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REVIEW ARTICLE

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What are the views of musculoskeletal physiotherapists and patients on person-centred practice? A systematic review of qualitative studies

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ABSTRACT

Purpose: There is a growing expectation of physiotherapists to adopt a person-centred approach to their practice. Person-centredness for musculoskeletal physiotherapy, however, remains an under-researched area. A synthesis of the findings from qualitative studies exploring perceptions of person-centredness in musculoskeletal physiotherapy was conducted to inform future clinical practice.
Methods: ENTREQ and PRISMA guidelines were used to develop a protocol for a qualitative systematic review registered with PROSPERO (registration number: CRD42020170762). Five electronic databases were searched to identify relevant primary studies. Studies were assessed for quality and data extracted. Data were analysed using thematic synthesis.
Results: A total of 3250 studies were identified and screened. Nine studies met the inclusion criteria. Four main themes emerged from the data: 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.
Conclusion: Empowerment of patients in musculoskeletal physiotherapy contexts might be improved through a more narrative approach to assessment, with clinical bravery recognised as a specific person-centred physiotherapy trait able to facilitate this. Physiotherapists should also consider the meaningfulness of any treatment activities they provide to maximise the person-centredness of their approach.

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KEYWORDS
Person-centred practice; physiotherapist; musculoskeletal; metasynthesis; qualitative research

➤ IMPLICATIONS FOR REHABILITATION

- Empowerment of patients in musculoskeletal physiotherapy contexts might be improved through a more narrative approach to assessment.
- Clinical bravery is a person-centred physiotherapy trait that facilitates certain conversational freedom to elicit the true patient narrative.
- Person-centred physiotherapists should reflect on how meaningful their treatment activities are for individual MSK outpatients.

Introduction

There is growing interest internationally for healthcare to focus on person-centred practice [1–3]. 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 [4]. 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 [5–11]. 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" [12, p. 5]. Person-centred practice has therefore yet to be established as a widespread practice but remains strategically important internationally [13].

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* [7]. Furthermore, the importance of patient experience in the UK is now enshrined within legislation following the publication of *The Health and Social Care Act* [14]. 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* [9]. Overall, this has led to 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 [10,15,16].

The formative "person-centred nursing framework" [17] was recently revised to a broader "practice framework" [18] 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 [19]. While most of the academic research on the implementation of person-centred practice has been associated with medicine or nursing, its

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adoption within physiotherapy research has been described as "embryonic" [20]. Physiotherapy governing boards internationally are calling for members to adopt a person-centred approach [21–24]. 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 [20]. 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 [25].

Clinical guidelines on the management of musculoskeletal (MSK) conditions consistently recommend the employment of a person-centred approach [26]. However, operational differences have been noted between MSK outpatients and more acute medical settings on which some of the existing person-centred practice models are based [27]. Furthermore, different professional groups and contexts tend to focus on different aspects of person-centredness [28]. 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 [29]. 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 [30]. Furthermore, training to support and promote psychosocial aspects of person-centredness, addressing the lack of knowledge and role clarity should be a requirement at the preregistration level and as part of a physiotherapist's continuous professional development [30–32]. If physiotherapy communication is poor, then this will constitute a barrier to the cornerstone of person-centred practice [33] for which core training will be essential. Patient barriers, on the other hand, include low health literacy levels [34], negative attitudes to recovery, and inappropriate expectations [35] 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."

A systematic review by O'Keeffe et al. reported "individualized patient-centered care" as one of four themes that were perceived by MSK patients' and physical therapists' to influence patient-therapist interactions [36]. 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. [37] took a broad approach to understand what patient-centredness in physiotherapy entailed but without focusing on a single clinical specialty. In seeking to build on this previous work [36,37], the aim of the current review was to explore systematically physiotherapists' and patients' views on person-centred practice within a musculoskeletal, rather than general, physiotherapy setting. This is important because person-centredness in MSK remains an under-researched area within physiotherapy.

