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Title: Being more than “just a bog-standard knee”: The role of person-centred practice in physiotherapy: A narrative inquiry.

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Being more than “just a bog-standard knee”: The role of person-centred practice in physiotherapy: A narrative inquiry.

Abstract

Purpose: The aim of this study was to understand how physiotherapeutic encounters were experienced over time by one service user and the extent to which the encounters were person-centred.

Methods: This narrative inquiry study had one participant purposively sampled due to their extensive experience of physiotherapy in healthcare systems in the United Kingdom. Data were collected through interviews and analysed using Clandinin and Connelly’s three-dimensional framework.

Results: Time-related aspects of physiotherapeutic encounters were noted in the evolutionary journey of physiotherapy practice. Personal and social aspects were evident in the words and attitude of the physiotherapists. The influence of place was noted in the role that external forces and the environment played in shaping how physiotherapy was experienced.

Conclusions: These narratives remind physiotherapists and healthcare providers to reflect on the role they play in shaping the experience of service users and whether those experiences are considered to be person, therapist, or institution centred. Those training pre-registration physiotherapy students need to consider giving students the opportunity to develop and reflect on their philosophy of practice early in the curriculum to enhance the experience of service users in the long-term.

Keywords

Physiotherapy

Person-centred practice

Patient-centred practice

Physiotherapists

Narrative inquiry

Background

There is a growing call internationally for healthcare to focus more explicitly on person-centred practice [1-5]. Initiatives to reform healthcare have sought to prioritise the philosophy of person-centredness as the core model for care delivery [6]. Being person-centred in practice refers to a philosophy in which the values and preferences of the person influence how their needs are met, thereby optimising the experience of care, and ensuring that the individual's perspective is paramount [7].

The International Alliance of Patients' Organizations [1], a global voice for patients, have highlighted five core principles of patient-centred healthcare: respect; choice and empowerment; patient involvement in health policy; access and support; and information.

There appears to be a general agreement on the core principles of person-centred practice, but how these principles are implemented in practice is open to question with different professions focusing on different elements of person-centredness [8,9]. Furthermore, distinction between the terms person or patient-centred are important. Despite there being similarities between the concepts of person and patient centred, differences in their overarching goals are noted. The goal of patient-centred practice focuses on a functional life, whereas person-centred practice focuses on the whole life requirements, thereby determining what makes life meaningful for an individual [10]. Person-centred practice is associated with greater engagement in health promoting behaviours and should therefore be the ultimate goal for health and care professionals [11].

We are at a critical juncture in physiotherapy where there is no standardised definition of patient or person-centred practice [12]. Definitions are viewed as being important because they help operationalise how services are delivered [13]. Although others suggest that we need to be comfortable with the lack of definition of the 'fuzzy' concept of person-centred practice [14]. It may be more beneficial to accept the elusiveness of a definition and instead

view person-centredness as a ‘constellation’ of multiple ideas that can be used to critically guide practice [15]. Either way, service users need to be involved in shaping our understanding of person-centred practice. After all, “if a service is to be patient-centred, then both the health care system and the patient have to be involved in determining what this means. Each has its own view of meaning, and patient-centred care will never be achieved if patients are not part of the solution.” [13] (p. 524).

For physiotherapists to deliver person-centred practice there is a need to understand how physiotherapy is experienced from the perspective of physiotherapy service users. Qualitative research methodologies are an important way to gain an in-depth understanding of person-centred perspectives [16]. To date, qualitative studies investigating views on person-centred practice from the perspective of service users have drawn on grounded theory [17-19], phenomenology [20,21], framework analysis [22], nominal group techniques [23], interpretive descriptive methodology [24], and metasynthesis [16]. As far as the authors are aware, narrative inquiry has not been used to develop knowledge on person-centredness in physiotherapy practice from the perspective of the person receiving physiotherapy.

Narrative inquiries are best for capturing detailed life experiences and stories [25] as their narratives allow us to “walk into the midst of stories” [26] (p. 47). These narrative stories are important in aiding understanding of complex, ‘fuzzy’ concepts such as person-centredness [14] from the perspective of the person at the centre of the healthcare interaction. As Frank [27] suggests in his collective portrait of those who live with illness or disability, “stories of people trying to sort out who they are figure prominently on the landscape of postmodern times. Those who have been the objects of others’ reports are now telling their own stories. As they do so, they define the ethic of our times: an ethic of voice, affording each a right to speak her own truth, in her own words.” [27] (p. xiii). It is as individuals are given the opportunity to tell their stories that we give voice to their experiences. This is what these

authors are seeking to do through a narrative inquiry into the experiences of an individual over the course of their life, within a physiotherapy healthcare system in the United Kingdom. The aim of this study was to understand how physiotherapeutic encounters were experienced over time and the extent to which they were person-centred from the perspective of an individual who received physiotherapy throughout their life.

