

Reflecting on challenges and opportunities for the practice of person-centred rehabilitation

Clinical Rehabilitation
2023, Vol. 37(8) 1026–1040
© The Author(s) 2023



Article reuse guidelines:

sagepub.com/journals-permissions
DOI: 10.1177/02692155231152970
journals.sagepub.com/home/cre



Nicola M Kayes¹  and Christina Papadimitriou²

Abstract

Objectives: To (1) reflect on challenges to the practice of person-centred rehabilitation; and (2) propose opportunities for the development of person-centred rehabilitation.

Challenges: Person-centred practice has received widespread endorsement across healthcare settings and is understood to be an important, positive approach in rehabilitation. However, the rhetoric of this approach does not always translate meaningfully into practice. Emphasis on patient choice, patient involvement in decision making, and increasing patient capacity for self-management have become a proxy for person-centred rehabilitation in lieu of a more fundamental shift in practice and healthcare structures. System (e.g. biomedical orientation), organisational (e.g. key performance indicators) and professional (e.g. identity as expert) factors compete with person-centred rehabilitation.

Opportunities: Four key recommendations for the development of person-centred rehabilitation are proposed including to: (1) develop a principles-based approach to person-centred rehabilitation; (2) move away from the dichotomy of person-centred (or not) rehabilitation; (3) build person-centred cultures of care in rehabilitation; and (4) learn from diverse perspectives of person-centred rehabilitation.

Conclusion: Fixed assumptions about what constitutes person-centred rehabilitation may limit our ability to respond to the needs of persons and families. Embedding person-centred ways of working is challenging due to the competing drivers and interests of healthcare systems and organisations. A principles-based approach, enabled by person-centred cultures of care, may achieve the aspirations of person-centred rehabilitation.

Keywords

Person-centred practice, rehabilitation, concept, theory

Received August 6, 2022; accepted January 7, 2023

Introduction

Person-centred rehabilitation has long been advocated for.¹ The rhetoric of person-centred rehabilitation is strong. It is embedded in health policy, professional competencies, and service frameworks.^{2–4} However, it is not always experienced as such by people and families accessing rehabilitation and research suggests the full scope and

¹Faculty of Health and Environmental Sciences, Centre for Person Centred Research, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand

²Department of Interdisciplinary Health Sciences, Oakland University, Rochester, MI, USA

Corresponding author:

Nicola M Kayes, Faculty of Health and Environmental Sciences, Centre for Person Centred Research, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand.
Email: nkayes@aut.ac.nz

potential of person-centred rehabilitation is yet to be realised.^{5–8} We are two researchers who have undertaken research to contribute to theory and evidence in person-centred rehabilitation from different perspectives. We have each worked with rehabilitation organisations and providers to support the implementation of person-centred rehabilitation in our respective countries. In this paper, we draw from our knowledge and experience to reflect on challenges to the practice of person-centred rehabilitation. We engage with existing evidence to examine the connection between theory and practice and identify opportunities for translating the rhetoric of person-centred rehabilitation into practical action.

We have organised this paper into two sections. In the first section, we focus on the *concept and practice* and the *system and organisational culture* of person-centred rehabilitation. We discuss the diversity of perspectives on the concept of person-centred rehabilitation and the consequences for person-centred rehabilitation. We then consider the system and organisational challenges which constrain person-centred rehabilitation. This section is not an exhaustive review of the literature on person-centred rehabilitation. Rather we draw attention to a range of existing theory and practice to illustrate challenges to the practice of person-centred rehabilitation.

In the second section, we offer *four opportunities* for the continued development of person-centred rehabilitation so it can be implemented to its full potential. These recommendations are not meant as quick fixes to cultural and systemic assumptions and practices. Rather, they are meant as a possible way forward to enable person-centred rehabilitation in a healthcare system with competing drivers and interests. Figure 1 provides a summary of the key points addressed in each of these sections.

Where our perspectives come from?