Materials and methods

Information sources and search strategy

This review followed a systematic review protocol (PROSPERO registration number: CRD42020170762). The PRISMA guidelines [38] and "enhancing transparency in reporting the synthesis of qualitative research" (ENTREQ) checklist [39] 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 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*") (Figure 1).

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 the EBSCOhost interface (see Table 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 MSK outpatient-type setting.

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 [40]. 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 [41]. Discrepancies were resolved by discussion and consensus among all three researchers (JN; CK; AG).

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 [42]. Formative demonstrations of qualitative research synthesis, based on ethnographic studies [43], have led to 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 [44]. In keeping with other recent physiotherapy studies [37,44,45], the synthesis here followed the methods of thematic synthesis described by Thomas and Harden [46].

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 [46]. Before thematic synthesis was commenced,

PIC search parameters
Population: Musculoskeletal physiotherapists and their patients
Interest: Person-centred (and synonym) approaches to physiotherapy practice
Context: Musculoskeletal (MSK) physiotherapy outpatients 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]
[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 1. PIC parameters and search strings.

Table 1. Inclusion and exclusion criteria for eligibility.

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

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 the 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 [46]. 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.

Results

Included articles

Study selection

The search strategy identified 5756 articles. Figure 2 shows the process of study selection based on a PRISMA diagram [38]. A total of nine qualitative studies met the inclusion criteria.

Study quality was assessed using the CASP qualitative appraisal checklist (see Table 2). The CASP tool's utility in addressing most of the principles and assumptions supporting qualitative research [44] is supported by its use in several recent qualitative systematic reviews in physiotherapy [36,44,53]. All nine studies were deemed to be of very high quality. Four received the maximum 10/10 and the remaining five were awarded 9/10 due to inadequate reporting of considerations about researcher-participant relationships.

Study characteristics

A range of qualitative methodological approaches were used including narrative enquiry [47]; phenomenology [27]; conversation analysis [25]; interpretive descriptive methodology [48]; grounded theory [49,50]; modified grounded theory [51]; constant comparison [35]; and interpretive phenomenological analysis [52]. 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 to 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 [25,27,52], Spain [35,51], Holland [50], Denmark [48], New Zealand [49], and Norway [47].

Qualitative synthesis

Thematic synthesis of the included studies led to the development of four themes that summarised MSK physiotherapists' and patients' views of person-centred practice (see Table 4): (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

