

# BMJ Open 'It's just a finger isn't it...': patients' perspectives of recovery following finger fractures and participation in surgical trials – a qualitative interview study

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## ABSTRACT

**Objectives** To (1) generate detailed, person-centred data about the experience of finger injury and treatment and (2) understand the patients' perspectives of research involvement with a view to informing better designed future studies in hand injury.

**Design** Qualitative study using semistructured interviews and framework analysis.

**Participants** 19 participants who were part of the Cohort study of Patients' Outcomes for Finger Fractures and Joint Injuries study in a single secondary care centre in the UK.

**Results** The results of this study showed that although finger injuries are frequently seen as minor by patients and healthcare professionals, their effects on peoples' lives are possibly greater than first anticipated. The relative importance of hand functioning means that the experience of treatment and recovery varies and is shaped by an individual's age, job, lifestyle and hobbies. These factors will also inform an individual's perspective on and willingness to participate in, hand research. Interviewees showed reluctance to accept randomisation in surgical trials. Interviewees would be more likely to participate in a study testing two variants of the same treatment modality (eg, surgery vs surgery), rather than two different modalities, (eg, surgery vs splint). The Patient-Reported Outcome Measure questionnaires that were used in this study were seen as less relevant by these patients. Pain, hand function and cosmetic appearance were considered important, meaningful outcomes.

**Conclusions** Patients with finger injuries need more support from healthcare professionals as they may experience more problems than first anticipated. Good communication by clinicians and empathy can help patients engage with the treatment pathway. Perceptions of an 'insignificant' injury and/or need for quick functional recovery will influence recruitment to future hand research (both positively and negatively). Accessible information about the functional and clinical consequences of a hand injury will be important in enabling participants to make fully informed decisions about participation.

## STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This study explored the lived experience of finger fracture injury, treatment and attitudes regarding research.
- ⇒ It was a unique opportunity for participants to inform future hand surgery research design and implementation.
- ⇒ The interviewees were mainly participants undergoing non-surgical treatments in a single secondary care centre.
- ⇒ Participants who were interviewed were more engaged in both the research and clinical pathways. We do not have data from participants who did not engage.

## INTRODUCTION

Finger injuries are common, presenting a significant burden to patients and healthcare, as well as potential for permanent morbidity to the patient.<sup>1–3</sup> Existing evidence on the optimal treatment of finger injuries is often of poor quality, making interpretation to inform clinical practice difficult.<sup>4</sup>

However, researching finger injuries presents challenges. Injuries are more common in active young males<sup>5</sup> who are less likely to engage in research.<sup>6</sup> Injuries usually require prompt attention,<sup>7</sup> making recruitment to surgical trials in emergency settings difficult due to time constraints.

Qualitative research—exploring patient perceptions and opinions in depth—can provide insight into acceptable study design, assess acceptability of interventions, inform choice of outcomes and improve communications.<sup>8,9</sup>

Prior qualitative research offers some insight for the experience of recovery in patients with hand injuries in general but is not extensive.<sup>10–12</sup> It has discussed the

psychological and social effects of these injuries at work, at home and in leisure activities. Prior qualitative research in attitudes towards research not specific to finger injuries, has found that recruitment to randomised controlled trials (RCTs) can be an issue,<sup>13</sup> sometimes because of clinicians' personal views,<sup>14</sup> and that patient engagement can help with this.<sup>15</sup>

