

Are physiotherapists comfortable with person-centred practice? An autoethnographic insight.

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## Abstract

**Purpose:** This study aimed to understand our shared conflicting response and discomfort to person-centred rehabilitation within the context of our physiotherapy rehabilitation culture by reflecting on our own experiences as research physiotherapists and clinicians.

**Method:** This study used autoethnographical methods to explore the personal and professional experiences of two physiotherapists in neurological rehabilitation. Data were collected through ten written reflections and five joint discussions. The data were analysed collaboratively through focused conversations and writing. We looked for patterns in our data and the literature to triangulate our findings. Joint narratives were structured based on three headings: *Where we have come from, Challenges to our position and Where we are now.*

**Results:** The four main topics of discussion were goal setting, hope, the physiotherapy paradigm and person-centred practice. Physiotherapy practice is typically underpinned by a biomechanical discourse, which separates the mind and the body. This paradigm limits our ability to manage aspects of person-centred practice, such as valuing patient preferences, fostering hope, managing expectation and building a positive therapeutic relationship.

**Conclusion:** Awareness of existing influences on theory and practice is necessary to move the physiotherapy profession towards a greater degree of understanding and application of the principles of person-centred practice.

## **Introduction**

The catalyst for this autoethnographical study was our experience as lead researchers on a research project piloting an activity coaching approach to improve usual walking in people with neurological conditions. Essentially, the project investigated the acceptability to physiotherapists and patients of the addition of a small behavioural change component to standard physiotherapy practice [1]. The philosophy of coaching is derived from psychotherapy [2] and is aligned with a person-centred approach in rehabilitation [3-5]. Key characteristics of a person-centred approach considered consistent with best rehabilitation practice include respect of the person, consideration of each person in their particular context and facilitating the person to be an active participant through sharing decision making [3,6]. Coaching uses a structured framework to work with patients in a collaborative manner to set goals, develop an action plan with explicit identification and management of barriers. It also provides a model of interacting with patients which emphasises shared expertise and priorities patients' preferences.

One of two research physiotherapists (Suzie and Caroline), both of whom had attended a two day training course, delivered the intervention to the patient while the patient's physiotherapist observed. Both the patient and the patient's physiotherapist were interviewed to determine acceptability and feasibility of the activity coaching approach. The data were analysed using content analysis. Although the approach was acceptable to the patients, it appeared as though aspects of the person-centred approach caused discomfort to the patients' physiotherapists [1]. At first this finding appeared at odds with our perception that physiotherapy practice, as it is commonly practiced, is congruent with a person-centred approach. However, on reflection, as researchers and clinicians, we recognised that we too experienced emotional and cognitive difficulty when using the non-directive goal setting approach as part of the research process. We found that the research process required us to work in a different way to our normal clinical practice and we both felt uncomfortable as a result. We thought it was important to understand our shared conflicting responses within the context of our professional background in an attempt to see ourselves as we really are, not simply as

we think we are. There has been a call to critically reflect on the theoretical basis of physiotherapy as one way of extending the knowledge base and understanding the influences underpinning physiotherapy practice [7]. We selected autoethnographical methods to more closely look at ourselves within our larger professional culture of physiotherapists working in neurological rehabilitation [8,9].

Autoethnography is derived from the words *auto* meaning self, *ethno* meaning culture and *graphos* meaning to write [10]. Autoethnography uses an introspective personal voice [11], in contrast to other more formal methods of academic writing, and reveals what is normally not readily observable and often considered private [10,12]. Emotions and thoughts that arise from our interaction with patients are made public for the reader to scrutinise [12]. Autoethnography aims to draw a response from the reader, by challenging the reader to reflect on their own experience in light of the writers' narrative [13]. In this case, the culture under study is neurological physiotherapy and the emotions and thoughts that arise from using a person-centred goal setting approach.

Specifically, the purpose of this study is to understand our shared conflicting responses and discomfort to person-centred rehabilitation within the context of our physiotherapy rehabilitation culture by reflecting on our own experiences as research physiotherapists and clinicians.

## **Method**

This study used co-autoethnographical methods [9] to draw from the experiences of two people who share the same culture. Co-autoethnography seeks to understand the 'self' relative to others within the same culture and it has been argued that this collaboration can result in a broader understanding of self [9]. We (Suzie and Caroline) are both New Zealand women who trained as physiotherapists in New Zealand in the early 90s. We have both worked the majority of our professional years in neurorehabilitation (Suzie mainly in private practice where she still currently works part-time and Caroline mainly in hospital settings) and we are both involved in teaching and

research at AUT University. We both completed Masters in the late 90s. Suzie completed her PhD in 2009 and Caroline is currently enrolled in her PhD.