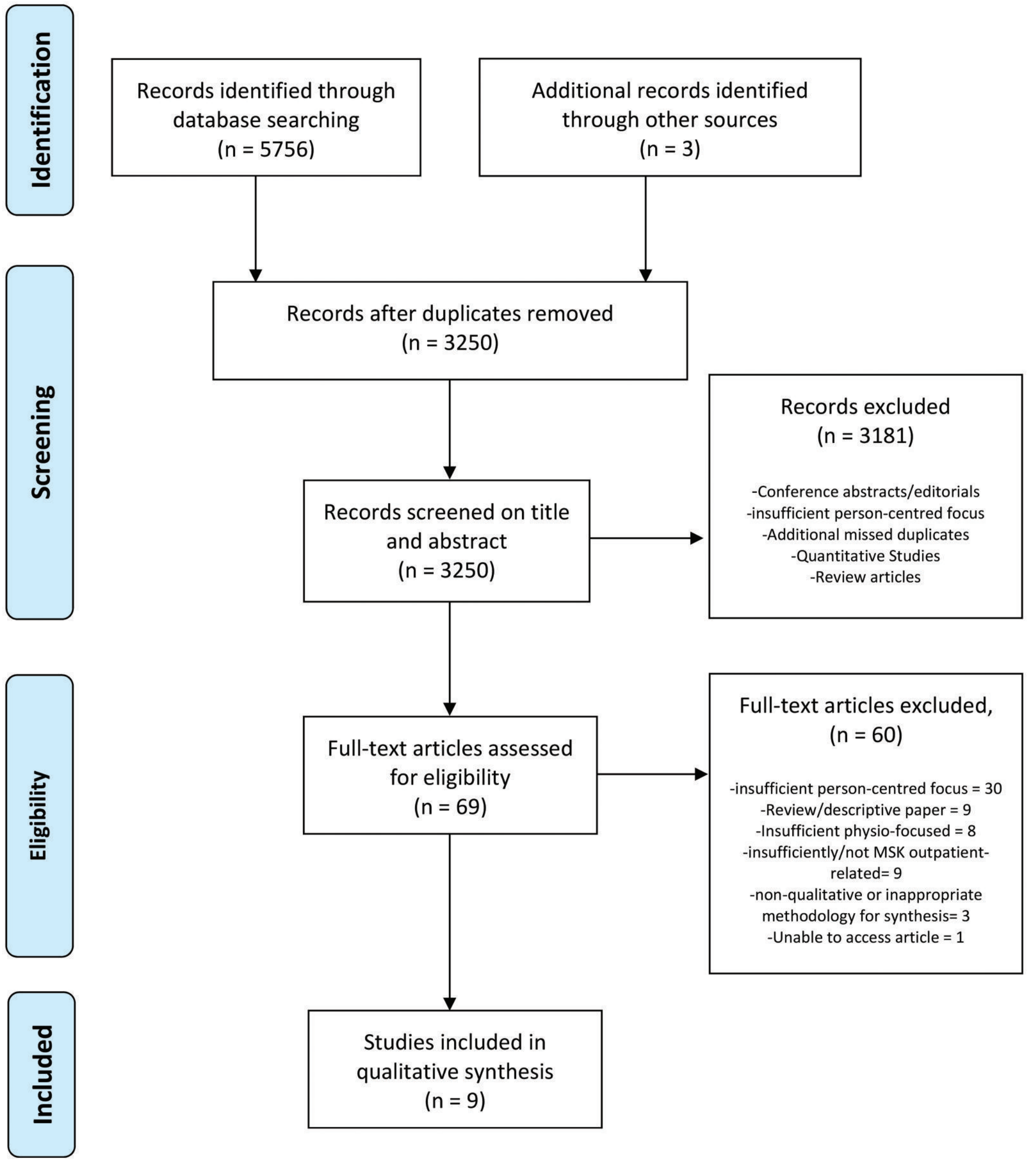

Figure 2. PRISMA flow diagram demonstrating the screening process for this review.

Table 2. Quality appraisal of included studies.

Criteria	Ahlsen et al. [47]	Cooper et al. [27]	Cowell et al. [25]	Ibsen et al. [48]	Kidd et al. [49]	Meerhoff et al. [50]	Morera-Balaguer et al. [51]	Morera-Balaguer et al. [35]	Sullivan et al. [52]
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
4. Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
5. Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y
6. Has the relationship between researcher and participants been adequately considered?	Y	N	N	Y	N	Y	N	N	Y
7. Have ethical issues been taken into consideration?	Y	Y	Y	Y	Y	Y	Y	Y	Y
8. Was the data analysis sufficiently rigorous?	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y
10. How valuable is the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total number of items with Y response	10/10	9/10	9/10	10/10	9/10	10/10	9/10	9/10	10/10

KEY: Y: Yes; U: Unclear; N: No.