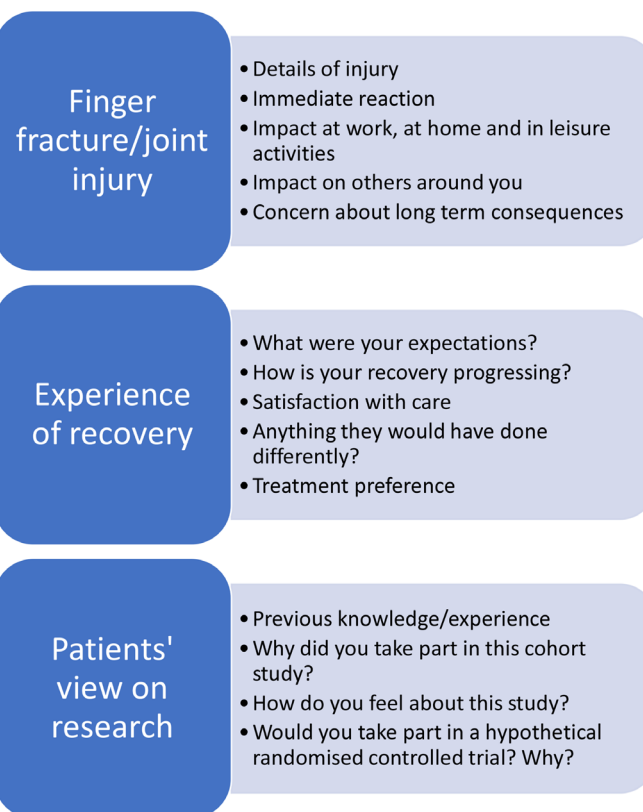
The aims of this qualitative study were to (1) generate detailed, person-centred data about the experience of finger injury and treatment which can inform specific person-centred research procedures and (2) understand the patients' perspectives of research involvement with a view to informing better designed future studies in hand injury.

## MATERIALS AND METHODS

This was a qualitative study using semistructured interviews that explored the lived experience of finger injury and treatment and considered attitudes about taking part in research.

This interview study was nested within a prospective, longitudinal observational cohort study of Outcomes for Finger Fractures and Joint Injuries (OFFJI),<sup>16</sup> which seeks to inform future multicentre RCTs on the treatment of common finger fractures and joint injuries. Patients with finger injuries were recruited in a fracture clinic and their recovery was documented with Patient-Reported Outcome Measure (PROM) questionnaires for 6 months (table 1). PROMs for this study were administered at baseline, 6 weeks, 3 months and 6 months.

OFFJI participants indicating a willingness to be interviewed were purposively sampled to build a study population representing a spectrum of injury, occupation, treatment modality and clinical course/outcome.<sup>17 18</sup> A purposive sample with a spectrum of injury, gender, age, occupation, presence of complications and treatment (conservative, surgical) was created a priori. Within this purposive sample the inclusion of young, employed males



**Figure 1** Interview guide.

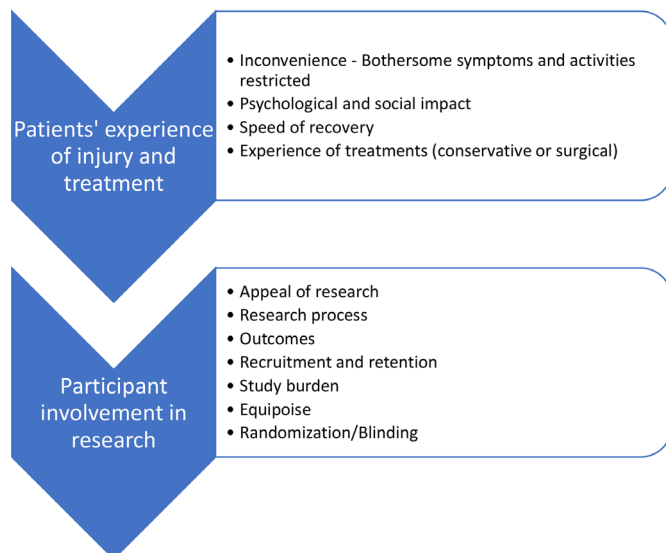
was explicitly sought, to reflect their prevalence in this fracture population.<sup>5</sup>

Interviews were semistructured to explore injury, recovery and opinion about research processes (figure 1). The aim of the interview guide was to create open-ended questions that would cover the totality of the experience and attitudes. Participants were encouraged to introduce any additional topic they thought relevant.