Methods

Study design

This study used a narrative inquiry design. This method focuses on one or two individuals and gathers data through the collection of their stories and experiences [25]. There is a strong collaborative feature in narrative inquiries as the story emerges through dialogue between the participant and the researcher [25]. Narrative inquiry as a methodology is suitable for understanding experiences of illness and healthcare and thus can provide invaluable knowledge in the development of person-centred approaches [28]. Exploring the life of an individual through narrative inquiry holds to a qualitative research paradigm as it seeks to highlight the emic or insider perspective of participants [29].

This narrative inquiry study was carried out using Clandinin and Connelly's [30] framework of narrative inquiry. This framework has been informed by a Deweyan view of experience which is used to frame a metaphorical three-dimensional narrative inquiry approach of the past, present, and future (temporality); personal and social (sociality); and place (spatiality) [26]. As such, "using this set of terms, any particular inquiry is defined by this three-dimensional space: studies have temporal dimensions and address temporal matters: they focus on the personal and the social in a balance appropriate to the inquiry: and they occur in specific places or sequences of places" [30] (p. 54). This framework was selected because it has previously been used in narrative inquiry studies of person-centredness in the context of

nursing [28]. Haydon and colleagues suggest that describing a person's experiences narratively adds clarity to where a person's wishes "collide with and bump up against the healthcare providers' view" [28] (p. 126). Clandinin and Connelly's [30] framework was used in two ways in this study. Firstly, it was used to structure the interview questions with a focus on temporality, sociality, and spatiality. Secondly, it was used to organise the narrative threads.

Participant recruitment and study context

This narrative inquiry study had one participant called Louise (a pseudonym) who has been purposively sampled due to her extensive experience of physiotherapy within the healthcare system in the United Kingdom. Louise has Hypermobile Ehlers-Danlos Syndrome and Osteoarthritis. At the time of the interviews, Louise was in her late 60s and has been involved with physiotherapists since she was an infant. Ethical approval for the study was obtained from the University of Hull Research Ethics Committee (ID FHS248).

Data collection

Data were collected through three interviews which were conducted via Skype due to the impact of COVID-19. They were audio recorded following written informed consent. Only the first author and participant were present for the interviews which were conducted between May and June 2020. In the first two interviews, several open-ended questions were asked as aligned with Clandinin and Connelly's three-dimensional space:

1. Tell me about the three most memorable physiotherapists you have interacted with.
2. Tell me about how your physiotherapy encounters have changed over time.
3. Tell me how you have changed through your encounters with physiotherapy over time.

4. Tell me about how the locations or situations in which you received your physiotherapy affected your experiences.
5. Tell me about your ideal physiotherapy service should you have any future needs.

Follow up prompts such as “tell me more about that experience” or “how did that make you feel” were used as necessary. At the end of these interviews, the participant was asked to draw a graph before the next interview reflecting the highs and lows of her experiences of physiotherapy over time. The concept of using a graph to illustrate the highs and lows was derived from the personal construct psychology [31]. It was applied in the final interview to give a more reflective approach. The participant was also asked to reflect on what she would have liked to communicate to her physiotherapists or their institution at three of the highpoints and three of the low points. Post-it notes were used to record key thoughts.

In the follow-up interview, the graph and reflections on what Louise would have liked to have communicated were used to prompt a deeper conversation. The interview opened with the question: “tell me about your graph” with follow-up questions of “tell me about what you’ve written on your post-it notes”. The graph and post-it notes were not used as data per se but rather as artefacts to prompt a deeper conversation. The interviews were carried out by the first author and were between 1.5 – 2 hours in length.

Data analysis

Following verbatim transcription into Microsoft Word documents, each interview was read and re-read multiple times by the first author (CK). This was an iterative, inductive process whereby relevant threads were highlighted by annotating the margin of each transcript [28,32]. These annotated transcripts were subsequently shared with the research team to ensure that the salient threads were highlighted. The three-dimensional framework of temporality (past, present, future); sociality (the personal, social, and cultural); and spatiality

(environment and institution) were then used to organise the narrative threads [28,30]. Once organised, these threads were again shared with the research team who cross-checked the transcripts alongside the organised threads to make sure no other threads were present.

The next stage of analysis drew on a creative non-fictional analytical technique [33]. This involved creating a narrative using an overall view of the threads to shape and convey the story which drew upon the participant's own words. The aim was to provide narratives which have little to no academic interruptions to create a more storied representation [34]. This approach was used in order to preserve the essence of the story of the participant as an individual and her use of language within the thematic threads of the three-dimensional framework of temporality, sociality, and spatiality [30]. As such, the results are presented as a collection of narratives under the three-dimensional framework. A copy of the results was sent to the participant after the analysis for her input to ensure that the narratives were faithful to her experiences.