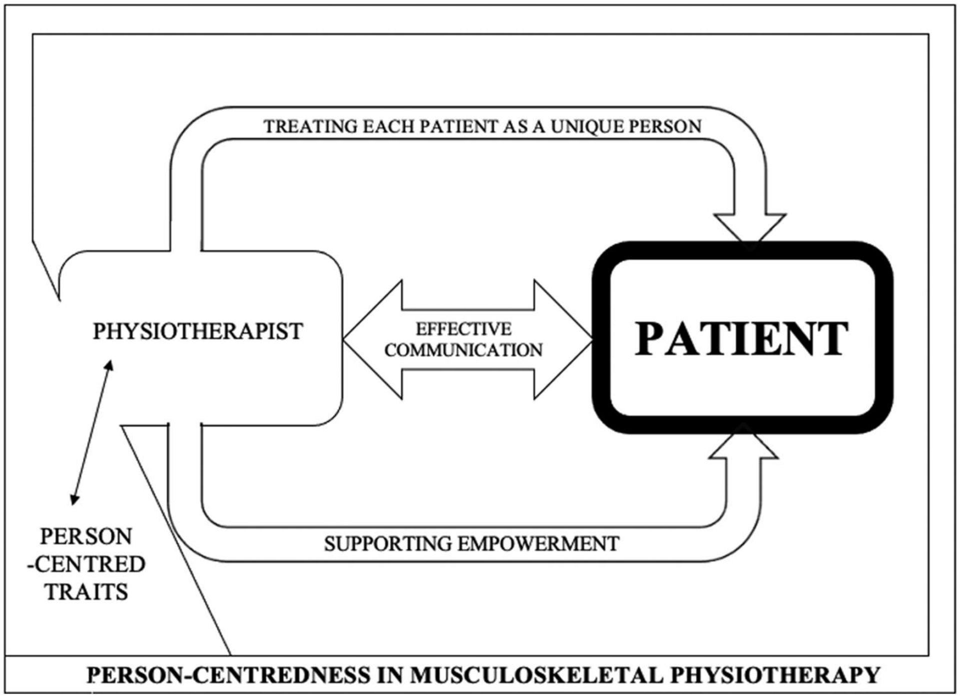

Figure 3. Schema representing review findings.

quotes from the original studies with a representative thematic schema presented in Figure 3.

Theme 1. Treating each patient as a unique person

For an MSK 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 [50]. 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 [27,35,48].

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 [47]. 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 [52].

> 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 [52].

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 [27,49]. 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 [27]. When treatment activities were meaningful to the patients, they felt that their needs were being addressed as unique people [27]. If, for example, the exercises were viewed as boring or too easy, and thus not meaningful, then they were more likely to disengage [27,49].

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 [47]. In the view of some physiotherapists, an approach tailored to the unique patient narrative or perspective allowed patients to use their own voice in the construction and development of new meanings for their concerns [25,47,52]. The addition of open-text boxes on a patient-reported outcome measure was one such example that, patients felt, enabled them to provide more details on their individual needs and functioning [48]. 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 [27,35,49]. This helped them feel like they were being seen as a unique person since the information was tailored to their own situation [27,49]. Similarly, the use of overly technical language was recognised as a barrier to developing individual patient understanding and resulted in patient disengagement [27,52].

> 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 [27].

As such, physiotherapists described their attempts to individualise understanding by deploying everyday analogies and metaphors [47,52]. For patients, the quality of the personalised

Table 3. Overview of included studies.