Interviews were conducted face to face or by telephone by CM. The interviewer was medically qualified, was not involved in their treatment and had only met the

**Table 1** Population, exposure, outcomes (PEO) table for OFFJI study

OFFJI study – cohort study of patient outcomes in the management of finger fractures and joint injuries	
Population (P)	Patients with finger injury presenting in the fracture clinic within 14 days of injury <ul style="list-style-type: none"> <li>▶ Proximal phalangeal fracture (intra and extra-articular)</li> <li>▶ Middle phalangeal fracture (intra and extra-articular)</li> <li>▶ Volar plate</li> <li>▶ Mallet finger</li> </ul>
Exposure (E)	Surgical or non-surgical treatment
Outcomes (O)	Patient-reported outcome measures <ul style="list-style-type: none"> <li>▶ Patient Evaluation Measure<sup>39</sup></li> <li>▶ EQ-5D-5L<sup>27</sup></li> <li>▶ PROMIS Physical Function-Upper extremity<sup>26</sup></li> <li>▶ Global Rating of Change<sup>41</sup></li> </ul>
EQ-5D-5L, European Quality of Life 5 Dimensions 5 Level Version; OFFJI, Outcomes for Finger Fractures and Joint Injuries; PROMIS, Patient Reported Outcomes Measurement Information System.	



**Figure 2** Themes and subthemes for proposed framework analysis.

patients at recruitment of the study. To capture potentially differing attitudes during recovery, interviews were conducted between 3 and 10 months postinjury in order to include a wide range of time since injury. Patients were contacted and the decision when to do the interview was based on patient availability.

Interviews were digitally recorded and transcribed in full. Personal identifiers were removed. Data were analysed in NVivo software (V.12) by a single author (CM), who identified codes to the different themes and subthemes from transcript excerpts. These were verified by the remaining research team at the level of the codes.

Framework analysis was used.<sup>19–21</sup> It is a pragmatic approach to studying an applied health problem and is structured and systematic. Using this approach, a set of themes are identified a priori based on the study objectives. The data analysis is then based on these themes even though they can be modified based on the interview data.

Themes were identified a priori, informed by the study aims and previous literature (figure 2),<sup>4 12 22</sup> and then combined with other themes identified de novo during analysis.<sup>23</sup> Framework analysis is preferable to other theoretical and exploratory approaches as it is more focused and time efficient.<sup>21</sup>

The interview study was reported according to the Standards for Reporting Qualitative Research (SPQR) reporting guidelines for qualitative studies.<sup>24</sup>

### Patient and public involvement

A small-scale patient and public involvement exercise was done to help shape this qualitative study. This was done at the planning phase. One of the investigators (CM) approached patients with finger injuries in the fracture clinic presenting them with the proposed study and the interview guide to obtain their opinion. They helped to refine it.

## RESULTS

Nineteen interviews, each lasting between 30 and 60 min, were conducted between 19 September 2019 and 30 April 2020. Demographics and injury of the participants are presented in table 2. The age range was between 21 and 78 years, and there were 10 women and 9 men. Two participants were treated operatively and 17 non-operatively.

The decision to interview 19 patients was taken because it was felt that data saturation was achieved informally. Framework analysis does not rest in ideas of thematic saturation as other analytic methods do.<sup>25</sup>

The coding framework, which was developed a priori, included 11 subthemes with 2 overarching themes (figure 2). Data are organised here to illustrate: (A) the experience of injury/treatment and (B) the experience of research. Online supplemental table I contains further representative quotes from the interviews.

### Participants' experience of injury and treatment

Participants described the initial impact of the injury, misconceptions about its severity and the inconvenient nature of sustaining a finger injury.

#### Inconvenience: bothersome symptoms and activities restricted

A finger injury is often initially considered minor. Some participants continued playing sport believing the injury to be inconsequential.

It happened playing football. I was hit by a ball. I carried on playing for an hour (participant 14, 55-60y male, volar plate).

A quick recovery to normality was predicted.

I thought, maybe it was just potentially a dislocation and they might be able to put the finger back in (participant 4, 44-50y male, proximal phalanx extra-articular shaft fracture)

I knew I'd hurt myself but I didn't think it was serious (participant 6, 60-65y male, proximal phalanx extra-articular base fracture).

However, any initial assumption was often replaced by a recognition of wider consequences; in the short-term many participants recognised practical limitations associated with their injury.

Well obviously I'm a university student, so I was unable to type my assignments or take notes in lectures (participant 11, 20-25y male, middle phalanx intra-articular base fracture).

In the longer term, some participants identified that full function had not returned, despite being back to their previous employment or hobbies.

Fully back at work... The only thing ... if I don't focus on forming a fist properly, I will pick small things up, like tablets, I might drop some if they're in my hand (participant 3, 50-55y female, proximal phalanx extra-articular shaft fracture).

