation, but with the aim in this case to facilitate the desired patient empowerment within musculoskeletal physiotherapy.

Secondly, for person-centred practice to occur in a physiotherapeutic musculoskeletal context a therapist must be in possession of certain traits. These include a level of technical expertise (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Morera-Balaguer et al., 2019; Sullivan et al., 2019); emotional intelligence and personality (Cooper et al., 2008; Kidd et al., 2011; Morera-Balaguer et al., 2018; Cowell et al., 2019; Morera-Balaguer et al., 2019; Sullivan et al., 2019; Ahlsen et al., 2020); and self-confidence (Morera-Balaguer et al., 2018; Sullivan et al., 2019) or the ability to inspire confidence (Kidd et al., 2011; Morera-Balaguer et al., 2019). The wider point of there being a need for certain traits is covered in the multi-professional literature on person-centredness (Scholl et al., 2014; Wijma et al., 2017; Santana et al., 2018; Eklund et al., 2019; Byrne et al., 2020). These traits were similarly evident in this current study. However, a further trait was also noteworthy; the notion of clinical bravery: a previously unacknowledged physiotherapy trait holding specific relevance for the delivery of person-centredness in the outpatient physiotherapy setting. With a definition of clinical bravery in the wider literature currently lacking, similarities can be found within general discourse on healthcare discussions that are difficult and uncomfortable (Wilcox and Varpio, 2019) which often pertain to life-changing diagnoses (Marcus and Mott, 2014). Difficult conversations that have gone well reportedly have the potential to affirm relationships, build trust and increase hopefulness of the patient (Campbell et al., 2010), albeit in the context of discussion on cancer prognosis. One common feature on managing difficult conversations, however, is a belief that this constitutes a genuine skill needing to be taught and practiced (Svarovsky, 2013) and for which effective communication is central.

Communication during a typical musculoskeletal assessment is highly therapist-centred since the direction and control of conversation is towards physical and biomedical topics, often via closed questioning and without regard for patient agenda (Hiller et al., 2015). “Brave and risky” forms of physiotherapy practice that emphasises openness, vulnerability, and transparency to address power relations have previously been proposed (Eisenberg, 2012:445). This means a willingness to follow the conversation where the patient needs to take it and reaching beyond the traditional musculoskeletal physiotherapist’s remit by moving clinicians out of the comfort zone, for example, engaging with a patient’s psychological distress, emotional reaction or conflict (Sullivan et al., 2019; Ahlsen et al., 2020). If, as proposed earlier, physiotherapy assessment based on a narrative approach can improve patient empowerment, then clinical bravery might also be a necessary precondition to achieve the challenging shift from physiotherapist-fixer to conversational partner (Launer, 2018).

Finally, as part of the theme of treating each patient as a unique person, the importance of pursuing meaningful therapeutic activity for the individual was the third point of discussion for this review. This strong representation in most reviewed articles matches previous reports that person-centred goal setting must be meaningful and relevant to the patient in their own environment, regardless of the setting or perspective (Melin et al., 2019). Meaningfulness has been defined as deriving “from a person's sense of the importance of participating in certain occupations or performing in a particular manner; or from the person's estimate of reward in terms of success or pleasure; or perhaps from a threat of bad consequences if the occupation is not engaged in" (Trombly, 1995:963). While fundamental to the concomitant occupational therapy profession, meaningful activity is not always central for outpatient physiotherapists, whose traditional preoccupation is with pain, range of motion or strength improvements; goals which are not necessarily shared with their patients (Gardner et al., 2015). However, the results of the current review support previous reports that for a physiotherapist to be truly person-centred, the goals and activities must extend beyond a physiotherapy judgement of their health problem and hold some meaning for the individual patient in question (Nicholls and Gibson, 2010).

While previous discussion points share a common focus on a person-centred consultation style, this final point considers what comes after the patient story is understood and rests on the imperative of constructing a therapeutic intervention that resonates with the individual's lifeworld. In essence, musculoskeletal outpatient physiotherapists may need to become more like their occupational therapy colleagues, in terms of a focus on both meaning, as well as purpose, during treatment design. Therapists' awareness of what constitutes meaningful therapeutic activity for an individual might only result from first embarking on a brave journey with a patient in a consultation where no topic is out of bounds through narrative assessment approaches.

3.6.1 Quality evaluation

Systematic reviews rely on the quality of individual included studies in such a way that the evidence in the review can only be as good, or as free from bias, as the included studies (MUSC, 2024) (see earlier section 3.5.1.2 'Quality of included studies'). The tool that is employed will reflect the study type, which in this case was qualitative data. The quality of individual included studies was, thus, judged using a CASP appraisal tool (CASP, 2018). The criteria that make up CASP range from the clarity of aims to the value of the research. According to CASP appraisal, all included studies were of very high quality, but five lacked clear reporting on researcher positionality and/or reflexivity. Quality in the review was also enhanced by developing a protocol registered with PROSPERO (registration number: CRD42020170762), that was based on ENTREQ checklist (Tong et al., 2007) and completion of a PRISMA diagram (Moher et al., 2009). The manuscript version of the systematic review successfully passing the peer review process for publication in Disability and Rehabilitation added another level of quality assurance.

3.6.2 Strengths and limitations

This study was strengthened by the authors following an a priori PROSPERO protocol and ENTREQ guidelines (Tong et al., 2007). A broad international perspective on person-centredness was achieved by inclusion of nine high quality studies from both physiotherapists and their patients from the UK, Spain, Holland, Denmark, Norway, and New Zealand.

Limitations of this review include the synthesis being based on a small number of studies and only one review author screened for eligibility of the retrieved records. It is possible that some relevant articles might not have made it into the initial screening. Finally, as qualitative research can often be found in the grey literature (Tong et al., 2007), the exclusion of grey literature, non-peer reviewed publications and non-English language publications constitutes a potential limitation for this review.

3.6.3 Conclusion

This review offers three novel contributions to the discourse of musculoskeletal physiotherapists and patients on person-centred practice. Firstly, the authors proposed a shift to more narrative-based assessments to overcome identified shortcomings in achieving empowerment. Secondly, that clinical bravery is a necessary trait relating to both the courage of therapists to hold difficult conversations and to go against the biomedical orthodoxy to elicit patient narratives. Finally, ensuring treatments constitute a meaningful activity reflective of the person's individual world is an important part of treating each patient as a unique person.

As the traditional physiotherapy landscape shifts in the UK with innovations such as the first contact practitioner model in primary care and emergency departments, it is important that research keeps pace if we are to understand the respective idiosyncratic person-centred requirements and avoid backsliding to the biomedical model. There has, therefore, never been a more pressing need for development of physiotherapy-specific person-centred frameworks that are able to provide clear, research-based guidance on how to operationalise person-centred practice in multifarious settings, including musculoskeletal outpatients.

3.6.4 Updated search

A systematic search was repeated on 29 April 2024 to ascertain whether any new studies had been published since the last search in Sept 2021. The updated search identified 2,568 papers, reduced to 2032 with duplicates removed. These were screened as per methods used for the review, namely on abstract and title revealing ten papers (Cowell et al., 2021; Dnes et al., 2021; Hammond et al., 2022; Rodríguez-Nogueira et al., 2022; Unsgaard-Tøndel and Søderstrøm, 2022; De Baets et al., 2023; Kleiner et al., 2023; Liddiard et al., 2023; Holmes et al., 2024; Savvoulidou et al., 2024) which underwent full text screening. However, none of the papers from the updated systematic search process met the inclusion criteria predominantly due to lack of main study focus on PCP, but also commonly the lack of musculoskeletal specific focus.

3.7 Summary of literature review chapter

This chapter reviewed the existing literature on the views of musculoskeletal physiotherapists and their patients on person-centred practice (PCP). This highlighted the existence of a small quantity of high-quality primary qualitative research that investigated PCP from the perspective of patients and physiotherapists in international musculoskeletal outpatient-type settings. Three studies covered the views of physiotherapists (Morera-Balaguer et al., 2018; Sullivan et al., 2019; Ahlsen et al., 2020), five of patients (Cooper et al., 2008; Kidd et al., 2011; Ibsen et al., 2019; Meerhoff et al., 2019; Morera-Balaguer et al., 2019), and one of both (Cowell et al., 2019). While some significant findings, such as the importance of treating each patient as a unique person, appeared more prevalently than others, for example, empowerment, their judgement by relevance to the research aims, rather than their frequency, rendered them of equivalent standing during analysis. The four themes developed surrounding treating the unique person; communication; PCP traits; and empowerment, led to a discussion that offered three novel contributions on subject of empowerment, clinical bravery and meaningful activity. These new offerings constitute an original contribution to the discourse on musculoskeletal physiotherapy PCP with the potential to improve patient experience of musculoskeletal physiotherapy. The systematic review in this chapter was published in Disability and Rehabilitation to assist with this expectation (Naylor et al., 2023) (see publication). The systematic review directly informed development of the survey questions for the mixed-method study as well as the interview guides for both subsequent studies.

Chapter 4 An exploration of person-centredness among emergency department physiotherapists: A mixed methods study (study 2)

4.1 Introduction

This chapter will present a mixed-methods exploration of the views of emergency department (ED) physiotherapists on person-centred practice (PCP). This study was undertaken to gain insights into how PCP is understood and interpreted by the growing number of UK physiotherapists who work at the point of first contact with patients in ED.

The chapter commences with a brief overview on the importance of PCP to contemporary healthcare followed by a discussion on PCP in ED before setting the aims for this study. After this follows the methods, results and discussion sections, respectively. The chapter is then summarised, which includes a brief introduction to the subsequent patient-facing study.

4.2 Background to the study

4.2.1 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 (NHSE, 2024b). Those in 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 (Health and Social Care Act, 2012; NHS, 2019) to professional practice frameworks (HEE, 2017; 2021). 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 (Karazivan et al., 2015).

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, wellbeing, and self-management (Rathert et al., 2013; Coulter et al., 2015; Mazurenko et al., 2015). Empirical studies measuring its occurrence are challenged by the range of patient types and context-specificity of the person-centred activities under investigation (Health Foundation, 2016). 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 (Byrne et al., 2020).

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 (Redding and Hutchinson, 2017). Clinicians themselves have reported difficulties incorporating person-centredness into their patient interactions (Mudge et al., 2014; Dukhu et al., 2018; Hall et al., 2018; Hutting et al., 2020). Guidance to support the clinical implementation of person-centred practice, including person-centred frameworks, has been developed in areas of healthcare, particularly nursing (Mead and Bower, 2000; McCormack and McCance, 2006; McCance and McCormack, 2017; Santana et al., 2018). Within the field of physiotherapy, interest in person-centred approaches is growing, with publications to support implementation with patients suffering from musculoskeletal pain, for example (Caneiro et al., 2020; Lin et al., 2020b; Hutting et al., 2022). Those with a rehabilitative focus have attempted to conceptualise elements of person-centred practice via models and frameworks (Miciak et al., 2019; Jesus et al., 2022), with a more ambitious overarching person-centred physiotherapy framework based on the synthesis of all existing studies (Killingback et al., 2022b). Due to the apparent context specificity of person-centred practice, the utility of any such frameworks, as these authors concede, requires empirical testing.

4.2.2 Physiotherapists in UK emergency departments

For the last decade we have seen significant growth in the number of physiotherapists practising as primary contact clinicians within UK emergency departments (ED). Research into ED-based physiotherapy services has provided evidence of improved clinical outcomes that include reduced patient waiting times (Taylor et al., 2011; Gill and Stella, 2013; Bird et al., 2016; Kinsella et al., 2017; Sayer et al., 2017; Steed and Moulson, 2022), reduced length of stay (Taylor et al., 2011; Gill and Stella, 2013; Sutton et al., 2015; Kinsella et al., 2017; Sayer et al., 2017; Pugh et al., 2020; Cassar et al., 2022), reduced referral to specialties (Henderson et al., 2020; Davies et al., 2022), reduced imaging (Sutton et al., 2015; Schulz et al., 2016; Pugh et al., 2020; Davies et al., 2022) and positive patient experience (Harding et al., 2015; Schulz et al., 2016; Barrett and Terry, 2018). There is also data to support ED physiotherapists' safety (de Gruchy et al., 2015; Sutton et al., 2015) alongside acceptance and positive perceptions by other ED staff (Lefmann and

Sheppard, 2014; de Gruchy et al., 2015; Fruth and Wiley, 2016; Barrett and Terry, 2018; Ferreira et al., 2018; Matifat et al., 2021).

Healthcare systems often draw from a biomedical model of care (Eisenberg, 2012; Rosewilliam, 2016) which matches biological and physical failing in the body with appropriate biomedical solutions (Rocca and Anjum, 2020). 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 musculoskeletal 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 (Engle et al., 2021).

4.2.3 Study aims

With the legitimacy of the emergency department physiotherapist role no longer in question (Lefmann and Crane, 2016), more nuanced knowledge on how ED physiotherapists perceive person-centred practices in such a service-centric and biomedical-oriented ‘macrosystem’ (Jesus et al., 2022) remain unexplored terrain. Fundamental tensions between standardisation of condition management (EBP) versus person-centredness (Engle et al., 2021) aside, the ‘structure’ of ED at a system and organisational level might be such that it prioritises ways of working other than person-centred (Jesus et al., 2022; Kayes, 2023). 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 (American Physical Therapy Association, 2018; Chartered Society of Physiotherapy, 2019; Physiotherapy Board of New Zealand, 2020). 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.

4.3 Methods

4.3.1 Study design

The study was the second of a three-phase PhD exploration of person-centredness: the first being a qualitative systematic review of musculoskeletal physiotherapist and patient views on person-centred practice (Naylor et al., 2023) and the last an ED patient-facing qualitative study (Naylor et al., 2024b). The researcher 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 (Dewey, 1958). 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 (Cresswell and Plano Clark, 2011) (Figure 4.1). 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 (see appendix 1) to ensure methodological rigour of the qualitative interview data collection methods (Tong et al., 2007).

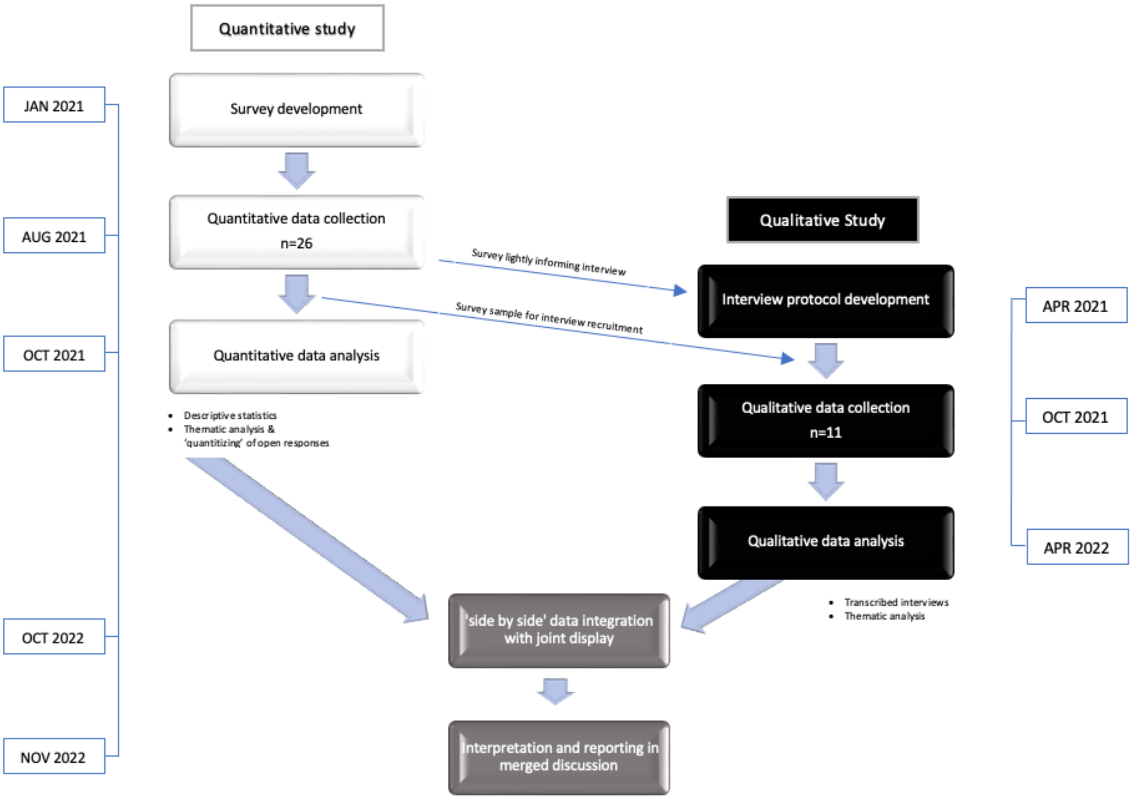


Figure 4.1 Procedural diagram of the convergent mixed method design used for this study.

4.3.2 Participant recruitment

Following university ethics board approval (REF FHS327 – see appendix 2), 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 (see appendix 3) 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 musculoskeletal 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 (Crouse and Lowe, 2018). At the end of the survey there was an optional link to participate in a follow up interview.

4.3.3 Data collection

4.3.3.1 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* (Killingback et al., 2022b). 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 and 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. (see full survey - appendix 6).

4.3.3.2 Interviews

A semi-structured interview guide (see appendix 7) 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 (Cresswell and Plano Clark, 2011). 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 (Malterud et al., 2016), with consideration of each of this model's 'continuum' dimensions. The broad study aims, and multi-case analysis approach pointed toward 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 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 generation of analytical ideas, suggested a sample of around 10 would be sufficient. A final judgement was made after the eleventh interview that sufficient data was collected for an analysis that could deliver on study aims.

4.3.4 Data analysis

Analyses of survey and interview data were initially carried out as independent processes as per simple parallel/convergent mixed method design (Cresswell and Plano Clark, 2011) prior to merged analyses in the discussion via joint display of data sets.

4.3.4.1 Survey

Quantitative survey data were presented through descriptive summary statistics by the main researcher (JN). Qualitative survey data were thematically coded (JN) and ‘quantitised’ by frequency of dichotomous response (i.e., response matching a category or not) (Nzabonimpa, 2018). ‘Quantitisation’ here allowed for merger and comparison of different data sources during explanatory analyses (Sandelowski et al., 2009).

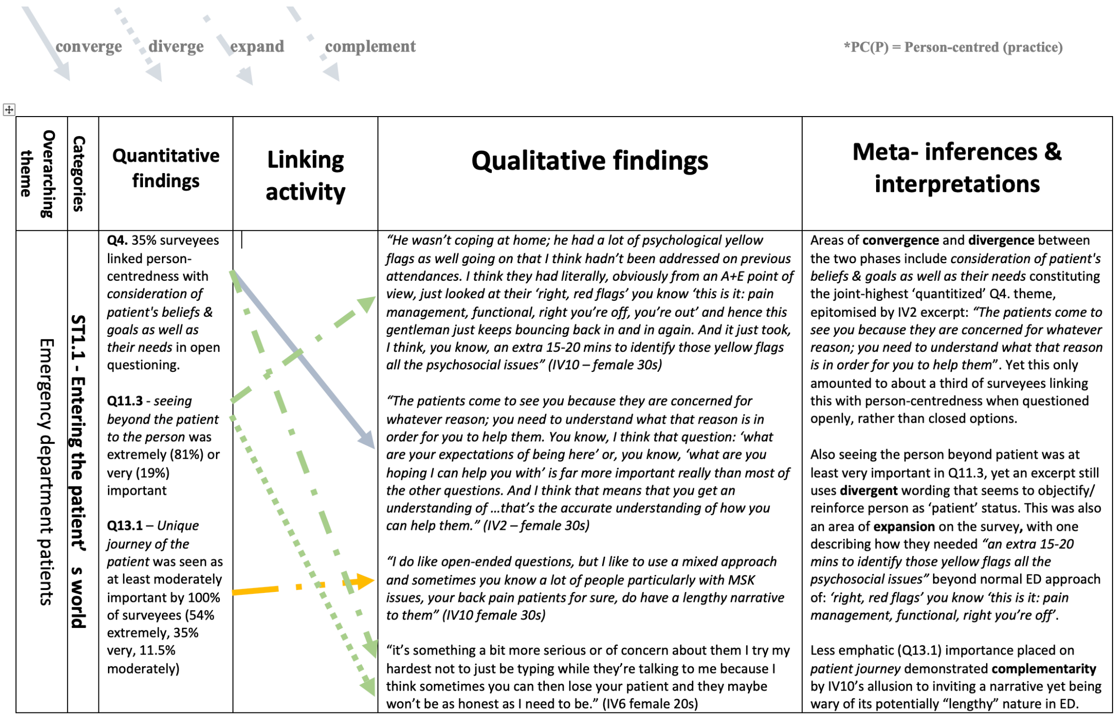
4.3.4.2 Interviews

Analysis followed the six stages of reflexive thematic analysis (RTA) of Braun and Clarke (2019; 2021) 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 the researcher’s lead supervisor (CK) with close involvement of both PhD supervisors (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 (Braun and Clarke, 2021). 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 eleven 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.

4.3.4.3 Joint analysis

The main ‘mixing’ of analysis occurred within the discussion, bringing the survey and interview findings together as per a parallel convergent mixed method design (Cresswell and Plano Clark, 2011). 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 (2022) (see appendix 12) (Figure 4.2)



*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 IV2 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 4.2 Excerpt of joint display

4.3.5 Researcher position statement

The main researcher (JN) is a middle-aged, white, British male senior musculoskeletal 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.

4.4 Results

4.4.1 Quantitative survey results

4.4.1.1 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 department, or equivalent centre, and managing a caseload of patients at the point of first contact (Table 4.1).

Table 4.1 Proportion and frequency of participant demographics for survey and interviews of UK ED physiotherapists

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)	-

4.4.1.1.1 Experience and academic attainment

92% 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).

4.4.1.1.2 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 and Southwest), plus one each from Wales and Northern Ireland, with Scotland alone unrepresented in this UK data sample.

4.4.1.2 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 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) (Table 4.2).

Table 4.2 Frequency of responses from quantitisation of qualitative open question on PCP.

Regardless of formal definitions, what do you understand the terms patient or person centredness to mean?			
Themes (Delineated by *relative surveyed frequency: high/medium/low*)	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)

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 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) (Table 4.3).

Table 4.3 Frequency of responses from quantitisation of qualitative open question on barriers to PCP.

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 surveyed frequency: high/medium/low*)	Frequency count	No. of 26 surveyed	(%)
waiting time pressures and targets	28	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)

4.4.2 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 musculoskeletal management, physiotherapists here were seeing patients ranging from traumatic injuries, such as hip fractures, through to non-traumatic musculoskeletal conditions like low back pain.

Thematic analysis of the qualitative data from 11 interviewed participants (two males; nine females, 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 (Table 4.4).

Table 4.4 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

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 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 in 30s with 0-5 years' experience 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 in 30s with 6-10 years' experience 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 in 30s with 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 in 30s with 0-5 years' experience 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 in 30s with 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 in 40s with 6-10 years' experience 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 in 30s with 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 in 30s with 0-5 years’ experience 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 in 30s with 0-5 years' experience *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 in 30s with 0-5 years' experience 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 in 30s with 0-5 years' experience 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 in 30s with 0-5 years' experience 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 in 20s with 0-5 years' experience 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 in 20s with 0-5 years’ experience 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 in 30s with 11-15 years’ experience 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 in 30s with 6-10 years' experience in ED)*.

Secondly, the checklist-type screening expected of, and by, non-physiotherapy colleagues drew 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 in 30s with 6-10 years' experience 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 in 40s with 6-10 years' experience 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 patients 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 in 30s with 0-5 years' experience 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 in 30s with 0-5 years' experience 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 in 30s with 0-5 years' experience 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-hours 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 in 30s with 0-5 years' experience 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 in 30s with 6-10 years' experience 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 in 30s with 6-10 years' experience 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 in 20s with 0-5 years' experience in ED

4.4.3 Results from joint analysis of survey and interview data

The purpose of this section is to highlight to the reader how joint display was applied in the context of this study. This will be done by presenting excerpts of the joint display table alongside a narrative summary of the interpretation. For ease of reporting, the presentation will follow convergence, complementarity, expansion, and diversion in the data set.

The merged analysis was achieved using the qualitative themes/subthemes as headings with cross tabulation of relevant quantitative survey findings and exemplar quotes within a joint display (Skamagki et al., 2022). A checklist was employed to ensure all subthemes were representing and ultimately cross-analysed with the survey questions allowing for a full joint display (see checklist – appendix 9). 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.

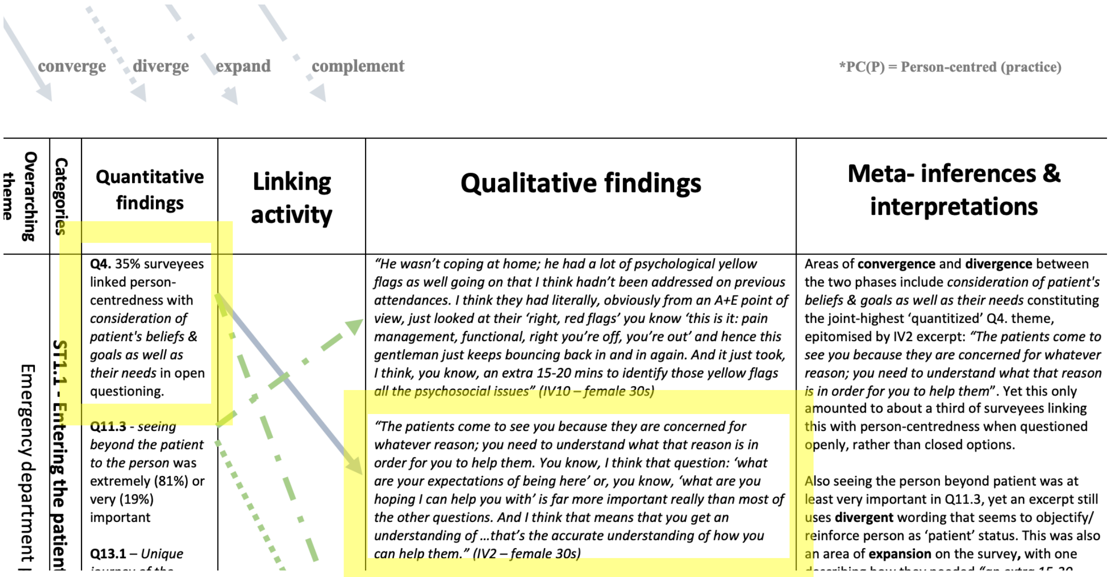
4.4.3.1 Narrative discussion of the joint display

While the full joint display is available in the appendix (appendix 8) some meta-inferences are now presented in narrative form, according to their linkage 'type'.

Convergence in data sets

Convergence, also referred to as confirmation or concordance, according to Fetters (2020), represents an interpretation where two sources of data essentially confirm each other. Convergence was by far the most prevalent linkage here. This is to be expected considering that the interviews amounted to a deeper dive, based on open questioning, from a survey based on closed questioning (in all but two questions which were, themselves, ultimately quantitised) of the same study population.

Beneath the ‘ED patients’ theme, within the first subtheme ‘entering the patient’s world’ (Figure 4.3), convergence was in evidence between the highest quantitised survey response about PCP meaning: *consideration of patient’s beliefs and goals as well as their needs,* and exemplar quote: “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” *(Participant #2)*.

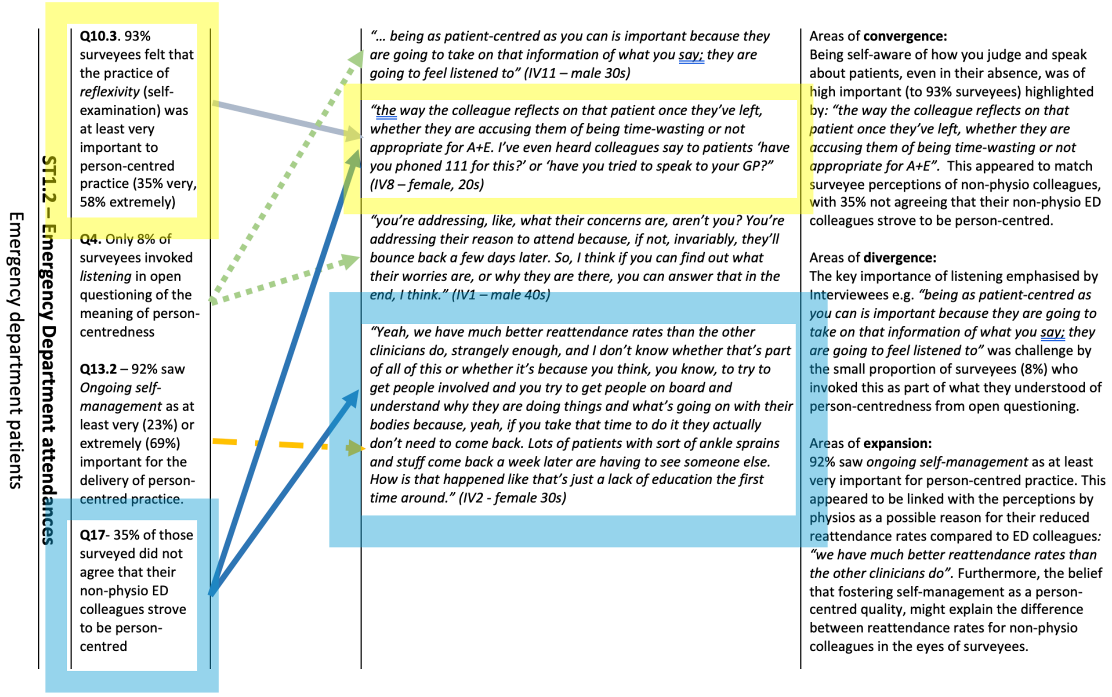


*PC(P) = Person-centred (practice)

Overarching theme	Categories	Quantitative findings	Linking activity	Qualitative findings	Meta- inferences & interpretations
Emergency department	ST1.1 - Entering the patien	**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*		*“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)*	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 IV2 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

Figure 4.3 Joint display excerpt ST1.1 - entering the patient's world

For the second subtheme ‘ED attendances’ (Figure 4.4), too, being self-aware on how you judge and speak about patients, even in their absence, was rated as being of high importance (to 93% surveyed) which matched with negative allusions to “the way the colleague reflects on that patient once they’ve left, whether they are accusing them of being time-wasting or not appropriate for A+E” *(Participant #8)*. The former quote, alongside “if you take that time to do it, they actually don’t need to come back. Lots of patients…come back a week later are having to see someone else” *(Participant #2)* also converged with survey perceptions about non-physio colleagues, with around a third surveyed disagreeing that they (non-physio ED colleagues) strove to be person-centred.



Emergency department patients

ST1.2 – Emergency Department attendances

Q10.3. 93% surveyees felt that the practice of *reflexivity* (self-examination) was at least very important to person-centred practice (35% very, 58% extremely)

Q4. Only 8% of surveyees invoked *listening* in open questioning of the meaning of person-centredness

Q13.2 – 92% saw *Ongoing self-management* as at least very (23%) or extremely (69%) important for the delivery of person-centred practice.

Q17- 35% of those surveyed did not agree that their non-physio ED colleagues strove to be person-centred

"… 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" (IV11 – male 30s)

"the way the colleague reflects on that patient once they've left, whether they are accusing them of being time-wasting or not appropriate for A+E. I've even heard colleagues say to patients 'have you phoned 111 for this?' or 'have you tried to speak to your GP?" (IV8 – female, 20s)

"you're addressing, like, what their concerns are, aren't you? 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." (IV1 – male 40s)

"Yeah, we have much better reattendance rates than the other clinicians do, strangely enough, and I don't know whether that's part of all of this or whether it's because you think, you know, to try to get people involved and you try to get people on board and understand why they are doing things and what's going on with their bodies because, yeah, if you take that time to do it they actually don't need to come back. Lots of patients with sort of ankle sprains and stuff come back a week later are having to see someone else. How is that happened like that's just a lack of education the first time around." (IV2 - female 30s)

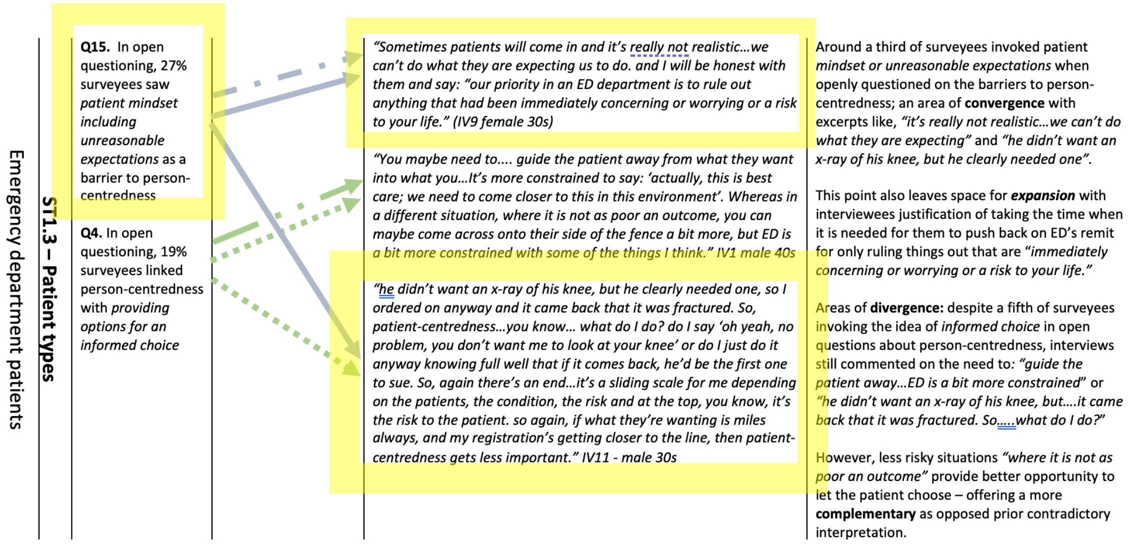
Areas of **convergence:**
Being self-aware of how you judge and speak about patients, even in their absence, was of high important (to 93% surveyees) highlighted by: *"the way the colleague reflects on that patient once they've left, whether they are accusing them of being time-wasting or not appropriate for A+E"*. This appeared to match surveyee perceptions of non-physio colleagues, with 35% not agreeing that their non-physio ED colleagues strove to be person-centred.

Areas of **divergence:**
The key importance of listening emphasised by Interviewees e.g. *"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"* was challenge by the small proportion of surveyees (8%) who invoked this as part of what they understood of person-centredness from open questioning.

Areas of **expansion:**
92% saw *ongoing self-management* as at least very important for person-centred practice. This appeared to be linked with the perceptions by physios as a possible reason for their reduced reattendance rates compared to ED colleagues*: "we have much better reattendance rates than the other clinicians do"*. Furthermore, the belief that fostering self-management as a person-centred quality, might explain the difference between reattendance rates for non-physio colleagues in the eyes of surveyees.

Figure 4.4 Joint display excerpt ST1.2 ED attendances

For the third subtheme 'patient types' (Figure 4.5), around a third of participants invoked a patient mindset or unreasonable expectations when openly questioned on the barriers to person-centredness; an area of convergence with excerpts like, "it's really not realistic…we can't do what they are expecting" *(Participant #9)* and "he didn't want an x-ray of his knee, but he clearly needed one" *(Participant #11)*.



Emergency department patients

ST1.3 – Patient types

Q15. In open questioning, 27% surveyees saw *patient mindset including unreasonable expectations* as a barrier to person-centredness

Q4. In open questioning, 19% surveyees linked person-centredness with *providing options for an informed choice*

"Sometimes patients will come in and it's really not realistic…we can't do what they are expecting us to do. and I will be honest with them and say: "our priority in an ED department is to rule out anything that had been immediately concerning or worrying or a risk to your life." (IV9 female 30s)

"You maybe need to…. guide the patient away from what they want into what you…It's more constrained to say: 'actually, this is best care; we need to come closer to this in this environment'. Whereas in a different situation, where it is not as poor an outcome, you can maybe come across onto their side of the fence a bit more, but ED is a bit more constrained with some of the things I think." IV1 male 40s

"he didn't want an x-ray of his knee, but he clearly needed one, so I ordered on anyway and it came back that it was fractured. So, patient-centredness…you know… what do I do? do I say 'oh yeah, no problem, you don't want me to look at your knee' or do I just do it anyway knowing full well that if it comes back, he'd be the first one to sue. So, again there's an end…it's a sliding scale for me depending on the patients, the condition, the risk and at the top, you know, it's the risk to the patient. so again, if what they're wanting is miles always, and my registration's getting closer to the line, then patient-centredness gets less important." IV11 - male 30s

Around a third of surveyees invoked patient *mindset or unreasonable expectations* when openly questioned on the barriers to person-centredness; an area of **convergence** with excerpts like, *"it's really not realistic…we can't do what they are expecting"* and *"he didn't want an x-ray of his knee, but he clearly needed one"*.

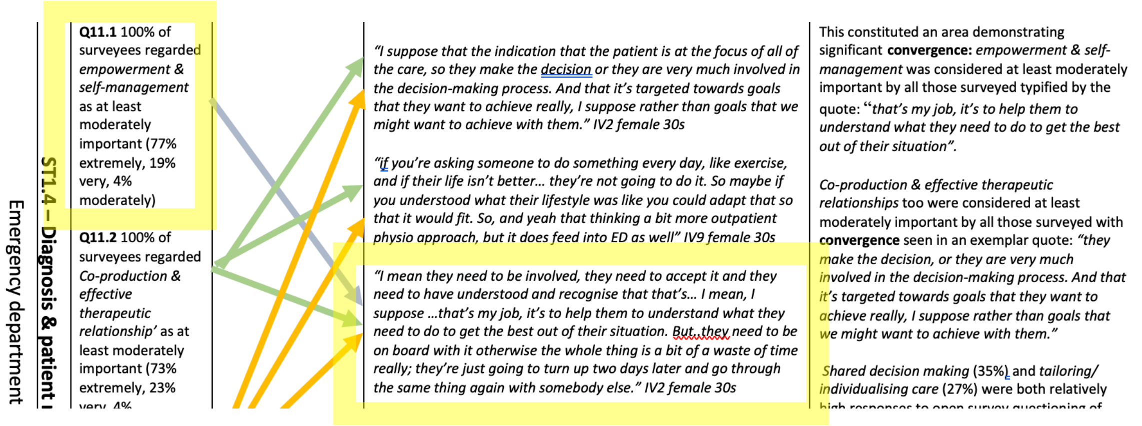
This point also leaves space for ***expansion*** with interviewees justification of taking the time when it is needed for them to push back on ED's remit for only ruling things out that are *"immediately concerning or worrying or a risk to your life."*

Areas of **divergence:** despite a fifth of surveyees invoking the idea of *informed choice* in open questions about person-centredness, interviews still commented on the need to*: "guide the patient away…ED is a bit more constrained*" or *"he didn't want an x-ray of his knee, but….it came back that it was fractured. So…..what do I do?"*

However, less risky situations *"where it is not as poor an outcome"* provide better opportunity to let the patient choose – offering a more **complementary** as opposed prior contradictory interpretation.

Figure 4.5 Joint display excerpt ST1.3 patient types

The final 'ED patient' subtheme 'diagnosis and patient management' (Figure 4.6), converged empowerment and self-management as being (at least moderately) important with comments like "that's my job, it's to help them to understand what they need to do to get the best out of their situation" *(Participant #2)*.


Emergency department

ST1.4 – Diagnosis & patient

Q11.1 100% of surveyees regarded *empowerment & self-management* as at least moderately important (77% extremely, 19% very, 4% moderately)

Q11.2 100% of surveyees regarded *Co-production & effective therapeutic relationship'* as at least moderately important (73% extremely, 23% very, 4%

"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." IV2 female 30s

"if you're asking someone to do something every day, like exercise, and if their life isn't better… they're not going to do it. So maybe if you understood what their lifestyle was like you could adapt that so that it would fit. So, and yeah that thinking a bit more outpatient physio approach, but it does feed into ED as well" IV9 female 30s

"I mean they need to be involved, they need to accept it and they need to have understood and recognise that that's… I mean, I suppose …that's my job, it's to help them to understand what they need to do to get the best out of their situation. But..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." IV2 female 30s

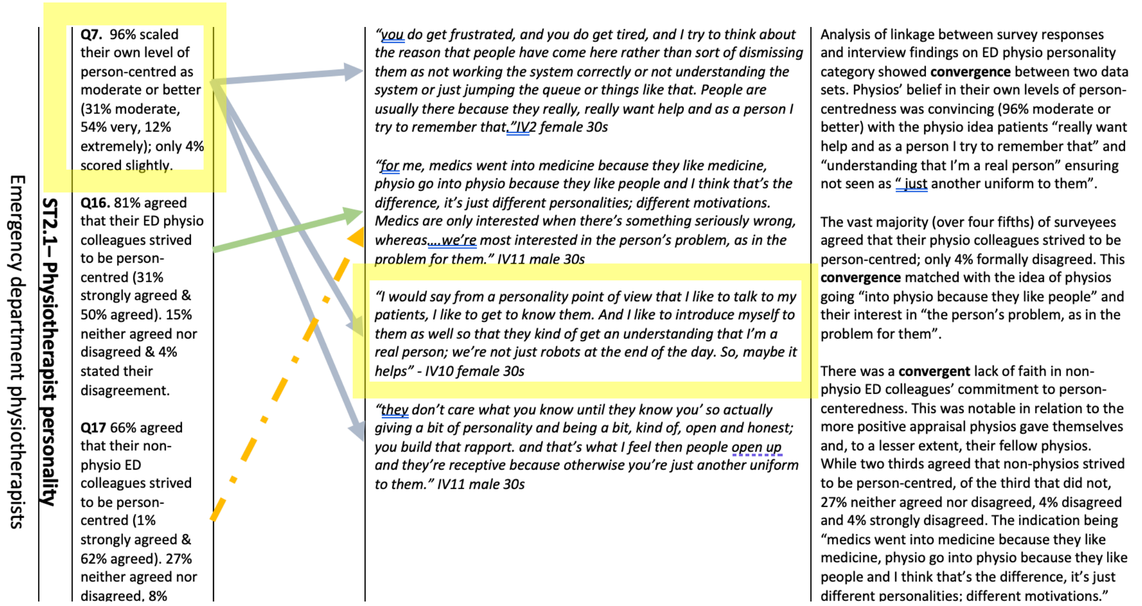
This constituted an area demonstrating significant **convergence:** *empowerment & self-management* was considered at least moderately important by all those surveyed typified by the quote: "*that's my job, it's to help them to understand what they need to do to get the best out of their situation".*

Co-production & effective therapeutic relationships too were considered at least moderately important by all those surveyed with **convergence** seen in an exemplar quote: *"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."*

Shared decision making (35%), and *tailoring/ individualising care* (27%) were both relatively high responses to open survey questioning of

Figure 4.6 Joint display excerpt ST1.4 diagnosis and patient management

Under the 'ED physiotherapists' overarching theme, for the first subtheme 'physiotherapist personality' (Figure 4.7), 96% scaled their own PCP as moderate or greater, converging with quotes like "I would say from a personality point of view….I like to introduce myself to them as well so that they kind of get an understanding that I'm a real person; we're not just robots at the end of the day" *(Participant #10)*.


Emergency department physiotherapists

ST2.1– Physiotherapist personality

Q7. 96% scaled their own level of person-centred as moderate or better (31% moderate, 54% very, 12% extremely); only 4% scored slightly.

Q16. 81% agreed that their ED physio colleagues strived to be person-centred (31% strongly agreed & 50% agreed). 15% neither agreed nor disagreed & 4% stated their disagreement.

Q17 66% agreed that their non-physio ED colleagues strived to be person-centred (1% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 8%

"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."IV2 female 30s

"for me, medics went into medicine because they like medicine, physio go into physio because they like people and I think that's the difference, it's just different personalities; different motivations. Medics are only interested when there's something seriously wrong, whereas….we're most interested in the person's problem, as in the problem for them." IV11 male 30s

"I would say from a personality point of view that I like to talk to my patients, I like to get to know them. And I like to introduce myself to them as well so that they kind of get an understanding that I'm a real person; we're not just robots at the end of the day. So, maybe it helps" - IV10 female 30s

"they don't care what you know until they know you' so actually giving a bit of personality and being a bit, kind of, open and honest; you build that rapport. and that's what I feel then people open up and they're receptive because otherwise you're just another uniform to them." IV11 male 30s

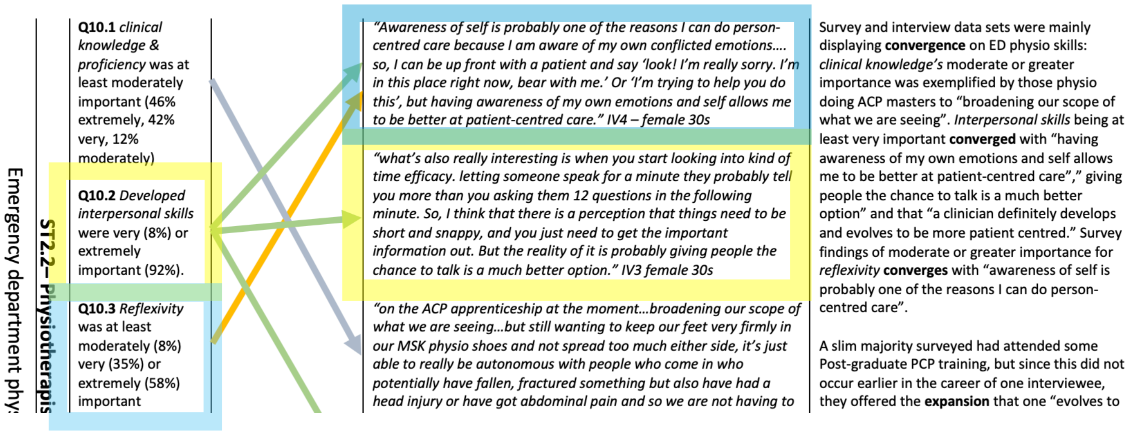
Analysis of linkage between survey responses and interview findings on ED physio personality category showed **convergence** between two data sets. Physios' belief in their own levels of person-centredness was convincing (96% moderate or better) with the physio idea patients "really want help and as a person I try to remember that" and "understanding that I'm a real person" ensuring not seen as " just another uniform to them".

The vast majority (over four fifths) of surveyees agreed that their physio colleagues strived to be person-centred; only 4% formally disagreed. This **convergence** matched with the idea of physios going "into physio because they like people" and their interest in "the person's problem, as in the problem for them".

There was a **convergent** lack of faith in non-physio ED colleagues' commitment to person-centeredness. This was notable in relation to the more positive appraisal physios gave themselves and, to a lesser extent, their fellow physios. While two thirds agreed that non-physios strived to be person-centred, of the third that did not, 27% neither agreed nor disagreed, 4% disagreed and 4% strongly disagreed. The indication being "medics went into medicine because they like medicine, physio go into physio because they like people and I think that's the difference, it's just different personalities; different motivations."

Figure 4.7 Joint display excerpt ST2.1 physiotherapist personality

Under the second subtheme 'physiotherapist skills' (Figure 4.8), developed interpersonal skills were at least very, but mostly extremely important (92%) indicating convergence with awareness and ability for "letting someone speak for a minute [and] they probably tell you more than you asking them 12 questions in the following minute." *(Participant #3)*. Also, reflexivity being at least moderate importance converges with "…having awareness of my own emotions and self allows me to be better at patient-centred care." *(Participant #4)*.



Q10.1 *clinical knowledge & proficiency* was at least moderately important (46% extremely, 42% very, 12% moderately)

Q10.2 *Developed interpersonal skills* were very (8%) or extremely important (92%).

Q10.3 *Reflexivity* was at least moderately (8%) very (35%) or extremely (58%) important

"Awareness of self is probably one of the reasons I can do person-centred care because I am aware of my own conflicted emotions.... so, I can be up front with a patient and say 'look! I'm really sorry. I'm in this place right now, bear with me.' Or 'I'm trying to help you do this', but having awareness of my own emotions and self allows me to be better at patient-centred care." IV4 – female 30s

"what's also really interesting is when you start looking into kind of time efficacy. 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." IV3 female 30s

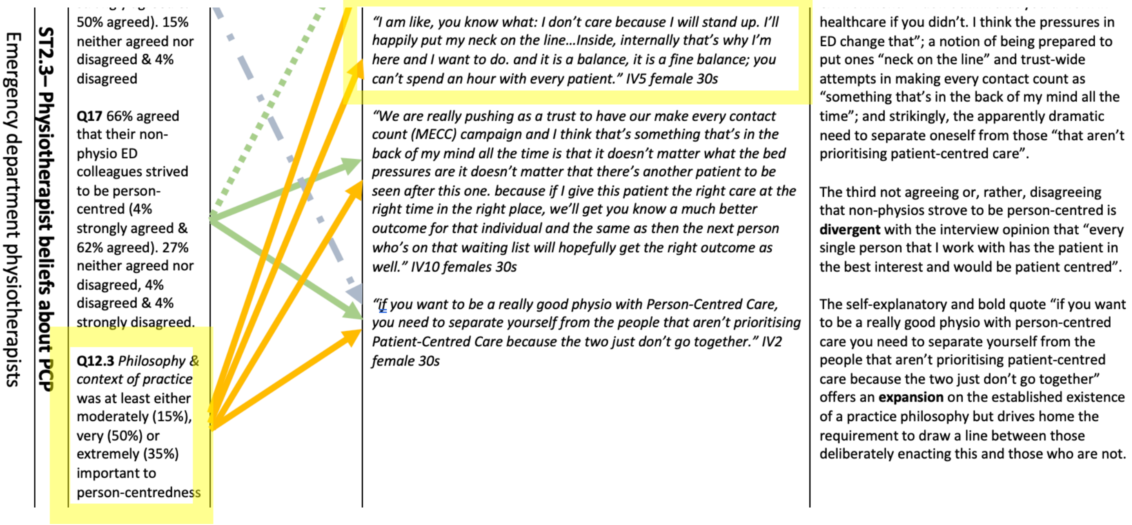
"on the ACP apprenticeship at the moment...broadening our scope of what we are seeing...but still wanting to keep our feet very firmly in our MSK physio shoes and not spread too much either side, it's just able to really be autonomous with people who come in who potentially have fallen, fractured something but also have had a head injury or have got abdominal pain and so we are not having to

Survey and interview data sets were mainly displaying **convergence** on ED physio skills: *clinical knowledge's* moderate or greater importance was exemplified by those physio doing ACP masters to "broadening our scope of what we are seeing". *Interpersonal skills* being at least very important **converged** with "having awareness of my own emotions and self allows me to be better at patient-centred care"," giving people the chance to talk is a much better option" and that "a clinician definitely develops and evolves to be more patient centred." Survey findings of moderate or greater importance for *reflexivity* **converges** with "awareness of self is probably one of the reasons I can do person-centred care".

A slim majority surveyed had attended some Post-graduate PCP training, but since this did not occur earlier in the career of one interviewee, they offered the **expansion** that one "evolves to

Figure 4.8 Joint display excerpt ST2.2 physiotherapist skills

For the final 'ED physiotherapist' subtheme 'physiotherapist beliefs about PCP' (Figure 4.9), philosophy and context of practice were at least moderately important to person-centredness which converges with "...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)*.



50% agreed). 15% neither agreed nor disagreed & 4% disagreed

Q17 66% agreed that their non-physio ED colleagues strived to be person-centred (4% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 4% disagreed & 4% strongly disagreed.

Q12.3 *Philosophy & context of practice* was at least either moderately (15%), very (50%) or extremely (35%) important to person-centredness

"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." IV5 female 30s

"We are really pushing as a trust to have our make every contact count (MECC) campaign and I think that's something that's in the back of my mind all the time is that it doesn't matter what the bed pressures are it doesn't matter that there's another patient to be seen after this one. because if I give this patient the right care at the right time in the right place, we'll get you know a much better outcome for that individual and the same as then the next person who's on that waiting list will hopefully get the right outcome as well." IV10 females 30s

"if you want to be a really good physio with Person-Centred Care, you need to separate yourself from the people that aren't prioritising Patient-Centred Care because the two just don't go together." IV2 female 30s

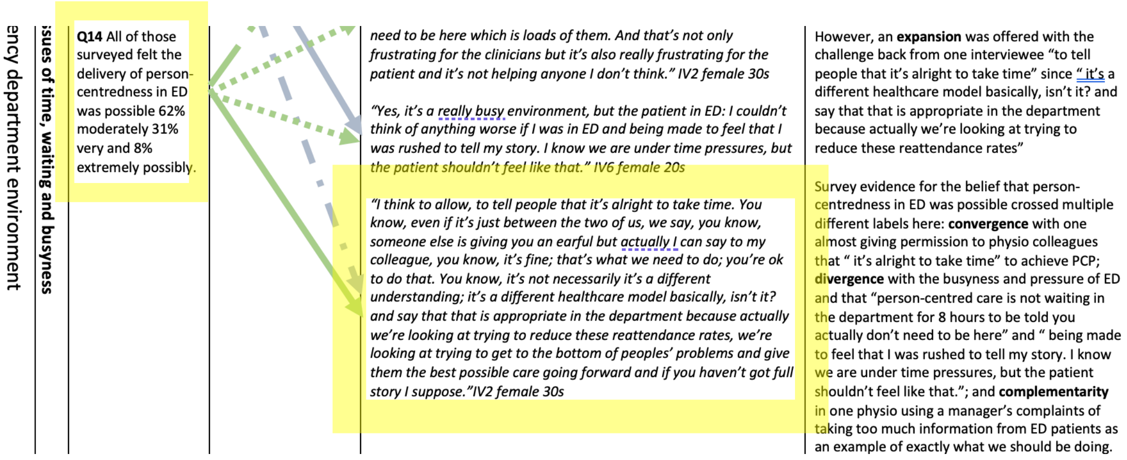
healthcare if you didn't. I think the pressures in ED change that"; a notion of being prepared to put ones "neck on the line" and trust-wide attempts in making every contact count as "something that's in the back of my mind all the time"; and strikingly, the apparently dramatic need to separate oneself from those "that aren't prioritising patient-centred care".

The third not agreeing or, rather, disagreeing that non-physios strove to be person-centred is **divergent** with the interview opinion that "every single person that I work with has the patient in the best interest and would be patient centred".

The self-explanatory and bold quote "if you want to be a really good physio with person-centred care you need to separate yourself from the people that aren't prioritising patient-centred care because the two just don't go together" offers an **expansion** on the established existence of a practice philosophy but drives home the requirement to draw a line between those deliberately enacting this and those who are not.

Figure 4.9 Joint display excerpt ST2.3 physiotherapist beliefs about PCP

Under the 'ED environment' subtheme, 'issues of time, waiting and busyness' (Figure 4.10), all of those surveyed felt the delivery of person-centredness in ED was at least moderately possible which converged with "I think to allow, to tell people that it's alright to take time... it's a different understanding; it's a different healthcare model basically, isn't it?... we're looking at trying to reduce these reattendance rates, we're looking at trying to get to the bottom of peoples' problems and give them the best possible care going forward and if you haven't got full story I suppose." *(Participant* #2).



ency department environment

sues of time, waiting and busyness

Q14 All of those surveyed felt the delivery of person-centredness in ED was possible 62% moderately 31% very and 8% extremely possibly.

need to be here which is loads of them. And that's not only frustrating for the clinicians but it's also really frustrating for the patient and it's not helping anyone I don't think." IV2 female 30s

"Yes, it's a really busy environment, but the patient in ED: I couldn't think of anything worse if I was in ED and being made to feel that I was rushed to tell my story. I know we are under time pressures, but the patient shouldn't feel like that." IV6 female 20s

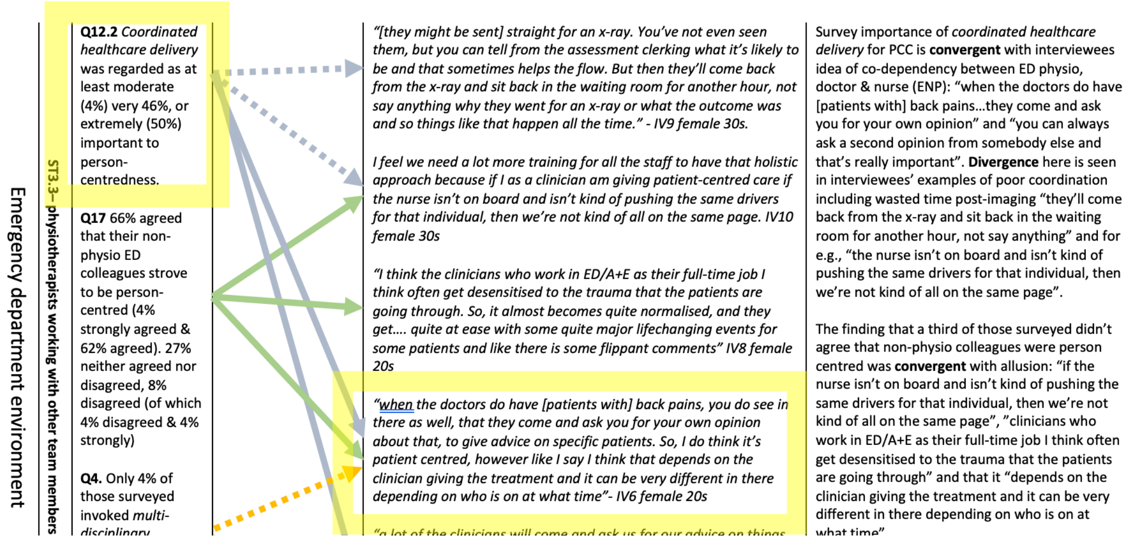
"I think to allow, to tell people that it's alright to take time. You know, even if it's just between the two of us, we say, you know, someone else is giving you an earful but actually I can say to my colleague, you know, it's fine; that's what we need to do; you're ok to do that. You know, it's not necessarily it's a different understanding; it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates, we're looking at trying to get to the bottom of peoples' problems and give them the best possible care going forward and if you haven't got full story I suppose."IV2 female 30s

However, an **expansion** was offered with the challenge back from one interviewee "to tell people that it's alright to take time" since " it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates"

Survey evidence for the belief that person-centredness in ED was possible crossed multiple different labels here: **convergence** with one almost giving permission to physio colleagues that " it's alright to take time" to achieve PCP; **divergence** with the busyness and pressure of ED and that "person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here" and " being made to feel that I was rushed to tell my story. I know we are under time pressures, but the patient shouldn't feel that."; and **complementarity** in one physio using a manager's complaints of taking too much information from ED patients as an example of exactly what we should be doing.

Figure 4.10 Joint display excerpt ST3.2 issues of time, waiting and busyness

For the final example of convergence, in the 'ED environment' subtheme, 'physiotherapists working with other team members' (Figure 4.11), coordinated healthcare delivery's being of, at least, moderate importance to PCP demonstrated a convergence with, "when the doctors do have [patients with] back pains…they come and ask you for your own opinion about that, to give advice on specific patients. So, I do think it's patient-centred" *(Participant* #6).



