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REVIEW

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The experiences of patients attending the emergency department who were managed by physiotherapists: a person-centred perspective

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ABSTRACT

Purpose: The expectation for all clinicians to deliver person-centred practices extends to the growing number of primary contact physiotherapists based in United Kingdom emergency departments (ED). Research on ED patients' experience of this physiotherapy role has yet to consider this through the lens of person-centredness. A qualitative exploration of person-centredness among ED physiotherapists through the experiences of attending patients targeted this knowledge gap to inform future clinical practice.

Methods: Semi-structured interviews with thematic analysis.

Results: 13 interviews were completed with four overarching themes generated: (1) patient experience of the ED; (2) the importance of connection, competence, and time; (3) recognising the benefits of being seen by a physiotherapist in ED; and (4) patient experience of the ED physical environment.

Conclusion: Novel contributions from the patient perspective, here, reflected a cognisance of certain environment limitations to PCP, as well as institutional challenges to their personhood, with a suggestion that ED patients anticipated a validation of their visit and valued the educational aspects that the physiotherapists provided. Considering this new knowledge can help ED physiotherapists to be more person-centred.

IMPLICATIONS FOR PRACTICE

- Those emergency department (ED) physiotherapists who validated an ED patient's attendance also provided an antidote to any incivility that they might have initially experienced.
- The ED environment had a negative impact on the patient experience because it was not designed through the lens of the service users or with person-centred practice in mind.
- Even in the maelstrom of ED, taking the time to fully educate patients on their condition was seen as an invaluable aspect of an ED physiotherapist's practice.
- Despite relentless pressures for rapid processing of patients, ED physiotherapists must take care to avoid adopting an impersonal checklist approach that denies a patient's personhood.

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Introduction

Person-centred practice (PCP) is now an internationally recognised dimension of high-quality healthcare [1] which requires differing paths depending on the country and context in which it occurs [2]. Despite the support for international and interdisciplinary person-centred care research, typified by the Gothenburg Centre for person-centred care (GPCC), the complexity and multifaceted character of PCP has created methodological issues – relating to variability of research evidence generated, that have hampered data synthesis [3–5]. The range of patient types and context-specificity of the person-centred activities pose a challenge to empirical study design [6] meaning few conceptualisations of PCP are grounded in empirical research [1]. Studies have tended to focus on discrete facets of PCP such as communication [7–9], shared decision making [7,10], self-management support [11] and goal setting [12,13] for example. Despite these challenges, there is evidence that a PCP approach can deliver positive patient outcomes [14] that include satisfaction and wellbeing [15] cost reduction [16] among other factors.

A fundamental aspect of PCP is its paradigmatic shift away from the paternalistic treatment of patients towards a partnership approach that regards the patient as a person rather than their presenting condition [17]. Several person-centred models and frameworks have been developed to support its realisation in clinical practice [18–20], most notably the *Person-centred Nursing Framework* [21]. This nursing-specific guidance has since been updated to a somewhat grander: *Person-centred Practice Framework*, that the authors present as a mid-range theory, applicable to broader healthcare systems [22]. Within the specific field of rehabilitation and physiotherapy also, there has been a development of models and frameworks to support person-centred clinical practice [23–25]. Prior studies reporting on patients' experience of physiotherapy person-centredness, based on qualitative interviews [26], focus groups [27] and synthesis of qualitative studies [28] have consistently highlighted the importance of PCP to the physiotherapist-patient interaction.

The physiotherapy profession has continued to adapt to the shifting demands placed on its workforce; the first contact practitioner (FCP) initiative for musculoskeletal physiotherapists in

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primary care [29] being a prime example. While physiotherapists have long performed a supporting role in the emergency department (ED), there has been a recent growth in those managing musculoskeletal patients at the point of first contact. While consensus regarding the precise characteristics of primary contact ED physiotherapists may be lacking, their introduction has tended to be framed around the potential to free up ED staff for dealing with more urgent cases [30]. Since the role has yet to be standardised, the precise scope of ED physiotherapy practice will necessarily reflect local governance arrangements. However, aside of those on advanced clinical practitioner (ACP) training programs, the typical ED physiotherapist caseload would tend to be musculoskeletal, rather than medical, which, except for first contact aspects, is in-keeping with musculoskeletal outpatient practice. Their presence in ED is based on evidence that this can reduce patient waiting times [31–36], length of stay [32–34,36–39], referral to specialties [40,41] and utilisation of imaging [38–40,42]. Other positive research findings here relate to safety [39,43] and approval by staff who work alongside ED physiotherapists [30,43–47]. A qualitative synthesis of seven studies involving patient and health professionals' experience of ED physiotherapists by Barratt and Terry [30] highlighted their expert clinical skills and educational role, albeit tempered by some confusion over their role and lack of integration within the ED team. A study by Schulz and colleagues, comparing physiotherapist management of musculoskeletal conditions across two Australian city EDs, found that they were less likely to order imaging, obtained similar outcomes in terms of analgesics and displayed equal or better patient satisfaction versus typical care [42]. Harding and colleagues' exploration of patient views from two different Australian EDs – one urban and one remote, found comparably positive themes including a patient experience of satisfaction and efficiency, with the physiotherapists' skills and attributes rendering them suitable alternatives to doctors for musculoskeletal cases [48].