Our reflections in this paper come from our own research^{6,7,9–16} and by listening to the experiences of people and families accessing rehabilitation and their practitioners. At a theoretical level, we are inspired by a field called critical rehabilitation

studies.^{12,17–22} In critical rehabilitation studies, researchers make visible and explore taken for granted assumptions inherent in everyday or common clinical practices and disciplines. For instance, Hammell^{22,23} pointed out the tendency to accept rehabilitation professional assumptions as truth without critical reflection, and highlighted tensions and inconsistencies between the ideology and practice of client-centredness.²² Similarly, Gibson et al.^{17,18} showed that rehabilitation professionals' assumptions about independence may be counter to a person-centred approach, because their views are individualistic rather than treating the person-served within the cultural and relational context in which they live and received their care. Other critics have argued that some people such as those with cognitive or communicative impairment may be inadvertently excluded from person-centred rehabilitation⁸ because of the emphasis on promoting autonomy, patient choice, and active involvement of clients in decisions about their care.²⁴

Challenges to the practice of person-centred rehabilitation

The concept and practice of person-centred rehabilitation

There are a range of competing definitions, concepts, and disciplinary-based frameworks for person-centred rehabilitation. In both rehabilitation research and practice, we have been at risk of working independently, without collaboration and in competition with each other in our endeavour to advance person-centred rehabilitation. This has likely hindered continued development in the practice of person-centred rehabilitation.

There is an extensive body of research aiming to conceptualise, define, operationalise, measure, and evaluate person-centred rehabilitation.^{25,26} A wide range of models have been established, including models specific to profession, diagnosis or setting.^{27–31} These efforts support the operationalisation of person-centred rehabilitation in different settings, which can be helpful in some instances. However, profession- or diagnosis-specific models may have limited application in rehabilitation