The authors were mindful of the inherent reflexive and active role they play as qualitative researchers. To provide clarity to the readers, the authors have included key credentials to help readers assess how these factors might have influenced the research process [35]. All authors were physiotherapists by background. CK, was a community physiotherapist by background and an experienced qualitative, post-doctoral researcher who now works in pre-registration physiotherapy training. AG is a lead clinical research therapist, and CC is an academic with many years of experience working with people with Hypermobile Ehlers-Danlos Syndrome as a clinician, educator, and researcher. As experienced physiotherapists, the researchers held certain views and assumptions about how physiotherapeutic encounters might be experienced. As such, assumptions were carefully acknowledged in the research process. Pre-conceptions prior to data collection and throughout the analytical process were documented by the first author in a reflexive diary [36,37]. This process of documentation

surprised the researcher in that the data collection and analysis were quite emotional and reflective experiences. Hearing the narrative accounts made her aware of times when she had acted in ways that possibly led to practice being far from person-centred. To address these epistemological conflicts of the views of the researcher, regular dialogue was maintained with the research team to debrief the research process.

Results

The results are presented as narratives under the thematic threads of the three-dimensional framework of temporality, sociality, and spatiality [30]. Each narrative draws out important aspects of the participant's life experiences with physiotherapy.

Temporality

“Braces have gone in and out of fashion over the years, a bit like hemlines have gone up and down”: A potted history of physiotherapy

In the '60s, physiotherapy was about exercising and having to move and do things with somebody beside you, showing you what to do. Then in the early '70s, I broke my ankle and then it was more hands-on, somebody actually working on the foot and massaging, getting their thumbs into the stiff muscles to get it moving again. I remember a physiotherapist whose thumbs felt like a vice.

I started having knee operations in the mid-70s, and then it was much more intensive. Once I was out of hospital, I would go back every day for quite some time, where it would be iced and get individual exercises, and then once it started to improve, I'd go into a class where there were 10 people with bad knees and three physiotherapists running the class. It was like circuit training; at one station you might do ankle exercise, then you move on to a static bike,

or an icing station. It went from daily to three times a week, to twice a week, to once a week. It was much more intensive than anything I've had since.

By the late '70s it was more passive, and a machine would do something to me. If it was my back that was the problem, you would have traction and the physiotherapist would put it on and go away and then come back and unplug it. Or I would have infrared for heat. It was all about machines and equipment with the patient having the treatment done to them, rather than taking part.

In the '90s, mostly because I was working and I was a headteacher by then, I still needed physiotherapy quite often, but I couldn't really take time to go to the hospital. So, I'd mostly go privately, and then it would be a mixture of all those things, massage or manipulation, but also, some sort of machinery like ultrasound, and braces. It seems to me that braces have gone in and out of fashion over the years, a bit like hemlines have gone up and down. At times physiotherapists said, "You need a brace for support," and other times, "That's not good. You shouldn't use them because you need to use your own strength, and if you've got a brace on, you become weak."

By the noughties, I found that if I was sent to physiotherapy, they would do an assessment to see which part of the body wasn't working well and they might put tape on it, or they might give me a TENS machine. Then I would get an exercise sheet and be sent away for a few weeks to do them. If there was an improvement, that's it, you were discharged. There were much longer gaps and it was about go away and do it yourself.

By the time I had my first knee replaced in the 2010s, physiotherapy felt like a conveyer belt. "This is the surgery you've had; this is what you do on day one, day two, day three, this is what you have to achieve before we can send you home." You were following a prescription really, like following a recipe.

“I want to go to Iceland, (the country not the frozen food shop)”: *Life plans as we grow older*

I’ve realised over the years that I’m dealing with two different issues. There will be millions of other people in this situation. One is having a chronic, long-term condition, which is always there and affects my joints in various ways. The second is having acute injuries. There is a mixture of the chronic and acute things. If I have an acute injury, what I’m looking for is somebody who can listen and take onboard that it’s in the context of a chronic injury. I do not want the prescription, if you like, for, “this is what you get when you have broken your wrist.” I need that to be seen in terms of the chronic injury as well. I want them to understand that if I had a broken wrist say, that has got implications for my elbow and my shoulder probably. Somebody who looks at it as a system, rather than one body part. I want somebody who is aware of the things that I need and what I still want to do in my life.

I have a great fear as I get older that anyone I see in physiotherapy; how can I say this? What they are after for me is smaller than what I want. That somebody would look and say, “Oh, well, she’s over 70, so she does not need to be able to do this or that,” when I still want to do those things. I’m worried that the treatment I get will have a smaller scope. I’ve got this picture in my head that they think it is enough for me to walk down the road and buy a loaf of bread, when I want to go to New York and walk along Broadway. Like I might say, “I want to go to Iceland,” and they will think it is Iceland the shop to buy a frozen dinner, but I mean the country.