### Data Collection

Data were collected through two sources, independent written reflections and joint discussions (Figure 1). The first reflections were written based on our response to one specific activity coaching session where the discomfort experienced as described above was particularly evident. We read the two reflections to each other to start the discussion, which flowed freely from that point. At the end of each discussion, we jointly agreed on the next topic for discussion, independently conducted a search of the literature related to the topic, read the articles retrieved and wrote a reflection prior to the joint discussion. This process was followed until data saturation was reached, determined by joint agreement that the data reflected an understanding of the issues contributing to the discomfort that precipitated these discussions. Each reflection was between 300 and 1000 words and each discussion was approximately 45-60 minutes long. The reflections and subsequent discussion was audiorecorded and transcribed verbatim. This process resulted in ten written reflections and five discussion transcripts, which provided the data for this study.

[Insert Fig 1 about here]

### Analysis

Each of us (SM and CS) read the transcripts independently multiple times and noted initial thoughts about the discussion. We analysed the data collaboratively through focused conversations and writing [9]. We triangulated the data by looking for patterns in our data and the literature [9]. We separately constructed a narrative for each topic and then used the narratives and the ensuing discussion to collaboratively write a joint narrative following a structure based on the three headings: *Where we have come from*, *Challenges to our position* and *Where we are now*. Four narratives were jointly written summarising the topics with supporting quotes drawn from the data.

## Rigour

We reached agreement for each narrative for description of the theme and inclusion of supporting quotes through discussion. Whenever the narrative was edited by one of us, the other read through to check agreement with the changes. We resolved any differences of opinion through discussion. Triangulation was achieved through comparing the data, the emerging narratives and the academic literature [9]. NK provided guidance, feedback and mentoring through the research process.

## Findings

The findings are presented in topics supported by quotes from the reflections and subsequent discussion, which are identified by italics. The findings are written in a first person plural voice, consistent with a co-autoethnographical narrative. The voice of *we* thus represents the shared voices of Suzie and Caroline, who are not differentiated in the narrative, except for a couple of specific instances.

The four main topics of discussion were goal setting, hope, the physiotherapy paradigm and person-centred practice. In each of these discussions we discussed how our views had changed over time and what had prompted the change. Much of the discussion centred on our current views in these topics, while we clearly recognised that our current position was by no means static.

## Goal setting

### Where we have come from

We have long considered person-centred goal setting to be a core requirement of good physiotherapy practice. But in practice, we have been frustrated that the complexities we encounter in the real world are not acknowledged and may actually limit goal setting [5]. *The mantra that surrounds goal setting seems to be led by academics or funding bodies and clinicians seem to take it on board, albeit with their own interpretation, which is so far removed from what is intended that it seems ludicrous.* This may lead to a gap between what is said and what actually happens [5]. As clinicians, we have experienced discomfort with goal setting, particularly when we have perceived

patients and their goals to be 'unrealistic', but recognition of this discomfort does not appear to have been acknowledged in the physiotherapy literature. Goal setting with 'complex' patients is difficult for clinicians and leads quickly to a sense of being out of your depth so that *we worry we will have nothing to say, that we will come up with nothing, or that something will be impossible and we will get ourselves into an awkward position*. In effect, we worry about causing harm to the patient, as Caroline describes her feelings after a specific activity coaching session with a woman who she described as *lacking insight* and with *unrealistic goals*:

*What had I done? Had I opened up a can of worms, was this mangled mess of expectations unrealisable, dreams and disappointments going to overwhelm them all?*

We often avoid the feeling that arises from this situation by directing the goal setting process so that the goals are in alignment with what we, as the therapists, deem clinically appropriate [14].

### **Challenges to our position**

After this particular activity coaching session, it became apparent that there was a disparity between both physiotherapists (patient's physiotherapist and Caroline) and the patient's points of view of the value of the activity coaching session. In contrast to the physiotherapists, the patient *was so strongly positive of Caroline and the process that we were struck that the process was working for her and that this was the 'right' process*. But when *she said Caroline was the only one that believed that she would achieve her goal*, we were reminded of *the fears of her therapist, who believes that her goal is unrealistic and that this process will only set her up to fail*. *We were both screaming inside 'Unrealistic goal, unrealistic goal!'* We were conflicted with these two points of view.