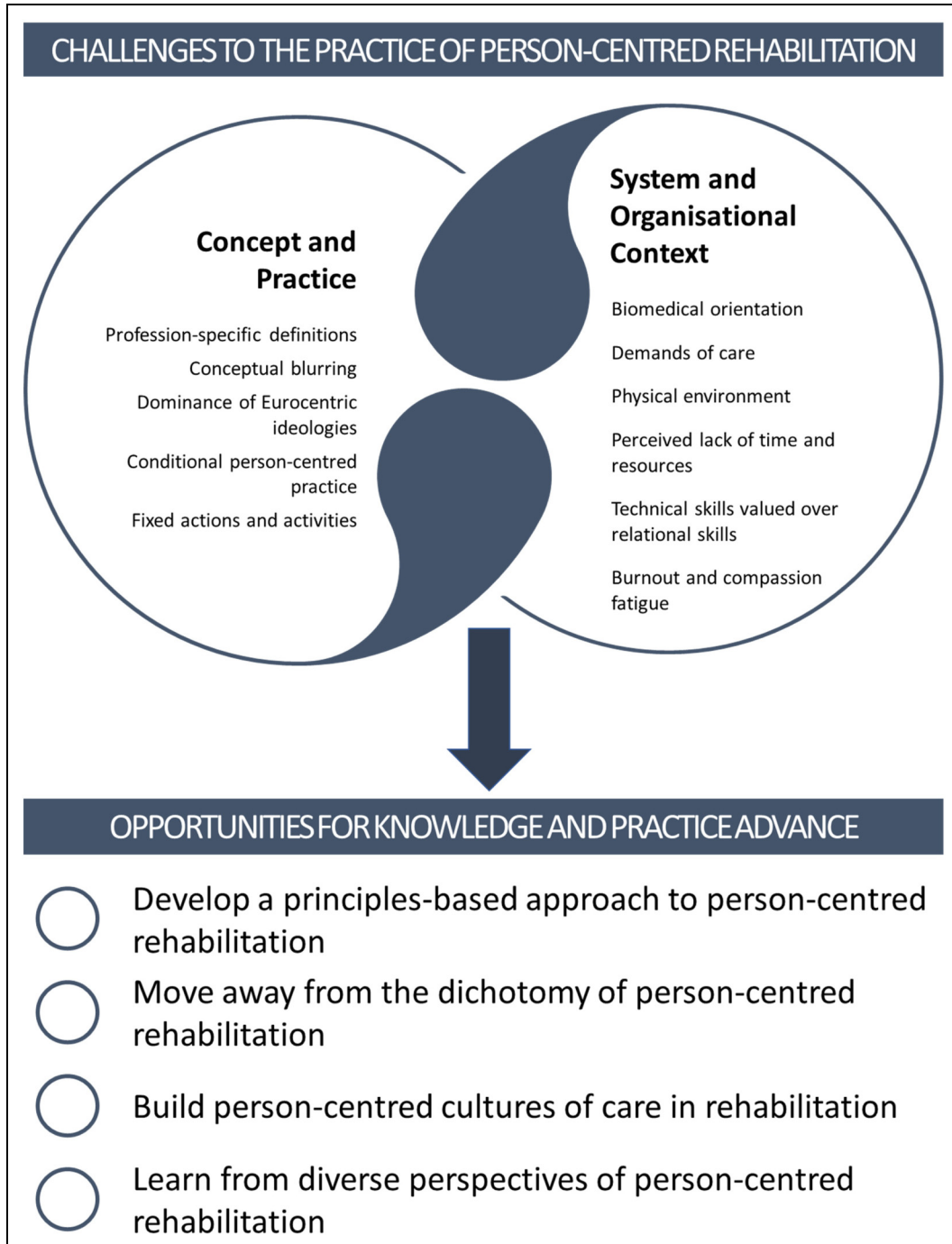


Figure 1. An overview of the key arguments presented in this paper.

which is argued to be a complex intervention involving a multidisciplinary team, and where multimorbidity is common.³² Further, the independent development of multiple models reduces the likelihood of negotiating a common understanding of person-centred rehabilitation.

The range of perspectives on person-centred rehabilitation makes it difficult to establish a shared sense of what constitutes person-centred rehabilitation and how to operationalise that for clinical practice. This is compounded by the availability of multiple, overlapping concepts. For example, the literature refers to relationship-centred,³³ family-centred^{34,35} and child-centred³⁶ care, all of which overlap with the central tenants of person-centred rehabilitation (see Table 1). There are also new approaches being

developed, such as lifeworld-led rehabilitation,³⁷ in response to the perceived shortcomings of existing models or the implementation of person-centred rehabilitation. These ideas, concepts and approaches have increased conceptual blurring and hampered improvement in defining, refining, and implementing person-centred rehabilitation.

Consistent with the broader rehabilitation evidence base,³⁸ most existing research exploring person-centred rehabilitation draws on western perspectives. Of the 170 papers included in our scoping review, there were no included papers engaging with indigenous perspectives of person-centred rehabilitation.^{25,26,39} This is likely to have an effect on how person-centred rehabilitation is understood and implemented in practice. For example, Eurocentric

Table 1. Examples of related concepts evident in the literature.

Concept	Explanation
Relationship-centred (RCC)	“RCC can be defined as care in which all participants appreciate the importance of their relationships with one another. RCC is founded upon 4 principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable.” (p. S3) ³³
Family-centred (FCC)	“A universal goal of FCC models to develop and implement patient care plans within the context of families. To facilitate this aim, family-centered care models require: 1) collaboration between family members and health care providers, 2) consideration of family contexts, 3) education for patients, families, and HCPs, and 4) dedicated policies and procedures.” (p. 5) ³⁴
Child-centred	“A truly child-centred approach includes both the adult’s child perspective concerning the children’s best interests in terms of care and the child’s perspective with respect to his or her preferences.” (p.103) ³⁶ “A model to encourage health care organizations and health professionals to support children’s right to participate in topics that concern them and to achieve the child’s perspective is offered by Shier (2001). This five-level model will be a useful aid to ensure that: 1. irrespective of age the child is listened to 2. the child is supported in expressing his/her views 3. the child’s views are taken into account 4. the child is involved in the decision-making process 5. the child can share power and responsibility in the decision-making.” (p. 104) ³⁶
Lifeworld-led rehabilitation	Humanising lifeworld-led practice principles include: <ul style="list-style-type: none"> • “Recognising a mutually arising reality rather than a reality ‘out there’ • Recognising a reality which was constantly changing rather than ‘fixed’. • Recognising that we needed to work from within, as part of a human living system rather than trying to control reality from the ‘outside’. • Understanding that this reality could be accessed through human knowing, involving embodied knowing rather than intellectual knowing alone.” (p. 3)³⁷

ideologies of individualism and independence are pervasive in rehabilitation^{17,18} and may impact how 'personhood' may be understood and conceptualised.⁴⁰