Study	Context	Methodology	Primary aims	Data collection methods
Ahlsen et al. [48]	Setting: Multidisciplinary Rehabilitation Clinic, Norway Types of conditions commonly seen: Chronic musculoskeletal Perspective: 5 physiotherapists Gender: 2 males, 3 females	Narrative inquiry	Examine therapists' understanding of patient-as-a-self in patient-centred practice	Semi-structured interviews
Cooper et al. [27]	Setting: Seven Physiotherapy Departments, Scotland Types of conditions commonly seen: chronic non-specific recurrent low back pain (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 low back pain	Semi-structured interviews
Cowell et al. [25]	Setting: Two primary care outpatient physiotherapy departments, London, UK Types of conditions commonly seen: Initial encounter, non-specific chronic low back pain Perspective: filmed observations Gender: 10 physiotherapists (7 males, 3 females) and 20 patients (9 males, 11 females).	Conversation analysis—qualitative observational method	How physiotherapists solicit and respond to the agenda of concerns that patients with non-specific chronic low back pain bring to initial encounters.	Video-recording initial physiotherapy consultations
Ibsen et al. [49]	Setting: Spine centre, Denmark Types of conditions commonly seen: low back pain Perspective: 7 patients Gender: 3 males, 4 females	Interpretive descriptive methodology	Explore patients' perspective and preferences as part of developing a new low back pain -specific patient reported outcome instrument	Semi-structured focus groups
Kidd et al. [50]	Setting: Hospital physiotherapy outpatient departments, New Zealand Types of conditions commonly seen: Musculoskeletal Perspective: 8 patients who had recently received physiotherapy Gender: 4 males, 4 females	Grounded theory	To determine patients' perspectives of components of patient-centred physiotherapy and its essential elements	Semi-structured interviews
Meerhoff et al. [51]	Setting: primary care physiotherapy practice of two regional networks, Holland Types of conditions commonly seen: Musculoskeletal problem Perspective: 21 patients Gender: 6 males, 15 females	Qualitative thematic analysis (Braun and Clarke, 2006)	Explore the perspective of patients with musculoskeletal health problems on using patient reported outcome measures for quality improvement in primary care physiotherapy practice and determine what barriers and facilitators patients perceive	Semi-structured interviews
Morera-Balaguer et al. [52]	Setting: Outpatient rehabilitation health centres, Spain Types of conditions commonly seen: Neuromusculoskeletal Perspective: 21 physiotherapists > 1 year working same place Gender: 5 males, 16 females	Qualitative study	Explore physical therapists' perceptions and experiences regarding barriers and facilitators of therapeutic patient-centred relationships in outpatient rehabilitation settings	Focus groups
Morera-Balaguer et al. [35]	Setting: Physiotherapy unit in primary care and hospitals, Spain Types of conditions commonly seen: Neuromusculoskeletal Perspective: 31 patients Gender: 10 males, 21 females	Qualitative thematic analysis with modified constant comparison	Explore the barriers and facilitators for the establishment of a person-centred relationship, based on the experience of physiotherapy patients	Focus groups
Sullivan et al. [53]	Setting: UK Types of conditions commonly seen: Chronic non-specific recurrent low back pain Perspective: 5 physiotherapists Gender: 2 males, 3 females	Interpretative phenomenological analysis	Explore participants' lived experiences of communicating the diagnosis of chronic non-specific low back pain to their patients during musculoskeletal physiotherapy practice	Interviews

explanations from the physiotherapist was helpful in building a trusting relationship with their therapist [49]. The importance of these individualised explanations was seen by both patients and physiotherapists as being part of a process that varies between individual patients and can take time, therefore should be "layered," as opposed to delivered all at once [27,49,52]. This tailoring of information thus ultimately facilitated a stronger patient-therapist collaboration [51,52].

Table 4. Overview of themes.

Theme 1. Treating each patient as a unique person
Theme 2. The importance of communication for achieving therapeutic alliance
Theme 3. Necessary physiotherapist traits for person-centredness
Theme 4. Supporting patient empowerment

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 MSK outpatient practise. Communication was notable in four key areas: clarity of communication that addressed expectations, facilitation of 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 [27,35,49,51]. Clear therapist communication was valued and constituted a source of satisfaction and trust in the therapeutic relationship [35,49,52].

> 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 [35].

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 [27,35]:

> 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 [27].

Thus, patient expectations were viewed as a burden by some physiotherapists [52]. 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 [47,51,52].

Secondly, clinicians and patients acknowledged the utility of open dialogue to achieve a mutually developed treatment approach [47,48,52]. 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 [27,47]. Rejoinders, such as "do you think," for example, were indicative of therapist attempts to reach a deeper understanding of patient perceptions and encourage the development of their concerns [25]. Supporting patients to communicate their beliefs and values in narrative form, therefore, appeared to enrich physiotherapist-patient relationships, furthering the aim of building a therapeutic alliance.

Thirdly, for an MSK outpatient consultation to be perceived as person-centred, both patients and therapists agreed on the importance of a physiotherapist's listening skills [25,27,35,47,49,51,52]. Listening was linked to maintaining focus on patient concerns [25] with an additional emphasis being placed by patients on the therapists not appearing to "judge" when hearing a patient's account [35]. 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 [52].

> 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 [52].

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 [25,52]. 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 [25]. 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 [25]. This resulted in patient disengagement and a feeling of belittlement and was damaging to therapeutic relationships [25,35].

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 MSK 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 [27,35,49,51,52]. 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 [25,27,35,47,49,52].