It was evident that *the emotional experience for her* [the patient] *was significant and she felt listened to, valued and more empowered than she did with previous approaches*. But we are compelled to ask, *is it good enough that we empower her through physiotherapy and that is the sole outcome? Is it good enough that we don't get a functional outcome?*

We appear to feel an incredible amount of discomfort when dealing with what we consider as patients with unrealistic goals [15]. *What we are still struggling with is why there is such emotional tension when the goal is unrealistic, is it merely that we are worried about our patient, or is it to do with the credibility of our role somehow, or is it the paternalistic nature of physios? What is our ideology, where has it come from? Is it...why does this type of behavior feel as though it is unprofessional or harmful; as though we are encouraging 'false hope' maybe?*

### **Where we are now**

We now recognise that the tension in clinical practice around the use of person-centred goal setting is widespread and is related to a clash between our biomedical roots and the person-centred approach we would espouse [5,16]. Physiotherapists *all talk about client-centred goal setting* and recognise its importance, yet the *issue around unrealistic goals* is a *common perception of physios traditionally* that arises when patients articulate goals that the therapist feels can't be achieved in rehabilitation [17,18]. We now understand that 'unrealistic' is an unhelpful label and the dichotomous categorisation of unrealistic and realistic goals is not necessarily valid [17]. If we think that *goals are aspirations, hopes and dreams*, it doesn't necessarily *mean you're going to do it, but it gives you something; it is that higher order, higher level dream. The power of dreams and vision is to create hope and therefore move forward.*

We now recognise that *goal setting requires some emotional work* for physiotherapists [12], which is an important component of the humanness of our practice [19]. Personal engagement with the patient entails feeling and sometimes even *swirling emotions*, which often seems foreign to our professional selves, but is a vital part of person-centred practice [20]. We believe that personal engagement and advanced communication skills can add considerable value to the therapeutic connection between the therapist and the patient [21].

### **Hope**

#### **Where we've come from:**

As physiotherapists we consider that the value in physiotherapy is derived from treatment factors rather than personal factors or factors related to the therapeutic interaction. As a result we, consider that what we do is more important than what we say. *We are acutely uncomfortable about talking and not doing.*

While we might *recognise the importance of maintaining hope*, the value of hope is something we don't think about explicitly. *We get scared that our rehab patients come in with big expectations, big aspirations and they can put too much hope in us in the process. We are limited in our ability to meet this hope as our processes are only a small part of the picture. Hope is an unrecognised role that we play;* consequently if it is fostered as a result of treatment, it is considered to be a by-product rather than a core component of what we do. We do not have explicit skills or knowledge so we *struggle to actually understand or tap into or appreciate that we are influencing hope.*

We place a higher value on not fostering false hope than we do on building hope, possibly because a *good physio should err on the side of caution rather than supporting false hope and to physios, being honest is more important than giving hope* [22]. We hold the *view that false hope is linked with 'unrealistic goals'* and patients with 'no insight' [15]. *We strive to avoid giving patients 'false hope' as we believe this will lead to disappointment and distress when their hopes are not realised.* We think a physiotherapist who fosters false hope displays *unprofessional behaviour.*

### **Challenges to our position**

Many other allied health professionals articulate and even further, value factors such as hope [23] that are active in the therapeutic process. The literature is clear that *health professionals have the power to impact hope positively* (either enhance hope or build false hope) or *negatively* (diminish hope, prevent or reduce false hope)[24]. *Hope does appear to be clearly linked to those more abstract concepts like quality of life and it feels like it's a more tangible touchable manageable*

*concept somehow. Even though we don't realise it, we can influence it significantly and it has significant therapeutic power. It feels like it is an essential but overlooked contributor to wellbeing.* Patients identify that hope is an important factor in their recovery and it appears to be related to quality of life [25,26]. Women with stroke *identified that they got hope from the rehabilitation process and their interaction with therapists* [24]. They noted that they continued to have *hope for recovery many years after a stroke and that it was fostered by very small improvements* [24].