While the ideal of person-centred rehabilitation has widespread support, in practice rehabilitation professionals find it challenging. Several tools and practices have been developed to support person-centred ways of working in rehabilitation. For example, there is extensive research aiming to optimise person-centred approaches to goal planning,⁴¹⁻⁴⁵ engagement,⁴⁶⁻⁴⁹ therapeutic relationship,⁵⁰⁻⁶⁰ communication,⁶¹⁻⁶⁴ education,^{65,66} interdisciplinary teamwork¹⁵ and self-management⁶⁷⁻⁶⁹ – all aiming to support the practice of person-centred rehabilitation through a focus on transdisciplinary rehabilitation processes.

Despite this, health professionals find it difficult to balance perceived professional responsibilities with the needs and preferences of persons and families accessing rehabilitation,^{5,41,42} struggle to let go of their role as expert,^{7,67,69} experience tensions in managing professional boundaries,⁵⁰ and feel limited in their ability to meet their own aspirations for care due to competing service demands.^{69,70} Language such as 'benign dictators'⁶⁹ and 'benevolent manipulation'⁶ has been used to articulate such tensions, argued to be a result of the biomedical model.^{7,69} Our reading of this literature is that, at best, we currently implement a form of conditional person-centred rehabilitation. Table 2 provides some illustrative examples of how conditional person-centred rehabilitation can materialise in practice.

This evidence suggests we may have been at risk of underestimating the complexity of putting person-centred rehabilitation into practice. We have fallen into a pattern of reducing person-centred rehabilitation down to a set of key actions and activities centred on activating people to be involved in their rehabilitation. As such, fixed actions and activities, such as involving patients in decision making about their care and increasing patient capacity for self-management, have become a proxy for person-centred rehabilitation in lieu of a more fundamental shift in practice and healthcare structures.

Led by Jesus,⁹ we recently carried out a thematic synthesis of the literature. In our findings, we conceptualised person-centred rehabilitation as a way of thinking about, organising, and delivering rehabilitation

which can be enabled and enacted across multiple layers (person-professional dyad, micro-system and macro-system), each with its own set of attributes. These findings highlight the importance of moving beyond what happens in the therapeutic encounter, to include the role of structures and processes that may constrain or make possible person-centred rehabilitation.

The system and organisational context of person-centred rehabilitation

Embedding person-centred rehabilitation into health-care delivery systems of care is challenging. Nonetheless, emerging evidence demonstrates the potential beneficial impacts of person-centred rehabilitation for patients, professionals, and teams. These benefits highlight the broader impact and value of person-centred cultures of care.

Healthcare systems are generally organised hierarchically and prioritise cost efficiency for the organisation.⁷¹ They often draw from the biomedical model of care⁷² wherein clinicians are given more authority and power compared to patients⁷ and patients often accept medical paternalism.⁷³ Although clinicians are treated as experts, they are not necessarily supported to provide high quality, person-centred services.⁷⁴ In other words, most health-care organisations' structures and processes – such as policies, professional obligations and responsibilities, practice conventions, clinical documentation, service drivers – do not value the perspectives and experiences of clinicians or their patients.⁶ If we want to provide services that are more person-centred, we need to challenge the usefulness of the biomedical model and reimagine structures and processes⁷⁵ which support, enable and make person-centred rehabilitation possible.

Often the demands of care compete with the practice of person-centred rehabilitation. For example, in inpatient stroke rehabilitation there is increasing pressure on services to reduce length of stay. Focusing on length of stay as a metric of service performance (structure) leads to a focus on reducing impairment and optimising function (process) for the primary purpose of getting someone safe to discharge (outcome). In this context, rehabilitation

Table 2. Examples of conditional person-centred rehabilitation drawing on quotes from research undertaken by the first author.