Emergency department environment

ST3.3– physiotherapists working with other team members

Q12.2 *Coordinated healthcare delivery* was regarded as at least moderate (4%) very 46%, or extremely (50%) important to person-centredness.

Q17 66% agreed that their non-physio ED colleagues strove to be person-centred (4% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 8% disagreed (of which 4% disagreed & 4% strongly)

Q4. Only 4% of those surveyed invoked *multi-disciplinary*

"[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." - IV9 female 30s.

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. IV10 female 30s

"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" IV8 female 20s

"when the doctors do have [patients with] back pains, you do see in there as well, that they come and ask you for your own opinion about that, to give advice on specific patients. So, I do think it's patient centred, however like I say I think that depends on the clinician giving the treatment and it can be very different in there depending on who is on at what time"- IV6 female 20s

"a lot of the clinicians will come and ask us for our advice on things

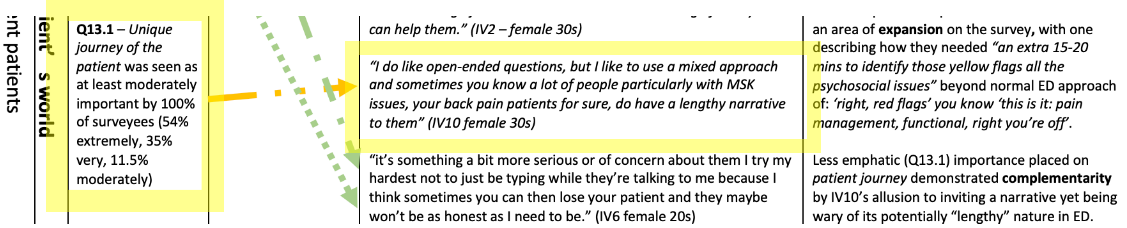
Survey importance of *coordinated healthcare delivery* for PCC is **convergent** with interviewees idea of co-dependency between ED physio, doctor & nurse (ENP): "when the doctors do have [patients with] back pains…they come and ask you for your own opinion" and "you can always ask a second opinion from somebody else and that's really important". **Divergence** here is seen in interviewees' examples of poor coordination including wasted time post-imaging "they'll come back from the x-ray and sit back in the waiting room for another hour, not say anything" and for e.g., "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".

The finding that a third of those surveyed didn't agree that non-physio colleagues were person centred was **convergent** with allusion: "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", "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" and that it "depends on the clinician giving the treatment and it can be very different in there depending on who is on at what time"

Figure 4.11 Joint Display ST3.3 physiotherapists working with other team members

Complementarity in data sets

Complementarity is where two sources illustrate different, non-conflicting interpretations. This was evident in subtheme 1.1 'entering the patient's world' (Figure 4.12) where all surveyed recorded the 'unique journey of the patient' as at least moderately important, which linked to the rather ambivalent quote "I do like open-ended questions, but I like to use a mixed approach and sometimes you know a lot of people particularly with musculoskeletal issues, your back pain patients for sure, do have a lengthy narrative to them" (*participant #10*), suggesting being both *for* and *against* this narrative approach, depending on the patient.



nt patients

ient' s world

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)

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)

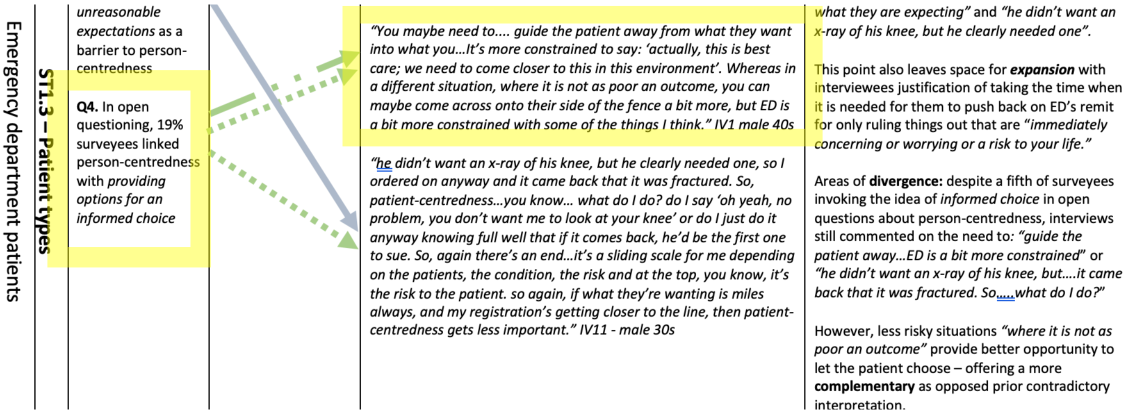
"it's something a bit more serious or of concern about them I try my hardest not to just be typing while they're talking to me because I think sometimes you can then lose your patient and they maybe won't be as honest as I need to be." (IV6 female 20s)

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 4.12 Joint display excerpt ST1.1 entering the patient's world

A similar circumspection was present with subtheme 1.3 'patient types' (Figure 4.13), where open questioning revealed mid-level linkage (i.e., raised by around a fifth of all survey respondents) between person-centredness and providing options for an informed choice, yet participant quotes implied that it was more a case of negotiated settlement than informed choice*, per se*, with the following example, "You maybe need to.... guide the patient away from what they want into what you...It's more constrained to say: 'actually, this is best care; we need to come closer to this in this environment'. Whereas in a different situation, where it is not as poor an outcome, you can maybe come across onto their side of the fence a bit more, but ED is a bit more constrained with some of the things I think" (*participant #1*).



Emergency department patients

ST1.3 – Patient types

unreasonable expectations as a barrier to person-centredness

Q4. In open questioning, 19% surveyees linked person-centredness with *providing options for an informed choice*

"You maybe need to.... guide the patient away from what they want into what you...It's more constrained to say: 'actually, this is best care; we need to come closer to this in this environment'. Whereas in a different situation, where it is not as poor an outcome, you can maybe come across onto their side of the fence a bit more, but ED is a bit more constrained with some of the things I think." IV1 male 40s

"he didn't want an x-ray of his knee, but he clearly needed one, so I ordered on anyway and it came back that it was fractured. So, patient-centredness...you know... what do I do? do I say 'oh yeah, no problem, you don't want me to look at your knee' or do I just do it anyway knowing full well that if it comes back, he'd be the first one to sue. So, again there's an end...it's a sliding scale for me depending on the patients, the condition, the risk and at the top, you know, it's the risk to the patient. so again, if what they're wanting is miles always, and my registration's getting closer to the line, then patient-centredness gets less important." IV11 - male 30s

what they are expecting" and *"he didn't want an x-ray of his knee, but he clearly needed one"*.

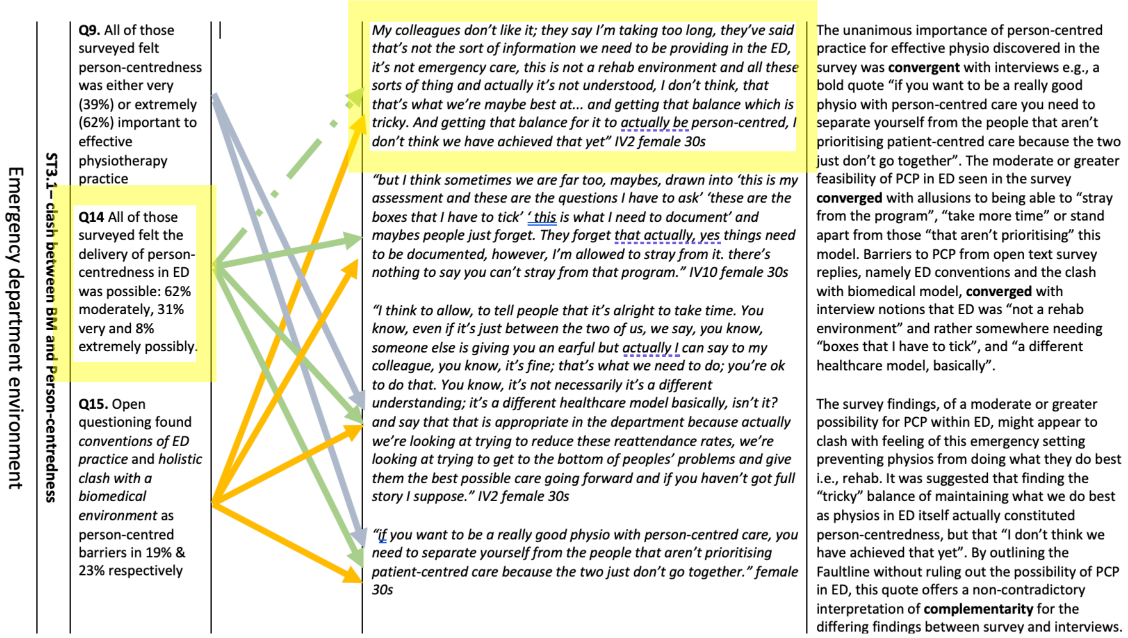
This point also leaves space for ***expansion*** with interviewees justification of taking the time when it is needed for them to push back on ED's remit for only ruling things out that are "*immediately concerning or worrying or a risk to your life."*

Areas of **divergence:** despite a fifth of surveyees invoking the idea of *informed choice* in open questions about person-centredness, interviews still commented on the need to*: "guide the patient away...ED is a bit more constrained"* or *"he didn't want an x-ray of his knee, but....it came back that it was fractured. So.....what do I do?"*

However, less risky situations *"where it is not as poor an outcome"* provide better opportunity to let the patient choose – offering a more **complementary** as opposed prior contradictory interpretation.

Figure 4.13 Joint display excerpt ST1.3 patient types

In the ED environment subtheme (ST3.1) 'a clash between biomedicine and PCP' (Figure 4.14), complementarity was in play where all those surveyed felt the delivery of ED PCP was (at least moderately) possible, yet one participant once again sat on the fence with the quote that "my [non-physio] 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 things 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*).



Emergency department environment

ST3.1– clash between BM and Person-centredness

Q9. All of those surveyed felt person-centredness was either very (39%) or extremely (62%) important to effective physiotherapy practice

Q14 All of those surveyed felt the delivery of person-centredness in ED was possible: 62% moderately, 31% very and 8% extremely possibly.

Q15. Open questioning found *conventions of ED practice* and *holistic clash with a biomedical environment* as person-centred barriers in 19% & 23% respectively

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” IV2 female 30s

“but I think sometimes we are far too, maybes, 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 maybes 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.” IV10 female 30s

“I think to allow, to tell people that it’s alright to take time. You know, even if it’s just between the two of us, we say, you know, someone else is giving you an earful but actually I can say to my colleague, you know, it’s fine; that’s what we need to do; you’re ok to do that. You know, it’s not necessarily it’s a different understanding; it’s a different healthcare model basically, isn’t it? and say that that is appropriate in the department because actually we’re looking at trying to reduce these reattendance rates, we’re looking at trying to get to the bottom of peoples’ problems and give them the best possible care going forward and if you haven’t got full story I suppose.” IV2 female 30s

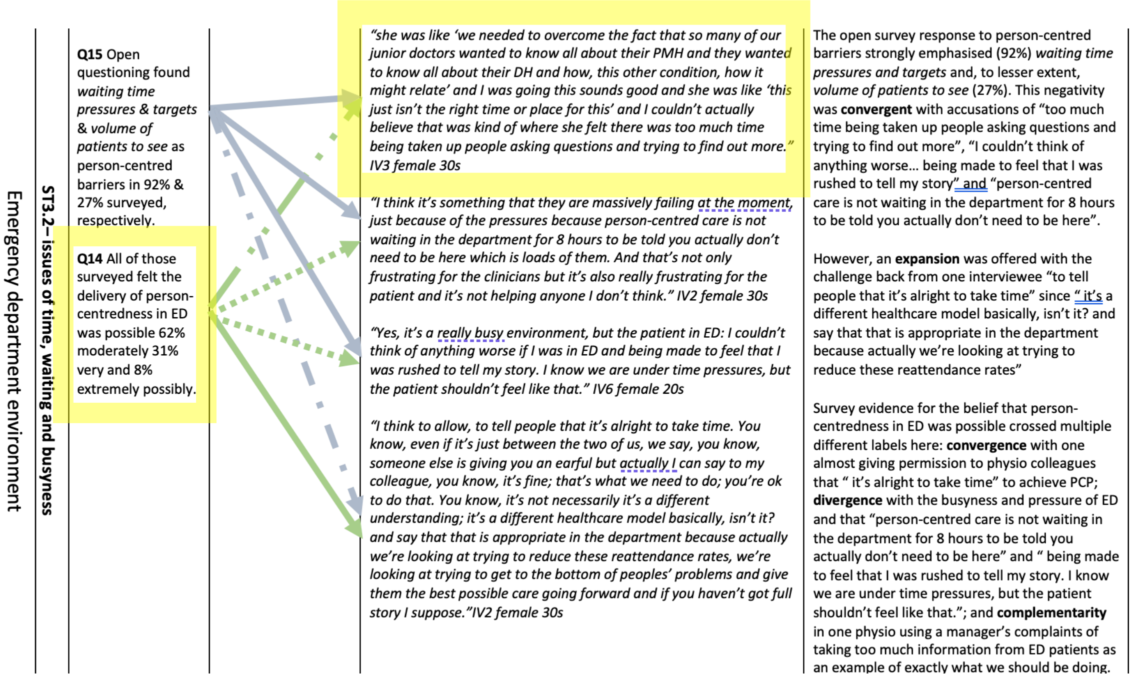
“if you want to be a really good physio with person-centred care, you need to separate yourself from the people that aren’t prioritising patient-centred care because the two just don’t go together.” female 30s

The unanimous importance of person-centred practice for effective physio discovered in the survey was **convergent** with interviews e.g., a bold quote “if you want to be a really good physio with person-centred care you need to separate yourself from the people that aren’t prioritising patient-centred care because the two just don’t go together”. The moderate or greater feasibility of PCP in ED seen in the survey **converged** with allusions to being able to “stray from the program”, “take more time” or stand apart from those “that aren’t prioritising” this model. Barriers to PCP from open text survey replies, namely ED conventions and the clash with biomedical model, **converged** with interview notions that ED was “not a rehab environment” and rather somewhere needing “boxes that I have to tick”, and “a different healthcare model, basically”.

The survey findings, of a moderate or greater possibility for PCP within ED, might appear to clash with feeling of this emergency setting preventing physios from doing what they do best i.e., rehab. It was suggested that finding the “tricky” balance of maintaining what we do best as physios in ED itself actually constituted person-centredness, but that “I don’t think we have achieved that yet”. By outlining the Faultline without ruling out the possibility of PCP in ED, this quote offers a non-contradictory interpretation of **complementarity** for the differing findings between survey and interviews.

Figure 4.14 Joint display excerpt ST3.1 a clash between biomedicine and PCP

A final example to complementarity appears on subtheme 3.2 ‘issues of time, waiting and busyness’ ED environment (Figure 4.15), where all those surveyed felt the delivery of ED PCP was (at least moderately) possible, yet one ED PCP proponent appeared to be swimming against the tide when reflecting on an ED manager’s stance that “‘we needed to overcome the fact that so many of our junior doctors wanted to know all about their PMH and they wanted to know all about their DH 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*).



Emergency department environment

ST3.2– issues of time, waiting and busyness

Q15 Open questioning found *waiting time pressures & targets & volume of patients to see* as person-centred barriers in 92% & 27% surveyed, respectively.

Q14 All of those surveyed felt the delivery of person-centredness in ED was possible 62% moderately 31% very and 8% extremely possibly.

"she was like 'we needed to overcome the fact that so many of our junior doctors wanted to know all about their PMH and they wanted to know all about their DH 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." IV3 female 30s

"I think it's something that they are massively failing at the moment, just because of the pressures because person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here which is loads of them. And that's not only frustrating for the clinicians but it's also really frustrating for the patient and it's not helping anyone I don't think." IV2 female 30s

"Yes, it's a really busy environment, but the patient in ED: I couldn't think of anything worse if I was in ED and being made to feel that I was rushed to tell my story. I know we are under time pressures, but the patient shouldn't feel like that." IV6 female 20s

"I think to allow, to tell people that it's alright to take time. You know, even if it's just between the two of us, we say, you know, someone else is giving you an earful but actually I can say to my colleague, you know, it's fine; that's what we need to do; you're ok to do that. You know, it's not necessarily it's a different understanding; it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates, we're looking at trying to get to the bottom of peoples' problems and give them the best possible care going forward and if you haven't got full story I suppose."IV2 female 30s

The open survey response to person-centred barriers strongly emphasised (92%) *waiting time pressures and targets* and, to lesser extent, *volume of patients to see* (27%). This negativity was **convergent** with accusations of "too much time being taken up people asking questions and trying to find out more", "I couldn't think of anything worse… being made to feel that I was rushed to tell my story" and "person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here".

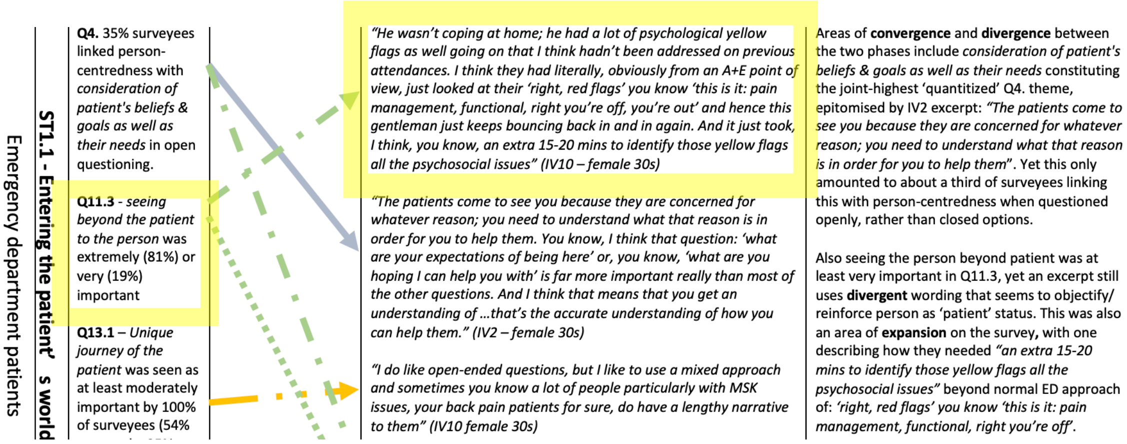
However, an **expansion** was offered with the challenge back from one interviewee "to tell people that it's alright to take time" since " it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates"

Survey evidence for the belief that person-centredness in ED was possible crossed multiple different labels here: **convergence** with one almost giving permission to physio colleagues that " it's alright to take time" to achieve PCP; **divergence** with the busyness and pressure of ED and that "person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here" and " being made to feel that I was rushed to tell my story. I know we are under time pressures, but the patient shouldn't feel like that."; and **complementarity** in one physio using a manager's complaints of taking too much information from ED patients as an example of exactly what we should be doing.

Figure 4.15 Joint display excerpt ST3.2 issues of time, waiting and busyness

Expansion in data sets

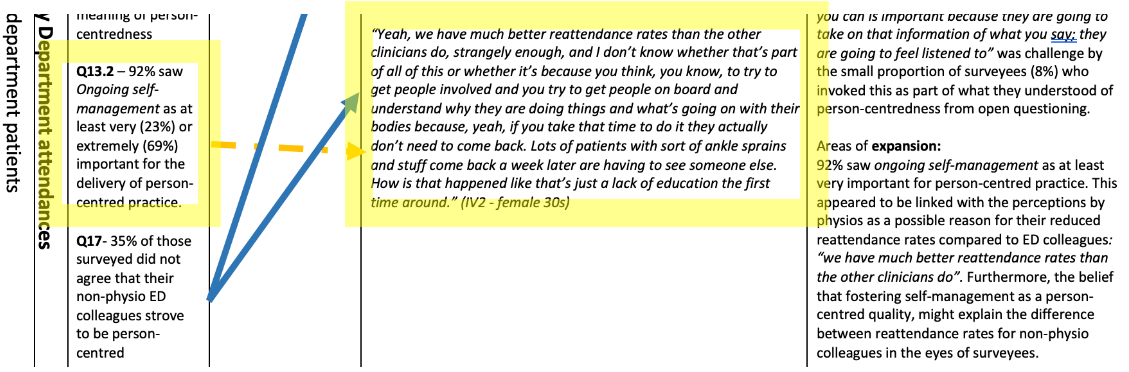
Expansion represents a situation of both overlapping and nonoverlapping interpretation that effectively makes this a hybrid of confirmation and complementarity (Fetters, 2020). This was evident in subtheme ST1.1 'entering the patient's world' (Figure 4.16) where seeing beyond the patient to the person was surveyed as (at least) very important and matched a longer qualitative quote that "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" (*participant #10*). This represented an expansive interpretation because, aside of the central convergence on the biopsychosocial exploration, this also provided new horizons surrounding the consequences of return visits, traded off against extra time taken in defiance of expected ED treatment for this kind of patient.



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%	*"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)*	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 IV2 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'*.

Figure 4.16 Joint Display excerpt ST1.1 entering the patient's world

Another good example in subtheme 1.2 'ED attendances' (Figure 4.17) was that all of those surveyed regarded 'ongoing self-management' as at least very important for ED PCP, with the following quote not only showing convergence, but also complementarity through elaboration that unfulfilled patients will return, as well as proffering the reasons why that might be case: "Yeah, we have much better reattendance rates than the other clinicians do, strangely enough, and I don't know whether that's part of all of this or whether it's because you think, you know, to try to get people involved and you try to get people on board and understand why they are doing things and what's going on with their bodies because, yeah, if you take that time to do it they actually don't need to come back. Lots of patients with sort of ankle sprains and stuff come back a week later are having to see someone else. How is that happened like that's just a lack of education the first time around." (participant #2).



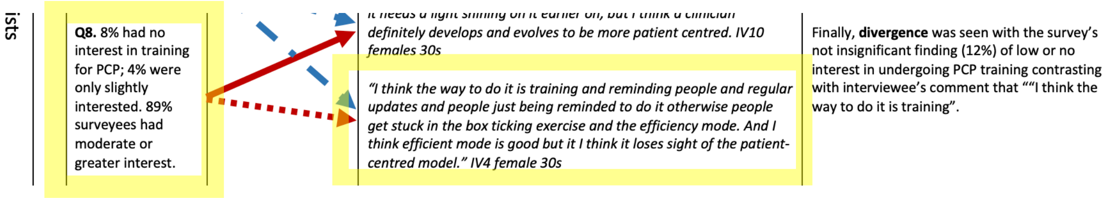
department patients	Department attendances	meaning of person-centredness **Q13.2** – 92% saw *Ongoing self-management* as at least very (23%) or extremely (69%) important for the delivery of person-centred practice. **Q17**- 35% of those surveyed did not agree that their non-physio ED colleagues strove to be person-centred	*"Yeah, we have much better reattendance rates than the other clinicians do, strangely enough, and I don't know whether that's part of all of this or whether it's because you think, you know, to try to get people involved and you try to get people on board and understand why they are doing things and what's going on with their bodies because, yeah, if you take that time to do it they actually don't need to come back. Lots of patients with sort of ankle sprains and stuff come back a week later are having to see someone else. How is that happened like that's just a lack of education the first time around." (IV2 - female 30s)*	*you can is important because they are going to take on that information of what you say: they are going to feel listened to"* was challenge by the small proportion of surveyees (8%) who invoked this as part of what they understood of person-centredness from open questioning. Areas of **expansion:** 92% saw *ongoing self-management* as at least very important for person-centred practice. This appeared to be linked with the perceptions by physios as a possible reason for their reduced reattendance rates compared to ED colleagues: *"we have much better reattendance rates than the other clinicians do"*. Furthermore, the belief that fostering self-management as a person-centred quality, might explain the difference between reattendance rates for non-physio colleagues in the eyes of surveyees.

Figure 4.17 Joint Display excerpt ST1.2 ED attendances

Divergence in data sets

Divergence, also referred to as discordance, denotes conflicting interpretations between data sets. In this final category much of the divergence could be explained by the way that the data was managed. The researcher used quantitised categories of responses to process the open text survey options by providing a percentage of how many of those surveyed invoked that category or not. There was no implication that participants did not agree, only that they didn't allude to this or its synonyms, and patient might have just forgotten to raise this point, whereas in closed questions, they are forced to answer this. In fact, the management of this small amount of open text with the quantitative data set was itself problematic for the researcher, which is why this is highlighted a reflection on the decision to include this (see reflexive log – appendix 11).

Yet, there were some divergences arising from areas other than quantitised open survey questions. The finding for subtheme 2.2 'physiotherapist skills' subtheme (Figure 4.18) that 8% had no interest in training for PCP and 4% were only slightly interested was challenged by an insightful quote on how to achieve just that in ED: "I think the way to do it is training and reminding people and regular updates and people just being reminded to do it otherwise people get stuck in the box ticking exercise and the efficiency mode. And I think efficient mode is good but it I think it loses sight of the patient-centred model" (participant #4). When analysing this supposed dissonance more closely, this finding represented only 12% as having little or no interest in PCP training which, with such low respondence rate, corresponds to only three participants out the 26 surveyed and may reflect that fact that some respondent will tend to have outlier views as part of a normal data spread. Furthermore, this was offset by the other 89% of those surveyed having moderate or greater interest in this, therefore this was perhaps not so divergent as first supposed.



Q8. 8% had no interest in training for PCP; 4% were only slightly interested. 89% surveyees had moderate or greater interest.

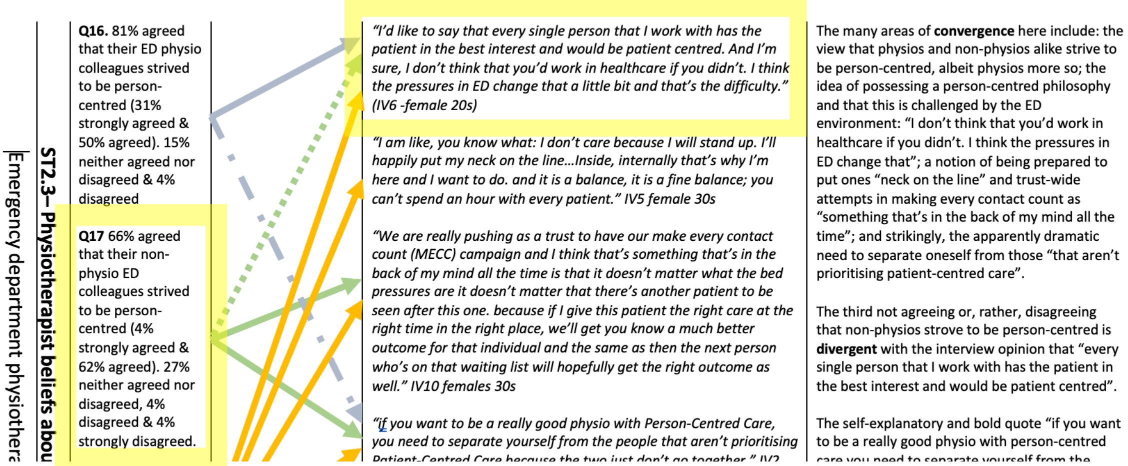
definitely develops and evolves to be more patient centred. IV10 females 30s

"I think the way to do it is training and reminding people and regular updates and people just being reminded to do it otherwise people get stuck in the box ticking exercise and the efficiency mode. And I think efficient mode is good but it I think it loses sight of the patient-centred model." IV4 female 30s

Finally, **divergence** was seen with the survey's not insignificant finding (12%) of low or no interest in undergoing PCP training contrasting with interviewee's comment that ""I think the way to do it is training".

Figure 4.18 Joint Display excerpt ST2.2 physiotherapist skills

A final and interesting divergent interpretation was present for subtheme 2.3 'physiotherapist belief about PCP' (Figure 4.19) where only two thirds agreed that non-physiotherapy colleagues strived to be person-centred, and a contrary quote that "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). The overall feeling from the survey and interview data, triangulated with the researcher's own experience from working as an ED physiotherapist for many years, suggested interprofessional relations in ED can be highly variable. Furthermore, it is possible that the closeness of the broader ED team; how they work together and perception of how ‘useful’ the ED physiotherapists are to the team, varies greatly across the UK, reflected in the negative (and positive) views captured here.


Emergency department physiothera

ST2.3– Physiotherapist beliefs abou

Q16. 81% agreed that their ED physio colleagues strived to be person-centred (31% strongly agreed & 50% agreed). 15% neither agreed nor disagreed & 4% disagreed

Q17 66% agreed that their non-physio ED colleagues strived to be person-centred (4% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 4% disagreed & 4% strongly disagreed.

“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.” (IV6 -female 20s)

“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.” IV5 female 30s

“We are really pushing as a trust to have our make every contact count (MECC) campaign and I think that’s something that’s in the back of my mind all the time is that it doesn’t matter what the bed pressures are it doesn’t matter that there’s another patient to be seen after this one. because if I give this patient the right care at the right time in the right place, we’ll get you know a much better outcome for that individual and the same as then the next person who’s on that waiting list will hopefully get the right outcome as well.” IV10 females 30s

“if you want to be a really good physio with Person-Centred Care, you need to separate yourself from the people that aren’t prioritising Patient-Centred Care because the two just don’t go together.” IV2

The many areas of **convergence** here include: the view that physios and non-physios alike strive to be person-centred, albeit physios more so; the idea of possessing a person-centred philosophy and that this is challenged by the ED environment: “I don’t think that you’d work in healthcare if you didn’t. I think the pressures in ED change that”; a notion of being prepared to put ones “neck on the line” and trust-wide attempts in making every contact count as “something that’s in the back of my mind all the time”; and strikingly, the apparently dramatic need to separate oneself from those “that aren’t prioritising patient-centred care”.

The third not agreeing or, rather, disagreeing that non-physios strove to be person-centred is **divergent** with the interview opinion that “every single person that I work with has the patient in the best interest and would be patient centred”.

The self-explanatory and bold quote “if you want to be a really good physio with person-centred care you need to separate yourself from the

Figure 4.19 Joint display excerpt ST2.3 physiotherapist beliefs about PCP

4.5 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 (Chartered Society of Physiotherapy, 2019).

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 (NHS, 2022), 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 (Nicholls and Holmes, 2012; Mudge et al., 2014). 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 (Schoenau et al., 2020; Belton et al., 2022); 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 (Trede and Haynes, 2009). 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 (NHSE, 2023) - 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 musculoskeletal physiotherapists in ED can reduce avoidable patient re-attendances (Salt, 2016). 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 (Miciak et al., 2019; Kinney et al., 2020). 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 (Pendleton et al., 2003). The assumption that ICE can provide helpful diagnostic clues and deeper insight into the reasons for patient encounters (Matthys et al., 2009) only serves to strengthen its application in this context. ‘Entering the patient’s world’ echoes broader narrative-based practices (Charon, 2009; Low, 2018; Ahlsen et al., 2020) that emerged in response to perceived shortcomings of the biomedical approach (Zaharias, 2018). 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 (Naylor et al., 2023). 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 (NHS, 2022), certain patients continue to make 'inappropriate' visits to ED (O'Keeffe et al., 2018). The well-publicised persistent and worsening pressures faced by emergency services has not, it seems, deterred non-emergency attenders (Illman, 2022; The King's Fund, 2022). 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' (Hillman, 2014) and patient 'worthiness' (Sbaih, 2002; McConnell et al., 2016). 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' musculoskeletal cases evidenced patients having their own host of reasons for attending. One contentious reason was unacceptable waits to see a GP (Adams, 2022), 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.

4.5.1 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 (Mudge et al., 2014), given the practical situation in ED, a framework to support this is currently lacking.

4.5.2 Quality evaluation

There is a bewildering array of quality criteria options available for appraising mixed methods studies. When considering the constituent studies themselves, there are even more quality assessment alternatives that include, for example, the Total Quality Framework (Roller and Lavrakas, 2015) and Quality Assessment Checklist for Survey Studies in Psychology (Protogerou and Hagger, 2020) for qualitative and quantitative arms, respectively. However, since the quality of mixed methods data analysis will depend heavily upon how well the data is integrated, it follows that the quality might also be judged as an integrated entity, rather than evaluating independently quantitative survey and qualitative interviews. In accordance with this rationale, the quality appraisal in this study was based on a new proposition for combining quality assessment procedures: the 'Core Quality Criteria of Mixed Methods Research' (Hirose and Creswell, 2023). What now follows is a quality assessment of the mixed methods study based on these respective criteria that Hirose and Creswell endorse for “new scholars… as models for their own rigorous research” (2023:25). The addition of a completed COREQ checklist (Tong et al., 2007) was an additional requirement by peer reviewers for the published version of this study that also reflected good practice (see appendix 3).

1. Advance a rationale for using mixed methods methodology

The exploratory nature of the research question: *how is person-centred practice understood and interpreted by physiotherapists working in the emergency department?* demanded the collection of both quantitative and qualitative data sets as either, alone, might be insufficient to answer this. Closed survey questions could establish numerical insights on the existence and proportionality of certain views or beliefs, from which interviews could offer a deeper understanding of why this might be. Even though physiotherapists who work in ED are plentiful, due to the advancing practice nature of the role being explored, only a very small proportion were anticipated to be managing patients at the point of first contact, thus making this a difficult sample to know and reach. Aside of the descriptive statistics provided, the initial survey also served as a pragmatic way to identify some of this niche group who could be interviewed. There was a significant benefit from integration of the data from survey and interview methods that ultimately allowed for a much richer and more comprehensive understanding of this novel research area that has yet to be investigated.

2. Write quantitative, qualitative, and mixed methods questions

To answer this criterion, the author can provide the following to represent the respective quantitative, qualitative and mixed methods research questions:

- *How do physiotherapists working in emergency department define and evaluate person-centred practice?*
- *What are the views and experiences on person-centred practice of physiotherapists working in the emergency department?*
- *How is person-centred practice understood and interpreted by physiotherapists working in the emergency department?*

3. Report separately the quantitative and qualitative data

Quantitative survey data amounted to closed-ended data from pre-set rating scales. There were only two survey questions that allowed for open textual response, yet these results were, themselves, quantitised to match the format of the broader numeral data set. For the analysis, these qualitative data were reported separately and in tabulated and narrative descriptive statistical formats. Qualitative interview data, corresponding to recorded answers to open questions, were transcribed, thematically analysed and reported separately as themes. The ways in which the data sets were collected was clearly defined and reported.

4. Name and identify the type of mixed methods design and present a diagram of it
The flexibility of mixed methods design may be one of its key strengths but given the reported existence of at least 15 different typologies (Creswell and Plano Clark, 2018), a lack of agreement on names can result in confusion. This study, however, followed a convergent mixed methods design, with sequential explanatory features. A clear diagram is provided as a visual illustration of how the data sets were timed and connected and at what points this occurred (Figure 4.1). The collection of quantitative data was followed-up with that of qualitative data to explain survey findings in more detail.

5. State the use of integration in a joint display
Since integration of data sets is central to any mixed method design, this merger must be made explicit to avoid accusations of summaries being provided in place of any true integration. The joint display table and process that was used to integrate data sets here (Figure 4.2) (see appendix 8) providing an explicit demonstrating of integration: utilising the theme headings as framework with which to link survey findings based on any data convergence, complementarity, expansion or divergence (Fetters, 2020). Thus, there was clear evidence data integration to fulfil this quality criterion.

6. Discuss how meta-inferences and value resulted from the integration analysis
Meta-inferences can be found in the righthand column of the joint display and were based on data convergence, complementarity, expansion or divergence (Fetters, 2020). In summary, *convergence* indicated an agreement between two sets of findings; *complementarity* occurred when finding illustrated non-contradictory interpretations; *Expansion* occurred where overlap of findings provided space for further interpretations; and *divergence* occurred when there was an interpretive conflict between data sets findings (Fetters, 2020). Many examples of each of these four data relationships are presented on the joint display, with the meta-inferences themselves further explained within the narrative description of the joint display (see section 4.4.3.1). Fetters' suggestion of possible reanalysis based on finding of discordance (2020) was also attempted in this section.

Taken here together, these six criteria serve to assure the quality of this mixed-methods study exploring the views of ED physiotherapists on PCP and where they feel that they currently stand on implementing this.

4.5.3 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 (Sandelowski, 2001). 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.

4.5.4 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.

4.6 Summary

This chapter employed a mixed methods design to explore the views of primary contact physiotherapists working in UK EDs on PCP. The interpretation here was that ED physiotherapists were mindful of an apparent, yet unspoken struggle between the competing philosophies of biomedicine and person-centredness such that entering a patient's world might help navigate the challenging line between what an ED attender wants and the clinical need of their visit.

The following chapter explores the experiences of emergency department patients on being managed by a primary contact physiotherapist, through the lens of person-centred practice with the research question: *what are the views and experiences of emergency department patients who are managed by primary contact physiotherapists on person-centred practice?*

Chapter 5 The experiences of patients attending the emergency department who were managed by physiotherapists: A person-centred perspective (study 3)

5.1 Introduction

This chapter will present a study exploring perceptions on person-centredness of emergency department (ED) patients who had their care episode managed by a primary-contact physiotherapist. Considering the unambiguous promotion of person-centredness within healthcare, generally, alongside the increasing number of ED patients now attended to by first contact physiotherapists, an understanding of how patients perceive person-centred practice (PCP) within this unique context becomes important.

The chapter commences with a brief overview that orientates the reader to the status of PCP in contemporary healthcare, followed by a discussion on PCP in ED before setting out the aims for this study. After this follows the methods, results and discussion sections, respectively. The chapter is then summarised, which includes a brief introduction to the subsequent discussion chapter and its attempted synthesis of the data generated.

5.2 Background for the study

5.2.1 Person-centred practice research: from challenges to frameworks

Person-centred practice (PCP) is now an internationally recognised dimension of high-quality healthcare (Giusti et al., 2020) which requires differing paths depending on the country and context in which it occurs (WHO, 2015). Despite the support for international and interdisciplinary person-centred care research, typified by the Gothenburg Centre for person-centred care (GPCC), the complexity and multifaceted character of PCP has created methodological issues - relating to variability of research evidence generated, that have hampered data synthesis (Olsson et al., 2013; Ahmad, 2014; Burgers et al., 2021). The range of patient types and context-specificity of the person-centred activities pose a challenge to empirical study design (Health Foundation, 2016) meaning few conceptualisations of PCP are grounded in empirical research (Giusti et al., 2020). Studies have tended to focus on discrete facets of PCP such as communication (Pinto et al., 2012; Altin and Stock, 2016; Hedberg et al., 2022), shared decision making (Altin and Stock, 2016; Hedberg et al., 2022), self-management support (Franklin et al., 2021) and goal setting (Boa et al., 2018; Cameron et al., 2018) for example. Despite these challenges, there is evidence that a PCP approach can deliver positive patient outcomes (Rathert et al., 2013) that include satisfaction and wellbeing (Kuipers et al., 2019) cost reduction (Pirhonen et al., 2020) among other factors.

A fundamental aspect of PCP is its paradigmatic shift away from the paternalistic treatment of patients towards a partnership approach that regards the patient as a person rather than their presenting condition (Coulter, 2002). Several person-centred models and frameworks have been developed to support its realisation in clinical practice (Mead and Bower, 2000; McCormack and McCance, 2006; Santana et al., 2018), most notably the *Person-centred Nursing Framework* (McCance and McCormack, 2017). This nursing-specific guidance has since been updated to a somewhat grander: *Person-centred Practice Framework*, that the authors present as a mid-range theory, applicable to broader healthcare systems (McCormack et al., 2021). Within the specific field of rehabilitation and physiotherapy also, there has been a development of models and frameworks to support person-centred clinical practice (Miciak et al., 2019; Jesus et al., 2022; Killingback et al., 2022b).

5.2.2 Establishing ED physiotherapy

The physiotherapy profession has continued to adapt to the shifting demands placed on its workforce; the first contact practitioner (FCP) initiative for musculoskeletal physiotherapists in primary care (Mercer and Hensman-Crook, 2022) being a prime example. While physiotherapists have long performed a supporting role in the emergency department (ED), there has been a recent growth in their managing musculoskeletal patients at the point of first contact here, based on evidence that this can reduce: patient waiting times (Taylor et al., 2011; Gill and Stella, 2013; Bird et al., 2016; Kinsella et al., 2017; Sayer et al., 2017; Steed and Moulson, 2022), length of stay (Taylor et al., 2011; Gill and Stella, 2013; Sutton et al., 2015; Kinsella et al., 2017; Sayer et al., 2017; Pugh et al., 2020; Cassar et al., 2022), referral to specialties (Henderson et al., 2020; Davies et al., 2022) and utilisation of imaging (Sutton et al., 2015; Schulz et al., 2016; Pugh et al., 2020; Davies et al., 2022). Other positive research findings here relate to safety (de Gruchy et al., 2015; Sutton et al., 2015) and approval by staff who work alongside ED physiotherapists (Lefmann and Sheppard, 2014; de Gruchy et al., 2015; Fruth and Wiley, 2016; Barrett and Terry, 2018; Ferreira et al., 2018; Matifat et al., 2021).

5.2.3 Identifying the research 'gap' and study aims

The authors of this current research share the widely held view, and UK National Health Service (NHS) vision, of the need for a fundamental shift in how we work with patients and individuals to deliver more person-centred care (NHS, 2019). Enacting person-centred practices for patients is, after all, a professional expectation for all physiotherapists (American Physical Therapy Association, 2018; Chartered Society of Physiotherapy, 2019; Physiotherapy Board of New Zealand, 2020). While decidedly positive in nature (Harding et al., 2015; Schulz et al., 2016; Barrett and Terry, 2018), the existing data on patient experience of ED physiotherapy has yet to consider specific interactional aspects such as person-centredness. Therefore, with the growth of this ED physiotherapist role no longer in question (Lefmann and Crane, 2016), it is now important to learn about more nuanced aspects of how patients are experiencing person-centred physiotherapy practices.

The explicit research question that this study aims to answer is: *what are the experiences of emergency department patients who are managed by primary contact physiotherapists viewed through a lens of person-centred practice?*

5.3 Methods

5.3.1 Study Design

A qualitative exploration of person-centredness among emergency department physiotherapists, from the patient perspective, was developed to fill the established knowledge gap to inform future clinical practice. New knowledge here is of general import to forward the interests of person-centred physiotherapy practice in areas of broadening professional scope. This study employed in-depth semi-structured qualitative interview methods within a broader qualitative research paradigm (Kidder and Fine, 1987). Interview data collection methods and a pragmatic semantic approach to reflexive thematic analytical were adopted (Braun and Clarke, 2021) as consistent with a pragmatist's philosophical lens and thus define the formal methodological paradigm adopted here.

The qualitative interview method was chosen based on its appropriateness for addressing exploratory research questions surrounding the meaning of events for research participants (Kelly, 2010). This study incorporated patient and participant involvement and engagement to test acceptability and practicality of aspects of this study.

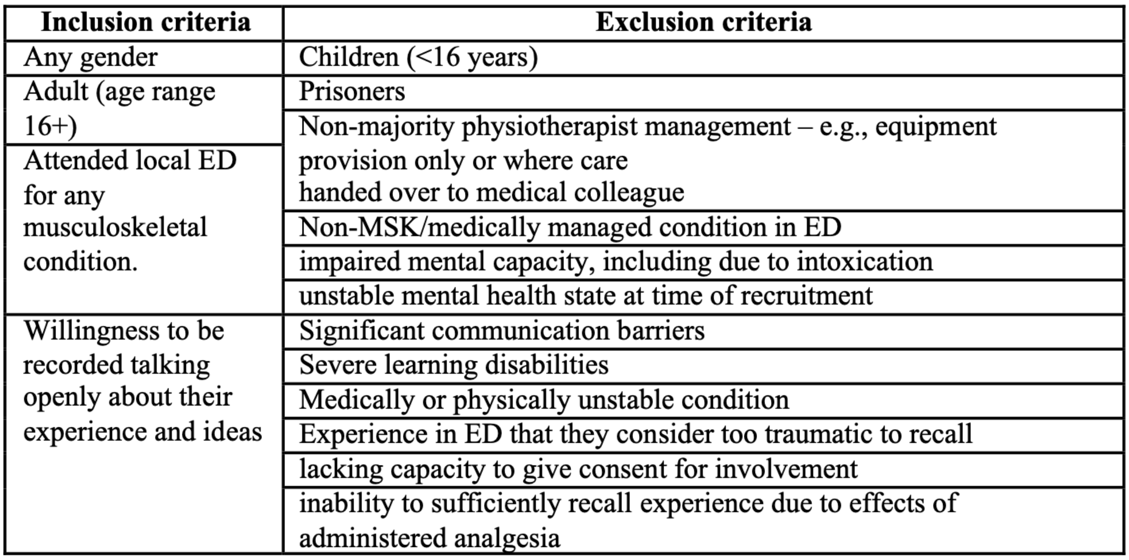
A Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was completed (see appendix 12) to ensure methodological rigour of the qualitative interview data collection methods (Tong et al., 2007).

5.3.2 Participant recruitment

Health Research Authority (HRA) approval was granted on 22 November 2022 following review by the Yorkshire & The Humber - Leeds East Research Ethics Committee (IRAS Project ID: 317609; REC reference 22/YH/0260 – see appendix 13). The research was also granted sponsorship by Hull University Teaching Hospitals NHS Trust (HUTH) with the Trust's 'capability and capacity' to conduct the study confirmed prior to commencing data collection (R2847). Anonymity and confidentiality of patient participants and their data was always respected, underpinned by an ethics-approved data protection plan and an informed consent process.

A sample of convenience was used to recruit participants. Potential participants were initially provided with information about the study via the attending ED physiotherapist. If they consented, their details were sent via secure NHS email to the lead researcher who then telephoned them to confirm consent and screen with the inclusion/exclusion criteria (Table 5.1) prior to setting up the interview.

Table 5.1 Study inclusion and exclusion criteria



Inclusion criteria	Exclusion criteria
Any gender	Children (<16 years)
Adult (age range 16+)	Prisoners
Attended local ED for any musculoskeletal condition.	Non-majority physiotherapist management – e.g., equipment provision only or where care handed over to medical colleague
	Non-MSK/medically managed condition in ED
	impaired mental capacity, including due to intoxication
	unstable mental health state at time of recruitment
Willingness to be recorded talking openly about their experience and ideas	Significant communication barriers
	Severe learning disabilities
	Medically or physically unstable condition
	Experience in ED that they consider too traumatic to recall
	lacking capacity to give consent for involvement
	inability to sufficiently recall experience due to effects of administered analgesia

5.3.3 Data collection

The main researcher (JN) conducted semi-structured interviews as the main data collection method to provide a greater depth of understanding of patient experience of being treated by a physiotherapist in ED. The interview guide was developed through a consideration of the literature on person-centred physiotherapy practice, the overarching aim of the study, and the research question (see appendix 17). Recruitment and interviews ran concurrently (between the period February 2023 to April 2023). Interviews were conducted by the researcher after at least one day, but no longer than two weeks, following the ED attendance, to maximise recall of their experience. To interview on site the same day would have been unethical and impractical due to COVID protocols. Having a minimal one-day gap also gave participants the chance to get their pain under control. Interviews were carried out via a web-based video platform or via telephone with audio recording; determined by patient preference and/or accessibility. No one else was present for the interviews beside the participant and the interviewer. The interviewer was introduced to the participants as an ‘ED physiotherapy researcher’.

As in the clinician-facing study, sample size for interviews here was guided by the concept of information power (Malterud et al., 2016), with consideration of each of this model's 'continuum' dimensions. The broad study aims, and multi-case analysis approach pointed toward 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 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 generation of analytical ideas, suggested a sample of around 10 would be sufficient. A final judgement was made after the thirteenth interview that sufficient data was collected for an analysis that could deliver on study aims.

5.3.4 Data analysis

A pragmatic semantic version of thematic analysis was carried out by the main researcher (JN) based on Braun and Clarke's six stages of reflexive thematic analysis (Braun and Clarke, 2019; 2021) from verbatim interview transcripts in NVivo QRS. One PhD research supervisor (CK) checked the coding accuracy, while PhD research supervisors (CK, AG) were closely involved with initial theme generation and refinement stages right through to drafting of a final report. An iterative collaborative approach provided different perspectives on the data, capturing interesting analytical aspects that might otherwise have been missed (Braun and Clarke, 2021).

A summary of themes was shared via email with those interview participants who consented to receive this to offer a form of member checking. This included an invitation for any comments for consideration within a one-month window, after which the manuscript would be submitted. No comments were forthcoming.

5.3.5 Researcher position statement

The main researcher (JN) is a middle-aged, white, British male senior musculoskeletal physiotherapist (BSc; MSc) and doctoral researcher. He introduced himself to participants as an 'ED physiotherapy researcher' and explained the purposes of the study to participants over the telephone during the formal screening and informed consent process, prior to meeting for the second and final time at interview.

The first author continued to practice in primary and secondary clinical settings while conducting the research. The PhD research supervisors 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.

5.4 Results

5.4.1 Demographics of survey participants

A total of 13 participants were interviewed (eight female; five male). In terms of age, five participants were in their 30s, three were in their 50s, two in their 60s, and three in their 70s. The presenting conditions included: low back pain 38% (n=5); suspected cauda equina syndrome (CES) 23% (n=3); knee pain 23% (n=3); and hip pain 15% (n=2). Participants were treated by five different clinicians (three males; two females) with experience of working specifically as a primary contact ED physiotherapist ranging from less than a year to over a decade. All interviews were completed within eleven days of being seen by an ED physiotherapist.

5.4.2 Qualitative results

Thematic analysis of the qualitative data from the 13 participants interviewed led to four overarching themes which were important to person-centredness from the perspective of patients attending ED whose care was managed by a primary contact physiotherapist: 1) patient experience of the emergency department; 2) the importance of connection, competence and time; 3) recognising the benefits of being seen by a physiotherapist in ED; and 4) patient experience of the ED physical environment.

Theme 1 – “You shouldn’t be here”: Patient experience of the emergency department.

This theme encompasses the experiences of participants on their visit to a UK emergency department who after initial triage were managed by a physiotherapist. Upon arrival at ED, the experience of participants at the streaming desk, including those referred by their GP with a letter in hand, often led them to feelings of annoyance or indignancy. Despite explaining their reasons for attending ED as not being able to get an appointment with their own general practitioner (GP), or even that their GP had sent them to ED as an emergency, many participants were still struck by the perceived incivility of the triage experience. Participants were especially angered at being told, somewhat ironically, by the welcoming nurse that they shouldn’t have come to ED in the first place:

> I went to the desk and the triage nurse said. “What seems to be the problem?” I said “I've got a really bad back pain and struggling to move”… And instantly, she said, “you shouldn't be here: You should be seeing your GP”. When I explained that the GP had said come to A&E her answer was “that's what they would say, you should really try and get an appointment with your GP”

-participant #6, male - 50s; presenting with back pain

This quote illustrates just how precarious and unwelcoming an experience attending ED can be. The challenge of the triage process, alongside the requirement to repeat their story multiple times to the reception, triage and physiotherapist, ultimately led some participants to doubt the legitimacy of their attendance. Others, however, appeared to remain in no doubt as to the correctness of their visit.

This initial negative experience was in sharp contrast to the subsequent positive experiences of having their care managed by a physiotherapist; one which led to a sense of validation of their attendance. What appeared to be important for participants was that the physiotherapist most often affirmed that they had been correct in attending ED for their presenting condition. This validation from the physiotherapist seemed to hold significant value for participants, akin to a relief that at least someone believed them:

> he said ‘no, they’ve absolutely done the right thing by sending me here’… I felt reassured because I did feel a bit of a phoney really for being there

-participant #2, female - 50s; presenting with possible CES

This was particularly important given that they may have had a very poor experience on arrival where they were given the impression that they should not be there.

Despite surprise at being informed they would be seeing an ED physiotherapist, participants seemed to trust that the streaming nurse had allocated them to the best person for their presenting problem. With most participants unaware that such primary contact physiotherapists even existed, they were naturally unclear of exactly what might follow when an ED physiotherapist, as opposed to doctor or nurse practitioner, called them in for treatment. This lack of awareness, according to one participant, stemmed from participants underestimating the advanced roles that practitioners such as physiotherapists carried out in ED. Even during physiotherapy treatment, several participants confessed to an expectation that their care would, at some point, be taken over by a doctor or nurse. Given their lack of familiarity of the primary contact ED physiotherapist role, it was unsurprising that participants did not anticipate their care being wholly managed in this way.

> When I went in, I thought possibly that it might have been a triage. Not realising that he was going to be taking full care from start to finish. I was a bit like “alright. He’s going to have a quick look. And then I'll be sent back to the waiting room and maybe I have to see a doctor.

-participant #1, female - 30s; presenting with knee pain

Framed by the possibility of waiting up to eight hours to be seen by whichever ED clinician was allocated, the significant shorter wait times to see the physiotherapist appealed to participants. This led to a sense of satisfaction with some even expressing shear amazement at the experience. Whether resulting in shorter wait times than expected or not, participants remained alert to their apparent queue position with respect to fellow patients, such that being called in early to physiotherapy was perceived as a positive outcome.

> The time that I waited, it was just ridiculously short compared to how long you would normally have to wait. Yeah, I was just blown away by being seen so soon. I think that is important for everybody; I think most people’s experience of A&E is the fact that you usually have to wait so long to be seen by anybody.... I was very surprised.

-participant #12, female - 60s; presenting with back pain

Theme 2 – “They genuinely seemed to take an interest”: having time to connect with the ED physiotherapy professional as a person.

This theme encompasses the views of participants on person-centred aspects of the attending UK emergency department physiotherapist and, more specifically, the importance of participant connection with the real person behind the professional armour. Three sub-themes are included as part of this overarching theme: soft skills that honour personhood; clinical competence; and having the time to care and be holistic.

Subtheme 2.1 - Soft skills that honour personhood.

Patient views about the importance of physiotherapist personality encompassed a whole host of specific positive traits, with a non-exhaustive list that includes being engaging; nice; happy; friendly; and open. One participant made it clear that being an expert alone was not enough as there also needed to be a personal connection for them to feel comfortable. The personal connection with an ED physiotherapist here was something realised through an active rapport-building process. An almost contradictory kind of *professional informality* was clearly appreciated by participants as revealing something of a clinician's true self. This suggests the adoption of more formal expert and patient roles, as per the traditional medical model, might serve as a barrier to a more person-centred and human level interaction so clearly valued by participants here.

> He was just a really nice guy. You know; just the way he was. He was really friendly, really chatty, but obviously professional....he wasn't sort of, you know, standoffish, like some doctors can be. I don't like to generalise. But yeah, just really comfortable.

-participant #1, female - 30s; presenting with knee pain

Participants often reported feeling like just another number on the ED production line in such a way that challenged their personhood. Patient dignity and privacy were also threatened by experiences such as having to change into and wearing gowns in public areas and being unable to move off beds or trollies while within the waiting room's gaze. It is notable therefore that patient participants in this study highlighted the deliberate steps taken by their ED physiotherapist to uphold their privacy, dignity, and personhood; and thus, in doing so facilitated person-centredness.

> There was just a really good level of respect there. Very high level of patient care, actually. I think just because you can find yourself feeling like you're not a person sometimes when you're in the hospital, you can feel quite a bit like a number: you're on the list and they've just got to try and get you through. So actually, someone sitting there and saying, you know what, you don't have to go and sit out there with no trousers on. In a gown. I'll just let you stay in here and I'll take you round, and I'll keep a look out for you when you come back.

-participant #13, female - 30s; presenting with knee pain

Some more subtle aspects which helped participants feel valued were around simple enquiries as to the patient's physical comfort and the checking and providing of progress reports on their ED status. ED physiotherapists' demonstration of empathy and concern for participants left them feeling genuinely cared about as people beyond their presenting condition. Therapist empathy, from their perspective, was prerequisite to being understood as a person and situated at the centre of their care.

Whether due to anxiety about their health or simply a result of being in this stressful situation, participants placed value on the physiotherapist being able to put them at ease. Assurances that nothing more serious was going on appeared to require more than just diagnostic credibility, however. The fact that participant assuagement was a consequence of the manner, as much as the content, of physiotherapist communication served to reemphasise the significance of highly developed interpersonal skills.

> The bedside manner of it, I just thought was quite relaxing. It made me feel definitely at ease and less worried about the fact that I was in hospital. It was nice.
>
> *-participant #4, female - 30s; presenting with back pain*

High level micro-communication skills such as good eye contact and active listening were perceived as important in helping the participants connect with the physiotherapist. Being able to share their full narrative without interruption was particularly helpful in making participants feel that the physiotherapist was engaged and that their full story was heard.

> He gave you the impression, even when I was talking to him, and I might have been talking a lot of rubbish, but he seems to get round it and be able to ask you questions in the right time when it was needed. He didn't interrupt at all; he listened until I stopped talking and then answered that question. Then asked me questions. He let me finish off.
>
> *-participant #5, female - 70s; presenting with possible CES*

Subtheme 2.2 - Clinical competence

While the ED physiotherapist personality was clearly an important aspect to their person-centredness, so too was a perceived professionalism, credibility, and clinical expertise. This bar was reached through various interactions with the physiotherapist but required, at the very least: a comprehensive history taking; a thorough physical examination; and possible investigations that could lead to an acceptable clinical diagnosis. Perceived clinical competence and credibility served to reassure participants that the physiotherapist knew exactly what they were doing; something of bearing given the fact that participants had been sent to see someone other than the doctor that they had expected. Many participants acknowledged a physiotherapist's prerequisite qualifications for this ED role, underpinned by their advanced knowledge and specialist skills. Despite not expecting to be seen by them, participants concluded that a physiotherapist was the best person to see when presenting to ED with musculoskeletal injuries due to their clinical competence in this area.

> it made it more of a comfortable experience knowing that you are seeing someone with those qualifications that can talk expertly about that particular problem. Physio was definitely the right person for this problem.
>
> *-participant #12, female - 60s; presenting with back pain*

Education and explanation of *everything* by the physiotherapist was evidently key to their achieving a successful patient outcome. This might include use of models, radiographic images, or the use of simple analogies to further a patient's understanding of their condition. The favouring of layman's terms over medical jargon really seemed to matter to participants here. Emphatic revelation by many that seeing an ED physiotherapist was the first time they felt they had truly understood the extent of their presenting problem, and what it might mean to their lives, reflected the proximity of clear explanation to person-centred practice.

> I got into the room, we had a little chat about what he was going to do, and he asked, "has anybody explained what happens with osteoarthritis", which was no...Got his little plastic knee joint and explained exactly what was going on with my knee. I've never experienced that before. And it was a proper eye-opener. I was like wow! Now I know what's going on, it was wonderful actually.
>
> *-participant #11, male - 60s; presenting with knee pain*

Subtheme 2.3 – Having the time to care and be holistic.

A key person-centred aspect highlighted by most participants was the premium placed on their clinical consultation not being rushed. Based on their previous GP or ED visit, many participants had apparently come to ED with the expectation of a long build up and a wait for hours that finally culminated in a cursory chat followed by hasty discharge. Offering enough time to fulfil their perceived needs was clearly essential to an ED physiotherapist achieving person-centred practice. An unrestricted chat enabled by the physiotherapist, coupled with their providing sufficient time to explain everything, were both considered by the patient as time well spent in realising their person-centred aims.

