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Physiotherapists Description of Patient-Centered Care, and Barriers and Facilitators Experienced to Implementation

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Abstract

Patient-centered care (PCC) is a growing standard for healthcare delivery due to the benefits to patient autonomy. Lacking a cohesive definition in the physiotherapy literature, it is also lacking in implementation. Employing interpretive description with semi-structured interviews, the goal was to understand how physiotherapists drawn from private for-profit clinics in Canada describe PCC, and barriers and facilitators to providing it. Results included requiring person-centered communication in PCC, seeing Health holistically, centering the patient in care, and being a skill that becomes clearer with practice experience. Barriers included: lack of practitioner reflexivity, patient not desiring self-directed care, and limited access to interprofessional care. Facilitators included: time available with patient, practice community support, learning from experience, continued education, and practitioner emotional resilience. Results display how PCC is described by participants from private physiotherapy care in Canada, and inform us on further exploration around how to best facilitated PCC in Canada.

Keywords

Key words: patient-centered care, person-centered care, physiotherapy, private-for-profit, biomedical model, biopsychosocial model, physical therapy

Summary for Lay Audience

Healthcare has traditionally been very provider-centric in its delivery. Care is provided to the patient in a way that keeps authority and power in the hands of the one providing the care. There has been increased movement in the last several decades to provide healthcare in all fields that is more centered on the patient. This means increasing the patient's voice in discussion with the medical professional, and shifting the professional's focus from "curing" a disease or repairing an injury to restoring the patient's ability to lead a meaningful life and function as they want. In this project, we investigated how this concept of "patient-centered care" (PCC) was seen by physiotherapists, as this is a field where implementation of the practice seems to be lacking. We also investigate factors they see as preventing them or assisting them in providing PCC. Using interviews and discussions with participants, several themes were uncovered including the importance of communication strategies that centered the patient, taking a deeper, broader view of a patient's health, and ensuring the patient was centered in the care. Barriers included practicing physiotherapy without being self-aware of your own biases and opinions, the patient not desiring self-directed care, and limited access to other healthcare resources when the patient was in need. Facilitators included the time available under the physiotherapy model of care, the availability of support from other physiotherapists around them, learning from experience or further education, and possessing strength in regard to listening and empathizing with patients over concerns and struggles. The results of this work are useful in helping to guide and inform future work that will help paint a more definitive picture of the experience of providing patient-centered care that physiotherapists live; showing policy makers ways in which they can assist and teach physiotherapists in providing the best possible care.

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Chapter 1

1 Introduction

The purpose of this chapter will be to situate the reader and give them the context they need to understand why this project was undertaken. The first section will be a review of relevant ideas that explain why Patient Centered Care (PCC) is of importance to healthcare providers and policy makers in this country. Next is a review of relevant literature around the topic that showcases the need for this work, showcasing the lack of cohesion in definition, and that evidence that it is not consistently put into practice in the field.

1.1 Importance of Patient-Centered Care

Rehabilitation services in Canada are of vital importance to the health of the population. With Physiotherapy services being accessed by 11.6% of the adult population in 2014 (Sutherland, 2017), physiotherapists play a key role in assessing and carrying out individualized care plans. Independently, or as part of a care team, they work to maintain, improve, or restore physical functioning, as well as alleviating pain and preventing physical dysfunction (Sutherland, 2017). Along with these responsibilities, the profession's core competencies in Canada include promoting health and well-being, communicating effectively with the patient and other healthcare professionals, building a sustainable practice through management of time and resources, advocating on behalf of the patient, practice, and wider community using their knowledge and expertise, and keeping informed on current knowledge and research in the field ("Competency Profile for Physiotherapists in Canada", 2017). The profession is also growing. By the end of 2014, more than 20,000 physiotherapists were employed in Canada. With the public and private sectors employing equal numbers of practitioners on average across the country, all sides are seeing an increase in consultations with an average annual increase of 3.8 percent ("Competency Profile for Physiotherapists in Canada," 2017).

In order to properly orient this project, PCC must first be explained. As described in the work of Stewart et al. (2013), PCC in medicine and healthcare as a whole is comprised of four interactive components. Exploring the illness experience, understanding the whole person, finding common ground, and enhancing the patient-clinician relationship.

Exploring the illness experience involves the clinician actively seeking to “enter the patient’s world” (Stewart et al., 2013), to get an idea of their perception of health, along with their unique experience of illness. Understanding the whole person encompasses an integration of understandings of health, disease and illness, with an understanding of the whole person. This idea thrives off of having an awareness of the multiple aspects of the patients life and the multiple contexts in which they live. Finding common ground involves defining the issue and establishing goals with patient input, and the fourth component of enhancing the patient-clinician relationship involves making sure compassion, empathy, and a sharing of power are present in the dynamic. Establishing for the reader what patient centered care is broadly, is an important first step in the discussion of its relevance, followed with an examination of how healthcare is provided.

The way in which healthcare is delivered to patients can be classified by care models. Traditionally, healthcare has seen the utilization of a biomedical model of care. This means practitioners operating under a view of disease being a deviation from a biological norm, where the remedy was the use of a corrective physical or chemical agent, given by a trained practitioner drawing knowledge and authority from certification under a governing collegiate body (Mehta, 2011). In rehabilitation care, this delivery model has proven inadequate for addressing pain and disability (Daluiso-King & Hebron, 2022). A biomedical model of healthcare delivery has shown to be non-optimal in isolation, as psychological and sociocultural understandings of human health grew (such as the connection between social class and health outcomes). A new approach, the biopsychosocial model (BPSM), was innovated to address these ideas. Supporting the idea of patient-centered care by giving space for patient narratives and opinions (Hiller et al., 2015), it aimed to provide a more humanistic method of providing healthcare, taking into account the biological, psychological, and social influences on a patient (Mescouto et al., 2022). The BPSM gained support from physiotherapy researchers as they saw the ways psychological factors such as beliefs, mood, and social factors such as family or

work issues have relationships with pain and disability outcomes (Daluiso-King & Hebron, 2022; Mescouto et al., 2022). However, some researchers have described the implementation of this model in physiotherapy practice as ‘simplistic’ (Stilwell & Harman, 2019). Originally intended to have the components implemented together, in practice, it has tended to result in a reductionistic application which gives an improper picture; fragmenting patients’ pain into biological, psychological, and social domains (Stilwell & Harman, 2019). Despite guidelines, including those from the World Health Organization, strongly encouraging the inclusion of contextual factors in physiotherapists clinical reasoning practices (Killick & Davenport, 2014), there still seems to be a lack of understanding of what the BPSM means in practice (Hiller et al., 2015; Mescouto et al., 2022). In an ethnographic project by Hiller et al. (2015), the way patients and physiotherapists interact in a private practice setting was explored. The report aimed to understand how physiotherapists communicate with their patients, and critique how their communication styles related to established communication models. What they found was sessions focused on physical aspects of pain, and although visits incorporated more holistic approaches such as using touch as communication, communication was largely physiotherapist-centric (Hiller et al., 2015). They found communication focused on physical and biomedical aspects of the patient’s condition, although not in total alignment with one model of communication. Practitioners’ communication was found to be responsive to patients' needs, however still representative of a practitioner-centered model (Hiller et al., 2015).

Situating the relevance of patient centered care, and establishing the benefit for the patient ensures that its importance is clear for the reader. The improvement of communication with the patient through a patient centered approach has an effect on outcomes that is likely indirect. The proximal outcomes of feeling known, respected and engaged in their care through a patient- centered approach allows for a mitigation of the illness experience through increased adherence and self-care (Epstein & Street, 2011). Patient nonadherence can be a pervasive threat to their health and wellbeing when dealing with a health issue (Martin et al., 2005), and on a larger scale, patient nonadherence can carry an economic burden of up to \$300 Billion a year (Robinson et

al., 2008). PCC also finds relevance in a more broad argument of the ethical good being given to the patient.

A discussion of physiotherapy care would benefit from a discussion of medical ethics. Medical ethics are described as the moral norms for proper conduct that provide guidance and evaluation of said conduct in the medical field. This is important in a field that finds many challenging questions at their intersection with law, public policy, or personal morality (Rhodes & Cohen, 2003; Varkey, 2021). Broad ethical standards across all healthcare fields include the 4 principles of medical ethics. These are autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2001)- A short explanation of each is warranted before a larger look at the most relevant idea for this project, which is autonomy.

Beneficence, simply put, is the obligation of the practitioner to act in a way that benefits the patient. It is a duty to “*further [another’s] important and legitimate interests*” (MacCiochi, 2009, p.72). Non-maleficence is the obligation of the practitioner to not harm the patient (Varkey, 2021). This principle exists so the practitioner may weigh the cost and benefits of a potential treatment. While several routes of treatment may be useful, some may lead to outcomes that conflict with what the patient wants, so it may be seen as an unnecessary harm. Autonomy is an idea that reflects the intrinsic and unconditional worth of a human being (Varkey, 2021) and that they should have the ability to make decisions and moral choices for themselves when of sound mind. The final principle is Justice. Justice can be divided into two categories, procedural, and distributive. Procedural speaks to the equitable treatment and experience of those engaged in healthcare, both consumer (patient) and deliverer (professional). Distributive justice looks at the equal distribution of resources, both time and material-based, at each level (Summers, 2013).

Autonomy gained importance, in part, due to the paternalistic nature of healthcare under the guise of beneficence in the years after World War two (Will, 2011). Those in the medical field had no issue commanding the trust and dependence of the patient. The attitude at the time stressed that the professional knew best, which often led to doctors

leaving out details or making decisions for the patients without telling them; a hallmark of this paternalistic model (Will, 2011). As time went on, and atrocities such as the mass forced medical experimentation by Germany on concentration camp victims became known, rules were put in place to govern the need to obtain informed consent from patients in treatment or research. Details of the 30-year Tuskegee syphilis study also became public. In the 1930's 400 African American men were recruited in the southern United States and knowingly denied treatment for their latent syphilis, while believing they were being treated for something unrelated. Knowledge of this experimentation caused great anger and desire for reform when details were made public in the 1970's (Heller, 2017). These events inspired a reform in practices, as it was noted that a reluctance in individuals to trust researchers to protect patient well-being quickly turned into an unwillingness to trust physicians with their patients as well (Will, 2011). Putting more decision-making power in the hands of the patient is essential to addressing the power dynamic that exists in these relationships (Louw et al., 2017).

Autonomy is essential for implementing Patient Centered Care (PCC). In *Crossing the Quality Chasm: A New Health System for the 21st Century* (Institute of Medicine, 2001), PCC is outlined as one of the core competencies needed for all health professionals to meet the needs of the healthcare system in the 21st century (Institute of Medicine, 2001; Lusk & Fater, 2013). Through the concept analysis of patient-centered care in nursing research conducted by Lusk and Fater (2013), patient autonomy was shown to increase as power was shared. The shared decision-making process allowed patients to have a hand in their care plan, thereby “*enhancing their ability to find inner control and problem solve*” (Lusk & Fater, 2013, pg.94). In the broadening research on autonomy in healthcare, illness is positioned as a personal experience that may play a role in affecting autonomous decision making. It may challenge life plans, and relationships, and disrupt self-identities (Entwistle et al., 2010). Advocates for PCC encourage clinicians and researchers to think about the subject of their attention (the patient or participant) as humans first, who themselves are embedded within complex social structures and networks that affect their autonomy through relational dynamics. This understanding has been termed ‘relational autonomy’ (Entwistle et al., 2010; Hunt & Ells, 2011). Relational autonomy in physical therapy leads to a focus on partnership and engagement with the

specific contextual factors that shape a patient's situation. It attempts to account for power differential and understanding of a patient as a being situated in relationships (Hunt & Ells, 2011). In a secondary analysis of their phenomenological interview data of physiotherapists, Kleiner et al (2022) found that relational autonomy was an important component of being a responsive physiotherapist. Practicing PCC was also found to be a component of this, with a review by Wijma et al. (2017) emphasizing the importance of individualized treatment, ongoing dialogue, and supporting and empowering patients within PCC (Wijma et al., 2017).

1.2 Review of Literature

In reviewing the literature on the topic, PCC in physiotherapy does not seem to be a coherently defined topic. Several reviews have been published over the last 15 years detailing how the term has been defined and operationalized in the field (Cheng et al., 2016; Dukhu et al., 2018; Killingback et al., 2022; Schoeb & Bürge, 2012; Wijma et al., 2017). To begin, Cheng et al. (2016), conducted a scoping review on how PCC was defined, operationalized, and implemented in physiotherapy literature. They did this by reviewing studies with a focus on aspects such as clinical and organizational outcomes, patient satisfaction, and additional outcomes found through themes in the qualitative research (Cheng et al., 2016). They aimed to capture a wide sample of relevant articles, so they placed few limits on the search strategy. In a systematic review by Wijma et al. (2017), the goal was to explore the understanding of the concept of patient-centeredness in physiotherapy. Their review aimed to “*expand and summarize themes related to patient-centeredness identified in qualitative research*” as well as “*provide a framework from which to develop applications to physiotherapy*” (Wijma et al., 2017, p.826). They included a review of qualitative studies of patient-centered care and related aspects in physiotherapy and rehabilitation care. In a narrative synthesis done by Schoeb & Bürge (2012), 11 studies were reviewed to collect evidence guided by established review questions (Schoeb & Bürge, 2012). The focus of this project was to explore how patients and physiotherapists perceive patient participation during treatment sessions. In the critical review conducted by Dukhu et al. (2018), several quantitative, qualitative, and mixed methods reports looking at person-centered care from the perspective of patients

with long-term disabilities were reviewed. They use the term “person-centered” to describe a relationship of equal partnership between healthcare professionals and persons in their care to ensure patient needs are met (Dukhu et al., 2018). In the work of Killingback et al. (2022), they developed a conceptual framework of constructs related to person-centered care in physiotherapy. This conceptual framework was developed through an iterative process of combining existing frameworks, theories, and models found in the reviewed papers (Killingback et al., 2022).

These reviews revealed some commonalities in how PCC and patient participation are conceptualized in the field. The utilization of shared decision-making was a common idea, appearing in each review. Cheng et al. (2016) saw its use as an alternative term to patient-centered care in reviewed papers, such as Jones et al. (2014), which saw it as *“both a philosophy and a process, whereby clinicians engage patients as partners to make choices about care, based on clinical evidence and patients’ informed preferences”* (Jones et al., 2014, p.13). While not named as clearly as it was in the work of Cheng et al. (2016), in Wijma et al. (2017) the ideas of continuous tailored communication, with patient-defined goals were present. As they described in their review, communication with the patient should be tailored to each patient in clear lay speech, which requires the therapist to be open about themselves and the therapy (Wijma et al., 2017). The education the patient is receiving should be tailored to the patient's needs and goals; goals that have been determined through the practitioner facilitating, guiding, and using education and discussion to determine (Wijma et al., 2017). The person-physiotherapist interaction was a construct in the framework of person-centered care put together by Killingback et al. (2022). They noted the importance of partnership in the relationship, where the physiotherapist respected the shared expertise between them. The patient is involved by the physiotherapist in a non-judgmental way, respecting the specifics of the patient’s personal life and decisions (Killingback et al., 2022). Although it is a review of patient participation in physiotherapy interactions specifically, Schoeb & Bürge (2012), noted that patient goal-setting and info exchange were important aspects. Although, they did note that some physiotherapists used patient participation as a means of keeping authority and direction, while others were the opposite, saying it was to give choice (Schoeb & Bürge, 2012).

Another commonality between these reviews was the idea of individualizing the care experience for the patient. In the review by Dukhu et al. (2018), they found that person-centered care in the population being studied was comprised of 6 components, one of which was individualization of care. It was seen as getting to know the patient and tailoring the care to fit their specific needs (Dukhu et al., 2018). The studies they reviewed showed that self-management advice for the patient must be “realistic and tailored to individual’s needs and circumstances” to assist in adherence (Cooper et al., 2009). The idea of individuality of care arose in the review by Wijma et al. (2017) as well. It was identified as a major theme in their review, with subthemes of “getting to know the patient” and “individualizing treatment”. When getting to know the patient, it was reported that the physiotherapist informing themselves on the patient's needs, preferences, personality, beliefs, and values all contributed to the patient being seen as an “integration of body and soul”, which the patient appreciated (Wijma et al., 2017). When treatment was individualized, patients knew that they rather than the techniques were the center of concern. The therapist would collaborate with the patient to build a plan where the patient may learn independently (Wijma et al., 2017). In the review by Cheng et al (2016), the ideas of respect for the person, and meeting the person in their own context were present in reviewed studies (Cheng et al., 2016). They were components presented under the idea of a ‘person-centered approach’, along with shared decision-making. In the work of Killingback (2022), they noted the importance of recognizing the ongoing unique journey of the patient and promoting self-management. An important aspect of this is the individualization of the care being provided so that it works best for the patient (Killingback et al., 2022).

How the physiotherapist presented themselves to the patient also played a role in the conceptualization of PCC. In the review by Wijma et al. (2017), a physiotherapist who could relate to the patient, showed confident body language, and was knowledgeable allowed for a transfer of understanding that increased reassurance and empowerment for the patient (Wijma et al., 2017). This was an idea also noted in Killingback (2022), as there was great value placed on a physiotherapist who was conscientious, present, genuine, empathetic, and compassionate in their delivery of care. Showing patients they were being taken seriously allowed them to feel as though they could share relevant

information the physiotherapist needed (Killingback et al., 2022). Patients also believed physiotherapists should be confident in their interactions. However, as much as the concept of a confident physiotherapist was brought up in reviewed works, the authors reported that these underlying concepts and behaviors were not expanded on in the reviewed works (Wijma et al., 2017). In the review by Dukhu et al. (2018), physiotherapist competence and personality were named as ideas that contributed to care that was person-centered. They saw physiotherapists as the ‘experts’ on their pain, and possessing a depth of knowledge, thereby influencing the trust the patient had in their care (Cooper et al., 2008; Dukhu et al., 2018).

Despite the evidence surrounding the conceptualization of patient-centered care, these several reviews (Cheng et al., 2016; Dukhu et al., 2018; Schoeb & Bürge, 2012; Wijma et al., 2017), all noted limitations that still existed surrounding the concept in the field. In the work by Cheng and colleagues (2016), they noted that patient-centered care was non-specifically defined in both the literature and in practice. They felt as though consultation with other professionals was important in order to arrive at an agreed-upon standard (Cheng et al., 2016). In the review by Dukhu et al. (2018), they concluded that the patient-centered care that was desired was not always fostered by the physiotherapist (Dukhu et al., 2018). They bring to attention the work of Mudge et al. (2014) and Hall et al. (2018) who present the idea that physiotherapists seem to still be functioning from a biomedical paradigm, lacking the “advanced communication skills” needed to address patient emotions and put the patient at the true center of care (Dukhu et al., 2018; Hall et al., 2018; Mudge et al., 2014). The review by Wijma et al. (2017) concludes with the idea that further work investigating the physiotherapist's perceptions of PCC was needed, as well as looking at possible differences between conditions and how it may be better implemented in practice (Wijma et al., 2017). The work on patient participation in physiotherapy care conducted by Schoeb and Burge (2012), explains that patients' actual participation often does not reach the level of what they might desire it to (Schoeb & Bürge, 2012). This leaves open a discussion into how patient involvement may be expanded, increasing the level of partnership in the physiotherapist-patient interaction.

Other works have identified a need for expanding the understanding and implementation of patient-centered strategies in care. The ethnographic investigation by Hiller et al. (2015) into physiotherapist-patient communication models is one example. In observation of 52 physiotherapist-patient interactions with interviews of nine physiotherapists, they found that communication happening in these visits was primarily “practitioner centered” (Hiller et al., 2015). In observing the clinical interactions, the researchers noted that there was a focus on the physical aspects of the patient and their pain. Questions asked and terms used were very specific, and the education provided to the patient was done in a scientific, anatomical manner (Hiller et al., 2015). The structure of the interaction seemed to be consistently Physiotherapist-directed as well. It was a repeated structure of physiotherapist questions to the patient, followed by manual therapy and exercise recommendations (Hiller et al., 2015). They also found that the communication was primarily physiotherapist-led in sessions. The physiotherapist spoke more often and at greater volume than the patient, with conversation and questions almost exclusively originating from the physiotherapist (Hiller et al., 2015). However, aspects of patient care with more connection in mind were present. Hiller and colleagues also noted the presence of casual conversation, and touch as communication in sessions (Hiller et al., 2015). Even if the sessions seemed to be primarily guided by them, the physiotherapists still managed to display empathy and communication through increased non-verbal cues and casual discussion. The conclusions drawn from this work, however, were that in the private care environment the physiotherapist-patient interactions were happening in an overly ‘practitioner-centered’ way (Hiller et al., 2015).

Along with research on conceptualizing patient-centered care, there have been studies done looking at perceived barriers and facilitators to patient-centered care in samples of physiotherapists, and healthcare overall (Moore et al., 2017; Morera-Balaguer et al., 2021). Moore et al (2017), explored barriers and facilitators to PCC in a variety of different healthcare contexts conducted by a team at the Center for Person-Centered Care (GPCC) at the University of Gothenburg in Sweden. Semi-structured interviews were conducted with subjects of various projects, including those in acute coronary syndrome, IBS, neurogenic communication disorders, healthy aging in migrant communities, and patient participation in hypertension treatment. Researchers reported that these projects

were chosen to offer a broad scope in terms of the provision of primary, secondary, and tertiary healthcare (Moore et al., 2017). The work by Morera-Balaguer et al., was a focus group study conducted to explore barriers and facilitators for the establishment of a person-centered relationship in physiotherapy care (Morera-Balaguer et al., 2021). 31 participants from physiotherapy units in 2 hospitals and 6 health clinics were split into 4 focus groups where their thoughts and experiences could be explored. A second project headed by Morera-Balaguer was also reviewed, looking at physiotherapist's perceptions and experiences regarding the barriers and facilitators of therapeutic patient-centered relationships in outpatient rehabilitation settings (Morera-Balaguer et al., 2018). Focus groups, comprised of 21 physiotherapists total, from public health centers in one city in Spain, were recruited. Using a grounded theory approach, researchers formed four focus groups to explore the conceptualizations around the topic of these physiotherapists.

These three projects provide useful context for considering what might impede care focused on the patient. A large theme emerging from the work of Moore et al. (2017), was that of the limiting positivist healthcare tradition. The biomedical paradigm impedes practitioners' ability to practice care that is centered on the patient. This is an idea supported in physiotherapy specifically, with the biomedical model being identified as a risk factor for poor patient outcomes in the profession (Daluiso-King & Hebron, 2022; Moore et al., 2017). The next barrier named in Moore's review is the time constraints that healthcare practitioners face. The time available for training, education, and developing partnerships was limited by the fast-paced nature of healthcare activities (Moore et al., 2017). Professionals' attitudes were also regarded as a barrier. Whether conscious or not, they reported reverting to comfortable patterns reflecting a biomedical standard; researchers reported they lack interest, knowledge, or commitment to the standard of patient-centered care (Moore et al., 2017). The work of Morera-Balaguer was conducted from the patient's point of view in physiotherapy settings. A notable barrier described was the physiotherapist displaying a negative attitude or lack of confidence in providing patient care (Morera-Balaguer et al., 2021). Several ideas emerged under this theme of interpersonal manners. Noting inappropriate non-verbal expressions, a lack of sensitivity to change in a patient's mental and physical

status, and a lack of skill in conveying bad news all contributed to the patient's lack of confidence in the care being provided. Patients noted barriers specific to themselves however, including having inappropriate expectations regarding care, or having a lack of affinity with the physiotherapist (Morera-Balaguer et al., 2021). These barriers specific to patients were also echoed in the work Morera-Balaguer conducted in focus groups with physiotherapists (Morera-Balaguer et al., 2018). Participants in this work noted that patients' inappropriate expectations and dependent personalities led to care that was less patient-centered, causing an issue in forming a connection. This work also recognized that physiotherapists saw their age or perceived poor physical or emotional status as a barrier (Morera-Balaguer et al., 2018). They also viewed their lack of training in communication skills as a barrier, saying that patients valued the ability to deliver bad news. Specific to the practice space and environment, they noted that lack of coordination with other services was an impediment, as well as the physical space being too open, preventing a level of intimacy from being reached with the patient (Morera-Balaguer et al., 2018).

Facilitators noted in these projects were of comparable categories; larger-scale administrative ideas under the investigation of Moore et al. (2017), and more specific to the practitioner under Morera-Balaguer (2021). Moore et al. (2017) found organization and leadership can play a strong role in facilitating patient-centered care. As noted by those interviewed, the focus coming from their work with the GPCC helped motivate them to practice in a more person-centered way (Moore et al., 2017). As well, researchers found that training was a large aid. Success was dependent on genuine knowledge of the patient and how to practice PCC, so these skills worked better when taught formally. Finally, the idea of the professional's attitude arose for consideration, as success was shown to be dependent on a professional's skills in communication or '*listening in a different way*' (Moore et al., 2017, p.667). The work of Morera-Balaguer (2021) saw professionalism as a facilitator; the physiotherapist made their competence clear, inspiring trust from the patient. The patient subjects of the focus groups also valued a warm approach; one where empathy was felt and communicated to them (Morera-Balaguer et al., 2021). They also valued authenticity, where the physiotherapist's actions

and words would line up. Shared decision-making also helped the patient feel as though it was care being delivered with them in mind (Morera-Balaguer et al., 2021). In the project focused on physiotherapists' voices, Morera-Balaguer found age to be a factor in instilling confidence and therefore facilitating care that was more patient-centered. Interpersonal manners such as patience, kindness, and warmth in their care delivery helped the practitioner to establish trust with the patient (Morera-Balaguer et al., 2018). In the physiotherapist's eyes, it was also supported by the patient presenting with realistic goals for treatment, as well as the use of a treatment space that allowed for privacy (Morera-Balaguer et al., 2018).

As described, PCC in physiotherapy exists through the utilization of a few different concepts. Shared decision making; ensuring the patient interaction sees partnership between the practitioner and the patient with respect paid to their shared expertise is important. The individualization of care for the patient, tailoring it to one's needs and circumstances is also important, along with the physiotherapist's presentation to the patient in ensuring a confident body language. These are basic ideas present in the literature on the topic, with a number of reviews still noting that the concept of PCC was non-specifically defined, and a standard that was not often reached. With physiotherapists still often operating from a biomedical paradigm of care, there is a need for expanding the understanding of PCC in this field, which this work aims to do. By questioning physiotherapists on how they view the concept, we can then investigate how they may be impeded or assisted in providing it, based on the descriptions they give.

1.3 Research Questions

Patient-centered care is a standard that healthcare aims to meet in this country, but thus far has struggled to, specifically in rehabilitation care (Hiller et al., 2015). This project aims to investigate:

How is Patient-Centered Care described by participants drawn from Private for-profit clinics in Canada?

What do these physiotherapist participants see as barriers and facilitators to providing Patient-Centered Care?

Semi-structured interviews will be used, employing a methodology of interpretive description, first developed by nursing researcher Sally Thorne (Thorne et al., 1997). Benefiting from a grounding in experience and context through background research, it is well suited for research in applied health science fields such as physiotherapy.

1.4 Thesis outline

Chapter one of this work aims to situate the importance of PCC in a broader context. By explaining the benefits PCC brings to a growing, vital field such as physiotherapy it gives the reader a greater sense of relevance as they read this thesis. Chapter one also aims to review the literature on the topic, explaining what is missing from the current understanding, and why this investigation is important in attempting to fill those holes.

Chapter two outlines the methodology of this project, giving the reader an explanation of how the study was conducted: the underlying approach taken towards data collection and analysis through the informing paradigm and methodology.

Chapter 3 is a presentation of the results. The themes are organized under a three-category framework. Originally taken from the interview guide (Appendix E), it went through multiple iterations before arriving at the concise, final version that best displays the themes garnered from the interviews.

Chapter 4 is a discussion of the results, suggestions for future research direction, and conclusions on the project. Connections to ideas in the literature supported by these results are given, along with support for future research through the new ideas brought forward in this work.

Chapter 2

2 Methodology and Methods

This section provides an exploration of the methods, methodology, and informing paradigm of this work, and how they connect to the collection and analysis of data. It also outlines the study processes, explaining how recruitment was undertaken, as well as a guideline of the other steps undertaken. A statement of researcher positionality is also included, as providing the reader context on who is conducting the work is important in establishing legitimacy.

2.1 Methodology

Interpretive description was developed by nursing researcher Sally Thorne with the goal of answering unclear clinical questions that had not proven amenable to investigation using conventional quantitative methods. Nursing researchers were drawn to phenomenological methods as its strong engagement between the subject and experience under study related well to the ethos of healthcare research that each person and experience was meaningful and important (Thorne, 2016). However, issues in methodological coherence arose. Bracketing, a practice undertaken in some forms of phenomenology, involves the purposeful removal or “putting aside” of your pre-existing notions, ideas, and experiences when investigating an experience or topic (Chan et al., 2013). This practice exists in more traditional Husserlian phenomenology to enable observation and interpretation of phenomena as ‘things-in-themselves’. In removing the researcher from the event or idea (phenomena) being studied, it is proposed that the researcher can reach the essence of the experience. Nursing phenomenology then aims to attribute humanism to phenomena where traditional phenomenological thinking views it as nonexistent. Nursing researchers in the field were looking for human description of human phenomena (Yegdich, 2000).

Interpretive description aims to allow for the framing of a study around the disciplinary and epistemological framework of the researcher. It aims to allow for the use of a large

amount of available qualitative techniques and methods outside their classic context (Thorne, 2016). The strong disciplinary grounding is needed to combat the claims of “method slurring” that had plagued the nursing research community. This allows it to be logical and defensible in how it positions the researcher in the investigation (Thorne, 2016). Having an awareness of how knowledge is taken in and made sense of in your field is essential for defensible design decisions. Interpretive description needs a credible question, backed up by an understanding of what is known or not based on available empirical evidence, and an understanding of the conceptual and contextual realm a target audience is in to receive the answers we generate (Thorne, 2016). Common across all qualitative research, interpretive description claims to generalization should be seen as tenuous. However, methods such as this in applied health sciences are important for humanistic reasons. It makes readers aware of important issues, gives voice to the vulnerable or oppressed, and offers a needed critique of health sciences, helping to create humanizing change (Morse, 2016).

2.2 Informing paradigm

A paradigm may be defined as a set of basic beliefs representing a “worldview” of the researcher (Guba & Lincoln, 1994). It is an interrelated set of assumptions about the social world that provides a philosophical and conceptual framework for the organized study of that world (Ponterotto, 2005). It sets the context for the study, and in the case of this research, I am operating from a constructivist paradigm. Within this positionality, I am addressing the project from a relativist ontology and a subjectivist epistemology. Through a constructivist positionality, meaning is hidden in the words of the participants and must be brought to the surface through deep reflection (Ponterotto, 2005). Ontology is the view on the state of reality and what it says about what can be known about it. In this study, a relativistic ontology is used to inform us that reality is comprised of multiple experience-derived mental constructions. It is personal and specific but also possesses factors that can be shared across several people, or whole social groups (Guba & Lincoln, 1994). The epistemology informing the work refers to the relationship between the ‘knower’ and what can be known. This is constrained by the informing ontology. In this

work a subjectivist epistemology is being utilized. This means findings are “created” by the interaction between the researcher and participants (Guba & Lincoln, 1994).

Through the interaction of the researcher and participant meaning can be unearthed in the experiences of the participant. In applying these considerations to the chosen methodology of interpretive description, the goal is to generate new insights that can shape new inquiries as well as translate them into practice (Thorne, 2016). In the constructivist environment of physiotherapists’ caretaking experiences (Plack, 2015), the goal is to enter the ‘field’ in a logical, systematic manner to create an environment where engagement with the data may enhance data interpretation to help inform clinical decision-making (Hunt, 2009). Interpretive description provides an exact philosophical basis and coherent logic for designing and implementing an inquiry that will yield legitimate knowledge for an applied health field (Thorne et al., 1997). Using interpretive description, the goal is to examine a clinical phenomenon, in this case PCC, and identify themes and patterns among the subjective perspectives of participants. Per Guba and Lincoln (Guba & Lincoln, 1994), the realities investigated are socially and experientially based, contingent on the persons who hold them.

2.3 Researcher positionality

Being aware and reflecting on your positionality in qualitative research is very important to increase integrity in the work (Finlay, 2002). Making clear to the reader where my beliefs lie as a researcher through a discussion of past experiences and education allows them a view of the role I have in co-creating the findings. Along with the reflexive journal kept throughout the research process (Appendix A), reflecting on positionality plays an important part in laying claim to the integrity and trustworthiness of the research completed (Finlay, 2002).

As an MSc student, I am neither a practicing nor a trained physiotherapist. I have an undergraduate degree in Health Science, through which I developed an awareness of the workings of the healthcare system in Canada and how this can influence care received by patients at all levels. It allows me to bring a critical attitude to my experiences and the ideas I am presented with in my life. Having dealt with many chronic health issues, I also

possess extensive lived experience in receiving care from a range of healthcare providers, including physiotherapists and surgeons. This allows me to have my idea as to what patient-centered care looks like in both contexts. My experiences receiving care from the same physiotherapist over five years have been what I consider very high-quality and patient-centered. Always placing an emphasis on listening to me, they are very adept at modifying treatment plans based on my current state. Having a chronic physical issue can lead to periods of strength and periods of pain, and their ability to integrate me into the decision-making by trusting what I reported my needs, goals, and current state to be always led to care of the highest quality. This contrasts with what I experienced in seeing the same specialist physician over eight years. In my experience with physical rehabilitation, I was motivated by the empowerment I felt in learning the intricacies of how the human body responds to injury and what the process of recovery looks like. It was this empowerment through education that motivated me to begin research on related topics in the field of physiotherapy, and that led me to explore the gap that was reported to exist in defining and implementing care that was focused on the patient.

These experiences regarding patient-centered care are meaningful ideas to draw on in conducting this investigation. Interpretive description supports full immersion in a field when researching a topic, as it is a methodology for applied healthcare research. So while I may not have the experience of a practicing physiotherapist, the knowledge and guidance of my advisory committee, along with my range of personal healthcare experiences act as great enrichment for the work. My personal bias influenced how the literature was interpreted and the questions I thought to ask, as well as the way the discussion was shaped in the interview sessions. It also may have played a role in shaping the way I analyzed and interpreted the data, however keeping a reflexive journal as I did is a good way to guide and document the process of analyzing data to recognize and see past bias (Thorne et al., 1997).

2.4 Sampling and recruitment

The sampling strategy employed in this work is best described as targeted convenience and snowball sampling. Taking the experience of participants who were close at hand to be recruited was deemed appropriate in this situation as they fit the context of experience

we desired to study. Convenience sampling may run the risk of skewing the researcher's interpretation of the phenomena because of the characteristics of the sample group (Thorne, 2016). Convenience sampling is deemed appropriate in instances where time and resources are an issue, as well as in the early instances of describing a shared experience. Thorne (2016) cautions the researcher to be aware of skewing that may occur in their perceptions due to commonalities among the participants based on their common population of origin. This can limit the credibility of making interpretations beyond the study context. This was deemed acceptable for this work as the major commonality came in the setting where the participants worked. An inclusion criterion was that they all be working in private practice community clinics, as the interest was on PCC in the Private-for-profit sector as it relates to the Canadian health care delivery model. There were potential participants turned away when it was revealed they did not meet this criterion.

There is no widely accepted standard for adequate sample size in qualitative research. Several prior authors have endorsed different “stop rules” regarding the need for further recruitment, including concepts such as saturation. Saturation, which is seen as the repetition of themes or results in a study to the point where these results can be expected, is not the best parameter in the eyes of Thorne (2016). In their view, it is antithetical to the epistemological foundation of healthcare research (Thorne, 2016). In a field where qualitative research aims to give voice to unique patient experience, it is more sensible to look at coherence, quality, and a traceable path of relevant decision-making from the researcher's question to conclusions (Thorne, 2020). In writing about their methodology, Thorne discusses that if what we are researching is the underlying subjective nature of a phenomenon, then a small sample size to share the experience will suffice (Thorne, 2016). They provide a range of 5 to 30, while also discussing the idea that it is not uncommon for time and resources to play a role in decisions to constrain sampling. Knowing this, a sample size of 10 was seen as appropriate due to time and resources being a major consideration in the completion of the MSc thesis project.

2.5 Analytical approach

In conducting interpretive description, the use of an analytical framework is encouraged to orient the inquiry, provide a rationale for anticipated boundaries, and make clear

theoretical assumptions and biases driving the work (Thorne et al., 1997; May, 1989). This framework was adjusted as the analytical process went on, as is encouraged in interpretive description, and scaffolding themes into categories based on questions asked of each participant via the interview guide was broadened as the extent and areas of richness in the data became more clear (Thorne et al., 2004).

In the inductive approach encouraged with interpretive description (Thorne et al., 1997), repeated immersion in the data was practiced concurrently with the data collection process. Interviews from each session were engaged with through transcription, prior to new participant interviews. This was done to allow questions and discussion to be adapted and informed by topics that were arising. Coding was not done prematurely, but rather after several rounds of engaging with the data. Repeated immersion was conducted by listening to audio, transcription, and reviewing each transcription several times. Thorne (1997) encourages a broader approach, such as asking “What is happening here?” and “What am I learning about this?” to stimulate more coherent analytic frameworks (Thorne et al., 1997). In several reviews of the transcripts, MJ began with drafting analytical memos on developing ideas to begin the process of working on themes (Knafel et al., 1988). Upon several reviews of the transcript data, NVIVO was used to organize the themes that emerged under 5 major categories. After repeated immersion and input from collaborators, MJ was able to organize these into a mind map of 4 major categories and corresponding themes. Through repeated revision and input from the research team, this was condensed to three categories and component themes.

2.6 Study procedure

Ethical approval was obtained via the Health Science Research Ethics Board of Western University (Appendix B: **Ethics Board Approval letter**). Once this approval was obtained, recruitment began by contacting the coordinator of policy and research at the Canadian Physiotherapy Association in the interest of advertising the study through their monthly newsletter. The study was advertised as an investigation into how private outpatient community clinic physiotherapists understand patient-centered care in physiotherapy, and the barriers and facilitators they experience to providing it. The inclusion criteria were: working in a community-based private outpatient setting for at

least 50% of their working hours in a week, providing direct patient care with a focus on musculoskeletal rehabilitation, practices within Canada, being fluent in English, and being willing to meet over Zoom. Invitations to participate were also distributed through the professional networks of the research team. All participants were offered the cash equivalent of a \$10 gift card as compensation for their participation in the up-to one-hour interview. Most participants were recruited through these avenues, with three recruited through the snowball approach from prior participants.

When interested individuals contacted MJ, he would then send a unique link to the information/consent letter for the project through Western University's hosting of Qualtrics (Appendix C: **Letter of Information and Consent**). Once this was signed, MJ would email the participant to schedule a meeting for the interview to take place using the script provided (Appendix D: **Email Script for Participant Recruitment**).

Interviews were scheduled at the participants' convenience. The interviews were audio recorded for ease of transcription by the researcher. Interviews lasted from 25 to 40 minutes and followed the interview transcript (Appendix E: **Interview Guide**). Audio recording files were saved with a coded title corresponding to the participant's name in the master identification list (i.e., P1, P2, P3, etc...). The audio interviews were transcribed verbatim by MJ, who also conducted the interviews. These transcripts were labeled with deidentified participant code for analysis.

2.7 Quality considerations

In writing on the methodology, Thorne (2016) comprises a list of quality considerations for when interpretive description is employed. Decisions made in the research process must be defensible, so a thoughtfully developed list of quality criteria is essential to ensure credibility (Thorne, 2016). Thorne (2016) developed these criteria from a number of writings on qualitative research credibility, including the work of Tracy's "*Big Tent*" criteria (Tracy, 2010).

These points of evaluation as outlined by Thorne (2016) will be laid out and connected to the related ideas under Tracy (2010), with support given as to how this project meets

these requirements. The first category under Thorne's criteria for measuring quality in interpretive description is epistemological integrity, which is described as a defensible line of reasoning from the assumptions made about the nature of knowledge to the methodological rules guiding the research process (Thorne, 2016). The next idea put forth for quality is representative credibility. This is described sampling for your study in alignment with the theoretical claims the study makes (Thorne, 2016). The third principle is that of clear analytic logic. The reasoning of the researcher needs to be clear, assuring the reader an inductive analysis took place is not sufficient, the evidence of the logic used must be visible (Thorne, 2016). The final principle is that of interpretive authority. This is the assurance that the researchers' interpretations are trustworthy and that individual subjective truth claims and more generalizable claims are distinguishable (Thorne, 2016).

Under epistemological integrity, it is essential for the researcher to make decisions in the research process that reflect the stated epistemological grounding. This aligns with the idea of meaningful coherence under Tracy's "*Big Tent*" criteria (Tracy, 2010). Work that is meaningfully coherent and shows epistemological integrity will meaningfully interconnect research design, data collection, and analysis with theoretical framework and goals. Decisions made in the research process will align with the positionality and epistemology you place yourself in as the researcher (Tracy, 2010). Meaningful coherence may also be achieved by ensuring study components work well in unison. In this project, these ideas were reached by achieving the stated goals as presented in the introduction chapter. As presented in the discussion of this work, descriptions of how participants view PCC are collected and reviewed, along with barriers and facilitators they report in trying to provide this care.

The next principle is that of representative credibility. Any theoretical claim the work makes must be consistent with how the phenomena in the study were sampled (Thorne, 2016). This is reflected also in the advocacy for prolonged engagement with the data, as discussed in Erlandson et al. (1993). This enables increased contextual understanding for both the native and outside observer (Erlandson et al., 1993). The themes brought forward in the discussion section of this report will be noted as not generalizable to all private-sector physiotherapists. Due to sampling being of a smaller scale in a population

of convenience, the results are viewed as prompts or guidance for further investigation in this relatively novel area of study. As noted previously, smaller sample sizes are acceptable in work utilizing interpretive description, but as the sample was small and the recruitment convenience based, claims of representation cannot be made off the results of this work alone.

The next principle is that of analytical logic, which describes the need for the reasoning of the researcher to be clearly reflected. The process of how the researcher arrived at the interpretations and knowledge claims through their inductive reasoning in the work must be clear (Thorne, 2016). An audit trail, or sufficient reasoning pathway, must be clear for the reader (Thorne, 2016) This is related to Tracy's (2010) idea of Credibility, and more specifically, thick description. This means accounting for the specifics and context of the data by providing clearly situated meanings and providing ample, strong data (Tracy, 2010). As put by Gonzalez (2000), "*things get bigger, not smaller and tighter, as we understand them*" (González, 2000, p. 629), so the author is implored to show sufficient evidence to the reader, rather than tell them what conclusions to arrive at (Tracy, 2010). In this project analytical logic and credibility were upheld through the use of repeated immersion in the data to ensure the points raised by participants were not taken out of context. An important aspect of this was utilizing larger passages from participants to display support for a theme. This provides as much context as possible and is truly 'showing' the reader, rather than 'telling'. The critique and advice of advisory committee members was vital in this regard. Having conducted extensive qualitative work, they were uniquely suited to help MJ see that the passages used were meaningful in what they showed the reader.

The final principle is that of interpretive authority. The reader needs to trust that the researcher's interpretations fairly reveal some truths that are external to their own bias and experience. In evaluating qualitative work you must be confident in what represents a subjective truth claim and what may be more shared or common in nature (Thorne, 2016). An important aspect of this is learning to account for reactivity within the research process, or the reaction between researcher and participant (Paterson, 1994). In completing this work, assistance was given in countering bias by the advice and critique

given during the analytical process by the advisory committee. Being a novice researcher, MJ greatly benefited from having three seasoned physiotherapy professionals to help guide reasoning and decision-making in this process. MJ's experience as a patient in the medical field is of note as well. Having seen numerous specialist physicians and having had dozens of visits to physiotherapy, a unique insight was brought to the work. Different than that of an experienced clinician, but valuable in prompting discussion on this topic while conducting the interviews as it elicits the patient's voice in the discussion on patient-centered care.

Chapter 3

3 Results

The results of this work are discussed here. Under a framework of three categories, the components themes of how patient-centered care is described, and how participants experience the barriers and facilitators to it, are explored.

Ten physiotherapy clinicians from across Canada participated in one semi-structured interview session each, with the session lasting from 25-45 minutes. Years of experience ranged from less than one (at the time of the interview) to 36 years, and an equal number of participants identified as male and female (Table 1).

Table 1- Participant demographics

Participant (P#)	Gender	Years of experience
P1	Male	1
P2	Female	36
P3	Male	21
P4	Female	12
P5	Female	19
P6	Male	<1
P7	Male	21
P8	Female	7
P9	Male	13
P10	Female	8

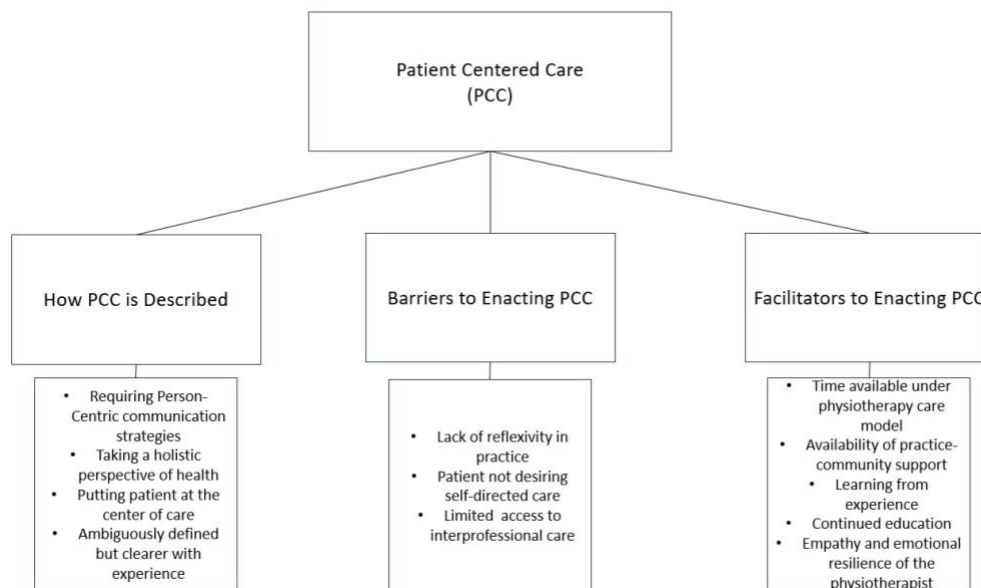


Figure 1- Visualization of themes

The results of the interpretive description analysis revealed richness and diversity in understanding, interpretations, and implementation of PCC. This required multiple rounds of immersion in the data and organizing themes and ideas by MJ, along with several major rounds of revisions as advised by DW, MK, and AR. Based upon the commonalities in discussion with participants, the results are organized into three categories with corresponding themes in each (Figure 1). These are explored in greater detail in the subsequent sections.

3.1 How PCC is described by participants

'Described' in this context was intentionally a broad concept, permitting freedom in how the participants chose to interpret and discuss their understanding in the interview. Their conceptualization of PCC was comprised of several components. These included reflections on how PCC was introduced during their professional training programs, how the concept was either learned, revised, or solidified through their practice experience, and how those experiences have shaped how they currently understand and implement it.

Four themes were identified that describe participants' perspectives of PCC: 1. PCC requires person-centric communication strategies; 2. PCC requires the clinician to adopt a holistic view of 'health' in their patients; 3. Putting the Patient at the center of care; and 4. PCC often defies a singular clear definition, and each clinician arrives at their personal understanding through practical experience.

3.1.1 PCC requires person-centric communication strategies

"Communication" was a common theme throughout interviews, though there were clear differences in how the term was defined and what role it played in PCC. One component that resonated related to asking questions of a patient from a position of *authentic curiosity* about their lives outside of the condition for which they were seeking care. This was described in contrast to 'rote' or 'routinized' questioning of the type often learned in professional training programs, where the questions are dictated by what is expected in a competency examination or as prompted by sections on a clinical assessment form.

Rather, participants understood PCC as asking targeted questions to better understand the patient's "*personal situation in terms of everything else that's going on for them*" (P5). One participant (P8) spoke about a "*meaning point*", that seemed to be a concept related to understanding the meaning ascribed to the condition being treated in the context of the patient's life pressures and values:

"Making sure you understand not only the presenting clinical conditions like an ankle sprain. But also what that ankle sprain means to the person- like what is it limiting, what are the activities they can't do in their life that they're passionate about? ... So understanding what ... matters to patients right... other clinicians have called this ... what is their meaning point." (P8)

Similarly, when reflecting on how their clinical experience had influenced their understanding of PCC, P10 noted that the biggest shift had been in how they now feel better equipped to explore biopsychosocial complexity with their patients. They described the process of moving from a novice clinician, more focused on technical skills, to being a more experienced physiotherapist who can spend "*much more time really truthfully paying attention to the patient*" and building relationships that actively

create space for exploring the more complex, interpersonal, psychological, or social issues a patient is experiencing.

Permeating these narratives appeared to be an endorsement of asking questions of a patient because the clinician authentically wants to know and understand their personal contexts, situations, and meanings. This is done in the interest of understanding them as a *person* rather than a disease process or a paying client. This theme of authentic curiosity; seeing the person first and health condition second seemed to be an important indicator of PCC for many participants.

Empathic communication as a strategy for enacting PCC was identified as important. P9 described the importance of recognizing emotions such as “*fear*” or uncertainty about whether a condition is “*serious, [or] is it something that is going to be simple*” (P9) and how identifying those emotional cues then leads to tailoring communication. This seemed to require the clinician to be fully present and attuned to changes in the patient’s physical or emotional state, knowing when it is necessary to “*calm the client*” (P9) and ensure they feel at ease. P4 described how an empathic communication strategy can facilitate PCC even in the presence of language barriers. This participant indicated a desire to “*want to help them feel engaged*” (P4) even if the patient did not seem to understand the words being used. By effective use of tone and body language in looking directly at the patient when speaking, this participant believed that an empathic approach could lead to a feeling of communicating directly with the client even if the words themselves were not easily understood. Similarly, this participant described how empathic communication strategies can facilitate working with children and their parents in rehabilitation, ensuring that “*they are the ones engaged in their care*” (P4). In different ways, participants indicated a belief that empathy in communication can lead to a connection with a client that transcends spoken language and heightens the quality of care.

Person-centric communication strategies were also recognizable within participant narratives related to actively discussing treatment satisfaction with patients. Participants discussed inviting feedback and constructive criticism from patients on the clinicians’ practice patterns and behaviors identified as person-centric communication. This

appeared to signal a belief that through creating an open space for feedback on practice, these clinicians were enacting PCC by creating a shared power dynamic in the clinic – one where clients could comment on the clinicians’ behavior, in the same way, clinicians can critique patient performance or program adherence. As P4 described, inviting feedback on their own practice helped the participant feel they were establishing a sense of engagement and ownership over the rehabilitation process. *” So, how I engage them throughout all of their sessions, how I incorporate their feedback, their priorities, into the sessions is how I implement (PCC).” (P4)* For the clinician, this opened avenues for conversation and exploration of what had been going well during the visits, what could be done better, and establishing a sense of partnership towards patient-centered goals and treatment strategies.

3.1.2 Taking a holistic perspective of health

Participants described an understanding of PCC that involves a willingness to understand health as a complex biopsychosocial phenomenon and the confidence to explore the often multifaceted and difficult influences on the health of their patients. As P1 stated:

”There's no doubt about it that it can be very draining to crawl into the mud with people and really engage with people who just told you... they lost a testicle to cancer and they're trying to have kids in your session, and to really make space for that conversation, in the context of their physical therapy. But I think it will serve the client better.” (P1)

In the context of providing care for a patient following a motor vehicle collision, one participant described how they consider workplace dynamics, litigation, or home environment and family members when understanding health and creating a treatment plan (P5). When considering a patient who was not progressing, P2 also spoke about considering an expanded view of a patient’s life:

“You look at other factors in their life, such as a sick child, an outstanding divorce; different stresses that may lead to a lack of sleep, and increased anxiety, therefore impeding the patient's recovery. You can then take this expanded view of the patient’s life

and pass along the reality of it to them, shining light on the effect these stressors may have on their recovery.” (P2)

The idea that PCC, and therefore the innate awareness of these holistic factors can become second nature was also discussed. As P3 explained,

“You don’t really think about [PCC] when you’re doing it. It’s one of those things that its who you are as a clinician and ... its really just about respect, compassion... being culturally sensitive to your patient, and ... being very responsive to their needs and belief systems.” (P3)

Ensuring treatment goals were personally meaningful to the patient was also described as important. In the context of goal setting, P6 described asking patients “*What do you need?*”, “*what are you working with?*”, or “*What can I help you with?*”. Another participant (P7) elaborated on the concept of personal meaning when establishing treatment goals that respect the totality of a patient’s life context. Invoking the value of understanding the “*why*”, this participant used the example of a patient with back pain who expressed a desire to be able and interact with their grandchildren more: “*We don’t necessarily need your back to feel better, but we need you to be able to pick your grandkids up off the floor.*” (P7).

3.1.3 Putting the patient at the center of care

Participants described PCC in a literal sense of placing the patient at the center of all aspects of physiotherapy care. They spoke about ensuring that “*what their goals are, or what their preferences are for treatment, what they found works for them in the past*” (P6) are prioritized as critical pieces of clinical information when partnering for goal setting. The concept of partnership was discussed as important. P4 offered “*its shared decision making with the focus... on what the patient needs, on what they want ... with the practitioner... viewed as someone else on the team.*” One participant (P7) stated: “*That’s where the patient-centered care comes from, it has to be all about them.*”

3.1.4 Ambiguously defined but clearer with experience

Some participants described difficulty defining the concept or boundaries of PCC, with narratives indicating that it is an idea not well defined in the physiotherapy professional community. As P1 stated, it “*seemed to [them] to be pretty poorly defined, and kind of weak in terms of what exactly It looked like, and what the implementation of [PCC] looked like.*” P7 took the view that what was taught in Physiotherapy education was a “*superficial understanding*” compared to an understanding learned with clinical practice as to “*how many more factors there are that are a part of patient-centered care*” beyond “just goal-setting”. Others supported the idea of this superficial conceptualization. As described by P8, PCC is a “*black box*”, or a term that is “*thrown around*”. This participant further shared:

“I think it sounds good but nobody really knows what it means. It’s never, that I can remember, been formally defined for me, in any capacity, and if it has been it’s been such a confusing and long-winded definition that I don’t remember it.” (P8)

3.2 Barriers to providing PCC

Barriers to providing PCC were described broadly, leading to three themes. 1. Lack of reflexivity in practice 2. Patients not desiring self-directed care, and 3. Limited access to interprofessional care.

3.2.1 Lack of reflexivity

While described by only a single participant, a potentially important barrier to PCC was what that participant described as a lack of willingness on the part of many physiotherapists to engage in authentic self-reflection. This participant appeared to endorse a perception of PCC that is necessarily contingent upon the practitioner’s awareness of, and willingness to challenge, their own biases and values in care provision. This participant (P7) shared an example of how non-challenged assumptions held by the clinician can interfere with PCC in the context of a patient who only has partial insurance coverage for PT care:

“You can’t tailor your care to what [insurance coverage] [sic] you think they might have. You ... have to tailor your care to what [treatment] they need and the patient can discuss [payment limitations]... with you” (P7).

In this context, there appears to be an implicit understanding of PCC as an approach to practice that requires a reflexive practitioner.

3.2.2 Patient not desiring self-directed care

Participants described what they perceived as a barrier to PCC being patients who do not desire self-directed care decisions. Participants described interacting with patients who want the physiotherapist to make treatment decisions for them. As described by P4, patients come in looking for a more *“traditional authority”*. Many of such patients, in the physiotherapist’s experience, seem to be older individuals who are surprised that the practitioner is asking them for their goals rather than setting goals on their behalf. P6 describes:

“ [some] patients aren’t used to directing their own care ... They’re used to being told what to do and when to do it. And leaving it all up to the person who’s making the decision. And I think that’s kind of how a lot of our healthcare system has been run for a long time. And that’s where the patients usually say “well, you’re the professional, you tell me what to do”...it just means that the principles of PCC are a little bit harder to apply in those circumstances ... you can probe and probe, and probe and maybe people just don’t want to be the ones directing care.” (P6)

Going into a patient interaction with an understanding of PCC as requiring patient involvement, and some level of shared decision-making can be impeded by differing patient desires. Adjusting plans and care approaches is how they manage these differing expectations of care.

3.2.3 Limited access to interprofessional care

Physiotherapist participants described difficulties with easy access to other healthcare disciplines as a barrier to enacting PCC. Participants described the complex nature of

many patient cases as requiring services or interventions they may not be able to provide themselves or even know how to access. For example, P5 noted:

“there’s a disconnect in professions In terms of knowing what the resources are or where to be referring or even my ability to get somebody to someone who can help with certain things, and whether that’s available. So obviously with something like an MVI (motor vehicle injury) that might actually be easier to access for somebody cause there’s funding potentially for some of those things. But I have to know it exists to refer them. Or to recommend the doctor refer them. But there isn’t necessarily a lot of other information available out there in terms of what else may be available or it’s not easy to come by and even if you are aware its available, is it available within the community, and who do you access, who does these things?” (P5)

P8 talked about patients needing the help of other types of healthcare providers with whom they may not have easy or prior contact with. P8 described a feeling of being held back by what they are not able to provide, which limits their ability to enact PCC. As they describe:

“Sometimes people who come in to see us need the help of multiple different practitioners, and as physio[therapists] we cannot prescribe pain medication, we cannot send people for imaging, we cannot provide a lot of different things. So if a person is in 10-out-of-10 pain ... they probably also need a pharmacological intervention to improve their pain before they can see us. Or [sic] they need psychological support and counselling as well because... being injured is very depressing especially if you can’t do the things you want to do But our healthcare system is not really set up that way and those things cost money and that’s problematic.” (P8)

3.3 Facilitators to providing PCC

Five themes were forefront in discussion of facilitators to PCC. The time available with patients allowed physiotherapists to build a connection. Support from their practice community allowed for a symbiotic sharing of ideas and experiences that were conducive to PCC. Practice experience and continued education facilitated PCC by opening the

participant's eyes to the complex realities of treating human beings that could not be entirely grasped through their licensing education alone. Finally, having the right personality, one where they could communicate with the patient in an empathetic manner was also seen as a facilitator to PCC.

3.3.1 Time available under the care model of physiotherapy

The time with patients and the independence offered under the care model of physiotherapy was described as a facilitator. As P1 said, spending around 45 minutes with each patient is beneficial.

“[having the time] to be able to build a rapport and talk to people about their condition in ... detail and really capture ... the impacts [on] their Quality of Life... [this] makes people trust you and it allows you to think about your plan of care ... in a way you couldn't do if you were only having a 10-20 minute visit with someone.” (P1)

P7 echoed this sentiment, saying *“When we look at physicians, certainly specialists... they just don't spend that much time with people so they can't dive [as] [sic] deep into the patient's wants and needs as a physiotherapist “ (P7)*

Having increased time to spend with each patient was beneficial in participants' eyes, as it allowed a deeper connection to be fostered compared to what a physician can do, and therefore assisted them in providing patient-centered care.

3.3.2 Availability of practice community support

Being a part of a practice community that values PCC approaches was described as important among participants. Having a community of physiotherapists who share their specialty with whom to discuss the intricacies of enacting PCC was described as “integral” to how P4 practices as a clinician. Also, knowing PCC is becoming more of a focal point in the profession gives clinicians a sense of empowerment to know, as P4 says, that those working around them *“are mindful of [its] importance” (P4)*. P10 echoed this sentiment, discussing the benefits of being able to draw on their coworker's unique skills and experiences:

“I think the openness in our clinic of us all being willing [sic] to help each other ... we share patients all the time, and bounce ideas off each other, and that’s been helpful I think in reaching those goals in ensuring client-centered care. Especially with everyone having taken different courses and having different skill sets outsourcing that and not just trying to take it all on yourself, and recognizing that maybe someone else can help them meet that goal a little bit better in a certain time.” (P10)

The symbiotic nature of a practice environment where each Physiotherapist is aligned on the importance of PCC was experienced as a benefit to the practitioner and patient experience.

3.3.3 Learning from experience

Gaining experience also played a role in facilitating PCC. As succinctly put by P3, *“You can’t understand PCC until you actually practice as a clinician.”* Participants described that as they began working they would gain the experience needed to deal with the complex interpersonal nature of providing patient-centered care. As P4 says,

“When... you’re a new practitioner or recent graduate, [sic] ... I had a certain idea of what my sessions might look like with clients. And I would say it’s changed drastically with a focus on those personal elements that now I am quite comfortable with. I think we have certain expectations of how things might be and over the years I’ve realized there’s only so much you can predict or know. So I’m far more comfortable with managing things [and] addressing things as they come up unexpectedly” (P4)

Part of building up this experience is learning communication skills such as compromise. Discussing how they encourage buy-in during the session, P6 talks about the trade-off that may be made.

“If they’re asking for modalities – if that’s what gets them to do the exercise, then I’ll do that because I know... it’s going to get them better overall if I do the ultrasound on someone’s knee. Is there great evidence for that? No, no there’s not, but it gets them to do the exercise, and that’s what’s going to get them better. So it’s a little bit of “I gotta play around with this a little bit” and finding out what’s worked with people and what

their goals are is the biggest thing I've been improving in my clinical practice and trying to make things more patient-centered “ (P6)

Participants were clear in outlining the benefits that come from giving their practice skills time to develop, and the improvements that come for the patient with time.

3.3.4 Continued education

The benefit of new knowledge in facilitating PCC is reflected in participants' discussions of their continued education in the physiotherapy field. These programs helped the participant to see the importance of learning how lifestyle factors play a role in the patient's well-being. P2, who owned and operated several manufacturing plant clinics, completed a Master of Science degree focused on patient outcomes in these settings. Seeing the effect sleep, nutrition, or workplace ergonomics had on patient outcomes forced her to *“adapt and understand how that might impact [the patient's] health”* Factors such as the patient's relationships within the workplace also played a role in how the patient might respond in their recovery. So, as P2 explains, *“learning [acquired during Master's education] that over time helped me shape how I can manage these various individuals by being an advocate for them and helping them understand the impact that might have.”* (P2). P10 echoed these ideas. Having completed an advanced integrative musculoskeletal program and holding the credential of Fellow of the Canadian Academy of Manipulative Physical Therapists (FCAMPT), they had to think about *“the patient and not just the injury in front of [them]”* (P10). During their advanced education, they were presented with numerous cases involving a lot of detail around lifestyle, activity, and social or environmental factors. Additional education in the field was described as a way to assist some participants in expanding their understanding of the holistic factors affecting a patient's health.

3.3.5 Empathy and emotional resilience of the physiotherapist

Empathy (the ability to experience someone else's emotions) and emotional resilience (the ability to cope with the negative emotions of another person) were discussed as aspects of connecting with patients and facilitating PCC. P10 reported that being a social individual helped them to connect with patients and get to know them. They also

discussed how empathy and showing they care about “*every little problem*” (P10) was helpful in providing PCC. They are aware of the importance of not letting emotions bring them down so they may continue to facilitate that deeper connection with patients, however. As they say

“Once I'm finished with that person if there's no serious issues, I can wipe it out of my brain. And I think maybe having a good mental health foundation as a physio is helpful in that way because you can get pretty bogged down when people are going through some tough stuff and they're unloading on you and they need to get it out somewhere. So just making sure you have a good foundation there. And you know your own strategies there is really helpful and has allowed me to do that a little bit better to support them” (P10)

As a clinic manager and owner, different components of the “right” personality were also something looked for in the physiotherapists they hired. As explained by P7, a clinic owner,

“We probably put more emphasis on [patient-centered skills] than the physiotherapy skills. Even when we're going through our recruitment process, we always tell them, we hire based on personality, on coachability... we need the people with the personality, the willingness to be coached that we can help to you know really develop empathy, that effective communication with patients.” (P7)

The ability to practice empathy and show associated emotional resilience was discussed as being important to assisting participants in practicing PCC.

Chapter 4

4 Discussion

A review of the ideas discussed in this project will be presented here. Connecting relevant themes to support existing literature lends relevance to the ideas brought forward in this work. Also, we present a discussion of areas for future investigation based on ideas collected here, along with limitations recognized through the method chosen, and a conclusion for the project.

4.1 Discussion

The examination of physiotherapists' description of patient-centered care, along with their experience of barriers and facilitators in their efforts to provide it, garnered several themes organized under these three categories. Participants depicted a number of themes in their description of how they define patient-centered care, including putting the patient at the center of care, taking a holistic view of health, along with PCC requiring Person-centric communication strategies. In investigating problems in the implementation of PCC, participants listed notable barriers such as a lack of reflexivity in practice, differing patient expectations, or limited access to interprofessional care. In discussion of aspects of practice that assist them in providing PCC, ideas such as practice community support, experience in practice and further education, and their own empathy and emotional resilience as practitioners were noted as important.

Participants' descriptions of PCC revealed many commonalities across reviews previously conducted in the field. The first theme was the participant's view that person-centered communication strategies were important to providing PCC. A major component of this was questioning the patient from a position of authentic, human interest in them as a person. This was supported by ideas found in the review by Naylor et al. (2023). Viewing the patient as a unique person, with a style of care reflective and adjusted for their needs was shown to be an important component of person-centered care (Naylor et al., 2023). There was great value in tailoring therapy to something meaningful, familiar, or of interest to the patient (Ahlsen et al., 2020; Naylor et al., 2023), as also

discussed among participants in our study. The importance of showing and practicing empathy has also been noted in the literature. It was outlined as an essential characteristic of physiotherapists with emotional intelligence; an essential component of person-centered care delivery (Killingback et al., 2022; Naylor et al., 2023). Feedback and collaboration, as described in our work, were also previously shown to be important aspects of patient-centered care, with collaboration being a main theme of the review on the qualities of a ‘good’ physiotherapist by Kleiner et al. (2023). Within this theme of ‘collaboration’, Kleiner notes the importance of individualizing treatment and accommodating patient preferences based on feedback (Bernhardsson et al., 2019; Cooper et al., 2008; Kleiner et al., 2023).

While not an idea that was widespread among participants, the sentiment that practitioners needed to be reflexive in their work and providing care came across as an important idea. It resonates with the finding in research that physiotherapists experience difficulties implementing patient-centered care principles into their practice (Dukhu et al., 2018; Hall et al., 2018; Hutting et al., 2020; Mudge et al., 2014). One participant mentions the need to be aware of your own assumptions, as they talk about the coaching they give to their clinic employees on not assuming insurance coverage when planning care. This may be supported by critiques raised of the experiential, apprenticeship-based learning model of physiotherapy. The focus being put on the replication of outcomes from an expert neglects the idea that profession-specific learning should be adaptive; giving the practitioner the tools to tackle sociocultural, or interpretive situations (Delany & Watkin, 2009). As noted by Ziebart & Macdermid (2019), reflection as a practice in the field of physiotherapy needs greater attention and would benefit from an established framework to assist in implementation (Ziebart & Macdermid, 2019).

Limited access to interprofessional care spans the scope of three major ideas brought forward by participants. Resource availability, awareness, and cost were discussed by participants, especially in rural communities and practice settings. These ideas all seem to be relevant when looking at the healthcare environment in this country. In a ranking by the Organization for Economic Co-operation and Development (OECD), Canada continually ranks average on healthcare performance despite spending almost the most

per capita (Lee et al., 2021). Critique has been raised over the comprehensiveness of Canada's healthcare system, which can diminish its effectiveness. Quality of care is decreased when primary care is covered, but services such as pharmaceuticals, mental healthcare, and other allied health professions require out-of-pocket costs (Lee et al., 2021). As mentioned by participants, there is the potential for mental health intervention when undergoing physical rehabilitation. Participants discussed the issues related to this, including difficulty in access and affordability of mental healthcare, which is a point of contention for many across the country (Moroz et al., 2020). Issues in accessibility of mental health resources are especially of note for those in rural environments of the country. Ontario for example, sees most of its psychiatrists and mental health professionals located in more densely populated Local Health Integration Networks (LHINs), with those in rural environments being closer to retirement on average, increasing the risk of further shortages (Friesen, 2019).

Participants discussed issues they had with awareness of resources or interprofessional communication. There has been an increase in team-based care models across the country in the last couple of decades, especially with the advent of the Family Health Team model in Ontario (Marchildon & Hutchison, 2016), an idea that can be conceptualized as the integration and cooperation of different healthcare professionals to optimize the use of healthcare resources by complimenting each other's competencies and skills (Donnelly et al., 2019). Family physicians come together to work in tandem with other professionals such as social workers, pharmacists, or physiotherapists (Donnelly et al., 2019).

Participants recognizing issues in connecting with this framework, and patients not having access themselves may be an area for future research. As the work by Donnelly et al. (2019) notes, across Canada there is little evidence as to whether the intended outcomes of interprofessional teams are being met (Donnelly et al., 2019). Performance indicators for these teams are often focused on physician-centered data, leading to a question of how other allied healthcare workers fit (Donnelly et al., 2019).

Gaining skill in something as it is practiced is an intuitive idea. Presented as a facilitator to patient-centered care by participants, gaining skill in patient-centered care through experience represents the idea of mastery-approach goals (MAP). MAP goals focused on

developing competence and acquiring task mastery. They are seen as the most optimal type of achievement goals for academic and life outcomes (Guo et al., 2023). It is noted that novice physiotherapists feel the stress of a transition period as they begin their own practice following graduation. While the problem-based learning model employed in their education is well suited to performance in interprofessional and social domains (Gunn et al., 2012), clinical reasoning, professional behavior, and effective interprofessional practice were all areas identified as underdeveloped in an interview study of new physiotherapy graduates and the more experienced physiotherapists they worked with (Stoikov et al., 2022). The Master's level certification program required in Canada has also been described by Physiotherapists as "too short", leaving inadequate time to reflect on and consolidate learned material (Walton, 2020). Physiotherapist participants of the work by Walton (2020) saw the education programs as missing topics such as advocacy, communication, empathy, and cultural safety (Walton, 2020). Continued education is also shown to play a role in increasing physiotherapists' clinical skills. Enhanced clinical abilities, along with increased job satisfaction, fulfillment of personal goals, and professional advancement were all seen as perceived benefits to continuing education programs for physical therapists in Canada (Sran & Murphy, 2009). While there was no specific focus on the benefits it makes in dealing with the interpersonal side of the patient interaction, as one would when providing PCC, it is still viable support for the idea that furthering your education after completion of the physiotherapy degree offers an opportunity to build upon existing competencies. In symbiosis with growing from what has been recognized as a possibly under-prepared beginning immediately following education, there is further evidence to support the growth in competencies that continuing education can bring for physiotherapists.

The importance of empathy and emotional resilience among healthcare practitioners is also well documented. As noted in the work by Morera-Balaguer, when looking at facilitators of patient-centered care among patients, interpersonal manners were highly valued. Traits such as warmth, empathy, kindness, and conveying positivity were listed as components (Morera-Balaguer et al., 2018). The ability to emotionally engage with many patients so they all feel the conveying of empathy is also an important aspect of patient-centered care in healthcare (Jawad Hashim, 2017). Practicing empathy itself can lead to

increased resilience among healthcare workers, an idea displayed in an investigation of social workers in India (Selwyn & Bhuvaneshwari, 2018). This lends credit to participants' view that emotional resilience was important in providing PCC. Various factors may interfere with a healthcare professional from being able to practice this interpersonal skill however, such as high patient load, lack of self-awareness, fear of boundary violations, or a lack of appropriate training (Moudatsou et al., 2020).

4.2 Areas for future research

This work should be considered an exploratory investigation in a relatively under-researched area. An expansion of this study, broadening the sample size and making recruitment more purposive, would be a logical next step. Qualitative works with smaller sample sizes, such as this project, hold value for prompting the rethinking of ideas and inspiring new thoughts. However variance in a sample is warranted to get a better ability to generalize findings in interpretive description (Thorne, 2016), therefore doing so on the subject matter covered in this project would be a warranted next step.

While there was existing literature to support some of what was communicated in the discussion of perceived barriers and facilitators, not all the themes had been previously reported to our knowledge. Broadening understanding around the role of practice community support in providing care would be an effective way to expand the understanding of physiotherapy practice. Prior scholars have documented the importance of social interaction in relation to best functioning (Hale et al., 2005); we need resources from others for proper psychological function (Jolly et al., 2021). These resources come in the form of social support or psychological resources coming from those around us, such as in the workplace. The support received may serve a buffering role between one's appraisal of stress and environmental stressors (Viswesvaran et al., 1999). An investigation into the specifics of how this concept works in healthcare environments, such as physiotherapy, would be warranted. Exploring how physiotherapists lean on each other for support, in the pursuit of PCC or otherwise, would contribute to a broader understanding of what it means to provide care.

Another idea in need of further examination is the concept of interprofessional communication in healthcare. Participants mentioned the struggles they sometimes faced when connecting patients with other resources, and as previously mentioned, there is little evidence of whether the intended outcomes of interprofessional care teams in Canada are being met (Donnelly et al., 2019). Ontario for example, operates under a model of Family Health Teams (FHT), where comprehensive primary care is provided by a team of physicians, nurses, and interdisciplinary health professionals (Government of Ontario, 2005). However, this leads to a question of how patients contact further resources when needed beyond those offered within the FHT. In work looking at how physiotherapists in Ontario see their roles within the broader role of interdisciplinary care teams, participants noted the importance they see in being able to implement management plans for patients by understanding the broader healthcare system and community resources (Dufour et al., 2014).

Research and literature in this area of healthcare seem to use “patient” and “person” centered care interchangeably at times. Several reviews covered in research for this project were titled with one term, then incorporated an examination of papers that may be titled with the other term (Cheng et al., 2016; Dukhu et al., 2018; Killingback et al., 2022). It is a common discussion across these reviews that a cohesive definition is lacking in the field, with another point being raised that we must accept the ‘fuzzy’ nature of the concept and focus on the implementation of a network of ideas when practicing it (Killingback et al., 2022). Due to the free use of both terms, “patient” was chosen as it seemed more common and therefore more likely to resonate with participants. The terms are used interchangeably throughout reviews and qualitative investigations, however in a comparison of the two, Håkansson Eklund et al. (2019) outlined the idea of person-centered as having much in common with patient-centered care. These commonalities included empathy, engagement, respect, and a holistic focus (Håkansson Eklund et al., 2019). However, they did note some differences, mainly in the way studies defined or operationalized certain ideas. When describing patient-centered care in this study, participants seem to describe a concept that lined up with the distinct idea of person-centered care as it was presented in that review. This leads us to the conclusion that the difference may be worth investigating further. Investigating the ways practitioners in

other health fields, as well as physiotherapy, conceptualize the two concepts; is there a meaningful difference in terms of the method of care they put into practice?

4.3 Limitations

Interpretive Description thrives off the use of field-specific knowledge in conducting research. Although not a trained physiotherapist, the primary researcher conducted ample background research and has abundant experience in being a patient, both through the healthcare system at large as well as in physical therapy. This, along with the supervision and assistance of Dr. Walton, Dr Kleiner, and Dr. Rushton, lends legitimacy to the views and ideas presented in this work. Interpretive description also benefits from multiple interviews with participants, as well as numerous forms of data collection (such as observational techniques). There is no doubt these would have strengthened the quality of data collected, however, due to time and practicality constraints, they could not happen. Participant recruitment was capped at a sample size of 10. This was not done on any claims of saturation in the data, but simply time constraints and feasibility, though is in general alignment with other studies using the same research method. However, that does not detract from the quality of the information collected, as it still offers a good beginning to investigations around the idea of barriers and facilitators to patient-centered care in physiotherapy. This study was the first of its kind that we could find looking at these ideas in Canadian private care physiotherapists, in expanding or building on the ideas presented it would be warranted to look at other practice fields of physiotherapy. Hospital-based inpatient care, home care, schools, or nursing homes are all areas of practice that may present distinct challenges for practitioners which would be worth investigating.

4.4 Conclusion

In conclusion, this work provided the useful beginnings of insight into how physiotherapists perceive patient-centered care, as well as their experience of barriers and facilitators to providing that care. Using interpretive description, semi-structured interviews were conducted with a total of ten participants equal numbers of men and women. Through this process, several themes were described under the ideas of how

patient-centered care was described, and the barriers and facilitators that participants experienced to providing it. A number of these themes showed support to existing ideas in the literature, such as the importance of person-centric communication strategies, taking a holistic view of health, or putting the patient at the center of care. This lends support to the conceptualization of PCC being relatively cohesive in the Physiotherapy, however, broader studies involving a greater variety of practice voices would be warranted to get closer to making this claim definitively.

Insights into the way participants described patient-centered care, along with the ideas presented in the discussion of barriers and facilitators provide useful insight to guide further investigation. Barriers such as limited access to interprofessional care, or facilitators such as the role of practice community support all play a role in the practitioner's ability to provide care focused on the patient. Further exploring these ideas will give the practice community a more definitive picture of the practice experience of physiotherapists working in this country, and therefore the best way to empower them to provide the highest quality care.

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Appendices

Appendix A: Reflexive Journal

March 6th

- Have spent a few days reviewing distinctions between person and patient centered care in the literature. Having done considerable research at this point, to me it seems as though with how broad and un-defined the ideas are overall in the field there is not a major difference at least theoretically. I recognize that in practice this could be totally different, but at least right now this is all I can go off of.

March 20th

- Finished transcribing first interview. They had a lot to say about how they viewed pcc as opposed to barriers. I guess that makes sense though if they feel like they practice it well and have a lot to say about how they see it? I get the sense some may not want to discuss barriers in that it could paint a picture they don't do a good job. But that is also how I view things sometimes so I should try not to project that onto participants. They made a point about how the pay for service system is helpful in it breeds commitment. My initial reaction to that was disappointment. I would never see out-of-pocket costs as a good thing, and as someone who has had to pay plenty of my own money in Physiotherapy treatment I do not enjoy having to pay. However, I understand as a practicing Physiotherapist they only mean that the patients who do come to see them are more motivated to commit and try, as they are putting money into it themselves. They still made the point that they wish it did not cost anyone out of pocket expenses at all, just that there was some positives to it.

March 31st

- Have around 8 ppl set to take part now. A few emails are waiting to come back to confirm. Thinking about the "framework" I initially put in as the structure for my analysis. The Santana paper was relevant, but as far as instituting it as a framework does it just go as far as informing my interview guide, and then structuring my analysis from there? I have each question set up as a heading with the relevant subheadings/themes underneath. Thornes writing makes note of being aware of clinical predispositions to leading a conversation as one would

in a clinical setting if you're making the move to researcher. I see myself as safe from that specifically, being a student with no clinical experience.

April 3rd

- Conducted an interview today. Second one overall. Nerve wracking experience to a degree, but I am finding as long as I focus on what they are saying, I am digesting the important components well. Stumbling a little as I try to organize thoughts seems to happen but as a novice researcher I feel as though this cannot be avoided. Transcribing an interview currently. I get the sense that a possible limitation of this work may be that as a physiotherapist you may only want to talk to a researcher about PCC if you explicitly make it a focus. "in our clinic" "we make a point of" etc it may be the reality that those who experience real barriers are not the ones who will want to talk to me about how they view or experience PCC.

April 4th

- Feel like I'm getting the hang of things a bit more in terms of interviewing. Learning how to best phrase a question that isn't too limiting based on something they say that piques my interest.
- Also still transcribing. Going back on what I said in regards to only ppl with things to say wanting to participate- I think this is a good thing. They have thoughts and feelings on the subject they want to share as they seem to make it a strong point in their everyday practice. The passion they have will lend itself to rich explanations or conceptualizations.

April 6th

- Participant asked if I was going to define PCC for them when I asked how they defined it. Interesting question that I hadn't considered, I guess I need to be more clear about WHY I'm asking that when I do. I guess ppl always feel as though they're being tested.

April 8th

- Transcribing session where respondent used a lot of language like “I think a lot of ppl would say” when talking about pcc and how they saw it. Interesting to me it feels like they think they’re on trial and are kind of echoing the initial sentiment they came in with which was that they didn’t know what pcc was as it wasn’t defined well in the literature and practice.

April 11-

- in discussion of comfort in providing care and dealing with ppl when fresh out of school compared to currently, I need to watch how I ask that question. I kind of ramble a little and add more to the question than I need to. Asking P6 about experience when right out of school compared to now I took it from an open question to a more closed one by the end so I should just work on stopping myself there. Own anxiety in trying to do a good job comes into play, need to work on keeping my head from racing.

April 12th

- Participant today was discussing importance of speaking TO children or those who spoke another language when treating them, and my own experience in healthcare sort of took over. Compared to the specialist I had at a children’s hospital vs who I see now and the difference in care and communication. Maybe it was a little biased to speak on my own experience but I feel as though it added to the conversation as I was able to relate and support this strategy they had for providing care.

April 18th

- Heard from many that experience makes them more able to focus on interpersonal side of the practice. Interviewed someone who teaches a bit who seems to think they are more likely to be good at pcc aspect when they are fresh out of school. Interesting to compare the two, im not a physical therapy student so I cant truly speak to what the education is like, but my experience as a student overall makes me wonder if it’s the bias of the prof coming through. Would seem more intuitive to think skills are more refined with experience.

May 11th

- I've been working on analysis for a couple weeks now. It's a tough process, its difficult to go through what's been said and try and capture the bigger picture while also using a fine tooth comb to make sure I'm picking up on all the ideas that are hiding between the lines. I'm sure this comes from being a novice researcher and not an educated physiotherapist as well so its just a process I need to focus on.

May 22, 2023

- "well I think its expectations really has been the toughest. Ppl that feel like they should be better yesterday or they want uhm a treatment that is really not been proven to be useful. Whether its that's cupping or various other modalities that were vogue during the Olympics its like well that's not really why it was done for your problem. So managing expectations is really the biggest and trying to find ways to help if its not the treatment program that I can provide that is going to make a difference, its helping them understand different options that might be a bit more suitable for them and for me to deliver that make sense from a professional perspective"
- Trying to make sense of this passage in the realm of barriers they experience to pcc. On the surface its clearly as simple as saying "managing expectation" but I feel as though there's a relevance here to the idea of the balancing act they have to play? Yes they need to include the patients goals and ideas and preferences but as much as they may want the patient to take the lead, they are still very well informed and need to have the final say. Maybe it is biased to take the view that they will always know more than the patient, maybe its more about intentions and the manner in which they want to provide care. They let the patient know what would be best, but still provide what the patient wants if it happens to be something else, etc.

May 30th

- There is a passage in P8 interview where they talk about patients who have no desire to change and nothing going on in their life. I had a response that I think they didn't understand but reading it now I can tell I was slightly bothered in the moment by them saying that only because of my own experiences dealing with injury and recovery. Reading it now it does not provoke a reaction as I can tell what they meant, but its interesting to me to look back on it now and realize it

kind of led me down a different path. I composed myself in the moment, but I can see my response and next question was more reacting to how I felt rather than the substance of what they said. Seems to be a tough part of this at times but at the same time I think it's a good element to bring to healthcare research, you always need a personal investment.

June 16 2023

- Consolidating codes. A few instances where I feel as though more context or information would help me. But I think this is just a natural limitation of being a first time researcher. Not to excuse it but it would be something I'd get better at with more experience.

July 8, 2023

- I'm trying to rephrase the idea of collaboration under holistic communication. The ideas underneath are interlinked but I am struggling to think of the best way to phrase what the commonality is, as collaboration doesn't work. Would "patient-oriented actions" work? Is that not too obvious.

July 9, 2023

- I am going to go with helping the patient to help themselves. It gets at the idea that as care provider you are using your skills to help the patient get more involved and be able to take part in the process in a more active way. Empowerment was always a big part of what I personally see as quality care, but I am confident that this idea holds objective legitimacy.

July 11, 2023

- How well does reading between the lines and inferring from the patient interaction fit below helping patient to help themselves? Is this making assumptions with too much power as a practitioner, i.e not respecting the dynamic of working together? Shared decision making but the physiotherapist is always in the drivers seat?

July 21, 2023

- It can be difficult to iron out what you know, what you don't know, how you know it and how to present it not only as a researcher but as a student researcher in a field where you aren't a practitioner. Feeling frustrated trying to iron these ideas out, but I recognize the opportunity to grow and learn the needed skills here.

August 21, 2023

- I am attempting to condense my results section and make it more succinct. Down from 16 pages single spaced to about 9 right now. It's a difficult, frustrating process because I want to keep everything in there but its opening my eyes to what producing good qualitative work is, as you need to make decisions on what results are worth putting forth. Its engaging in a way too as its pushing me to be a better writer and really think about what I want to show when this project is done.

September 16th

- Just a small note, I am removing a part of the results where I felt like a very articulate point was made. However, it does not match with any other ideas raised throughout the research process. I still feel as though it is valid as it was a great example of a practitioners thought and experience, but I suppose this is a case of forming an attachment to a piece of data as it is making a point you feel would be great evidence to introduce. Is there overall legitimacy to it? I feel like there is, but it is a case of being able to present results as concise as possible for this project, so I had to remove it.

September 23rd

- Working on methodology currently. Real test of how to best communicate what I understand of the methods used and describing my own positionality. Makes me realize how different the approach to 'data' is in a qualitative work compared to the very positivist approach you get year after year in grade school and high school. Can be a difficult thing to contextualize at times.

October 18th

- Working on my introduction chapter currently. Had begun this last spring before starting interviews and basically had to rework what I had done, which was several pages. I didn't like the plan I had in place for it and felt I could do something better. Interesting and rewarding to see how that decision to rework came so quickly and naturally, it really makes me feel as though I am growing as a researcher here and getting what I should be getting out of this project. The plan I have in place now should flow much better and be less choppy.

November 17th

- In completing the discussion, it is so interesting to see all the ways my results are supported in different ways through the literature. It makes the whole process very rewarding and makes me feel as though a good job was done. I recognize the limits of the research in the way I completed it, but I am still very happy with what is put together. It was a long process but still a rewarding one.

Appendix B: Ethics Board Approval letter



Date: 18 January 2023

To: Professor Alison Rushton

Project ID: 120841

Review Reference: 2023-120841-75106

Study Title: Exploring barriers and facilitators to implementing patient-centered care as experienced by community-based physiotherapists

Application Type: HSREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 07/Feb/2023

Date Approval Issued: 18/Jan/2023 15:38

REB Approval Expiry Date: 18/Jan/2024

Dear Professor Alison Rushton

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
End of Study Letter Outline	End of Study Letter	19/Dec/2022	
Email script for scheduling interview time	Email Script	19/Dec/2022	
NewsletterScriptJan8th	Recruitment Materials	08/Jan/2023	2
LetterofInformationJan12	Recruitment Materials	12/Jan/2023	
LetterofconsentJan12	Written Consent/Assent	12/Jan/2023	
WREBprotocolMacleanJordan	Protocol	12/Jan/2023	
interviewguide	Interview Guide	12/Jan/2023	

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000940.

Please do not hesitate to contact us if you have any questions.

Electronically signed by:

Ms. Nicola Geoghegan-Morphet, Ethics Officer on behalf of Dr. Philip Jones, HSREB Chair, 18/Jan/2023 15:38

Reason: I am approving this document

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations, See [Electronic System Compliance Review](#))

Appendix C: Letter of Information and Consent



Letter of Information and Consent

Exploring Barriers and Facilitators to Implementing Patient-Centered Care as Experienced by Community-based Physiotherapists

Principal investigator

Dr. Dave Walton

Associate Professor, School of Physical Therapy

Canadian Centre for Precision Spinal Pain Rehabilitation,

University of Western Ontario

1201 Western Rd. London ON, N6G 0K8

Additional Research Staff

Maclean Jordan B.HSc., M.Sc. student (Health and Rehabilitation Science)

1. Invitation to Participate

You are receiving this letter because of your interest in study involvement as seen in the advertisement through the CPA. We are looking for physiotherapists who practice primarily in a community-based private outpatient setting who would be interested in joining this interview study. You are being invited to participate in this qualitative study which seeks to explore your experience in providing patient-centred care as a physiotherapist. Analyzing your experience against the framework developed by Santana et al (2017), we wish to investigate your views on the caregiving environment you are apart of each day.

2. Why is this study being done?

Healthcare in any field that is more centered on patient needs (patient centered care) has been shown to lead to improved results for those being treated. Research on the topic of patient centered care in physiotherapy has shown that care experienced by patients is more physiotherapist centered. It has also been shown that many healthcare practitioners

in various fields face systemic barriers to providing patient centered care. To our knowledge, no investigation specific to physiotherapists has been done in this area, and we look forward to gaining a deeper understanding of the practice. We are investigating facilitators as well, to gain an understanding of what physiotherapists experience that helps them provide this kind of care, or what they may wish they had access to help provide care that is more patient centered.

This study is being done in order to fulfil the degree requirements of Maclean Jordan in the M.Sc in Health and Rehabilitation Science program at the University of Western Ontario

3. How long will you be in this study?

This is an interview-based investigation, so apart from the initial contact to collect information and set up a time for the interview, study duration will be approximately 30-40 minutes for the interview.

4. What are the study procedures?

This interview study will involve a session of 30-40 minutes with research team member Maclean Jordan. You will be guided through a series of open-ended questions designed to investigate and interpret your experience as a physiotherapist providing patient-centered care to your clients. You will be questioned on how you conceptualize patient centered care, as well as what you see as being barriers or facilitators in the practice to reaching this ideal.

Consent will be obtained over a unique link to a survey on Western's licensed Qualtrics software. Western University's instance of Zoom will be used to conduct the interviews remotely. Sessions will have their audio recorded. Sessions will then be transcribed with identifiers removed before NVIVO software will be used for data analysis. Analysis of the data will be conducted through a methodology of interpretive description, and a final thesis project will be written using the information gathered. A final letter detailing primary and secondary findings will be made available to you as a participant once the project is finalized.

5. What are the risks and harms of participating in this study?

There is risk of data breach with the information you give being accessed by someone outside the research team. With gender, years of experience, and clinic being collected prior to the interview this information poses a risk of identification. Steps will be taken to prevent this, such as only Maclean and Dr. Walton having access to data and care being taken to keep that information from being shared. Depending on scheduling for the interview there is a possibility of losing patient treatment time, and therefore income for you as a practicing physiotherapist. However, the research team is flexible in available hours for the interview sessions.

6. What are the benefits of participating in this study?

There are no immediate benefits to participation in the study. The results of the study will hopefully act as a steppingstone to a discussion around improving patient treatment and experience through policy.

7. Can participants choose to leave the study?

You may leave the study at any time after giving consent and before having your interview session. However, a deadline of 10 days will be applied after the interview session if you wish to have your contribution removed from the material being analyzed. This is to allow Maclean Jordan to finish analyzing the data within the timeframe allotted in the pursuit of his M.Sc degree. The researcher may choose to remove your data from the study at any time if you are shown to not fit the inclusion criteria, which include

- Working in a community-based private outpatient setting for at least 50% of your working hours in a week, providing direct patient care with a focus on musculoskeletal rehabilitation
- Being fluent in English

8. How will participants' information be kept confidential (data handling procedures)?

This process necessitates the use of third-party software in Qualtrics to collect and store the signed consent forms for a period. Data is housed in Ireland. A link to the privacy statement for the software can be found in the Qualtrics 2015 security white paper, linked [here](#). As it is a third party, there is always increased risk of data breach. However, they ensure that access to the data can only be had by the user collecting it (Maclean Jordan in this case). Consent surveys will be exported from Qualtrics and saved to Dr. Walton's OneDrive after each participants session, when you will receive a fully executed copy as well. They will then be deleted off Qualtrics.

Audio files of the session recorded over Zoom will be saved to Dr. Walton's OneDrive where Maclean will have access to transcribe them verbatim minus identifiers. These files will not be saved to the Zoom cloud at any time. The software NVIVO will also be used for data analysis. However, these files will be saved to the OneDrive of Dr. Walton, and used locally, so the risk of security breach does not change.

Information collected will be name, email and signed consent form. Years of practice, gender and clinic location will be collected at the beginning of the Zoom call with consent. These are collected only for the possibility of analysis later. The list of participants and their information will be kept on Dr. Walton's secure UWO OneDrive, with Maclean Jordan having access. Zoom audio recordings and transcriptions of these sessions will be stored separately on the OneDrive, with both researchers having access.

Audio and video of the zoom sessions will be recorded, but video will be destroyed immediately after and not saved. Our best attempts will be made to remove identifying information from any published portions of transcripts in the final manuscript, as well as the initial transcriptions from the recorded interviews. Identifiable information will be kept in Dr. Walton's possession for 7 years after completion of the project, as per UWO policy.

9. Are participants compensated to be in this study?

You will not be compensated for participation in this study.

10. What are the rights of participants?

You do not waive any legal right by signing this consent form.

11. Whom do participants contact for questions?

If you have any questions please feel free to contact Maclean Jordan B.H.Sc (*email redacted*)

Exploring Barriers and Facilitators to Implementing Patient-Centered Care as Experienced by Community-based Physiotherapists

This study has been explained to me and any questions I had have been answered. I know that I may leave the study at any time and request the information I provided be removed within the allowed timeframe stated above. I agree to take part in this study.

Print name of participant Signature Date (DD/MM/YYYY)

My signature means that I have explained the study to the participant named above. I have answered all questions.

Print name of person obtaining consent Signature

Date (DD/MM/YYYY)

This letter is yours to keep for future reference.

Appendix D: Email Script for Participant Recruitment

RE: interview session availability

Hello! Thank you for returning your consent form. I am contacting you now to schedule a time for us to meet in order to conduct the interview for your part in this project. Please provide up to 3 dates and times that would be convenient for you, and I will do my best to make one work.

Thank you,

Maclean Jordan, B.H.Sc.

M.Sc. student (Health and Rehabilitation Science)

Appendix E: Interview Guide

Interview guide- Physiotherapists Perceptions of Barriers to Patient Centered Care

Opening

Thank you for joining me today. I just want to confirm that even though you have consented to being apart of this interview, you are still free to leave and request that your information is withdrawn at anytime during this session. You are free to skip over any questions I ask or provide as much or as little of a response as you wish. Nothing you say here is attached to you personally, identifiers will be removed once I transcribe the session. I do need to record the session for transcription later, but only the audio file will be kept. The video will be destroyed as soon as we are done. I will let you know when I am about to begin recording. Do you wish to begin?

I have a few preliminary questions I will ask. Data from these is only being collected as a means of possible analysis later In based on answers you may give. This information will not be attached to your by name, as each audio file and transcription file will be coded so your name only remains on our master list which is stored securely.

Preliminary Questions

How long have you been practicing?

What is your gender?

What are the most common types of patients (injuries, issues etc) that you see?

What is the name and location of your clinic?

In your own formal education, how has patient centered care been defined for you?

- How does this definition line up with your current understanding based on practice?

OR

- If they cannot remember or it was not defined
 - o What is your current understanding of patient centered care?

Follow up

- How did you arrive at this current understanding?
 - o *Education, post grad reading/courses, experience*

Can you describe how you practice/ implement these PCC principles in your daily practice

- They are unsure or cannot say
 - o Under an ideal circumstance, based on your experience in care, how could you?
 - o How do you see others implement it?
- Are there other ways in which you practice PCC?

In your experience, what are some barriers or challenges to implementing PCC in your practice?

- Lack of professional autonomy?
- Focus on biomedical paradigm?
- Lack of professional education on the topic?
- Time constraints?

In your experience, what are some things that have made enacting PCC easier in your practice?

- Education?
- Administrative and college level support ?

Curriculum Vitae

Name: Maclean Jordan

**Post-secondary
Education and
Degrees:** University of Western Ontario
London, Ontario, Canada
2016-2021 B.HSc.

The University of Western Ontario
London, Ontario, Canada
2021-2024 M.Sc.

**Related Work
Experience** Teaching Assistant- Faculty of Health Science
The University of Western Ontario
2022 (June-December)

Teaching Assistant- Department of Physiotherapy
The University of Western Ontario
2021-2022