Sociality

“I felt like we were a team”: *The power of attitude*

The attitude of the physiotherapist is really important. In the 90s I was having huge problems with my neck and shoulders and my doctor sent me to physiotherapy. But they said they couldn't do anything for me and told me that my joints were so bad that I should plan my life knowing that I would be in a wheelchair soon. On the way home I got off the bus early and, on a whim, I went into the local gym to see if I could use the pool to do some exercise in the water. I saw they had a physiotherapist there and I heard somebody coming out saying that he was really good. So, I made an appointment to see him, and he had a totally different attitude. His view was it's never too late; you can always do something. His attitude was important because he gave me hope. The hospital physiotherapists had taken away the hope and he gave me back the hope.

When I fell and broke my ankle I had quite a big surgery with lots of plates and pins and great big, long screws. The x-ray looks like it was fixed by somebody at B&Q (a hardware store) rather than a surgeon. But my physiotherapists were great and didn't just see my broken ankle but saw all the other problems in my body. They understood that if I'm lying in a hospital bed with a badly broken leg, other things come into play, like it's harder for me to move myself because of pain in my other joints. They were really good at looking at me, listening to what I said, summing up all the different issues and then coming up with something that fitted me. They saw me as the expert in my own body and let me know that, and what was really special was I felt like we were a partnership. I felt like we were a team. We were using my history and their expertise to come together and make a team plan that was in my best interest, and that was why it was so special.

The trouble is sometimes you meet people, and it is as if they have already decided that people do not do as they are told. At one point, I developed a really awful pain in the back of the knee, so I was referred to the physiotherapist at the community hospital. I said that I'd had the knee replacement and now I had really bad pain in the back of the knee. She just

looked at me and said, “Oh, well, that’s probably because you have just been sitting on the sofa piling on the pounds and you have not been using it enough.” Without asking a single thing about me she made that judgement. Then I said that I had been doing lots of strengthening exercises. She said, “You need to do the exercises for your quads.” I said, “I’ve been doing those every day since the mid 70s.” She shoved her fingers in my leg, and she said, “I don’t see any evidence of this exercise.”

Maybe I just caught her on a bad day. But it’s important to get the feeling of being a team with the physiotherapist. You cannot imagine being in a team with somebody who just says, “Oh, you have probably just sat on the sofa and piled on the pounds.”

“Oh, how weird is that? That’s really gross”: The power of words

Words are so important. I guess in some ways because they show you what the attitude of the physiotherapist really is. I was once sent to see a physiotherapist by the occupational health department. I was beginning to fall quite often, and they were concerned about me at work. I’d had to fill in a form beforehand with history of any surgery or fractures, so it was quite a long list. When I was called in to see the physiotherapist, she picked up the paper with my history and said, “You said on here that you’ve had your kneecaps removed. I don’t think so,” and I said, “I’ve had them both removed, back in the mid-70s. I know they don’t do that now, but they did then.”

She spoke to me in the most patronising way and said, “Perhaps they took your cartilage out,” and she was saying it she was, sort of, spelling it all out, like, “Cart-i-lage, did it sound like cartilage?” and I said, “No, it wasn’t. It was the patella,” and I thought if I said ‘patellectomy’, she might believe me more because it was a more technical phrase.

Then she said, “Well, I’ll find these missing kneecaps,” and when she said, ‘these missing kneecaps’, she did those little inverted commas with her hands. I realised at that point that she still didn’t believe me. She put her hands on my knee and realised that there was no kneecap and said, “Oh, how weird is that? That’s really gross.” I felt terrible once she’d said that and no apology for not believing me. She just said she’d need to give me some strengthening exercises. She showed me a few exercises that I would never have been able to do in a million years and said that I need to tell the doctor that I need a knee replacement. I said the doctors had explained that they think they’ve only got one chance and they want me to wait until I’m 60 because they’re afraid that the knees might wear out. She said, “well tell them that you want one done and if it’s a complete write-off, don’t have the other one done.”

That was a very cavalier attitude to my knees. And those words, ‘complete write-off’ have stuck in my head forever more. It’s the kind of language you use with a car, isn’t it? Like, if a car is in a crash and it’s a complete write-off and goes on the scrapheap doesn’t it, and I don’t think she ever could have considered how that phrase affected my mind and my thinking, and how much it frightened me. Ending up on the scrapheap like an old car which is no good to anyone, and I think it was one of the most powerful things a health person ever said to me, powerful in its negativity and feeding a fear.

On another occasion, after one of my knee replacements I was in hospital for several weeks. I had only been expected to be there for about five days, but the knee was infected, and I ended up being in there for a month. One of the physiotherapy assistants had been trying all the time to make me do things that were difficult for me, and I could not do. When a new physiotherapist came into the team and explained how my previous medical history would have affected what I can do now, I said to the assistant that I’d been trying to tell her that these things are really hard for me. She responded by saying, “Oh, well, we thought that you were just a bog-standard knee.” I don’t know how she could say that any patient in this

situation could be bog-standard or need bog-standard treatment because I was in a room with six people and we all had quite complex medical backgrounds, none of us were “bog-standard”.