The authors of this current research share the widely held view, and UK National Health Service (NHS) vision, of the need for a fundamental shift in how we work with patients and individuals to deliver more person-centred care [49]. Enacting person-centred practices for patients is, after all, a professional expectation for all physiotherapists [50–52]. While decidedly positive in nature [30,42,48], the existing data on patient experience of ED physiotherapy has yet to consider specific interactional aspects such as person-centredness. Therefore, with the growth of this ED physiotherapist role no longer in question [53], it is now important to learn about more nuanced aspects of how patients are experiencing person-centred physiotherapy practices.

The question that the current research aims to answer is therefore: *what are the experiences of emergency department patients on being managed by a primary contact physiotherapist viewed through a lens of person-centred practice?*

Materials and methods

Study design

A qualitative exploration of ED patients' experience of being managed by ED physiotherapists, considered through the lens of PCP, was developed to fill the established knowledge gap to inform future clinical practice. New knowledge here is of general import to forward the interests of person-centred physiotherapy practice in areas of broadening professional scope. This study employs in-depth semi-structured qualitative interview methods using a pragmatist's research paradigm as one that views the world as determined by human actions with people shaping their experiences through action and intelligence that find meaning in consequences [54]. The pragmatic approach here attempts to address practical problems in the real world, rather than those related to the nature of reality and truth [55].

The qualitative interview method was chosen based on its appropriateness for addressing exploratory research questions surrounding the meaning of events for research participants [56]. This study incorporated patient and participant involvement and engagement to test acceptability and practicality of aspects of this study. A Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was completed to ensure methodological rigour of the qualitative interview data collection methods [57].

Participant recruitment and ethics

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

A sample of convenience was used to recruit participants – a pragmatic decision considering: uncertainty of conducting research during a COVID-19 pandemic (at time of research ethics application); the time available for the part-time PhD clinical researcher; and the local access to ED participants at the time. The sampling design was purposive, with the members of the physiotherapists team requested to recruit continuously, for the duration of the recruitment period, all willing patients (fulfilling the inclusion criteria) just prior to their discharge from ED. The inclusion criteria were designed to maximise those that might be involved, with exclusion based only on what was absolutely necessary—something scrutinised, but ultimately satisfying the NHS ethics panel. Potential participants were initially provided with information about the study *via* the attending ED physiotherapist. If they consented, their details were sent *via* secure NHS email to the lead researcher who then telephoned them to confirm consent and screen with the inclusion/exclusion criteria (see Table 1) prior to setting up the interview.

Data collection

The main researcher (JN) conducted semi-structured interviews as the main data collection method to provide a greater depth of understanding of patient experience of being treated by a physiotherapist in ED. Since patients were not anticipated to have a clear understanding of this model, capturing aspects of PCP from these participants, without inadvertently telling them what to say, constituted a significant challenge. Due to the highly abstracted and necessarily non-directional nature of questioning, an interview guide (see Table 2) was developed by considering the research question alongside: the literature on PCP generally; the researchers' prior systematic review on musculoskeletal PCP specifically [28]; and their co-authored person-centred physiotherapy framework [24]. The latter resource significantly influenced the interview questions through its helping to understand

Table 1. Study inclusion and exclusion criteria.

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

Table 2. Interview guide.

Question	Prompts
Loosener: Can you tell me a little about what prompted your recent visit to the accident and emergency department?	
1. Could you tell me about something good about your experience of physiotherapy in the emergency department? (then another until three)	What were your expectations & were they met?
	Were there options & choices offered (SDM)?
	Was there an interpersonal connection with physio?
…(or three good things off the bat)	
2. Could you tell me about something bad about your experience of physiotherapy in the emergency department? (then another until three)	Did physio offer encouragement & give you confidence to manage your condition (empowerment)
	Did the physio appeared concerned (showing empathy, respect, dignity)
…(or three bad things off the bat)	
3. Could you tell me about how your experience of physiotherapy in the emergency department might be improved?	*Tell me more about that….*
	What do you mean by that…
	Can you give an example…
	how did that make you feel….
4. Is there anything else that you want to add which we haven't already spoken about?	*what sense did you make of that….*
	what do you think that is…
	which elements of that were….

the core concepts of person-centredness in physiotherapy rather than in healthcare more generally. The interviews questions were rigorously piloted, adjusted and effectively co-authored with persons who had regularly attended ED in the past; those who had attended ED and had their care managed by an ED physiotherapist; as well as undergoing a formal PPIE panel review and approval. Consideration of researcher positioning, *post hoc*, and reflective journaling during the interview phase, were used to log potential risks for incomplete data collection and suspected bias.