Example	Illustrative quote
We endorse personalised goal planning, but then put boundaries around what constitutes a legitimate goal based on what is perceived to be within scope or can be achieved within that specific episode of care.	<i>“She did have a lot of goals around her mobility which were really difficult though, for the physio to manage, because there weren’t realistic things that she wanted to be doing.”</i> (Occupational therapist)
Even when our instincts suggest it would not be the right thing for this person right now, we proceed in the interests of following protocol.	<i>“Some of the questions are very sensitive, so at times you are like ‘I don’t know if this is actually the right time for me to ask this?’ But, that’s... you know, how we do our first visit.”</i> (Speech and Language therapist)
While on one hand we promote patient choice and control, we can sometimes be at risk of being paternalistic and/or making assumptions about what a persons’ own needs and preferences might be.	<i>“He has got a lot going on in his head sort of brain injury wise [...] he’s not going to want a bar of this.”</i> (Physiotherapist)
We tend to withdraw from people who don’t meet our expectations of engagement and attribute blame to them, rather than considering our role in creating the context for engagement.	<i>“Well generally if they refuse therapy, like say I put them on my timetable twice a week for three weeks and they refuse, you know, 80% of the sessions, or someone brings them down for two sessions but then they don’t come for the rest or something like that [then] I’ll take them off because I’m really, really busy and I can’t waste an hour trying to get someone out of bed each time.”</i> (Speech and Language therapist)
While we recognise that getting to know and understand a persons’ psychosocial context may be formative to rehabilitation input and outcome, we can sometimes be hesitant to engage with it.	<i>“I was a bit concerned about how my client would actually respond for the simple reason that he had a lot of social things going on in his life, and I just wondered whether it un-earthed stuff...”</i> (Physiotherapist)
We give emphasis to educating people, privileging our professional knowledge and expertise, sometimes devaluing their knowledge and experience of what living with that condition is like for them in their unique and particular circumstances.	<i>“...our responsibility is to set a programme for them and to educate them on why they’re doing those bits and pieces we’ve given to them and an idea of how often they need to be doing them so quite clear prescription and then from there my expectation is that they commit to that.”</i> How do you think a patient would describe self-management? <i>“Depends how much education they’ve had.”</i> (Physiotherapist)

is time-limited, focused on what is achievable from the professionals’ perspectives and in the time-frames they have.⁴¹ It contributes to professionals privileging ‘realistic’,⁷⁶ service-centric, discipline-specific goals⁴¹ over what may matter to the person (similar to the first example provided in Table 2). This can have the effect of limiting people’s hope and sense of possibility for the future despite this being a critical resource for recovery.^{76–78}

The physical environment can also play a role in enabling or hindering person-centred rehabilitation.^{79,80} Recent research drawing on experience-based

co-design with patients and professionals in stroke units introduced changes in the environment in collaboration with staff and patients.⁸⁰ For example, changes included reclaiming shared spaces (which had become storage facilities or staff meeting spaces) so that patients could socialise with each other and their visitors, reorganising the ward and reducing clutter, painting corridors and introducing artwork, and creating space for personal belongings and pictures at the bedside. Staff and patients reported that these changes made the ward feel more inclusive, led to increased activity opportunities for patients, and changed the nature

of bedside conversations prompted by the items from home.

Healthcare professionals often highlight that time (or lack of) is a barrier to person-centred rehabilitation.^{73,81} However, person-centred rehabilitation does not necessarily need to take more time.⁷⁰ Rather, the values of person-centred rehabilitation can be integrated into all that we do and embedded in how we work. Instead of focusing on *how much* time we have (or don't have), it may be important to examine how we *prioritise and use* our time (and what demands that we prioritise our time in that way). The inpatient stroke rehabilitation example above highlights that our structures contribute to some ways of working being prioritised (e.g. service-centric, discipline-specific processes and outcomes) over others (e.g. person-centred processes and outcomes) in the time we have.