The second trait which was perceived to be important for person-centred practice in an MSK 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 [25,27,35,47,49,51,52]. The clear expectations from one patient provide their own checklist of therapist attributes for person-centredness [49]:

> 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 [49].

Traits, such as niceness or competence alone were not sufficient. There appears a complex mixture of idiosyncratic factors, including the physiotherapist's persona, that combines to shape this [27].

Patients' perception of negative therapist personality traits, which 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 [27,35,49]:

> 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 … [35].

Thirdly, for physiotherapy encounters to be person-centred there was an expectation from patients that they needed to feel confident in their therapist [35,49]. Similarly, therapists perceived their self-confidence to be important in supporting patients [51,52].

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, to truly achieve person-centredness [47,52]. Clinical bravery is characterised by an MSK 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 [47].

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 [47]. When attempts to achieve patient empowerment were unsuccessful or neglected, this had the potential to result in patient disempowerment [25,51]. The strong focus on empowerment is evident in only one therapist-facing article was itself noteworthy.

For more complex MSK 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 [47]. 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 [47].

Clinicians' views regarding opportunities and barriers for achieving patient empowerment were present in several studies [25,47,51]. A traditional MSK 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 [25]. 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 [51]. Indeed, from the patient perspective, some exhibited a dependence on the therapist, preferring to defer decision making to the physiotherapist [27,35,49]. The therapeutic management of a patient in possession of low self-efficacy was deemed to require more professional and personal effort [51].

The level of patient self-awareness regarding their current MSK issues emerged as a person-centred practice-relevant concept that was linked to empowerment in patient and physiotherapist studies [47,50]. For example, patient-reported outcome measures were considered by some patients as a useful tool for improving self-awareness and empowerment to manage their condition [48,50]. This is because the detailed questions about health problems made them more aware of their MSK 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.

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 [37,54–60]. However, what this review adds is that, within the well-reported principles of person-centredness, there are some nuanced differences that 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 [57,60]. 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 [37]. One proposed link between patient-centredness and empowerment, although not physiotherapy-specific, positioned patient-centredness as antecedent, and possibly prerequisite, to patient empowerment [55]. 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 make 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 [61–63]. 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 [64]. One possible way to achieve this desired shift might be through the adoption of the narrative approach modelled by Ahlsen et al. [47] who sought to empower patients. Narrative-based practice, like person-centred practice, emerged as a response to the perceived shortcomings of the biomedical approach [65]. A critical area of narrative-based practice is in the sharing of power between clinician and patient [66], 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 hold 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 [47,65–69] 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 [27,35,49,51,52]; emotional intelligence and personality [25,27,35,47,49,51,52] and self-confidence [51,52] or the ability to inspire confidence [35,49]. The wider point of there being a need for certain traits is covered in the multi-professional literature on person-centredness [37,54,56,59,60]. 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 the general discourse on healthcare discussions that are difficult and uncomfortable [70] which often pertain to life-changing diagnoses [71]. Difficult conversations that have gone well reportedly have the potential to affirm relationships, build trust and increase the hopefulness of the patient [72], albeit in the context of the 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 [73] and for which effective communication is central.

Communication during a typical musculoskeletal assessment is highly therapist-centred since the direction and control of the conversation is towards physical and biomedical topics, often *via* closed questioning and without regard for patient agenda [74]. "Brave and risky" forms of physiotherapy practice that emphasises openness, vulnerability, and transparency to address power relations have previously been proposed [75]. 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 [47,52]. 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 [69].

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 [76]. 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" [77, p. 963]. While fundamental for occupational therapy, 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 [78]. 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 [79].

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 meanings, 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.

Strengths and limitations

This study was strengthened by the authors following an *a priori* PROSPERO protocol and ENTREQ guidelines [39]. A broad international perspective on person-centredness was achieved by the 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 [39], the exclusion of grey literature, non-peer-reviewed publications, and non-English language publications constitute a potential limitation for this review.

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 the development of physiotherapy-specific person-centred frameworks that can provide clear, research-based guidance on how to operationalise person-centred practice in multifarious settings, including musculoskeletal outpatients.

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