Recruitment and interviews ran concurrently (between the period February 2023 to April 2023). Interviews were conducted by JN after at least one day, but no longer than two weeks, following the ED attendance, to maximise recall of their experience. To interview on site the same day would have been unethical and impractical due to COVID protocols. Having a minimal one-day gap also gave participants the chance to get their pain under control. Interviews were carried out *via* a web-based video platform or *via* telephone with audio recording; determined by patient preference and/or accessibility. No one else was present for the interviews beside the participant and the interviewer. The interviewer was introduced to the participants as an "ED physiotherapy researcher."

Sample size for interviews here was guided by the concept of information power [58], with consideration of each of this model's "continuum" dimensions. The broad study aims, and multi-case analysis approach pointed toward requirement for a moderate to high sample. Conversely, high sample specificity, use of existing model/theory and high quality of interview dialogue was suggestive of lower sample size requirements. The author's relative inexperience as a researcher was offset by his specific clinical experience and insight as an ED physiotherapist and from prior publications on the topic of person-centred practice. High level communication skills, allowing for rapport building with interviewees, and support from an experienced supervision team produced a tentative approximation for 10 to 15 interviews. The depth and quality of interview data, established from preliminary analysis after several interviews—allowing for generation of analytical ideas, suggested a sample of around 10 would be sufficient. A final judgement was made after the thirteenth interview that sufficient data was collected for an analysis that could deliver on study aims.

Data analysis

Thematic analysis was carried out by the main researcher (JN) from verbatim interview transcripts in NVivo QRS based on Braun and Clarke's six stages of reflexive thematic analysis [59,60] which include: (1) familiarising with dataset; (2) coding; (3) initial theme generation; (4) developing and reviewing themes; (5) refining and naming themes and; (6) writing up (see Figure 1). PCP was used as the frame in which these patients' experiences were analysed. One co-author (CK) checked the coding accuracy, while both co-authors (CK, AG) were closely involved with initial theme generation and refinement stages right through to drafting of a final report. An iterative collaborative approach provided different perspectives on the data, capturing interesting analytical aspects that might otherwise have been missed [59].