> he can only work off the information I give him and if I'm in a rushed environment, I'm not going to get it all out because obviously you're in so much pain. You are forgetting half of what you need to say.
>
> *-participant #6, male - 50s; presenting with back pain*

Having sufficient time was linked with delivery of a holistic approach - recognised by participants as another facet of person-centred ED physiotherapist practice. Such holism here, according to participants, considers the patient beyond their presenting condition and makes allowances for the social context of a patient's reality. In circumstances where friends or family members were present, the acknowledgement and involvement of these significant others, such as offering them a voice within the clinical consultation, helped support participants in their journey through ED and was appreciated as a person-centred thing for ED physiotherapists to do.

> Involving my husband made me feel more confident because most of the time I hear, but if, for instance, they turn round when talking to you - I don't always catch all that. Well, because my husband was there, on a couple of occasions, I'd ask something, and my husband would say he's already said that I hadn't heard it.

-participant #5, female - 70s; presenting with possible CES

Patient anxiety at being in an ED environment was commonly compounded by worries about their chaperone not knowing what was going on; their waiting or worrying about the patient. As trivial as it might sound, even consideration or acknowledgement of a patient's anxiety about their dog being left at home unattended resided within an ED physiotherapist's person-centred holistic approach.

> The physio made my friend welcome as well; she gave her somewhere to sit which was nice. This was important because I needed my friend there...I thought, that's nice of her to care; she asked her who she was and everything...sometimes they just say, "sit down!" I think if they didn't do this [i.e., consider the thought and feelings of your family members or carers as well as yourselves] I think I'd feel as though I was being a nuisance.

-participant #9, female - 70s; presenting with hip pain

Holism was further demonstrated by physiotherapists concerning themselves with the patient's ability to manage at home and work following discharge from ED. A consultation that didn't directly address patient questions about an appropriate return to work or hobby, for example, would fall short of any perceived person-centred threshold:

> Asking about my interests was important because when people go to the gym you might think maybe just a run on a treadmill twice a week or something. Whereas I'm properly training, very heavily, all the time, really. So obviously, to me, is very important when I have treatment or anything like that, that is known because it's very relevant to what I do.
>
> *-participant #2, female - 50s; presenting with possible CES*

Theme 3 – "That was the best I felt I'd ever been cared for in hospital": recognising the benefits of being seen by a physiotherapist in ED.

This theme is characterised by the ringing endorsement of an ED physiotherapy model of care, generally regarded by participants as excellent. Being able to get all that they needed from the visit left participants reporting being happy to see an ED physiotherapist again. Participant reflections upon contrasting experiences of physiotherapist versus medical management within ED led to favourable judgements for this alternative model of care. Participants cited the more comfortable interactions, having more time and better aftercare with a musculoskeletal specialist, rather than medical generalist, as justification for this point of view. Their ability to orchestrate the entire patient journey through ED, in particular, was a route through which participants experienced the person-centred ED physiotherapist approaches.

> There're not really any negatives I could think of because that was the best I felt I'd ever been cared for in hospital and I've been there a few times. So, I couldn't really have anything negative to say about the physio side of things
>
> *-participant #3, male - 30s; presenting with LBP*

Acknowledging the general lack of familiarity with the concept of ED physiotherapists and their extended scope for managing imaging and medication, for example, led one participant to recommend the need for clearer messaging about the physiotherapist presence and what they could offer. Something as simple as posters in the waiting room, they felt, could dispel any confusion as to who was triaging and who was treating.

> I think there needs to be posters up saying exactly what they [i.e., ED physios] can do within the ED department: they can order your x-rays, give your mobility aids. You know, really, push it that if that's who the nurse says, you need to see, that's who you need to see. They're going to be able to do everything that you need. Possibly quicker than a doctor because they might want to call someone else in if it's not what they usually deal with day-to-day.

-participant #1, female - 30s; presenting with knee pain

Innovative suggestions by participants included ideas about pre-booked appointments with the ED physios, patient receiving follow up telephone calls and a dedicated area for those patients streamed to physiotherapist management. Finally, having all ED physiotherapist staff able to administer medications was seen as a beneficial development.

Theme 4 – "I don't think anyone thinks of it as nice area": patient experience of the ED physical environment.

This theme captures how participants experienced being patients within in ED's physical environment. The negative perceptions of this environment by most served as an unfortunate, yet inevitable, limitation to the person-centredness of their overall ED experience. Responses that emphasised the shortcomings of the waiting areas and physiotherapist's room constituted the most common complaints. A specific criticism repeated by participants related to their not being told to wait near to the physiotherapist's room, or not knowing where the physiotherapist room was. This created a source of anxiety that they might miss their name being called or the room being too far for them to reach without some help. The waiting room itself was regarded by many as too small, poorly designed, and uncomfortable, with patients seemingly waiting everywhere.

> The waiting room is tiny...I mean, it's not a nice place, is it? I don't think anyone thinks of it as nice area...and I've spent a lot of time in my life sat in it.

-participant #13, female - 30s; presenting with knee pain

The physiotherapist room was characterised as insufficiently equipped or sized for its anticipated function by some, while others rated it adequate; a fact possibly reflecting the variable room allocation on different days. The invitation for participants to enter the ED physiotherapist's room, however, seemed to provide an ameliorative contrast to the previous setting, which despite its own limitations, constituted a sanctuary effect of sorts.

When challenged on how the ED physical environment might be improved, some participants recommended a separate area for sitting when waiting to see the physiotherapist. One participant even recommended a bespoke area for physiotherapist-managed patients to extricate their patients from those waiting for more medical attention and thus maximising their person-centred model of care.

> There could be sections.... you know, different areas and I think that would help a lot. ...it would put your mind at rest that you're in that specific area. ... if there was a physio area and they are going through, you know, roughly, what time you are going to be in there. But when you're stuck with everybody else, you haven't got a clue.
>
> *-participant #10, male - 70s; presenting with back pain*

5.5 Discussion

The aim of this study was to explore the views of emergency department patients on their experiences of physiotherapy through the focused lens of person-centred practice. With person-centredness central to an international vision of how quality health care should be enacted (McCormack et al., 2015; Moore et al., 2017), this knowledge constitutes one small but important step forward within this profession-specific setting. The qualitative themes led to the generation of four novel contributions that further understanding of the person-centred practices of ED physiotherapists from the perspective of their patients which are discussed here.

The first new knowledge surrounding the experience of those attending ED was about participants receiving some form of validation of their ED visit by the physiotherapist. This 'validation' was important because, prior to meeting the physiotherapist, the patient experiences were, at times, reportedly bordering on uncivil. Incivility describes a specific kind of rudeness and disregard for others that violates the norms for mutual respect (Andersson and Pearson, 1999; Pearson and Porath, 2005). Incivility has been shown to endanger patient safety and wellbeing (Leape et al., 2012; Riskin et al., 2015; Katz et al., 2019; Johnson et al., 2020).

The challenges of incivility need to be situated within the context of the practice environment. The practice environment, which relates to the context and culture, is important as it can impact person-centred practice (McCormack and McCance, 2010; Killingback et al., 2022b). The UK healthcare context has been severely challenged following periods of austerity, Brexit, COVID-19, and ongoing industrial action (Health Foundation, 2023). This has led to hospitals being required to function at near maximum capacity with long waiting list backlogs, compounded by chronically insufficient staffing levels (UK Parliament Committees, 2022; NHS Providers, 2023; RCSEng, 2023). Thus, it is not surprising that pressured triage staff sometimes struggle to remember to keep the person at the centre of their practice. In response to the widening health inequalities following COVID-19 (Tonkin, 2022), the Emergency Medicine Public Health Special Interest Group recommended broadening the scope of ED to the delivery of public health interventions (RCEM, 2021). Based on the perceived level of incivility experienced by those attending ED in this study, any change beyond the purely emergency remit does not appear to have filtered down to the triage stations of all ED departments.

A literature review on person-centredness from an ED nursing standpoint offers some perspective here with staff reported as focusing more on medical tasks than patient wellbeing (McConnell et al., 2016). Ethnographic inquiry into the emotional labour and feeling rules of ED provides the analogous notion of 'legitimacy' the authors define as a patient's "appropriateness to be in the ED" (Kirk et al., 2021). Here, Kirk and colleagues (2021) reported certain patient visits, perceived by ED nurses as inappropriate, challenged the healthcare staff's capacity to feel empathy over resentment about the attendance.

While tempers of patients and staff are understandably tested by such high-pressure health environments, most patients would not expect to fall victim to incivility by clinical staff who are there to serve their healthcare needs. The specific manifestation of incivility in this study materialised as a summary judgement by triage staff on the appropriateness of participants' visit; an added indignity came from some reporting that they had to publicly argue their case with ED triage staff.

Primary contact physiotherapists in this study were not responsible for the undeniably challenging 'gatekeeper' role of ED patient triage. Therefore, once past this stage, there appears no reason why physiotherapists should not offer some form of explicit validation of individual patient attendance. In fact, when patients experienced the triage process as an ordeal, such gestures of validation appeared to constitute acts of kindness, offering sharp relief in ameliorating a stressful situation. While a conciliatory approach, with validation at its heart, was sufficient to turn around negative participant experiences in this study, there appeared to be consequences in terms of necessary effort required to make this right. This chimes with recent physiotherapy research reporting clinicians feeling the need to work harder to make up for the incivility of other staff (Naylor et al., 2022).

Given the current healthcare context and positive reaction by participants in this study, a seemingly person-centred gesture of validation by physiotherapists of all patients' attendance in ED might go some way towards rebalancing any unfortunate exposure to incivility.

The second new knowledge relates to an endorsement by ED attenders for the educational and explanatory approach adopted by ED physiotherapists in this study. Visits to ED are often associated with fear and uncertainty; as primary drivers for attendance (Rising et al., 2016). The centrality of uncertainty to the conceptual model of fear is such that anxiety can be fuelled through an intolerance of not knowing (Gu et al., 2020). Carleton's (2016:31) definition of fear of the unknown includes "an individual's propensity to experience fear caused by the perceived absence of information…". ED attenders presenting in pain without trauma, e.g., low back pain, can conflate pain with damage - often catastrophising (Lethem et al., 1983) due, in part, to lack of understanding about their present condition. The transformative effect of eliciting understanding appears consistent with the empowering intent of delivering person-centred practice, setting firmer foundations for any shared decision making to follow (McCance and McCormack, 2017).

When lack of information and insight are the problem, it follows that education and understanding are the remedy. The current study provides a strong endorsement for the educational role that primary contact ED physiotherapists can have on imparting understanding and quietening worried minds. This impact is demonstrated in revelatory moments that occurred at the point of a patient feeling they finally understood their condition. The notion of this being the first time someone had properly explained the problem to the patient served as a cathartic experience from which acceptance and empowerment could follow; in a sense confirming the idea that the fear of pain can be more disabling than the pain itself (Waddell et al., 1993).

The type of physiotherapist explanation characterised in the current study was one which typically included jargon-free anatomy lessons, phrased in lay-language - supported by use of models and metaphor. The participants' idea of an ED physiotherapist being able to cover explanation of 'everything' was also strongly represented in the data. Thus, the ED physiotherapist's education-supporting role appeared to extend beyond simple information provision to something more akin to a navigator for the person's ongoing health journey. Considering the patients' journey before and beyond ED, resonates with the fourth construct of the person-centred physiotherapy framework (Killingback et al., 2022b). 'Ongoing unique journey of the person and self-management', in this model, similarly alludes to moments of patient intersection with healthcare services as opportunities to develop self-efficacy to sustain self-management.

The third new knowledge considers negative patient perceptions about ED's physical environment as barriers to achieving person-centred practice. A study in Australian EDs, noted the longer patients waited in ED, the more aware they become of negative aspects of the physical environment e.g., wear and tear, poor cleanliness, and unwanted noise; the reverse was also reportedly true (Bull et al., 2021). Aside of patients suffering from physical pain, aspects of the ED environment such as feeling too cold, being crowded by other people, a lack of privacy during clinical interactions and poor amenities had the capacity to negatively affect their experience (Bull et al., 2022). In their review of ED environmental impacts on patient experience, Rowe and Knox highlighted the three main factors of overcrowding and waiting times; privacy; and communication (Rowe and Knox, 2023) - confirming dominant factors discovered in prior studies (Lin and Lin, 2011; Sonis et al., 2018; Viotti et al., 2020). These findings are consistent with the present study in terms of participant experiences of crowding and difficulty finding a comfortable space to face the long waits; lack of privacy while in gowns and when sharing information within earshot of strangers; and a lack of humanised communication between staff and waiting patients, respectfully. With no EDs in England having met the NHS operational standard - to have admitted, transferred, or discharged 95% of patients within four hours - for over a decade (RCEM, 2023), prolonged exposure to such environmental risk factors would appear set to continue.

This current study speaks to a generality of negative ED environmental effects on patient experience. This patient experience of the ED environment is not unique and has been similarly reported by other authors, including from an international perspective (Bull et al., 2021; Bull et al., 2022). One obvious barrier to any sudden upturn of UK patients' experience of the ED environment relates to the structural limitations of existing NHS hospital sites. Limited government funding on big infrastructure projects (Norris and Tetflow, 2023) means that many of the existing tower block constructions are still in use dating back to the hospitals building boom of the 1960s (Greengross et al., 1999). It has been suggested that the same environmental features of ED that allow for a swift response to a patients' medical needs (i.e., open plan spaces in central ground floor positioning and curtains) might also be compromising patient experience (Rowe and Knox, 2023). With such intractable physical limitations to privacy, for example, the barriers to achieving person centred communication of the kind that might lead to therapeutic alliance become clear. This is borne out in the patient experience of ED, serving as an unfortunate glass-ceiling to how person-centred the ED environment might be. Those responsible for decisions on how the space in ED is configured need to consider this physical place through a person-centred lens if things are to improve (Killingback et al., 2022a).

The final knowledge here endorses the type of ED physiotherapeutic approach that strives to maintain a patient's personhood. Personhood is a status "bestowed upon one human being, by others, in the context of relationship and social being" (Kitwood, 1997:8). Given the stressful clinical ED environment (Basu, 2017); under such relentless pressure, considerations of personhood and person-centred practice are, understandably, not always forefront of the mind. Furthermore, emergency departments are reported as having a 'powerful performance culture' affecting how staff perform their jobs (Mind, 2023). Attempts to improve quality in ED have thus tended to be based around structures, processes, and outcomes rather than person-centredness, despite the challenges in ED reflecting a lack of person-centred practice (Walsh et al., 2022). A philosophical chasm remains between biomedical foundations of ED and a person-centred medicine that rejects such a disease-centred ethic (Fuller, 2017).

What is interesting is that in this current study, many participants attended to by ED physiotherapists reported the exact opposite in not being made to feel like just another number in the ED production line. The experience of being managed by an ED physiotherapist, it seems, was in sharp contrast to participants' experiences during previous visits when managed by the medical team. Participants reported the physiotherapist approach as better able to maintain their privacy and dignity and, by extension, their personhood. They did this in a way that did not leave them feeling like they were being check listed: an allusion to the value of individualised care, so central to person-centred practice.

The positive response to ED physiotherapists' humanised approach here echoes the findings of Viotti and colleagues (2020) where patient satisfaction in ED was not compromised by a long wait, provided the clinical interactions were consistent with higher levels of person-centred-adjacent practices. This demonstration of inverse correlation between wait time and satisfaction when less humanised care was delivered (Viotti et al., 2020) support the idea of a person-centred push back against biomedicine as worthwhile.

Time must be a consideration as part of clinical workload and patient experience in relation to maintaining their personhood. A study of nursing practice presented the original suggestion that person-centred interactions might take on average 10-20 minutes longer to deliver (Wolf et al., 2008). It is therefore possible that as an outsider with almost peripatetic status within the ED team, physiotherapists in this study had a luxury of time not afforded to the rest of the medical team; a clear advantage given the focus on person-centredness. Given the inherent value clinicians and waiting patients place on time, it is unsurprising that person-centredness is considered so fragile a concept in settings like ED where time is of the essence (Kennedy, 2017)

When entering a busy ED environment, seemingly geared up for the swift medical processing of an endless procession of patients, a patient's personhood is clearly on the line. Despite all the challenges faced, including the effects of the culture within ED itself, delivery of person-centred practices can still be achieved. (McConnell et al., 2016). Adopting an ED-specific person-centred approach was, in this study at least, instrumental to why ED physiotherapy care was so well-received by participants, albeit with the benefit of having time in which to deliver this.

5.5.1 Quality evaluation

A lack of consensus regarding how rigour in qualitative research should be defined and evaluated is reflected by the wide range of quality criteria used to assess this (Flick, 2018). Failure to establish a single approach here may reflect the absence of unifying qualitative methodological paradigm (Rolfe, 2006). If we consider quality standards as something transcending methodology orientation (Morrow, 2005), the quality framework must reflect how well the research was done, regardless of theoretical paradigm (Roller and Lavrakas, 2015).

For the current study a Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was completed (see appendix 12) to ensure methodological rigour of the qualitative interview data collection methods (Tong et al., 2007). Quality assessment, itself, was judged according to the *total quality framework (TQF)*, which, in sum, calls for a completeness and accuracy of data collection – '*credibility*'; completeness and accuracy of analysis and interpretations – '*analysability*'; completeness and disclosure of reporting in the final document – '*transparency*'; and a demonstrable ability to do something of value with the outcomes – '*usefulness*' (Roller and Lavrakas, 2015). This approach is based on the logical principle that better quality data collection will lead to more robust and valid data interpretations, which in turn lead to useful outcome from the research. Quality considerations in this study will now be discussed in depth beneath these framework headings:

5.5.1.1 Credibility

Scope

The *target population* in the current study was defined as all ED attendees at a single hospital research site during the three-month data collection period (February 2023 to April 2023) who ultimately had their care predominantly managed by a member of the primary contact physiotherapist team. Considering, as the *total quality framework* does, the target population as a *list*, here this list would include any patient presenting at this large type-1 ED with a musculoskeletal-adjacent condition, that had been appropriately added to ED physiotherapy 'stream'. Streaming, itself, occurred after a patient presented at the ED reception or having initially arrived by ambulance, was ultimately transferred to ED 'minors' reception to receive their care. The *sampling design* was purposive, with the members of the physiotherapists team who worked independently each day (seven days a week; 375 days a year) being requested to continuously recruit all patients (fulfilling the study inclusion criteria) just prior to discharge. Of course, this approach depended heavily on the individual physiotherapists' selection, ability to sell the research to the patients, compliance, and the patients' willingness to be involved in the study – limitations of which, including choosing only those interactions that went well, being discussed later (see Strengths and limitations). With all those recruited being contacted within days and, except for one, being interviewed within a week, the researcher transcribed and analysed data between interviews to make a live determination of when sufficient participants had been captured. Rejecting quantitative notions of sample size, this was determined based on considerations of information power; a contemporary method described in data collection section, according to Malterud et al (2016). The access strategy for this sample was thus clearly stated.

Data gathering

A key quality consideration here, akin to *construct validity*, is on how well the data gathered represents what it claims to measure (Roller and Lavrakas, 2015). The broad focus of this study was on person-centredness and, more specifically, person-centred ED physiotherapy practice: a rather complex and apparently context-specific construct, that not only lacks an agreed definition, but also encompasses many different sub-constructs such as shared decision-making, communication etc. Given this nebulous nature, it is unsurprising that the research discourse on PCP acknowledges this shortcoming and appears to have moved on from seeking universal definition, in lieu of more operationalising pursuits.

There was the added challenge, here, not present in the clinician study, on how best to capture aspects of PCP from patients without inadvertently telling participants what to say; since patients, unlike physiotherapists, are less likely to have a clear understanding of PCP. Due to the highly abstracted and necessarily non-directional nature of questions, the following steps were therefore taken to maximise construct validity before collecting interview data,

1. A prior literature review on PCP generally (background to the study)
2. A systematic review on musculoskeletal PCP specifically (systematic review)
3. Co-authoring of person-centred physiotherapy framework (Killingback et al., 2022b)

The above steps formed the basis for creation of an interview guide able to capture aspects of PCP without inadvertently telling participants what to say. The interviews questions were rigorously piloted, adjusted and effectively co-authored with persons who had regularly attended ED in the past; those who had attended ED and had their care managed by an ED physiotherapist; as well as undergoing a formal PPIE panel review and approval. The exploratory nature meant that attributes of the PCP constructs here were being defined by this actual research within the novel ED setting. The research question: *what are the views and experiences of emergency department patients who are managed by primary contact physiotherapists on person-centred practice?* meant both an indirect patient questioning on PCP, but also analysis of responses through the theoretical lens of PCP.

Pre-piloted, online audio data collection, based on a semi-structured in-depth interview method, was not only the most convenient, but also best suited for patients, from a wide geographical catchment area, who were only recently struggling enough with musculoskeletal conditions to feel the need to go to ED – therefore shouldn't be inconvenienced by an unnecessary return to the hospital.

Sources of bias in the data collection were addressed through rigorous and ethical study design but also through researcher reflexivity. The prior study (An exploration of person-centredness among emergency department physiotherapists: A mixed methods study (study 2)) allowing for development of researcher interviewing skills and piloting of questions undoubtably enhanced the overall quality here. Consideration of researcher positioning, post hoc, and reflective journaling during the interview phase, were used to log potential risks for incomplete data collection and suspected bias (see appendix 18).

However, no such issues were identified pertaining to incomplete participant data provision.

Analysability

Processing

Verbatim transcripts of recorded audio interviews were typed and checked twice by the researcher for any errors, with no missing data identified or additional data transformation required. Iterative coding on transcribed data occurred following closely the six-stages of thematic analysis (Braun and Clarke, 2021) and data-relevance to the research question, namely, patient views on experiencing ED physiotherapy that pertained to PCP (code book – appendix 19). Excerpts were checked by primary PhD supervisor for intercoder reliability and codes were developed by the main researcher, but with subsequent supervisory team agreement. The themes developed were interpreted through analytical discussion by the researcher on the new knowledge offered.

Verification

Peer debriefing occurred with the PhD researcher's supervisory team, themselves experienced qualitative researchers, as well broader discussions on issues of quality with independent researchers during researcher's annual review, for example. Reflective journaling here included entries on interview issues (see appendix 18). Data and method triangulation were achieved by considering the findings (see 6.3) from this study alongside those of the previous two studies, which used different samples as well as alternative quantitative method collection.

Real time questioning of interviewees answers featured as a real-time member-checking of sorts, with paraphrased follow-up questions confirming a patient's meaning of what they had just said. A summary of themes was ultimately shared with those participants that consented to this via email, which offered them a chance to respond, however none did. Some, including Roller and Lavrakas themselves (2015), challenge the veracity of such member-checking, which with patients in this case, particularly, lacking sufficient insight to be able to judge relevance of their answers to complex construct like PCP on which they were only indirectly questioned.

5.5.1.2 Transparency

Reporting

There was clear reporting of the thematic data, including a discussion contextualising finding within the extant literature. Additional relevant documents are appended to support transparency here which allow the reader to adjust applicability and transferability to other contexts – in this case other ED sites, nationally and internationally (see appendix 18,19).

5.5.1.3 Usefulness

The impetus for this overall PhD project was deliver something of usefulness to fellow ED physiotherapists to enhance their PCP and improve patient experience. Given the findings from this study add new and interesting knowledge and fill an identified research gap on how patient experience PCP when managed by an ED physiotherapist, this, in the authors opinion, is emphatically achieved. This study was submitted for publication in manuscript form in a high impact factor, peer-reviewed journal but also synthesised alongside other study data to provide practicable recommendations that can be used by ED physiotherapists.

5.5.2 Strengths and limitations

The author acknowledges both strengths and limitations to their research. Firstly, there was a period between participant recruitment and interviewing which may have introduced an element of recall bias. This was, however, offset by the fact that all but one interview was completed within a week of the ED attendance.

Secondly, since patients with the strongest views may be more inclined to contribute, the overall excellent experience of ED physiotherapy could reflect a gratitude and feeling of obligation for patients to take part. While this could swing both ways if patient wished to air their frustrations, it is anticipated that the recruiting physiotherapist would be more disposed to target those consultations that went well and vice versa as this reflected their performance. While one physiotherapist did feature more highly than others this was offset by the fact that five different clinicians with a spread of gender, age, experience in the job were represented in the data: a clear strength of the study.

Finally, another real strength of the study was that it captured people of wide range of ages. Despite the sample being representative of the area in which the research was conducted, all of those interviewed were white British and thus constituted an ethnically non-diverse sample.

5.5.3 Conclusion

This study offers four novel contributions that further our understanding of the person-centred practices of ED physiotherapists from the perspective of their patients. Firstly, that those attending ED appeared to place an importance on obtaining some form of validation by the physiotherapist regarding their ED visit. Secondly, that ED attenders strongly endorsed the educational and explanatory approach adopted by ED physiotherapists in this study. Thirdly, that patient perceptions about ED's physical environment were negative in such a way as to constitute a barrier to achieving person-centred practice. Finally, that an ED physiotherapeutic approach that strives to maintain a patient's personhood was recognised and appreciated by patients in this study.

The current situation in the UK is that many patients, reportedly unable to access primary care, are presenting at ED; adding pressure to already stretched emergency services. In a climate of such unrelenting pressure on staff who work in ED, the patient experience, which incorporates person-centred practice, may be compromised.

This study addresses how ED attenders managed by physiotherapists experience person-centredness and builds on previous research on the ED physiotherapist perspective of person-centred practices. A model or framework to support operationalisation of person-centredness in ED is currently lacking and should be a target for future research in the interest of improving patient experience and delivering on person-centred healthcare visions.

5.6 Summary

This chapter employed a qualitative research design to explore the views of patients attending ED on PCP having had their care managed by a primary contact physiotherapist. Interpretation of the findings here indicate that ED patients are cognisant of both environment limitations to PCP and institutional challenges of ED to their personhood. The implication for ED physiotherapists for realising PCP here were that ED patients expected a validation of their visit and that they greatly valued the educational and explanatory aspects provided by attending physiotherapists.

In the following discussion chapter, the attempt is made to summarise and synthesis the combined study findings using three, key 'threads', pertaining to PCP, interwoven with the wider literature. These threads serve as a framing to answer the overarching PhD research question: *how is person-centred practice understood and experienced by patients and physiotherapists within the emergency department*?

Chapter 6 Discussion

6.1 Introduction

The overarching aim of this thesis was to explore PCP in ED to answer the specific research question: *how is person-centred practice understood and experienced by patients and physiotherapists within the emergency department*?

Individualised person-centred approaches are important as they ensure people's preferences, needs, and values guide clinical decision-making through care that is respectful and responsive toward them (NHSE, 2024b). PCP is relevant to all physiotherapists due to the professional expectation they enact such approaches with their patients (American Physical Therapy Association, 2018; Chartered Society of Physiotherapy, 2019; Physiotherapy Board of New Zealand, 2020). Further research of PCP is said to offer the potential to improve patient interactions and treatment outcomes (O'Keeffe et al., 2016). Since, if and how physiotherapists might achieve PCP within an ED setting is yet unexplored terrain, this forms the basis for this thesis.

This overarching PhD research question was operationalised through three respective studies:

1. Systematic review of musculoskeletal physiotherapists and patients views on PCP.

2. Mixed-method exploration of how PCP is understood and interpreted by ED physiotherapists.

3. Qualitative inquiry of how PCP is experienced by ED patients managed by ED physiotherapists.

6.2 Overview of each study

6.2.1 Study 1 – Systematic review

The first study was a qualitative systematic review with the aim of exploring the views of musculoskeletal physiotherapists and patients on person-centredness and the specific research question: *What are the views of musculoskeletal physiotherapists and patients on person-centred practice?*

The setting and participants included in this review reflected the absence of literature linking ED physiotherapy with PCP. This constituted the closest available proxy for that cohort of physiotherapists who manage musculoskeletal caseload at the point of first contact within ED. Pre-existing competence and confidence in managing musculoskeletal conditions has meant that it is, by default, predominantly musculoskeletal outpatient physiotherapists who perform this primary contact physiotherapist role in ED.

This research is important as the outpatient musculoskeletal model is so formative in how physiotherapists assess and treat musculoskeletal conditions in ED. This may have its own unique barriers to operationalising PCP that are also relevant within the ED setting.

A bibliographic database search (Academic Search Premier, CINAHL Complete, MEDLINE, APA PsycINFO, SPORTDiscus) of 'person-centred' and its synonyms was carried out to identify relevant qualitative research reporting the perspectives of musculoskeletal physiotherapists and their patients on person-centredness. The findings from relevant primary qualitative studies underwent qualitative metasynthesis following the methods described by Thomas and Harden (Thomas and Harden, 2008).

Thematic synthesis of the nine included qualitative studies resulted in four main themes: treating each patient as a unique person; the importance of communication for achieving a therapeutic alliance; necessary physiotherapist traits for person-centredness; and supporting patient empowerment.

The key conclusions drawn from the study were that empowerment of patients in musculoskeletal physiotherapy contexts might be improved through a more narrative approach to assessment, with the novel concept of clinical bravery recognised as a specific person-centred physiotherapy trait that might facilitate this. It was also concluded that physiotherapists should consider the meaningfulness of any treatment activities provided to maximise the person-centredness of their approach for example, ensuring that the therapy is sufficiently, but not excessively, challenging and linked to any hobbies or interests that makes it resonate with the individual's world.

6.2.2 Study 2 – Mixed methods clinician-facing study

The second study was a mixed methods inquiry with the aim of exploring ED physiotherapists' relationship to PCP to answer the specific question: *how is person-centred practice understood and interpreted by physiotherapists working in the emergency department?* The growth of the primary contact ED physiotherapist role, coupled with the requirement to be person-centred, means that it is important to learn more about ED person-centred physiotherapy practices. This mixed method investigation was based on the respective quantitative research question: *how do physiotherapists working in emergency department define and evaluate person-centred practice?* and qualitative question: *what are the views and experiences on person-centred practice of physiotherapists working in the emergency department?*

This study followed a convergent mixed methods design, with sequential explanatory features. The data sets from an online survey and semi-structured interviews were analysed separately using descriptive statistics and thematic analysis (Braun and Clarke, 2021) respectively, before merging the analysis in the discussion using a joint display. The merged analysis was achieved using the qualitative themes as headings with cross tabulation of relevant quantitative survey findings within a joint display (Skamagki et al., 2022). The resulting mixed interpretations offered a general theoretical underpinning for the discussion, but also reinforced specific analytical points.

A total of 11 in-depth interviews generated three overarching themes: ED patients; ED physiotherapists; and ED environment, which were integrated with the data from 26 quantitative surveys.

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

6.2.3 Study 3 – Qualitative patient- facing study

The aim of the third study was to explore the experiences of emergency department patients on being managed by a primary contact physiotherapist, through the lens of person-centred practice with the research question: *what are the views and experiences of emergency department patients who are managed by primary contact physiotherapists on person-centred practice?* With more patients being managed by ED physiotherapists, it is important to learn about the nuanced aspects of how patients are experiencing person-centred physiotherapy practices within this ED context.

This study constituted a qualitative exploration of person-centredness among ED physiotherapists from the perspective of attending patients, employing semi-structured interviews and thematic analysis methods.

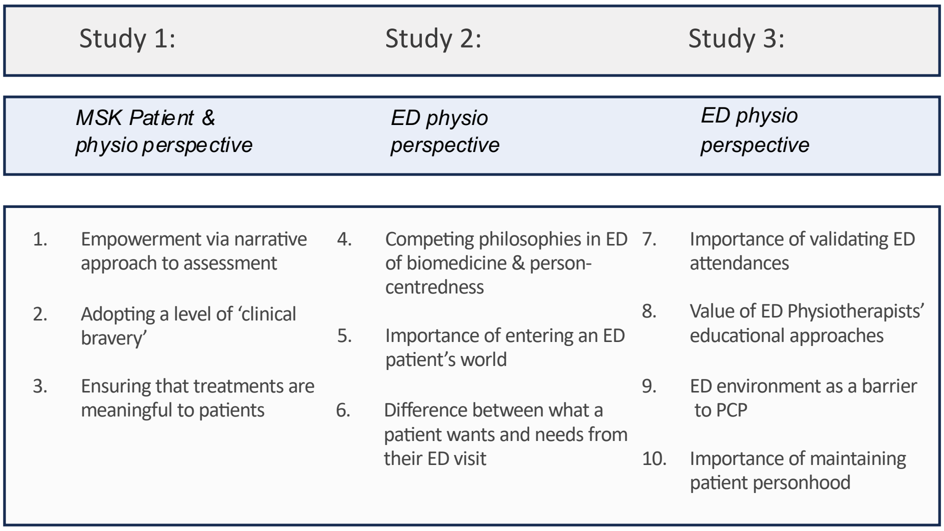
Thematic analysis of 13 interviews resulted in the following four overarching themes: patient experience of the ED; the importance of connection, competence, and time;

recognising the benefits of being seen by a physiotherapist in ED; and patient experience of the ED physical environment.

The interpretations here included the importance placed on physiotherapists validating the ED patient visit; an endorsement of the physiotherapists' educational and explanatory approach; the idea of ED's physical environment acting as a barrier to achieving person-centred practice; and the value placed on a physiotherapist approach that strived to maintain a patient's personhood.

6.3 Synthesising the study findings: visually and narratively

The figure below (Figure 6.1) summarises the new knowledge generated from each study.



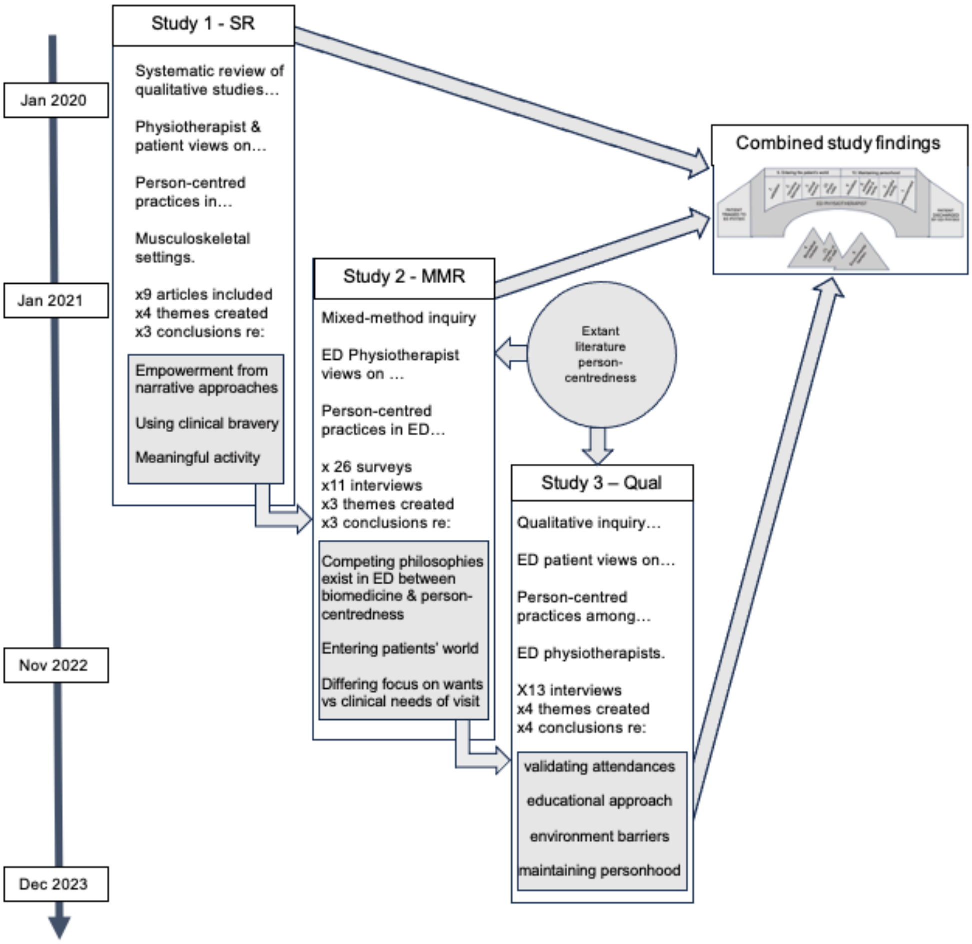
Study 1:	Study 2:	Study 3:
MSK Patient & physio perspective	*ED physio perspective*	*ED physio perspective*
1. Empowerment via narrative approach to assessment	4. Competing philosophies in ED of biomedicine & person-centredness	7. Importance of validating ED attendances
2. Adopting a level of 'clinical bravery'	5. Importance of entering an ED patient's world	8. Value of ED Physiotherapists' educational approaches
3. Ensuring that treatments are meaningful to patients	6. Difference between what a patient wants and needs from their ED visit	9. ED environment as a barrier to PCP
		10. Importance of maintaining patient personhood

Figure 6.1 Summary of key study findings.

Brought together, these studies represent a musculoskeletal patient and physiotherapist view; an ED physiotherapist view; and ED patient view, respectively.

The interrelatedness of respective study findings and their contribution to this discussion are also pictorially represented below (Figure 6.2).

Figure 6.2 Linkage between studies.



Given the large volume of data, and the range of perspectives involved in understanding *how person-centred practice is understood and experienced by patients and physiotherapists within the emergency department*, it was important to find a way to synthesise the findings. Although the development of a theory or framework was not necessarily the goal of the thesis, it seemed prudent to consider how the study findings relate to existing frameworks of PCP.

6.3.1 Consideration of existing person-centred frameworks

There already exists several person-centred frameworks that can be used to support operationalisation of PCP within clinical practice (Mead and Bower, 2000; McCormack and McCance, 2006; Santana et al., 2018), the *Person-centred Nursing Framework*

(McCance and McCormack, 2017) most notably among them. While initially put forward as guidance that was specific to the nursing profession, the latter framework has since been updated and presented as a mid-range theory relevant to a broader healthcare audience, including physiotherapy, under the iteration of the *Person-centred Practice Framework* (McCormack et al., 2021). Other models and frameworks have been devised that support person-centred clinical practice within rehabilitation and physiotherapy (Miciak et al., 2019; Jesus et al., 2022; Killingback et al., 2022b), which constitute a closer relation to the current study.

While there will, of course, be some transferable aspects to these models, none of the frameworks were specifically developed within, or to address, an ED environment; somewhere with its own unique pressures and challenges for the delivery of PCP. The context-specificity of PCP means that any framework would require its applicability to a given setting to be empirically tested, but this is something beyond the scope of this PhD project.

Despite not leading to development of an ED PCP framework as such, the exploration of *person-centred practice within the emergency department* is able to provide novel and practical insights regarding PCP in ED. These will be presented and discussed through three threads, common to all studies (see section 6.4) namely, the importance of therapists holding an empowering attitude toward patients; the importance of listening to patients; and the importance of pursuing meaningful interaction with patients.

To better understand how the findings of this thesis linked to existing frameworks, a pictographic representation, with supporting narrative, was created to combine and position key findings in terms of how a person-centred ED journey might look and feel to the patient (Figure 6.3). Additional interpretations, in the form of recommendations for those ED physiotherapists seeking to enact PCP, are provided later in this discussion and the thesis conclusion chapter.

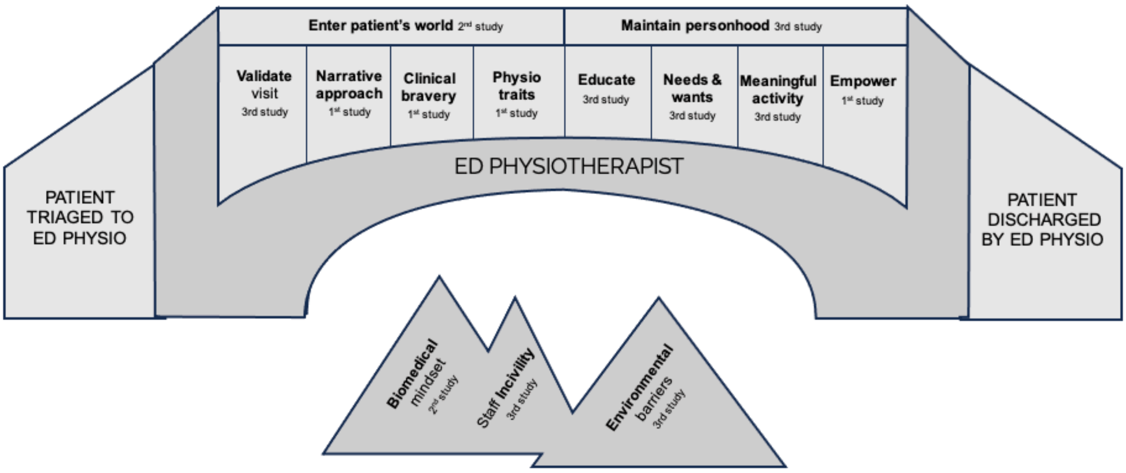


Figure 6.3 Pictorial representation combining all the study findings.

In this person-centred journey through ED (Figure 6.3), the physiotherapist forms the backbone of the person-centred 'bridge' that is traversed by patients from left to right, starting with a visit to ED and, in this case, immediate triaging to the physiotherapy stream. The physiotherapy assessment stage proceeds with validation as the first key step of a musculoskeletal assessment followed by an overriding requirement for the physiotherapist to enter the patient's world through open questioning to share their unique narrative. Person-centred ED assessment here is underpinned by certain necessary physiotherapist traits such as, confidence, personality, strong communication and soft skills. This requires a level of empathy and emotional intelligence, but also a possible prerequisite 'clinical bravery' to venture where the patient needs to go as a narrative assessment partner - no matter how uncomfortable it might be for the physiotherapist.

The patient then progresses to the righthand side of the bridge - to the condition management stage, for which physiotherapeutic maintenance of a patient's personhood is of fundamental concern. This stage is characterised by individualised approaches toward acceptable education and explanation of the patient's unique situation. It is important, here, for the physiotherapist to address directly patient expectations (wants) on top of their obvious clinical needs. This can be achieved by co-authoring of a management plan based on what could constitute a meaningful activity *for them*; ultimately empowering a person to self-manage. Self-management is something that is of benefit to the individual, and the health service through avoidance of unnecessary reattendance for the same complaint (Barker et al., 2017; NHSE, 2024a).

The pitfalls below the bridge symbolise the key challenges in achieving PCP in ED and including incivility of ED staff; intractable environmental factors that limit PCP; and an endemic philosophical bend toward biomedical, rather than a person-centred, ED model of care.

The aforementioned three ‘threads’, that were common across all three studies, are now discussed.

6.4 Using the study findings to answer the research questions

As the three studies were considered in their entirety, and in relation to the overarching research question, certain threads pertaining to PCP, that connect the three studies became apparent. These threads will now be presented with interrelation to the wider literature. These threads serve as a stepping off point used as a framing to answer the overarching PhD research question: *how is person-centred practice understood and experienced by patients and physiotherapists within the emergency department*?

The first thread concerns the importance of therapists holding an empowering attitude toward patients; the second, the importance of listening to patients; and finally, the importance of pursuing meaningful interaction with patients.

6.4.1 The importance of empowerment

In the first study, systematic review of the literature highlighted the view from musculoskeletal physiotherapists that an attitude of empowerment was necessary to practice in a person-centred manner (Ahlsen et al., 2020; Naylor et al., 2023). Empowerment, according to ED physiotherapists in the second study, resulted from offering patients choice and consideration of pros and cons of the management options, as part of the subtheme ‘*involving the patient in decision making’* (Naylor et al., 2024a). The empowering outcome of ED physiotherapists’ educational and explanatory approach was a consequence of ED attenders achieving an understanding and acceptance of their problem in the third study.

The systematic review (study 1) proposes a novel connection between person-centredness, empowerment and the utilisation of narrative approaches to musculoskeletal assessment. This led to conceptualisation of the novel application of clinical bravery in musculoskeletal assessments as a willingness to follow the conversation where the patient needs to take it, even out of a physiotherapist’s comfort zone (study 1 - see Figure 6.1, point 2). This corresponds to the patient’s ‘‘explanatory model’’ - constituting a person’s own narrative conceptualisations of their problem

(Melander Wikman and Fältholm, 2006) and thus emphasises the importance of listening to find common ground and considering the person behind their presenting condition. The inference being that letting the person's story, with all its contextual richness, co-exist and complement the therapist's clinical perspective, was a positive progression from purely structural consideration of their presenting condition. Another important consideration here is that PCP, as a means to empower individuals, presumes a disempowered individual in the first place that might not be the case (Pulvirenti et al., 2014).

Empowerment, and its general outlook for 'acquiring more control over one's life or circumstance' (OED, 2023), holds a significant place within the extant literature on PCP. Person-centredness is, after all, complementary to (Holmström and Röing, 2010), and rooted in, the empowerment of patients to manage and improve their own health (McCance and McCormack, 2017); something that is achieved by facilitating patient contribution to health consultations (May and Mead, 1999). A concept analysis of the term 'empowerment' (Castro et al., 2016), however, established a much broader conceptual meaning than just patient participation and person-centredness; going so far as to highlight its antecedent, or prerequisite relationship to PCP. The inclusion of empowerment as the first of five World Health Organisation strategy recommendations for enabling person-centred health services is, itself, noteworthy (WHO, 2016).

In-keeping with its finding as a main theme in this study's own review, empowerment appears as a subtheme in a prior systematic review on physiotherapy person-centredness (Wijma et al., 2017). A more nuanced view from qualitative enquiry of empowerment in hospital rehabilitation found patients, unaware of their opportunity to exert an influence, 'making their own way' - in accordance with a 'self-regulatory model', while at the same time juggling compliance with the demands of the healthcare system (Melander Wikman and Fältholm, 2006). In this case, the therapists were fashioned more as basic guides, offering support and motivation to facilitate a coping strategy; a characterisation the paper's authors saw more in-keeping with the traditional medical model than PCP or empowerment.

In a more recent qualitative investigation of nurses and physiotherapists' perceptions of PCP across social media communities, there was a particular emphasis placed on education to empower, with a key aspect of the physiotherapy role to enable greater participation in informed and shared decision making (Ward et al., 2018). Most recently, a PCP physiotherapy framework consolidated the importance of empowerment for self-management under an overarching physiotherapist-person interactional domain (Killingback et al., 2022b).

Thus, empowerment is not a new finding per se from this thesis based on the wider literature, however, with its importance to person-centred healthcare at the global health and physiotherapy level well-established, discussion turns to the application of empowerment among ED physiotherapist specifically and its centrality to how ED physiotherapists operationalise PCP.

Empowerment, in health contexts, is defined by a *relationship* between health and power, but also by a *type of patient*, namely, one empowered by the health education programs of a given healthcare system (Holmström and Röing, 2010). In the context of ED physiotherapy, the latter interpretation would appear most relevant to the patient-facing study (study 3), where ED attenders offered a strong endorsement of the educational and explanatory approach of their ED physiotherapists (see Figure 6.1, point 8). If health education is, as the literature would imply, a central precept of patient empowerment, then there is a linking purpose of PCP for developing knowledge, skills and confidence needed to manage and make decisions about their health (Health Foundation, 2016). The transformative effect of eliciting patient understanding in the third study was thus fittingly linked to the empowering intent of delivering PCP.

Empowerment, embedded in the PCP model, has been likened to a rudimentary form of 'health literacy' - with respect to patients' capacity to handle basic health information and services and as a foundation for making informed decisions (Pulvirenti et al., 2014). Having their problems properly explained to them for the first time by an ED physiotherapist, as reported in the patient-facing study (study 3), served as a cathartic experience from which acceptance and empowerment could follow (see Figure 6.1, point 8).

When presented as an end goal, empowerment relates to achieving an 'expert patient' status: with patients equipped and motivated for engagement in self-management, mediated through the sharing of 'power' represented by clinical knowledge and support (McWilliam, 2009). Self-management is, thus, built on the foundations of empowerment as a key dimension of health promotion, facilitating a broader patient control over decision-making (Heggdal et al., 2021). It is apt then that empowerment of an ED physiotherapy patient was, furthermore, linked with the informed shared decision-making that could stem from an understanding of their condition (study 3). Patient empowerment, according to the findings of the clinician-facing study (study 2), was considered by participants as being a direct consequence of providing patients with choice, aligning with the findings of a particular ED physiotherapy focus on delivering what the patients wants as well as their clinical needs (see Figure 6.1, point 6). This included pros and cons of management options, with the resultant shared decision-making being key to the ultimate achievement of self-management. This ties together notions of PCP, empowerment, and self-management. Despite a patient having the right to access health information that can form the basis for any future decision-making, it should not, however, be assumed that information alone will automatically lead to more empowerment (Melander Wikman and Fältholm, 2006).

While some musculoskeletal physiotherapists (study 1) considered empowerment as necessary for PCP (Ahlsen et al., 2020; Naylor et al., 2023), its lacking in other reviewed studies was a possible indication of the challenges faced in mastering this concept within a musculoskeletal type setting. If the traditional musculoskeletal physiotherapy assessment format constitutes a barrier to patient empowerment, then the prevailing biomedical philosophy of the ED setting where physiotherapists manage these patients (study 2), should, by extension, only deepen the challenge in sustaining an empowering attitude, with obvious knock-on constraints for PCP (see Figure 6.1, point 4).

PCP has come to dominate the contemporary discourse on chronic disease management (Bogaert, 2021), particularly through the ideal of patients co-managing their care. This offers a seductive solution given the growing challenges faced by modern healthcare services, attending to the needs of an ageing population with increasing prevalence of multimorbidity and chronic disease. The current reality in the UK is that of an overwhelmed health service, with emergency care in particular disarray, with patients seemingly unable to access care elsewhere defaulting to an ED visit (Tilley, 2021). NHS hospitals have for some time been required to operate at near capacity; a challenge compounded by chronically insufficient staffing levels and physical environments unconducive to PCP delivery (UK Parliament Committees, 2022; RCSEng, 2023; Rowe and Knox, 2023) (study 3 - see Figure 6.1, point 9). With this backdrop, an empowerment ideal that places such high expectation on patient education to ensure adherence to self-management, could be construed as a ‘disguised paternalism’ (Skelton, 1994), violating the fundamental basis of PCP. This may be particularly true when the education is intended as a means for ensuring adherence based on priorities of the health institution, as opposed to that of the individuals it purports to serve (Bogaert, 2021). The importance of maintaining a patient’s personhood was aptly highlighted as key finding in the patient-facing study (study 3 - see Figure 6.1, point 10). For ED patient education to be PCP, it must be individualised to what the person *wants* to learn rather than some standardised clinician's 'spiel' or handout. This again, links with ED study finding on the important distinction of ED physiotherapists' addressing what the patients wants as well as their clinical needs (study 2 - see Figure 6.1, point 6).

Caution must be applied to conflating empowered relationships with empowered outcomes, since assumptions regarding power transfer from PCP might miss the fact that not all patients will use this power to self-care (Holmström and Röing, 2010). As the systematic review (study 1) found, with some patients preferring to have the therapist lead the management of their condition (Morera-Balaguer et al., 2018), outcomes may not be as predictable as supposed.

Applying the empowerment findings from ED patients to the earlier interpretation from the general hospital literature (Melander Wikman and Fältholm, 2006): a commonly reported failure in ED patients' attempts to cope, in accordance with a suggested 'self-regulatory model', appeared to precede a reluctant submission to the ED production line, and thus a compliance with demands of the healthcare system. This conceptualisation did not appear to do justice to what ED physiotherapists were offering in terms of their reported holistic person-centredness that far surpassing a basic guidance.

To summarise, one important way in which *person-centred practice is understood and experienced by patients and physiotherapists within the emergency department* is therefore through facilitating patients' empowerment. Realisation of empowerment in ED is a necessary precondition for PCP. This offers the potential to maintain a patient's personhood and avoid surrender to dominant, traditional biomedical attitudes of ED - improving self-management of a patient's condition that, in turn, offers the potential to prevent unnecessary reliance on already stretched primary and secondary UK health services.

6.4.2 The importance of listening to patients

A second notable thread, common across all three studies, and underpinning PCP, was the importance of ED physiotherapists listening closely to what their patients had to say. Listening was central to the *'importance of communication for achieving therapeutic alliance'* theme of the systematic review (study 1). In study 2 this was formative to both '*physiotherapist skills'* and '*entering the patient's world'* subthemes. In the clinician-facing study (study 3) listening was a constituent of the subtheme *'soft skills that honour personhood'*.

Listening may be inseparable from the term *communication*, but it holds a key distinction in directionality: the person-centred model thus presumes an effective two-way communication where listening results in the understanding of another person (King, 2022). Effective communication in healthcare requires patients to feel that what they are conveying is being heard and understood, but also sense a genuine interest in what they are saying (Shipley, 2010). *Hearing* is therefore only one component of a listening process that, alone, is insufficient to understand another person's lived experience (Fredriksson, 1999).

Listening, according to Gearhart and Brodie, is a multidimensional construct of affective, cognitive, and behavioural processes represented by a listener's motivation to attend, understand, and communicate responses, respectively (2011). However, the human tendency to listen with an intent to reply, rather than truly understand what is being said, (McKenna et al., 2020) is at odds with a person-centred model of care. This serves to underline the significance of more dynamic aspects of listening that will now be discussed by weaving the pertinent thesis findings through the extant literature.

One key finding from the physiotherapist-facing study (study 2) was a cautionary warning against assumptions of what a patient needed from their ED visit since these were often at odds with a physiotherapist's expectations. The alternative recommendation was for a more explicit questioning and listening of a person's reasons for attending ED; with the *ideas, concerns, and expectations (ICE) framework* (Matthys et al., 2009) as one person-centred way to support this end.

An exploration of factors influencing patient-therapist interaction by physiotherapist researcher Mary O'Keeffe and colleagues emphasised listening as part of their first theme *physical therapist interpersonal and communication skills* (O'Keeffe et al., 2016). Here, active listening and allowing the patient to tell their story were important for clinicians and patients in allowing a bond to develop and for patient to feel they were valued. Conversely, an interrupted narrative that prevented a patient's story from being told was a source of unhappiness as the physiotherapist understanding what the patient was saying was very important to them (O'Keeffe et al., 2016). The *physiotherapist skill* subtheme of the clinician-facing study (study 2), too, underlined the importance of not interrupting, but also the benefits of listening in terms of enhanced engagement, better understanding of the patient, rapport building and avoiding missing subtle clinical symptoms. This also highlighted a self-awareness of body language with eye contact and affirmative nods to emphatically convey their listening. The risks to PCP when a physiotherapist allowed their patient to feel they were not being listening to was also present (in study 2) as an essential consideration as part of the *entering the patient's world* subtheme. When a patient is led to feel that they are not being listened to, this ultimately constitutes a threat to the therapeutic alliance so central to PCP.

Listening has been variously and non-exhaustively categorised as active, dialogic, and mindful, with contemporary iterations encompassing additional facets such as empathy, emotional involvement and authenticity (King, 2022). The interactional nature of dialogic listening, in terms of focus on what is happening *between* participants, is particularly pertinent to person-centredness due to a close association with co-constructive narratives for building meaning. Recommendations from the systematic review (study 1) proposed a shift to more narrative approaches in musculoskeletal and, by extension, ED physiotherapy consultations. With its focus on apprehension and understanding of the individual's unique lived experience, a narrative reasoning approach might therefore be considered as a core competency aspect for PCP (Edwards et al., 2004). Through seeking their narrative, the patient is permitted to share experiences of their condition along with its impact on activities of daily life (Melin et al., 2021) in a way that signals that these are important considerations for the listening physiotherapist (Ekman et al., 2011). A search beyond a patient's *condition,* to understand what the problem *meant* to them, was a finding that was of importance to PCP in ED, that, like not being listened to, constituted a part of the *entering the patient's world* subtheme (study 2).

Many of the ED physiotherapists surveyed and interviewed for this project (study 2) declared both extensive clinical experience and a commitment to person-centredness which, it is probably fair to assume, might include well-developed communication skills. The clinician-centric tendencies of inexperienced physiotherapists, such as top-heavy focus on symptoms, on the other hand, could make it difficult from them to incorporate the patient perspective, meaning narrative reasoning approaches might become more of a challenge (Cruz et al., 2012; Cruz et al., 2014). In the example of the ED physiotherapist, it is possible that a more novice clinician might advance their cognitive energies generating a diagnosis or enacting the optimal management plan, rather than eliciting the full narrative. Despite this potential barrier to enacting PCP, narrative approaches should still be endorsed due to a reported utility in helping less experienced physiotherapists establish more empathic relationships, which in turn makes them better listeners who give more attention to their words and silences (Cruz et al., 2014).

A concept analysis of listening from the nursing perspective advanced the idea of listening as ‘a deliberate act that requires conscious commitment from the listener’ - requiring certain essential characteristics like empathy, silence, non-verbal communication and a non-judgemental and accepting approach (Shipley, 2010:125). Considering the mental effort required by the listener in freeing themself of prejudices, resisting standard response patterns and thinking beyond their own frame of reference, for example, skilful listening evidently extends way beyond a simple information gathering process (Robertson, 2005). This perhaps explains why advanced communication skills and personal engagement are reportedly necessary for person-centred goal setting (Mudge et al., 2014).

Despite its association with high quality healthcare delivery, reinforced by evidence of patient dissatisfaction of poor communication experiences (Kagan, 2008), listening does not appear to receive the same research or theoretical attention afforded to other professional skills (King, 2022). Assumptions about listening might serve to diminish this into a routine act that anyone can instinctively perform; something unbefitting of any specialist training. Yet, in rehabilitation conversations at least, it is reported that this should be regarded as a core skill or advanced competency (King, 2022). *Silence* is a particular tool for listening and trickier to execute than one might suppose (Fredriksson, 1999). When applying the finding from the systematic review in terms of the petition for clinical bravery (study 1): accommodating such a narrative shift beyond traditional comfort zones demands the person-centred physiotherapist activate essential characteristics such as timely silences. Enabling such clinically brave conversational turns, where the patient wishes to take it - into areas of emotional distress for example, offers a route for musculoskeletal physiotherapists to achieve person-centredness. A failure to listen due to underdeveloped listening skills, however, can only lead to an incomplete understanding of the patient’s lived experience. Patients evidently appreciate being actively listened to by physiotherapists along with the appearance of interests in what they said and an understanding of their problem (O'Keeffe et al., 2016).

An autoethnographic study on physiotherapy and person-centredness by Mudge and colleagues highlighted the utility of mindful listening, emphasising the importance of allowing patient sufficient time (2014). In another study of patient-therapist interaction, many physiotherapists felt providing sufficient time to listen to patients describe their problem was an essential aspect of positive consultations (O'Keeffe et al., 2016). An exploration of person-centred physiotherapy goal setting by Melin and colleagues found that, while clinical flexibility was underpinned by mindful listening and providing their patients with sufficient time, some physiotherapists might lack the skills or resources, particularly time, to be able to involve patients in their care (Melin et al., 2021). The key implication here is that it is harder for healthcare professionals to effectively listen while under pressure (King, 2022). This has obvious resonance with the caricature of a stressed ED physiotherapist, who might continue to mull over appropriateness of how they managed the previous patient, while working through the queue of waiting patients ahead of them. Within the maelstrom of emergency care, where at any given time the waits to see health professionals, such as the physiotherapist, might stretch into hours, the issue of time is always a pressing concern. There is the added requirement from ED physiotherapists, as rehabilitation specialists, to shift their listening beyond attempts to understand and support as they must also facilitate a patient’s behaviour change toward achieving rehabilitative goals e.g., stability or strength following ankle injury. Within the present person-centred model of healthcare practice, a focused empathic listening to people's stories and experiences was a necessary prerequisite to facilitate therapeutic outcomes (McKenna et al., 2020).