**Table 2** Characteristics of participants interviewed

Participant	Occupation	Type of fracture	Time from injury (months)	Type of treatment and complications
1 (F) 40–45 years	Agency employee	Proximal phalanx extra-articular	3.5	Non-operative (Bedford gaiter)
2 (M) 20–25 years	Student	Proximal phalanx extra-articular	6.5	Operative (ORIF, had minimal extension lag)
3 (F) 50–55 years	Receptionist	Proximal phalanx extra-articular	8	Non-operative (Zimmer splint, had stiffness)
4 (M) 45–50 years	IT	Proximal phalanx extra-articular	6	Non-operative (Zimmer splint, had stiffness)
5 (F) 50–55 years	Education manager	Proximal phalanx fracture extra-articular	3.5	Non-operative (Zimmer splint)
6 (M) 60–65 years	Engineer	Proximal phalanx extra-articular	4	Non-operative (Bedford gaiter)
7 (F) 40–45 years	Not currently working	Proximal phalanx base	10	Non-operative (Zimmer splint)
8 (M) 35–40 years	Student	Proximal phalanx intra-articular	4	Non-operative (Zimmer splint)
9 (M) 30–35 years	Clerical	Proximal phalanx intra-articular	4	Non-operative (Mobilisation freely)
10 (F) 20–25 years	Banker	Middle phalanx intra-articular	4	Non-operative (resting splint)
11 (M) 20–25 years	Student	Middle phalanx intra-articular	5	Non-operative (Zimmer splint, had extensor lag)
12 (M) 40–45 years	Driver	Middle phalanx intra-articular	7	Operative (K wire fixation)
13 (F) 40–45 years	Not currently working	Volar plate	3.5	Non-operative (resting splint)
14 (M) 55–60 years	Healthcare professional	Volar plate	10	Non-operative (bedford gaiter)
15 (F) 25–30 years	Scientist	Bony mallet	4.5	Non-operative (mallet splint)
16 (F) 75–80 years	Retired	Bony mallet	4	Non-operative (mallet splint, had extension lag)
17 (M) 65–70 years	Lecturer	Bony mallet	4	Non-operative (mallet splint)
18 (F) 50–55 years	Music teacher	Bony mallet	6.5	Non-operative (mallet splint, had reduced function)
19 (F) 50–55 years	Clerical	Bony mallet	9	Non-operative (mallet splint)

ORIF, open reduction and internal fixation.

### Psychological and social impact

The impact of injury and ongoing functional limitations differed between participants, influenced by both the injury itself and their prior employment or lifestyle. Some were accepting that their injured finger may always have a degree of limitation.

Well it's not a huge problem because it's my little finger. I mean if it was my other fingers, I guess it would be more of a problem (participant 10, 20-25y female, pilon fracture).

For others, the consequences were considered much more significant.

Also I'm a music tutor... I still cannot play to my standard... Yeah, it does affect me... it's what I do (participant 18, 50-55y female, bony mallet injury).

### Speed of recovery

Recovery was frequently longer than expected, despite no participants reporting any complications.

The only thing I really didn't understand, the length of time it would take (participant 3, 50-55y female, proximal phalanx extra-articular shaft fracture).

### Experience of treatments

Participants generally expressed positive feelings about their care when asked directly. However, some criticisms were discussed. The need for improved communication, especially when discussing prognosis, was highlighted. People wanted to know about the likely time to recovery, in terms of pain and function. This was particularly apparent for participants undergoing non-operative treatment, when functional recovery 'feels slow'.

There was one point when I was worried.... Because the swelling wasn't going down, and I went to see them and they said: this is normal. It would take time (participant 15, 25-30y female, bony mallet).

One participant indicated a retrospective preference for surgery due to a perceived better functional return.

My finger has healed weird so the top of the finger is bent and you can't straighten it. I'd probably have gone with the operation (participant 10, 20-25y female, pilon fracture)'.

In contrast, a participant who had undergone surgery expressed disappointment at the time taken to recover.

I think that was what I was most upset about, that I just couldn't go back to living normally for a prolonged period of time... It was just more of an inconvenience (participant 2, 20-25y male, proximal phalanx extra-articular shaft injury).

### Participant involvement in research

Participants demonstrated a generally positive attitude towards research and offered insight about the OFFJI processes that they had experienced.