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

Researcher position statement

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

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

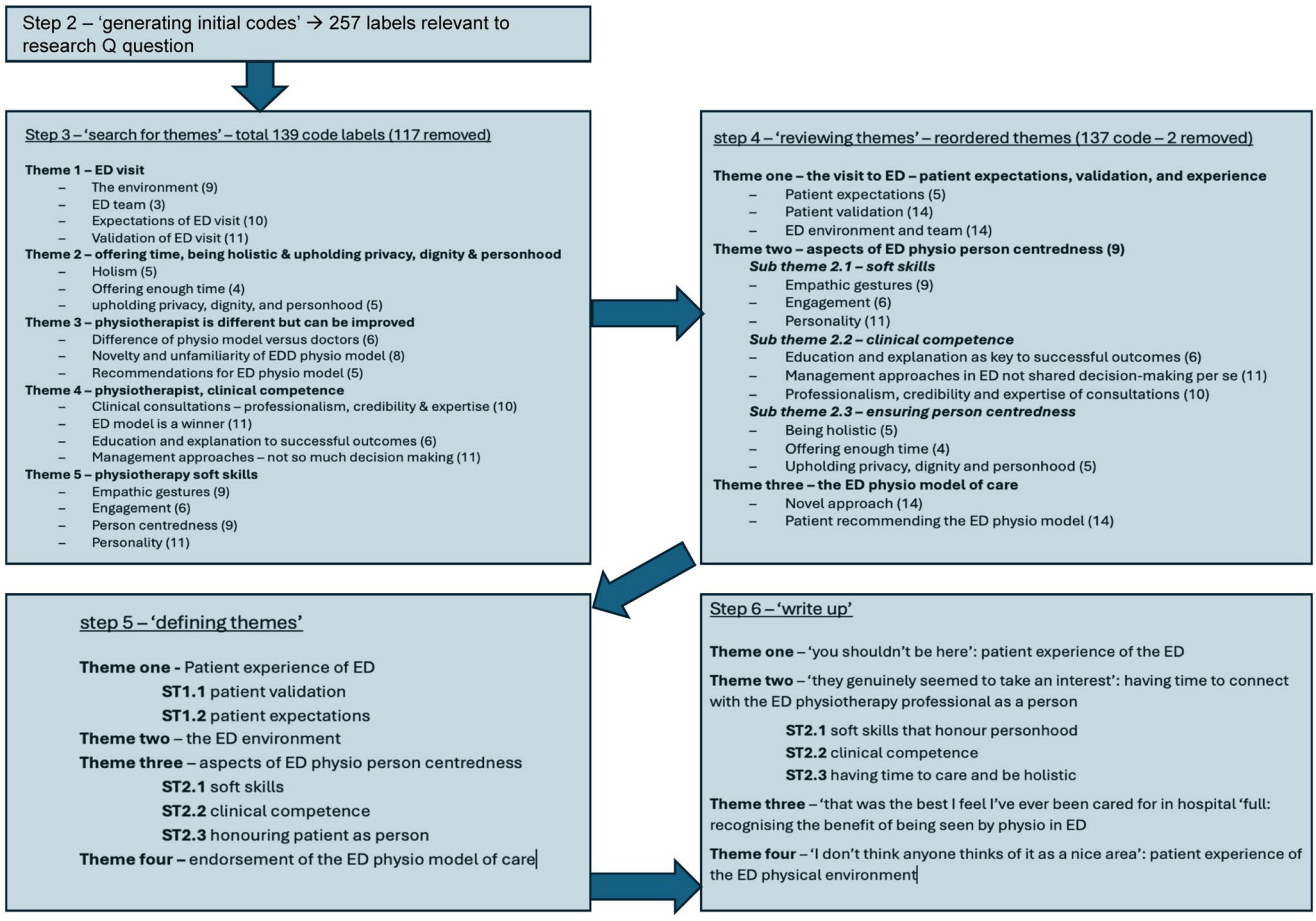

Figure 1. Coding tree demonstrating how themes were developed.

Results

Demographics of participants

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

Qualitative results

Thematic analysis of the qualitative data from the 13 participants interviewed led to four overarching themes, and three subthemes for theme 2, that were important to person-centredness from the perspective of patients attending ED whose care was managed by a primary contact physiotherapist: (1) patient experience of the emergency department; (2) the importance of connection, competence and time; with subthemes: 2.1. soft skills that honour personhood; 2.2. clinical competence and; 2.3 having the time to care and be holistic; (3) recognising the benefits of being seen by a physiotherapist in ED; and (4) patient experience of the ED physical environment.

Theme 1 – "You shouldn't be here": patient experience of the emergency department

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

> I went to the desk and the triage nurse said. "What seems to be the problem?" I said "I've got a really bad back pain and struggling to move"… And instantly, she said, "you shouldn't be here: You should be seeing your GP." When I explained that the GP had said come to A&E her answer was "that's what they would say, you should really try and get an appointment with your GP." (Participant 6, male – 50s)

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

This initial negative experience was in sharp contrast to the subsequent positive experiences of having their care managed by a physiotherapist; one which led to a sense of validation of their attendance. What appeared to be important for participants was that the physiotherapist most often affirmed that they had been correct in attending ED for their presenting condition. This validation from the physiotherapist seemed to hold significant value for participants, akin to a relief that at least someone believed them: "*he said 'no, they've absolutely done the right thing by sending me here'… I felt reassured because I did feel a bit of a phoney really for being there*" (participant 2, female – 50s). This was particularly important given that they may have had a very poor experience on arrival where they were given the impression that they should not be there.

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

> When I went in, I thought possibly that it might have been a triage. Not realising that he was going to be taking full care from start to finish. I was a bit like "alright. He's going to have a quick look. And then I'll be sent back to the waiting room and maybe I have to see a doctor. (Participant 1, female – 30s)

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

> The time that I waited, it was just ridiculously short compared to how long you would normally have to wait. Yeah, I was just blown away by being seen so soon. I think that is important for everybody; I think most people's experience of A&E is the fact that you usually have to wait so long to be seen by anybody…. I was very surprised. (Participant 12, female – 60s)

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

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

Subtheme 2.1 – Soft skills that honour personhood. Patient views about the importance of physiotherapist personality encompassed a whole host of specific positive traits, with a non-exhaustive list that includes being engaging; nice; happy; friendly; and open. One participant made it clear that being an expert alone was not enough as there also needed to be a personal connection for them to feel comfortable. The personal connection with an ED physiotherapist here was something realised through an active rapport-building process. An almost contradictory kind of *professional informality* was clearly appreciated by participants as revealing something of a clinician's true self. This suggests the adoption of more formal expert and patient roles, as per the traditional medical model, might serve as a barrier to a more person-centred and human level interaction so clearly valued by participants here.