While it would appear entirely reasonable for patients to expect that health professionals should listen to them, the commonest complaint about patient-healthcare interactions, suggesting the opposite, indicates that this is not always the case (Kagan, 2008). A critical review of listening in rehabilitation conversations - a topic aligned to the current research project, concluded listening, as well as other relational outcomes, to be an essential step in achieving mutual engagement, ultimately disposing a person to pursue their goals (King, 2022). From the novel associations that King draws between listening and engagement here, deliberate adoption of person-centred approaches is made manifest through the intent to be an ‘engaged and person-centred listener’. The resulting *conceptual framework of effective listening in healthcare conversations* positioning listening as a personal *characteristic* of style or competency; considers the *attributes* of an engaged and person-centred listener; presents *relational* and *client outcomes* all within the conceptual *relational space* (King, 2022).

The key findings in the patient-facing study regarding the importance of patient validation chimes with previous associations that have been made in the literature between listening and validation (Rogers, 1980; Langs, 1992; Arnold, 1999; Graybar and Leonard, 2005; Clementi, 2006). Experiential listening (Friedman, 2005) is, according to Clementi, an empathetic and supportive method to allow validation through clarification that the message’s meaning is understood (Clementi, 2006). The validation resulting from an active listening process, first described in the therapy setting by Rogers, reportedly held the power to reinforce a person's worth as a human being, helping to clarify their problems (Rogers, 1980) and promoting their validation as a person (Arnold, 1999). Listening, too, has been conceptualised as a validation process of both verbal and non-verbal communication (Langs, 1992) resulting in validation of person's life experience (Graybar and Leonard, 2005).

While validation was in evidence throughout the active listening process of receiving the patient narrative, the emphasis on validation by the ED physiotherapists (study 3) was something that occurred much earlier within the ED physiotherapy consultation. Therapist attempts to reverse prior negative triage experiences, that were at times bordering on uncivil - and redolent of a trial by ordeal in some cases (study 3, participant 5), necessitated listening to the grievance before any attempts could be made to assuage a patient chastened by their preceding experience. The strength of feeling and ultimate appreciation by the patients speaks to a restoration of self-worth or even personhood, through a listening consistent with that described by Rogers (Rogers, 1980) and the key findings proposed by the patient-facing interviews (study 3), respectively. Beyond this initial flurry, gestures of validation would feature throughout the active, dialogical listening processes that typified the person-centred ED physiotherapist consultation.

To summarise, as was the case with empowerment, ensuring that a patient feels they have been heard through narrative approaches, something underpinned by clinical bravery, in an attempt to enter their world holds the potential to preserve their personhood in an environment where their voice can easily be lost from exposure to pervasive biomedical attitudes endemic to ED. Achieving a broader understanding of a patient's condition and what aspects of this matters to them, again, offers the potential to prevent unnecessary reattendances to primary and secondary UK health services.

6.4.3 The importance of pursuing meaningful interaction

The final common thread bridging all three studies, and something seemingly preconditional to the realisation of PCP, was the emphasis physiotherapists placed on achieving a meaningful interaction with their patients. While there may be some common features in what constitutes a meaningful interaction in the literature more generally, variation across different contexts is anticipated. The specific framing of *meaningful interaction* within this ED physiotherapeutic context, therefore, is around a therapist's pursuit of a management plan constituted by *meaningful activity* based on a *meaningful connection* with the ED attender as part of their PCP.

That meaningful treatment activities could make patients feel that their needs were being addressed as unique people was evident in the systematic review (study 1) through the theme *'treating each patient as a unique person'*; with meaningful connection represented through the '*importance of communication for achieving therapeutic alliance'* theme. In the second study, ED physiotherapists seeking to establishment meaningful connections was evident by their attempts to enter a patient's world through a consideration of broader psychosocial factors during the co-construction of holistic patient narratives. In the third study, establishing a meaningful connection with the patient featured prominently in what it was to be a person-centred ED physiotherapist, evidenced through literal representation in the theme '*importance of connection, competence, and time'* and the subtheme *'soft skills that honour personhood'* (study 3).

Humans have an inherent need for engagement in meaningful activities (Cruyt et al., 2023) to the point where negative consequences can result when these are felt to be missing (Klinger, 2012). Meaning, from an occupational therapy perspective, has been characterised as something that "we create for ourselves in our mind that explains experiences and, in turn, motivates us and spurs us on to create new experiences" (Polatajko, 2013:61). Meaningful activity within this 'occupational' context may be considered a broad subjective experience with a tendency to the social, encompassing aspects such as motivation, purposive action and self-efficacy (Eakman, 2013). A metasynthesis on the dimensions of personal meaning from engagement in 'occupations' confirms the relevance to personal and social identity (Roberts and Bannigan, 2018) and justifies the therapeutic use of meaningful activities within occupational therapy (Roberts and Bannigan, 2018; Cruyt et al., 2023). Considering its status as a concomitant health profession, the findings in occupational therapy are expected to hold a similar relevance for physiotherapy.

Despite its centrality to occupational therapy and, to a lesser extent, physiotherapy professional process and outcomes, definitional challenges to meaningful activity remain. Irrespective of definition, it is linked with positive impacts on an individual's health and well-being (Wilcock, 1998) as well as important contributions to meaning in life that fulfil some basic psychological needs (Eakman, 2013). Meaningfulness, according to social psychologist Roy Baumeister, is underpinned by four specific 'needs for meaning', namely: *purpose; value justification; self-efficacy;* and *self-worth* (Baumeister, 1991). Purposiveness, with its orientation towards worthwhile goals that lead to attainment of future desired states, aligns neatly with the ED version of meaningful activity, illustrated through the following quote:

> “All that matters (for the sake of making life meaningful) is that the person’s current activities derive meaning from the ideas of possible future events, states, or outcomes.” (Baumeister, 1991:36)

Baumeister’s evocation of ‘future states’ here might be important in the case of ED attendees. Their insights on the relationship between current health state and any meaningful goals set to improve this, align well with, and can be interpreted using the Multiple Discrepancies Theory (Michalos, 1985). Realisation of subjective wellbeing, according to this theory, is considered a function of the perceived gap between what a person has, and what they want to have (among other measurable outcomes) in such a way that the perception of greater needs correlates with a reduced happiness and satisfaction (Michalos, 1985). Actualisation of PCP in ED remains similarly challenged by patient perceptions, and likely frustrations, of not being where they want to be in the present moment and moreover, not feeling able to get there at all. A possible implication for person-centred ED physiotherapists here, considering its one-shot interactional nature, might therefore be the need to frame any of their ‘prescribed’ activities in terms of their attainability, as well as their *meaningfulness,* in such a way as to narrow this perceived gap. This overlaps well with an ED patient’s belief that they have it within themself to attain the agreed therapeutic goals; something that speaks to Baumeister’s second ‘need for meaning’ that is *self-efficacy* (Baumeister, 1991).

Of the remaining ‘needs’, the *value* domain might be contemplated through the tacit expectation on patients to at least do *something* to get better - exercise or medication, for example, to uphold the unwritten social contract between themselves and their health service that this is the right thing, and what they ought to do.

While Baumeister’s final domain of *self-worth* may hold less relevance in the context of this current discussion, his general thesis of finding *meaning in life* through pursuit of personal goals, and engagement in rewarding relationships, holds undeniable relevance to this discussion on meaningful activity and connection, respectively. The systematic review too (study 1 - see Figure 6.1, point 1) found similar linkage between narrative meaning and relationships through a mutual search for meaning and sense-making - holding the patient’s story as central here was most likely to strengthen the physiotherapist-patient relationship.

Shared decision-making is a person-centred construct relevant to any discussions on meaningful activity. While shared decision-making is itself reportedly complex and irreducible to a single, universal model, common aspects include actions such as discussing the issue, discussing possible options, and agreeing on a course of action (NICE, 2021). Meaningful activity, according to the current research findings on person-centred ED physiotherapy, was achievable through enacting the shared decision-making processes so fundamental to the person-centred model of care. Yet, the frenetic, and sometimes, chaotic nature of ED makes this a uniquely challenging environment in which to enact shared decision-making processes (Hess et al., 2015).

Baumeister's emphasis on the life-balancing effects of having multiple avenues through which to fulfil the need for meaning clearly alludes to more disparate aspects of life than a narrow focus on ED physiotherapy treatment options. However, this might be tenuously applied to a shared decision-making process where meaning arises from choice and option speak enacted by the person-centred ED physiotherapist. Ekman's proposal that shared decision making should be built upon the partnership arising from receiving *patient narratives* (Ekman et al., 2011) certainly echoes the findings from both the systematic review (see discussion on narrative approaches - study 1) and clinician-facing study (see discussion on entering the patient's world - study 2).

Any discussion about shared decision-making would be amiss without due consideration of the goal setting so central to rehabilitative practices. Getting patients actively involved in their care through the setting of their own rehabilitation goals is, after all, an acknowledged route to increasing person-centredness (Cameron et al., 2018; Jesus et al., 2022). Furthermore, a content analysis by Melin and colleagues found that, for both patient and physiotherapists across all sites, a person-centred goal-setting approach required goals to be meaningful and relevant for the patient (Melin et al., 2021).

According to the systematic review, physiotherapists' attempts to understand what was meaningful for patients, be it hobbies, interests or simply something enjoyable or familiar, underpinned an acknowledgement of their uniqueness as well as the theme *treating each patient as a unique person* (study 1). The importance of rehabilitation goals being experienced by patients as personally meaningful, rather than what the physiotherapist assumed best for the patient, relates to improving their intrinsic rehabilitative motivation (Littooij et al., 2022). Goals based on objective measures important to the musculoskeletal physiotherapists, like joint range of motion or power, are reportedly less important to patients than those relating to physical activity and work (Gardner et al., 2015). This supports the idea that clinicians overestimate the extent to which their goal setting is person-centred (Cameron et al., 2018). Due to the one-off nature of the ED physiotherapy interaction, there will necessarily be a big difference compared with goal setting in outpatients - with ED goals necessarily more ‘proximal’ than those set in a typical rehabilitation setting where regular follow-ups can occur.

At a more existential level, the broader implementation of shared decision-making within ED is further challenged by the endemic and pervasive biomedical culture highlighted by person-centred ED physiotherapists (see key findings study 2). This is supported by research findings of emergency doctors’ perception that patients prefer to be told what is best for them (Kanzaria et al., 2015). The systematic review, too, reported *some* physiotherapy patients preferring the therapist’s lead in managing their condition, and warned that dogged pursuit of person-centredness in the face of such resistance leads to a “person-centred paradox” (study 1).

Attempts to apply shared decision-making research based on lifesaving ‘every second counts’ ED medicine, to support the type of care delivered by ED physiotherapists, here, may also be misleading due to its comparatively non-urgent nature. Invoking the ED doctor-physiotherapist comparison once again provides an opportunity to emphasise the ED physiotherapy philosophy as less biomedically-oriented and more reflective of a person-centred outpatient model of care, albeit one transferred to the ED environment.

A meaningful patient-clinician connection is something that is reported to occur when both parties involved feel seen, heard, and appreciated; something bringing them closer - along with the feeling that they are in this together (Miciak et al., 2019). Meaningful connection is a constituent element of therapeutic alliance - a common feature in characterisations of PCP.

An existing framework (Figure 6.4) for establishing connections in physiotherapy practice offers structured guidance of ways to create such meaningful connections, namely: to *acknowledge the individual; to use the body as a pivot point; and to give-of-self* (Miciak et al., 2019). These points offer an ideal scaffold on which to graft their relations discovered from this exploration of PCP among ED physiotherapists.

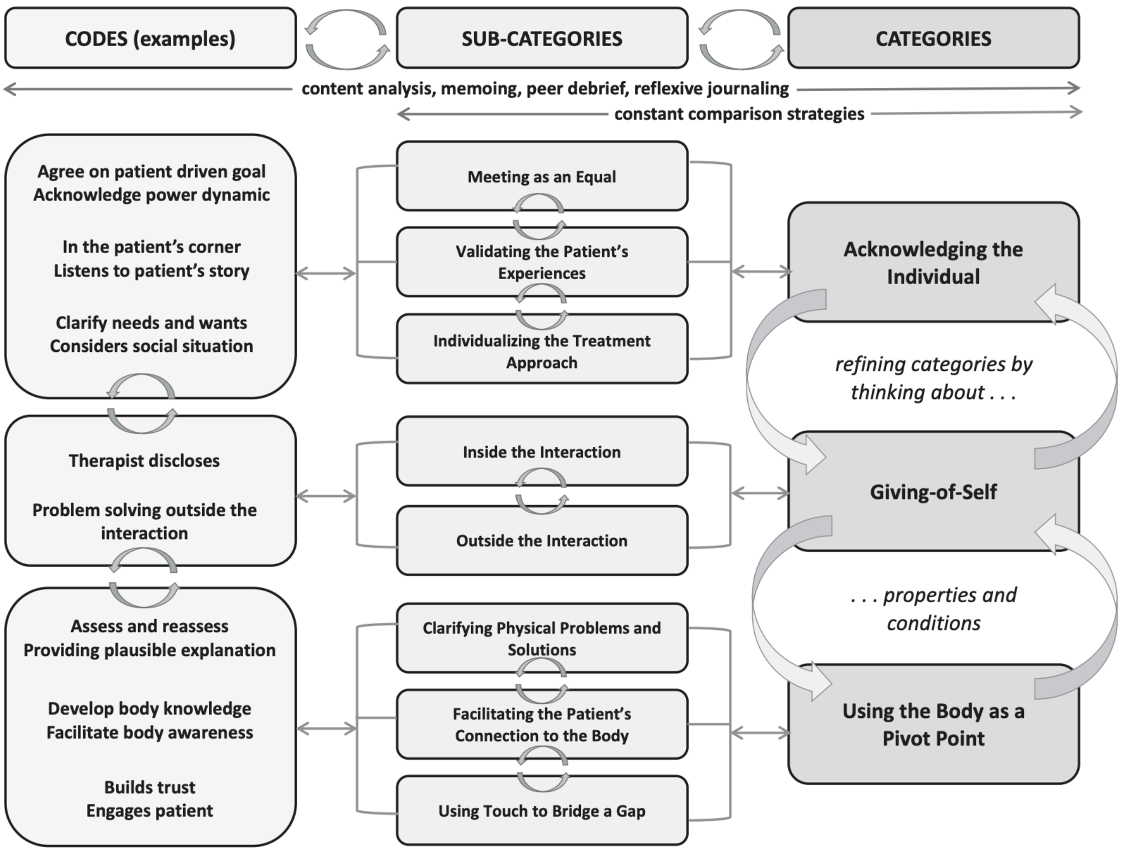


Figure 6.4 Analytical process framework for establishing connections in physiotherapy practice (Miciak et al, 2019).

The first subcategory of '*acknowledging the individual'* namely, '*meeting as an equal'*, speaks to the very power dynamics that ED physiotherapists acknowledged (study 2), and were mindful to resist, while working in an environment seeped in biomedicine and 'doctor as expert' mindset. The second subcategory of '*validating the patient's experiences'* was manifest in contributions of the patient-facing study (study 3) where the incivility of triage nurses demanded a reparatory validation of their visit by the attending ED physiotherapist. The third sub-category of the first domain, '*individualizing the treatment approach'* would appear to demonstrate a literal synonymity with the first theme of the systematic review (study 1), *'treating each patient as a unique person'* and thus negates the need for elaboration.

The category, '*use of body as a pivot point'* is, again, broken down into three subcategories (Miciak et al., 2019). The first, *'clarifying physical problems and solutions'* and the second, *'facilitating the patient's connection to the body'* link with the discussion point from the patient-facing study (study 3) where there was a strong endorsement of the education and explanatory approaches enacted by ED physiotherapists. The third, *'using touch to bridge a gap'* links with the skilful physical examination and hands-on demonstration of exercise that constitutes the ED therapy. Physiotherapy is, after all, a hands-on profession that, despite its acceptance of evidence-informed practice, acknowledges that factors improving outcomes may still derive from so-called non-specific positive effects (Hall et al 2010).

The remaining category, *'giving-of-self'* from Miciak and colleagues (2019) speaks to the emotional capital invested within the empathic person-centred consultation. The idea of clinical bravery (see study 1), where the physiotherapist allows conversational turns to wherever the patient needs, no matter how uncomfortable this may be, attests to the physiotherapist's willingness to give of themselves more than might be anticipated. Concomitant empathic active listening to the full patient narrative (study 1), with prolonged earnest engagement as part of entering the patient's world (study 2), must come with a cost; having a certain fatiguing effect on the ED physiotherapist, given the rapid succession of new patients they are tasked with managing. Also, as discussed in the clinician-facing study (study 2), there remains a requirement to navigate the fluid boundary between what a patient wants and needs from their visit. This iteration of *giving of self* – one where time is permitted for patient ideas, concerns, and expectations to be explored, conflicts with the rapid screening and discharge pressures reportedly felt by these person-centred musculoskeletal physiotherapist *ducks out water*.

Returning to the previously made point made about non-specific affects in relation to *'using touch to bridge a gap'*, it is important to remember that the interactive relationship between physiotherapist and patient, itself, constitutes an important nonspecific factor - fundamental to the therapeutic process (O'Keeffe et al., 2016). Acknowledging and emphasising all interactions as unique is one of the foundations of person-centredness, through its focus on individualisation.

In their systematic review of factors influencing the musculoskeletal physiotherapist-patient relationship, O'Keefe and colleagues reported very similar findings to that of musculoskeletal physiotherapists and patients view on PCP (study 1). Here their overarching themes included: communication; therapist skills; individualising PCP; and organisational and environmental factors – with respective subthemes including: active listening, empathy, friendliness, encouragement, confidence and non-verbal communication; education, expertise and training; individualisation, taking patient preferences into consideration; and time and flexibility (O'Keeffe et al., 2016). One point of contrast, according to their review, was the finding that physiotherapists failed to share patients' opinions on the importance of education for achieving interactional quality. In the clinician-facing study of the ED project, however, while not constituted as a theme as such, education formed an important aspect of the subtheme *involving the patient in decision-making (ST1.4)*, serving to increase patient understanding and acceptance.

As has been proposed, receipt of patient narrative should form the basis for a strong clinical partnership, akin to a therapeutic alliance. From this foundation, understanding by both parties about needs and wants can be manifested in person-centred goals that can be arrived through meaningful activities. When ED physiotherapists attain a clear understanding of what a problem means for an individual and uses this as the basis for shared decision about its management, they can overcome strong biomedical headwinds, upholding of a person-centred philosophy and thus, the patient's personhood. Allowing for rare exceptions to the rule, assumptions that patient wants to be told what to do are best avoided to prevent backsliding to a *clinician knows best* paternalism that might fail to empower the self-management preferable for all. Achieving a broader understanding of what constitutes a meaningful approach to managing a patient's condition reduces the likelihood of 'failure' – in terms of patient satisfaction and unnecessary reattendances to primary and secondary UK health services.

In summary, the final way in which *person-centred practice is understood and experienced by patients and physiotherapists within the emergency department* is therefore through a meaningful interaction constituted by a meaningful connection with, and meaningful activity devised by, a person-centred ED physiotherapist.

6.5 Recommendations

Those summary points pertaining to an ED physiotherapist's PCP, arrived at through analytic discussion on the threads of empowerment, listening and pursuing meaningful interaction, respectively, also form recommendations for future ED physiotherapy practice.

The following summary of considerations are offered to physiotherapists to promote patient empowerment within an ED setting:

- health education is a key part of empowerment, but alone does not fulfil it.
- an empowering attitude is necessary precondition for person-centredness.
- an empowered patient does not necessarily equate to empowered outcome.
- a narrative journey employing clinical bravery is a route to empowerment.
- Self-management is a product of empowerment, facilitated through informed and shared decision-making.

The following summary of considerations are offered to physiotherapists to promote how to ensure the patient feels listened to during consultation in an ED setting:

- active listening is an advance skill and a distinct entity from simply *hearing*.
- listening is deliberate and requires conscious commitment from the listener.
- active listening is necessary precondition for person-centredness.
- active listening is the basis for a narrative journey employing clinical bravery.
- manifold benefits of listening are undermined by interruptions that constitutes a threat to the therapeutic alliance so central to PCP.
- explicit questioning and listening of a person's reasons for attending ED is recommended, employing the *ideas, concerns, and expectations (ICE) framework*.
- active listening can offer validation of person's life experience.

The following summary of considerations are offered to ED physiotherapists to ensure that any treatments they provide are constructed around meaningful activity for the individual patient; achieved through meaningful connections with the ED physiotherapist:

- Meaningful activities are a necessary aspect to enacting PCP in ED.
- Meaningful activities should be framed in context of their attainability.
- Despite challenges posed for ED physiotherapists realising shared decision-making, meaningful activity can still be achieved through pursuing this approach.
- Shared decisions are built on partnerships forged by receiving *patient narratives*.
- Person-centred goal setting requires goals to be meaningful and relevant.
- Established a meaningful connection is key to ED physiotherapy PCPs.

An overview of all recommendations is presented in the table below (Table 6.1).

Table 6.1 Summary overview of the recommendations

Empowerment	**Active Listening**	**Meaningful activities**
requires...	is...	are...
Health education processes	An advance skill that is distinct from hearing	A result of meaningful interaction
An empowering physiotherapeutic attitude	Deliberate & required conscious commitment from the listener	A necessary aspect to ED PCP
A narrative journey that features clinical bravery	A necessary precondition for PCP	Need to be framed in terms of their attainability
Results in....	The basis for a narrative journey featuring clinical bravery	Can be achieved through shared decision making

	Undermined by patient interruptions that serve to threaten ED physiotherapist PCP	Based on shared decisions from a partnership forged by receipt of a patient's narrative
self-management facilitated by shared decision-making	Supported by ideas, concerns and expectations framework	Are facilitated by meaningful and relevant goal setting
Attainment of empowered patient outcomes, but this does not always follow.	A way to validate a person's life experience	Based on meaningful connection that is key to ED physiotherapeutic PCP

6.6 Strengths and limitations

6.6.1 Strengths

There were several strengths to the novel exploration of PCP among ED physiotherapists from this thesis. The first key strength was its incorporation of three differing PCP perspectives, namely, that from the international literature on musculoskeletal physiotherapists and their patients; from primary contact ED physiotherapists based in the UK; and from patients managed by primary contact ED physiotherapists at a single, large ED in the north east and Yorkshire NHS region. This targeting of distinct data sources through a research lens that shifted its focus, from *broad*-international down to *focused*-local, provided newly synthesised knowledge to the discourse on PCP.

Another key strength here derives from the necessary inclusion in the systematic review of a proxy musculoskeletal context - due to other physiotherapy systematic reviews on PCP (Wijma et al., 2017), nursing-specific reviews on ED PCP (McConnell et al., 2016), and the wider extant literature exploring PCP lacking the required focus for the thesis. Aside of its application to this niche ED setting and way it was used to inform subsequent studies, however, this also offers new insights for those countless physiotherapists, based in musculoskeletal outpatient departments, who are seeking to increase their own person-centredness.

Within the second study, the integration of data collected by survey *and* interview methods, here, allowed for a more comprehensive understanding of the research problem (Ivankova et al., 2006). The data from quantitative (and quantitised) surveys, and qualitative ED physiotherapist interviews, were integrated at the *reporting level* within the discussion via a *joint display* method (Skamagki et al., 2022). The provision of clarity from exactly *how* and *when* integration took place – i.e., a joint display, supported by a narrative description, served to strengthen the so-called *analysability* quality aspect of inferences drawn (Roller and Lavrakas, 2015).

An additional strength of the mixed methods approach employed for the second study was its canvassing of diverse, national, ED physiotherapist positions on PCP. The geographic spread of data was inclusive of that from all seven English NHS regions, Wales and Northern Ireland. This provided a broad national snapshot of ED physiotherapists' practice that, apart from a Scottish voice, constituted a truly UK picture.

A final strength from this thesis came from the patient-facing study and its capturing participants with a range of different age, gender and presenting conditions. Furthermore, these participants were managed by five different physiotherapists who themselves represented a range of ages, genders and years of experiences within the ED physiotherapist role. The spread of participant demographics, as well as variation in the attending clinician, about whom the interaction was focused, was a strength in this study, with the diversity of experience being captured from the chosen study population enhancing *credibility* of findings (Roller and Lavrakas, 2015).

With a general philosophical shift aware from paternalistic model of care through a growing expectation that all clinicians are delivering on PCP, the novelty of a project that explores PCP in a challenging and previously unexplored area of the ED physiotherapy interaction - to improve future patient experience, is of real value; with this *importance* considered an added study strength, particularly in terms of the research quality aspect of potential *usefulness (Roller and Lavrakas, 2015)*.

6.6.2 Limitations

There were several limitations to this thesis. Firstly, the choice of setting and participant included in its systematic review reflected the absence of any literature linking ED physiotherapy with PCP and, thus, constituted the closest available proxy for that cohort of physiotherapists who manage musculoskeletal caseload at the point of first contact within ED. Pre-existing competence and confidence in managing musculoskeletal conditions has meant that it is, by default, predominantly musculoskeletal outpatient physiotherapists who perform this primary contact physiotherapist role in ED. However, even though it is, generally, those musculoskeletal physiotherapists who treat, what is generally, musculoskeletal populations in ED, by having to use this best available proxy, the systematic review cannot claim direct representation of ED physiotherapists and patients views on PCP. This is due to both a supposed specificity of context for PCP (WHO, 2015) as well as the possibility that the ED physiotherapist is from a background other the musculoskeletal practice.

The number of qualitative studies included in the systematic review, while sufficient for producing a useful synthesis, was small enough to warrant consideration as a possible limitation. Even though qualitative researchers will judge data by its relevance to the research question, as opposed to coding frequency, the lower the number of studies included in the synthesis could have had a limiting effect on the breath of such codes and themes possibly generated.

Best efforts were made to disseminate the survey through known ED networks, advanced practice and research interest groups, social media, as well as word of mouth, yet the challenges in capturing this very specific, and undefined, population of UK first-contact ED physiotherapists, and them being willing to complete the survey, were evident from the response rate achieved. Despite the number of primary contact physiotherapists practising within UK emergency departments being an unknown, there remains the possible limitation that the survey sample being small (n=26) limits the generalisability of findings. It is fortunate, then, that the survey findings were not used to this end i.e., in the fashion of traditional quantitative research. The low response rate here was, offset by the survey's status as the junior partner in qualitative-centric mixed-method approach; its utility to enable an integrated analysis in mixed methods joint display; and its ability to deliver a sufficient pool of interviewees for the qualitative arm, among other facets.

Of those 26 ED physiotherapists who completed the survey, a total of 11 were subsequently interviewed. Considering the barriers to accessing survey responses, those that did complete the survey and went on to interview were more likely to have been suggestive to, or at least interested in, a person-centred philosophy. Reversing this assumption would infer those with negative views were unlikely to see any value in contributing to the study, let alone giving up an hour of their precious time for interviews. The overall implication here being that this sampling approach, pragmatic as it was, remained vulnerable to capturing positive visions of ED and PCP: a possible source of uneven sampling from the spectrum of views on PCP.

Another limitation to this study surrounds the challenges of discussing a nebulous term like PCP with lay persons for whom this was likely unfamiliar. PCP is, after all, a term that is widely misunderstood and, lacking universal definition, assumes various synonyms to imply the same meaning. The challenge remained to ensure that participants were not simply being led to mirror the researcher interpretations of PCP during the interviews. Initial ideas to overcome this, including using filmed observational and content analysis of the interaction, were halted by uncertainty regarding possible COVID-19 pandemic lockdowns and this placing unnecessary pressure on clinicians already having to adapt to the effects of the pandemic in ED. While accepting its imperfections, the ultimate, pragmatic solution was to inquire about general positive and negative experiences of ED physio experience through the researcher's analytical lens of PCP, using additional prompts. Despite the exact wording of the questions undergoing significant PPIE testing and approval prior to selection, the difficultly of asking someone about something as poorly understood as PCP, without inadvertently polluting their answers, was still a major limitation.

An additional limitation from the patient-facing study included the use of a single large ED site and one that was geographically placed in relatively ethnically non-diverse region. While all of those interviewed might have superficially fitted with the White British ethnicity grouping, lack of formal demographic data collection on ethnicity here meant this could be an assertion only.

Recall bias was considered a lesser limitation due to the rapid turnaround from ED attendance to interview date resulting in only one patient being interviewed a week after their attendance. A more significant limitation of the recruitment process was the expectation that the ED physiotherapists would be unlikely, or unable, to recruit patients who were apparently unsatisfied with their care as this might reflect upon them professionally. This effect might be exaggerated by knowing, as they did, that the interviewer was also a clinical lead within their ED team who would, effectively, be appraising their performance through patient interviews. Conversely, the gratitude of patients for the ED physiotherapists attention increased the likelihood that only those patients that had something good to say would want to get involved in the study, with the possibility that even these participants might be afraid of the future consequence for their ED care of saying something bad about their local ED experience.

6.6.3 Quality assurances

In the systematic review (study 1), quality of individual, included studies was judged using the CASP appraisal tool (CASP, 2018). According to CASP appraisal, all included studies were of very high quality. Quality in the review was also enhanced by developing a protocol registered with PROSPERO (registration number: CRD42020170762), that was based on ENTREQ checklist (Tong et al., 2007) and completion of a PRISMA diagram (Moher et al., 2009).

There exists a bewildering array of quality criteria for appraising mixed methods studies. It is the researcher's belief that if the crux of mixed methods data analysis rests on considerations of how the data is integrated, then the quality too should also be judged as an integrated entity, rather than evaluating quantitative survey and qualitative interviews individually. The approach used for quality assurance in the clinician-facing study (study 2) was, thus, based on a contemporary approach for combining quality assessment procedures known as the 'core quality criteria of mixed methods research' (Hirose and Creswell, 2023). Since this is elaborated in studies' individual chapters (see 4.5.2) what is provided here is a table summary of the quality considerations for the clinician-facing study, according to this core quality criteria (Table 6.2).

Table 6.2 Overview of core quality criteria of mixed methods research (from Hirose and Creswell, 2023)

Core Criteria	***Response for current study***
1. Advance a rationale for using mixed methods methodology	Exploratory nature of the research question demands both quantitative & qualitative data sets as either alone insufficient to answer this. Integrating data triangulated from survey & interview methods allowed for richer & more comprehensive understanding of novel problem not previously investigated.
2. Write quantitative, qualitative, & mixed methods questions	**Quan Q** - how do physiotherapists working in emergency department define and evaluate person-centred practice? **Qual Q** - what are the views and experiences on person-centred practice of physiotherapists working in the emergency department? **MMR Q** - how is person-centred practice understood and interpreted by physiotherapists working in the emergency department?
3. Report separately the quantitative & qualitative data	Quantitative (and quantitized) survey data were reported separately in tabulated and narrative descriptive statistical formats. Qualitative interview data were transcribed, thematically analysed and reported separately as themes.
4. Name & identify the type of mixed methods design & present a diagram of it	This study followed a convergent mixed methods design, with sequential explanatory features: follow up on quantitative data with qualitative data to explain survey findings in more detail.
5. State the use of integration in a joint display	A joint display utilised theme headings as framework with which to link/integrate survey findings based on any data convergence, complementarity, expansion or divergence
6. Discuss how meta-inferences & value resulted from the integration analysis	Metainferences can be found in the righthand column of the joint display based on data convergence, complementarity, expansion or divergence (Fetters, 2020)

For the qualitative patient facing study (study 3), quality assessment was judged according to the *total quality framework (TQF)*, which as an overview, calls for a completeness and accuracy of data collection – '*credibility*'; and of analysis and interpretations – '*analysability*'; completeness and disclosure of reporting in the final document – '*transparency*'; and an ability to do something of value with the outcomes – '*usefulness*' (Roller and Lavrakas, 2015). As with the clinician-facing study, a much deeper conversation is provided in the respective section (chapter 5) so instead, here, a table (Table 6.3) is provided to summarise responses to these criteria.

Table 6.3 Summary of quality according to the total quality framework (Roller and Lavrakas, 2015)

Total quality framework	How addressed in the current study
Credibility *completeness & accuracy of* ***data collection***	*Scope*- target population 'list' includes all ED attendees at single hospital site during stated period, treated by any primary contact ED physio team member- from which a purposive sample & stated access strategy used to obtain a sample size justified through *information power* (Malterud, 2016).
	Data collection - PCP was chosen construct as defined by formal literature review MSK physio (study 1); general multi-professional literature review; concurrent co-authored framework for PC physio (Killingback et al., 2022). Exploratory nature meant attributes of the construct defined *by* the research within the novel ED setting. Pre-piloted, online audio data collection using semi-structured in-depth interview method & guide based on prior above-mentioned sources, plus extensive PPIE. Bias addressed by reflective journals considering e.g., power, rapport, experience as physio-researcher. Also logged reflection on possible risks for incomplete data collections & suspected bias
Analysability *completeness & accuracy of* ***analysis*** *& interpretations*	*Processing* - verbatim transcription & repeated error checking of audio recorded interviews by researcher –no missing data or additional data transformation. Iterative coding by thematic analysis (Braun & Clarke, 2021) as relevant to PCP (see e.g., decisions in code book). Excerpt checks for inter-coder reliability. Developed codes to categories to themes through agreement with co-researchers. Themes interpreted in analytical discussion on new knowledge offered.
	verification - engaged in peer debriefings with other researchers (supervisor & independent) (reflection QA Annual review). Reflexive entry on coding & interview issues. Data/methods triangulation considering data next to that of MMR physio study. Member checking: real time question-answer validity process (with paraphrased follow-up question confirming participant meaning) and summary of themes shared with all participants so chance to respond.
Transparency *completeness of* ***reporting***	*Reporting* - clear reporting of thematic data including a discussion that contextualises to extant literature. Supported by appended transcripts excerpt, codebook/tree & reflective log entries.
Usefulness *Show that* ***can do something*** *with outcomes*	Findings from this study add new knowledge and fill a research gap on how ED patients experience PCP when managed by ED physio. Study submitted for publication in high impact factor journal and synthesised with other studies to create some recommendations for ED physiotherapists on how improve their own PCP.

6.7 Reflexivity

When participants agree to take part in any research it is assumed they will, in some way, and to a varying extent, be affected by the experience; in other words, this cannot help but change the way that they act (Streubert and Carpenter, 2011:22; McCambridge et al., 2014). While it is also true that the researcher, too, will be affected by their role and positioning within the research, the more pressing concern here is on considering the effects of *their* subjectivity on the data that *they* are collecting (Sutton and Austin, 2015). As the author of this thesis, I will now endeavour to explicate my subjectivity within this research through consideration of how - *who I am*, and *my chosen approaches* to this research, might have influenced data collection, and vice versa.

In qualitative research, the researcher is considered as *an instrument of data collection* to the extent that any data, and subsequent interpretations, cannot be fully accepted without a disclosure of their interests and positioning of 'self' within a given study (Sutton and Austin, 2015). This includes dry demographic details regarding their: age, gender, race, class, experience, and so on, but also details of their deeper research philosophy, and the stance taken with the research e.g., insider/outsider view. This demonstration of self-awareness can be arrived at through a process known as *researcher reflexivity* that offers more insight in terms of how this newly generated knowledge has come to be known (Olmos-Vega et al., 2023). It is through reflexivity that the reader is afforded the opportunity to evaluate the researcher as an active participant in the process of meaning creation (Hertz, 1997). Reflexivity is, thus, an important aspect of qualitative research that makes it possible for the reader to legitimise and validate what is being reported.

Disclosure of my own demographic positioning is that of a middle-aged and middle class, white male from the north of England, who has worked as a health professional in both the NHS and private sectors since 2016. My professional specialty is that of musculoskeletal physiotherapy, and I am a lead therapist in areas of outpatient, ED and primary care. I have attained a BSc and MSc in physiotherapy, and this doctoral research thesis is in partial submission for a PhD award.

During interviews in the clinician-facing study (study 2), I introduced myself as an ED physiotherapist who was conducting research within a shared specialty in what was a presumed common interest for improving ED patient experiences. By doing this I was emphatically conveying my status as one of *them*; someone in possession of the insider's perspective, or *emic view* (Streubert and Carpenter, 2011:172). I attempted to build rapport through what we had in common, as fellow ED physiotherapy professionals, reassuring them that this was more of a chat than a quiz, and there were, thus, no 'wrong' answers. After the necessary clarification that I was "starting the recording now", the online interviews deliberately factored in time for small talk, followed by a softener question about how participant came to this ED role. This served to disarm participants' natural unease of going on record such that participants opened-up with the apprehension of a this being a recorded interview appearing to quickly fade from view.

Yet, such conversational style proved a double-edged sword, particularly when participants sought my opinion as their peer. When this happened, my attempted deflections with comments like "what I think is not the important thing here", only served to bring down the *fourth wall* of their being the subject of the recording. I had read widely and considered recommendations for qualitative interviews from the likes of McGrath and colleagues (McGrath et al., 2019), yet my inexperience as an interviewer at this stage, I reflected, was just part of my research journey. Since semi-structure, in-depth interviews aligned with my methodological approach of wanting to understand participants' subjective perspectives and this afforded me the chance to probe deeper with follow up questions like "why do you think that was?" and "was there anything else that you want to tell me about that experience?".

I had ample opportunity to kick myself while transcribing the initial interviews for giving too much of myself in facilitating the interaction. This speaks to what I understand about my own social skills and personal values: prioritising authentic communication; being helpful and putting people at ease being of real consequence to me. The reflection that I needed to speak less, and more slowly, was confirmed by my supervisor from analysis of the pilot and early recordings. While I do not believe that this damaged the data collection, I soon realised my words were useless for the analysis, requiring unnecessary transcription. I therefore used an iterative approach, based on continual analysis after each recording - considering the associated feedback to improve my subsequent interviews, but acknowledge that perhaps some of the earlier interviews might have been of a lower standard for the reasons discussed.

By the time I had conducted the patient-facing interviews (study 3) I felt my interview skills had improved - with notably less transcribed text of my own words serving as evidence for this. It was again vital to loosen tongues and disarm interviewees to get the most out of their answers. Despite the close nature of the ED patient-physiotherapeutic partnership, there remains a division between participants' *emic*-insider views, as those that are living with a problem that is typically pain-related, and the physiotherapists' inability to internalise a situation they have not lived. This appeared to bestow upon me, as the researcher, an *etic*-outsider perspective (Streubert and Carpenter, 2011:172), since I was coming to them with the intention to learn of their experience, to improve the experiences of future ED attendees. On further consideration, this viewpoint might not be quite so black and white as, yes, I am a physiotherapy researcher, but I have also been a patient who has recently attended the same ED with my own acute injury. While not managed by a physiotherapist as such, I did share some insider perspectives of being a patient who attended ED. This was inclusive of all the associated worries about what the injury could mean for me, my work, and my hobbies. This was in such a way that perhaps the stance here might possibly be considered as somewhere between the *etic* and *emic* poles.

With the participants as patients in this third study, the pre-chat and softener questions appeared, even more important, and were seemingly employed to good effect. There was, however, an inescapable feeling that people were not going to surrender their precious time unless they had something either particularly good or bad to say. Thankfully, it was predominantly the former, yet participants were evidently not fazed by making negative comments about the ED experience beyond physiotherapy aspects. The influence of a possible polarised sample of participants on the data collected was duly considered in terms of it being a limitation (see limitations). While not setting out to capture only positive comments about the ED physiotherapy experience, it was vital to glean that which was characterised as a good interaction to explore in what way this could be considered person-centred.

One consideration from the clinician-facing study (study 2), supported by the survey data, is that due to associated medicolegal/professional risk of missing important pathologies or injuries, those physiotherapists working in ED tended to be positioned at a senior level. The idea of these being *highfliers* was alluded to by one participant at least and was familiar in my own pride from occupying such a role. However, there may be consequences for such personal and professional pride that might even extent to competitive thoughts of superiority for a given Trust. Furthermore, as a team lead at one of the interviewed ED physiotherapy sites, self-aware of my senior status, I tried to target physiotherapists with equivalent experience. Despite this, one interviewee was of a lower banding such that I was unable to exclude the possibility of power dynamics coming into play. It is entirely possible that participants would not wish to reveal the shortcoming of their own service to a perceived rival team, for which I was a member, or disclose any negative commentary of a service for which I am a lead. While this did not come across in the interviews, it is not beyond the realms of possibility that this might have affected the data that I collected in terms of less negative comments provided.

Another way that my position might have affected the data was through the patient-participants knowledge that I was part of the same team as their attending physiotherapists: a necessary disclosure for the recruiting process. This meant that participants might think twice before saying anything bad about the team colleagues who had treated them. Even though it was made abundantly clear that what they said would have no bearing on the future care that they received, deep down, some of the participants, particular the older individuals, might fear having their card marked, so possibly pulled their punches. I addressed this with repeated assurances regarding their anonymity, conveying how none of us are perfect; even framing in terms of any feedback as being a gift.

For the patient-participants interviews there was the additional challenge to me, as a caring and instinctively helpful person, *not* to revert to my physiotherapist role. Gladly, I was able to resist this and maintained the fact that, for the purposes of the interview, I was wearing the cap of a researcher as opposed to clinician. When the conversation did drift to clinical questions, I politely shifted to "I am going to keep my researcher hat on for this, if that's OK?". Fortunately, there were no safety issues that would have necessitated invocation of my duty of care as a physiotherapist at that hospital, I was, therefore, able to remain in the researcher role.

Chastened by re-listens to earlier recordings, at some point before the end of the clinical-facing study and the start of the patient-facing study, I had learnt to weaponise the use of silence rather than fill the gaps in conversation to make myself comfortable; something that I would liken to a game of chicken. Biting my lip and waiting for the interviewee to add more, often yielded content I hadn't considered, making this a key learning point for the subsequent interviews. I got better at supressing the desire to put patients at ease, once rapport was established of course, with the consequence of participants offering more and richer data without prompting.

Learning from my collection of data through the interview method, I now realise the importance of establishing my stance, be it insider or outsider, and sticking to this for consistency of reflexivity reporting at the end. Aside of the new skills developed from around 24 hours of interviewing in total (24 in-depth interview, lasting around an hour each), not to mention the weeks of transcription where my shortcomings were laid bare, the experience has had an impact on my way of thinking about how such small gesture by health professionals can mean so much to the individual patient. For example, the value that an ED patient placed on timely communication from staff that clarified what they were waiting for, to manage their expectations. Another way this experience has affected me was in my realising the importance of showing kindness to patients that were often feeling so vulnerable and who needed a therapeutic ally. This all serves to reinforce the key reported finding of how important it is to uphold an ED attender's personhood in this stressful environment.

6.8 Dissemination

The findings of this thesis have been disseminated via various platforms (see full publications and conferences section) in my attempts to communicate with the broadest range of potentially interested parties from physiotherapy academics, musculoskeletal rehabilitation professionals to the public.

The results from the systematic review (study 1) were published the Disability and Rehabilitation journal (Naylor et al., 2023). These findings were also presented at the Chartered Society of Physiotherapy (CSP) Annual conference in Birmingham, 1 Nov 2023.

The results from the clinician-facing study (study 2) were published the Disability and Rehabilitation journal (Naylor et al., 2024a). These findings were also presented, in poster form, at the Chartered Society of Physiotherapy (CSP) Annual conference in Birmingham, 1 Nov 2023 and at Hull University Teaching Hospitals (HUTH) research day, 21 April 2023 at the University of Hull. The former provided an opportunity to share findings about this rather niche area of person-centred ED physiotherapy to the wider physiotherapy community at their main annual conference, while the latter was more focused on disseminating to fellow clinical academics from the local university hospitals.

The results from the patient facing study (study 3) were published the Disability and Rehabilitation journal (Naylor et al., 2024b). An abstract from this study entitled '"*They genuinely seemed to take an interest*" - The experiences of patients attending a UK emergency department who were managed by a physiotherapist: A person-centred perspective', was submitted for presentation at the 2024 Global Conference on Person-centred Care in Gothenburg, Sweden with the ambition for dissemination to an international audience. Unfortunately, the desired platform presentation was not accepted and, considering the cost and time involved, the offer of attending in person to instead present a poster was impractical.

A synthesis of the broader research project entitled, 'person-centred care in the emergency department: a physiotherapist's perspective' was drafted and presented at Café Scientifique, in Atom Bar, Beverley on 5th September 2023. This constituted the author's attempt to disseminate to public as well as academic and professional audiences.

6.9 Future horizons

When considering where this field of research might be heading, it is vital to understand the history and current trajectory for those *would-be* ED physiotherapists i.e., musculoskeletal specialist physiotherapists. Those who might once have seen out their professional careers in outpatients now have much wider opportunities in terms of the primary contact enhanced and advance practice roles available to them. Two key recent developments in particular: the advanced clinical practitioner (ACP) and first contact practitioner (FCP) roles, warrant further discussion due to their potential impact on the ED physiotherapist position and, thus, applicability of the current research within this practice context.

The initiative for UK physiotherapists to move into, and assist with the flow of patients within, ED gained traction around a decade ago. Unhindered by issues of safety or acceptance by ED patients or clinical teams, these primary ED physiotherapist numbers appeared to gradually increase. While this was happening there was also a growth in the number of advanced clinical practitioners (ACP) dwarfing that of ED physiotherapists such that advanced clinical practitioners now find themselves in great demand across a wide range of clinical settings. Given the bespoke credentialing for advanced clinical practitioners in specific clinical areas such as that developed and successfully piloted between 2015 and 2017 by the Royal College of Emergency Medicine (RCEM), this has led to a notable expansion of advanced clinical practitioner in specialist areas like ED.

An advanced clinical practitioner, according to the multi-professional framework for advanced clinical practice in England (HEE, 2017), is someone in possession of a master's level, or equivalent, award and who works autonomously across the '*four pillars'*: clinical practice; leadership and management; education; and research. As more allied health professions (AHP), from physiotherapists to podiatrists, complete advanced clinical practitioner curricula in their respective specialist areas, the pool of clinicians able to manage medical conditions, on top of their prior credentials, continues to grow. With advanced clinical practitioners cheaper to employ than doctors and requiring only a few years from enrolment to qualification before being able to manage a much broader caseload, the benefits to this roll out are self-evident. In natural selection terms, by negating the need for any further ED physiotherapists - with their narrower musculoskeletal remits, the era of the advanced clinical practitioner could possibly lead to the extinction of ED physiotherapist as we currently know it at least. It is therefore unsurprising that many existing ED physiotherapists have and continue to seize the opportunity to cross over to advanced clinical practitioner roles in lieu of their limitations in the medical aspects of holistic ED patient management.

Since the advanced ED clinical practitioner piloting was completed in 2017; and more specifically, the five years taken to complete this PhD project - this situation has evolved rapidly and provides an indication of the current rate of change in this field. The current advanced ED clinical practitioner curriculum capabilities incorporate delivery of '*patient-centred care including shared decision making'*, as well as '*improving person-centred* *outcomes for older people including structure, resources and processes'* (RCEM, 2022) acknowledging the importance of PCP to this new role, on paper at least.

In 2019, this author set out to explore *how person-centred practice is understood and experienced by patients and physiotherapists within the emergency department* as part of a PhD project to support existing and future ED physiotherapy teams in realising PCP for the ultimate benefit of patients. Shortly after commencing this project, however the world changed when the COVID-19 pandemic struck. COVID-19 has had a catalysing effect, resulting in rapid changes to healthcare delivery, particularly in terms of digital health, telehealth, and remote working. While this might not have changed too much in settings like ED, that are inherently face-to-face in nature, much is heard in the general media about the difficulty in accessing in-person consultations with a GP. The role of PCP in a telehealth context is thus something that needs to be explored further. Due to the context specificity of PCP, all those key aspects and recommendations that relate to empowerment, active listening and meaningful interaction relevant to ED physiotherapeutic PCP, would need to be reconsidered within such a different healthcare interaction. This would constitute a substantial piece of work but, given the shifting sands of patient-clinician interaction, would be something of real importance for the broader discourse on PCP. A specific investigation of PCP in physiotherapeutic musculoskeletal telehealth consultations is therefore a proposed recommendation that would be a trajectory option for the author's post-doc research.

As the author moves to completing this thesis in 2024, there have been some further changes with musculoskeletal physiotherapy too with the growth in First Contact Practitioner (FCP) model of care. Within a few years of the ED physiotherapist initiative there began a slow movement of musculoskeletal physiotherapists into primary care. This was planned to address the growing challenges of clinical access for patients, under the guise of a First Contact Practitioner (FCP) model – with FCP being a term formalised by its appearance in the NHSE handbook 'transforming MSK and orthopaedic services' in 2017. Since musculoskeletal complaints, it is claimed, account for up to 30% of those patients seeking to access their GP (Mercer and Hensman-Crook, 2022) it follows that an existing cohort of clinicians, highly skilled in the assessment and management of these musculoskeletal conditions, should cater for this need, relieving the pressure on GPs.

Established in 2019, the additional roles reimbursement scheme (ARRS), provided a funding structure for primary care networks to recruit FCPs to increase capacity and help solve their workforce shortages. An FCP, in contrast to an AP, is regarded as an ‘enhanced’ role in light of its fulfilling in entirety only the clinical pillar of advanced practice according to the FCP roadmap to practice framework (HEE, 2021). While it is difficult to provide accurate figures on FCP numbers, the commitment in the NHS long term plan (NHS, 2019) was that by 2024 all adults in England would be able to see a musculoskeletal FCP at their GPs without a referral. Based on this unsubstantiated claim, and with around 6000 general practices in England, the figure might be estimated as at least a few thousand FCPs.

The published framework guidance to support roll out of the FCP project, the so-called ‘Roadmap’ (HEE, 2021), outlines explicitly the prerequisite knowledge, skills and attributes required for the job. The first of four domains is entitled ‘personalised approaches’ with its second ‘capability’ encompassing PCP under the heading of ‘personalised care’. Such pre-eminence in the FCP framework, as well as the multi-professional framework for advanced clinical practice in England (HEE, 2017), offers a clear indication of PCP’s importance to the respective clinical practices. Furthermore, despite accepted implementation delays due to COVID-19, ‘personalised care’ was, in April 2021, added to the service specification for the 1200+ primary care networks (PCN) in England. While the former frameworks explicitly relate to the PCP of this PhD, the extent to which ‘personalised care’ in the latter example refers to the same, or rather the personalised payment budgets discussed in the introduction chapter, remains unclear. The definitional challenges are ever-present; particularly when the prominent voices like the Coalition for Personalised Care (C4PC) itself uses ‘personalised care’ as a term that includes all person-centred approaches (C4PC, 2024).

The movement of musculoskeletal physiotherapists into primary care is of relevance to the author as someone who has continued to work as a primary contact physiotherapist in both ED and primary care throughout the data collection period. This has provided a good position and insider view as to where research into person-centred physiotherapy for primary contact interactions might be headed. While most published research on FCP has been on audits and patient satisfaction rates, some studies around FCP have covered niche areas such as: FCPs dealing with uncertainty (Ingram et al., 2023); factors that affected patient awareness and understanding of the role (Goodwin et al., 2020); and how patients access FCP appointments (Lamb et al., 2023). To the authors best knowledge there has not been to any research that has specifically investigated how physiotherapists and their patients experience person-centredness in primary care. Given the commitments to PCP within NHS publications and frameworks, as well as this now constituting part of professional requirements, the area would appear ripe for a post-doctoral project. It is therefore the author's current intention to pursue this avenue of inquiry post-doctorally. It is possible that such a project might take a similar format to that of the PhD: commencing with a systematic review of PCP among first contact practitioners; survey and in-depth interviews with existing first contact practitioners; and in-depth interviews for a patient-facing study. Another interesting option might be to conduct an observational study: using video recording to capture the key interactional aspects that make up a person-centred consultation. Despite posing significant challenges in terms of obtaining NHS research ethics approval, such research would promise great benefits to first contact practitioners and the growing number of patients they manage in terms of guiding PCP in primary care.

6.10 Summary

This chapter began by clarifying the research aims and questions, providing an overview of all the included studies and their findings. After consideration of these findings in the context of the existing PCP frameworks, it then went on the synthesise them using the structure of the following common threads: the importance of therapists holding an empowering attitude toward patients; the importance of listening to patients; and finally, the importance of pursuing meaningful interaction with patients. This framing was used to answer the overarching research question: *how is person-centred practice understood and experienced by patients and physiotherapists within the emergency department*? The output here was a series of recommendations presented. This was then followed by considerations of strengths; limitations; issues of quality; researcher reflexivity; dissemination and future horizons for this research. The next chapter will be the conclusion which sets out what needs to change, in terms of healthcare policy, practice and education, based on the new knowledge provided by this thesis.

Chapter 7 Conclusion

The purpose of this thesis was to explore the views of primary contact ED physiotherapists and their patients on PCP. This is important due to the wide scale adoption of this model as a core aspect of quality healthcare, internationally (Wolfe, 2001; The King's Fund, 2013; WHO, 2016).

Despite the acknowledged challenges in operationalising PCP, including a supposed setting-specificity, the absence of explicit guidance to support ED physiotherapists in achieving this constituted a targetable research gap. Previous investigations that have focused on specific areas such as nursing (McCormack and McCance, 2006), or physiotherapy (Killingback et al., 2022b), or PCP more generally (McCance and McCormack, 2017), appeared to lack the necessary context-specificity to actualise this challenging healthcare model within ED. This may be particularly true given the frenetic nature of clinical practice in ED, corresponding more closely to a biomedical, rather than person-centred, philosophy of practice. The current study offers precisely what was found to be lacking in the extant literature, namely, research-based guidance to support ED physiotherapists' necessary pursuit of PCP.

Through its three respective studies, the current exploration reported 10 key interpretive findings that were important to ED physiotherapy PCP that include: empowerment through narrative approaches; adopting a level of clinical bravery; ensuring any treatments are meaningful; acknowledging competing ED philosophies of biomedicine and PCP; the importance of entering the person's world; varying focus between ED clinicians over ED patients' wants and their actuals needs; the importance of validating a patients ED visit; the value of ED physiotherapists educational approach; the ED environment as a barrier to PCP; and the importance of maintaining personhood in ED. These findings were synthesised through respective broad lenses of empowerment, listening and meaningful interaction with ED patients. This synthesis led to a series of recommendations for future ED physiotherapy practice that are now revisited as per their respective threads. For readers who fairly question why such recommendations might not apply to *any* physiotherapy setting, the author - an ED physiotherapist with a musculoskeletal background – acknowledges this possibility but reiterates the unique challenges faced in attempts to operationalise PCP in such high intensity, biomedical arenas.

Firstly, considerations on empowerment demonstrated that empowered ED patient outcomes, such as self-management and improved health intelligence, are underpinned by person-centred aspects of health education and shared decision-making. Narrative approaches to consultation, which include clinical bravery, are capable of driving patient empowerment as part of a broad empowering person-centred clinical attitude, leading to those desirable empowered outcomes. However, not all empowered patients will go on to realise empowered outcomes. The bottom line for ED physiotherapists is that to realise PCP they must harness an empowering attitude for achieving patient empowerment and, despite achieving this goal, empowered patient outcomes such as self-management should not be assumed to automatically follow.

Secondly, this study discovered an important association between active listening and PCP for ED physiotherapists: that there were deliberate and cognitive processes involved in active listening that are distinct from just hearing which, alone, is insufficient. Important PCP constructs shown to apply in the case of ED physiotherapy include therapeutic alliance; patient validation; the use of person-centred questioning via the ideas, concerns and expectations (ICE) framework; and the use of active listening as prerequisite for a narrative journey that features clinical bravery. The key recommendation here is that ED physiotherapists need to adopt an active listening approach and recognise the significant threat to PCP that results from patient perceptions of the physiotherapists not listening - typified by interrupting the patient narrative; something serving to undermine the therapeutic alliance that is central to PCP.

Finally, the recommendations from the discussion on meaningful interaction indicates how receipt of the full patient narrative initiates the move toward meaningful activity, and that this is affected by aspects including meaningful partnership, ideas of attainability, shared decision-making and goal setting. PCP in ED is ultimately achieved through management strategies that channel activities meaningful to the individual patient. The consequences of missing this target increase the chances of subsequent ED reattendance for the same presenting condition.

The findings and recommendations from this study are important due to what they add to the literature on person-centred physiotherapy practices, generally, and ED physiotherapy PCP, specifically. This can, in turn, be used to enhance the experience of ED patients who have their care managed by the increasing number of primary contact ED physiotherapists. Despite some anticipated interest from a readership beyond the ED physiotherapy workforce, including the wider ED medical team, perhaps, the main target group for these recommendations remains those physiotherapists wishing to enhance their levels of person-centredness in an ED setting where patient personhood can be uniquely exposed.

These study findings can also be framed in terms of *physiotherapy theory* and *physiotherapy policy and practice recommendations.* By providing the first qualitative synthesis on the views of musculoskeletal physiotherapists and their patients on PCP, this study offers a formative contribution to the *theoretical* literature on PCP ED physiotherapy. Furthermore, the systematic review's use of the musculoskeletal outpatient model as the basis for the ED physiotherapist's way of working - the closest proxy for ED physiotherapy practice - itself, establishes specific person-centred guidance for musculoskeletal physiotherapists more broadly, whether they remain in outpatients or move to ED.

The findings from this thesis can also offer much in the way of *physiotherapy policy and practice recommendations* at local, national and international levels. At the local level, namely the researcher's own NHS Trust, the recommendation is made for developing 'PCP workshops' for *all* musculoskeletal physiotherapists, with specific additional aspects for ED physiotherapy staff. This is anticipated to be of benefit to all new starters within the musculoskeletal setting, on top of the few that eventually move on from outpatients to ED. Those due to start, or who are already, in ED will be provided with more extensive ED-specific PC training elements based on recommendation from this study. To ensure compliance, the completion of this PCP training will be linked to performance aspects of their role by this featuring as a mandatory aspect within the staff personal development plans.

At a national level, the work of primary contact ED physiotherapists falls under the umbrella of 'advancing practice', which, in turn, falls under the auspices of NHS England workforce, training and education's *Centre for Advancing Clinical Practice* ('the Centre'). There has been a recent move here towards 'credentialing' to define and capture evidence of competency for capabilities in particular areas. As the Centre endorses developed credentials and requires these to be delivered by higher education institutions, the author must seek to embed the study findings at the level of advanced education provision. It will therefore be necessary to ensure incorporation of study findings at the time that a specific ED credential, or bolt-on to the existing advanced musculoskeletal practice framework (Musculoskeletal Partnership Group, 2022), is created. This will necessitate close correspondence with the leading organisations commissioned to develop such content, including the Advanced Practice Physiotherapy Network (APPN), the Musculoskeletal

Association of Chartered Physiotherapists (MACP) and the Society of Musculoskeletal Medicine (SOMM). Success here would ultimately be constituted by the findings exerting influence at the national policy level.