### Appeal of research

Overall, participants were keen to take part in research. Wanting to advance the overall care that the health service provides they acknowledged that the benefit of research would impact on others, rather than benefiting themselves directly.

I think obviously future patients will benefit, but also, I'm sure research has been done before my own injury, so we all benefit for it overall. And also for the clinicians, the doctors, the trainees, I would have thought it would be a benefit for everybody overall (participant 3, 50-55y female, proximal phalanx extra-articular shaft fracture)

I think it is good to have a dialogue between patients and the NHS [National Health Service] (participant 9, 30-35y male, proximal phalanx intra-articular base fracture).

### Recruitment and retention

When deciding on participation in a trial, participants felt that being told about the scope and value of the study is important.

I suppose you'd want to know what the study was about, what it was trying to achieve... the time involved... what was physically involved...what the risks would be involved... what sort of study size ... whether it was just based locally or is it something that's going off nationally or internationally (participant 19, 50-55y female, bony mallet injury).

Participants indicated that they felt that they might be less inclined to join a research study if they were in physical, or emotional, distress at the time of recruitment. In this circumstance, research might be perceived to be an unwanted burden.

...because if it is very painful, my main concern will be me, getting better first...., like I don't care about your research now, maybe in the second visit after a few weeks when I feel less painful, probably I would be more willing (participant 13, 40-45y female, volar plate injury).

Participants reported that an earlier appreciation of the consequence of a hand injury and the time taken to recover might encourage them to engage with a research study, rather than presuming that research is unnecessary in such a 'minor' injury.

Monetary incentives were important for some participants, but not others.

It's not something that would instantly attract me to... this survey... It's more about the service kind of thing (participant 8, 35-40y male, proximal phalanx intra-articular base fracture).

Regular contact from the research team, detailing study progress and impact was described as good for ongoing engagement.

Whether it would be a newsletter or email, I think it's probably the best way to keep people engaged (participant 9, 30-35y male, proximal phalanx intra-articular base fracture).

### Outcomes

Participants reported pain, function and cosmetic appearance as important following finger injury, with pain being paramount.

It doesn't work in quite the same way as it used to, or my right-hand works (participant 14, 55-60y male, volar plate).

Interviewer: ...long term, which one do you think is worse? Having pain or difficulty moving the finger? Or are they both equally bad?

Respondent: Probably having pain (participant 7, 40-45y female, proximal phalanx base fracture).

However, the impact of cosmetic differences was noted as impactful.

It's embarrassing, yes. I try to keep my hand like, not showing my hand, because everybody will go "Oh look at your finger" or "What have you done to your finger?" (participant 7, 40–45 y female, proximal phalanx base fracture).

Participants completed various PROM and quality of life questionnaires as part of the OFFJI study (table 1); interviews reflected on these and the process of completing them. Regarding acceptability, participants liked that the follow-up questionnaires were short and were sent to them as an email and they could do it in their own time. Although they felt that access to previous responses (for repeated measures) would enable them to be more accurate in their scoring.

I'd say the only thing is to... maybe give the answers from the previous time because I want to make sure that I've not answered differently to avoid confusion for the person that's reading the answers (participant 2, 20–25y male, proximal phalanx extra-articular fracture).

Specific items within these instruments were, however, highlighted as inappropriate or irrelevant, items such as the ability to 'change a light bulb' in the Patient Reported Outcomes Measurement Information System (PROMIS) Physical Function-Upper Extremity<sup>26</sup> and 'anxiety and depression' in the European Quality of Life 5 Dimensions 5 Level Version (EQ-5D-5L).<sup>27</sup> Participants noted that while they may experience issues in these domains, this was not as a result of their finger injury.

I can't do, but it's not got anything to do with my finger, that's to do with the fact that I've lost my hearing and I've got no balance! (participant 18, 50–55y female, bony mallet).

I think some of them (questions) were... not linked to the hand... it was something like... do you feel depressed?... Some people may be unhappy for other reasons, other than the injury (participant 4, 45–50y male, proximal phalanx extra-articular shaft fracture).

An individualised approach to outcome questioning was considered a better way of capturing outcomes, and interviews were also recognised as a possible way of generating meaningful data.