### **Where we are now**

The literature describes generalized hope or the state of being hopeful as critical to life, which many patients identify as an emotional motivator [22,27]. Generalised hope is *the hope, you don't want to destroy*. It can be differentiated from particularized or specific hope, which is described as a more active focused hope, which, in rehabilitation, is often related to the person's condition [25,26,28]. The cautions about false hopes are *around that specific goal or hope for recovery*. As health professionals, we now recognise that whether we accept it or not, *we hold power to build or diminish hope, which is both the joy of our work and the burden* [25]. *The role of a physio as carrier of hope makes sense to us.*

The concept of a continuum of hope-as-a-want and hope-as-an-expectation [28] may provide therapists with a way to *talk about what people want and expect* in order to understand them better. Suzie described a patient she saw recently who said that *she wanted to walk like she used to before her stroke*. Suzie used the distinction of wants and expectations to question her further, to which she responded, *'Oh no, it's not what I expect, that's what I want. And what I'd like to work on now is...'* The patient *essentially reframed what had been, what we would have considered an unrealistic goal to 'this is what I want to work on right now'*. *Before I would've just labeled the goal as unrealistic* but now we have a different way of communicating with her that doesn't minimize her perspective.

It is possible that *goal setting gives us a process to create, develop, scale, manage and adjust hope* [15], a process acknowledged by patients [24]. Specifically, we can think of *stated goals as aspirations and wants*, which can be scaled *into achievable goals or hope-as-an-expectation* [28] through the *goal setting process*. This shift in thinking has made us *feel more comfortable about working with patients whom we consider have 'unrealistic' goals*.

The concern about building up false hopes seems to be disproportionately discussed in comparison to building hope [15,29,30]. *Our balance point has shifted and we don't know how damaging false hope really is*. We suggest *there seems to be more damage from destroying hope than from fostering false hopes* [28]. In fact, *we should consider the possibility that it's not necessarily a bad thing for patients to have false hopes and should we be so concerned that their hope is, in our opinion, unrealistic?*

## **Physiotherapy paradigm**

### **Where we've come from**

The profession of physiotherapy is characterised by a 'body as a machine' (biomechanical) perspective [31] and this has provided a distinctive and powerful focus, particularly in the early days of the profession, who drew on a *biomedical paradigm* for legitimacy [19]. This perspective leans toward prioritising expert professional knowledge over patient perspectives, the part rather than the whole, normal over abnormal [32]. In our relationships with patients we usually prioritise expert professional knowledge over patient perspectives and *physiotherapists are often typified as 'do-ers'*, rather than talkers.

### **Challenges to our position**

*We have never made an effort to consider where physiotherapy has come from*, which is perhaps reflective of our *profession, that hasn't reflected* on the theoretical basis of physiotherapy [31]. Most of us acknowledge our *biomedical* roots but more than that, Nichols and Gibson point out *the body is central to physiotherapy practice* [31]. They also argue that *although function and dysfunction of*

*the body is the core of our work, there is little theory relating to the body [31]. Our professional disinterest in our underlying school of thought may be compounded because we don't view it as related, let alone valuable to our clinical practice [7]. We still feel like we can't articulate very clearly the benefit, the purpose, the need, the value in considering new ways of working or incorporating practice which considers anything different to what we currently do.*

It is not surprising then that we experience some resistance or discomfort when exposed to social, psychological and ethical issues that do not fit clearly into our body-as-a machine paradigm. If we examine our emotional response to a different paradigm, we find *'it freaks us out' basically*. It makes us *feel really uncomfortable; we can't do anything with it*. It has been suggested that our *body as a machine view limits our profession's uptake of other possible views such as client-centred care, holism, the bio-psychosocial model and disablement models [19,31]*.

### **Where we are now**

We are now aware that the therapeutic school of thought underlying our shared physiotherapy identity is less clear than we previously assumed. *Our current lack of clarity is holding back our development as a profession [19,31]*. We also recognise that our previous physio-centric approach is *quite paternalistic and I think that we have both been quite shocked at the paternalism that we recognise in ourselves. We think we have embraced client-centred care but we haven't; we don't have a clue about it*. We will struggle to adopt a person-centred approach with our current understanding of practice [19]. The feeling of resistance we experienced when moving toward a more person-centred model is likely to also be felt by other physiotherapists.

### **Person-centred practice**

#### **Where we have come from**

Previously we considered person-centredness to be the *antithesis of the biomedical model* and by extension, dichotomous. We either were or we weren't and therefore we were. Of course we rejected the biomedical model and *embraced client-centred practice!* Our assumption of our own

person-centred practice was evidenced by the good rapport that physiotherapists invariably develop with patients. We like to think that, as physiotherapists, we understand what patients need; after all, our expertise in health and functioning gives us considerable insight [33].