The words of the physiotherapist can get stuck in your brain. Those words and the feelings that go with them are lodged there. The words that the health professional says become gigantic words by the time they’ve reached my ears.

Spatiality

“They came into my world, into my house, sat on my chair”: *The role of space*

I had community physiotherapy after I broke my ankle, and that was just brilliant because, then they came into my world, into my house, sat on my chair. In hospital it’s different. You’re in their building, wearing their gown, following their rules. That changes the power dynamic somehow which changes the communication. Like if you were to bump into the physiotherapist in the supermarket and have a chat, there’s no power difference there but in hospital you’re on their turf.

What was nice as well was sometimes she came when my husband was here. He’s often said he feels quite shut out of things in the hospital setting, when people might come and talk to me but ignore him sitting there. Involving him in what she was doing and explaining things meant he could be involved in helping me afterwards.

I talked to her about how exercise in water was really great for me, and previously, when I’d broken my ankles, as soon as the plasters were gone, I would go to the swimming pool and walk up and down in the water. I’d found that really helped because you’re not scared of falling over in the water. So, the first time I went back in the water, she came with me. She

knew that was really what I wanted to do as this keeps me strong. So, it was that partnership again.

But just because I've had physiotherapy at home doesn't mean it's always been positive as I guess it still depends on the attitude of the person coming into your space. One time my doctor referred me to the physiotherapist because I'd fallen a few times and been stuck on the floor until my husband got home. I wanted some advice, to show me how to get up from the floor. The physiotherapist came to see me at home, but it really wasn't helpful.

She said, "Well, let's see what advice I can give you," and she said, "Well, first of all, we're going to look for obstacles, things on the floor. We're going to put away the trailing wires and rugs you could trip over." Well, I haven't got any. I've already done that. Next, she said, "We've got to look at your slippers, because lots of people who fall, fall because their slippers are loose". Well, I don't own slippers; I always wear good shoes because my feet hurt much more otherwise. So, she couldn't advise me on the slippers, and all the things that she was telling me, she said, "Well, you can look at furniture," and she said, "Oh, you've already done it, haven't you?" She said, "What can I tell you?" and, "You've done all the things," and I said, "But what I really wanted was advice about how to get up," and she said, "Oh, well that's something you've got to work out for yourself. I can't help you with that."

So, where my first community physiotherapist had really worked out what I wanted to do and helped me get there, the other physiotherapist knew what I wanted to do, but said, "Just figure it out yourself." But what I'd hoped was I might get a strategy for getting up from the floor if I fall. That's what I want, strategies to be able to do things myself. I don't want people to do it for me. I want somebody to teach me how to do it, because that's helpful.

“Nobody had ever thought about it from the patient’s point of view”: The role of the stairs

I’d been in hospital after a total knee replacement, and you have to prove that you can go up and down stairs before you can go home. The hospital I was in was all on one level, so instead, they had a mock flight of stairs out in the main corridor. They came to tell me that I was going to have to go on these stairs, but I’d been really sick in the night so was in a hospital nightdress which was open at the back.

The physiotherapists came to me and said, “We are taking you out to go on the steps.” So, I said, “Could I put something else on.” They said, “Oh, no, you can come now.” I said, “I really want to put something else on and cover myself up.” They said, “Oh, it doesn’t matter. You don’t need to do that.” I said, “Well, I do.” They said, “No, come on, we haven’t got time. It will only take a minute.” As if only taking a minute makes it okay.

Because the steps were in the main corridor it was very busy. There was a row of chairs where people were waiting for the pharmacy, and it was like they were your audience. There was a family there and one of the kids said, “Oh, look at that lady’s knee, look at her legs, it’s really horrible.” Because it was. Blood was leaking down my leg because the wound was infected.

I got up the steps okay, but I couldn’t come down the way they told me to do it; not because of my new knee replacement but because I had had surgery to remove my kneecaps years ago which meant coming downstairs was very difficult for me. I’d learned that if I could not hold both banisters then it was safer for me to go down sideways, one foot at a time holding one banister with two hands. But they wouldn’t let me do this. Instead, they said I had to do it their way. When I tried to explain that I hadn’t done it their way for years they said “Well, you’re not getting away with that here.” So, they would not let me, they were really shouting

at me. Well, it seemed like that. Maybe they weren't but it felt like it because to them I was doing it wrong.

Afterwards, when I got home, I wrote this story and I sent it to the head physiotherapist. She came to see me and some months later, I had a letter from the hospital explaining that when they put those steps there, it was actually the end of the corridor. But then they built more buildings at the back and had to knock a way through, so it became a throughway for the rest of the hospital. After my letter they realised that nobody had ever considered the patients on the steps, nobody had ever thought about it from the patient's point of view. They've now moved the steps to a private room.

Discussion

This study has found that aspects of temporality, sociality, and spatiality were important in understanding how physiotherapeutic encounters were experienced and the extent to which they were person-centred. This knowledge is important because for physiotherapists to deliver person-centred practice, there is a need to understand how physiotherapy is experienced from the perspective of those receiving physiotherapy services.