Ideas about what constitutes the core of rehabilitation practice are embedded in health curricula and organisations – where 'hard' technical skills are routinely prioritised over 'soft' relational skills – rather than promoting a more integrated way of working that weaves them together. Indeed, there is an inferred hierarchy in the language of 'hard' versus 'soft'. Relational skills are critical to the implementation of person-centred rehabilitation. However, they are often positioned as innate, or an ingrained personality trait, rather than something that can be taught, developed, and nourished. This inevitably results in limited investment in the ongoing growth and development of relational ways of working in education and practice.^{79,81} This may in turn influence how person-centred rehabilitation is positioned in everyday rehabilitation practice, particularly in the context of other competing demands and limited time and resources.

Rehabilitation professionals report experiencing work-related stress and burnout.^{82–86} Compassion fatigue, characterised as a stress response in health professionals 'culminating in a decrease in compassionate feelings towards others because of an individual's occupation' (p. 10)⁸⁷ highlights the potential for a direct relationship between work-related stress and one's capacity to offer person-centred rehabilitation services. This relationship may be influenced by

intra-team and organisational factors. For example, support and cooperation, shared understanding and goals, mutual respect and flexibility and sharing tasks are relationship characteristics that enhance person-centredness within interdisciplinary teams.¹⁵ Similarly, patients have observed that when professionals treat each other in person-centred ways, their interactions appear less hierarchical and there is a greater sense of interprofessional congruity.⁸¹ Implementing person-centred ways of working may be beneficial for professionals and rehabilitation teams, potentially countering work-related stress.

In summary, person-centred practice has received widespread endorsement across health settings and contexts, and is understood to be an important, and positive approach in rehabilitation. However, the rhetoric of person-centred rehabilitation does not always translate into clinical practice. Research highlights a tension between organisational, system and professional factors and attending to the needs and preferences of persons.

In the following section, we highlight four opportunities for the ongoing development of person-centred rehabilitation.

Opportunities for the continued development of person-centred rehabilitation

In this section, our recommendations draw from several literatures and in a certain sense are not novel. Indeed, Restall et al. touched on many of the points we make in their framework of strategies for client-centred practice published 20 years ago.⁸⁸ Our suggestions are intended as focused reminders and practical steps that we can take to address challenges to the implementation of person-centred rehabilitation. Our intention is for these suggestions to support rehabilitation professionals and organisations reimagine how they may enable person-centred rehabilitation in diverse settings and communities. In this sense, our work follows current calls for unpacking how social and political determinants of health impact our lives, decolonising clinical practice, resisting neo-liberal policies that ration care, and reimagining healthcare that embraces disability justice.^{89,90}

Develop a principles-based approach to person-centred rehabilitation

Attempts to reduce person-centred rehabilitation to a fixed set of behaviours have resulted in a transactional approach to person-centred rehabilitation.⁹¹ Greater recognition of the multidimensional nature of person-centred rehabilitation – which is both person- and context-bound – would help us move beyond person-centred rehabilitation as a particular set of actions or behaviours. Instead, we suggest focusing less on ‘what’ constitutes person-centred rehabilitation and more on ‘how’ we work and ‘who’ we are, and how what we do is experienced by people.

A focus on principles which can underpin ways of working, rather than specific behaviours, may enable a more responsive and reflexive way of working. A reflexive way of practicing may be best described as asking oneself the question ‘what am I doing when I am doing what I am doing?’⁹² Further, a principles-based approach doesn’t rely on the cognitive or communication capacities of individuals to meet the demands of person-centred rehabilitation and so ensures the aspirations of person-centred rehabilitation can be universally available to all. We might call this a person-centred approach to person-centred rehabilitation.

There are already examples evident in the literature which are consistent with a move towards a principles-based approach. For example, findings from a secondary analysis of qualitative data examining examples of care that were experienced by persons served as person-centred¹¹ drew attention to an orientation to care including: recognising and responding to the context of care for persons and families; prioritising and investing in the development of relationships; building a currency of trust; and developing a belief in self and one’s capabilities. In our thematic synthesis of literature exploring person-centred rehabilitation⁹ we identified five attributes of person-centred rehabilitation including: (1) respectful of and tailored to the person, (2) reflexive and adaptive to the situation at hand, (3) nurtures a supportive relationship, (4) focused on meanings, hope, and strengths, and (5) collaborative, empowering, and enabling. Both

examples describe an approach to person-centred rehabilitation which is reflexive and responsive, rather than a pre-defined set of professional behaviours and actions.