With the call for abstracts to present at the World Physiotherapy Congress in Tokyo, 2025 opening in June 2024, a submission to present the findings of this study on this conference platform will be made as a route to influence practice and policy at the international level.

Further areas for research have been highlighted based on the work of this thesis. There was a recommendation from the systematic review on the need for development of physiotherapy-specific person-centred frameworks to provide clear, research-based guidance on how to operationalise person-centred practice in multifarious musculoskeletal-adjacent settings such as ED. Given the rapid and extensive spread of traditional musculoskeletal outpatient physiotherapists into first contact physiotherapists in primary care, as well as ED, since that call was made, this recommendation becomes ever more pertinent. While the aim of this study's systematic review was not to produce a framework, as such, it does provide a firm foundation for further research into musculoskeletal PCP in first contact physiotherapists for which research is currently lacking. To the author's best knowledge there has not been to any research specifically investigating how physiotherapists and their patients experience person-centredness in primary care. Given the commitments to PCP within NHS publications and frameworks including the *First Contact Practitioner and Advanced Practitioners in Primary Care: (*musculoskeletal*) A roadmap to practice,* itself (HEE, 2021), as well as this now constituting part of professional requirements (Chartered Society of Physiotherapy, 2019), this area would appear ripe for future investigation. A mixed methods survey and in-depth interviews on PCP among first contact practitioners, as well as that for a patient-facing study, would be a possible approach. An alternative option might be to conduct focus groups involving first contact physiotherapists who work in primary care to capture the interactive elements between these clinicians at the vanguard of developing musculoskeletal practice.

Reference list

Adams, S. (2022) Patients made 4.7million trips to A&E because they couldn't get advice or treatment from their GP, UK's health watchdog suggests, *Mail Online.* 15 May. Available online: https://www.dailymail.co.uk/news/article-10817249/Patients-4-7million-trips-E-advice-treatment-GP.html [Accessed 26/1/2023].

Ahlsen, B., Engebretsen, E., Nicholls, D. & Mengshoel, A. M. (2020) The singular patient in patient-centred care: physiotherapists' accounts of treatment of patients with chronic muscle pain. *Medical humanities*, 46(3), 226-233.

Ahmad, N., Ellins, J., Krelle, H. & Lawrie, M. (2014) *Person-centred care: from ideas to action* [eBook]. London: Health Foundation.

Alexanders, J. & Douglas, C. (2016) The role of psychological skills within physiotherapy: a narrative review of the profession and training. *Physical Therapy Reviews*, 21(3-6), 222-227.

Altin, S. V. & Stock, S. (2016) The impact of health literacy, patient-centered communication and shared decision-making on patients' satisfaction with care received in German primary care practices. *BMC health services research*, 16(1), 1-10.

American Physical Therapy Association (2018) *Position statement on 'commitment to person-centred services'*. Available online: https://www.apta.org/apta-and-you/leadership-and-governance/policies/commitment-to-person-centered-services [Accessed 23/9/2023].

Andersson, L. M. & Pearson, C. M. (1999) Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24(3), 452-471.

Arnold, E. (1999) Developing therapeutic communication skills in the nurse-client relationship, in Arnold, E. & Boggs, K. U. (eds), *Interpersonal relationships professional communication skills for nurses*. Philadelphia, PA: W. B. Saunders Company, 209-239.

Balint, E. (1969) The possibilities of patient-centered medicine. *The Journal of the Royal College of General Practitioners*, 17(82), 269.

Barker, I., Steventon, A. & Deeny, S. (2017) Patient activation is associated with fewer visits to both general practice and emergency departments: a cross-sectional study of patients with long-term conditions. *Clinical Medicine*, 17, s15-s15.

Barrett, R. & Terry, L. (2018) Patients' and healthcare professionals' experiences and perceptions of physiotherapy services in the emergency department: a qualitative systematic review. *International Journal of Emergency Medicine*, 11, 1-10.

Basu, S., Qayyum, H. & Mason, S. (2017) Occupational stress in the ED: a systematic literature review. *Emergency Medicine Journal*, 34(7), 441-447.

Baumeister, R. F. (1991) *Meanings of life*. NY: Guilford press.

Bearman, M. & Dawson, P. (2013) Qualitative synthesis and systematic review in health professions education. *Medical education*, 47(3), 252-260.

Belton, J. L., Slater, H., Ravindran, T. S. & Briggs, A. M. (2022) Harnessing people's lived experience to strengthen health systems and support equitable musculoskeletal health care. *Journal of Orthopaedic & Sports Physical Therapy*, 53(4), 162-171.

Bird, S., Thompson, C. & Williams, K. E. (2016) Primary contact physiotherapy services reduce waiting and treatment times for patients presenting with musculoskeletal conditions in Australian emergency departments: an observational study. *Journal of Physiotherapy*, 62(4), 209-214.

Boa, S., Duncan, E., Haraldsdottir, E. & Wyke, S. (2018) Patient-centred goal setting in a hospice: a comparative case study of how health practitioners understand and use goal setting in practice. *International Journal of Palliative Nursing*, 24(3), 115-122.

Bogaert, B. (2021) Need for patient-developed concepts of empowerment to rectify epistemic injustice and advance person-centred care. *Journal of medical ethics*, 47(12), e15-e15.

Braun, V. & Clarke, V. (2019) Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, 11(4), 589-597.

Braun, V. & Clarke, V. (2021) *Thematic analysis: a practical guide*. London: Sage.

Bull, C., Latimer, S., Crilly, J. & Gillespie, B. M. (2021) A systematic mixed studies review of patient experiences in the ED. *Emergency Medicine Journal*, 38(8), 643-649.

Bull, C., Latimer, S., Crilly, J., Spain, D. & Gillespie, B. M. (2022) 'I knew I'd be taken care of': Exploring patient experiences in the Emergency Department. *Journal of Advanced Nursing*, 78(10), 3330-3344.

Burgers, J. S., van der Weijden, T. & Bischoff, E. W. M. A. (2021) Challenges of Research on Person-Centered Care in General Practice: A Scoping Review. *Front Med*, 8, 669491.

Byrne, A.L., Baldwin, A. & Harvey, C. (2020) Whose centre is it anyway? Defining person-centred care in nursing: An integrative review. *PLoS ONE*, 15(3), 1-21.

C4PC (2024) *Coalition for personalised care: personalised care*. Available online: https://www.communitycatalysts.co.uk/coalitionforpersonalisedcare/personalised-care/ [Accessed 14/4/2024].

Cameron, L. J., Somerville, L. M., Naismith, C. E., Watterson, D., Maric, V. & Lannin, N. A. (2018) A qualitative investigation into the patient-centered goal-setting practices of allied health clinicians working in rehabilitation. *Clinical Rehabilitation*, 32(6), 827-840.

Campbell, T. C., Carey, E. C., Jackson, V. A., Saraiya, B., Yang, H. B., Back, A. L. & Arnold, R. M. (2010) Discussing prognosis: balancing hope and realism. *Cancer journal (Sudbury, Mass.)*, 16(5), 461-466.

Caneiro, J., Roos, E. M., Barton, C. J., O'Sullivan, K., Kent, P., Lin, I., Choong, P., Crossley, K. M., Hartvigsen, J. & Smith, A. J. (2020) It is time to move beyond 'body region silos' to manage musculoskeletal pain: five actions to change clinical practice. *British Journal of Sports Medicine*, 54, 438-439.

Carleton, R. N. (2016) Fear of the unknown: One fear to rule them all? *Journal of anxiety disorders*, 41, 5-21.

CASP (2018) *Critical Appraisal Skills Programme Qualitative Checklist*. Available online: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf. [Accessed 18/5/2020].

Cassar, M. R., Davies, F., Braddock, S., Massalha, V. & Pace, J. (2022) The role for physiotherapists in the management of minor musculoskeletal injuries presenting to an emergency department: an evaluation of the physiotherapy service at the Emergency Department of Mater Dei Hospital. *Malta Med J*, 34(2), 78-86.

Castro, E. M., Van Regenmortel, T., Vanhaecht, K., Sermeus, W. & Van Hecke, A. (2016) Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. *Patient Education and Counseling*, 99(12), 1923-1939.

Charon, R. (2009) Narrative medicine as witness for the self-telling body. *Journal of Applied Communication Research*, 37(2), 118-131.

Chartered Society of Physiotherapy (2019) *Code of members' professional values and behaviour*. Available online: https://www.csp.org.uk/system/files/publication_files/000529_Code%20of%20Members%20Professional%20Values%20and%20Behaviours%202019.pdf [Accessed 23/9/2022].

Clark, A. M. (2016) Why qualitative research needs more and better systematic review. *International journal of qualitative methods*, 15(1). Available online: https://doi.org/10.1177/1609406916672741 [Accessed 23/9/2023].

Clarke, E. (2021) Methodological Pragmatism--Freedom from the Squeeze? *International Journal of Multiple Research Approaches*, 13(3), 267-282.

Clementi, P. S. (2006) *Patient expectations during health care encounters theory: a grounded theory study*. PhD thesis. Chicago (IL): Loyola University.

Cook, D. J., Mulrow, C. D. & Haynes, R. B. (1997) Systematic reviews: synthesis of best evidence for clinical decisions. *Annals of internal medicine*, 126(5), 376-380.

Cooper, K., Smith, B. H. & Hancock, E. (2008) Patient-centredness in physiotherapy from the perspective of the chronic low back pain patient. *Physiotherapy*, 94(3), 244-252.

Coulter, A. (2002) *The autonomous patient: ending paternalism in medical care*. London: Stationery Office (for the Nuffield Trust).

Coulter, A., Entwistle, V. A., Eccles, A., Ryan, S., Shepperd, S. & Perera, R. (2015) Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews,* (3). Available online: https://doi.org/10.1002/14651858.CD010523.pub2 [Accessed 23/9/2023].

Cowell, I., McGregor, A., O'Sullivan, P., O'Sullivan, K., Poyton, R., Schoeb, V. & Murtagh, G. (2019) How do physiotherapists solicit and explore patients' concerns in back pain consultations: a conversation analytic approach. *Physiotherapy Theory And Practice*, 1-17. Available online: https://doi.org/10.1080/09593985.2019.1641864 [Accessed 23/9/2023].

Cowell, I., McGregor, A., O'Sullivan, P., O'Sullivan, K., Poyton, R., Schoeb, V. & Murtagh, G. (2021) Physiotherapists’ approaches to patients’ concerns in back pain consultations following a psychologically informed training program. *Qualitative Health Research*, 31(13), 2486-2501.

Cresswell, J. W. & Plano Clark, V. L. (2011) *Designing and conducting mixed methods research*, 2nd edition. Thousand Oaks, California: SAGE.

Creswell, J. W. & Plano Clark, V. L. (2018) *Designing and conducting mixed methods research*, 3rd edition. Thousand Oaks, California: SAGE.

Crouse, T. & Lowe, P. A. (2018) Snowball sampling. *The SAGE encyclopedia of educational research, measurement, and evaluation*, 1, 1532-1532.

Cruyt, E., Jarrey, M., Eijkelkamp, A., Vlerick, P., De Letter, M., Oostra, K., Calders, P., De Pauw, R., Costenoble, A., Bautmans, I., Van de Velde, D. & De Vriendt, P. (2023) Cross-cultural adaptation and psychometric properties of the engagement in meaningful activities survey. *British Journal of Occupational Therapy*, 86(11), 755-766.

Cruz, E. B., Caeiro, C. & Pereira, C. (2014) A narrative reasoning course to promote patient-centred practice in a physiotherapy undergraduate programme: a qualitative study of final year students. *Physiotherapy Theory and Practice*, 30(4), 254-260.

Cruz, E. B., Moore, A. P. & Cross, V. (2012) A qualitative study of physiotherapy final year undergraduate students' perceptions of clinical reasoning. *Manual Therapy*, 17(6), 549-553.

Darzi, A. (2008) *High quality care for all. NHS Next Stage Review. Final Report.* London: The Stationery Office. Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf [Accessed 19/11/2020].

Davies, F., Pace, J., Angus, M., Chan-Braddock, S. & Jagadamma, K. (2022) Physiotherapists with musculoskeletal training in an emergency department for patients with non-specific low back pain: A service evaluation. *Musculoskeletal Care*, 20(4), 960-963.

De Baets, L., Meulders, A. N. N., Van Damme, S., Caneiro, J. P. & Mathevi, T. (2023) Understanding Discrepancies in a Person's Fear of Movement and Avoidance Behavior: A Guide for Musculoskeletal Rehabilitation Clinicians Who Support People With Chronic Musculoskeletal Pain. *Journal of Orthopaedic & Sports Physical Therapy*, 53(5), 307-316.

de Gruchy, A., Granger, C. & Gorelik, A. (2015) Physical therapists as primary practitioners in the emergency department: six-month prospective practice analysis. *Physical Therapy*, 95(9), 1207-1216.

Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. London: The Stationery Office.

Department of Health (2013) *The NHS Constitution for England*. London: Department of Health.

Dewey, J. (1958) *Experience and nature*. Courier Corporation.

Dickson, C., Van Lieshout, F., Kmetec, S., McCormack, B., Skovdahl, K., Phelan, A., Cook, N. F., Cardiff, S., Brown, D. & Lorber, M. (2020) Developing philosophical and pedagogical principles for a pan-European person-centred curriculum framework. *International*

Practice Development Journal, 1-20. Available online: https://doi.org/10.19043/ipdj.10Suppl2.004 [Accessed 23/9/2022].

Dnes, N., Coley, B., Frisby, K., Keller, A., Suyom, J., Tsui, C., Grant, G., Vader, K. & Hunter, J. (2021) 'A little bit of a guidance and a little bit of group support': A qualitative study of preferences, barriers, and facilitators to participating in community-based exercise opportunities among adults living with chronic pain. *Disability and Rehabilitation: An International, Multidisciplinary Journal*, 43(23), 3347-3356.

Driver, C., Kean, B., Oprescu, F. & Lovell, G. P. (2017) Knowledge, behaviors, attitudes and beliefs of physiotherapists towards the use of psychological interventions in physiotherapy practice: a systematic review. *Disability and rehabilitation*, 39(22), 2237-2249.

Driver, C., Lovell, G. P. & Oprescu, F. (2021) Psychosocial strategies for physiotherapy: A qualitative examination of physiotherapists' reported training preferences. *Nursing & Health Sciences*, 23(1), 136-147.

Dukhu, S., Purcell, C. & Bulley, C. (2018) Person-centred care in the physiotherapeutic management of long-term conditions: a critical review of components, barriers and facilitators. *International Practice Development Journal*, 8(2), 1-20.

Eakman, A. M. (2013) Relationships between Meaningful Activity, Basic Psychological Needs, and Meaning in Life: Test of the Meaningful Activity and Life Meaning Model. *OTJR: Occupational Therapy Journal of Research*, 33(2), 100-109.

Edgar, D., Wilson, V. & Moroney, T. (2020) Which is it, person-centred culture, practice or care? It matters. *International Practice Development Journal*, 10(1), 1-17.

Edwards, I., Jones, M., Carr, J., Braunack-Mayer, A. & Jensen, G. M. (2004) Clinical Reasoning Strategies in Physical Therapy. *Physical Therapy*, 84(4), 312-330.

Eisenberg, N. R. (2012) Post-structural conceptualizations of power relationships in physiotherapy. *Physiotherapy Theory & Practice*, 28(6), 439-446.

Eklund, J. H., Holmström, I. K., Kumlin, T., Kaminsky, E., Skoglund, K., Höglander, J., Sundler, A. J., Condén, E. & Meranius, M. S. (2019) "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient education and counseling*, 102(1), 3-11.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I.-L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L.-E., Rosén, H., Rydmark, M. & Sunnerhagen, K. S. (2011) Person-centered care — Ready for prime time. *European Journal of Cardiovascular Nursing*, 10(4), 248-251.

Elvén, M. & Dean, E. (2017) Factors influencing physical therapists' clinical reasoning: qualitative systematic review and meta-synthesis. *Physical Therapy Reviews*, 22(1-2), 60-75.

Engel, G. L. (1977) The Need for a New Medical Model: A Challenge for Biomedicine. *Science*, 196(4286), 129-136.

Engle, R. L., Mohr, D. C., Holmes, S. K., Seibert, M. N., Afable, M., Leyson, J. & Meterko, M. (2021) Evidence-based practice and patient-centered care: Doing both well. *Health care management review*, 46(3), 174.

Ferreira, G. E., Traeger, A. C., O'Keeffe, M. & Maher, C. G. (2018) Staff and patients have mostly positive perceptions of physiotherapists working in emergency departments: a systematic review. *Journal of Physiotherapy*, 64(4), 229-236.

Fetters, M. D. (2020) The Mixed Methods Research Workbook: Activities for Designing, Implementing, and Publishing Projects [eBook]. Thousand Oaks: SAGE Publications, Inc. Available online: https://methods.sagepub.com/book/the-mixed-methods-research-workbook [Accessed 22/8/2021].

Flick, U. (2018) Managing Quality in Qualitative Research, 2nd edition, [eBook]. London: SAGE Publications Ltd. Available online: https://methods.sagepub.com/book/managing-quality-in-qualitative-research-2e [Accessed 22/12/2022].

Foster, C. (2024) Methodological pragmatism in educational research: from qualitative-quantitative to exploratory-confirmatory distinctions. *International Journal of Research & Method in Education*, 47(1), 4-19.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (HC 898-1)*. London: The Stationery Office.: Available online: http://www.midstaffspublicinquiry.com/report [Accessed 27/8/2020].

Franklin, M., Willis, K., Lewis, S., Rogers, A. & Smith, L. (2021) Between knowing and doing person-centredness: A qualitative examination of health professionals' perceptions of roles in self-management support. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine*, 25(3), 339-356.

Fredriksson, L. (1999) Modes of relating in a caring conversation: a research synthesis on presence, touch and listening. *Journal of Advanced Nursing*, 30(5), 1167-1176.

Friedman, N. (2005) Experiential listening. *Journal of Humanistic Psychology*, 45(2), 217-238.

Fruth, S. J. & Wiley, S. (2016) Physician impressions of physical therapist practice in the emergency department: descriptive, comparative analysis over time. *Physical therapy*, 96(9), 1333-1341.

Fuller, J. (2017) The new medical model: a renewed challenge for biomedicine. *Canadian Medical Association journal*, 189(17), E640-E641. Available online: https://doi.org/10.1503/cmaj.160627. [Accessed 20/5/2020]

Gardner, T., Refshauge, K., McAuley, J., Goodall, S., Hübscher, M. & Smith, L. (2015) Patient led goal setting in chronic low back pain—What goals are important to the patient and are they aligned to what we measure? *Patient Education and Counseling*, 98(8), 1035-1038.

Gearhart, C. C. & Bodie, G. D. (2011) Active-Empathic Listening as a General Social Skill: Evidence from Bivariate and Canonical Correlations. *Communication Reports*, 24(2), 86-98.

Gerteis, M., Edgman-Levitan, S., Daley, J. & Delbanco, T. (1993) *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. San Francisco: Jossey-Bass Publishers.

Giddings, L. S. & Grant, B. M. (2007) A Trojan Horse for Positivism?: A Critique of Mixed Methods Research. *Advances in Nursing Science*, 30(1), 52-60.

Gill, S. D. & Stella, J. (2013) Implementation and performance evaluation of an emergency department primary practitioner physiotherapy service for patients with musculoskeletal conditions. *Emergency Medicine Australasia*, 25(6), 558-564.

Gillespie, A., Glăveanu, V. & de Saint Laurent, C. (2024) Pragmatism, *Pragmatism and Methodology: Doing Research That Matters with Mixed Methods*. Cambridge: Cambridge University Press.

Gillespie, R., Florin, D. & Gillam, S. (2004) How is patient-centred care understood by the clinical, managerial and lay stakeholders responsible for promoting this agenda? *Health Expectations*, 7(2), 142-148.

Giusti, A., Nkhoma, K., Petrus, R., Petersen, I., Gwyther, L., Farrant, L., Venkatapuram, S. & Harding, R. (2020) The empirical evidence underpinning the concept and practice of person-centred care for serious illness: a systematic review. *BMJ global health*, 5(12), e003330.

Goldkuhl, G. (2012) Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems*, 21(2), 135-146.

Goodwin, R., Moffatt, F., Hendrick, P., Timmons, S., Chadborn, N. & Logan, P. (2020) First point of contact physiotherapy; a qualitative study. *Physiotherapy*, 108, 29-36.

Graybar, S. R. & Leonard, L. M. (2005) In defense of listening. *American journal of psychotherapy*, 59(1), 1-18.

Greene, J. C. (2008) Is Mixed Methods Social Inquiry a Distinctive Methodology? *Journal of Mixed Methods Research*, 2(1), 7-22.

Greengross, P., Grant, K. & Collini, E. (1999) *The history and development of the UK National Health Service 1948-1999.* Available online: https://assets.publishing.service.gov.uk/media/57a08d91e5274a31e000192c/The-history-and-development-of-the-UK-NHS.pdf [Accessed 10/10/2023].

Greenhalgh, T. & Hurwitz, B. (1999) Narrative based medicine: why study narrative? *BMJ: British Medical Journal (International Edition)*, 318(7175), 48-50.

Gu, Y., Gu, S., Lei, Y. & Li, H. (2020) From uncertainty to anxiety: How uncertainty fuels anxiety in a process mediated by intolerance of uncertainty. *Neural Plasticity*, Volume 2020, Article ID 8866386. Available Online: https://doi.org/10.1155/2020/8866386. [Accessed 20/12/2023]

Guba, E. G. & Lincoln, Y. S. (1994) competing paradigms in qualitative research, in Denzin, N. K. & Lincoln, Y. S. (eds), *The SAGE handbook of qualitative reasearch*, 2nd edition. London: SAGE, 105-117.

Hall, A. J., Burrows, L., Lang, I. A., Endacott, R. & Goodwin, V. A. (2018) Are physiotherapists employing person-centred care for people with dementia? An exploratory qualitative study examining the experiences of people with dementia and their carers. *BMC Geriatrics*, 18(1), 63-63.

Hammond, R., Stenner, R. & Palmer, S. (2022) What matters most: a qualitative study of person-centered physiotherapy practice in community rehabilitation. *Physiotherapy Theory and Practice*, 38(9), 1207–1218. Available online: https://doi.org/10.1080/09593985.2020.1825577 [Accessed 22/8/2023]

Hannes, K. (2011) Chapter 4: Critical appraisal of qualitative research, in Noyes, J., Booth, A., Hannes, K., Harden, A., Harris, J., Lewin, S. & Lockwood, C. (eds), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions. Version 1* Cochrane Collaboration Qualitative Methods Group.

Harding, P., Prescott, J., Block, L., O'Flynn, A. M. & Burge, A. T. (2015) Patient experience of expanded-scope-of-practice musculoskeletal physiotherapy in the emergency department: a qualitative study. *Australian Health Review*, 39(3), 283-289.

Health and Social Care Act, Part 1, Section 2 (2012) Chapter London: The Stationary Office.

Health Foundation (2016) *Health Foundation. Person-centred care made simple: what everyone should know about person-centred care.* Health Foundation. Available online: www.health.org.uk/publications/person-centred-care-made-simple [Accessed 10/10/2023].

Health Foundation (2023) *How the public views the NHS as 75 - July 2023.* Available online: https://www.health.org.uk/news-and-comment/charts-and-infographics/how-the-public-views-the-nhs-at-75 [Accessed 03/10/2023].

Healthwatch (2019) *Healthwatch brings people's voices to Westminster.* Available online: https://www.healthwatch.co.uk/news/2019-01-30/healthwatch-brings-peoples-voices-westminster [Accessed 19/11/2020].

Hedberg, B., Wijk, H., Gäre, B. A. & Petersson, C. (2022) Shared decision-making and person-centred care in Sweden: Exploring coproduction of health and social care services. *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen*, 171, 129-134.

HEE (2017) Multi-professional framework for advanced clinical practice in England. *London: Health Education England*.

HEE (2021) First Contact Practitioners and Advanced Practitioners in Primary Care: (Musculoskeletal) A Roadmap to Practice. *London: Health Education England*.

Heggdal, K., Mendelsohn, J. B., Stepanian, N., Oftedal, B. F. & Larsen, M. H. (2021) Health care professionals' assessment of a person centred intervention to empower self-management and health across chronic illness: Qualitative findings from a process evaluation study. *Health Expectations*, 24(4), 1367-1377.

Henderson, J., Gallagher, R., Brown, P., Smith, D. & Tang, K. (2020) Emergency department after-hours primary contact physiotherapy service reduces analgesia and orthopaedic referrals while improving treatment times. *Australian Health Review*, 44(3), 485-492.

Hertz, R. (1997) Introduction: Reflexivity and Voice, in Hertz, R. (ed), *Reflexivity and Voice*. Thousand Oaks, CA: Sage, vi–xviii.

Hess, E. P., Grudzen, C. R., Thomson, R., Raja, A. S. & Carpenter, C. R. (2015) Shared Decision-making in the Emergency Department: Respecting Patient Autonomy When Seconds Count. *Academic Emergency Medicine*, 22(7), 856-864.

Hiller, A., Guillemin, M. & Delany, C. (2015) Exploring healthcare communication models in private physiotherapy practice. *Patient education and counseling*, 98(10), 1222-1228.

Hillman, A. (2014) ‘Why must I wait?’The performance of legitimacy in a hospital emergency department. *Sociology of Health & Illness*, 36(4), 485-499.

Hirose, M. & Creswell, J. W. (2023) Applying core quality criteria of mixed methods research to an empirical study. *Journal of Mixed Methods Research*, 17(1), 12-28.

Holmes, M. B., Camarinos, J. & Driscoll, L. (2024) Exploring how common factors influence experience and outcomes in painful musculoskeletal conditions: a qualitative study. *International Journal of Therapy & Rehabilitation*, 31(3), 1-12.

Holmström, I. & Röing, M. (2010) The relation between patient-centeredness and patient empowerment: a discussion on concepts. *Patient education and counseling*, 79(2), 167-172.

Holopainen, R., Simpson, P., Piirainen, A., Karppinen, J., Schütze, R., Smith, A., O’Sullivan, P. & Kent, P. (2020) Physiotherapists' perceptions of learning and implementing a biopsychosocial intervention to treat musculoskeletal pain conditions: a systematic review and metasynthesis of qualitative studies. *Pain*, 161(6), 1150-1168.

Hutting, N., Caneiro, J., Ong'wen, O. M., Miciak, M. & Roberts, L. (2022) Patient-centered care in musculoskeletal practice: Key elements to support clinicians to focus on the person. *Musculoskeletal Science and Practice*, 57, 102434.

Hutting, N., Oswald, W., Staal, J. B. & Heerkens, Y. F. (2020) Self-management support for people with non-specific low back pain: A qualitative survey among physiotherapists and exercise therapists. *Musculoskeletal Science and Practice*, 50, 102269.

Ibsen, C., Schiøttz-Christensen, B., Maribo, T., Nielsen, C. V., Hørder, M. & Handberg, C. (2019) "Keep it simple": Perspectives of patients with low back pain on how to qualify a patient-centred consultation using patient-reported outcomes. *Musculoskeletal Care*, 17(4), 313-326.

Illman, J., Discombe, M., & Moore, A (2022) Waiting list jumps as A&E chaos persists, *HSJ*. Online, 12 May. Available online: https://www.hsj.co.uk/quality-and-performance/waiting-list-jumps-as-aande-chaos-persists/7032434.article, [Accessed 26/1/2023].

Ingram, S., Stenner, R. & May, S. (2023) The experiences of uncertainty amongst musculoskeletal physiotherapists in first contact practitioner roles within primary care. *Musculoskeletal Care*, 21(3), 644-654.

Ivankova, N. V., Creswell, J. W. & Stick, S. L. (2006) Using mixed-methods sequential explanatory design: From theory to practice. *Field methods*, 18(1), 3-20.

Janerka, C., Leslie, G. D. & Gill, F. J. (2023) Development of patient-centred care in acute hospital settings: A meta-narrative review. *International Journal of Nursing Studies*, 140, 104465.

Jesus, T. S., Bright, F., Kayes, N. & Cott, C. A. (2016) Person-centred rehabilitation: what exactly does it mean? Protocol for a scoping review with thematic analysis towards framing the concept and practice of person-centred rehabilitation. *BMJ open*, 6(7), e011959.

Jesus, T. S., Papadimitriou, C., Bright, F. A., Kayes, N. M., Pinho, C. S. & Cott, C. A. (2022) Person-centered rehabilitation model: framing the concept and practice of person-centered adult physical rehabilitation based on a scoping review and thematic analysis of the literature. *Arch Phys Med Rehabil*, 103(1), 106-120.

Johnson, R. B. & Onwuegbuzie, A. J. (2004) Mixed methods research: A research paradigm whose time has come. *Educational researcher*, 33(7), 14-26.

Johnson, S. L., Haerling, K. A., Yuwen, W. & Huynh, V., Le C. (2020) Incivility and Clinical Performance, Teamwork, and Emotions: A Randomized Controlled Trial. *J Nurs Care Qual*, Jan/Mar;35(1), 70-76.

Kagan, P. N. (2008) Listening: Selected Perspectives in Theory and Research. *Nursing Science Quarterly*, 21(2), 105-110.

Kanzaria, H. K., Brook, R. H., Probst, M. A., Harris, D., Berry, S. H. & Hoffman, J. R. (2015) Emergency physician perceptions of shared decision making. *Academic emergency medicine*, 22(4), 399-405.

Karazivan, P., Dumez, V., Flora, L., Pomey, M.-P., Del Grande, C., Ghadiri, D. P., Fernandez, N., Jouet, E., Las Vergnas, O. & Lebel, P. (2015) The patient-as-partner approach in health care: a conceptual framework for a necessary transition. *Academic Medicine*, 90(4), 437-441.

Katz, D., Blasius, K., Isaak, R., Lipps, J., Kushelev, M., Goldberg, A., Fastman, J., Marsh, B. & DeMaria, S. (2019) Exposure to incivility hinders clinical performance in a simulated operative crisis. *BMJ Quality & Safety*, 28(9), 750-757.

Kaushik, V. & Walsh, C. A. (2019) Pragmatism as a Research Paradigm and Its Implications for Social Work Research. *Social Sciences*, 8(9), 255.

Kayes, N. M., and Papadimitriou, C. (2023) Reflecting on challenges and opportunities for the practice of person-centred rehabilitation. *Clinical Rehabilitation*, 37(8), 1026-1040.

Kelly, S. (2010) Qualitative interviewing techniques and styles. In: Bourgeault, I., Dingwall, R. & de Vries, R. (Eds) *The Sage Handbook of Qualitative Methods in Health Research*. SAGE Publications Ltd.

Kennedy, C. J. (2017) What is person-centred care and can it be achieved in emergency departments? *Emergency Nurse*, 25(2).

Kidd, M. O., Bond, C. H. & Bell, M. L. (2011) Patients' perspectives of patient-centredness as important in musculoskeletal physiotherapy interactions: a qualitative study. *Physiotherapy*, 97(2), 154-162.

Kidder, L. H. & Fine, M. (1987;) Qualitative and quantitative methods: When stories converge. *New directions for program evaluation*(35), 57-75.

Killingback, C., Clark, C. & Green, A. (2022a) Being more than “just a bog-standard knee”: the role of person-centred practice in physiotherapy: a narrative inquiry. *Disability and rehabilitation*, 44(20), 5847-5854.

Killingback, C., Green, A. & Naylor, J. (2022b) Development of a framework for person-centred physiotherapy. *Physical Therapy Reviews*, 1-16.

King, G. (2022) Central yet overlooked: engaged and person-centred listening in rehabilitation and healthcare conversations. *Disability and Rehabilitation*, 44(24), 7664-7676.

Kinney, M., Seider, J., Beaty, A. F., Coughlin, K., Dyal, M. & Clewley, D. (2020) The impact of therapeutic alliance in physical therapy for chronic musculoskeletal pain: a systematic review of the literature. *Physiotherapy theory and practice*, 36(8), 886-898.

Kinsella, R., Collins, T., Shaw, B., Sayer, J., Cary, B., Walby, A. & Cowan, S. (2017) Management of patients brought in by ambulance to the emergency department: role of the advanced musculoskeletal physiotherapist. *Australian Health Review*, 42(3), 309-315.

Kirk, K., Cohen, L., Edgley, A. & Timmons, S. (2021) “I don’t have any emotions”: An ethnography of emotional labour and feeling rules in the emergency department. *Journal of Advanced Nursing*, 77(4), 1956-1967.

Kitson, A., Marshall, A., Bassett, K. & Zeitz, K. (2013) What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*, 69(1), 4-15.

Kitwood, T. (1997) *Dementia reconsidered: the Person comes first*. Buckingham, Great Britain: Open University Press.

Kivunja, C. & Kuyini, A. B. (2017) Understanding and applying research paradigms in educational contexts. *International Journal of higher education*, 6(5), 26-41.

Kleiner, M. J., Kinsella, E. A., Miciak, M., Teachman, G. & Walton, D. M. (2023) The ‘responsive’ practitioner: physiotherapists’ reflections on the ‘good’ in physiotherapy practice. *Physiotherapy Theory and Practice*, 39(12), 2625-2638.

Klinger, E. (2012) The search for meaning in evolutionary goal-theory perspective and its clinical implications, *The human quest for meaning: Theories, research, and applications, 2nd ed.* Personality and clinical psychology series. New York, NY, US: Routledge/Taylor & Francis Group, 23-56.

Kuipers, S. J., Cramm, J. M. & Nieboer, A. P. (2019) The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Services Research*, 19(1), 13.

Lamb, K., Comer, C., Walsh, N. & McHugh, G. (2023) Access to first contact physiotherapy appointments in primary care: A scoping review. *Musculoskeletal Care*, 21(4), 1182-1194.

Langs, R. (1992) *The listening process*. Northvale, NJ: Jason Aronson Inc.

Launer, J. (2018) *Narrative-based practice in health and social care: conversations inviting change.*, 2nd edition. London: Routledge.

Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S. & Healy, G. B. (2012) Perspective: A Culture of Respect, Part 1. *Academic Medicine*, 87(7), 845-852.

Lefmann, S. & Sheppard, L. (2014) Perceptions of emergency department staff of the role of physiotherapists in the system: a qualitative investigation. *Physiotherapy*, 100(1), 86-91.

Lefmann, S. A. & Crane, J. L. (2016) Establishing the diverse value of the emergency department physiotherapist. *Journal of physiotherapy*, 62(1), 1-3.

Legg, C. & Hookway, C. (2021) Pragmatism, in Zalta, E. N. (ed), *The Stanford Encyclopedia of Philosophy (Summer 2021 Edition),* [eBook]. Available online: https://plato.stanford.edu/archives/sum2021/entries/pragmatism/ [Accessed 19/5/24].

Lethem, J., Slade, P. D., Troup, J. D. G. & Bentley, G. (1983) Outline of a fear-avoidance model of exaggerated pain perception—I. *Behaviour Research and Therapy*, 21(4), 401-408.

Liddiard, K. J., Raynor, A. J., DeJong, H. & Brown, C. A. (2023) The experience of meaningful rehabilitation as perceived by people with chronic pain: A phenomenological study. *Work*, 75(2), 689-701.

Lin, I., Wiles, L., Waller, R., Caneiro, J. P., Nagree, Y., Straker, L., Maher, C. G. & O'Sullivan, P. P. B. (2020a) Patient-centred care: the cornerstone for high-value musculoskeletal pain management. *British journal of sports medicine*, 54(21), 1240-1242.

Lin, I., Wiles, L., Waller, R., Goucke, R., Nagree, Y., Gibberd, M., Straker, L., Maher, C. G. & O'Sullivan, P. P. B. (2020b) What does best practice care for musculoskeletal pain look like? Eleven consistent recommendations from high-quality clinical practice guidelines: systematic review. *British journal of sports medicine*, 54(2), 79-86.

Lin, Y. K. & Lin, C. J. (2011) Factors predicting patients' perception of privacy and satisfaction for emergency care. *Emergency Medicine Journal*, 28(7), 604-608.

Littooij, E., Doodeman, S., Holla, J., Ouwerkerk, M., Post, L., Satink, T., ter Steeg, A. M., Vloothuis, J., Dekker, J. & de Groot, V. (2022) Setting meaningful goals in rehabilitation: A qualitative study on the experiences of clients and clinicians in working with a practical tool. *Clinical Rehabilitation*, 36(3), 415-428.

Low, M. (2018) Managing complexity in musculoskeletal conditions: reflections from a physiotherapist. *In Touch*, 164, 22–28.

Malterud, K., Siersma, V.D. & Guassora, A.D. (2016) Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, 26(13), 1753-1760.

Marcus, J. D. & Mott, F. E. (2014) Difficult Conversations: From Diagnosis to Death. *Ochsner Journal*, 14(4), 712-717.

Matifat, E., Lavoie-Côté, P., Kounda, N., Charrier, L., Perreault, K. & Desmeules, F. (2021) The acceptability of physiotherapy care in emergency departments: an exploratory survey of emergency department physicians. *Journal of Research in Interprofessional Practice and Education*, 11(1), 1-19.

Matthys, J., Elwyn, G., Van Nuland, M., Van Maele, G., De Sutter, A., De Meyere, M. & Deveugele, M. (2009) Patients' ideas, concerns, and expectations (ICE) in general practice: impact on prescribing. *British Journal of General Practice*, 59(558), 29-36.

May, C. & Mead, N. (1999) *Patient-centredness: A history. In General practice and ethics: Uncertainty and responsibility*. London: Routledge 77-89.

Mazurenko, O., Bock, S., Prato, C. & Bondarenko, M. (2015) Considering shared power and responsibility: Diabetic patients' experience with the PCMH care model. *Patient Experience Journal*, 2(1), 61-67.

McCambridge, J., Kypri, K. & Elbourne, D. (2014) Research participation effects: a skeleton in the methodological cupboard. *Journal of clinical epidemiology*, 67(8), 845-849.

McCance, T. & McCormack, B. (2017) *Person-centred practice in nursing and health care: theory and practice*, 2nd edition. Chichester, West Sussex: Wiley Blackwell.

McConnell, D., McCance, T. & Melby, V. (2016) Exploring person-centredness in emergency departments: a literature review. *International emergency nursing*, 26, 38-46.

McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T. E., Porock, D., van Lieshout, F. & Wilson, V. (2015) Person-centredness - the 'state' of the art. *International Practice Development Journal*, 5(Suppl.1), 1-15.

McCormack, B. & McCance, T. (2010) *Person-centred Nursing: Theory and Practice*. Oxford: Wiley Blackwell.

McCormack, B., McCance, T., Bulley, C., Brown, D., McMillan, A. & Martin, S. e. (2021) *Fundamentals of person-centred healthcare practice*. John Wiley & Sons.

McCormack, B. & McCance, T. V. (2006) Development of a framework for person-centred nursing. *Journal of Advanced Nursing*, 56(5), 472-479.

McGrath, C., Palmgren, P. J. & Liljedahl, M. (2019) Twelve tips for conducting qualitative research interviews. *Medical teacher*, 41(9), 1002-1006.

McKenna, L., Brown, T., Oliaro, L., Williams, B. & Williams, A. (2020) Listening in Health Care. In Worthington, D.L. & Bodie, G. D. (eds) *The Handbook of Listening*. New Jersey: John Wiley & Sons, 373-383.

McWhinney, I. (1989) The need for a transformed clinical method. In Stewart, M. & Roter, D. (eds) *Communicating with medical patients*. London: Sage.

McWilliam, C. L. (2009) Patients, persons or partners? Involving those with chronic disease in their care. *Chronic illness*, 5(4), 277-292.

Mead, N. & Bower, P. (2000) Patient-centredness: a conceptual framework and review of the empirical literature. *Social science & medicine*, 51(7), 1087-1110.

Meerhoff, G. A., van Dulmen, S. A., Maas, M. J. M., Bakker-Jacobs, A., Nijhuis-Van der Sanden, M. W. G. & van der Wees, P. J. (2019) Exploring the perspective of patients with musculoskeletal health problems in primary care on the use of patient-reported outcome measures to stimulate quality improvement in physiotherapist practice; a qualitative study. *Physiotherapy theory and practice*, 1-12.

Melander Wikman, A. & Fältholm, Y. (2006) Patient empowerment in rehabilitation: "Somebody told me to get rehabilitated". *Advances in Physiotherapy*, 8(1), 23-32.

Melin, J., Nordin, Å., Feldthusen, C. & Danielsson, L. (2019) Goal-setting in physiotherapy: exploring a person-centered perspective. *Physiotherapy Theory And Practice*, 1-18.

Melin, J., Nordin, Å., Feldthusen, C. & Danielsson, L. (2021) Goal-setting in physiotherapy: exploring a person-centered perspective. *Physiotherapy Theory and Practice*, 37(8), 863-880.

Mercer, C. & Hensman-Crook, A. (2022) Editorial: First contact practitioners – New opportunities for musculoskeletal expertise in primary care. *Musculoskeletal science & practice*, 62, 102623.

Michalos, A. C. (1985) Multiple discrepancies theory (MDT). *Social Indicators Research*, 16, 347-413.

Miciak, M., Mayan, M., Brown, C., Joyce, A. S. & Gross, D. P. (2019) A framework for establishing connections in physiotherapy practice. *Physiotherapy Theory And Practice*, 35(1), 40-56.

Miles, A. & Asbridge, J. (2017) Person-Centered Healthcare- Moving from rhetoric to methods, through implementation to outcomes. *European Journal for Person Centered Healthcare*, 5(1), 1-9.

Mind (2023) *'Sink or swim?' Improving the mental health of staff in hospital emergency departments: A report for Mind.* Available online: https://www.mind.org.uk/media-a/4579/mind_rr_mentalhealthinterventions-final.pdf [Accessed 10/10/2023].

Mitchell, P., Cribb, A. & Entwistle, V. (2022) Vagueness and variety in person-centred care. *Wellcome Open Research*, 7, 170.

Moher, D., Liberati, A., Tetzlaff, J. & Altman, D. G. (2009) Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS medicine*, 6(7), e1000097.

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M. & Wolf, A. (2017) Barriers and facilitators to the implementation of person centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, 31(4), 662-673.

Morera-Balaguer, J., Botella-Rico, J. M., Catalán-Matamoros, D., Martínez-Segura, O.-R., Leal-Clavel, M. & Rodríguez-Nogueira, Ó. (2019) Patients' experience regarding therapeutic person-centered relationships in physiotherapy services: A qualitative study. *Physiotherapy Theory and Practice*, 1-11.

Morera-Balaguer, J., Botella-Rico, J. M., Martínez-González, M. C., Medina-Mirapeix, F. & Rodríguez-Nogueira, Ó. (2018) Physical therapists' perceptions and experiences about barriers and facilitators of therapeutic patient-centred relationships during outpatient rehabilitation: a qualitative study. *Brazilian Journal Of Physical Therapy*, 22(6), 484-492.

Morgan, D. L. (2007) Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, 1(1), 48-76.

Morgan, D. L. (2014) Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, 20(8), 1045-1053.

Morgan, S. & Yoder, L. H. (2012) A concept analysis of person-centered care. *Journal of holistic Nursing: Official Journal of the American Holistic Nurses' Association*, 30(1), 6-15.

Morrow, S. L. (2005) Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250.

Mudge, S., Stretton, C. & Kayes, N. (2014) Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disability & Rehabilitation*, 36(6), 457-463.

MUSC (2024) *Medical University of South Carolina Libraries: Systematic reviews - risk of bias/quality assessment*. Available online: https://musc.libguides.com/systematicreviews/qualityassessment# [Accessed 18/5/2024].

Musculoskeletal Partnership Group (2022) *The United Kingdom Musculoskeletal Advanced Practice Standards*. Arthritis and Musculoskeletal Alliance. Available online: https://arma.uk.net/wp-content/uploads/2022/10/UK-MSK-AdvancedPractice-Standards-FINAL.pdf [Accessed 24/4/2024].

National Voices (2014) *Person centred care 2020*. Available online: https://www.nationalvoices.org.uk/publications/our-publications/person-centred-care-2020 [Accessed 21/1/2021].

Naylor, J., Killingback, C. & Green, A. (2023) What are the views of musculoskeletal physiotherapists and patients on person-centred practice? A systematic review of qualitative studies. *Disability and rehabilitation*, 45(6), 950-961.

Naylor, J., Killingback, C. & Green, A. (2024a) An exploration of person-centredness among emergency department physiotherapists: a mixed methods study. *Disability and Rehabilitation*, 1-14. Available online: https://doi.org/10.1080/09638288.2024.2310179 [Accessed 15/3/2023].

Naylor, J., Killingback, C. & Green, A. (2024b) The experiences of patients attending the emergency department who were managed by physiotherapists: a person-centred perspective. *Disability and Rehabilitation*, 1-13. Available online: https://doi.org/10.1080/09638288.2024.2382311 [Accessed 09/08/2024].

Naylor, M. J., Boyes, C. & Killingback, C. (2022) “You’ve broken the patient”: Physiotherapists’ lived experience of incivility within the healthcare team - An Interpretative Phenomenological Analysis. *Physiotherapy*, 117, 89-9.

NHS (2019) *The NHS long term plan.* Available online: https://www.longtermplan.nhs.uk/ [Accessed 15/3/2021].

NHS (2022) *When to go to A&E.* Available online: https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-go-to-ae/ [Accessed 15/12/2022].

NHS Providers (2023) *NHS industrial action: the impact on patients, staff and performance - July 2023.* Available online: https://nhsproviders.org/media/696855/nhs-providers-briefing-nhs-industrial-action-the-impact-on-patients-staff-and-performance-july-2023-members.pdf [Accessed 3/10/2023].

NHSE (2023) A&E Attendances and Emergency Admissions December 2022 Statistical Commentary, *NHS England.* January 2023. Available online: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/01/Statistical-commentary-December-2022-cftre1.pdf, [Accessed 26/1/2023].

NHSE (2024a) *NHS England website personalised care - supported self-management.* Available online: https://www.england.nhs.uk/personalisedcare/supported-self-management/ [Accessed 26/1/2024].

NHSE (2024b) *Person-centred care, NHS England Website*. Available online: https://www.hee.nhs.uk/our-work/person-centred-care [Accessed 22/1/2024].

NHSE (2024c) *what is personalised care?* Available online: https://www.england.nhs.uk/personalisedcare/what-is-personalised-care/ [Accessed 08/3/2024].

NICE (2021) *Shared decision making. National Institute for Health and Care Excellence (NICE) guideline. NG197.* Available online: https://www.nice.org.uk/guidance/ng197/chapter/Recommendations#putting-shared-decision-making-into-practice [Accessed 18/4/2024].

Nicholls, D. A. & Gibson, B. E. (2010) The body and physiotherapy. *Physiotherapy Theory and Practice*, 26(8), 497-509.

Nicholls, D. A. & Holmes, D. (2012) Discipline, desire, and transgression in physiotherapy practice. *Physiotherapy Theory and Practice*, 28(6), 454-465.

Noblit, G. W., Hare, R. D. & Hare, R. D. (1988) *Meta-ethnography: Synthesizing qualitative studies* - Qualitative research series, 11. Sage.

Nolte, E., Merkur, S. & Anell, A. (2020) Person-centredness: exploring its evolution and meaning in the health system context, in Nolte, E., Merkur, S. & Anell, A. (eds) *Achieving Person-Centred Health Systems: Evidence, Strategies and Challenges*. European Observatory on Health Systems and Policies. Cambridge: Cambridge University Press, 19-40.

Norris, E. & Tetflow, G. (2023) *'HS2 is a fiasco of change and churn', Institute for Government;*. Available online: https://www.instituteforgovernment.org.uk/comment/hs2-fiasco-change-churn, [Accessed 03/10/23].

Nzabonimpa, J. P. (2018) Quantitizing and qualitizing (im-) possibilities in mixed methods research. *Methodological Innovations*, 11(2), 2059799118789021.

O'Keeffe, C., Mason, S., Jacques, R. & Nicholl, J. (2018) Characterising non-urgent users of the emergency department (ED): a retrospective analysis of routine ED data. *PLoS One*, 13(2), e0192855.

O'Keeffe, M., Cullinane, P., Hurley, J., Leahy, I., Bunzli, S., O'Sullivan, P. B. & O'Sullivan, K. (2016) What influences patient-therapist interactions in musculoskeletal physical therapy? Qualitative systematic review and meta-synthesis. *Physical therapy*, 96(5), 609-622.

OED (2023) "Empowerment, N.". *Oxford English Dictionary*. Available online: https://doi.org/10.1093/OED/4348829585 [Accessed 23/1/2024].

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L. & Kahlke, R. (2023) A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, 45(3), 241-251.

Olsson, L.-E., Jakobsson Ung, E., Swedberg, K. & Ekman, I. (2013) Efficacy of person-centred care as an intervention in controlled trials – a systematic review. *Journal of Clinical Nursing*, 22(3-4), 456-465.

Parry, A. (1997) New paradigms for old: Musings on the shape of clouds. *Physiotherapy*, 83(8), 423-433.

Patient Experience Library (2021) *Patient experience and patient/public involvement in health and care services*. Patient Experience magazine, Winter. Available online: https://pexlib.net/?228428 [Accessed 31/1/2021].

Patient's Association (2017) *Comment on person-centred, co-ordinated care*. Available online: https://www.patients-association.org.uk/news/comment-on-national-voices-report-on-person-centred-co-ordinated-care [Accessed 21/1/2021].

Patton, M. (2005) *Qualitative Research & Evaluation Methods*, 4th edition. Los Angeles, CA: SAGE.

PCP-ICoP (2024) *The Person-centred Practice International Community of Practice*. Available online: https://www.cpcpr.org/icop [Accessed 23/4/2024].

Pearson, C. M. & Porath, C. L. (2005) On the nature, consequences and remedies of workplace incivility: No time for "nice"? Think again. *Academy of Management Perspectives*, 19(1), 7-18.

Pendleton, D., Schofield, T., Tate, P. & Havelock, P. (2003) *The new consultation: developing doctor-patient communication*. Oxford: OUP.

Physiotherapy Board of Australia (2021) Code of conduct: Principle 1. Melbourne: APHRA. Available from: https://www.physiotherapyboard.gov.au https://www.physiotherapyboard.gov.au [Accessed 23/7/2021].

Physiotherapy Board of New Zealand (2020) *Physiotherapy Standards framework 2020*. Wellington. Available online: https://www.physioboard.org.nz/wp-content/uploads/2018/03/Physiotherapy-Board-Code-Standards-Thresholds.pdf [Accessed 23/9/2022].

Picker (2024) *A person centred health service: our vision for the NHS.* Oxford: Picker Institute Europe. Available online: https://picker.org/wp-content/uploads/2024/03/Picker-NHS-Manifesto.pdf [Accessed 07/3/2024].

Pinto, R. Z., Ferreira, M. L., Oliveira, V. C., Franco, M. R., Adams, R., Maher, C. G. & Ferreira, P. H. (2012) Patient-centred communication is associated with positive therapeutic alliance: a systematic review. *Journal of Physiotherapy*, 58(2), 77-87.

Pirhonen, L., Gyllensten, H., Olofsson, E. H., Fors, A., Ali, L., Ekman, I. & Bolin, K. (2020) The cost-effectiveness of person-centred care provided to patients with chronic heart failure and/or chronic obstructive pulmonary disease. *Health Policy OPEN*, 1, 100005.

Pluut, B. (2016) Differences that matter: developing critical insights into discourses of patient-centeredness. *Medicine, Health Care & Philosophy*, 19(4), 501-515.

Polatajko, H. J., Backman, C., Baptiste, S., Davis, J., Eftekhar, P., Harvey, A., Jarman, J., Krupa, T., Lin, N., Pentland, W., Laliberte-Rudman, D., Shaw, L., Amoroso, B., Connor-Schisler, A. (2013) Human occupation in context, in Townsend, E. A., & Polatajko, H. J. (ed), *Enabling Occupation II: Advancing an occupational therapy vision for health, well-being and justice through occupation*, 2nd edition. Ottawa, ON: CAOT Publications ACE, 37-61.

Protogerou, C. & Hagger, M. S. (2020) A checklist to assess the quality of survey studies in psychology. *Methods in Psychology*, 3, 100031.

Pugh, A., Roper, K., Magel, J., Fritz, J., Colon, N., Robinson, S., Cooper, C., Peterson, J., Kareem, A. & Madsen, T. (2020) Dedicated emergency department physical therapy is associated with reduced imaging, opioid administration, and length of stay: a prospective observational study. *PLoS One*, 15(4), e0231476.

Pulvirenti, M., McMillan, J. & Lawn, S. (2014) Empowerment, patient centred care and self-management. *Health expectations*, 17(3), 303-310.

Rathert, C., Wyrwich, M. D. & Boren, S. A. (2013) Patient-centered care and outcomes: a systematic review of the literature. *Medical Care Research and Review*, 70(4), 351-379.

RCEM (2021) *Position statement on public health in emergency medicine. RCEM Special Interest Group - Feb 2021.* Available online: https://res.cloudinary.com/studio-republic/images/v1635418127/Combined_PH_Role_Description_and_Position_Statement/Combined_PH_Role_Description_and_Position_Statement.pdf?_i=AA [Accessed 03/10/23].

RCEM (2022) *Emergency Medicine – Advanced Clinical Practitioner (EM-ACP).* Available online: https://rcem.ac.uk/emergency-care-advanced-clinical-practitioners/ [Accessed 16/4/2024].

RCEM (2023) *RCEM performance tracker.* Available online: https://rcem.ac.uk/data-statistics/ [Accessed 03/10/23].

RCSEng (2023) “NHS waiting list in England hits record 7.7 million”, *Royal College of Surgeons of England News*. Available online: https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/nhs-waiting-list-hits-record-high/ [Accessed 3/10/2023].

Redding, D. & Hutchinson, S. (2017) *Person-centred care in 2017–Evidence from service users*. National Voices. Available online: https://www.nationalvoices.org.uk/sites/default/files/public/publications/person-centred_care_in_2017_-_national_voices.pdf [Accessed 19/11/2020].

Richardson, W. C., Berwick, D., Bisgard, J., Bristow, L., Buck, C. & Cassel, C. (2001) *Crossing the quality chasm: a new health system for the 21st century*. Washington: National Academy Press.

Rising, K. L., Hudgins, A., Reigle, M., Hollander, J. E. & Carr, B. G. (2016) “I'm just a patient”: fear and uncertainty as drivers of emergency department use in patients with chronic disease. *Annals of emergency medicine*, 68(5), 536-543.

Riskin, A., Erez, A., Foulk, T. A., Kugelman, A., Gover, A., Shoris, I., Riskin, K. S. & Bamberger, P. A. (2015) The Impact of Rudeness on Medical Team Performance: A Randomized Trial. *Pediatrics*, 136(3), 487-95.

Roberts, A. E. K. & Bannigan, K. (2018) Dimensions of personal meaning from engagement in occupations: A metasynthesis. *Canadian Journal of Occupational Therapy*, 85(5), 386-396.

Robertson, K. (2005) Active listening: more than just paying attention. *Australian family physician*, 34(12).

Rocca, E. & Anjum, R. L. (2020) Complexity, Reductionism and the Biomedical Model., in Anjum, R. L., Copeland, S., Rocca, E. (ed), *Rethinking Causality, Complexity and Evidence for the Unique Patient*. [eBook].Springer, Cham. Available online: https://doi.org/10.1007/978-3-030-41239-5_5 [Accessed 23/5/2021]

Rodríguez-Nogueira, Ó., Leirós-Rodríguez, R., Pinto-Carral, A., Álvarez-Álvarez, M. J., Morera-Balaguer, J. & Moreno-Poyato, A. R. (2022) The association between empathy and the physiotherapy-patient therapeutic alliance: A cross-sectional study. *Musculoskeletal science & practice*, 59, 102557.

Rogers, C. R. (1951) Perceptual reorganization in client-centered therapy, *Perception: An approach to personality*. New York, NY, US: Ronald Press Company, 307-327.

Rogers, C. R. (1980) *A way of being*. Boston, MA: Houghton Mifflin Company.

Rolfe, G. (2006) Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of advanced nursing*, 53(3), 304-310.

Roller, M. R. & Lavrakas, P. J. (2015) *Applied qualitative research design: A total quality framework approach*. New York: The Guilford Press.

Rorty, R. (1980) Pragmatism, Relativism, and Irrationalism. *Proceedings and Addresses of the American Philosophical Association*, 53(6), 717-738.

Rosewilliam, S., Sintler, C., Pandyan, A.D., Skelton, J. & Roskell, C.A. (2016) Is the practice of goal-setting for patients in acute stroke care patient-centred and what factors influence this? A qualitative study. *Clinical Rehabilitation*, 30(5), 508-519.

Rowe, A. & Knox, M. (2023) The Impact of the Healthcare Environment on Patient Experience in the Emergency Department: A Systematic Review to Understand the Implications for Patient-Centered Design. *HERD: Health Environments Research & Design Journal*, 16(2), 310-329.

Rushton, A., Beeton, K., Jordaan, R., Langendoen, J., Levesque, L. & Maffey, L. (2016) IFOMPT educational standards. *International Federation of Orthopaedic Manipulative Physical Therapists*.

Salt, E. (2016) Effectiveness of Musculoskeletal Emergency Physiotherapy Practitioners. Open Journal of Therapy and Rehabilitation, 4, 146-149.

Sandelowski, M. (2001) Real qualitative researchers do not count: The use of numbers in qualitative research. *Research in Nursing & Health*, 24(3), 230-240.

Sandelowski, M. & Barroso, J. (2007) *Handbook for synthesizing qualitative research*. Springer Publishing Company.

Sandelowski, M., Voils, C. I. & Knafl, G. (2009) On quantitizing. *Journal of Mixed Methods Research*, 3(3), 208-222.

Sanders, T., Foster, N. E., Bishop, A. & Ong, B. N. (2013) Biopsychosocial care and the physiotherapy encounter: physiotherapists' accounts of back pain consultations. *BMC Musculoskeletal Disorders*, 14, 1-10.

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H. & Lu, M. (2018) How to practice person-centred care: A conceptual framework. *Health Expectations: An International Journal Of Public Participation In Health Care And Health Policy*, 21(2), 429-440.

Saunders, M., Lewis, P. & Thornhill, A. (2007) *Research methods for business*. London: Pitman.

Savvoulidou, K., Papageorgiou, A., Kolokotroni, O., Kapreli, P., Tsokani, A., Strimpakos, N. & Kapreli, E. (2024) Facilitators and barriers of empathetic behaviour in physiotherapy clinical practice: A qualitative focus group study. *Musculoskeletal science & practice*, 70, 102923.

Sayer, J. M., Kinsella, R. M., Cary, B. A., Burge, A. T., Kimmel, L. A. & Harding, P. (2017) Advanced musculoskeletal physiotherapists are effective and safe in managing patients with acute low back pain presenting to emergency departments. *Australian Health Review*, 42(3), 321-326.

Sbaih, L. C. (2002) Meanings of immediate: the practical use of the Patient's Charter in the accident and emergency department. *Social Science & Medicine*, 54(9), 1345-1355.