The practice of physiotherapy is temporal with a past, present, and future. The evolutionary nature of that practice was highlighted in these narratives; Louise was part of that evolutionary journey and in many instances had been on that journey for longer than some of the physiotherapists she met. This potted history of physiotherapy is a reminder that physiotherapists need to be cognisant of the evolutionary journey of therapeutic care. In particular, the change from service users being passive recipients to becoming an active participant with a voice. In rehabilitation this presents a cultural change in service user and physiotherapist roles [38-42]. Being mindful of this shift in culture and setting expectations at

the beginning of a consultation would enhance the understanding of both parties as they navigate the roles they can play in enabling self-management of long-term health conditions.

The social aspects of physiotherapy were central to how physiotherapeutic encounters were experienced. For example, the attitude of the physiotherapist influenced the interaction between Louise and the therapist; for better or for worse long after the therapeutic interaction had been completed. The narratives demonstrate that therapists with positive, person-centred attitudes realised high-quality, trusting, patient-therapist relationships. These were perceived as partnerships in which both Louise and the physiotherapists offered their respective expertise. Shared expertise and trust are important in promoting collaborative, person-centred, therapeutic relationships which promote self-management [43,44]. These narratives serve to highlight the link between person-centredness and long-term self-management where self-management is one of the central themes at the heart of what high-quality, person-centred practice should involve [2,45].

The attitude of the physiotherapists and the impact this had on how encounters were experienced raises questions about where professional attitudes stem. Higgs and colleagues [46] note that “values influence what is seen as valuable knowledge in practice and shape the attitudes that underpin professional identities” (p 94). Each physiotherapist will have their own values, philosophy or model of practice which is developed from a range of sources including: their accumulated professional and personal life experiences, learning from reflective practice, their education, or practice setting [46,47]. The challenge is that most therapists will not have consciously considered the philosophical underpinnings or values which shape their practice [47]. Given the link between values, attitudes and how physiotherapeutic encounters were experienced in these narratives, these authors would encourage those training pre-registration physiotherapists to consider how this is taught as part of the curriculum. Providing students with an opportunity to develop their personal

philosophy and attitudes towards person-centred practice early in their training may help enhance the experiences of service users in the long-term.

Louise's social narratives also highlight the power of communication; the words used by physiotherapists seemed to give, or remove, life and hope. The importance of verbal and non-verbal communication is noted in a qualitative systematic review of person-centredness in physiotherapy [16], but these narratives demonstrate the unique power that a single word or phrase can have on a person's life. Thus, the relationship between words used in communication and person-centred physiotherapy is an important one. Martin Buber's work on his philosophy of dialogue asserts that dialogue involves our attitudes toward each other in the process of communication [48]. Dialogue, according to Buber, is considered an orientation in communication rather than a specific method or format [48]. Good communication is central to person-centred practice [7,16,49-52], but these narratives demonstrate that communication is far more of an existential question of the attitude we hold towards one another (including service users) rather than a specific technique or method [48]. This study found that the space in which physiotherapy is practiced changes how encounters are experienced. Just as the social aspects or internal forces such as the words and attitude of the physiotherapist impact on the experience, so too do external forces. These external forces could include economic, political, or cultural factors [46]. Some of these external forces shaped the environment in which Louise experienced physiotherapy. For example, the stairs used to assess whether service users will manage safely once they get home grew into a physical space in the hospital that was determined by external forces such as estate departments and managers. This serves to highlight why the physical environment is an important construct in the most recent iteration of the person-centred practice framework by McCormack and Colleagues [52]. They promote the importance of balancing the aesthetics with function in a healthcare environment through consideration of the design, dignity,

privacy, safety, and access concerns with a view to improving outcomes [52]. The challenge is for institutions to see their place through the eyes of the people accessing their services. This requires the involvement of service users in contributing to future estates developments and emphasises why the International Alliance of Patients' Organizations place importance on the need for patients and patients' organisations to be engaged in healthcare policy and decision making, such that services are designed with the patient at the centre [1]. It is not sufficient for the physiotherapists to practice in a person-centred manner, but the estates and management teams need to consider the physical place through a person-centred lens.

Physiotherapy practiced within someone's home in Louise's experience led to a change in the rules and levelling of power in some instances; they came into Louise's world and provided therapeutic solutions that were more relevant to Louise as a person, tailored to her space and environment. However, the change in place did not always lead to a levelling of power. Thus although place is important, it is still heavily influenced by the attitude of the physiotherapist, highlighting the complexity of practice being shaped by both internal and external forces [46,52].

Strengths and limitations

This was an in-depth narrative study with only one participant and as such, the results cannot be transferred to all individuals who experience physiotherapy. However, the narratives presented real-life stories of the experiences of someone who has interacted with a number of physiotherapy services over an extended period of time and as such give insights into the nature of patient-therapist encounters.