### **Challenges to our position**

Although patients are not necessarily dissatisfied with physiotherapy in general, their perspectives on what they want from rehabilitation as articulated in the literature [4-6] has challenged our position of thinking we provide what patients want and need. Patients want *to be seen as a whole person* [3] and to share *power* with therapists [4,6,33] and be *empowered*. *The importance of an individually tailored programme designed to meet individual needs is also essential* [6,34]. Patients *generally want and expect their providers to understand their specific situations and specific needs as individuals* [6]. *This may be different from what is considered by professionals to represent evidence based practice or even best practice* [16].

*Human beings have a significant need for connection* [21] *and a sense of continuity over their life course and the introduction of disease and disability usually produces a significant challenge to both these aspects with the neurological event and related disability often permanently affecting both their sense of who they are and their intimate social relationships* [35]. *A common theme emerging from qualitative studies reflects the sense of 'biographical disruption' that a neurological condition or disability brings* [36]. *Rehabilitation clients often raise these challenges related to identity and family relationships which are seldom, if ever, addressed in most rehabilitation settings* [4].

### **Where we are now**

If we recognise our natural tendency towards paternalism, we can make a more conscious commitment to practice in a person-centred way that avoids assumptions about patients' needs and wants, *which are often problematic and inaccurate*. *Physiotherapy as a profession can become*

*irrelevant if it doesn't incorporate some of the more humanistic aspects of its heritage and prioritise clients' expressed needs and preferences and support autonomy. We now believe that mindful listening, the need for emotional support and the need for supporting hope are important facets of person-centred practice. We are now more comfortable with talking and not doing as being a therapeutic intervention of value on its own. We're now more aware of what physiotherapy can offer, but also its limitations from a patient's perspective.*

Person-centred practice poses a number of challenges for our profession [5,37]. Physiotherapists often lack capabilities to *collaborate and share power and knowledge* [5], which results in a *lack of readiness and confidence to recognise shared expertise of patients and take on a broader view of functioning which is needed before patient-centred care can move beyond its current nominal adoption* [33]. This change of relationship from one of the expert, all knowing, physically focused physiotherapist to a relationship of greater collaboration and connection *will require a range of more advanced communication skills* [38], for which most physiotherapists are ill-equipped.

Patients may also be unprepared for taking up a collaborative role, which in part may be due to cognitive, emotional and/or psychosocial factors related to the condition or health beliefs [4,37]. Therapists need to recognise that patients may require *a continuum of interaction styles* from an approach where the patient adopts a *more passive* role, through to very collaborative approaches where the patient is *more active, empowered and involved* [21,33,34]. This way of working with patients provides a flexible view of person-centredness, which offers a degree of responsiveness to each person's individual needs.

## **Discussion**

The purpose of this study was to understand the causes of discomfort that we experienced when delivering a person-centred intervention that required us to focus on goals that were meaningful to the patient and not what we assumed were the patient's needs [6,39]. As a result of this

autoethnographic study we were able to gain insight into the causes of this discomfort which provided some surprising findings for us.

In summary, we were uncomfortable with aspects of person-centred practice, because as we now understand, our practice is often more focused on a 'body as a machine' perspective that separates the mind from the body and positions the physiotherapist as the primary expert in a way that discounts the views and preferences of the patient. As a consequence, we prioritise 'doing to' rather than 'being with', the collaborative approach that underpins person-centred practice [40]. A second and related source of discomfort stemmed from a subconscious belief that allowing a patient to express a rehabilitation goal that we considered to be 'unrealistic' was psychologically unhelpful. A final source of discomfort was the recognition that goal setting in rehabilitation required emotional work [41], for which physiotherapists were not well prepared.

Physiotherapy practice is dominated by a biomedical discourse, positioning the health professional as the expert and the patient as the recipient of care [33]. This role of the expert can lead physiotherapists to assume knowledge of the needs and priorities of the client. Although this approach does not deliberately discount the patient's view, it does limit the value physiotherapists place on gaining the patient's perspective [14,33], a key feature of person-centred practice. Our usual way of working as an expert focuses on our own perspective that makes it difficult to work in a person-centred way.

A second key feature of person-centred practice is a commitment to work in partnership with patients, sharing rather than exerting power [5]. Our findings suggest that if we are to truly work in a person-centred way, we need to recognise that we often underestimate the capabilities of patients and we need to value the knowledge that only the patient has, namely expertise about their needs, preferences and life situation. It is also important to appreciate that patients may hesitate to become an active 'partner' if they lack the confidence to be engaged in the rehabilitation process [5]. Therefore it is also part of our professional responsibility to incorporate strategies to help

patients better prepare themselves for greater collaboration so they can be more active in the management of their condition. Such strategies include acknowledging patient's expertise at the outset, seeking out and carefully listen to the patient's perspective and showing flexibility in response to patients' changing needs and situations [5].

It is also important to appreciate that patients are not always in a position to assume power [4] and may wish for a more directive relationship from the therapist [21]. Peoples et al assert that enabling empowerment may involve recognising that patients have the right to assume responsibility, as well as the right not to assume responsibility [4]. However, there is a risk that physiotherapists could use this rationale for the continued use of an unconscious paternalistic approach [33] without clearly determining the wishes of an individual patient at a particular moment in time. Careful questioning and listening are the first steps to avoid this pitfall followed by ongoing assessment of the patient's wishes to assume responsibility, as this often changes over time [5].

Physiotherapists have been quick to appreciate the value of person-centred goal setting, yet a tension arises when a patient generates a goal that we perceive to be 'unrealistic' and unachievable [14] and we inevitably focus on the potential detrimental consequences of failing to achieve the goal. There is evidence to suggest that striving towards meaningful goals (even 'unrealistic' ones) is fundamental to human behaviour and psychologically beneficial [17]. Explicitly distinguishing when expressed goals are 'future aspirations' (i.e. 'hope-as-a-want') and when they are expectations related to treatment outcomes (i.e. 'hope-as-an-expectation') may be helpful during goal negotiation. Suggestions for a tiered response related to hope that include strategies to increase therapist awareness through to more active intervention may be useful for physiotherapists [27]. In addition, both the role that the physiotherapist plays and the physiotherapeutic interventions themselves are worth exploring further with respect to the development of hope.

We suggest that because physiotherapists separate the mind and the body in practice, we are unprepared for the emotional work that person-centred goal setting entails for the physiotherapist,

as well as how different interaction styles can influence the therapist-patient relationship and consequently, the degree of emotional support experienced by our patients. We need to both recognise and value the emotional side of our clinical practice and develop an awareness of the value that open communication, allowing time and mindful listening have in supporting a patient emotionally [40] and in enhancing the therapist-patient relationship [42].

On the basis of our research, we argue that we have struggled to adopt a person-centred approach because of the strong biomechanical discourse that underpins our practice and suggest that our experience is not isolated; on the contrary it is likely to reflect the position of the profession as a whole [5,7,16,18,31,43]. We also can see that our profession has little theory in comparison with other professions and so would repeat the call of others to develop theory in relation to our identity as a profession [31] and develop a shared understanding of how to incorporate principles from person-centred practice into physiotherapy.

One common criticism of autoethnography is the subjectivity of the process and content. However the focus on the subjective and the emotional is not necessarily the antithesis of the academic objective and rational view. Indeed, our professional practice is simultaneously constructed of the objective and rationale professional view with the subjective personal view that, too often is hidden [13]. These methods made us feel both vulnerable and exposed and we found it was nearly always challenging. But the opportunity to systematically explore and challenge our underlying assumptions, question our backgrounds and ways of working has been a useful process in our professional development. The sharing of our reflections, thoughts and emotions with a colleague made the process even more powerful. It is hoped that this exposure will strike a chord of familiarity to other physiotherapists, who may also find the chance to compare to our experiences of professional practice an equally useful self-reflective process [11].

## **Conclusion**

There is general agreement amongst patients and clinicians that person-centred care is important. Our findings suggest that as physiotherapists we may encounter a tension when we attempt to amalgamate person-centred practice with our current way of working in rehabilitation. We suggest adopting a more active communication style that focuses on gaining the patient's perspective as a practical strategy consistent with the application of person-centred practice. However, a greater awareness of existing historical and theoretical influences on physiotherapy practice (both implicit and explicit) would provide a good basis for discussion and debate within the profession. This may both aid critical reflection regarding the current state of the profession as well as provoke the theory development work necessary to move the physiotherapy profession towards a greater degree of understanding of the principles of person-centred practice.

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## Declarations of Interest

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