> He was just a really nice guy. You know; just the way he was. He was really friendly, really chatty, but obviously professional….he wasn't sort of, you know, standoffish, like some doctors can be. I don't like to generalise. But yeah, just really comfortable. (Participant 1, female – 30s)

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

> There was just a really good level of respect there. Very high level of patient care, actually. I think just because you can find yourself feeling like you're not a person sometimes when you're in the hospital, you can feel quite a bit like a number: you're on the list and they've just got to try and get you through. So actually, someone sitting there and saying, you know what, you don't have to go and sit out there with no trousers on. In a gown. I'll just let you stay in here and I'll take you round, and I'll keep a look out for you when you come back. (Participant 13, female – 30s)

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

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

> The bedside manner of it, I just thought was quite relaxing. It made me feel definitely at ease and less worried about the fact that I was in hospital. It was nice. (Participant 4, female – 30s)

High level micro-communication skills such as good eye contact and active listening were perceived as important in helping the participants connect with the physiotherapist. Being able to

share their full narrative without interruption was particularly helpful in making participants feel that the physiotherapist was engaged and that their full story was heard.

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

Subtheme 2.2 – Clinical competence. While the ED physiotherapist personality was clearly an important aspect to their person-centredness, so too was a perceived professionalism, credibility, and clinical expertise. This bar was reached through various interactions with the physiotherapist but required, at the very least: a comprehensive history taking; a thorough physical examination; and possible investigations that could lead to an acceptable clinical diagnosis. Perceived clinical competence and credibility served to reassure participants that the physiotherapist knew exactly what they were doing; something of bearing given the fact that participants had been sent to see someone other than the doctor that they had expected. Many participants acknowledged a physiotherapist's prerequisite qualifications for this ED role, underpinned by their advanced knowledge and specialist skills. Despite not expecting to be seen by them, participants concluded that a physiotherapist was the best person to see when presenting to ED with musculoskeletal injuries due to their clinical competence in this area.

> it made it more of a comfortable experience knowing that you are seeing someone with those qualifications that can talk expertly about that particular problem. Physio was definitely the right person for this problem. (Participant 12, female – 60s)

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

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

Subtheme 2.3 – Having the time to care and be holistic. A key person-centred aspect highlighted by most participants was the premium placed on their clinical consultation not being rushed. Based on their previous GP or ED visit, many participants had apparently come to ED with the expectation of a long build up and a wait for hours that finally culminated in a cursory chat followed by hasty discharge. Offering enough time to fulfil their perceived needs was clearly essential to an ED physiotherapist achieving person-centred practice. An unrestricted chat enabled by the physiotherapist, coupled with their providing sufficient time to explain everything, was both considered by the patient as time well spent in realising their person-centred aims.

> he can only work off the information I give him and if I'm in a rushed environment, I'm not going to get it all out because obviously you're in so much pain. You are forgetting half of what you need to say. (Participant 6, male – 50s)

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

> Involving my husband made me feel more confident because most of the time I hear, but if, for instance, they turn round when talking to you—I don't always catch all that. Well, because my husband was there, on a couple of occasions, I'd ask something, and my husband would say he's already said that I hadn't heard it. (Participant 5, female – 70s)

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

> The physio made my friend welcome as well; she gave her somewhere to sit which was nice. This was important because I needed my friend there…I thought, that's nice of her to care; she asked her who she was and everything…sometimes they just say, "sit down!" I think if they didn't do this [i.e., consider the thought and feelings of your family members or carers as well as yourselves] I think I'd feel as though I was being a nuisance. (Participant 9, female – 70s)

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

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

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

This theme is characterised by the ringing endorsement of an ED physiotherapy model of care, generally regarded by participants as excellent. Being able to get al.l that they needed from the visit left participants reporting being happy to see an ED physiotherapist again. Participant reflections upon contrasting experiences of physiotherapist versus medical management within ED led to favourable judgements for this alternative model of care. Participants cited the more comfortable interactions, having more time and better aftercare with a musculoskeletal specialist, rather than medical generalist, as justification for this point of view. Their

ability to orchestrate the entire patient journey through ED, in particular, was a route through which participants experienced the person-centred ED physiotherapist approaches.