Conclusion

This study sought to explore how physiotherapeutic encounters were experienced over time and the extent to which these encounters were person-centred. This study found that the

aspects of temporality, sociality, and spatiality from Clandinin and Connelly's [30] framework of narrative inquiry were important in understanding physiotherapeutic experiences. Temporal aspects of physiotherapeutic encounters were noted in the evolutionary journey of physiotherapy practice. Aspects of sociality were evident in the attitude of the physiotherapists and the words they used within clinical encounters. Spatiality was noted in the role that external forces and the environmental space played in shaping how physiotherapeutic care was experienced. Collectively, these dimensions and narratives remind physiotherapists and healthcare providers to reflect on the role they play as individuals and institutions in shaping the experiences of service users and whether those experiences are perceived as being person, therapist, or institution centred. The authors would urge those training pre-registration physiotherapists to consider providing students with early opportunities to develop and reflect on their philosophy and values of practice thereby enhancing the experience of service users in the long-term.

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Declaration of interest

The authors report no conflict of interests.

References

1. Groves J. International alliance of patients' organisations perspectives on person-centred medicine. *International Journal of Integrated Care*. 2010;10(5).
2. Foot C, Gilbert H, Dunn P, et al. People in control of their own health and care: The state of involvement. London: The King's Fund; 2014.
3. NICE. Tailored resources: Working with adults to ensure person-centred care and support for admissions. London: National Institute for Health and Care Excellence; 2017.
4. WHO. WHO global strategy on people-centred and integrated health services. Geneva: World Health Organization; 2015.
5. van Dulmen S, van der Wees P, Nijhuis-Van der Sanden M. Patient-centered approach in clinical guidelines; a position paper of the guideline international network (G-I-N) allied health community. *Physiotherapy*. 2015;101:E1575-E1576.

6. Health Do. Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry. London: Department of Health; 2013.
7. Jesus T, Bright F, Kayes N, et al. 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*. 2016;6.
8. Kitson A, Marshall A, Bassett K, et al. 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*. 2013;69(1):4-15.
9. Gibson B, Terry G, Setchell J, et al. The micro-politics of caring: tinkering with person-centered rehabilitation. *Disability & Rehabilitation*. 2020;42(11):1529-1538.
10. Håkansson Eklund J, Holmström I, Kumlin T, et al. "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Education and Counseling*. 2019;102:3-11.
11. Hooker S, Masters K, Park C. A Meaningful Life is a Healthy Life: A Conceptual Model Linking Meaning and Meaning Salience to Health. *Review of general psychology*. 2018;22(1).
12. Cheng L, Leon V, Liang A, et al. Patient-centered care in physical therapy: definition, operationalization, and outcome measures. *Physical Therapy Reviews*. 2016;21:109-123.
13. Lorig K. Patient-Centered Care: Depends on the Point of View. *Health Education & Behavior*. 2012;39(5):523-525.
14. Pluut B. Differences that matter: developing critical insights into discourses of patient-centeredness. *Medicine, Health Care and Philosophy*. 2016;19:501-515.
15. Aittokallio J, Rajala A. Perspectives On 'Person-Centeredness' From Neurological Rehabilitation and Critical Theory: Toward a Critical Constellation. *The Journal of Humanities in Rehabilitation*. 2020.
16. Wijma AJ, Bletterman AN, Clark JR, et al. Patient-centeredness in physiotherapy: What does it entail? A systematic review of qualitative studies. *Physiotherapy Theory & Practice*. 2017;33(11):825-840.
17. Trede F. Physiotherapists' Approaches to Low Back Pain Education. *Physiotherapy* 2000;86(8):427-433.
18. Melander Wikman A, Fältholm Y. Patient empowerment in rehabilitation: "Somebody told me to get rehabilitated". *Advances in Physiotherapy*. 2006;8(1):23-32.
19. Kidd M, Bond C, Bell M. Patients' perspectives of patient-centredness as important in musculoskeletal physiotherapy interactions: a qualitative study. *Physiotherapy*. 2011;97(2):154-162.
20. Rutberg S, Kostenius C, Öhrling K. Professional tools and a personal touch – experiences of physical therapy of persons with migraine. *Disability and Rehabilitation*. 2013;35(19):1614-1621.
21. Stenner R, Palmer S, Hammond R. What matters most to people in musculoskeletal physiotherapy consultations? A qualitative study. *Musculoskeletal Science & Practice*. 2018;35:84-89.
22. Cooper K, Smith B, Hancock E. Patient-centredness in physiotherapy from the perspective of the chronic low back pain patient. *Physiotherapy*. 2008;94(3):244-252.
23. Potter M, Gordon S, Hamer P. The physiotherapy experience in private practice: The patients' perspective. *Australian Journal of Physiotherapy*. 2003;49(3):195-202.
24. Ibsen C, Schiøttz-Christensen B, Maribo T, et al. "Keep it simple": Perspectives of patients with low back pain on how to qualify a patient-centred consultation using patient-reported outcomes. *Musculoskeletal Care*. 2019;17(4):313-326.
25. Creswell JW. *Qualitative inquiry & research design : choosing among five approaches* / John W. Creswell. Los Angeles, [Calif.] ; London : SAGE, c2013. 3rd ed.; 2013 2013.