Move away from the dichotomy of person-centred rehabilitation

Embracing the multidimensional nature of person-centred rehabilitation would also help us to move away from thinking about person-centred rehabilitation as a dichotomy – that you are either person-centred or not. Most rehabilitation providers inherently believe in the value of a person-centred approach.⁹¹ However, conceptualising person-centred rehabilitation as a dichotomy fails to acknowledge the complexity of person-centred rehabilitation as a human endeavour, which is subject to our fallibilities and vulnerabilities and which takes place within complex and competing organisational structures and demands. We should acknowledge the potential for ‘simultaneous moments of person-centred and non-person-centred care’ (p. 2)⁷⁹ and that we may be person-centred with some people, in some contexts, on some days and not on others.

Moving away from the dichotomy of person-centred rehabilitation will allow for a more open, honest, and respectful conversation about person-centred rehabilitation. A conversation that acknowledges these complexities, and where humility is not just welcome, but necessary for continued practice advance. We could consider a continuum of person-centred rehabilitation, similar to the continuum of engagement.⁹³ Or, we could reconsider person-centred rehabilitation as part of a complex adaptive system⁹⁴ which enables a learning culture characterised by an ‘ability to tolerate productive tensions, learn from mistakes, support and enable innovation, maximise individual potential, and understand the interrelationship between team/system processes and the effectiveness of outcomes achieved’ (p. 2).⁷⁹

Fundamentally, this more reflexive engagement with person-centred rehabilitation may mean we are more likely to examine and address some of the tensions experienced by clinicians in the

implementation of person-centred rehabilitation. It may help us to reimagine some of the central tenets of our professional identities that constrain person-centred rehabilitation. For example, critically reflecting on the what, why and how of professional boundaries, or indeed challenging the basic premise of *boundary*.⁹⁵ Or, extending how we think about what constitutes *expertise* in rehabilitation and how to retain credibility while also showing vulnerability.⁹⁶ We suggest moving beyond the dichotomy of person-centred rehabilitation is a necessary step in this reimagining.

Build person-centred cultures of care in rehabilitation

We need to make ‘person-centred moments’ an ‘everyday cultural pattern or norm’ (p. 2).⁷⁹ For this, we need to build person-centred cultures of care which enable person-centred rehabilitation (see Figure 2). This includes having a system-wide commitment to person-centred rehabilitation. Person-centred practice needs to be top-down.⁸¹ That is, it needs to be valued and embedded within health curricula, by healthcare service organisations, and in healthcare policy. For person-centred rehabilitation to be embedded in the social fabric of what we do and how we practice, we need to develop an understanding of person-centred rehabilitation across multiple stakeholders, including funders, insurers, and policy makers.

Structures and processes that drive how we work – such as key performance indicators, documentation practices, assessment processes, discharge planning – need to be reimagined to make person-centred rehabilitation possible. Earlier we referred to the example of inpatient stroke rehabilitation and length of stay as a metric of service performance. What if the only key performance indicator was the person with stroke living the life they want to live, and the key outcome of interest their long-term health and well-being. How would this change what is prioritised in stroke rehabilitation? It is these kinds of thought experiments that help us to envisage *what could be* or *how it could be different*.

A person-centred culture of care includes recognising *all* persons involved in person-centred rehabilitation including patients, family, care partners, and professionals. The Senses Framework proposes that in the best care environments *all* parties should experience six senses, including a sense of security, belonging, continuity, purpose, achievement, and significance,⁹⁷ resonating with theories of well-being.⁹⁸ Nolan et al. provides an excellent example of how these six senses might be experienced by patients, families/care partners and professionals in dementia care.

For example, they suggest a sense of security in this context may include ‘attention to essential physiological and psychological needs and to feel safe and free from threat, harm, pain and discomfort’ (for patients), ