

Physiotherapy Theory and Practice

An International Journal of Physical Therapy

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/iptp20>

Shifting roles: physiotherapists' perception of person-centered care during a pre-implementation phase in the acute hospital setting - A phenomenographic study

Veronica Sjöberg & Maria Forsner

To cite this article: Veronica Sjöberg & Maria Forsner (2020): Shifting roles: physiotherapists' perception of person-centered care during a pre-implementation phase in the acute hospital setting - A phenomenographic study, *Physiotherapy Theory and Practice*, DOI: [10.1080/09593985.2020.1809042](https://doi.org/10.1080/09593985.2020.1809042)

To link to this article: <https://doi.org/10.1080/09593985.2020.1809042>



© 2020 The Author(s). Published with license by Taylor & Francis Group, LLC.



Published online: 19 Aug 2020.



Submit your article to this journal [↗](#)



Article views: 542



View related articles [↗](#)



View Crossmark data [↗](#)

Shifting roles: physiotherapists' perception of person-centered care during a pre-implementation phase in the acute hospital setting - A phenomenographic study

Veronica Sjöberg RPT, PhD ^a and Maria Forsner RN, PhD ^b

^aDepartment of Care Sciences, School of Education, Health and Social Sciences, Dalarna University, Falun, Sweden; ^bDepartment of Nursing, Faculty of Medicine, Umeå University, Umeå, Sweden

ABSTRACT

Background: Person-centered care (PCC) is an acknowledged health care practice involving increased patient influence regarding decisions and deliberation. Research indicates that physiotherapists (PTs) embrace patient participation, but that PCC is difficult to grasp and fully implement.

Objective: To contribute to knowledge about how PCC influences physiotherapy by eliciting PTs' experiences from the acute care setting, this study aims to describe and illuminate variations in perceptions of PCC during a pre-implementation phase, among PTs in acute hospital care.

Methods: Phenomenological approach: individual interviews with PTs in acute care (n = 7) combined with focus group interviews (n = 3).

Findings: The analysis yielded two main categories: 1) Physiotherapists perceived a transformed patient role involved in the transition from patient to person; and 2) Physiotherapists perceived a challenged professional role when departing from the expert role, and entailed restrictions to prescribing the best treatment and, instead, meant aiming for a collaborative and equal relationship with the patient.

Conclusion: Although the interviewed PTs embraced PCC in principle, PCC does seem to challenge the professional roles of patient and PT. The findings indicate that theories of power relations need to be considered, and further reflection may facilitate implementation. More research is needed to deepen the knowledge of how PTs perceive PCC during all implementation phases.

ARTICLE HISTORY

Received 26 June 2018

Revised 28 May 2020

Accepted 12 July 2020

KEYWORDS

Physiotherapy; professional role; person-centered care; shared decision making; power relations

Introduction



Person-centered care (PCC) has become an acknowledged and recommended approach in health care including physiotherapy (World Health Organization, 2018). However, physiotherapy practice is strongly influenced by natural science and biomedical theory, which only marginally considers the psychological, behavioral and social aspects of patients' experiences in relation to their circumstances in life (Engel, 1977). Already in the 1970s Engel stated that the biomedical model is "insufficient" for understanding health because of its inability to explain the impact of disease or the experience of the disease for the individual (Eisenberg, 2012; Engel, 1977; Grönblom-Lundström, 2008). In the last few decades, the biopsychosocial theory has gained ground in both medical and physiotherapy practice (Allan et al., 2006). One example is the International Classification of Functioning, Disability and Health (ICF), which includes behavioral, social and psychological dimensions of health and illness to fill the gaps in biomedical theory (Allan et al., 2006). Modern physiotherapists (PTs'), despite the emphasis on biomedical science, favor the ICF model in

physiotherapy practice (World Confederation for Physical Therapy, 2016).

Person-centered care is based on a holistic perspective, which means that health care professionals need to see the patient in a biopsychosocial context (Ekman et al., 2011; Leplege et al., 2007; Olsson, Jakobsson-Ung, Swedberg, and Ekman, 2013). However, there is no consensus regarding a definition and conceptualization of the core features of PCC (Kogan, Wilber, and Mosqueda, 2016; Olsson, Jakobsson-Ung, Swedberg, and Ekman, 2013). This study adopts the definition of PCC by Ekman et al. (2011), namely: "Person-centered care sees patients as persons who are more than their illness. Person-centered care emanates from the patient's experience of his/her situation and his/her individual conditions, resources and restraints."

Background

Originally, PCC was developed for chronic care. Several studies have been published including research on PCC

CONTACT Veronica Sjöberg  vsj@du.se  Department of Care Sciences, School of Education, Health and Social Sciences, Dalarna University, Falun 791 88, Sweden

© 2020 The Author(s). Published with license by Taylor & Francis Group, LLC.

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

in dementia care, by Clissett, Porock, Harwood, and Gladman (2013). Clissett, Porock, Harwood, and Gladman (2013) found that hospital staff seemed unable to deliver PCC, in part because of hospital organizations' failure to empower their staff to provide. Recently PCC has been implemented in other contexts, not least in acute care settings (Clissett, Porock, Harwood, and Gladman, 2013; Ekman et al., 2012; Hansson et al., 2016). Despite growing interest and incentive to provide PCC within acute care settings, this particular setting seems to entail certain obstacles to provide PCC.

Person-centered care suggests that the care recipient should not be identified in terms of their disease or disability but should be integrated and given the opportunity to claim an active and informed role as a contractual partner in every step of the health care chain (Ekman et al., 2011; Leplege et al., 2007; Olsson, Jakobsson-Ung, Swedberg, and Ekman, 2013). According to Ekman et al. (2011), PCC has to be grounded in the philosophy of personalism, by which they refer to the French philosopher Paul Ricoeur. Ricoeur (1992) emphasized coherence in life and the ethical obligation to recognize and acknowledge the fragility of fellow humans. Furthermore, Ricoeur (1992) elucidated that the person experiences meaning in life holistically and understands new events in the light of previous experiences. It is not possible to share another person's experience; however, when narrating to someone who listens it may be possible to share the meaning of the experienced. Consequently, a care recipient has a unique understanding of how a disease or disability affects circumstances in their life, and this is unknown to the professionals if not narrated. Cornerstones in PCC practice, according to the model adopted by Ekman et al. (2011) are: patient's narrative (i.e. what the patient is sharing); partnership between the patient and the caregiver (i.e. the alliance between health care staff and the patient), and documentation of the mutually agreed health care plan. Ekman et al. (2011) stressed the importance of the co-creation of care between the patient, their family and health professionals as the core component in PCC.

Regarding PCC in physiotherapy practice, Mudge, Stretton, and Kayes (2014) conducted an auto-ethnographic study aiming to explore PTs' conflicting response to person-centered rehabilitation. They identified four important domains in person-centered physiotherapy: 1) goal setting; 2) patient's expressions of hope; 3) physiotherapy paradigm; and 4) the PCC practice within physiotherapy and argued that these four domains could be seen as barriers to implementing

PCC in clinical practice. PTs' are in general focused on patients own resources, and treatments often assume a motivated patient. Mudge, Stretton, and Kayes (2014) critically examined how PTs' ensure the patients participation when he/she not are able to claim an active role in the deliberation process. Authors, point out the ongoing persistence in viewing physiotherapy as being purely biomedically based, may create resistance during the transition to a PCC approach, and argue the need for greater awareness within the profession to move toward PCC practice. The Normalization Process Theory (NPT) is a framework used to support identification of inhibiting or promoting factors that may occur during implementation processes of complex interventions within health care (Murray et al., 2010). In accordance with NPT, a successful implementation process requires, in addition to coherence, collective action and reflexive monitoring also individual cognitive participation (Murray et al., 2010). To be able to embrace a new practice, the individual has to understand and engage with the new practice (Finch et al., 2012; Murray et al., 2010). Persons involved in the process of implementation must be clear of the core meaning of the intervention and be convinced of the positive outcome that lies within the intervention (Murray et al., 2010).

Person-centered care from the health caregiver's perspective

Person-centered care is a widely recommended approach to caregiving in Western countries and has been advocated to be beneficial both for the care receiver and for the caregiver (Ekman et al., 2012; Fors et al., 2015; Hansson et al., 2016; Ulin, Olsson, Wolf, and Ekman, 2016; World Health Organization, 2018). Today health care professionals seem to be experiencing a change in clinical practice. This change is characterized by increased patient participation where patients are encouraged to share their knowledge in collaboration with the health professional in order to achieve treatment goals and interventions that are meaningful for the patient (Dudas et al., 2013; Mudge, Stretton, and Kayes, 2014; Solvang and Fougner, 2016; Womack, 2013). In physiotherapy, an increased patient-therapist collaboration seems to be valued by PTs', and to supplement and contribute to good clinical practice (Solvang and Fougner, 2016).

Person-centered care has elsewhere been studied in acute hospital care settings. In one study, length of hospital stay was reduced by 30% in chronic heart failure patients treated according to PCC compared with conventional care (Hansson et al., 2016). The PCC intervention targeted to identify barriers and

resources for every individual patient by conducting a comprehensive narrative in order to create a healthcare plan including a prognosis for hospital length of stay (Hansson et al., 2016). In addition, treating chronic heart failure patients with PCC decreased costs compared with conventional care. A comprehensive narrative was obtained from patients in the intervention group targeting were about everyday life experiences on how the illness affects his/her life (Ekman et al., 2012). Clissett, Porock, Harwood, and Gladman (2013) as well as McBrien (2009) and Solvang and Fougner (2016) reported that though health care professionals in acute hospital care appreciate the features of increased patient collaboration, they seem to miss numerous opportunities to provide PCC. Regarding the PT's professional role, research has revealed the existence of a power asymmetry in the PT-patient relationship which may constitute a barrier for increased patient participation in deliberation and in decision-making (Praestegaard and Gard, 2011; 2013; Trede, 2012).

Although the importance of PCC has been acknowledged by the World Health Organization (WHO) and although PCC has been increasingly implemented to strengthen quality of care, the conceptualization of PCC seems to be insufficient (Clissett, Porock, Harwood, and Gladman, 2013; McBrien, 2009; Solvang and Fougner, 2016). Despite reports of positive outcomes in both acute and sub-acute hospital care, it has been pointed out that health care staff seem to struggle to fully grasp core features of PCC, which might constitute an obstacle during implementation (Clissett, Porock, Harwood, and Gladman, 2013; Finch et al., 2012; McBrien, 2009; Solvang and Fougner, 2016). Moore et al. (2017) provided us with findings from a qualitative study where 18 researchers were interviewed with the aim to explore barriers and facilitators to deliver PCC interventions in different healthcare contexts. Several obstacles to deliver PCC were identified (e.g. traditional practices and structures, time constraints, and professional attitudes). Accordingly, knowledge about how PTs perceive PCC in the acute setting in the early phases of the implementation process may provide rare information on how PTs understand and make sense of PCC and appraise its effects. According to NPT, these constructs are known and central prerequisites for successful implementation (Finch et al., 2012). This study aims to describe and illuminate variations in perceptions of PCC, during a pre-implementation phase, among PTs' working in acute hospital care.

Methods

Study design

The study used a qualitative design based on a phenomenographical approach, which aims to describe how people make sense of a certain phenomenon in the world, as they understand it (Karlberg-Traav, Forsman, Eriksson, and Cronqvist, 2018; Marton, 1981). The phenomeno-graphical method was originally applied in pedagogical research and there are several examples of the usefulness of the approach in research focusing on how health care professionals perceive their practice (Karlberg-Traav, Forsman, Eriksson, and Cronqvist, 2018; Marton, 1981; Mattsson, Forsner, and Arman, 2011; Sjöström and Dahlgren, 2002; Stenfors-Hayes, Hult, and Dahlgren, 2013).

Recruitment strategy

The study was performed in line with Swedish law and the Declaration of Helsinki regulating research involving humans (World Medical Association, 1964). The Head of the Physiotherapy Department approved the study and an ethical evaluation in accordance with Dalarna University's ethics policy was performed. Participants received written and verbal information about the study. Their right to withdraw from the study at any time without further explanations was underlined. Each participant gave written informed consent before entering the study. Confidentiality regarding participation was ensured; it was possible to participate without revealing any identifying information. Data were stored de-identified on a computer secured with a password. Risks of harm to participants and possible gains by conducting the study were assessed as altogether minimal.

When recruiting participants for the study, we targeted PTs' working in the acute in-patient setting of three regional hospitals in Sweden during a pre-implementation phase of PCC. Information about the study and an invitation to participate in an individual interview and a focus group interview was sent to all PTs' at the three hospitals. The letter clearly stated that the invitation was intended for PTs working in in-patient care, but was being distributed to all PTs' for convenience reasons. A substantial percentage of PTs' in Sweden work in both in- and out-patient care. The managers at the hospitals distributed the researchers' e-mail addresses and PTs' who were interested in participating were able to respond directly to the researchers. We aimed for a broad age range and gender mix, as well as a range of

Table 1. Sample questions from the individual interview and focus group.

Individual interview	Focus group
Please, can you share your thoughts on person-centered care (PCC) in the acute hospital context?	Please, can you share your thoughts on PCC in the acute hospital context?
Please, can you share a clinical situation where a patient has received what you think is PCC?	Are there, as you see it, any advantages or disadvantages to a PCC approach in physiotherapy?
Please, can you share your experiences of a clinical situation where a patient received the opposite to PCC?	Please, can you share your thoughts on a scenario where patients have a great deal of influence over treatment options and goal formulation?
Please, can you share your thoughts on the process of determining treatment goals for the patient?	Please, can you share your thoughts on the physiotherapy (PT) profession as you see it and in relation to a PCC approach?

years in the profession in order to maximize the variations in perception (Stenfors-Hayes, Hult, and Dahlgren, 2013). The inclusion criteria were: registered PT; employed at the Physiotherapy Department at one of three minor hospitals; and at least 1 year of work experience and currently working in acute hospital inpatient care.

Seven PTs' responded to the invitation. All seven met the inclusion criteria and completed an individual interview. Thereafter they were sent an e-mail invitation to participate in a focus group interview; four participants accepted. Unfortunately, one fell ill and made a late cancellation.

The context

Participating PTs' were working in acute medicine, surgery, orthopedic and rheumatology care. The work as PT in such care involves servicing the designated wards with physiotherapy competence in collaboration with other members of the team. At the time of the study, the Swedish Legislation SFS 2014:821 aiming to strengthening patient involvement in health care, was fairly new (Ministry of Health and Social Affairs Sweden, 2014). The county where the three hospitals were located had decided to implement PCC. At the current department, PCC was highlighted in the clinical guidelines and goals in the operational plans, but no specific action to implement PCC had been taken. However, PCC was frequently discussed between colleges.

Data collection

To be able to describe and illuminate variations in perceptions of PCC, data collection was conducted by semi-structured individual and focus group interviews which were hoped to encourage reflection (Baker, 1997; Stenfors-Hayes, Hult, and Dahlgren, 2013). Moreover, triangulation is known to enrich qualitative data (Guba, 1981); therefore, these two methods were combined. Combining individual interviews with focus group interviews provides an additional condition for confidential conversation, while at the same benefiting from the dynamics of group interaction, thus possibly facilitating for the participants to share and further explore perceptions regarding ethics and decision making (Kitzinger, 1995; Stalmeijer, McNaughton, and Van Mook, 2014). Semi-structured individual and focus group interviews were conducted by the first author (V.S). The authors had mutually created two semi-structured interview guides for each sampling strategy (Table 1). Interviews started with a short clarification of the study aim. The interviews took place at the participants' workplace, during participants' working hours, and at a time requested by the participants (Doody, Slevin, and Taggart, 2013a, 2013b; Stenfors-Hayes, Hult, and Dahlgren, 2013).

Seven PTs', six women and one man (27–53 years old), with 1–16 years' (mean 8 years') experience in the profession, participated in individual interviews (Table 2). Three of them also participated in a focus group. The individual interviews lasted a mean of 31 (range 21–42) minutes. The focus group interview lasted 48 minutes.

Table 2. Characteristics of the physiotherapists (PT's) participating in individual interviews and the focus group.

	Individual interview	Focus group
Participants	<i>n</i> = 7	<i>n</i> = 3
Sex: female/male	6/1	2/1
Age, yrs: mean (range)	35 (27–53)	29.6 (27–32)
Years in the profession: mean (range)	8 (1–16)	6 (4–8)
Context of physiotherapy	acute medicine, surgical, orthopedic, rheumatic care	acute medicine, surgical care

Table 3. Overview of the main descriptive categories and subcategories of how physiotherapists perceived patient-centered care (PCC).

Descriptive categories: main outcome	
Physical Therapists Perceived a Transformed Patient Role	Physical Therapists Perceived a Challenged Professional Role
Subcategories	
I Transformation from <i>patient</i> to <i>person</i> .	I Shift in decision making, from PT to patient.
II Overestimating patients' competence.	II Changes in clinical practice, from employing a hands-on approach to being a conversation partner.
III Strengthened patient influence.	III Decreased demands for professional expertise.

During the interview, participants were encouraged to share their clinical experiences, thoughts and reflections on PCC in acute in-hospital care. All interview questions were open-ended and constructed to capture participants' personal and specific thoughts and perceptions on the interview topics, or themes, which were based on Mudge, Stretton, and Kayes (2014) four domains.

Interviews started with the open question "Could you share your thoughts and reflections on person-centered care within acute in-hospital care?", followed by questions such as "Could you elaborate?" and "Could you provide an example from your clinical work?" (Baker, 1997; Stenfors-Hayes, Hult, and Dahlgren, 2013). The interviewer listened actively, showing a genuine interest, and sought to provide a relaxed and friendly interview environment, encouraging participants to speak freely and share clinical experiences aligned to the interview themes (Stenfors-Hayes, Hult, and Dahlgren, 2013). Data collection took place from April to May 2016. All interviews were audio-taped and transcribed verbatim by the first author (V.S.).

Data analysis

Data analysis followed Sjöström and Dahlgren's (2002) application of phenomenography in health and nursing research. Data from individual as well as focus group interviews were analyzed jointly. The analysis consisted of a consecutive, seven-step analysis process aiming to qualitatively categorize how and when a certain phenomenon was perceived. The first step involved familiarization (i.e. repeatedly reading the transcripts as an introduction to and familiarization with the data). The second step entailed compilation, where all the participants' answers to a certain question were collected and compiled together. The third step involved a condensation of the individual answers, preserving the core meaning of each answer. The fourth step involved preliminary classification, or grouping, of all similar answers. In the fifth step, a preliminary comparison was made of the groups or categories attempting to establish clear categories,

distinguishable from each other. The sixth step consisted of naming the categories to further clarify their content, while the last step involved a contrastive comparison of categories to describe the unique character of each category (Sjöström and Dahlgren, 2002). Concurrently during all the steps, the authors returned to the original material to ensure that the revealed categories were securely anchored. The study started out as a Master's thesis and was discussed in seminars with other students and senior researchers. Thereafter data were re-analyzed in close collaboration between the authors. Analysis steps four through seven were repeated several times and discussed before the analysis was deemed satisfactory.

Findings

The analysis resulted in two main, qualitatively different categories, contrasted from each other in terms of perspectives: 1) Physiotherapists perceived that the patient role was transformed through PCC; and 2) that the Physiotherapists professional role was challenged. The subcategories illustrate a further range of variations in extracted perceptions (Table 3).

Physiotherapists perceived a transformed patient role

The participants perceived PCC as truly present when the "patient" was transformed to "a person": no longer "just" a patient passively receiving treatment, but an individual actively joining the treatment team. In addition, the PTs' described that they perceived PCC as it would increase the knowledge demands on the patient. The transformation of the patient role that was due to PCC was described under the subcategories: 1) Transformation from patient to person; 2) Overestimating patients' competence; and 3) Strengthened patient influence.

Transformation from patient to person

The participants expressed the view that in general the PT, in comparison with other health care professionals, has a good ability to view the patient holistically as a person. Several participants perceived that the PCC approach could contribute to an even more holistic view of patients, in their own as well as other health care professions. The PTs' perceived that it was necessary to see patients as individuals to be able to individually adjust health care measures. They said that PCC prevents identifying patients in terms of their disabilities or diseases.

I'm thinking of one particular patient, who needed a bit more support than these patients normally do [when going home]. We arranged additional support after discharge, we acknowledged the patient's needs, and did not just take for granted that it would work out as it usually does ... (Participant 6, 16 years in the profession, individual interview)

Overestimating patients' competence

The PTs' recognized that the PCC approach requires a well-informed and cognitively able patient. They emphasized that the average patient cannot be assumed willing or able to make adequate decisions regarding their care. One argument was that some patients seek health care expertise, while others do not have sufficient knowledge to make qualified decisions without proper information from health care professionals.

Yes, it depends a little on how you look at it. I think of the purely medical questions, like, should we let a patient direct their own treatment? But they don't have the medical knowledge to make all the decisions. So it can have a lot of consequences for the patients. But it depends a little on how aware the patients are ... of their own condition – that is, on what the consequences of the different choices can be. So I think ... (Participant 3, 6 years in the profession, individual interview)

Elderly patients expect to see an expert who knows what to do ... (Participant 5, 1.5 years in the profession, individual interview)

The participants also reflected on how the principles of PCC can apply to patients with less ability to make decisions, for example those with cognitive disability. One view was that patients with cognitive disability could not be assumed to be fully aware of their needs.

Yeah but I think also that if you have a, patient who perhaps isn't totally with it, cognitively ... that you maybe can't, that is if you're going to think about what the patient needs if they don't have ability to judge the facts. That it can have negative consequences because the patient maybe says no to treatment despite the fact that you see a huge need because the person should be

able to go home or whatever is involved ... (Participant 3, 6 years in the profession, focus group)

Strengthened patient influence

The PTs' unanimously experienced that increased patient participation (i.e. a collaboration between the PT and the patient) is preferable both to the PTs' perspective and to the patient's point of view. The PTs clearly recognized the benefits in viewing patients' needs from a holistic perspective. A prerequisite for enhanced rehabilitation outcome was to gain a deeper understanding of the patient's psychosocial environment.

No, but there are often several alternatives ... I think it motivates the patient to actually ..., due to the fact that there is so much for the patient to do themselves. So, I think that it motivates them to be more involved ... (Participant 5, 1.5 years in the profession, individual interview)

The analysis also revealed that PTs' perceived PCC to imply that patients have increased influence in general. More specifically, it meant that patients had an increased and reinforced right to discontinue the "best treatment" or in fact, any treatment. Physiotherapists expressed that it created feelings of frustration when they were not able to help, despite having the knowledge that would surely help the patient significantly.

But then it can be the case that this shouldn't be allowed to go to extremes. It shouldn't be the case that the patient says that ... [i.e. that what the patient says, goes, no matter what]. I have met a patient who is very sick with their illness and refuses medicine. I can see that patient in front of me; it's a terrible example. She feels terrible, is completely stiff, bedridden, can't move at all, must have help with everything and is 25 years old ... (Participant 2, 16 years in the profession, individual interview)

Physiotherapists perceived a challenged professional role

The PTs' perceived that PCC challenged their professional role in terms of goal setting, expectations of treatment outcomes and decision making. The changes that PT's assumed in the professional role due to PCC-practice were described in the subcategories: 1) Shift in decision making from PT to patient; 2) Changes in clinical practice, from employing a hands-on approach to being a conversation partner; and 3) Decreasing demands for professional expertise.

Shift in decision making from physiotherapist to patient

The PTs' perceived PCC to mean a shift in power in terms of decision making regarding treatment options and goal setting. The PTs' described the existing demands within their profession, for example the demand to practice evidence-based physiotherapy, and to follow organizational guidelines and council regulations. They reflected that increased patient power could lead to situations where the PT could end up in a moral dilemma, on the one hand being compelled to follow ethical guidelines and evidence-based professional practice, and on the other granting the patient maximum influence. They perceived that some treatment suggestions given by patients may be not as well considered or as well informed as the evidence-based treatment options recommended by the PT.

Yeah, because we [i.e. PTs'] are supposed to work in an evidence-based way and if there is something like massage, that you know "won't help", like, as far as healing is concerned, then ... basically if we use those treatments, we go against our way of working. (Participant 6, 16 years in the profession, individual interview)

... I can't really do that, and it doesn't really go with the council's guidelines on what I should do. I must do things according to my qualifications and according to what I am employed to do. Ehh ... so there are those boundaries. (Participant 1, 5 years in the profession, individual interview)

Changes in clinical practice, from employing a hands-on approach to being a conversation partner

The participants interpreted PCC to be a more conversation-based treatment method where patients were encouraged to express their expectations. This was perceived as a crucial part of PCC practice. During the interviews, it emerged that PTs' perceived an ongoing change in clinical practice, from the current "hands-on" approach, to a seemingly less qualified, conversation-based treatment approach. The PTs' felt that this was not as valid as the hands-on approach that they had been trained to use, and said that it was often more time-consuming. Additionally, it was perceived as professionally unsatisfactory compared with existing practice.

There's also the risk that – something that's already started to happen for physiotherapists – is that you change from working manually with hands-on things to being more of a conversational therapist ... (Participant 7, 4 years in the profession, focus group)

Decreasing demands for professional expertise

The participants expressed the importance of being able to share their theoretical and clinical expertise with

patients and other team members. However, they worried that their expertise as professionals might be compromised because of increased patient influence and expressed the feeling of being pinioned by PCC. A clash between what they, as professionals, knew was best for the patient, and increased patient participation as per the PCC approach was described. The participants said that the PTs' expertise constitutes an important decision basis for patients, which facilitates the patient's informed decision making.

Because even if you work in a person-centred way, we have to, in our role, be able to tell them that "we've seen that this doesn't have so much effect on that". So the patient still has some sort of basis on which to make decisions. (Participant 3, 6 years in the profession, focus group)

But at the same time, you have to think, "Is there a reason that someone is the treater, and someone is the patient?" (Participant 1, 5 years in the profession, individual interview)

Discussion

This study aims to describe and illuminate variations in perceptions of PCC during a PCC pre-implementation phase, among PTs' working in acute hospital care. The PTs' perceived PCC as a truly beneficial and proper care approach, which may have potential to facilitate the important transition in how health care professionals view patients. Person-centered care was understood to facilitate acknowledgment of the person behind the disease or disability, facilitating the health professional's ability to take heed of individual restraints, resources and conditions, thus promoting the essence of PCC. The PTs' realized that they, as well as others in the health care team, mostly viewed the care receiver as a patient, whom they often identified by their disability or disease. Recent research confirms that physiotherapy practice relies on a biomedical base in health care (Eisenberg, 2012; Engel, 1977). By contrast, the PTs' in this study argued that PTs' generally have a holistic view embracing patients' lifeworld and social context (Praestegaard and Gard, 2011; Solvang and Fougner, 2016) and expressed that a PCC approach could reinforce an anti-reductionism in their own profession as well as in other health professions.

Furthermore, our data revealed a conflicting perception of the transformed patient role. The participants reflected that PCC assumes that patients are well informed about their disease or disability, as well as about the treatment options that are available. However, they expressed explicit concern about the

risk of overestimating patients' knowledge and their ability to make informed decisions. Several PTs' voiced concern about being unprofessional if overestimating the patient's ability to do what is best for them in a given situation. A central question that needs to be addressed is where we as health care professionals draw the line between beneficial paternalism, where the patient is objectified, and the increased demands on patients' autonomy. It seems that there may be situations where it is clinically relevant to compromise patients' autonomy (e.g. if patients have a decreased ability to make decisions beneficial to their health). It seems obvious that we need further exploration of the balance between increased patient participation and the PT professions biomedical heritage and how it affects the power relationships. This is especially crucial for those patients with limited ability to claim an active and contractual role in decision-making and deliberation.

The patient's influence is a core issue in PCC. In PCC, the person's own experience is emphasized, as is the health care professional's obligation to recognize and acknowledge the fragility in the other person (Ekman et al., 2011). However, as highlighted by Mudge and coworkers, PTs' may experience discomfort when patients express what the PTs' believe to be unrealistic treatment expectations and goals (Mudge, Stretton, and Kayes, 2014). In the current study, the PTs' emphasized a power shift in decision making, which seemed to go against their idea of their professional role. According to this idea, PTs' know and express what a patient needs in order to recover or rehabilitate. These paternalistic tendencies are also described by Eisenberg (2012) who pointed out that during training, PTs' are often not attentive to how power relations between the patient and the therapist manifest in the clinical situation. Both Mudge, Stretton, and Kayes (2014) and Eisenberg (2012) research calls for a deeper reflective discussion targeting PTs' ability to achieve PCC in their clinical work. Moore et al. (2017) even went further, when elucidating the uneven power relation between patient and healthcare staff as a clear barrier to implement PCC in several healthcare contexts. In addition, these difficulties regarding power relations are not clearly discussed in PCC theory, as reported by Ekman et al. (2011). Rushton and Edvardsson (2018) outlined an ethical theory for how nurses in acute hospital settings judge and make sense of their responsibilities toward the patient. After consulting the work of Foucault (1982) and Løgstrup (1971), Rushton and Edvardsson (2018) concluded that the organization itself needs to be reflexive, creative and person-centered to facilitate

a transformation toward a PCC approach. Applying Foucault's thoughts on power relation characteristics to our study findings, the connection between power relations, knowledge and language becomes central. According to Foucault (1982) power relations exist in personal relations, and only there. One of the cornerstones of PCC is the partnership between the therapist and the patient (Ekman et al., 2011). Any relations between a therapist and patient inform some sort a power relation, which will affect the characteristics of the relationship (Foucault, 1982). In contrast to the ethical obligation to recognize and acknowledge the fragility of fellow humans, our findings as well as those of several other research studies, reveal a paternalistic tendency in PTs' as health professionals. Physiotherapists assume the role of expert toward the patient, which may negatively affect the opportunity to create an equal partnership between the therapist and the patient. This ongoing adherence connection to the biomedical approach may serve as a barrier to a holistic engagement in the treatment process (Mudge, Stretton, and Kayes, 2014) which is also highlighted by Moore et al. (2017). This may be one explanation for several reports suggesting that PCC is difficult to grasp and that health care professionals miss opportunities to provide PCC in the clinical context (Clissett, Porock, Harwood, and Gladman, 2013). Although the theory on PCC, as described by Ekman et al. (2011) adds to the understanding of PCC, findings in this study highlight the importance, in PCC theory, of embodying theories of power relations. In addition, the determinant issue of the power relationship between the therapist and the patient needs to be explicitly addressed in undergraduate studies and basic training of PTs'.

Strengths and limitations

This study contributes by providing a novel glimpse at how PCC is perceived by PTs' in acute hospital care before any actual implementation has taken place. To ensure trustworthiness the researchers used the phenomenographical method as described by Sjöström and Dahlgren (2002). To ensure credibility, triangulation was applied (Guba, 1981). The researchers contributed different perspectives and the sampling strived for participants with a range of experiences, as well as combining different interview techniques. However, credibility may have been limited by the small sample size and the uneven gender distribution, providing little variation in perceptions. Conversely, in qualitative research the content is of more interest than the number of participants and in phenomenographical studies this normally ranges

from ten to 30 (Stenfors-Hayes, Hult, and Dahlgren, 2013). The small sample size might have limited variations in PCC experiences; however unique aspects of how PTs' from a wide range of clinical fields perceive PCC came up in the interviews. To strengthen credibility of the findings, several original quotations from participants have been provided in this study (Stenfors-Hayes, Hult, and Dahlgren, 2013). In phenomenographical method any data sampling encouraging participants to share their experiences, thoughts and reflections can be used (Karlberg-Traav, Forsman, Eriksson, and Cronqvist, 2018; Kroksmart, 2007; Marton and Booth, 2009). Since the phenomenographic method aims to elucidate variation in perceptions, semi-structured interviews were conducted individually and in focus groups. The beneficial dimension of group processes and interaction is known to enrich data, yielding more, and wider and deeper, perceptions from participants (Doody, Slevin, and Taggart, 2013a; 2013b; Karlberg-Traav, Forsman, Eriksson, and Cronqvist, 2018; Kitzinger, 1995; Stalmeijer, McNaughton, and Van Mook, 2014).

Different perspectives were also pursued: the first author (V.S.) is a PT with extensive clinical experience; the second author (M.F.), with more than 30 years' clinical experience as registered nurse and senior researcher, was able to contribute an outside perspective and methodology. Being a PT herself, V.S. was judged to facilitate the interview situation, by making the participants comfortable in speaking about the interview themes. To counteract the influence of pre-understanding, V.S. performed peer debriefing and practiced self-reflection, both to impartially focus on how the participants perceived the phenomenon and to avoid un-reflexivity (Guba, 1981; Stenfors-Hayes, Hult, and Dahlgren, 2013). The authors' continuous critical reflection regarding the contents of the perceptions and the descriptive categories has strengthened the trustworthiness.

Clinical implications

Our findings point out the importance of adequate education and support for PTs' in acute settings prior to implementation and in the early implementation phase of PCC. These findings could contribute to current knowledge in the field by arguing the importance of coherence and cognitive participation when successfully implementing a new practice such as PCC in health care (Beck, Damkjaer, and Tetens, 2009).

For the PT in clinical practice, the findings of this study may suggest that the power relations between the therapist and the patient are unequal. It is hoped that the current findings may facilitate a discussion within the profession on how we can strengthen our trust in patients in acute in-hospital care and their own knowledge of themselves concurrently as we respect our own professional knowledge. If we as a profession increase our awareness of the clinical benefits and challenges of implementation of PCC, we may contribute to a greater understanding of how the underpinning theories that frame the practice need to be constantly discussed and developed.

Conclusions

The findings in this study is represented of a small number of PTs' naïve assumptions of PCC during an pre-implementation phase. We conclude that when PCC is the subject of discussion within the PT profession, PT's are generally positive to PCC, but also indicate some challenges. They perceive PCC as a challenge to their professional role, which includes recognizing the patient in their transformed patient role. Findings indicate a need for PTs', before and during the implementation process, to acquire further knowledge about core features of PCC as well as about the philosophy of personalism. Physiotherapists working in acute hospital care should be provided with opportunities to reflect on role changes and changed power relations.

Difficulties to truly grasp and implement PCC are well documented, and current findings may contribute by indicating reasons for these difficulties. We report that individual coherence and cognitive participation are crucial when implementing new practices in health care. Novel findings emerged from this study also indicate a need to revisit the theoretical base that still influences and shapes basic training in physiotherapy, to facilitate PTs' transition toward a true partnership with the patient. Physiotherapists need to be more aware of the paternalistic tendencies in the profession and how to manage this in order to strengthen the patient in their knowledge of themselves. Power relations are not central in the philosophy of personalism, and need to be addressed if we want to enhance our possibilities to implement PCC in practice. Further research is needed to verify the findings in this study and furthermore explore

how PTs' understand and practice PCC as they understand it.

Acknowledgments

We would like to thank all the participants of the study who generously shared their time and experiences. We also thank Jeff Gracie for kind support with the translation of participant 's quotes.

ORCID

Veronica Sjöberg RPT, PhD  <http://orcid.org/0000-0002-3843-0407>

Maria Forsner RN, PhD  <http://orcid.org/0000-0003-1169-2172>

Declaration of interest

The authors report no declaration of interest.

References

- Allan CM, Campbell WN, Guptill CA, Stephenson FF, Campbell KE 2006 A conceptual model for interprofessional education: The international classification of functioning, disability and health (ICF). *Journal of Interprofessional Care* 20: 235–245. doi:10.1080/13561820600718139.
- Baker JD 1997 Phenomenography: An alternative approach to researching the clinical decision-making of nurses. *Nursing Inquiry* 4: 41–47. doi:10.1111/j.1440-1800.1997.tb00136.x.
- Beck AM, Damkjaer K, Tetens I 2009 Lack of compliance of staff in an intervention study with focus on nutrition, exercise and oral care among old (65+ yrs) Danish nursing home residents. *Aging Clinical Experimental Research* 21: 143–149. doi:10.1007/BF03325222.
- Clissett P, Porock D, Harwood RH, Gladman JR 2013 The challenges of achieving person-centred care in acute hospitals: A qualitative study of people with dementia and their families. *International Journal of Nursing Studies* 50: 1495–1503. doi:10.1016/j.ijnurstu.2013.03.001.
- Doody O, Slevin E, Taggart L 2013a Focus group interviews in nursing research: Part 1. *British Journal of Nursing* 22: 16–19. doi:10.12968/bjon.2013.22.1.16.
- Doody O, Slevin E, Taggart L 2013b Focus group interviews. Part 3: Analysis. *British Journal of Nursing* 22: 266–269. doi:10.12968/bjon.2013.22.5.266.
- Dudas K, Olsson LE, Wolf A, Swedberg K, Taft C, Schaufelberger M, Ekman I 2013 Uncertainty in illness among patients with chronic heart failure is less in person-centred care than in usual care. *European Journal of Cardiovascular Nursing* 12: 521–528. doi:10.1177/1474515112472270.
- Eisenberg NR 2012 Post-structural conceptualizations of power relationships in physiotherapy. *Physiotherapy Theory and Practice* 28: 439–446. doi:10.3109/09593985.2012.692585.
- Ekman I, Swedberg K, Taft C, Lindseth A, Norberg A, Brink E, Carlsson J, Dahlin-Ivanoff S, Johansson IL, Kjellgren K, et al. 2011 Person-centered care - Ready for prime time. *European Journal of Cardiovascular Nursing* 10: 248–251. doi:10.1016/j.ejcnurse.2011.06.008.
- Ekman I, Wolf A, Olsson LE, Taft C, Dudas K, Schaufelberger M, Swedberg K 2012 Effects of person-centred care in patients with chronic heart failure: The PCC-HF study. *European Heart Journal* 33: 1112–1119. doi:10.1093/eurheartj/ehr306.
- Engel GL 1977 The need for a new medical model: A challenge for biomedicine. *Science* 196: 129–136. doi:10.1126/science.847460.
- Finch T, Mair F, O'Donnell C, Murray E, May CR 2012 From theory to “measurement” in complex interventions: Methodological lessons from the development of an e-health normalisation instrument. *BMC Medical Research Methodology* 12: 69. doi:10.1186/1471-2288-12-69.
- Fors A, Ekman I, Taft C, Bjorkelund C, Frid K, Larsson ME, Thorn J, Ulin K, Wolf A, Swedberg K 2015 Person-centred care after acute coronary syndrome, from hospital to primary care - A randomised controlled trial. *International Journal of Cardiology* 187: 693–699. doi:10.1016/j.ijcard.2015.03.336.
- Foucault M 1982 The subject and power. *Critical Inquiry* 8: 777–795. doi:10.1086/448181.
- Grönblom-Lundström L 2008 Further arguments in support of a social humanistic perspective in physiotherapy versus the biomedical model. *Physiotherapy Theory and Practice* 24: 393–396. doi:10.1080/09593980802511789.
- Guba EG 1981 ERIC/ECTJ annual review paper: Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology* 29: 75–91.
- Hansson E, Ekman I, Swedberg K, Wolf A, Dudas K, Ehlers L, Olsson LE 2016 Person-centred care for patients with chronic heart failure - A cost-utility analysis. *European Journal of Cardiovascular Nursing* 15: 276–284. doi:10.1177/1474515114567035.
- Karlberg-Traav M, Forsman H, Eriksson M, Cronqvist A 2018 First line nurse managers' experiences of opportunities and obstacles to support evidence-based nursing. *Nursing Open* 5: 634–641. doi:10.1002/nop2.172.
- Kitzinger J 1995 Qualitative research: Introducing focus groups. *British Medical Journal* 311: 299–302. doi:10.1136/bmj.311.7000.299.
- Kogan AC, Wilber K, Mosqueda L 2016 Person-centered care for older adults with chronic conditions and functional impairment: A systematic literature review. *Journal of American Geriatrics Society* 64: e1–7. doi:10.1111/jgs.13873.
- Kroksmart T 2007 Fenomenografisk didaktik - En didaktisk möjlighet [Phenomenographic didactics - A didactic possibility]. *Didaktisk Tidskrift* 17: 1–50.
- Leplege A, Gzil F, Cammelli M, Lefevre C, Pachoud B, Ville I 2007 Person-centredness: Conceptual and historical perspectives. *Disability and Rehabilitation* 29: 1555–1565. doi:10.1080/09638280701618661.
- Løgstrup KE 1971 The ethical demand. Notre Dame, USA: University of Notre Dame Press.