If I am very honest, some of the questions, I found were too broad and probably irrelevant to the injury I had... maybe try to have a specific sheet to insert with your questionnaire that is targeted towards an individual's injury (participant 6, 60–65y male, proximal phalanx extra-articular base fracture).

Certainly, because when you've got a conversation you can express and have that dialogue, whereas when you are answering on a paper or an email

format, you can't have that conversation (participant 5, 50–55y female, proximal phalanx extra-articular base fracture).

### Study burden

Participants recognised that research is separate to health-care and that it requires additional time. They indicated that study burden is important and should be discussed at the recruitment approach. Some participants took part in this study because they were not working and they had more free time.

I just moved to the city, I am not working and I have time, so I thought why not help people, that is all. I mean I have time (participant 13, 40–45y female, volar plate).

### Research process

Participants were asked about how they felt about participating in the OFFJI cohort study and the advantages and disadvantages of different types of research methodologies. They expressed very positive views about qualitative interviews.

Certainly, because when you've got a conversation you can express and have that dialogue, whereas when you are answering on a paper or an email format, it is very... you can't have that conversation (participant 5, 50–55y female, proximal phalanx extra-articular base metaphyseal fracture)

### Equipose

Participants were asked whether they would take part in a hypothetical RCT. Even if they did understand the principles of RCT, only a minority of participants understood the notion of equipose and said they would be happy to take part.

Obviously it's clear that if the doctor doesn't know which way to go, that means obviously there's still more learning to be done (participant 3, 50–55y female, proximal phalanx extra-articular shaft fracture).

### Randomisation/blinding

Some found it difficult to accept that there was genuine uncertainty in what treatment was the best, and others wanted their surgeon to decide their treatment.

If you weren't sure then I would expect you to refer back to any studies that you've done in the past, maybe look at a second opinion, talk it over with other people, and then come back to me and say well this is the best choice for you, let's go with this and see what happens (participant 1, 40–45y female, proximal phalanx extra-articular fracture).

that's a hard one really because obviously as a patient, you want to receive the most appropriate intervention (participant 19, 50–55y female, bony mallet).

Participants frequently had a treatment preference and randomisation was seen as risky.

I want obviously full range of movement, and it is a little bit like a gamble, isn't it? (participant 5, 50-55y female, proximal phalanx extra-articular base fracture).

Most perceived surgery as something major and unnecessary and were happy that they did not require it.

I'm glad surgery didn't take place and if someone had suggested it then I probably would have said "does it really need to happen" (participant 4, 45-50y male, proximal phalanx extra-articular shaft fracture).

Participants were more likely to participate in a study testing two variants of the same treatment modality, that is, surgery versus surgery, rather than a study comparing two different modalities that is, surgery versus splint.

A different kind of splint, then that's a little bit different, but if it's between a splint, which is non-invasive, to something that's invasive, you've got to be very careful with that (participant 18, 50-55y female, bony mallet injury).

## DISCUSSION

Finger injuries were generally considered minor by participants both at time of injury and during the initial recovery phase. However, this study found that hand injuries can have long term impact and they are often a greater burden to the individual than initially expected. The impact of the course varies according to the severity of the injury and the individual's personal circumstances (their job, hobbies, familial circumstances, etc). Accepting that 'normality' might not be regained was common in this sample to cope with the long-term effects of the injury. Participants here recognised that a 'minor' injury might not be an obvious candidate for conducting research, but the long-term consequences of a finger injury make it worthy of consideration. Many here would be willing to take part in trials of finger injury, but they would prefer those studies to be low risk, straightforward and with minimal commitments outside normal clinical care.

Previous literature has found that patients with a hand injury in general may need to rely on others at work or at home, which can affect their confidence.<sup>28</sup> This was not the case for the participants in this study as they remained independent despite their injury. Previous literature has pointed out an issue about the lack of information on the recovery that can affect satisfaction with the treatment.<sup>29</sup> This study found that patients who were interviewed expressed feelings of lack of interest and reassurance by healthcare staff. This might suggest that a positive patient experience can be improved by not only improving patients' function, but also overtly demonstrating interest and approval of their recovery. Reassurance from the

learnt clinician concerning recovery is crucial to improve experience.<sup>10 12 30</sup> This study found that participants should be told the longer-term natural history of the injury and its treatments without scaremongering.