Schoenau, M. N., Hansen, M., Ulvestad, S., Sommer, M. S., Pedersen, J. H. & Missel, M. (2020) The lived experiences, perceptions, and considerations of patients after operable lung cancer concerning nonparticipation in a randomized clinical rehabilitation trial. *Qualitative Health Research*, 30(5), 760-771.

Scholl, I., Zill, J. M., Härter, M. & Dirmaier, J. (2014) An integrative model of patient-centeredness - a systematic review and concept analysis. *Plos One*, 9(9), e107828-e107828.

Schulz, P., Prescott, J., Shifman, J., Fiore Jr, J., Holland, A. & Harding, P. (2016) Comparing patient outcomes for care delivered by advanced musculoskeletal physiotherapists with other health professionals in the emergency department—A pilot study. *Australasian Emergency Nursing Journal*, 19(4), 198-202.

Schwandt, T. A. (2015) The SAGE Dictionary of Qualitative Inquiry, Fourth edition [eBook]. Thousand Oaks, California: SAGE Publications, Inc. Available online: https://methods.sagepub.com/book/the-sage-dictionary-of-qualitative-inquiry-4e [Accessed 13/5/2023].

Seers, K. (2015) Qualitative systematic reviews: their importance for our understanding of research relevant to pain. *British Journal of Pain*, 9(1), 36-40.

Shaw, J. A., Connelly, D. M. & Zecevic, A. A. (2010) Pragmatism in practice: Mixed methods research for physiotherapy. *Physiotherapy Theory and Practice*, 26(8), 510-518.

Shipley, S. D. (2010) Listening: A Concept Analysis. *Nursing Forum*, 45(2), 125-134.

Skamagki, G., King, A., Carpenter, C. & Wåhlin, C. (2022) The concept of integration in mixed methods research: a step-by-step guide using an example study in physiotherapy. *Physiotherapy Theory and Practice*, 1-8.

Skelton, R. (1994) Nursing and empowerment: concepts and strategies. *Journal of Advanced Nursing*, 19(3), 415-423.

Sonis, J. D., Aaronson, E. L., Lee, R. Y., Philpotts, L. L. & White, B. A. (2018) Emergency department patient experience: a systematic review of the literature. *Journal of Patient Experience*, 5(2), 101-106.

Steed, L. & Moulson, A. (2022) The impact of introducing a musculoskeletal physiotherapy practitioner role into the emergency department of an acute hospital–A service evaluation. *Physiotherapy*, 114, e236-e237.

Stewart, M., Brown, J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L. & Freeman, T. R. (1995) *Patient-centered medicine: Transforming the clinical method*. Thousand Oaks, CA, US: Sage Publications, Inc.

Stilwell, P. & Harman, K. (2019) An enactive approach to pain: beyond the biopsychosocial model. *Phenomenology and the Cognitive Sciences*, 18(4), 637-665.

Streubert, H. J. & Carpenter, D. R. (2011) *Qualitative research in nursing: Advancing the humanistic imperative*, 5th edition. Philadelphia, PA: Lippincott Williams & Wilkins.

Sullivan, N., Hebron, C. & Vuoskoski, P. (2019) "Selling" chronic pain: physiotherapists' lived experiences of communicating the diagnosis of chronic nonspecific lower back pain to their patients. *Physiotherapy Theory And Practice*, 1-20.

Sutton, J. & Austin, Z. (2015) Qualitative research: Data collection, analysis, and management. *The Canadian journal of hospital pharmacy*, 68(3), 226.

Sutton, M., Govier, A., Prince, S. & Morphett, M. (2015) Primary-contact physiotherapists manage a minor trauma caseload in the emergency department without misdiagnoses or adverse events: an observational study. *Journal of Physiotherapy*, 61(2), 77-80.

Svarovsky, T. (2013) Having Difficult Conversations: The Advanced Practitioner's Role. *Journal of the Advanced Practitioner in Oncology*, 4(1), 47-52.

Taylor, N. F., Norman, E., Roddy, L., Tang, C., Pagram, A. & Hearn, K. (2011) Primary contact physiotherapy in emergency departments can reduce length of stay for patients with peripheral musculoskeletal injuries compared with secondary contact physiotherapy: a prospective non-randomised controlled trial. *Physiotherapy*, 97(2), 107-114.

Tenny, S., Brannan, J. M. & Brannan, G. D. (2024) *Qualitative Study, StatPearls*. Treasure Island (FL): StatPearls Publishing.

The King's Fund (2013) *Patient Centred Leadership: Rediscovering Our Purpose*. London: The King's Fund.

The King's Fund (2022) What's going on in A&E, Online, May 26 2022 [Online]. Available online: https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters [Accessed 26/1/2023].

Thomas, J. & Harden, A. (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8, 45-45.

Tilley, C. (2021) 'Correct' that lack of GP appointments has led to 'increased A&E pressure', says Javid, *Pulse Today*. 03 November 2021 Available online: https://www.pulsetoday.co.uk/news/urgent-care/correct-that-lack-of-gp-appointments-has-led-to-increased-ae-pressure-says-javid/, [Accessed 18/4/2024].

Tong, A., Flemming, K., McInnes, E., Oliver, S. & Craig, J. (2012) Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*, 12(1), 181-188.

Tong, A., Sainsbury, P. & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, 19(6), 349-357.

Tonkin, T. (2022) *"Health inequality exacerbated effects of COVID, finds report" - BMA Website; July 2022*. Available online: https://www.bma.org.uk/news-and-opinion/health-inequality-exacerbated-effects-of-covid-finds-report#:~:text=Population%20health%20inequalities%2C%20under%2Dresourced,reports%20published%20by%20the%20BMA. [Accessed 10/10/2023].

Toombs, S. K. (2013) *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient*. Springer Netherlands.

Trede, F. & Haynes, A. (2009) Developing person-centred relationships with clients and families, *Contexts of physiotherapy* practice. Elsevier, 246-259.

Trombly, C. A. (1995) Occupation: Purposefulness and meaningfulness as therapeutic mechanisms. *American Journal of Occupational Therapy*, 49(10), 960-972.

UK Parliament Committees (2022) "Persistent understaffing of NHS a serious risk to patient safety, warn MPs". *UK Parliament News*. 25 July. Available online: https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/172310/persistent-understaffing-of-nhs-a-serious-risk-to-patient-safety-warn-mps [Accessed 3/10/2023].

Unger, J., Singh, H., Mansfield, A., Hitzig, S. L., Lenton, E. & Musselman, K. E. (2019) The experiences of physical rehabilitation in individuals with spinal cord injuries: a qualitative thematic synthesis. *Disability and Rehabilitation*, 41(12), 1367-1383.

Unsgaard-Tøndel, M. & Søderstrøm, S. (2022) Building therapeutic alliances with patients in treatment for low back pain: A focus group study. *Physiotherapy Research International*, 27(1), 1-8.

Viotti, S., Cortese, C. G., Garlasco, J., Rainero, E., Emelurumonye, I. N., Passi, S., Boraso, F. & Gianino, M. M. T. (2020) The buffering effect of humanity of care in the relationship between patient satisfaction and waiting time: a cross-sectional study in an emergency department. *International Journal of Environmental Research and Public Health*, 17(8), 2939.

Waddell, G., Newton, M., Henderson, I., Somerville, D. & Main, C. J. (1993) A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability. *Pain*, 52(2), 157-168.

Walsh, A., Bodaghkhani, E., Etchegary, H., Alcock, L., Patey, C., Senior, D. & Asghari, S. (2022) Patient-centered care in the emergency department: a systematic review and meta-ethnographic synthesis. *International Journal of Emergency Medicine*, 15(1), p.36.

Wanless, D. (2002) *Securing our future health: taking a long term view. Final Report*. London: HMGO.

Ward, A., Eng, C., McCue, V., Stewart, R., Strain, K., McCormack, B., Dukhu, S., Thomas, J. & Bulley, C. (2018) What matters versus what's the matter - exploring perceptions of person-centred practice in nursing and physiotherapy social media communities: a qualitative study. *International Practice Development Journal*, 8(2), 1-18.

WHO (2015) *World Health Organization. WHO global strategy on people-centred and integrated health services: interim report (No. WHO/HIS/SDS/2015.6)*. Geneva, Switzerland: WHO. Available online: https://interprofessional.global/wp-content/uploads/2019/11/WHO-2015-Global-strategy-on-integrated-people-centred-health-services-2016-2026.pdf [Accessed 23/1/2024].

WHO (2016) *Framework on integrated, people-centred health services*. Geneva: World Health Organization.

Wijma, A. J., Bletterman, A. N., Clark, J. R., Vervoort, S. C. J. M., Beetsma, A., Keizer, D., Nijs, J. & Van Wilgen, C. P. (2017) Patient-centeredness in physiotherapy: What does it entail? A systematic review of qualitative studies. *Physiotherapy Theory And Practice*, 33(11), 825-840.

Wilcock, A. A. (1998) Reflections on Doing, Being and Becoming. *Canadian Journal of Occupational Therapy*, 65(5), 248-256.

Wilcox, S. L. & Varpio, L. (2019) Finding Comfort in the Discomfort of Difficult Conversations with Military Patients. *Military Medicine*, 184(11-12), e590-e593.

Wolf, D. M., Lehman, L., Quinlin, R., Zullo, T. & Hoffman, L. (2008) Effect of patient-centered care on patient satisfaction and quality of care. *Journal of Nursing Care Quality*, 23(4), 316-321.

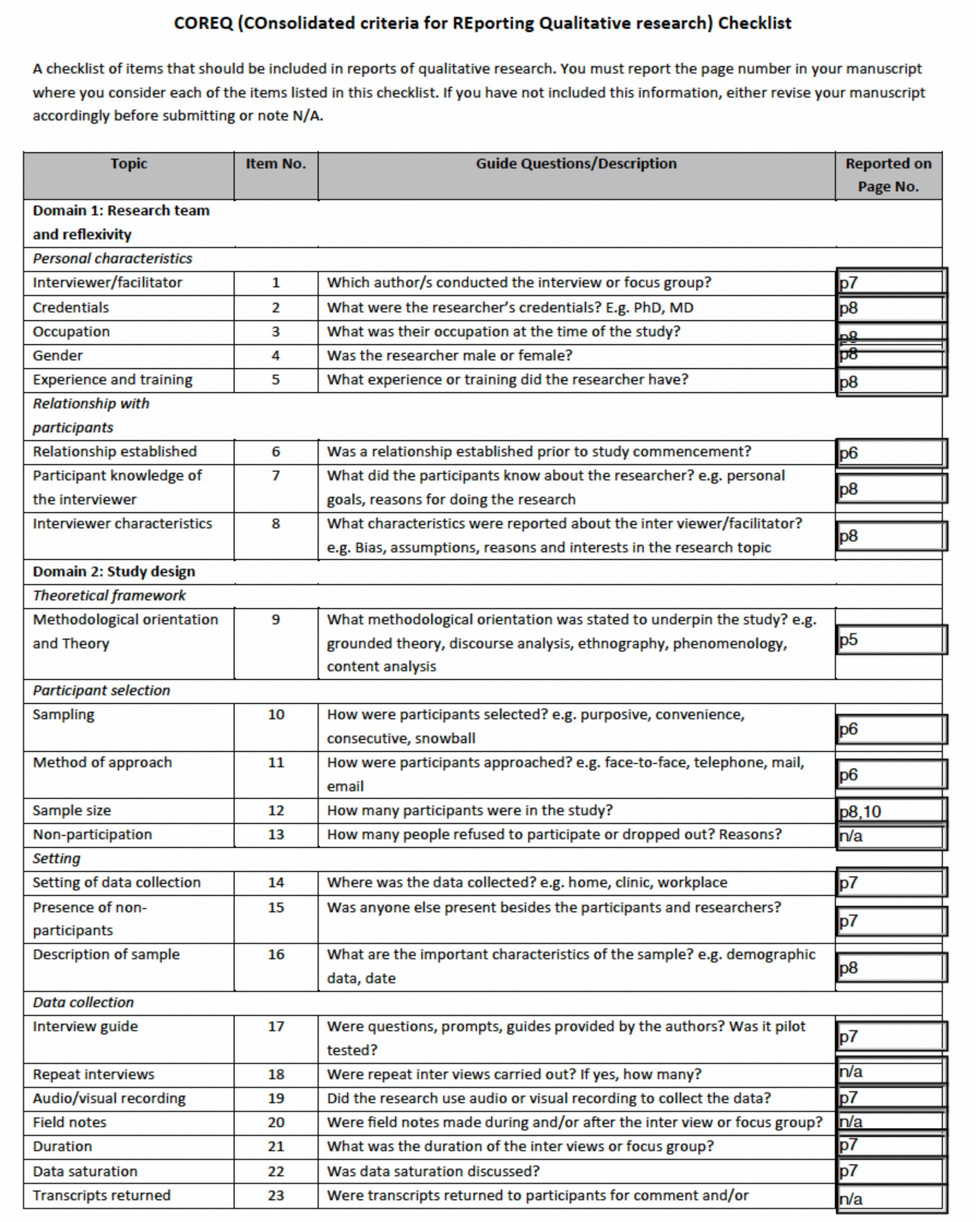
Wolfe, A. (2001) Institute of Medicine Report: Crossing the Quality Chasm: A New Health Care System for the 21st Century. *Policy, Politics, & Nursing Practice*; 2(3), 233-235. Available online: doi:10.1177/152715440100200312 [Accessed 23/9/2023].

Yao, L. & Kabir, R. (2024) Person-Centered Therapy (Rogerian Therapy), *StatPearls*. Treasure Island (FL) companies.: StatPearls Publishing.

Zaharias, G. (2018) What is narrative-based medicine? Narrative-based medicine 1. *Canadian Family Physician*, 64(3), 176-180.

Žukauskas, P., Vveinhardt, J. & Andriukaitienė, R. (2018) Philosophy and Paradigm of Scientific Research, in Žukauskas, P., Vveinhardt, J. & Andriukaitienė, R. (eds), *Management Culture and Corporate Social Responsibility*. Rijeka: IntechOpen, Ch. 6.

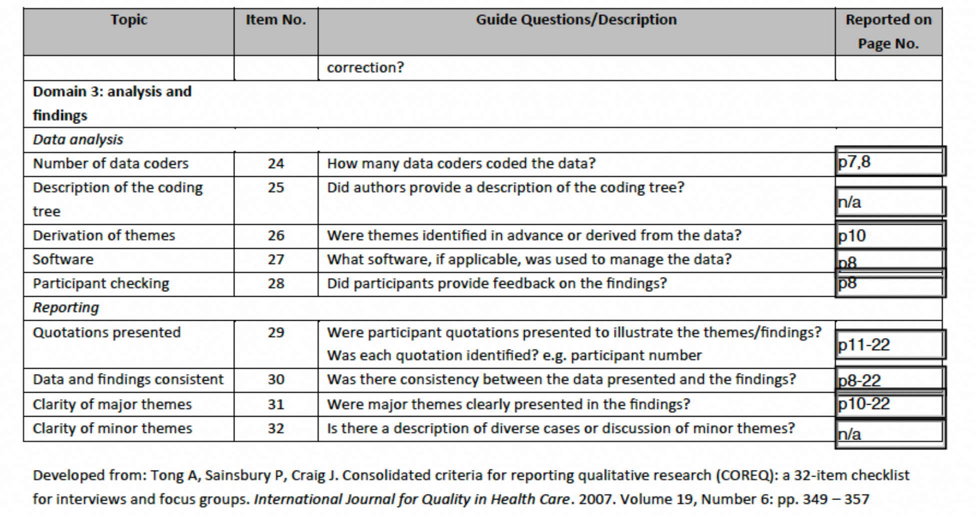
Appendix 1: COREQ checklist for study 2



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	p7
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	p8
Occupation	3	What was their occupation at the time of the study?	p8
Gender	4	Was the researcher male or female?	p8
Experience and training	5	What experience or training did the researcher have?	p8
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	p6
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p8
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p8
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p5
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p6
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	p6
Sample size	12	How many participants were in the study?	p8,10
Non-participation	13	How many people refused to participate or dropped out? Reasons?	n/a
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	p7
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	p7
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	p8
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p7
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	p7
Field notes	20	Were field notes made during and/or after the inter view or focus group?	n/a
Duration	21	What was the duration of the inter views or focus group?	p7
Data saturation	22	Was data saturation discussed?	p7
Transcripts returned	23	Were transcripts returned to participants for comment and/or	n/a



Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	p7,8
Description of the coding tree	25	Did authors provide a description of the coding tree?	n/a
Derivation of themes	26	Were themes identified in advance or derived from the data?	p10
Software	27	What software, if applicable, was used to manage the data?	p8
Participant checking	28	Did participants provide feedback on the findings?	p8
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	p11-22
Data and findings consistent	30	Was there consistency between the data presented and the findings?	p8-22
Clarity of major themes	31	Were major themes clearly presented in the findings?	p10-22
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	n/a

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix 2: University of Hull research ethics committee study approval (study 2)

UNIVERSITY
OF HULL

University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 463336 | **E:** e.walker@hull.ac.uk
w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
John Naylor
Faculty of Health Sciences
University of Hull
Via email

13th April 2021

Dear John

REF FHS327 - An exploration of person-centred physiotherapy practice in emergency departments

Thank you for submitting your ethics application to the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY
OF HULL

Liz Walker | Professor of Health and Social Work Research |
Faculty of Health Sciences
University of Hull
Hull, HU6 7RX, UK
www.hull.ac.uk
e.walker@hull.ac.uk | 01482 463336
@UniOfHull /UniversityOfHull universityofhull

Appendix 3: Participant recuitment email (study 2)

Dear xxxx

I am a physiotherapist currently completing a research project as part of my PhD with the Faculty of Health Sciences at the University of Hull. The aim of my study is to explore the views of Emergency Department Physiotherapists on person-centred practice. This will be achieved using an online survey with the option of follow-up interviews. The results may be used to develop a guidance/framework to assist in the delivery of person-centred care in the emergency department.

I would be extremely grateful if you could disseminate the link to this survey to any first contact ED physiotherapists at your Trust.

Please forward this survey link to the physiotherapist.
https://insert link here once survey ready

If you are not the best point of contact at the hospital, I would be grateful if you would forward this email to the appropriate individual.

If you have any queries regarding this project, please do not hesitate to contact me: j.naylor-2019@hull.ac.uk or my supervisor Dr Clare Killingback: c.killingback@hull.ac.uk

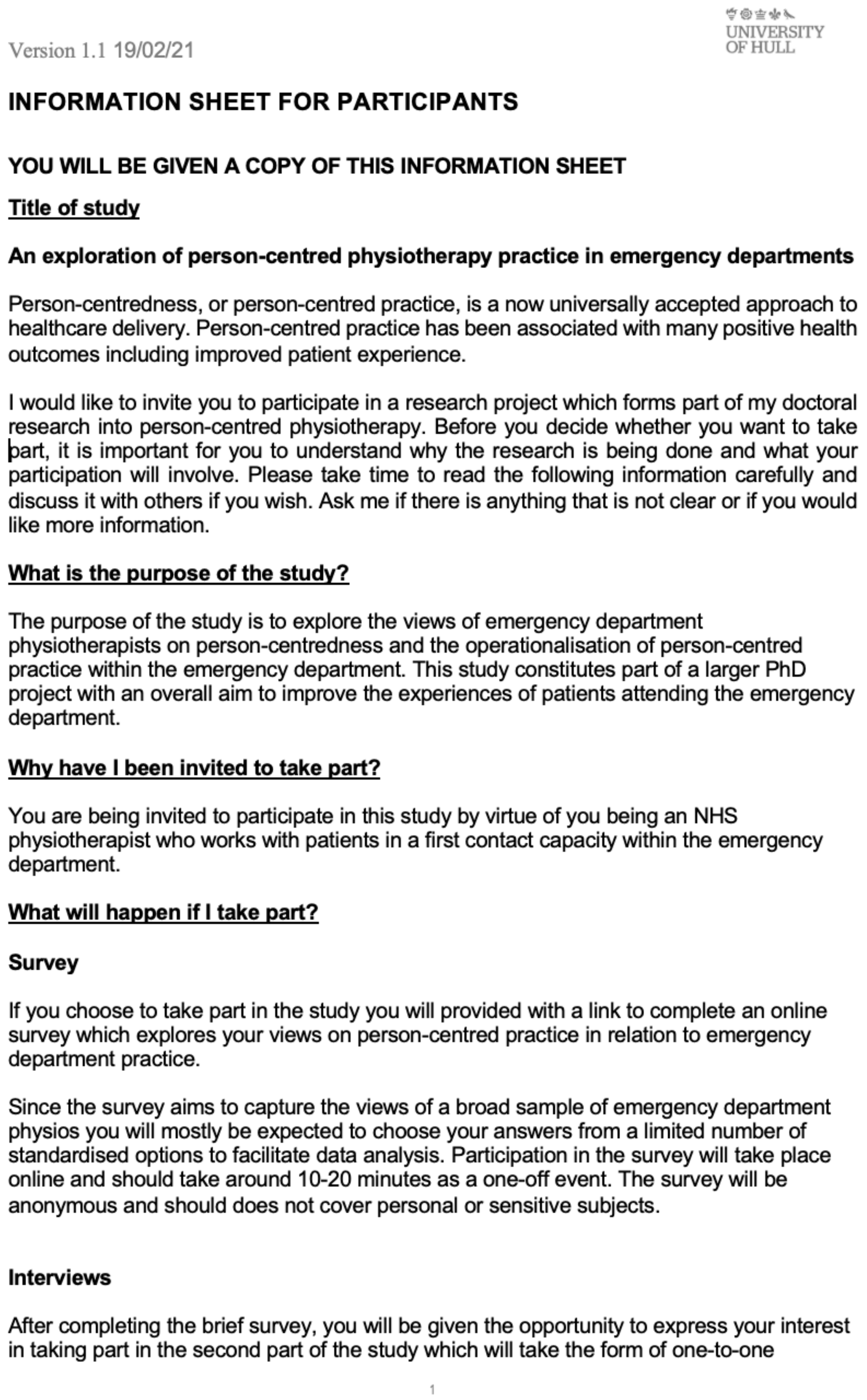
Many thanks,

John Naylor

Clinical Lead Physiotherapist

j.naylor-2019@hull.ac.uk

Appendix 4: Participant information Sheet (study 2)



Version 1.1 19/02/21

UNIVERSITY
OF HULL

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study

An exploration of person-centred physiotherapy practice in emergency departments

Person-centredness, or person-centred practice, is a now universally accepted approach to healthcare delivery. Person-centred practice has been associated with many positive health outcomes including improved patient experience.

I would like to invite you to participate in a research project which forms part of my doctoral research into person-centred physiotherapy. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of the study is to explore the views of emergency department physiotherapists on person-centredness and the operationalisation of person-centred practice within the emergency department. This study constitutes part of a larger PhD project with an overall aim to improve the experiences of patients attending the emergency department.

Why have I been invited to take part?

You are being invited to participate in this study by virtue of you being an NHS physiotherapist who works with patients in a first contact capacity within the emergency department.

What will happen if I take part?

Survey

If you choose to take part in the study you will provided with a link to complete an online survey which explores your views on person-centred practice in relation to emergency department practice.

Since the survey aims to capture the views of a broad sample of emergency department physios you will mostly be expected to choose your answers from a limited number of standardised options to facilitate data analysis. Participation in the survey will take place online and should take around 10-20 minutes as a one-off event. The survey will be anonymous and should does not cover personal or sensitive subjects.

Interviews

After completing the brief survey, you will be given the opportunity to express your interest in taking part in the second part of the study which will take the form of one-to-one interviews. The follow up interviews are designed to gather more in-depth data from a limited pool of respondents. The interviews will constitute an attempt to explain the survey findings and therefore should not cover especially personal or sensitive subjects. Interviews will be based around a limited number of more open questions, to be answered in your own words. The interviews will be recorded (with your consent) for transcription purposes. Once transcription is complete the recording will be deleted

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part a statement of consent will be included within the survey, with additional option to give consent at the end of the survey to be contacted for interviews.

Payment/Incentives

There will be no payments for taking part.

What are the possible risks of taking part?

We do not anticipate any risks for taking part in this study.

What are the possible benefits of taking part?

The benefits to taking part will be in terms of your contribution to improving the research base that underpins your own advanced clinical practice and that of the wider emergency department physiotherapy community. The improved understanding and delivery of person-centred practice in the emergency department setting will ultimately benefit the patients that we treat.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

The survey is **anonymous** so no individual will be directly identifiable, only the region in which they work. Care will be taken to ensure the greatest level of confidentiality possible to prevent demographic data being used to deduce who said what.

Your confidentiality will be protected by allocating a code to each interview. Interviews will be digitally recorded and only the research team analysing the data will have access.

You will be allocated an identity code on the consent form. The electronic informed consent form that contains information that link identities to the transcript and the data will be held separately to the digital transcripts on a secure University of Hull server.

For the purposes of research, the data will be kept for 5 years after completion of the project and will be stored appropriately for this duration.

If you chose to take part in the interviews anonymised direct quotations may be used in the write-up of the study and possible subsequent publication. These quotations will not be linked to any personal identifiable information.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in the public interest’ You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner’s Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible.

What will happen to the results of the study?

The results of the study will be summarised in my final PhD thesis, but may also be presented at conference and/or published in article format within a relevant academic journal. All results will be anonymised in such a way as to prevent identification of individual respondents. Final published articles will be available online but may sit behind a paywall depending on the individual publisher arrangements.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by the Faculty of Health Sciences Ethics Committee, University of Hull

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

John Naylor –e-mail address: j.naylor-2019@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Clare Killingback
Physiotherapy Programme Lead
Senior Lecturer in Physiotherapy
Faculty of Health Sciences
University of Hull
HU6 7RX
c.killingback@hull.ac.uk

Alternatively please contact registrar@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 5: Participant consent form (study 2)

Version 1.1 19.02.21

CONSENT FORM

Title of study: An exploration of person-centred physiotherapy practice in emergency departments

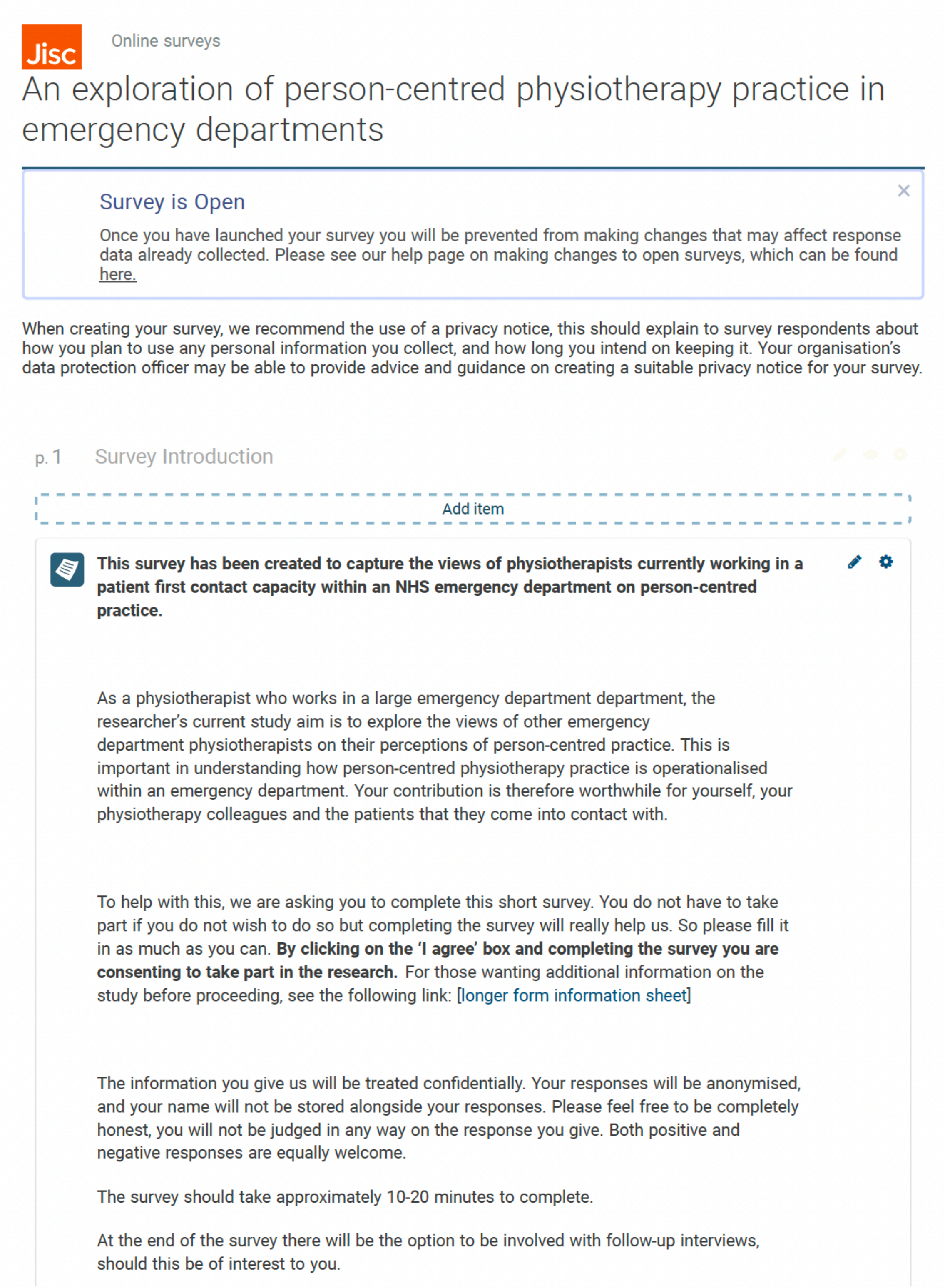
Name of Researcher: John Naylor

Please initial box

1. I confirm that I have read the information sheet dated 19.02.21 version 1.1 for the above study. I have had the opportunity to consider the information, ask questions and have had any questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I understand that once I have completed my interview I cannot withdraw my anonymised data. ☐
3. I understand that the research interview will be audio recorded and that my pseudonymised verbatim quotes may be used in research reports and conference presentations. ☐
4. I understand that the research data, which will be anonymised (not linked to me), will be retained by the researchers and may be shared with others and publicly disseminated to support other research in the future. ☐
5. I understand that my personal data will be kept securely in accordance with data protection guidelines and will only be available to the immediate research team. ☐
6. I give permission for the collection and use of my data to answer the research question in this study. ☐
7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 6: Online JISC survey (study 2)



An exploration of person-centred physiotherapy practice in emergency departments

Survey is Open

Once you have launched your survey you will be prevented from making changes that may affect response data already collected. Please see our help page on making changes to open surveys, which can be found here.

When creating your survey, we recommend the use of a privacy notice, this should explain to survey respondents about how you plan to use any personal information you collect, and how long you intend on keeping it. Your organisation's data protection officer may be able to provide advice and guidance on creating a suitable privacy notice for your survey.

p. 1 Survey Introduction

This survey has been created to capture the views of physiotherapists currently working in a patient first contact capacity within an NHS emergency department on person-centred practice.

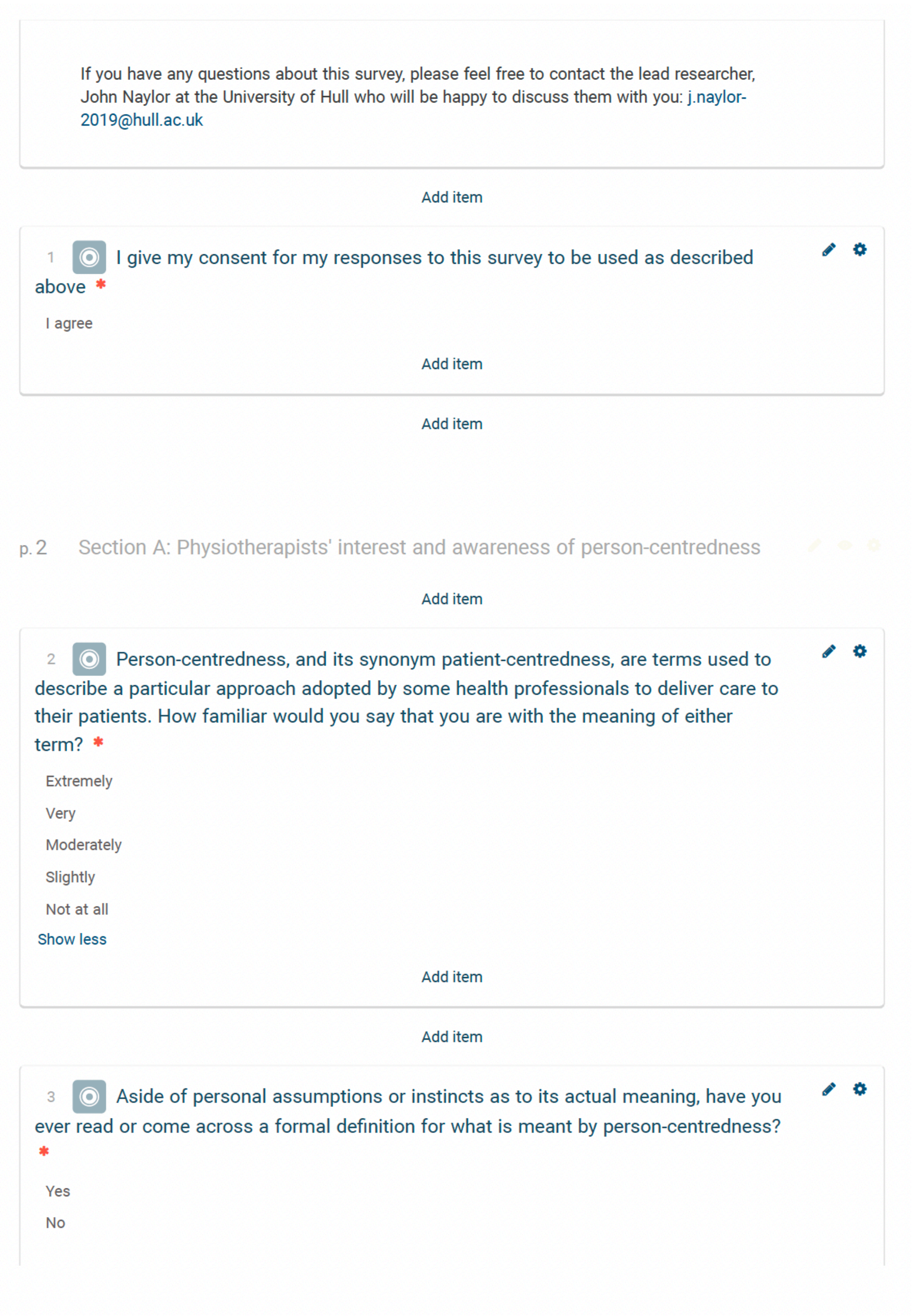
As a physiotherapist who works in a large emergency department department, the researcher's current study aim is to explore the views of other emergency department physiotherapists on their perceptions of person-centred practice. This is important in understanding how person-centred physiotherapy practice is operationalised within an emergency department. Your contribution is therefore worthwhile for yourself, your physiotherapy colleagues and the patients that they come into contact with.

To help with this, we are asking you to complete this short survey. You do not have to take part if you do not wish to do so but completing the survey will really help us. So please fill it in as much as you can. **By clicking on the 'I agree' box and completing the survey you are consenting to take part in the research.** For those wanting additional information on the study before proceeding, see the following link: [longer form information sheet]

The information you give us will be treated confidentially. Your responses will be anonymised, and your name will not be stored alongside your responses. Please feel free to be completely honest, you will not be judged in any way on the response you give. Both positive and negative responses are equally welcome.

The survey should take approximately 10-20 minutes to complete.

At the end of the survey there will be the option to be involved with follow-up interviews, should this be of interest to you.



If you have any questions about this survey, please feel free to contact the lead researcher, John Naylor at the University of Hull who will be happy to discuss them with you: j.naylor-2019@hull.ac.uk

1 I give my consent for my responses to this survey to be used as described above *

I agree

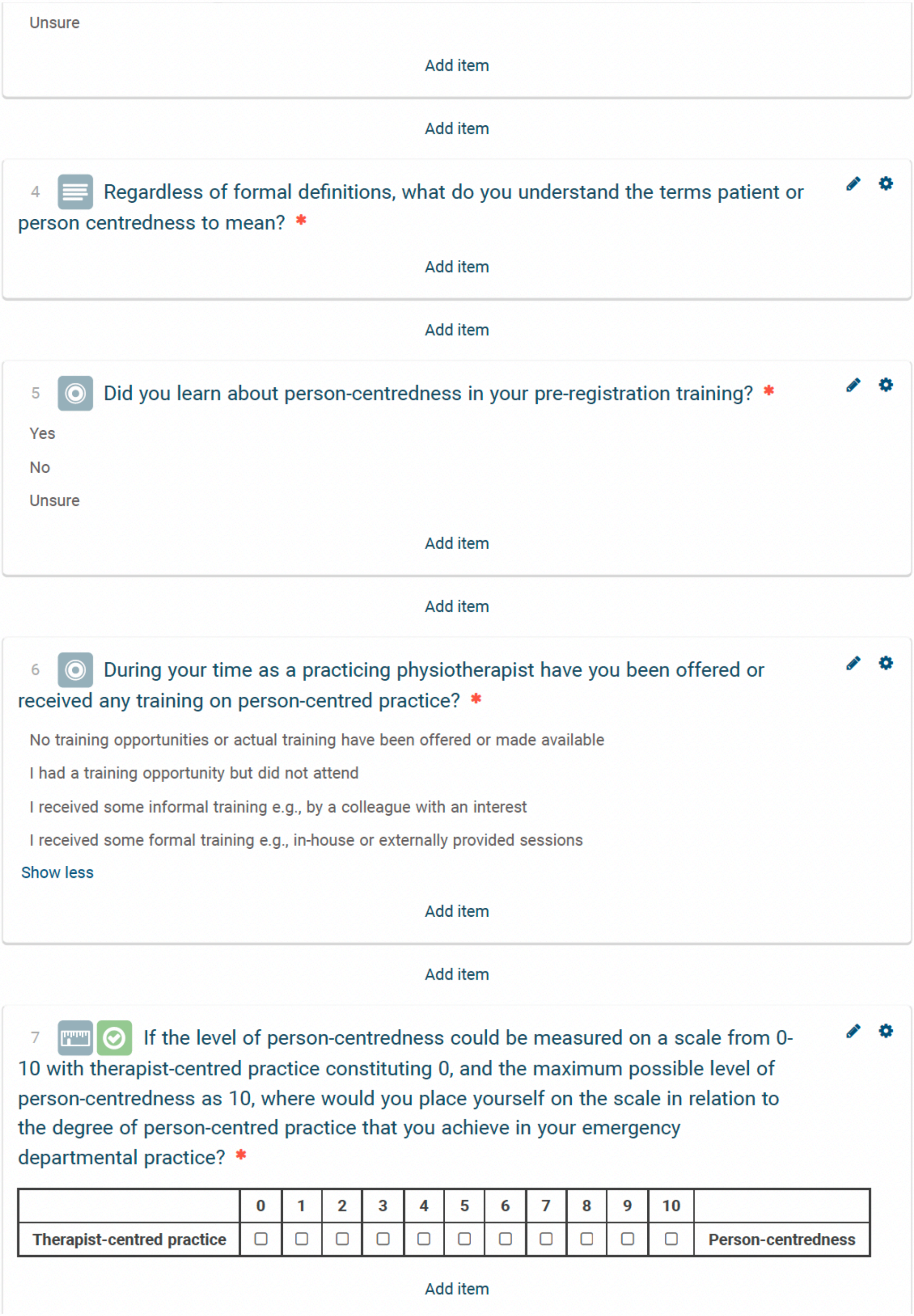
p.2 Section A: Physiotherapists' interest and awareness of person-centredness

2 Person-centredness, and its synonym patient-centredness, are terms used to describe a particular approach adopted by some health professionals to deliver care to their patients. How familiar would you say that you are with the meaning of either term? *

Extremely
Very
Moderately
Slightly
Not at all

3 Aside of personal assumptions or instincts as to its actual meaning, have you ever read or come across a formal definition for what is meant by person-centredness? *

Yes
No



Unsure

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

5 Did you learn about person-centredness in your pre-registration training? *

Yes

No

Unsure

6 During your time as a practicing physiotherapist have you been offered or received any training on person-centred practice? *

No training opportunities or actual training have been offered or made available

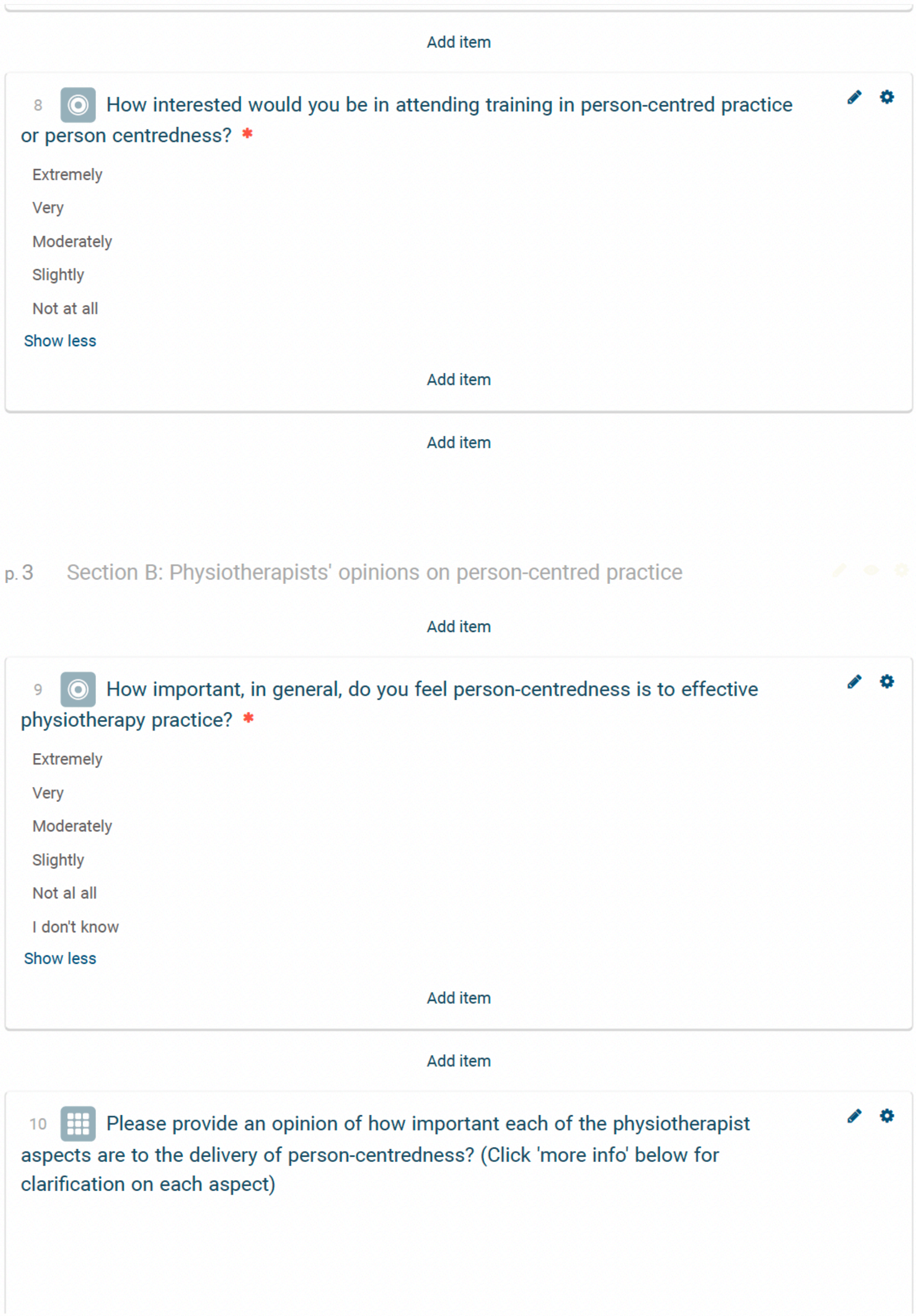
I had a training opportunity but did not attend

I received some informal training e.g., by a colleague with an interest

I received some formal training e.g., in-house or externally provided sessions

7 If the level of person-centredness could be measured on a scale from 0-10 with therapist-centred practice constituting 0, and the maximum possible level of person-centredness as 10, where would you place yourself on the scale in relation to the degree of person-centred practice that you achieve in your emergency departmental practice? *

	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Therapist-centred practice	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Person-centredness**



Add item

8 How interested would you be in attending training in person-centred practice or person centredness? *

Extremely

Very

Moderately

Slightly

Not at all

Show less

Add item

Add item

p. 3 Section B: Physiotherapists' opinions on person-centred practice

Add item

9 How important, in general, do you feel person-centredness is to effective physiotherapy practice? *

Extremely

Very

Moderately

Slightly

Not al all

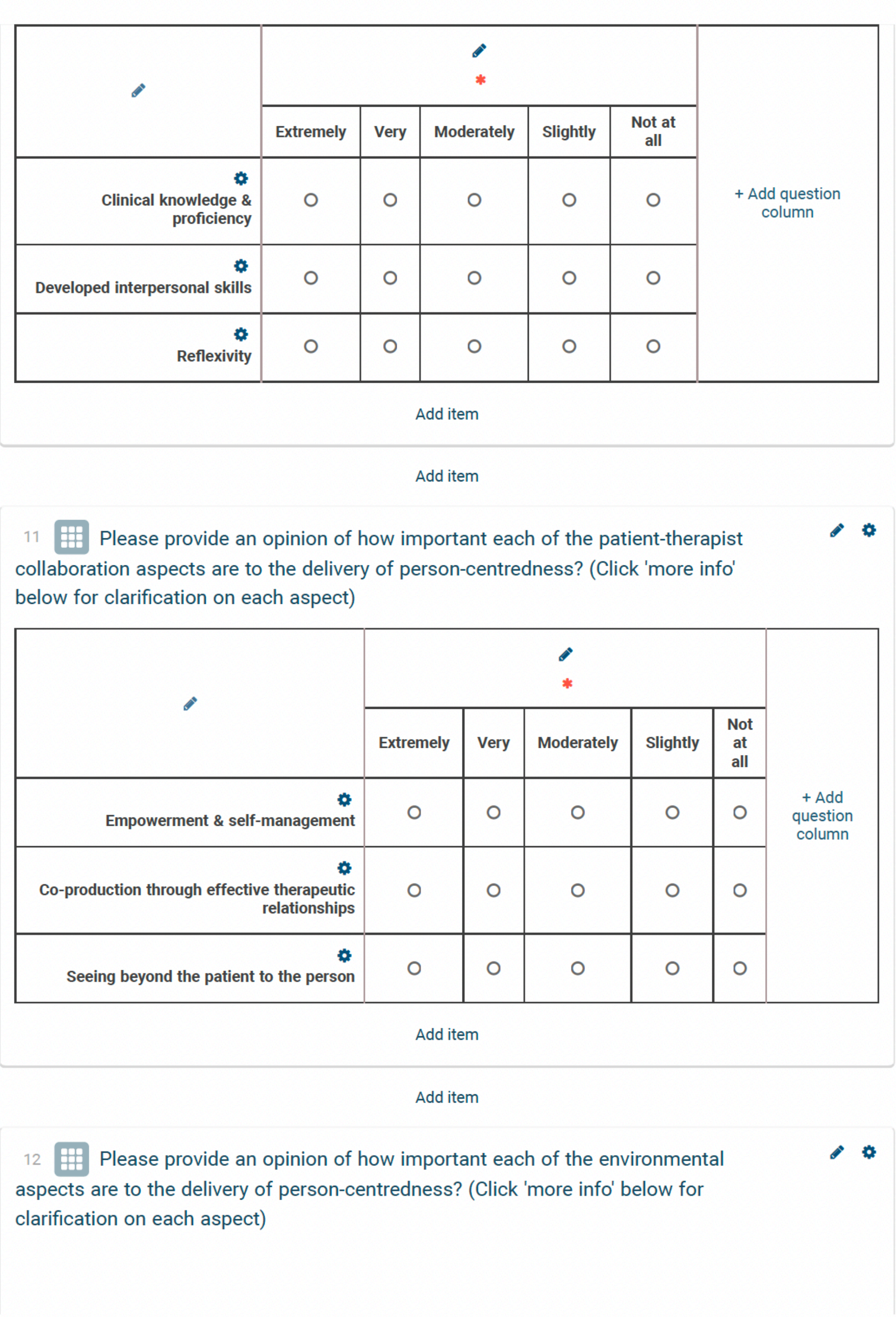
I don't know

Show less

Add item

Add item

10 Please provide an opinion of how important each of the physiotherapist aspects are to the delivery of person-centredness? (Click 'more info' below for clarification on each aspect)

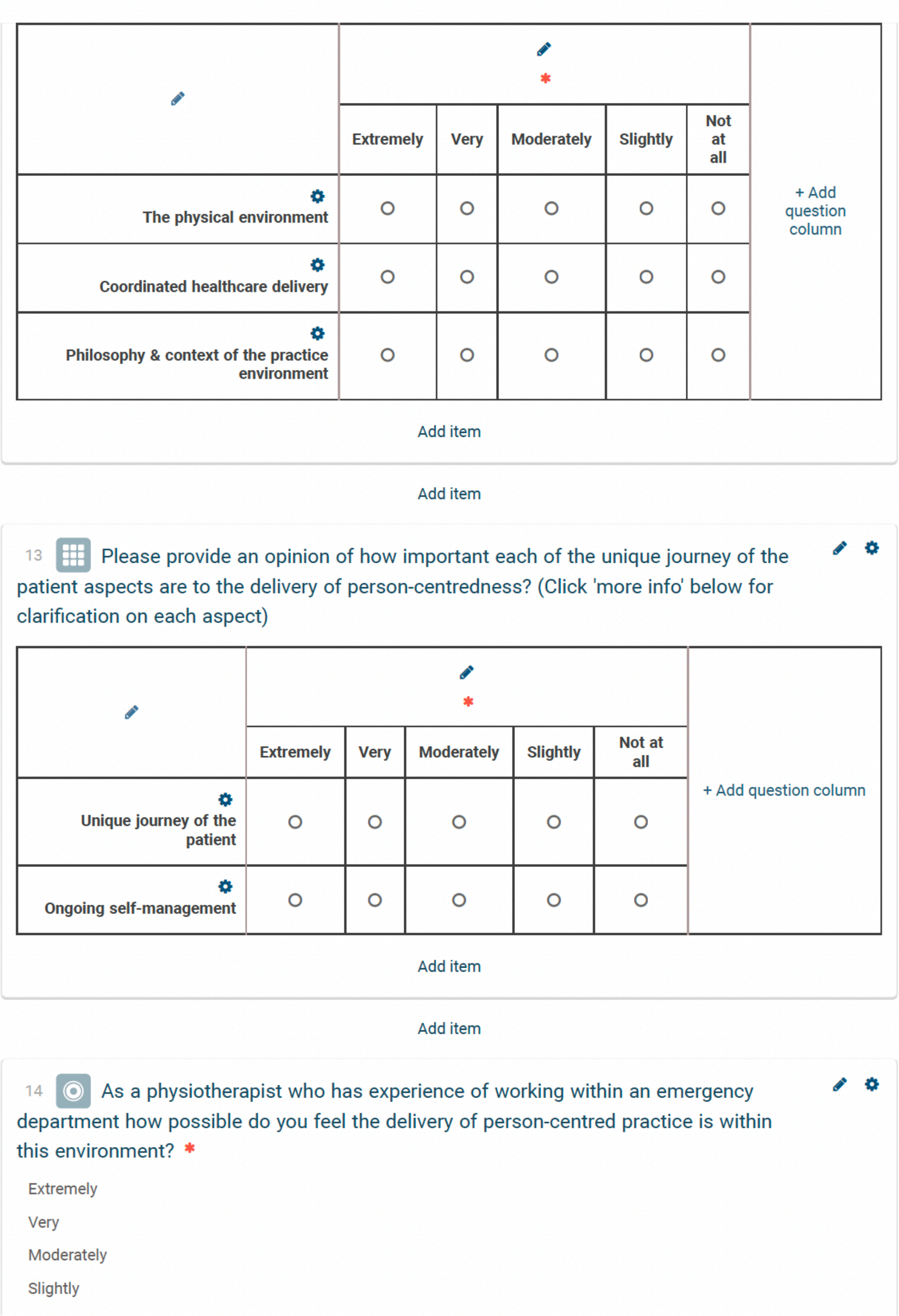


	*					
	Extremely	Very	Moderately	Slightly	Not at all	+ Add question column
Clinical knowledge & proficiency	○	○	○	○	○	
Developed interpersonal skills	○	○	○	○	○	
Reflexivity	○	○	○	○	○	

11 Please provide an opinion of how important each of the patient-therapist collaboration aspects are to the delivery of person-centredness? (Click 'more info' below for clarification on each aspect)

	*					
	Extremely	Very	Moderately	Slightly	Not at all	+ Add question column
Empowerment & self-management	○	○	○	○	○	
Co-production through effective therapeutic relationships	○	○	○	○	○	
Seeing beyond the patient to the person	○	○	○	○	○	

12 Please provide an opinion of how important each of the environmental aspects are to the delivery of person-centredness? (Click 'more info' below for clarification on each aspect)



	*					
	Extremely	Very	Moderately	Slightly	Not at all	+ Add question column
The physical environment	○	○	○	○	○	
Coordinated healthcare delivery	○	○	○	○	○	
Philosophy & context of the practice environment	○	○	○	○	○	

Add item

Add item

13 Please provide an opinion of how important each of the unique journey of the patient aspects are to the delivery of person-centredness? (Click 'more info' below for clarification on each aspect)

	*					
	Extremely	Very	Moderately	Slightly	Not at all	+ Add question column
Unique journey of the patient	○	○	○	○	○	
Ongoing self-management	○	○	○	○	○	

Add item

Add item

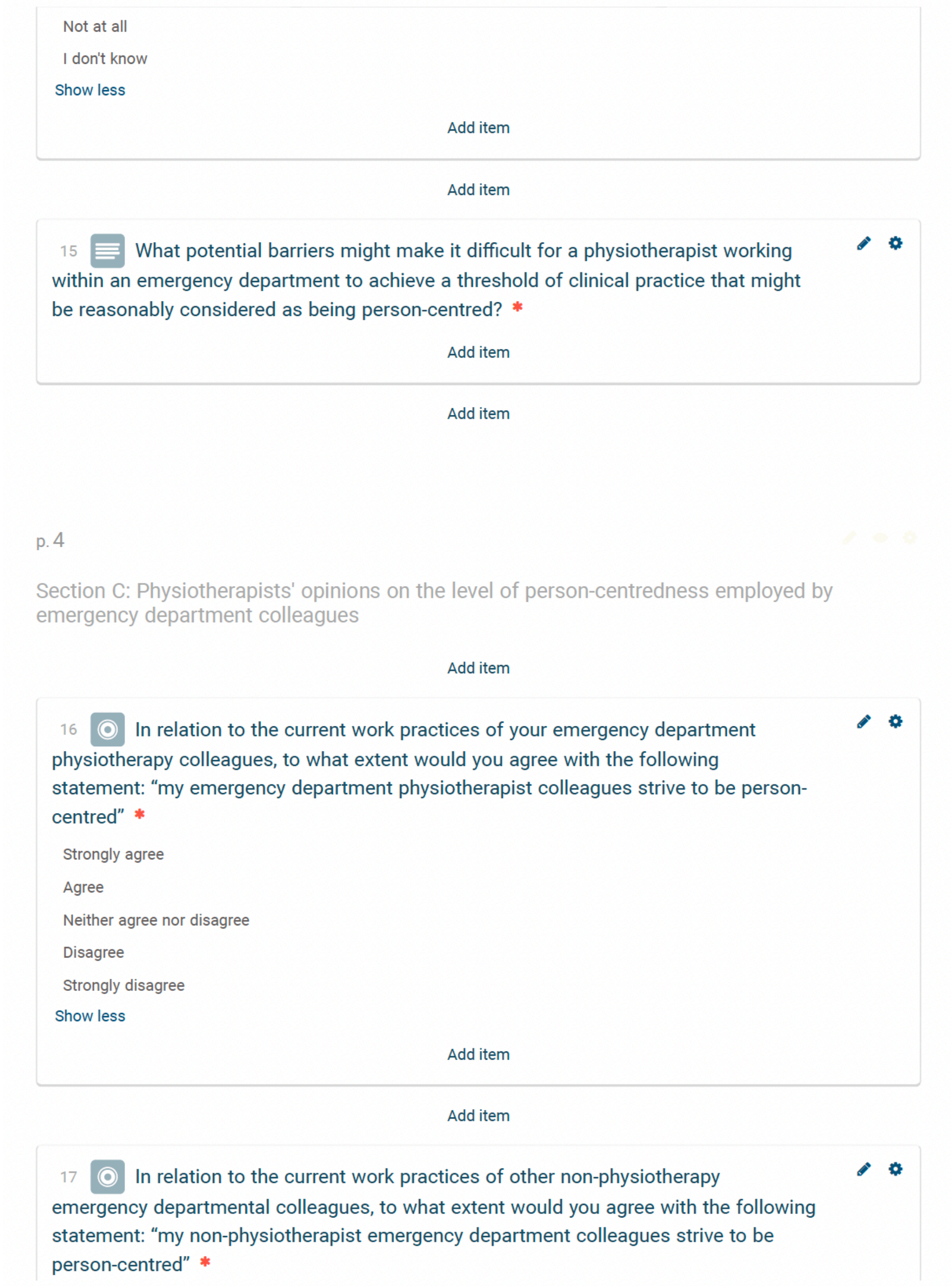
14 As a physiotherapist who has experience of working within an emergency department how possible do you feel the delivery of person-centred practice is within this environment? *

Extremely

Very

Moderately

Slightly



Not at all

I don't know

15 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? *

p. 4

Section C: Physiotherapists' opinions on the level of person-centredness employed by emergency department colleagues

16 In relation to the current work practices of your emergency department physiotherapy colleagues, to what extent would you agree with the following statement: “my emergency department physiotherapist colleagues strive to be person-centred” *

Strongly agree

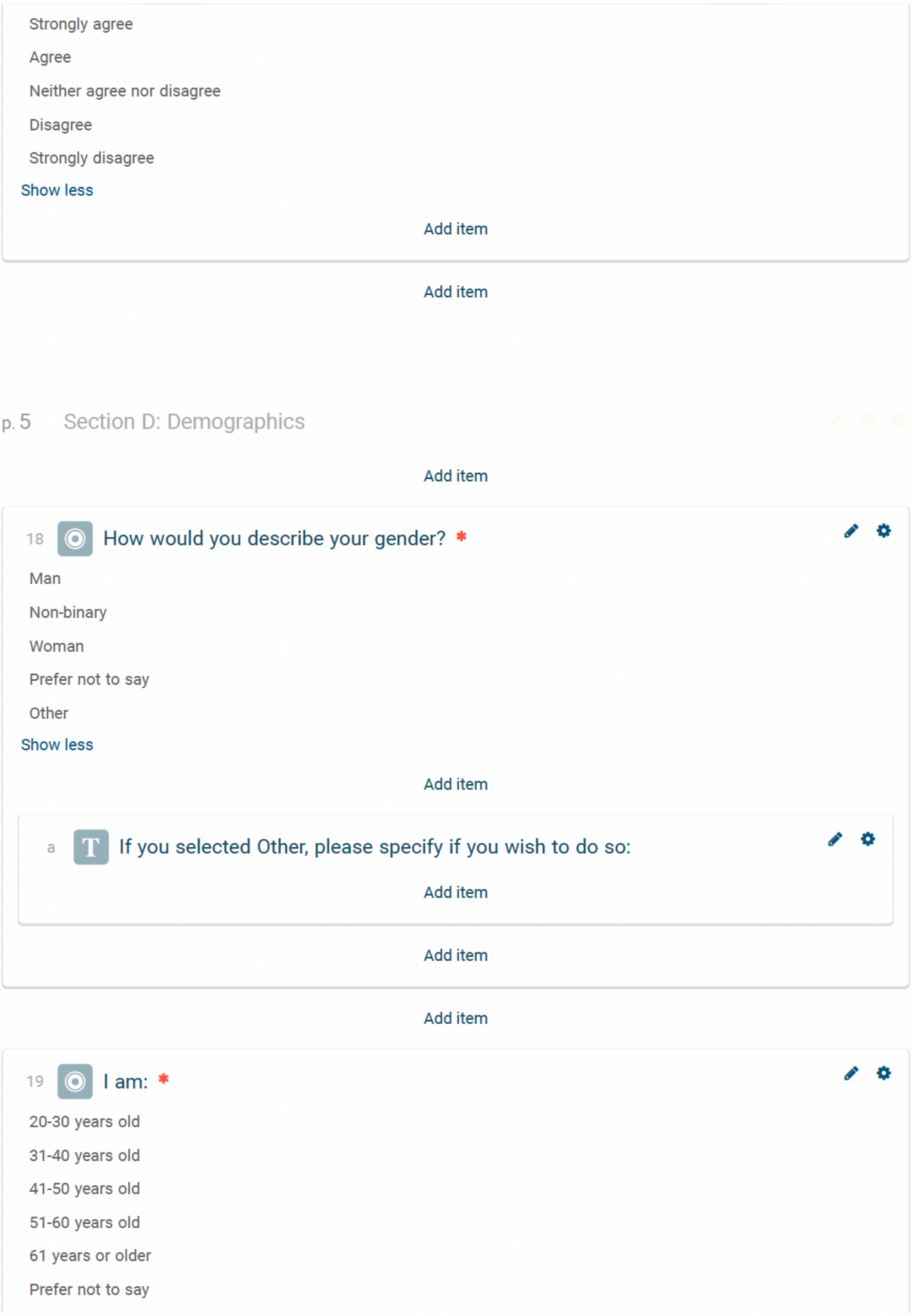
Agree

Neither agree nor disagree

Disagree

Strongly disagree

17 In relation to the current work practices of other non-physiotherapy emergency departmental colleagues, to what extent would you agree with the following statement: “my non-physiotherapist emergency department colleagues strive to be person-centred” *



Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

p. 5 Section D: Demographics

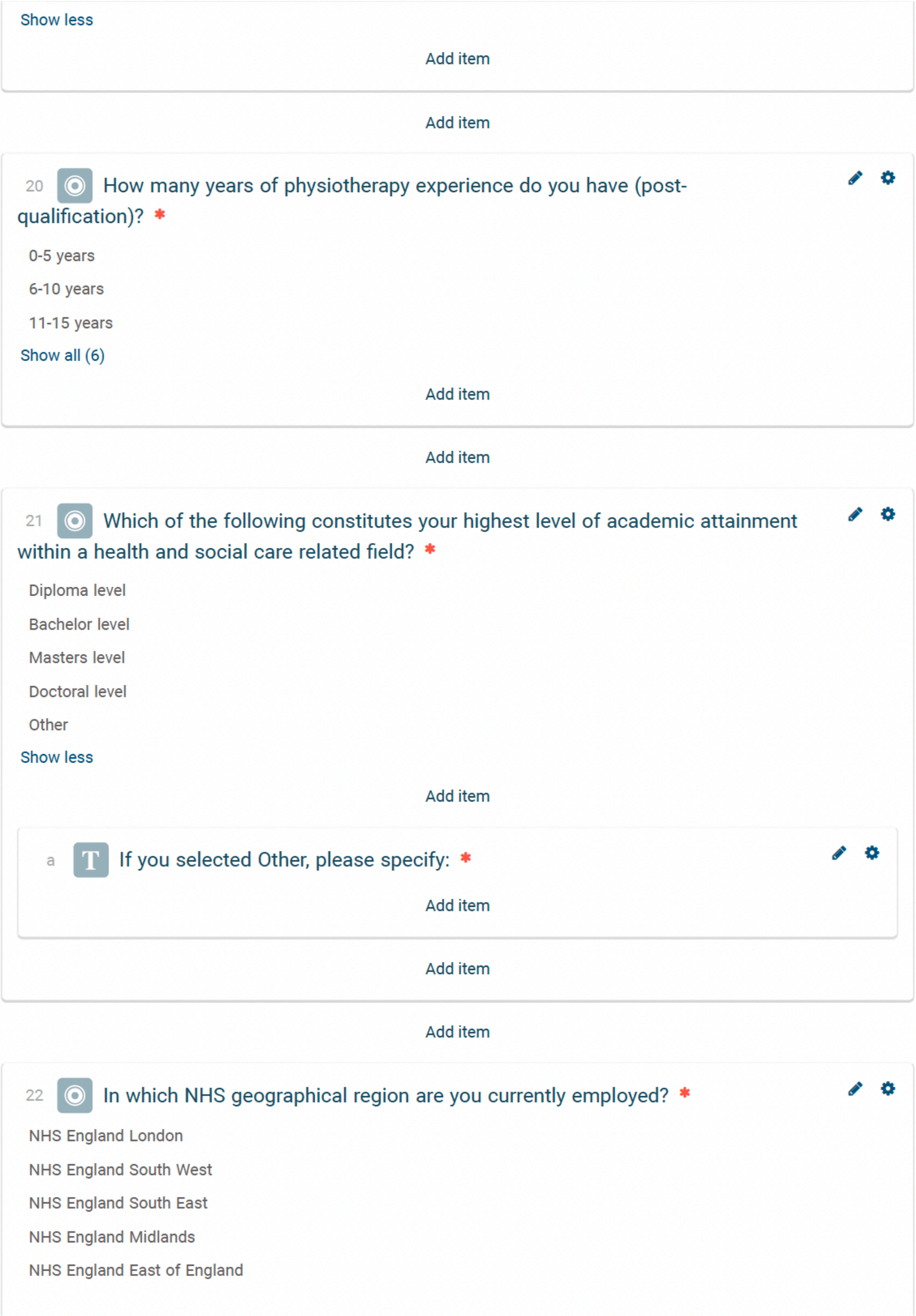
18 How would you describe your gender? *

Man
Non-binary
Woman
Prefer not to say
Other

a If you selected Other, please specify if you wish to do so:

19 I am: *

20-30 years old
31-40 years old
41-50 years old
51-60 years old
61 years or older
Prefer not to say



20 How many years of physiotherapy experience do you have (post-qualification)? *

0-5 years
6-10 years
11-15 years

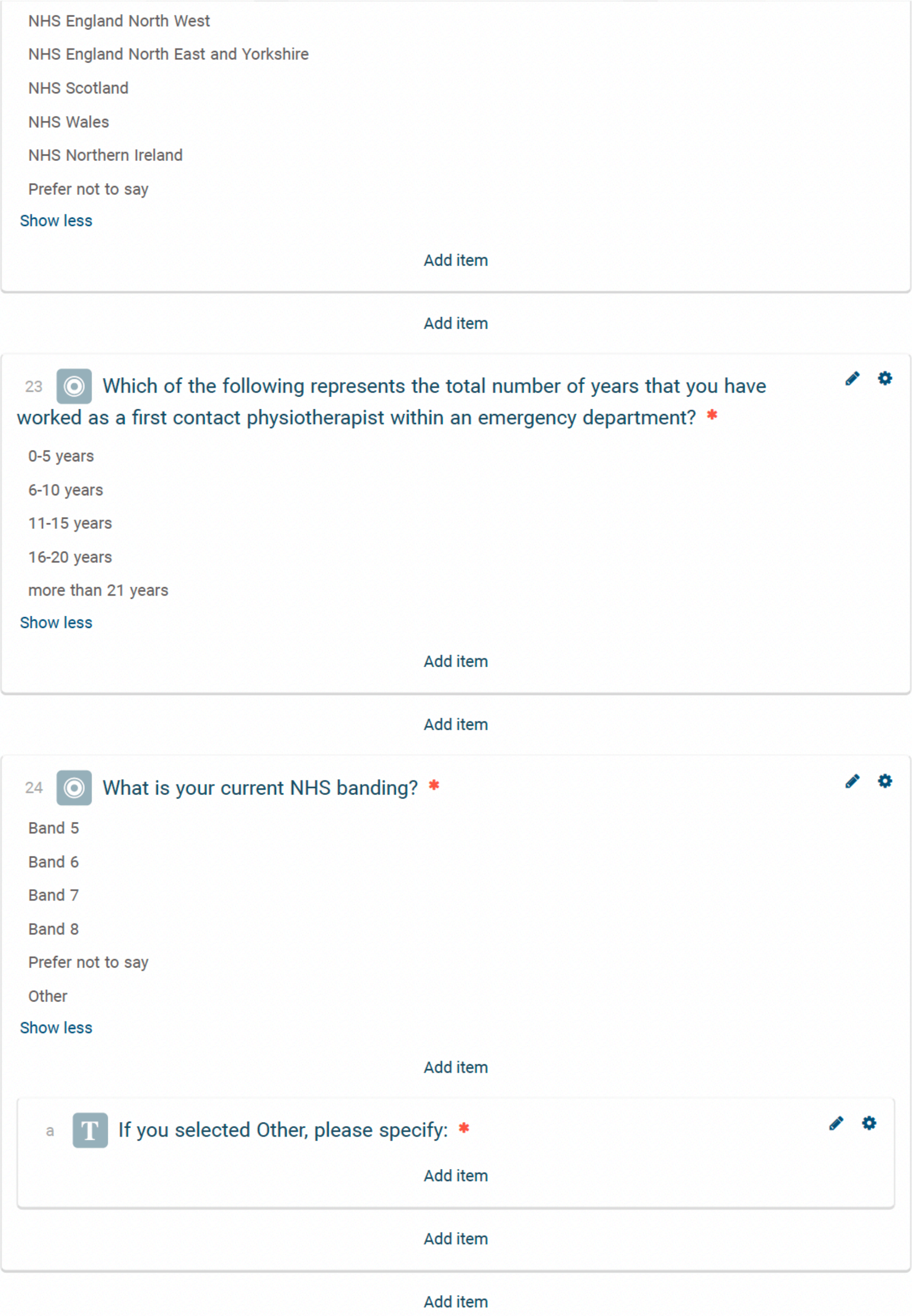
21 Which of the following constitutes your highest level of academic attainment within a health and social care related field? *

Diploma level
Bachelor level
Masters level
Doctoral level
Other

a If you selected Other, please specify: *

22 In which NHS geographical region are you currently employed? *

NHS England London
NHS England South West
NHS England South East
NHS England Midlands
NHS England East of England



NHS England North West

NHS England North East and Yorkshire

NHS Scotland

NHS Wales

NHS Northern Ireland

Prefer not to say

Show less

Add item

Add item

23 Which of the following represents the total number of years that you have worked as a first contact physiotherapist within an emergency department? *

0-5 years

6-10 years

11-15 years

16-20 years

more than 21 years

Show less

Add item

Add item

24 What is your current NHS banding? *

Band 5

Band 6

Band 7

Band 8

Prefer not to say

Other

Show less

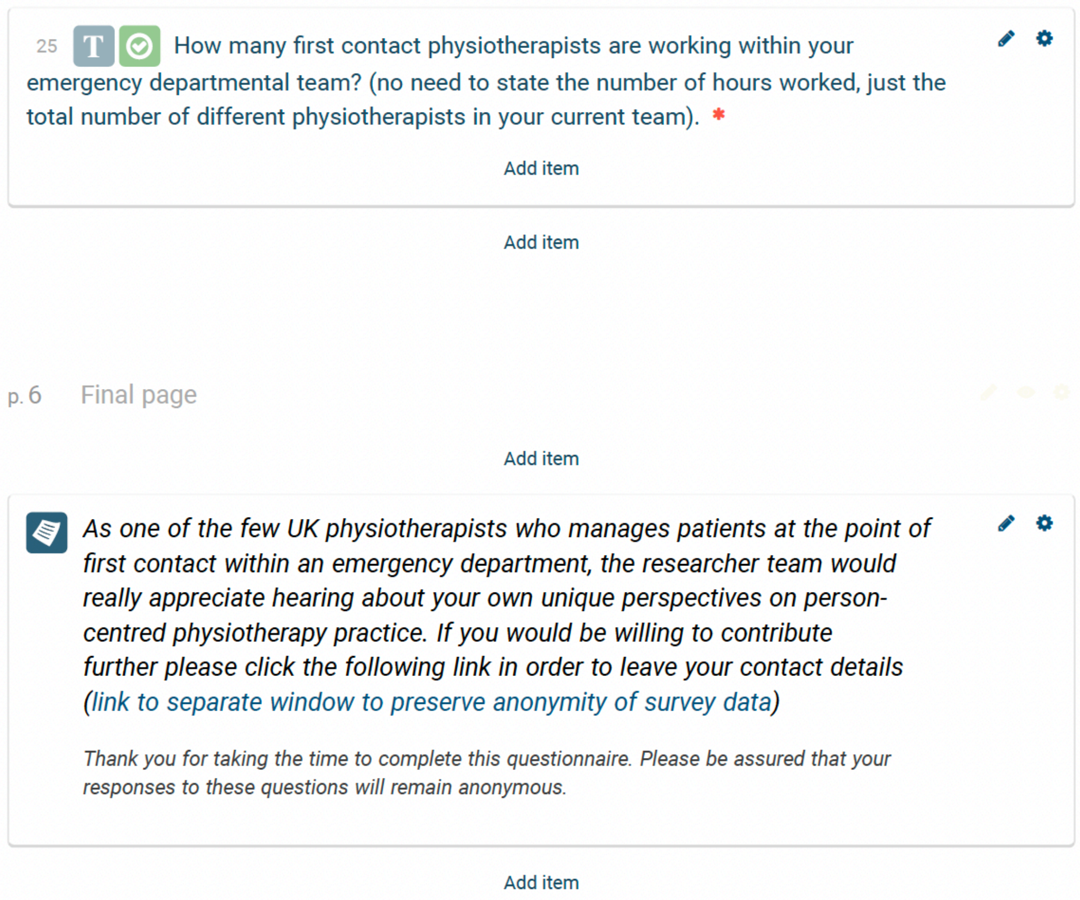
Add item

a If you selected Other, please specify: *

Add item

Add item

Add item

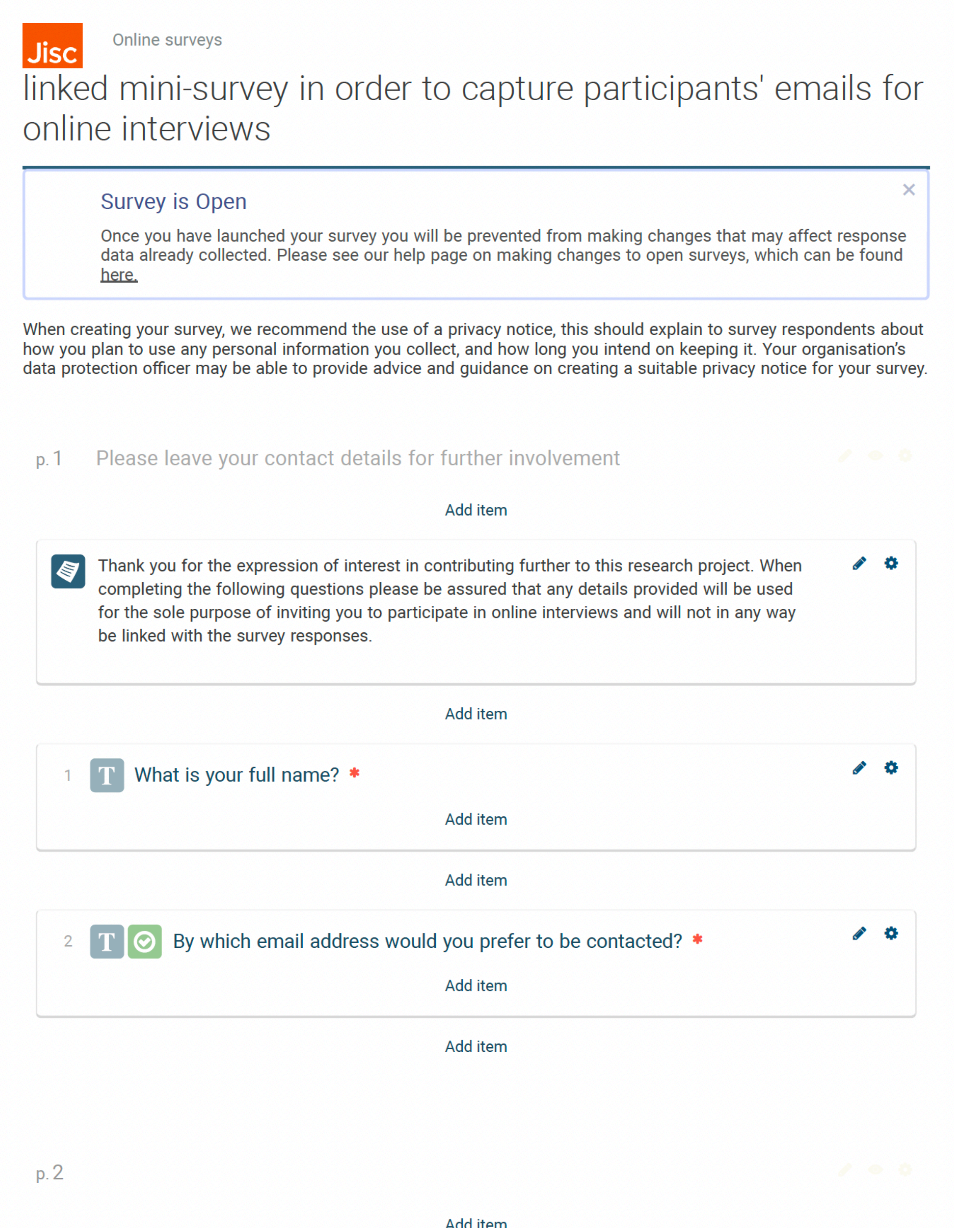


25 How many first contact physiotherapists are working within your emergency departmental team? (no need to state the number of hours worked, just the total number of different physiotherapists in your current team). *

p. 6 Final page

As one of the few UK physiotherapists who manages patients at the point of first contact within an emergency department, the researcher team would really appreciate hearing about your own unique perspectives on person-centred physiotherapy practice. If you would be willing to contribute further please click the following link in order to leave your contact details (link to separate window to preserve anonymity of survey data)

Thank you for taking the time to complete this questionnaire. Please be assured that your responses to these questions will remain anonymous.



linked mini-survey in order to capture participants' emails for online interviews

Survey is Open

Once you have launched your survey you will be prevented from making changes that may affect response data already collected. Please see our help page on making changes to open surveys, which can be found here.

When creating your survey, we recommend the use of a privacy notice, this should explain to survey respondents about how you plan to use any personal information you collect, and how long you intend on keeping it. Your organisation's data protection officer may be able to provide advice and guidance on creating a suitable privacy notice for your survey.

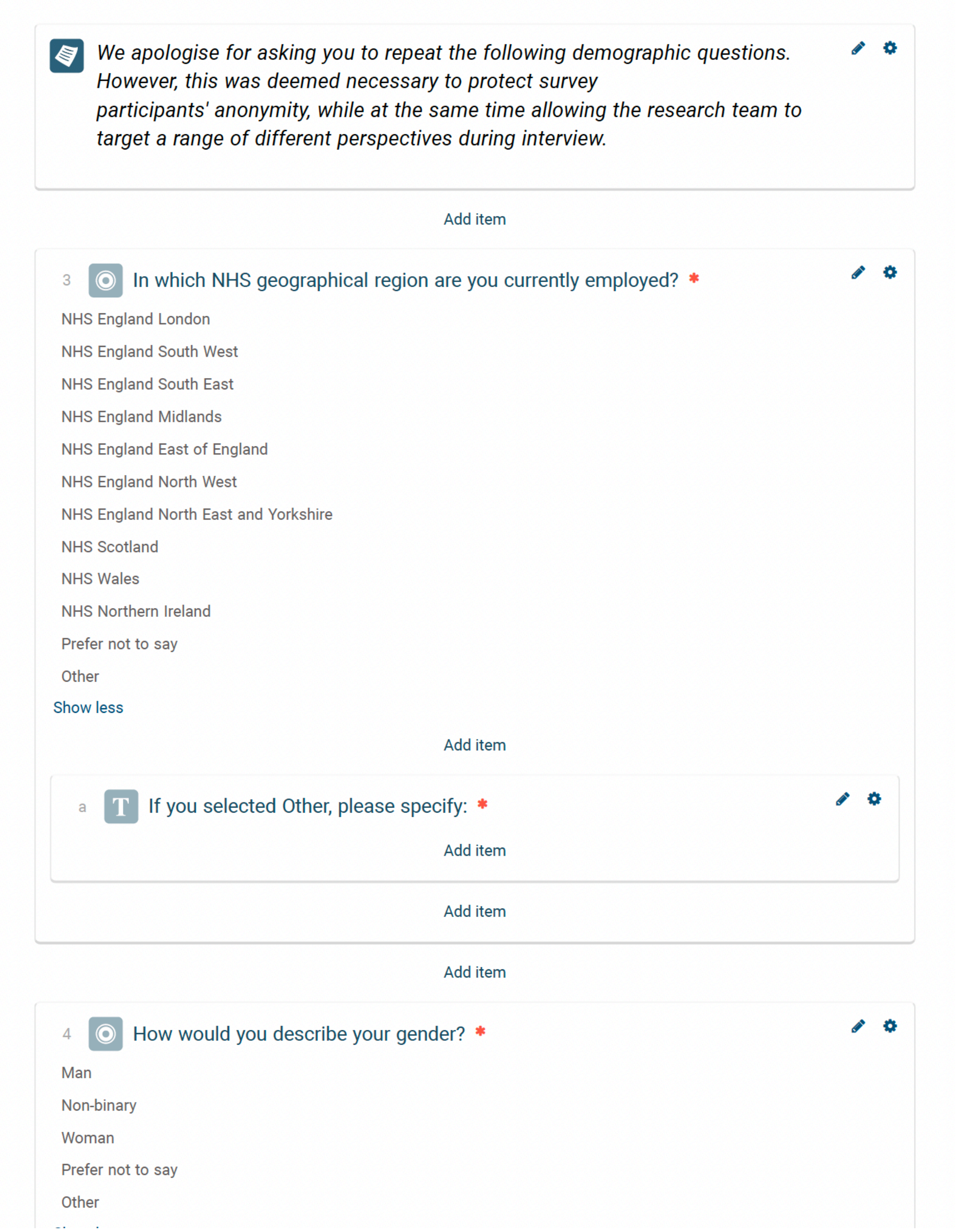
p. 1 Please leave your contact details for further involvement

Thank you for the expression of interest in contributing further to this research project. When completing the following questions please be assured that any details provided will be used for the sole purpose of inviting you to participate in online interviews and will not in any way be linked with the survey responses.

1 T What is your full name? *

2 T By which email address would you prefer to be contacted? *

p. 2



We apologise for asking you to repeat the following demographic questions. However, this was deemed necessary to protect survey participants' anonymity, while at the same time allowing the research team to target a range of different perspectives during interview.

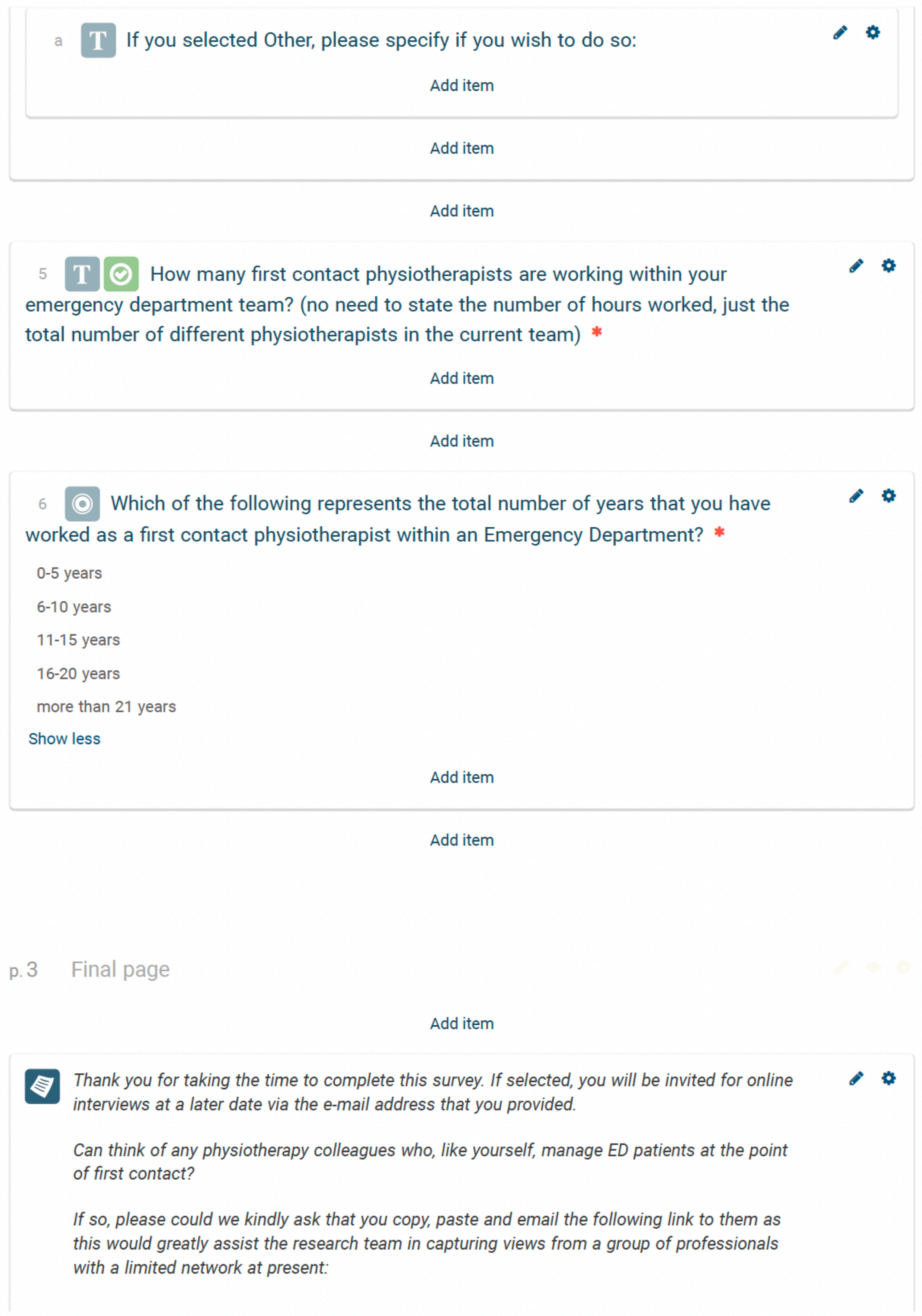
3 In which NHS geographical region are you currently employed? *

- NHS England London
- NHS England South West
- NHS England South East
- NHS England Midlands
- NHS England East of England
- NHS England North West
- NHS England North East and Yorkshire
- NHS Scotland
- NHS Wales
- NHS Northern Ireland
- Prefer not to say
- Other

a If you selected Other, please specify: *

4 How would you describe your gender? *

- Man
- Non-binary
- Woman
- Prefer not to say
- Other



a If you selected Other, please specify if you wish to do so:

5 How many first contact physiotherapists are working within your emergency department team? (no need to state the number of hours worked, just the total number of different physiotherapists in the current team) *

6 Which of the following represents the total number of years that you have worked as a first contact physiotherapist within an Emergency Department? *

0-5 years
6-10 years
11-15 years
16-20 years
more than 21 years

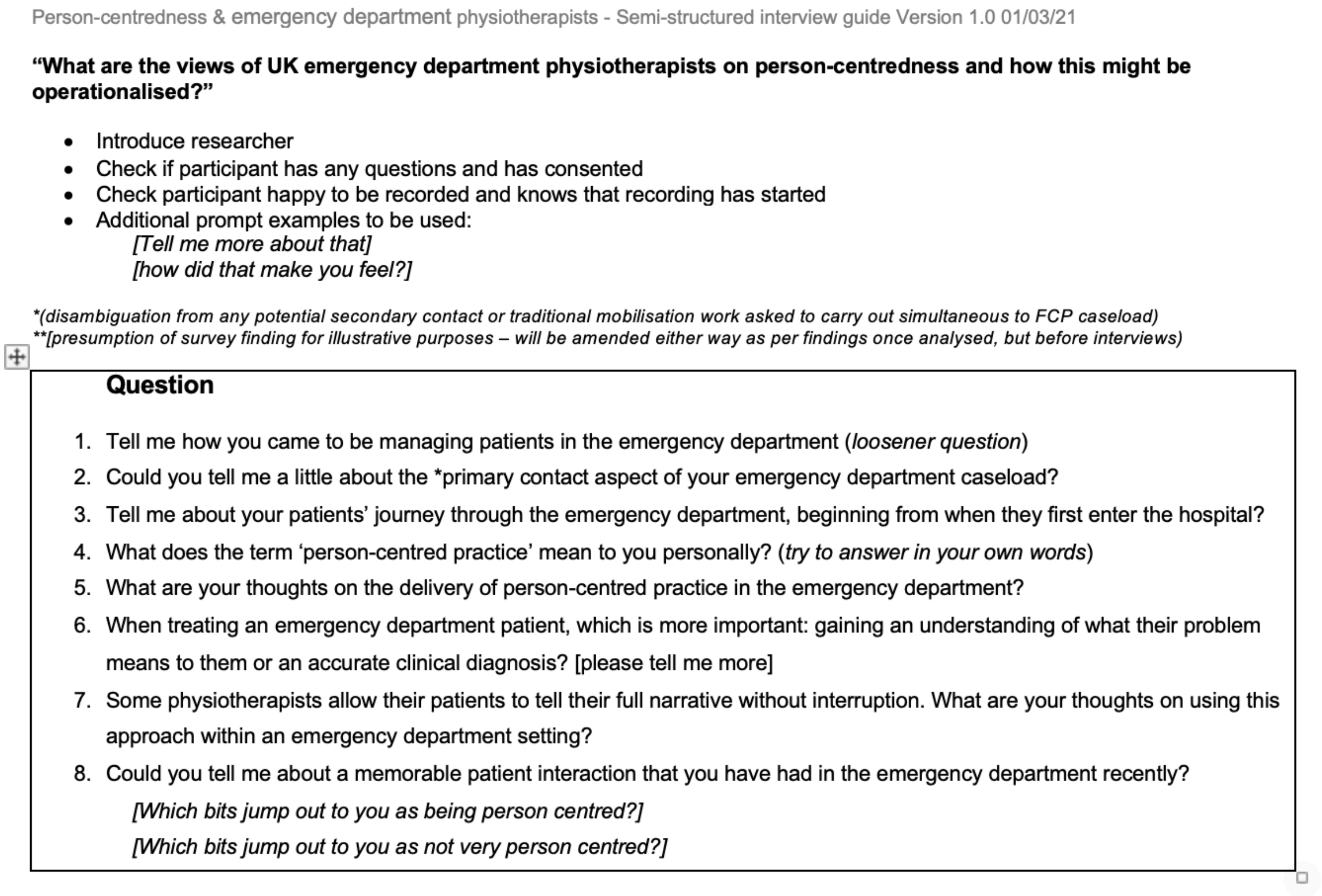
p. 3 Final page

Thank you for taking the time to complete this survey. If selected, you will be invited for online interviews at a later date via the e-mail address that you provided.

Can think of any physiotherapy colleagues who, like yourself, manage ED patients at the point of first contact?

If so, please could we kindly ask that you copy, paste and email the following link to them as this would greatly assist the research team in capturing views from a group of professionals with a limited network at present:

Appendix 7 : Interview guide (study 2)



Person-centredness & emergency department physiotherapists - Semi-structured interview guide Version 1.0 01/03/21

"What are the views of UK emergency department physiotherapists on person-centredness and how this might be operationalised?"

- Introduce researcher
- Check if participant has any questions and has consented
- Check participant happy to be recorded and knows that recording has started
- Additional prompt examples to be used:
    [Tell me more about that]
    [how did that make you feel?]

***(disambiguation from any potential secondary contact or traditional mobilisation work asked to carry out simultaneous to FCP caseload)**
****[presumption of survey finding for illustrative purposes – will be amended either way as per findings once analysed, but before interviews)**

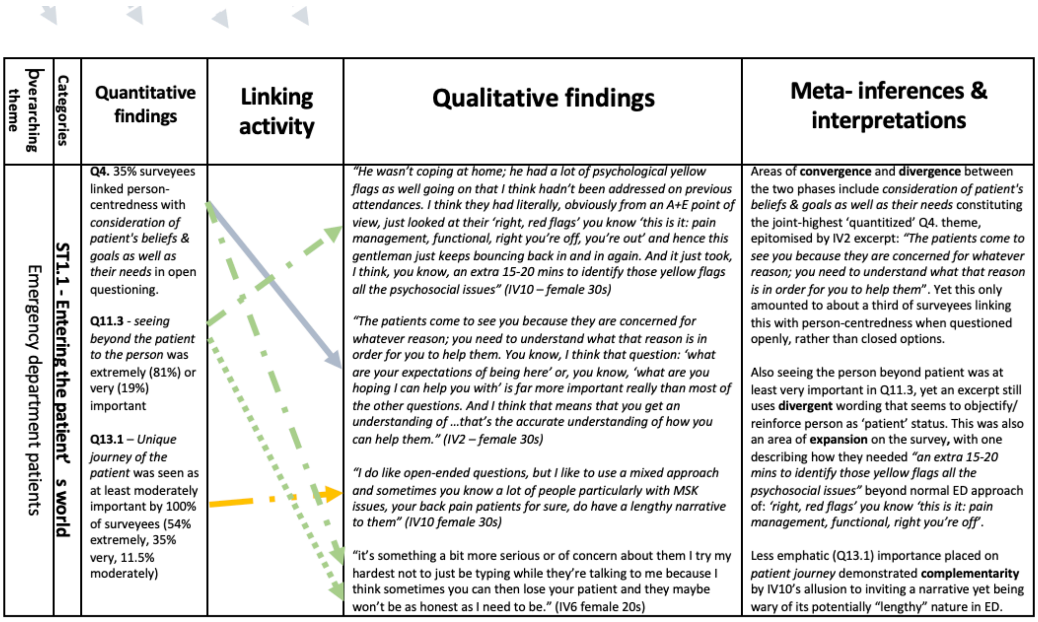
Question

1. Tell me how you came to be managing patients in the emergency department (*loosener question*)
2. Could you tell me a little about the *primary contact aspect of your emergency department caseload?
3. Tell me about your patients' journey through the emergency department, beginning from when they first enter the hospital?
4. What does the term 'person-centred practice' mean to you personally? (*try to answer in your own words*)
5. What are your thoughts on the delivery of person-centred practice in the emergency department?
6. When treating an emergency department patient, which is more important: gaining an understanding of what their problem means to them or an accurate clinical diagnosis? [please tell me more]
7. Some physiotherapists allow their patients to tell their full narrative without interruption. What are your thoughts on using this approach within an emergency department setting?
8. Could you tell me about a memorable patient interaction that you have had in the emergency department recently?
    [Which bits jump out to you as being person centred?]
    [Which bits jump out to you as not very person centred?]

9. Body language is acknowledged as key component of communication. I would therefore be really interested to hear how you read a patient's body language during emergency department assessments?
10. ..and how do you think a patient might interpret a therapist's own body language?
11. An interesting finding from the survey completed by you and your peers revealed {**e.g., the limited opportunities emergency department physios felt that they had to develop their own levels of PC}. Could you discuss your own thoughts on this?
12. What value do you place on the patients' own opinions of what is going on (in terms of the particular problems that brought them to the emergency department)?
13. How important is a patient's contribution to your treatment plans or any final decision that you make in the emergency department?
    [tell me more]
14. Is there anything about you as a person that you believe allows you to practice in a person-centred way?
15. Is there anything else that you want to add which we haven't already spoken about?

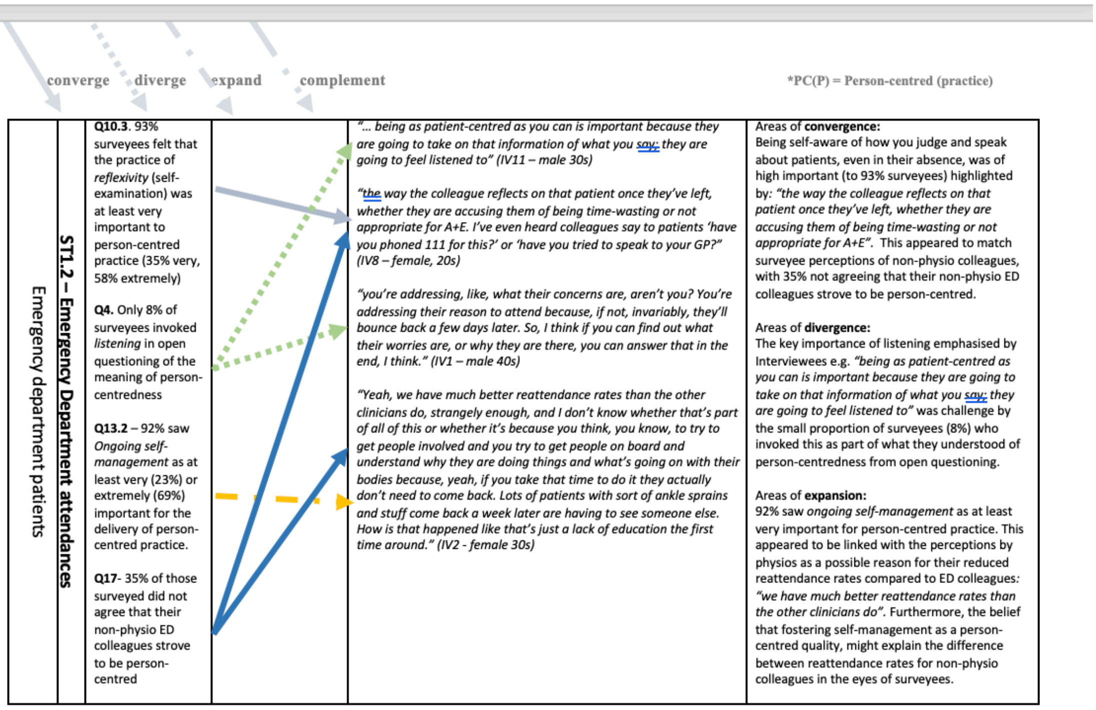
Thank you for your time – I am now turning the recorder off

Appendix 8: Joint display in full (study 2)



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 IV2 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.

Table Supplement. Joint display table of the mixed methods data linking activity



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

Emergency department patients	ST1.2 – Emergency Department attendances	**Q10.3**. 93% surveyees felt that the practice of *reflexivity* (self-examination) was at least very important to person-centred practice (35% very, 58% extremely) **Q4.** Only 8% of surveyees invoked *listening* in open questioning of the meaning of person-centredness **Q13.2** – 92% saw *Ongoing self-management* as at least very (23%) or extremely (69%) important for the delivery of person-centred practice. **Q17**- 35% of those surveyed did not agree that their non-physio ED colleagues strove to be person-centred		*"… 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" (IV11 – male 30s)* *"the way the colleague reflects on that patient once they've left, whether they are accusing them of being time-wasting or not appropriate for A+E. I've even heard colleagues say to patients 'have you phoned 111 for this?' or 'have you tried to speak to your GP?" (IV8 – female, 20s)* *"you're addressing, like, what their concerns are, aren't you? 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." (IV1 – male 40s)* *"Yeah, we have much better reattendance rates than the other clinicians do, strangely enough, and I don't know whether that's part of all of this or whether it's because you think, you know, to try to get people involved and you try to get people on board and understand why they are doing things and what's going on with their bodies because, yeah, if you take that time to do it they actually don't need to come back. Lots of patients with sort of ankle sprains and stuff come back a week later are having to see someone else. How is that happened like that's just a lack of education the first time around." (IV2 - female 30s)*	Areas of **convergence:** Being self-aware of how you judge and speak about patients, even in their absence, was of high important (to 93% surveyees) highlighted by: *"the way the colleague reflects on that patient once they've left, whether they are accusing them of being time-wasting or not appropriate for A+E"*. This appeared to match surveyee perceptions of non-physio colleagues, with 35% not agreeing that their non-physio ED colleagues strove to be person-centred. Areas of **divergence:** The key importance of listening emphasised by Interviewees e.g. *"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"* was challenge by the small proportion of surveyees (8%) who invoked this as part of what they understood of person-centredness from open questioning. Areas of **expansion:** 92% saw *ongoing self-management* as at least very important for person-centred practice. This appeared to be linked with the perceptions by physios as a possible reason for their reduced reattendance rates compared to ED colleagues: *"we have much better reattendance rates than the other clinicians do"*. Furthermore, the belief that fostering self-management as a person-centred quality, might explain the difference between reattendance rates for non-physio colleagues in the eyes of surveyees.

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

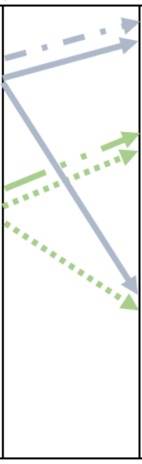
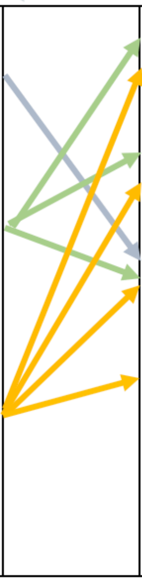
Emergency department patients	**ST1.3 – Patient types**	**Q15.** In open questioning, 27% surveyees saw *patient mindset including unreasonable expectations* as a barrier to person-centredness **Q4.** In open questioning, 19% surveyees linked person-centredness with *providing options for an informed choice*		*"Sometimes patients will come in and it's really not realistic…we can't do what they are expecting us to do. and I will be honest with them and say: "our priority in an ED department is to rule out anything that had been immediately concerning or worrying or a risk to your life." (IV9 female 30s)* *"You maybe need to…. guide the patient away from what they want into what you…It's more constrained to say: 'actually, this is best care; we need to come closer to this in this environment'. Whereas in a different situation, where it is not as poor an outcome, you can maybe come across onto their side of the fence a bit more, but ED is a bit more constrained with some of the things I think." IV1 male 40s* *"he didn't want an x-ray of his knee, but he clearly needed one, so I ordered on anyway and it came back that it was fractured. So, patient-centredness…you know… what do I do? do I say 'oh yeah, no problem, you don't want me to look at your knee' or do I just do it anyway knowing full well that if it comes back, he'd be the first one to sue. So, again there's an end…it's a sliding scale for me depending on the patients, the condition, the risk and at the top, you know, it's the risk to the patient. so again, if what they're wanting is miles always, and my registration's getting closer to the line, then patient-centredness gets less important." IV11 - male 30s*	Around a third of surveyees invoked patient *mindset or unreasonable expectations* when openly questioned on the barriers to person-centredness; an area of **convergence** with excerpts like, *"it's really not realistic…we can't do what they are expecting"* and *"he didn't want an x-ray of his knee, but he clearly needed one"*. This point also leaves space for ***expansion*** with interviewees justification of taking the time when it is needed for them to push back on ED's remit for only ruling things out that are "*immediately concerning or worrying or a risk to your life."* Areas of **divergence:** despite a fifth of surveyees invoking the idea of *informed choice* in open questions about person-centredness, interviews still commented on the need to*: "guide the patient away…ED is a bit more constrained"* or *"he didn't want an x-ray of his knee, but….it came back that it was fractured. So…what do I do?"* However, less risky situations *"where it is not as poor an outcome"* provide better opportunity to let the patient choose – offering a more **complementary** as opposed prior contradictory interpretation.

Table Supplement. Joint display table of the mixed methods data linking activity

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

Emergency department patients	**ST1.4 – Diagnosis & patient management**	**Q11.1** 100% of surveyees regarded *empowerment & self-management* as at least moderately important (77% extremely, 19% very, 4% moderately) **Q11.2** 100% of surveyees regarded *Co-production & effective therapeutic relationship'* as at least moderately important (73% extremely, 23% very, 4% moderately) **Q4.** In open questioning, 35% surveyees linked person-centredness with *shared decision making* and 27% linked this with *tailoring/ individualising care; both* relatively high responses to Q4.		*"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." IV2 female 30s* *"if you're asking someone to do something every day, like exercise, and if their life isn't better… they're not going to do it. So maybe if you understood what their lifestyle was like you could adapt that so that it would fit. So, and yeah that thinking a bit more outpatient physio approach, but it does feed into ED as well" IV9 female 30s* *"I mean they need to be involved, they need to accept it and they need to have understood and recognise that that's… I mean, I suppose …that's my job, it's to help them to understand what they need to do to get the best out of their situation. But, 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." IV2 female 30s* *"Person-centred care: it is just making sure that as the professional the patient is at the centre of the decision making; they're informed, they're aware of the risks and benefits and they are central in that decision-making" IV8 female 20s*	This constituted an area demonstrating significant **convergence:** *empowerment & self-management* was considered at least moderately important by all those surveyed typified by the quote: "*that's my job, it's to help them to understand what they need to do to get the best out of their situation"*. *Co-production & effective therapeutic relationships* too were considered at least moderately important by all those surveyed with **convergence** seen in an exemplar quote: *"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."* *Shared decision making* (35%) and *tailoring/ individualising care* (27%) were both relatively high responses to open survey questioning of what was understood by person-centredness - with **convergence** in respective exemplar quotes: *"Person-centred care: it is just making sure that as the professional the patient is at the centre of the decision making"* and *"maybe if you understood what their lifestyle was like you could adapt that so that it would fit."*

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

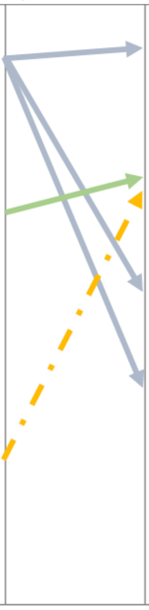
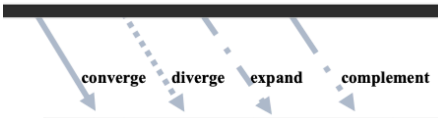
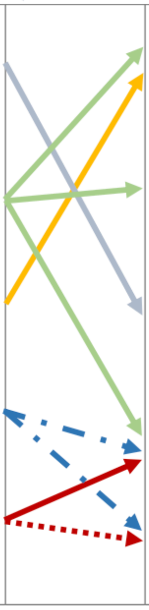
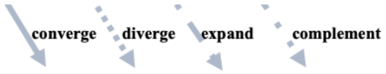
Emergency department physiotherapists	**ST2.1 – Physiotherapist personality**	**Q7.** 96% scaled their own level of person-centred as moderate or better (31% moderate, 54% very, 12% extremely); only 4% scored slightly. **Q16.** 81% agreed that their ED physio colleagues strived to be person-centred (31% strongly agreed & 50% agreed). 15% neither agreed nor disagreed & 4% stated their disagreement. **Q17** 66% agreed that their non-physio ED colleagues strived to be person-centred (1% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 8% disagreed (of which 4% disagreed & 4% strongly so)		*"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."IV2 female 30s* *"for me, medics went into medicine because they like medicine, physio go into physio because they like people and I think that's the difference, it's just different personalities; different motivations. Medics are only interested when there's something seriously wrong, whereas….we're most interested in the person's problem, as in the problem for them." IV11 male 30s* *"I would say from a personality point of view that I like to talk to my patients, I like to get to know them. And I like to introduce myself to them as well so that they kind of get an understanding that I'm a real person; we're not just robots at the end of the day. So, maybe it helps" - IV10 female 30s* *"they don't care what you know until they know you' so actually giving a bit of personality and being a bit, kind of, open and honest; you build that rapport. and that's what I feel then people open up and they're receptive because otherwise you're just another uniform to them." IV11 male 30s*	Analysis of linkage between survey responses and interview findings on ED physio personality category showed **convergence** between two data sets. Physios' belief in their own levels of person-centredness was convincing (96% moderate or better) with the physio idea patients "really want help and as a person I try to remember that" and "understanding that I'm a real person" ensuring not seen as " just another uniform to them". The vast majority (over four fifths) of surveyees agreed that their physio colleagues strived to be person-centred; only 4% formally disagreed. This **convergence** matched with the idea of physios going "into physio because they like people" and their interest in "the person's problem, as in the problem for them". There was a **convergent** lack of faith in non-physio ED colleagues' commitment to person-centeredness. This was notable in relation to the more positive appraisal physios gave themselves and, to a lesser extent, their fellow physios. While two thirds agreed that non-physios strived to be person-centred, of the third that did not, 27% neither agreed nor disagreed, 4% disagreed and 4% strongly disagreed. The indication being "medics went into medicine because they like medicine, physio go into physio because they like people and I think that's the difference, it's just different personalities; different motivations." The idea by physios that "medics are only interested when there's something seriously wrong" allows for some **expansion** here.

Table Supplement. Joint display table of the mixed methods data linking activity



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

Emergency department physiotherapists	**ST2.2– Physiotherapist skills**	**Q10.1** *clinical knowledge & proficiency* was at least moderately important (46% extremely, 42% very, 12% moderately) **Q10.2** *Developed interpersonal skills* were very (8%) or extremely important (92%). **Q10.3** *Reflexivity* was at least moderately (8%) very (35%) or extremely (58%) important **Q6.** 58% attended some postgraduate PCP training **Q8.** 8% had no interest in training for PCP; 4% were only slightly interested. 89% surveyees had moderate or greater interest.		*"Awareness of self is probably one of the reasons I can do person-centred care because I am aware of my own conflicted emotions…. so, I can be up front with a patient and say 'look! I'm really sorry. I'm in this place right now, bear with me.' Or 'I'm trying to help you do this', but having awareness of my own emotions and self allows me to be better at patient-centred care." IV4 – female 30s* *"what's also really interesting is when you start looking into kind of time efficacy. 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." IV3 female 30s* *"on the ACP apprenticeship at the moment…broadening our scope of what we are seeing…but still wanting to keep our feet very firmly in our MSK physio shoes and not spread too much either side, it's just to really be autonomous with people who come in who potentially have fallen, fractured something but also have had a head injury or have got abdominal pain and so we are not having to sort of pick other peoples' brains and get other people to help us with those contacts" IV2 female 30s* *earlier on in my career, no, [I had] no formal training at all so I think it needs a light shining on it earlier on, but I think a clinician definitely develops and evolves to be more patient centred. IV10 females 30s* *"I think the way to do it is training and reminding people and regular updates and people just being reminded to do it otherwise people get stuck in the box ticking exercise and the efficiency mode. And I think efficient mode is good but it I think it loses sight of the patient-centred model." IV4 female 30s*	Survey and interview data sets were mainly displaying **convergence** on ED physio skills: *clinical knowledge's* moderate or greater importance was exemplified by those physio doing ACP masters to "broadening our scope of what we are seeing". *Interpersonal skills* being at least very important **converged** with "having awareness of my own emotions and self allows me to be better at patient-centred care"," giving people the chance to talk is a much better option" and that "a clinician definitely develops and evolves to be more patient centred." Survey findings of moderate or greater importance for *reflexivity* **converges** with "awareness of self is probably one of the reasons I can do person-centred care". A slim majority surveyed had attended some Post-graduate PCP training, but since this did not occur earlier in the career of one interviewee they offered the **expansion** that one "evolves to be more patient centred". While another endorsed the view that "the way to do it is training and reminding people and regular updates and people just being reminded" Finally, **divergence** was seen with the survey's not insignificant finding (12%) of low or no interest in undergoing PCP training contrasting with interviewee's comment that ""I think the way to do it is training".



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

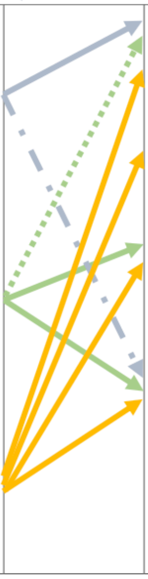
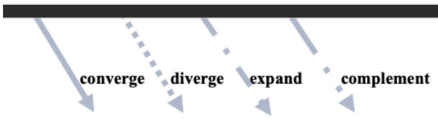
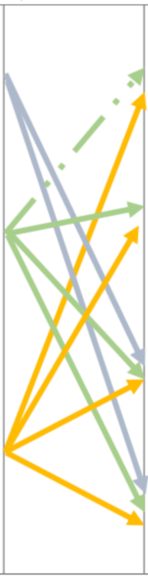
Emergency department physiotherapists	**ST2.3– Physiotherapist beliefs about PCP**	**Q16.** 81% agreed that their ED physio colleagues strived to be person-centred (31% strongly agreed & 50% agreed). 15% neither agreed nor disagreed & 4% disagreed **Q17** 66% agreed that their non-physio ED colleagues strived to be person-centred (4% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 4% disagreed & 4% strongly disagreed. **Q12.3** *Philosophy & context of practice* was at least either moderately (15%), very (50%) or extremely (35%) important to person-centredness		*"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." (IV6 -female 20s)* *"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." IV5 female 30s* *"We are really pushing as a trust to have our make every contact count (MECC) campaign and I think that's something that's in the back of my mind all the time is that it doesn't matter what the bed pressures are it doesn't matter that there's another patient to be seen after this one. because if I give this patient the right care at the right time in the right place, we'll get you know a much better outcome for that individual and the same as then the next person who's on that waiting list will hopefully get the right outcome as well." IV10 females 30s* *"if you want to be a really good physio with Person-Centred Care, you need to separate yourself from the people that aren't prioritising Patient-Centred Care because the two just don't go together." IV2 female 30s*	The many areas of **convergence** here include: the view that physios and non-physios alike strive to be person-centred, albeit physios more so; the idea of possessing a person-centred philosophy and that this is challenged by the ED environment: "I don't think that you'd work in healthcare if you didn't. I think the pressures in ED change that"; a notion of being prepared to put ones "neck on the line" and trust-wide attempts in making every contact count as "something that's in the back of my mind all the time"; and strikingly, the apparently dramatic need to separate oneself from those "that aren't prioritising patient-centred care". The third not agreeing or, rather, disagreeing that non-physios strove to be person-centred is **divergent** with the interview opinion that "every single person that I work with has the patient in the best interest and would be patient centred". The self-explanatory and bold quote "if you want to be a really good physio with person-centred care you need to separate yourself from the people that aren't prioritising patient-centred care because the two just don't go together" offers an **expansion** on the established existence of a practice philosophy but drives home the requirement to draw a line between those deliberately enacting this and those who are not.

Table Supplement. Joint display table of the mixed methods data linking activity



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

Emergency department environment	**ST3.1– clash between BM and Person-centredness**	**Q9.** All of those surveyed felt person-centredness was either very (39%) or extremely (62%) important to effective physiotherapy practice **Q14** All of those surveyed felt the delivery of person-centredness in ED was possible: 62% moderately, 31% very and 8% extremely possibly. **Q15.** Open questioning found *conventions of ED practice* and *holistic clash with a biomedical environment* as person-centred barriers in 19% & 23% respectively		*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" IV2 female 30s* *"but I think sometimes we are far too, maybes, 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 maybes 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." IV10 female 30s* *"I think to allow, to tell people that it's alright to take time. You know, even if it's just between the two of us, we say, you know, someone else is giving you an earful but actually I can say to my colleague, you know, it's fine; that's what we need to do; you're ok to do that. You know, it's not necessarily it's a different understanding; it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates, we're looking at trying to get to the bottom of peoples' problems and give them the best possible care going forward and if you haven't got full story I suppose." IV2 female 30s* *"if you want to be a really good physio with person-centred care, you need to separate yourself from the people that aren't prioritising patient-centred care because the two just don't go together." female 30s*	The unanimous importance of person-centred practice for effective physio discovered in the survey was **convergent** with interviews e.g., a bold quote "if you want to be a really good physio with person-centred care you need to separate yourself from the people that aren't prioritising patient-centred care because the two just don't go together". The moderate or greater feasibility of PCP in ED seen in the survey **converged** with allusions to being able to "stray from the program", "take more time" or stand apart from those "that aren't prioritising" this model. Barriers to PCP from open text survey replies, namely ED conventions and the clash with biomedical model, **converged** with interview notions that ED was "not a rehab environment" and rather somewhere needing "boxes that I have to tick", and "a different healthcare model, basically". The survey findings, of a moderate or greater possibility for PCP within ED, might appear to clash with feeling of this emergency setting preventing physios from doing what they do best i.e., rehab. It was suggested that finding the "tricky" balance of maintaining what we do best as physios in ED itself actually constituted person-centredness, but that "I don't think we have achieved that yet". By outlining the Faultline without ruling out the possibility of PCP in ED, this quote offers a non-contradictory interpretation of **complementarity** for the differing findings between survey and interviews.

converge diverge expand complement *PC(P) = Person-centred (practice)

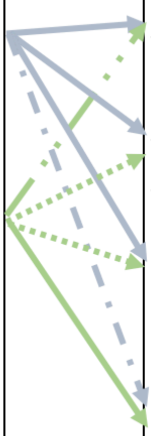
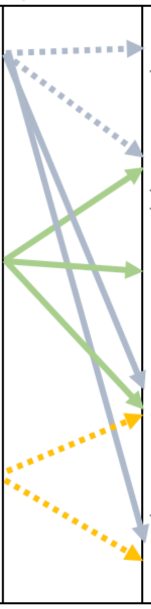
Emergency department environment	ST3.2– issues of time, waiting and busyness	**Q15** Open questioning found *waiting time pressures & targets* & *volume of patients to see* as person-centred barriers in 92% & 27% surveyed, respectively. **Q14** All of those surveyed felt the delivery of person-centredness in ED was possible 62% moderately 31% very and 8% extremely possibly.		*"she was like 'we needed to overcome the fact that so many of our junior doctors wanted to know all about their PMH and they wanted to know all about their DH 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." IV3 female 30s* *"I think it's something that they are massively failing at the moment, just because of the pressures because person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here which is loads of them. And that's not only frustrating for the clinicians but it's also really frustrating for the patient and it's not helping anyone I don't think." IV2 female 30s* *"Yes, it's a really busy environment, but the patient in ED: I couldn't think of anything worse if I was in ED and being made to feel that I was rushed to tell my story. I know we are under time pressures, but the patient shouldn't feel like that." IV6 female 20s* *"I think to allow, to tell people that it's alright to take time. You know, even if it's just between the two of us, we say, you know, someone else is giving you an earful but actually I can say to my colleague, you know, it's fine; that's what we need to do; you're ok to do that. You know, it's not necessarily it's a different understanding; it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates, we're looking at trying to get to the bottom of peoples' problems and give them the best possible care going forward and if you haven't got full story I suppose."IV2 female 30s*	The open survey response to person-centred barriers strongly emphasised (92%) *waiting time pressures and targets* and, to lesser extent, *volume of patients to see* (27%). This negativity was **convergent** with accusations of "too much time being taken up people asking questions and trying to find out more", "I couldn't think of anything worse… being made to feel that I was rushed to tell my story" and "person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here". However, an **expansion** was offered with the challenge back from one interviewee "to tell people that it's alright to take time" since "it's a different healthcare model basically, isn't it? and say that that is appropriate in the department because actually we're looking at trying to reduce these reattendance rates" Survey evidence for the belief that person-centredness in ED was possible crossed multiple different labels here: **convergence** with one almost giving permission to physio colleagues that " it's alright to take time" to achieve PCP; **divergence** with the busyness and pressure of ED and that "person-centred care is not waiting in the department for 8 hours to be told you actually don't need to be here" and " being made to feel that I was rushed to tell my story. I know we are under time pressures, but the patient shouldn't feel like that."; and **complementarity** in one physio using a manager's complaints of taking too much information from ED patients as an example of exactly what we should be doing.

Table Supplement. Joint display table of the mixed methods data linking activity

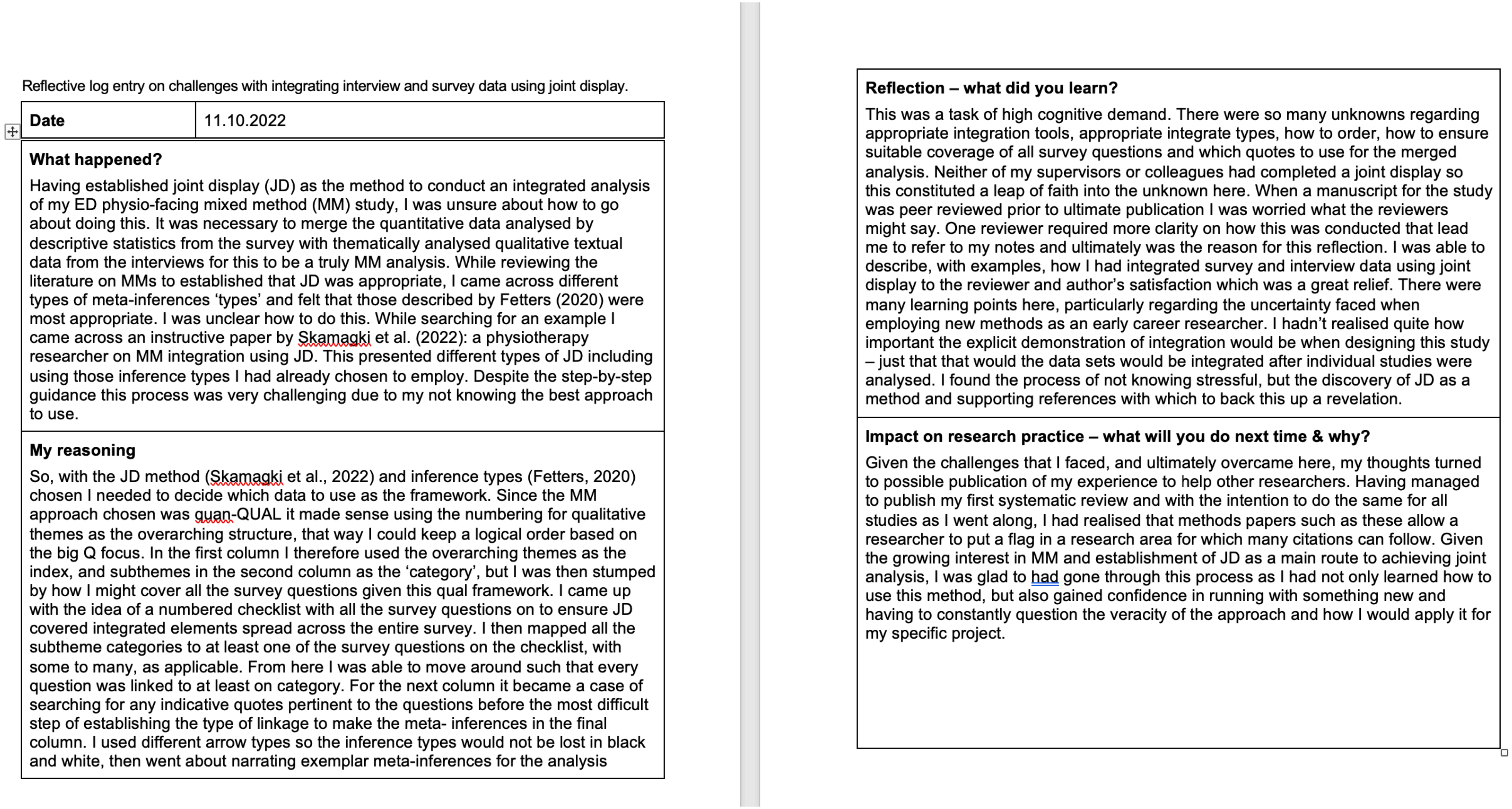
converge diverge expand complement *PC(P) = Person-centred (practice)

Emergency department environment	ST3.3– physiotherapists working with other team members	**Q12.2** *Coordinated healthcare delivery* was regarded as at least moderate (4%) very 46%, or extremely (50%) important to person-centredness. **Q17** 66% agreed that their non-physio ED colleagues strove to be person-centred (4% strongly agreed & 62% agreed). 27% neither agreed nor disagreed, 8% disagreed (of which 4% disagreed & 4% strongly) **Q4.** Only 4% of those surveyed invoked *multi-disciplinary teamwork* in open questioning of the meaning of person-centredness		*"[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." - IV9 female 30s.* *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. IV10 female 30s* *"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" IV8 female 20s* *"when the doctors do have [patients with] back pains, you do see in there as well, that they come and ask you for your own opinion about that, to give advice on specific patients. So, I do think it's patient centred, however like I say I think that depends on the clinician giving the treatment and it can be very different in there depending on who is on at what time"- IV6 female 20s* *"a lot of the clinicians will come and ask us for our advice on things, so if you are thinking about PCC and they've got, you know, an ENP for example has picked up a patient that is an MSK condition and they're not sure they have, from us being there, they have the ability to come and ask us so we can come and do a mini assessment and give our thoughts and I think that's one of the nice things about the department; is that you can always ask a second opinion from somebody else and that's really important.IV2 female 30s*	Survey importance of *coordinated healthcare delivery* for PCC is **convergent** with interviewees idea of co-dependency between ED physio, doctor & nurse (ENP): "when the doctors do have [patients with] back pains…they come and ask you for your own opinion" and "you can always ask a second opinion from somebody else and that's really important". **Divergence** here is seen in interviewees' examples of poor coordination including wasted time post-imaging "they'll come back from the x-ray and sit back in the waiting room for another hour, not say anything" and for e.g., "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". The finding that a third of those surveyed didn't agree that non-physio colleagues were person centred was **convergent** with allusion: "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", "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" and that it "depends on the clinician giving the treatment and it can be very different in there depending on who is on at what time" Only 4% surveyees invoking teamwork in open questions is **divergent** with teamwork examples provided by interviewees: "doctors do have [patients with] back pains…ask you for your own opinion" and "you can always ask a second opinion from somebody else".

Appendix 9: Checklist linking survey questions to joint display (study 2)

Q	Survey question		Joint display link					
			ST1.1, 1.2, 1.3, 1.4					
			ST2.1, 2.2, 2.3					
			ST3.1, 3.2, 3.3					
1.	consent							
2.	Establishing familiarity with PCP							
3.	Aware formal definition							
4.	Open text understanding PCP		1.1	1.3	1.4	~~2.2~~	3.3	1.2
5.	Pre-reg training PCP		~~2.2~~					
6.	Non-tabulated post-grad training (narrative comment only)		2.2					
7.	Scale own PCP 0-10		2.1					
8.	how interested in training PCP		2.2					
9.	Importance in general PCP to effective PT practice		3.1					
10.	Importance physio aspects	Knowledge proficiency	2.2					
		Interpersonal skills	2.2					
		reflexivity	1.2	2.2				
11.	Importance patient-physio collaborative aspects	Empowerment and self-mx	1.4					
		Co-production/therapeutic relationships	1.4					
		See person beyond patient	1.1					
12.	Importance environmental aspects	Physical environment	~~3.1~~					
		Coordinated HC delivery	3.3					
		Philosophy and context practice environ	2.3					
13.	Importance patient journey aspects	Unique journey of patient	1.1	~~3.3~~				
		Ongoing self-management	~~1.4~~	1.2				
14.	PCP possible in ED		3.1	3.2				
15.	Open question barriers PCP in ED		1.3	~~2.3~~	3.1	3.2		
16.	Believe other ED PT colleagues try to be PC		2.1	2.3				
17.	Believe other ED non- PT colleagues try to be PC		2.1	2.3	3.3	1.2		
18.	demographics							

Appendix 10: Reflexive log entry – challenges with joint display (study 2)



Reflective log entry on challenges with integrating interview and survey data using joint display.

Date	11.10.2022

What happened?

Having established joint display (JD) as the method to conduct an integrated analysis of my ED physio-facing mixed method (MM) study, I was unsure about how to go about doing this. It was necessary to merge the quantitative data analysed by descriptive statistics from the survey with thematically analysed qualitative textual data from the interviews for this to be a truly MM analysis. While reviewing the literature on MMs to established that JD was appropriate, I came across different types of meta-inferences 'types' and felt that those described by Fetters (2020) were most appropriate. I was unclear how to do this. While searching for an example I came across an instructive paper by Skamagki et al. (2022): a physiotherapy researcher on MM integration using JD. This presented different types of JD including using those inference types I had already chosen to employ. Despite the step-by-step guidance this process was very challenging due to my not knowing the best approach to use.

My reasoning

So, with the JD method (Skamagki et al., 2022) and inference types (Fetters, 2020) chosen I needed to decide which data to use as the framework. Since the MM approach chosen was quan-QUAL it made sense using the numbering for qualitative themes as the overarching structure, that way I could keep a logical order based on the big Q focus. In the first column I therefore used the overarching themes as the index, and subthemes in the second column as the 'category', but I was then stumped by how I might cover all the survey questions given this qual framework. I came up with the idea of a numbered checklist with all the survey questions on to ensure JD covered integrated elements spread across the entire survey. I then mapped all the subtheme categories to at least one of the survey questions on the checklist, with some to many, as applicable. From here I was able to move around such that every question was linked to at least on category. For the next column it became a case of searching for any indicative quotes pertinent to the questions before the most difficult step of establishing the type of linkage to make the meta- inferences in the final column. I used different arrow types so the inference types would not be lost in black and white, then went about narrating exemplar meta-inferences for the analysis

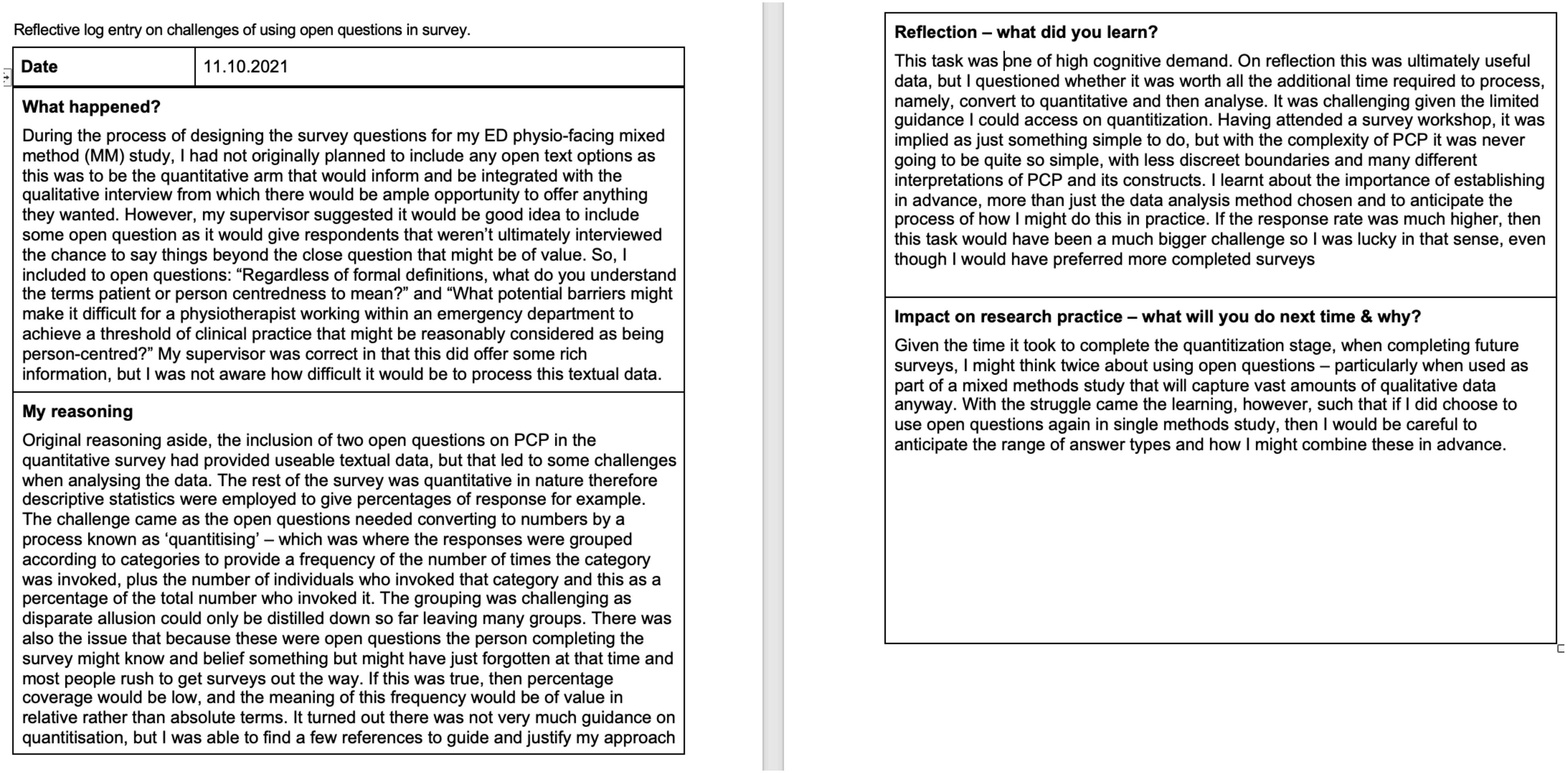
Reflection – what did you learn?

This was a task of high cognitive demand. There were so many unknowns regarding appropriate integration tools, appropriate integrate types, how to order, how to ensure suitable coverage of all survey questions and which quotes to use for the merged analysis. Neither of my supervisors or colleagues had completed a joint display so this constituted a leap of faith into the unknown here. When a manuscript for the study was peer reviewed prior to ultimate publication I was worried what the reviewers might say. One reviewer required more clarity on how this was conducted that lead me to refer to my notes and ultimately was the reason for this reflection. I was able to describe, with examples, how I had integrated survey and interview data using joint display to the reviewer and author's satisfaction which was a great relief. There were many learning points here, particularly regarding the uncertainty faced when employing new methods as an early career researcher. I hadn't realised quite how important the explicit demonstration of integration would be when designing this study – just that that would the data sets would be integrated after individual studies were analysed. I found the process of not knowing stressful, but the discovery of JD as a method and supporting references with which to back this up a revelation.

Impact on research practice – what will you do next time & why?

Given the challenges that I faced, and ultimately overcame here, my thoughts turned to possible publication of my experience to help other researchers. Having managed to publish my first systematic review and with the intention to do the same for all studies as I went along, I had realised that methods papers such as these allow a researcher to put a flag in a research area for which many citations can follow. Given the growing interest in MM and establishment of JD as a main route to achieving joint analysis, I was glad to had gone through this process as I had not only learned how to use this method, but also gained confidence in running with something new and having to constantly question the veracity of the approach and how I would apply it for my specific project.

Appendix 11: Reflexive log entry – challenges with open survey question (study 2)



Reflective log entry on challenges of using open questions in survey.

Date	11.10.2021

What happened?

During the process of designing the survey questions for my ED physio-facing mixed method (MM) study, I had not originally planned to include any open text options as this was to be the quantitative arm that would inform and be integrated with the qualitative interview from which there would be ample opportunity to offer anything they wanted. However, my supervisor suggested it would be good idea to include some open question as it would give respondents that weren't ultimately interviewed the chance to say things beyond the close question that might be of value. So, I included to open questions: "Regardless of formal definitions, what do you understand the terms patient or person centredness to mean?" and "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?" My supervisor was correct in that this did offer some rich information, but I was not aware how difficult it would be to process this textual data.

My reasoning

Original reasoning aside, the inclusion of two open questions on PCP in the quantitative survey had provided useable textual data, but that led to some challenges when analysing the data. The rest of the survey was quantitative in nature therefore descriptive statistics were employed to give percentages of response for example. The challenge came as the open questions needed converting to numbers by a process known as 'quantitising' – which was where the responses were grouped according to categories to provide a frequency of the number of times the category was invoked, plus the number of individuals who invoked that category and this as a percentage of the total number who invoked it. The grouping was challenging as disparate allusion could only be distilled down so far leaving many groups. There was also the issue that because these were open questions the person completing the survey might know and belief something but might have just forgotten at that time and most people rush to get surveys out the way. If this was true, then percentage coverage would be low, and the meaning of this frequency would be of value in relative rather than absolute terms. It turned out there was not very much guidance on quantitisation, but I was able to find a few references to guide and justify my approach

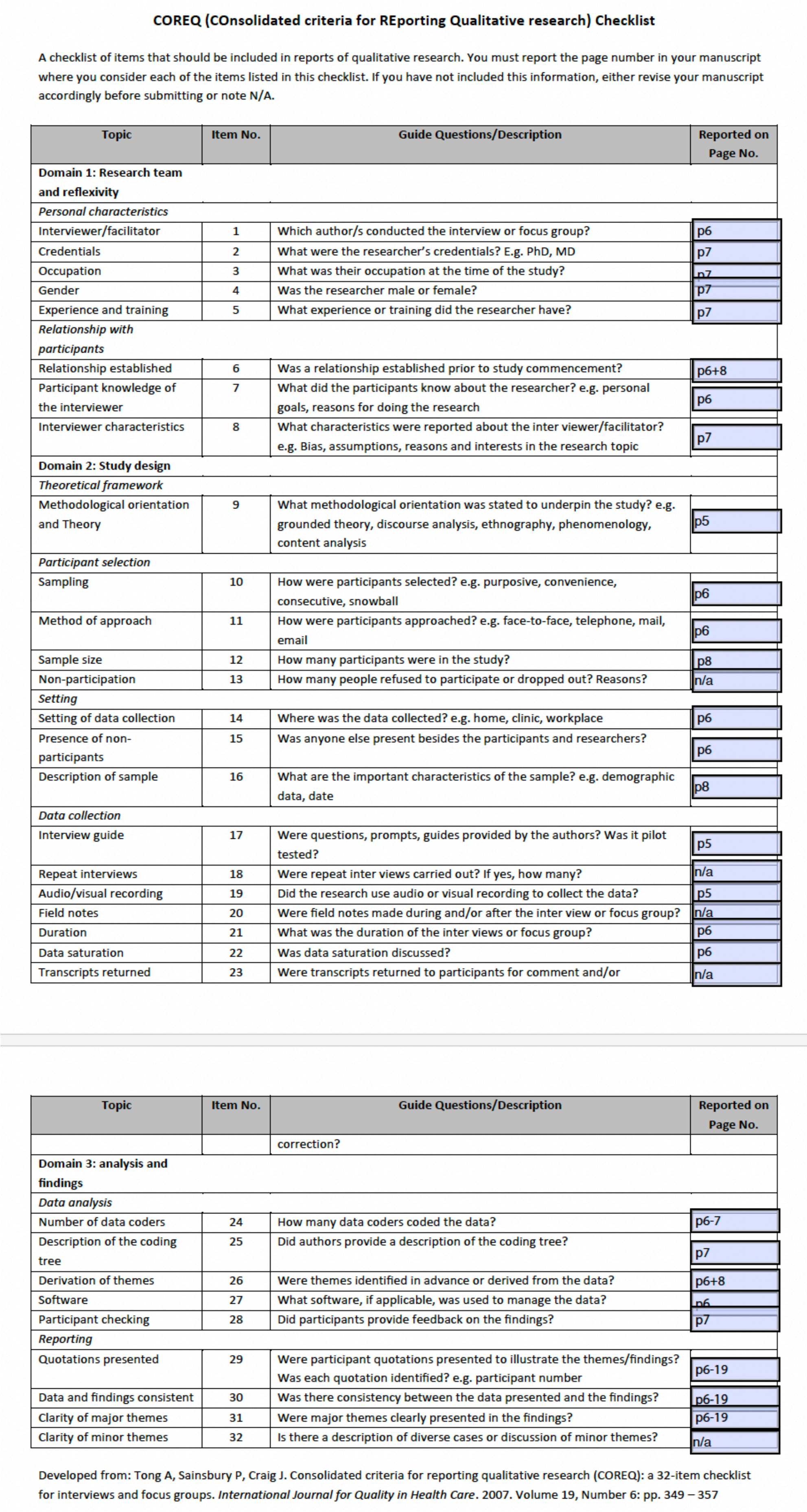
Reflection – what did you learn?

This task was one of high cognitive demand. On reflection this was ultimately useful data, but I questioned whether it was worth all the additional time required to process, namely, convert to quantitative and then analyse. It was challenging given the limited guidance I could access on quantitization. Having attended a survey workshop, it was implied as just something simple to do, but with the complexity of PCP it was never going to be quite so simple, with less discreet boundaries and many different interpretations of PCP and its constructs. I learnt about the importance of establishing in advance, more than just the data analysis method chosen and to anticipate the process of how I might do this in practice. If the response rate was much higher, then this task would have been a much bigger challenge so I was lucky in that sense, even though I would have preferred more completed surveys

Impact on research practice – what will you do next time & why?

Given the time it took to complete the quantitization stage, when completing future surveys, I might think twice about using open questions – particularly when used as part of a mixed methods study that will capture vast amounts of qualitative data anyway. With the struggle came the learning, however, such that if I did choose to use open questions again in single methods study, then I would be careful to anticipate the range of answer types and how I might combine these in advance.

Appendix 12: COREQ checklist (study 3)



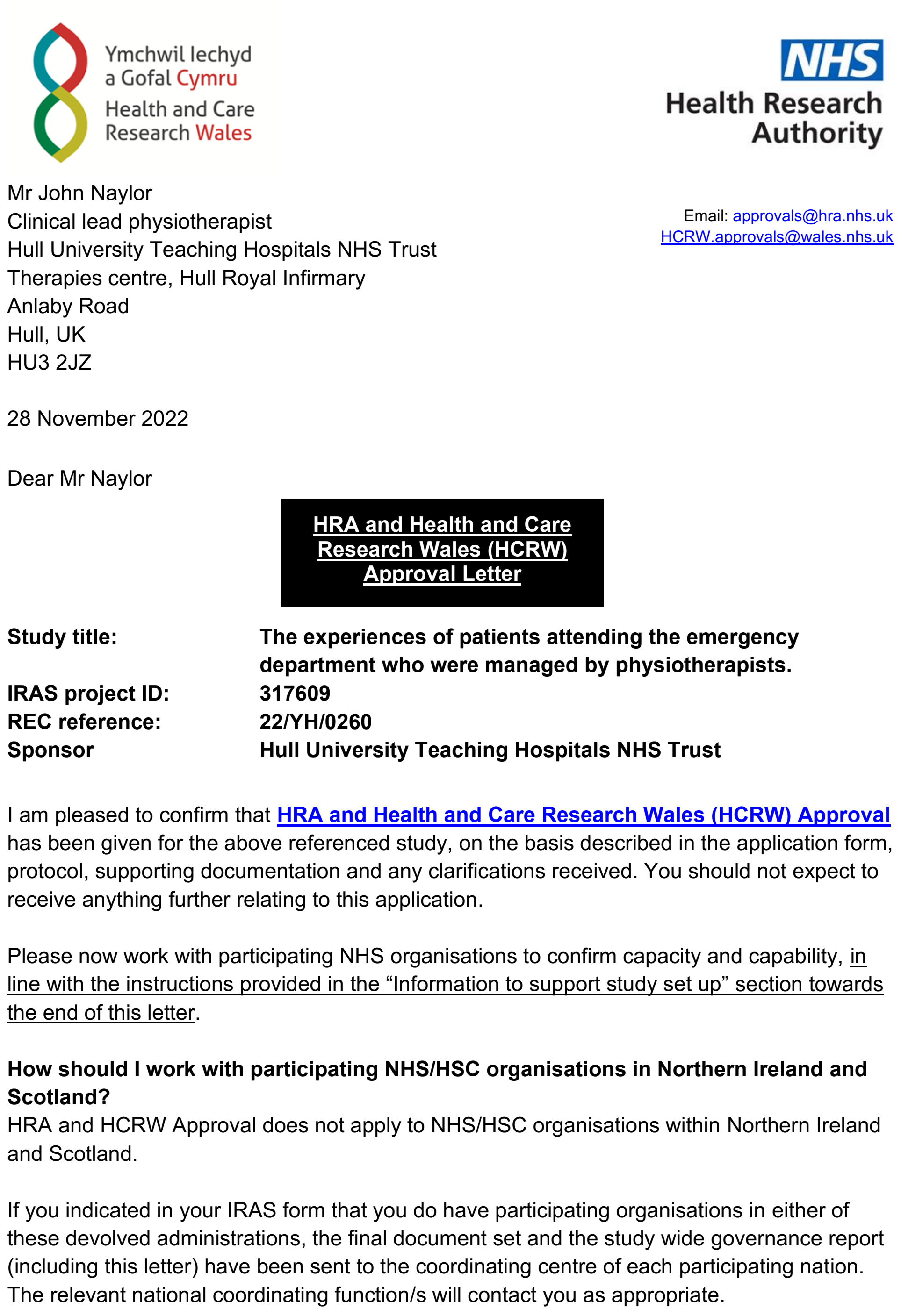
COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	p6
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	p7
Occupation	3	What was their occupation at the time of the study?	p7
Gender	4	Was the researcher male or female?	p7
Experience and training	5	What experience or training did the researcher have?	p7
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	p6+8
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	p6
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	p7
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	p5
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	p6
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	p6
Sample size	12	How many participants were in the study?	p8
Non-participation	13	How many people refused to participate or dropped out? Reasons?	n/a
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	p6
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	p6
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	p8
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	p5
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	p5
Field notes	20	Were field notes made during and/or after the inter view or focus group?	n/a
Duration	21	What was the duration of the inter views or focus group?	p6
Data saturation	22	Was data saturation discussed?	p6
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	n/a
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	p6-7
Description of the coding tree	25	Did authors provide a description of the coding tree?	p7
Derivation of themes	26	Were themes identified in advance or derived from the data?	p6+8
Software	27	What software, if applicable, was used to manage the data?	p6
Participant checking	28	Did participants provide feedback on the findings?	p7
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	p6-19
Data and findings consistent	30	Was there consistency between the data presented and the findings?	p6-19
Clarity of major themes	31	Were major themes clearly presented in the findings?	p6-19
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	n/a

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix 13: Health Research Authority NHS ethics approval (study 3)



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr John Naylor
Clinical lead physiotherapist
Hull University Teaching Hospitals NHS Trust
Therapies centre, Hull Royal Infirmary
Anlaby Road
Hull, UK
HU3 2JZ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

28 November 2022

Dear Mr Naylor

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**The experiences of patients attending the emergency department who were managed by physiotherapists.**
IRAS project ID:	**317609**
REC reference:	**22/YH/0260**
Sponsor	**Hull University Teaching Hospitals NHS Trust**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

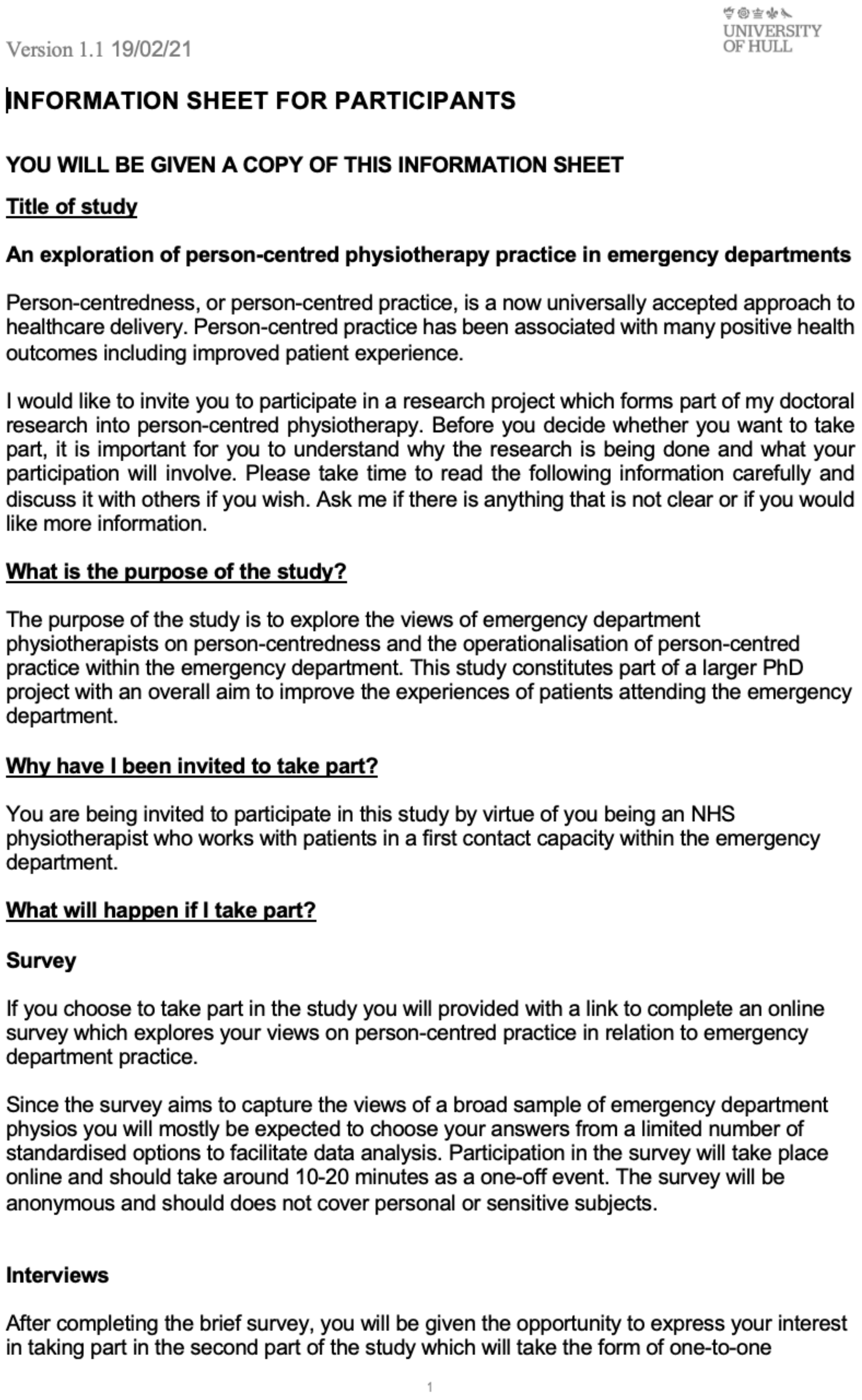
Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix 14: Participant information Sheet (study 3)



INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study

An exploration of person-centred physiotherapy practice in emergency departments

Person-centredness, or person-centred practice, is a now universally accepted approach to healthcare delivery. Person-centred practice has been associated with many positive health outcomes including improved patient experience.

I would like to invite you to participate in a research project which forms part of my doctoral research into person-centred physiotherapy. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of the study is to explore the views of emergency department physiotherapists on person-centredness and the operationalisation of person-centred practice within the emergency department. This study constitutes part of a larger PhD project with an overall aim to improve the experiences of patients attending the emergency department.

Why have I been invited to take part?

You are being invited to participate in this study by virtue of you being an NHS physiotherapist who works with patients in a first contact capacity within the emergency department.

What will happen if I take part?

Survey

If you choose to take part in the study you will provided with a link to complete an online survey which explores your views on person-centred practice in relation to emergency department practice.

Since the survey aims to capture the views of a broad sample of emergency department physios you will mostly be expected to choose your answers from a limited number of standardised options to facilitate data analysis. Participation in the survey will take place online and should take around 10-20 minutes as a one-off event. The survey will be anonymous and should does not cover personal or sensitive subjects.

Interviews

After completing the brief survey, you will be given the opportunity to express your interest in taking part in the second part of the study which will take the form of one-to-one interviews. The follow up interviews are designed to gather more in-depth data from a limited pool of respondents. The interviews will constitute an attempt to explain the survey findings and therefore should not cover especially personal or sensitive subjects. Interviews will be based around a limited number of more open questions, to be answered in your own words. The interviews will be recorded (with your consent) for transcription purposes. Once transcription is complete the recording will be deleted

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part a statement of consent will be included within the survey, with additional option to give consent at the end of the survey to be contacted for interviews.

Payment/Incentives

There will be no payments for taking part.

What are the possible risks of taking part?

We do not anticipate any risks for taking part in this study.

What are the possible benefits of taking part?

The benefits to taking part will be in terms of your contribution to improving the research base that underpins your own advanced clinical practice and that of the wider emergency department physiotherapy community. The improved understanding and delivery of person-centred practice in the emergency department setting will ultimately benefit the patients that we treat.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

The survey is **anonymous** so no individual will be directly identifiable, only the region in which they work. Care will be taken to ensure the greatest level of confidentiality possible to prevent demographic data being used to deduce who said what.

Your confidentiality will be protected by allocating a code to each interview. Interviews will be digitally recorded and only the research team analysing the data will have access.

You will be allocated an identity code on the consent form. The electronic informed consent form that contains information that link identities to the transcript and the data will be held separately to the digital transcripts on a secure University of Hull server.

For the purposes of research, the data will be kept for 5 years after completion of the project and will be stored appropriately for this duration.

If you chose to take part in the interviews anonymised direct quotations may be used in the write-up of the study and possible subsequent publication. These quotations will not be linked to any personal identifiable information.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Data Protection Officer [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible.

What will happen to the results of the study?

The results of the study will be summarised in my final PhD thesis, but may also be presented at conference and/or published in article format within a relevant academic journal. All results will be anonymised in such a way as to prevent identification of individual respondents. Final published articles will be available online but may sit behind a paywall depending on the individual publisher arrangements.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by the Faculty of Health Sciences Ethics Committee, University of Hull

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

John Naylor –e-mail address: j.naylor-2019@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the details below for further advice and information:

Dr Clare Killingback
Physiotherapy Programme Lead
Senior Lecturer in Physiotherapy
Faculty of Health Sciences
University of Hull
HU6 7RX
c.killingback@hull.ac.uk

Alternatively please contact registrar@hull.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 15: Participant recuitment email (study 3)

Dear xxxx

I am a physiotherapist currently completing a research project as part of my PhD with the Faculty of Health Sciences at the University of Hull. The aim of my study is to explore the views of Emergency Department Physiotherapists on person-centred practice. This will be achieved using an online survey with the option of follow-up interviews. The results may be used to develop a guidance/framework to assist in the delivery of person-centred care in the emergency department.

I would be extremely grateful if you could disseminate the link to this survey to any first contact ED physiotherapists at your Trust.

Please forward this survey link to the physiotherapist.
https://insert link here once survey ready

If you are not the best point of contact at the hospital, I would be grateful if you would forward this email to the appropriate individual.

If you have any queries regarding this project, please do not hesitate to contact me: j.naylor-2019@hull.ac.uk or my supervisor Dr Clare Killingback: c.killingback@hull.ac.uk

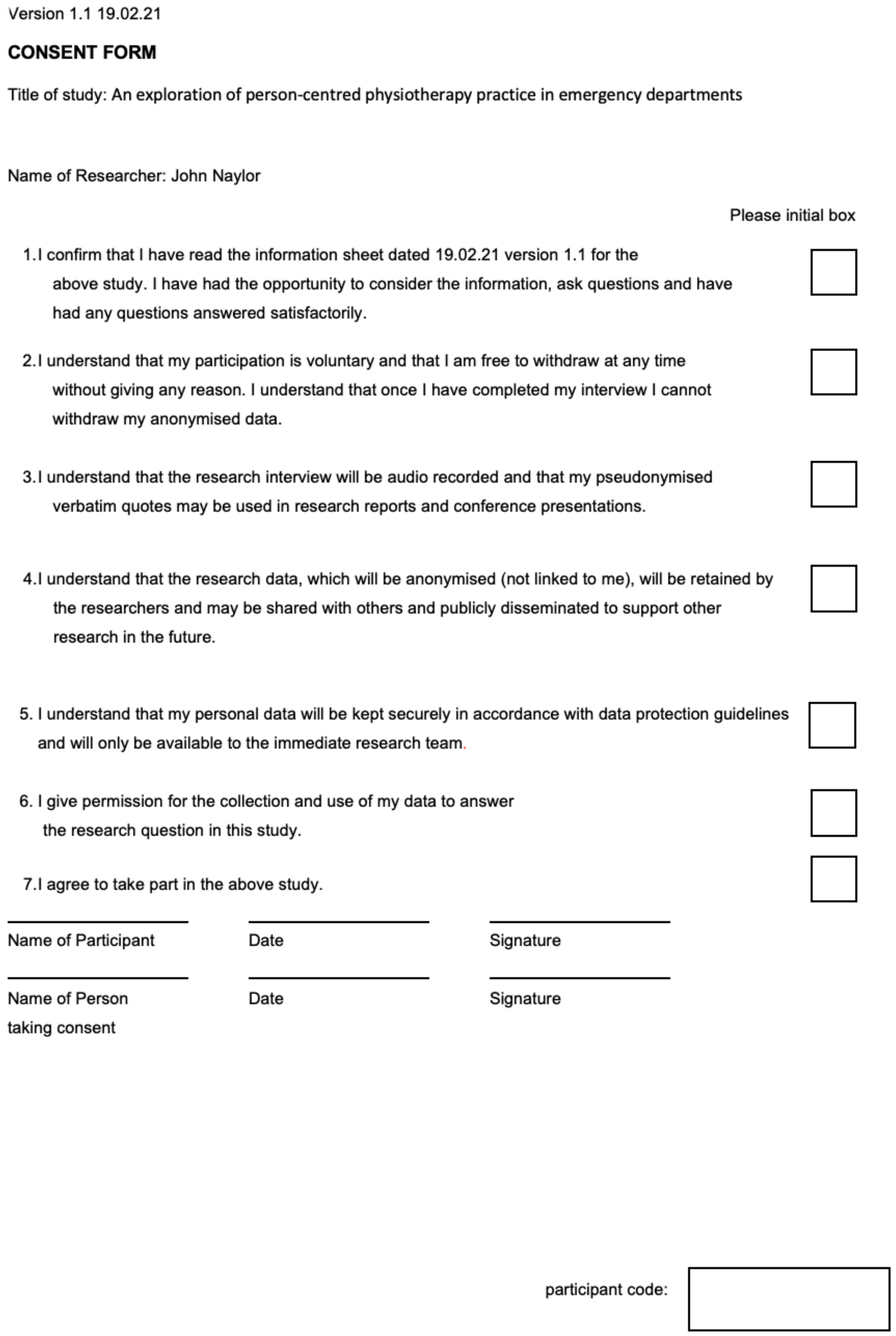
Many thanks,

John Naylor

Clinical Lead Physiotherapist

j.naylor-2019@hull.ac.uk

Appendix 16: Participant consent form (study 3)



Version 1.1 19.02.21

CONSENT FORM

Title of study: An exploration of person-centred physiotherapy practice in emergency departments

Name of Researcher: John Naylor

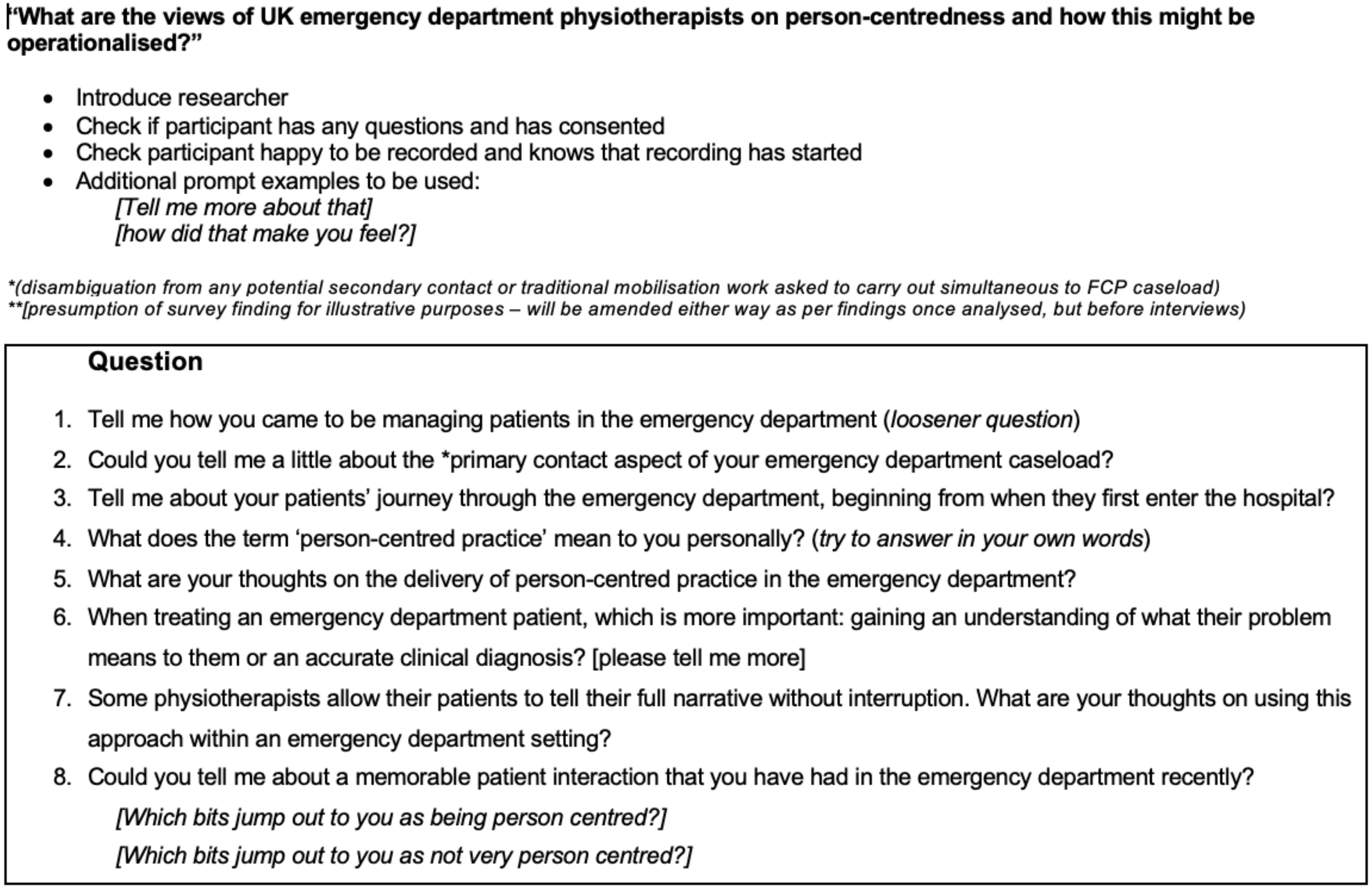
Please initial box

1. I confirm that I have read the information sheet dated 19.02.21 version 1.1 for the above study. I have had the opportunity to consider the information, ask questions and have had any questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I understand that once I have completed my interview I cannot withdraw my anonymised data. ☐
3. I understand that the research interview will be audio recorded and that my pseudonymised verbatim quotes may be used in research reports and conference presentations. ☐
4. I understand that the research data, which will be anonymised (not linked to me), will be retained by the researchers and may be shared with others and publicly disseminated to support other research in the future. ☐
5. I understand that my personal data will be kept securely in accordance with data protection guidelines and will only be available to the immediate research team. ☐
6. I give permission for the collection and use of my data to answer the research question in this study. ☐
7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

participant code: ☐

Appendix 17: Interview guide (study 3)



"What are the views of UK emergency department physiotherapists on person-centredness and how this might be operationalised?"

- Introduce researcher
- Check if participant has any questions and has consented
- Check participant happy to be recorded and knows that recording has started
- Additional prompt examples to be used:
  [Tell me more about that]
  [how did that make you feel?]

**(disambiguation from any potential secondary contact or traditional mobilisation work asked to carry out simultaneous to FCP caseload)*
***[presumption of survey finding for illustrative purposes – will be amended either way as per findings once analysed, but before interviews)*

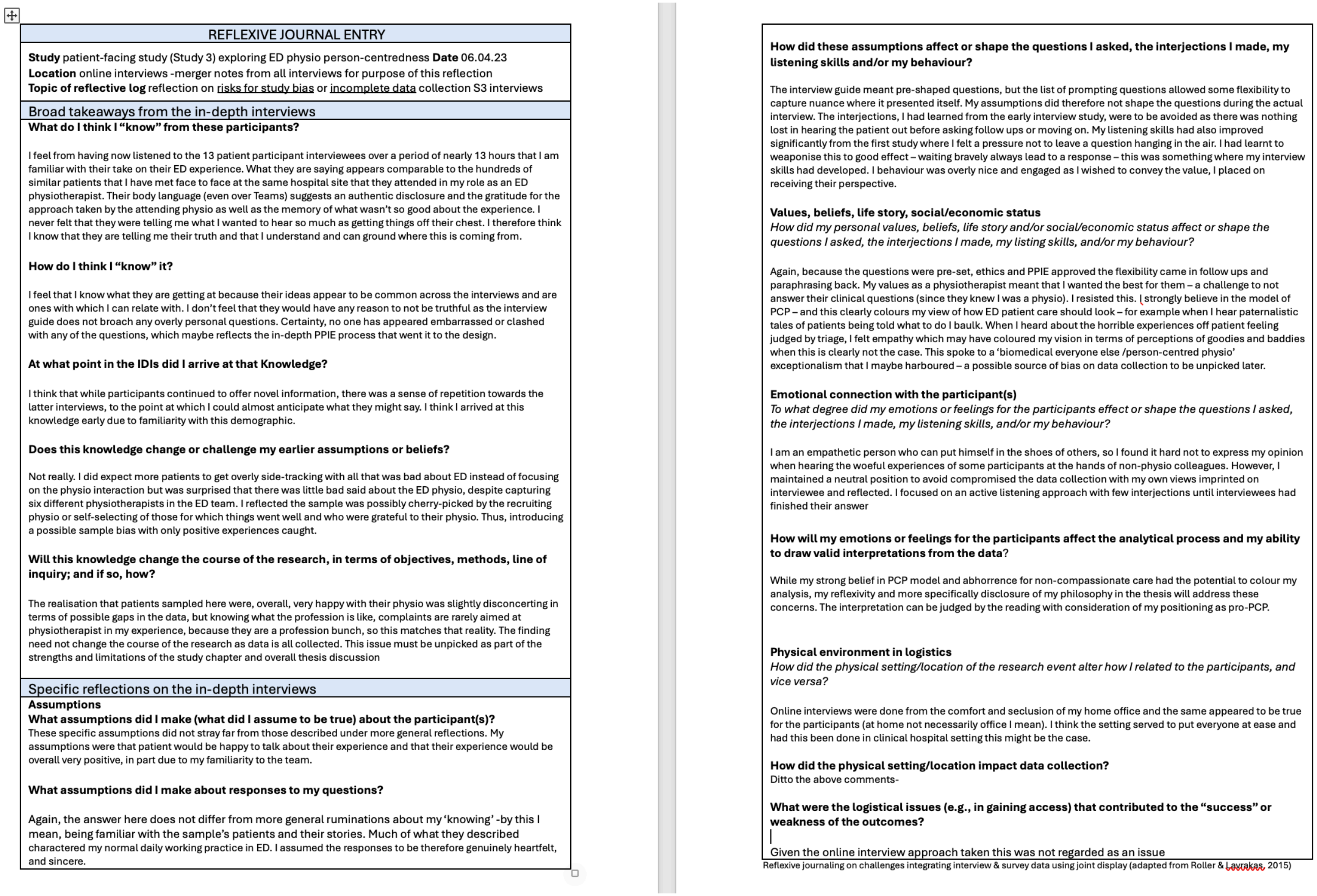
Question

1. Tell me how you came to be managing patients in the emergency department (*loosener question*)
2. Could you tell me a little about the *primary contact aspect of your emergency department caseload?
3. Tell me about your patients' journey through the emergency department, beginning from when they first enter the hospital?
4. What does the term 'person-centred practice' mean to you personally? (*try to answer in your own words*)
5. What are your thoughts on the delivery of person-centred practice in the emergency department?
6. When treating an emergency department patient, which is more important: gaining an understanding of what their problem means to them or an accurate clinical diagnosis? [please tell me more]
7. Some physiotherapists allow their patients to tell their full narrative without interruption. What are your thoughts on using this approach within an emergency department setting?
8. Could you tell me about a memorable patient interaction that you have had in the emergency department recently?
   [Which bits jump out to you as being person centred?]
   [Which bits jump out to you as not very person centred?]

9. Body language is acknowledged as key component of communication. I would therefore be really interested to hear how you read a patient’s body language during emergency department assessments?
10. ..and how do you think a patient might interpret a therapist’s own body language?
11. An interesting finding from the survey completed by you and your peers revealed {**e.g., the limited opportunities emergency department physios felt that they had to develop their own levels of PC}. Could you discuss your own thoughts on this?
12. What value do you place on the patients’ own opinions of what is going on (in terms of the particular problems that brought them to the emergency department)?
13. How important is a patient’s contribution to your treatment plans or any final decision that you make in the emergency department?
    [tell me more]
14. Is there anything about you as a person that you believe allows you to practice in a person-centred way?
15. Is there anything else that you want to add which we haven’t already spoken about?

Thank you for your time – I am now turning the recorder off

Appendix 18: Reflexive log entry – data collection (study 3)



REFLEXIVE JOURNAL ENTRY

Study patient-facing study (Study 3) exploring ED physio person-centredness **Date** 06.04.23
Location online interviews -merger notes from all interviews for purpose of this reflection
Topic of reflective log reflection on risks for study bias or incomplete data collection S3 interviews

Broad takeaways from the in-depth interviews

What do I think I "know" from these participants?

I feel from having now listened to the 13 patient participant interviewees over a period of nearly 13 hours that I am familiar with their take on their ED experience. What they are saying appears comparable to the hundreds of similar patients that I have met face to face at the same hospital site that they attended in my role as an ED physiotherapist. Their body language (even over Teams) suggests an authentic disclosure and the gratitude for the approach taken by the attending physio as well as the memory of what wasn't so good about the experience. I never felt that they were telling me what I wanted to hear so much as getting things off their chest. I therefore think I know that they are telling me their truth and that I understand and can ground where this is coming from.

How do I think I "know" it?

I feel that I know what they are getting at because their ideas appear to be common across the interviews and are ones with which I can relate with. I don't feel that they would have any reason to not be truthful as the interview guide does not broach any overly personal questions. Certainty, no one has appeared embarrassed or clashed with any of the questions, which maybe reflects the in-depth PPIE process that went it to the design.

At what point in the IDIs did I arrive at that Knowledge?

I think that while participants continued to offer novel information, there was a sense of repetition towards the latter interviews, to the point at which I could almost anticipate what they might say. I think I arrived at this knowledge early due to familiarity with this demographic.

Does this knowledge change or challenge my earlier assumptions or beliefs?

Not really. I did expect more patients to get overly side-tracking with all that was bad about ED instead of focusing on the physio interaction but was surprised that there was little bad said about the ED physio, despite capturing six different physiotherapists in the ED team. I reflected the sample was possibly cherry-picked by the recruiting physio or self-selecting of those for which things went well and who were grateful to their physio. Thus, introducing a possible sample bias with only positive experiences caught.

Will this knowledge change the course of the research, in terms of objectives, methods, line of inquiry; and if so, how?

The realisation that patients sampled here were, overall, very happy with their physio was slightly disconcerting in terms of possible gaps in the data, but knowing what the profession is like, complaints are rarely aimed at physiotherapist in my experience, because they are a profession bunch, so this matches that reality. The finding need not change the course of the research as data is all collected. This issue must be unpicked as part of the strengths and limitations of the study chapter and overall thesis discussion

Specific reflections on the in-depth interviews

Assumptions

What assumptions did I make (what did I assume to be true) about the participant(s)?

These specific assumptions did not stray far from those described under more general reflections. My assumptions were that patient would be happy to talk about their experience and that their experience would be overall very positive, in part due to my familiarity to the team.

What assumptions did I make about responses to my questions?

Again, the answer here does not differ from more general ruminations about my 'knowing' -by this I mean, being familiar with the sample's patients and their stories. Much of what they described charactered my normal daily working practice in ED. I assumed the responses to be therefore genuinely heartfelt, and sincere.

How did these assumptions affect or shape the questions I asked, the interjections I made, my listening skills and/or my behaviour?

The interview guide meant pre-shaped questions, but the list of prompting questions allowed some flexibility to capture nuance where it presented itself. My assumptions did therefore not shape the questions during the actual interview. The interjections, I had learned from the early interview study, were to be avoided as there was nothing lost in hearing the patient out before asking follow ups or moving on. My listening skills had also improved significantly from the first study where I felt a pressure not to leave a question hanging in the air. I had learnt to weaponise this to good effect – waiting bravely always lead to a response – this was something where my interview skills had developed. I behaviour was overly nice and engaged as I wished to convey the value, I placed on receiving their perspective.

Values, beliefs, life story, social/economic status

How did my personal values, beliefs, life story and/or social/economic status affect or shape the questions I asked, the interjections I made, my listing skills, and/or my behaviour?

Again, because the questions were pre-set, ethics and PPIE approved the flexibility came in follow ups and paraphrasing back. My values as a physiotherapist meant that I wanted the best for them – a challenge to not answer their clinical questions (since they knew I was a physio). I resisted this. I strongly believe in the model of PCP – and this clearly colours my view of how ED patient care should look – for example when I hear paternalistic tales of patients being told what to do I baulk. When I heard about the horrible experiences off patient feeling judged by triage, I felt empathy which may have coloured my vision in terms of perceptions of goodies and baddies when this is clearly not the case. This spoke to a 'biomedical everyone else /person-centred physio' exceptionalism that I maybe harboured – a possible source of bias on data collection to be unpicked later.

Emotional connection with the participant(s)

To what degree did my emotions or feelings for the participants effect or shape the questions I asked, the interjections I made, my listening skills, and/or my behaviour?

I am an empathetic person who can put himself in the shoes of others, so I found it hard not to express my opinion when hearing the woeful experiences of some participants at the hands of non-physio colleagues. However, I maintained a neutral position to avoid compromised the data collection with my own views imprinted on interviewee and reflected. I focused on an active listening approach with few interjections until interviewees had finished their answer

How will my emotions or feelings for the participants affect the analytical process and my ability to draw valid interpretations from the data?

While my strong belief in PCP model and abhorrence for non-compassionate care had the potential to colour my analysis, my reflexivity and more specifically disclosure of my philosophy in the thesis will address these concerns. The interpretation can be judged by the reading with consideration of my positioning as pro-PCP.

Physical environment in logistics

How did the physical setting/location of the research event alter how I related to the participants, and vice versa?

Online interviews were done from the comfort and seclusion of my home office and the same appeared to be true for the participants (at home not necessarily office I mean). I think the setting served to put everyone at ease and had this been done in clinical hospital setting this might be the case.

How did the physical setting/location impact data collection?

Ditto the above comments-

What were the logistical issues (e.g., in gaining access) that contributed to the "success" or weakness of the outcomes?

Given the online interview approach taken this was not regarded as an issue

Reflexive journaling on challenges integrating interview & survey data using joint display (adapted from Roller & Lavrakas, 2015)

Appendix 19: Coding tree (study 3)

Step 2 – 'generating initial codes - 257 labels relevant research

Step 3 – 'search for themes' – total 139 code labels (117 removed)

Theme 1 – ED visit
- The environment (9)
- ED team (3)
- Expectations of ED visit (10)
- Validation of ED visit (11)

Theme 2 – offering time, being holistic & upholding privacy, dignity & personhood
- Holism (5)
- Offering enough time (4)
- upholding privacy, dignity, and personhood (5)

Theme 3 – physiotherapist is different but can be improved
- Difference of physio model versus doctors (6)
- Novelty and unfamiliarity of EDD physio model (8)
- Recommendations for ED physio model (5)

Theme 4 – physiotherapist, clinical competence
- Clinical consultations – professionalism, credibility & expertise (10)
- ED model is a winner (11)
- Education and explanation to successful outcomes (6)
- Management approaches – not so much decision making (11)

Theme 5 – physiotherapy soft skills
- Empathic gestures (9)
- Engagement (6)
- Person centredness (9)
- Personality (11)

step 4 – 'reviewing themes' – reordered themes (137 code – 2 removed)

Theme one – the visit to ED – patient expectations, validation, and experience
- Patient expectations (5)
- Patient validation (14)
- ED environment and team (14)

Theme two – aspects of ED physio person centredness (9)

Sub theme 2.1 – soft skills
- Empathic gestures (9)
- Engagement (6)
- Personality (11)

Sub theme 2.2 – clinical competence
- Education and explanation as key to successful outcomes (6)
- Management approaches in ED not shared decision-making per se (11)
- Professionalism, credibility and expertise of consultations (10)

Sub theme 2.3 – ensuring person centredness
- Being holistic (5)
- Offering enough time (4)
- Upholding privacy, dignity and personhood (5)

Theme three – the ED physio model of care
- Novel approach (14)
- Patient recommending the ED physio model (14)

step 5 – 'defining themes'

Theme one - Patient experience of ED
- **ST1.1** patient validation
- **ST1.2** patient expectations

Theme two – the ED environment

Theme three – aspects of ED physio person centredness
- **ST2.1** soft skills
- **ST2.2** clinical competence
- **ST2.3** honouring patient as person

Theme four – endorsement of the ED physio model of care

Step 6 – 'write up'

Theme one – 'you shouldn't be here': patient experience of the ED

Theme two – 'they genuinely seemed to take an interest': having time to connect with the ED physiotherapy professional as a person

- **ST2.1** soft skills that honour personhood
- **ST2.2** clinical competence
- **ST2.3** having time to care and be holistic

Theme three – 'that was the best I feel I've ever been cared for in hospital 'full: recognising the benefit of being seen by physio in ED

Theme four – 'I don't think anyone thinks of it as a nice area': patient experience of the ED physical environment