> There're not really any negatives I could think of because that was the best I felt I'd ever been cared for in hospital and I've been there a few times. So, I couldn't really have anything negative to say about the physio side of things. (Participant 8, male – 30s)

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

> I think there needs to be posters up saying exactly what they [i.e., ED physios] can do within the ED department: they can order your x-rays, give your mobility aids. You know, really, push it that if that's who the nurse says, you need to see, that's who you need to see. They're going to be able to do everything that you need. Possibly quicker than a doctor because they might want to call someone else in if it's not what they usually deal with day-to-day. (Participant 1, female – 30s)

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

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

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

> The waiting room is tiny…I mean, it's not a nice place, is it? I don't think anyone thinks of it as nice area…and I've spent a lot of time in my life sat in it. (Participant 13, female – 30s)

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

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

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

Discussion

The aim of this study was to explore the views of emergency department patients on their experiences of physiotherapy through the focused lens of person-centred practice. With person-centredness central to an international vision of how quality health care should be enacted [61,62], this knowledge constitutes one small but important step forward within this profession-specific setting. The qualitative themes led to the generation of four novel contributions that further understanding of the person-centred practices of ED physiotherapists from the perspective of their patients which are discussed here. These include ED physiotherapists' validation of a patient's attendance; their educational and explanatory approach; ED's physical environment as a barrier to PCP; and patient endorsement of an approach that maintains their personhood.

The fledgling physiotherapist role in ED is based around a deployment of their expertise in handling musculoskeletal cases—particularly those time-consuming back pain presentation, ostensibly freeing up the ED team's capacity to deal with more urgent presenting cases. The musculoskeletal physiotherapist brings with them the contemporary approaches of the outpatient department which, for back pain especially, includes significant biopsychosocial considerations. While the emergency medicine of ED will differ significantly from the scheduled nature of physiotherapy outpatients, despite their change of workplace, these physiotherapists do not appear to have fundamentally changed the way in which they interact with patients. Consequently, patients experience the novelty of this contact with an ED physiotherapist in contrast to interactions with other non-physiotherapist clinicians. The outsider status and perspective that accompanies the ED physiotherapist position thus has implication for patients.

The first new knowledge surrounding the experience of those attending ED was about participants receiving some form of validation of their ED visit by the physiotherapist. This "validation" was important because, prior to meeting the physiotherapist, the patient experiences were, at times, reportedly bordering on uncivil. Incivility, itself, is a specific kind of rudeness and disregard for others that violates the norms for mutual respect [63,64], which has been shown to endanger patient safety and wellbeing [65–68]. That a feeling of incivility, as conveyed by participants attending ED, was threaded through the findings was interesting.

The challenges of incivility need to be situated within the context of the practice environment. The practice environment, which relates to the context and culture, is important as it can impact person-centred practice [24,69]. The UK healthcare context has been severely challenged following periods of austerity, Brexit, COVID-19, and ongoing industrial action [70]. This has led to hospitals being required to function at near maximum capacity with long waiting list backlogs, compounded by chronically insufficient staffing levels [71–73]. Thus, it is not surprising that pressured triage staff sometimes struggle to remember to keep the person at the centre of their practice. In response to the widening health inequalities following COVID-19 [74], the Emergency

Medicine Public Health Special Interest Group recommended broadening the scope of ED to the delivery of public health interventions [75]. Based on the perceived level of incivility experienced by those attending ED in this study, any change beyond the purely emergency remit does not appear to have filtered down to the triage stations of all ED departments.

A literature review on person-centredness from an ED nursing standpoint offers some perspective here with staff reported as focusing more on medical tasks than patient wellbeing [76]. Ethnographic inquiry into the emotional labour and feeling rules of ED provides the analogous notion of "legitimacy" the authors define as a patient's "appropriateness to be in the ED" [77]. Here, Kirk and colleagues [77] reported certain patient visits, perceived by ED nurses as inappropriate, challenged the healthcare staff's capacity to feel empathy over resentment about the attendance.

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

Primary contact physiotherapists in this study were not responsible for the undeniably challenging "gatekeeper" role of ED patient triage. Therefore, once past this stage, there appears no reason why physiotherapists should not offer some form of explicit validation of individual patient attendance. In fact, when patients experienced the triage process as an ordeal, such gestures of validation appeared to constitute acts of kindness, offering sharp relief in ameliorating a stressful situation. While a conciliatory approach, with validation at its heart, was sufficient to turn around negative participant experiences in this study, there appeared to be consequences in terms of necessary effort required to make this right. This chimes with recent physiotherapy research reporting clinicians feeling the need to work harder to make up for the incivility of other staff [78].