- Marton F 1981 Phenomenography - Describing conceptions of the world around us. *Instructional Science* 10: 177–200. doi:10.1007/BF00132516.
- Marton F, Booth S 2009 *Om Lärande [About Learning]*. Lund, Sweden: Studentlitteratur.
- Mattsson JY, Forsner M, Arman M 2011 Uncovering pain in critically ill non-verbal children: Nurses' clinical experiences in the paediatric intensive care unit. *Journal of Child Health Care* 15: 187–198. doi:10.1177/1367493511406566.
- McBrien B 2009 Translating change: The development of a person-centred triage training programme for emergency nurses. *International Emergency Nursing* 17: 31–37. doi:10.1016/j.ienj.2008.07.010.
- Ministry of Health and Social Affairs Sweden 2014 Patientlagen (Patient Act) Stockholm. https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/patientlag-2014821_sfs-2014-821.
- Moore L, Britten L, Lydahl D, Ö N, Elam M, Wolf A 2017 Barriers and facilitators to the implementation of person-centred care in different healthcare context. *Scandinavian Journal of Caring Sciences* 31: 662–673. doi:10.1111/scs.12376.
- Mudge S, Stretton C, Kayes N 2014 Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disability and Rehabilitation* 36: 457–463. doi:10.3109/09638288.2013.797515.
- Murray E, Treweek S, Pope C, MacFarlane A, Ballini L, Dowrick C, Finch T, Kennedy A, Mair F, O'Donnell C, et al. 2010 Normalisation process theory: A framework for developing, evaluating and implementing complex interventions. *BMC Medicine* 8: 63. doi:10.1186/1741-7015-8-63.
- Olsson LE, Jakobsson-Ung E, Swedberg K, Ekman I 2013 Efficacy of person-centred care as an intervention in controlled trials - A systematic review. *Journal of Clinical Nursing* 22: 456–465. doi:10.1111/jocn.12039.
- Praestegaard J, Gard G 2011 The perceptions of Danish physiotherapists on the ethical issues related to the physiotherapist-patient relationship during the first session: A phenomenological approach. *BMC Medical Ethics* 12: 21. doi:10.1186/1472-6939-12-21.
- Praestegaard J, Gard G 2013 Ethical issues in physiotherapy - Reflected from the perspective of physiotherapists in private practice. *Physiotherapy Theory and Practice* 29: 96–112. doi:10.3109/09593985.2012.700388.
- Ricoeur P 1992 *Oneself as another*. University of Chicago Press. Chicago. .
- Rushton C, Edvardsson D 2018 Reconciling conceptualizations of ethical conduct and person-centred care of older people with cognitive impairment in acute care settings. *Nursing Philosophy* 19: e12190. doi:10.1111/nup.12190.
- Sjöström B, Dahlgren LO 2002 Applying phenomenography in nursing research. *Journal of Advanced Nursing* 40: 339–345. doi:10.1046/j.1365-2648.2002.02375.x.
- Solvang PK, Fougner M 2016 Professional roles in physiotherapy practice: Educating for self-management, relational matching, and coaching for everyday life. *Physiotherapy Theory and Practice* 32: 591–602. doi:10.1080/09593985.2016.1228018.
- Stalmeijer RE, McNaughton N, Van Mook WN 2014 Using focus groups in medical education research: AMEE Guide No. 91. *Medical Teacher* 36: 923–939. doi:10.3109/0142159X.2014.917165.
- Stenfors-Hayes T, Hult H, Dahlgren MA 2013 A phenomenographic approach to research in medical education. *Medical Education* 47: 261–270. doi:10.1111/medu.12101.
- Trede F 2012 Emancipatory physiotherapy practice. *Physiotherapy Theory and Practice* 28: 466–473. doi:10.3109/09593985.2012.676942.
- Ulin K, Olsson LE, Wolf A, Ekman I 2016 Person-centred care - An approach that improves the discharge process. *European Journal of Cardiovascular Nursing* 15: 19–26. doi:10.1177/1474515115569945.
- Womack J 2013 The relationship between client-centered goal-setting and treatment outcomes. *Perspectives on Neurophysiology and Neurogenic Speech and Language Disorders* 22: 28–35. doi:10.1044/nnsld22.1.28.
- World Confederation for Physical Therapy 2016 The international classification of functioning, disability and health. <https://www.wcpt.org/icf>.
- World Health Organization 2018 Framework on integrated people-centred health services. <https://www.who.int/service-deliverysafety/areas/people-centred-care/en/>.
- World Medical Association 1964 Declaration of Helsinki - Ethical principles for medical research involving human subjects. <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>.