Previous literature has shown that an honest discussion detailing the potential importance of the study as well as effective communication of equipoise, randomisation and blinding is crucial to improve recruitment rates.<sup>15 31 32</sup> Patients in this study were in accordance with this. Randomisation is generally a concept that is difficult to communicate to participants due to misconceptions around equipoise<sup>33</sup> and participants in this study were less likely to agree to take part in a hypothetical RCT. Participants in this study demonstrated three conflicting stances regarding equipoise—those who understood the role of equipoise in treatment, those who view the injury as minor and consider surgery as an inappropriate treatment, and those in acute pain who regard their personal circumstance inappropriate for participation in research, wanting treatment as a priority. Previous studies have shown that recruitment in a finger injury RCT may be lower when potential participants do not accept treatment uncertainty or clinicians are not in true equipoise.<sup>14</sup> The former was true about the participants of this study as many of them would not want to take part in a hypothetical RCT as they felt they wanted the best treatment, which for them was the non-surgical option. The latter was not tested in this study. Trials of interventions which are very different from a participants' perspective, such as surgery versus non-surgical treatment, are likely to be the hardest to recruit to.<sup>34 35</sup> This was the case for participants in this study.

The strength of this study is that it adds to the limited literature of hand and finger injury exploring the lived experience of finger fracture injury, treatment and attitudes regarding research. It has provided a unique opportunity for participants to inform future hand surgery research design and implementation. However, the study also has some limitations. The interviewees were mainly participants undergoing non-surgical treatments as the OFFJI study recruited mainly participants treated non-surgically and thus the inferences for recruitment to a purely surgical trial may be less robust. Nevertheless, most finger injuries, overall, do not require surgery.<sup>36</sup> Furthermore, as with any such study, participants who agree to participate in interviews may reflect the views of motivated people only, who are engaging fully in both the research and clinical pathways. We do not have data from participants who declined to join or failed to complete follow-up in the observational study. Participants were treated in a single tertiary centre. Moreover, this study did not interfere with routine care, hence interviews occurred after participants were offered and underwent a specific treatment by their clinical team. Hence, clinical equipoise was often absent, this being a key factor in influencing participant views regarding theoretical willingness to be randomised. Finally, the interview guide was more focused on the injury experience and treatment

than research. However, patients found the discussion about research interesting.

The implications for clinical practice were that good communication by clinicians, provision of information, empathy and more time spent with patients is likely to improve overall engagement in their treatment pathway. Some participants may still have issues after 6 months postinjury and may not return to the clinic even if having symptoms since they think it is a minor injury.

The implications for future research are that the most important outcomes were thought to be pain, hand function and appearance. A scoping review of treatment interventions of hand fractures and joint injuries found that pain is usually recorded with a Visual Analogue Scale (VAS),<sup>37</sup> hand function using a PROM (eg, Disabilities Arm, Shoulder and Hand (DASH),<sup>38</sup> Patient Evaluation Measure (PEM),<sup>39</sup> Michigan Hand Outcomes Questionnaire (MHQ)<sup>40</sup>) and appearance using a quality of life or satisfaction measures. With regard to the PROMs completed during the OFFJI study, interviewees perceived that they may be inadequate in delineating their true outcome.

## CONCLUSIONS

Finger injuries were generally considered minor by participants but are often a greater burden to the individual than initially expected. If healthcare professionals empathise with the patients and provide more information about the normal trajectory of recovery, this can help in the recovery process. A perception of hand injuries being a minor event, and the acute presentation of these injuries with potentially differing nature of proposed treatment interventions, might not motivate involvement in a study, so the importance of the research and aims need to be highlighted and explained. The PROM questionnaires that were used in this study were seen as less relevant by these patients. Pain, hand function and cosmetic appearance were considered important outcomes for future hand surgery research.

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**Competing interests** None declared.

**Patient and public involvement** Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

**Patient consent for publication** Not applicable.

**Ethics approval** This study involves human participants and was approved by Ethical approval was obtained from NHS REC West Midlands—Coventry and Warwickshire (REC Reference 19/WM/0087). Participants gave informed consent to participate in the study before taking part.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** Data are available on reasonable request. Data are available at the Results section of this study and the online supplemental material. Deidentified data are available on request by the research team.

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