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

The second new knowledge relates to an endorsement by ED attenders for the educational and explanatory approach adopted by ED physiotherapists in this study. Visits to ED are often associated with fear and uncertainty; as primary drivers for attendance [79]. The centrality of uncertainty to the conceptual model of fear is such that anxiety can be fuelled through an intolerance of not knowing [80]. Carleton's [81, p.31] definition of fear of the unknown includes "an individual's propensity to experience fear caused by the perceived absence of information…". ED attenders presenting in pain without trauma, e.g., low back pain, can conflate pain with damage—often catastrophising [82] due, in part, to lack of understanding about their present condition. The transformative effect of eliciting understanding appears consistent with the empowering intent of delivering person-centred practice; setting firmer foundations for any shared decision making to follow [21].

When lack of information and insight are the problem, it follows that education and understanding are the remedy. The current study provides a strong endorsement for the educational role that primary contact ED physiotherapists can have on imparting understanding and quietening worried minds. This impact is demonstrated in revelatory moments that occurred at the point of a patient feeling they finally understood their condition. The notion of this being the first time someone had properly explained the problem to the patient served as a cathartic experience from which acceptance and empowerment could follow; in a sense confirming the idea that the fear of pain can be more disabling than the pain itself [83].

The type of physiotherapist explanation characterised in the current study was one which typically included jargon-free anatomy lessons, phrased in lay-language—supported by use of models and metaphor. The participants' idea of an ED physiotherapist being able to cover explanation of "everything" was also strongly represented in the data. Thus, the ED physiotherapist's education-supporting role appeared to extend beyond simple information provision to something more akin to a navigator for the person's ongoing health journey. Considering the patients' journey before and beyond ED, resonates with the fourth construct of the person-centred physiotherapy framework [24]. "Ongoing unique journey of the person and self-management," in this model, similarly alludes to moments of patient intersection with healthcare services as opportunities to develop self-efficacy to sustain self-management.

The third new knowledge considers negative patient perceptions about ED's physical environment as barriers to achieving person-centred practice. A study in Australian EDs, noted the longer patients waited in ED, the more aware they become of negative aspects of the physical environment e.g., wear and tear, poor cleanliness, and unwanted noise; the reverse was also reportedly true [84]. Aside of patients suffering from physical pain, aspects of the ED environment such as feeling too cold, being crowded by other people, a lack of privacy during clinical interactions and poor amenities had the capacity to negatively affect their experience [85]. In their review of ED environmental impacts on patient experience, Rowe and Knox highlighted the three main factors of overcrowding and waiting times; privacy; and communication [86]—confirming dominant factors discovered in prior studies [87–89]. These findings are consistent with the present study in terms of participant experiences of crowding and difficulty finding a comfortable space to face the long waits; lack of privacy while in gowns and when sharing information within earshot of strangers; and a lack of humanised communication between staff and waiting patients, respectfully. With no EDs in England having met the NHS operational standard—to have admitted, transferred, or discharged 95% of patients within four hours—for over a decade [90], prolonged exposure to such environmental risk factors would appear set to continue.

This current study speaks to a generality of negative ED environmental effects on patient experience. This patient experience of the ED environment is not unique and has been similarly reported by other authors, including from an international perspective [84,85]. One obvious barrier to any sudden upturn of UK patients' experience of the ED environment relates to the structural limitations of existing NHS hospital sites. Limited government funding on big infrastructure projects [91] means that many of the existing tower block constructions are still in use dating back to the hospitals building boom of the 1960s [92]. It has been suggested that the same environmental features of ED that allow for a swift response to a patients' medical needs (i.e., open plan spaces in central ground floor positioning and curtains) might also be compromising patient experience [86]. With such intractable physical limitations to privacy, for example, the barriers to achieving person centred communication of the kind that might lead to therapeutic alliance become clear. This is borne out in the patient experience of ED, serving as an unfortunate glass-ceiling to how person-centred the ED environment might be. Those

responsible for decisions on how the space in ED is configured need to consider this physical place through a person-centred lens if things are to improve [93].

The final knowledge here endorses the type of ED physiotherapeutic approach that strives to maintain a patient's personhood. Personhood is a status "bestowed upon one human being, by others, in the context of relationship and social being" [94, p.8]. Given the stressful clinical ED environment [95]; under such relentless pressure, considerations of personhood and person-centred practice are, understandably, not always forefront of the mind. Furthermore, emergency departments are reported as having a "powerful performance culture" affecting how staff perform their jobs [96]. Attempts to improve quality in ED have thus tended to be based around structures, processes, and outcomes rather than person-centredness, despite the challenges in ED reflecting a lack of person-centred practice [97]. A philosophical chasm remains between biomedical foundations of ED and a person-centred medicine that rejects such a disease-centred ethic [98].