26. Clandinin D. Narrative inquiry: A methodology for studying lived experience. *Research studies in music education*. 2006;27:44-54.
27. Frank A. *The wounded storyteller: Body, illness, and ethics*. Chicago: The University of Chicago Press; 1995.
28. Haydon G, Browne G, van der Riet P. Narrative inquiry as a research methodology exploring person centred care in nursing. *Collegian*. 2018;25:125-129.
29. Holloway I, Wheeler S. *Qualitative research in nursing and healthcare [electronic resource]*. Chichester, West Sussex, U.K. ; Ames, Iowa : Wiley-Blackwell, 2010. 3rd ed.; 2010 2010.
30. Clandinin D, Connelly F. *Narrative Inquiry: Experience and story in qualitative reserach*. San Fransisco: Jossey-Bass; 2000.
31. Salmon P. *Living in time, A new look at personal development*. London: JM Dent and Sons Ltd; 1985.
32. Haydon G, van der Riet P, Inder K. Long-term survivors of cardiac arrest: A narrative inquiry. *European Journal of Cardiovascular Nursing*. 2019;18(6):458-464.
33. Carless D, Sparkes A. The physical activity experiences of men with serious mental illness: Three short stories. *Psychology of Sport & Exercise*. 2008;9(2):191-210.
34. Collard S, Marlow C. The psychosocial impact of exercising with epilepsy: A narrative analysis. *Epilepsy and Behaviour*. 2016;61:199-205.
35. 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;19(6):349-357.
36. Renganathan S. Exploring the Researcher--Participant Relationship in a Multiethnic, Multicultural and Multilingual Context Through Reflexivity. *Qualitative Research Journal*. 2009 2009-12;9(2):3-17.
37. Holt R, Thorpe R. *The Sage Dictionary of Qualitative Management Research*. London: SAGE; 2008 2008.
38. Solvang PK, Fougner M. Professional roles in physiotherapy practice: Educating for self-management, relational matching, and coaching for everyday life. *Physiotherapy Theory and Practice*. 2016 Nov 2016;32(8):591-602.
39. Sanders T, Foster N, Bishop A, et al. Biopsychosocial care and the physiotherapy encounter: physiotherapists' accounts of back pain consultations. *BMC Musculoskeletal Disorders*. 2013;14(65).
40. Shaw J, DeForge R. Physiotherapy as bricolage: Theorizing expert practice. *Physiotherapy Theory & Practice*. 2012;28(6):420-427.
41. Trede F. Emancipatory physiotherapy practice. *Physiotherapy Theory & Practice*. 2012;28(6):466-473.
42. Killingback C, Thompson M, Chipperfield S, et al. Physiotherapists' views on their role in self-management approaches: A qualitative systematic review. *Physiotherapy Theory & Practice*. 2021.
43. Cowell I, O'Sullivan P, O'Sullivan K, et al. Perceptions of physiotherapists towards the management of non-specific chronic low back pain from a biopsychosocial perspective: A qualitative study. *Musculoskeletal Science & Practice*. 2018 12 2018;38:113-119.
44. Killingback C, Thompson M, Chipperfield S, et al. Transitions from healthcare to self-care: a qualitative study of falls service practitioners' views on self-management. *Disability & Rehabilitation*. 2020.
45. Foot C, Goodwin N, Sonola L. *From vision to action: Making patient-centred care a reality*. UK: The King's Fund; 2012.
46. Higgs J, Smith M, Webb G, et al. *Contexts of physiotherapy practice*. Australia: Elsevier Churchill Livingstone; 2009.
47. Trede F. *A critical practice model for physiotherapy*: University of Sydney; 2006.

48. Johannesen R. Nel Noddings's uses of Martin Buber's philosophy of dialogue. *Southern Communication Journal*. 2000;65(2):151-160.
49. Dukhu S, Purcell C, Bulley C. Person-centred care in the physiotherapeutic management of long-term conditions: a critical review of components, barriers and facilitators. *International Practice Development Journal*. 2018;8(2):1-20.
50. Constand M, MacDermid J, Dal Bello-Haas V, et al. Scoping review of patient-centered care approaches in healthcare *BMC Health Services Research*. 2014;14.
51. Santana M, Manalili K, Jolley R, et al. How to practice person-centred care: A conceptual framework. *Health Expectations*. 2018;21:429-440.
52. McCormack B, McCance T, Bulley C, et al. *Fundamentals of Person-Centred Healthcare Practice*. Oxford: Wiley Blackwell; 2021.