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

The positive response to ED physiotherapists' humanised approach here echoes the findings of Viotti and colleagues [89] where patient satisfaction in ED was not compromised by a long wait, provided the clinical interactions were consistent with higher levels of person-centred-adjacent practices. This demonstration of inverse correlation between wait time and satisfaction when less humanised care was delivered [89] support the idea of a person-centred push back against biomedicine as worthwhile.

Time must be a consideration as part of clinical workload and patient experience in relation to maintaining their personhood. A study of nursing practice presented the original suggestion that person-centred interactions might take on average 10–20 min longer to deliver [99]. It is therefore possible that as an outsider with almost peripatetic status within the ED team, physiotherapists in this study had a luxury of time not afforded to the rest of the medical team; a clear advantage given the focus on person-centredness. Given the inherent value clinicians and waiting patients place on time, it is unsurprising that person-centredness is considered so fragile a concept in settings like ED where time is of the essence [100].

When entering a busy ED environment, seemingly geared up for the swift medical processing of an endless procession of patients, a patient's personhood is clearly on the line. Despite all the challenges faced, including the effects of the culture within ED itself, delivery of person-centred practices can still be achieved. [76]. Adopting an ED-specific person-centred approach was, in this study at least, instrumental to why ED physiotherapy care was so well-received by participants, albeit with the benefit of having time in which to deliver this.

Strengths, limitations and conclusions

Quality assurances

Quality assessment was judged according to the *total quality framework (TQF)*, which as an overview, calls for a completeness and accuracy of data collection – "*credibility*"; and of analysis and interpretations – "*analysability*"; completeness and disclosure of reporting in the final document – "*transparency*"; and an ability to do something of value with the outcomes – "*usefulness*" [101]. A table is provided to summarise responses to these criteria (see Table 3).

Strengths and limitations

The authors acknowledge both strengths and limitations to their research. Firstly, there was a period between participant recruitment and interviewing which may have introduced an element

Table 3. Summary of quality according to the total quality framework (Roller & Lavrakas, 2015).

Total quality framework	How addressed in the current study
Credibility *completeness & accuracy of data collection*	*Scope*- target population 'list' includes all ED attendees at single hospital site during stated period, treated by any primary contact ED physio team member- from which a purposive sample & stated access strategy used to obtain a sample size justified through *information power* (Malterud, 2016). *Data collection* – PCP was the chosen construct as defined by literature review MSK physio (Naylor et al. 2023) general multi-professional literature review; concurrent co-authored framework for PC physio (Killingback et al. 2022). Exploratory nature meant attributes of the construct defined *by* the research within the novel ED setting. Pre-piloted, online audio data collection using semi-structured in-depth interview method & guide based on prior above-mentioned sources, plus extensive PPIE. Bias addressed by reflective journals considering e.g., possible risks for data collections.
Analysability *completeness & accuracy of analysis & interpretations*	*Processing* – verbatim transcription & repeated error checking of audio recorded interviews by researcher –no missing data or additional data transformation. Iterative coding by thematic analysis (Braun & Clarke, 2021) as relevant to PCP (see e.g., decisions in code book). Excerpt checks for inter-coder reliability. Developed codes to categories to themes through agreement with co-researchers. Themes interpreted in analytical discussion on new knowledge offered. *verification* – engaged in peer debriefings with other researchers (supervisor & independent PhD annual reviewer). Reflexive entry on interviews. Data/methods triangulation considering data next to that of prior mixed-methods physio study (Naylor et al. 2024). Member checking: real time question-answer validity process (with paraphrased follow-up question confirming participant meaning) and summary of themes shared with all participants so chance to respond.
Transparency *completeness of reporting*	*Reporting* – clear reporting of thematic data including a discussion that contextualises to extant literature. Supported by appended transcripts excerpt, codebook/tree & reflections.
Usefulness *Show that can do something with outcomes*	Findings add new knowledge and fill a research gap on how ED patients experience PCP when managed by ED physio. Study submitted for publication in journal and synthesised with other studies to create some recommendations for ED physiotherapists on how improve their own PCP (PhD Thesis and manuscript pending publication).

of recall bias. This was, however, offset by the fact that all but one interview was completed within a week of the ED attendance.

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

Finally, another real strength of the study was that it captured people of wide range of ages. Despite the sample being representative of the area in which the research was conducted, all of those interviewed were ostensibly white British, thus constituting an ethnically non-diverse sample. The lack of formal inquiry regarding ethnicity here, however, constitutes a limitation.

Conclusion

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

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

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

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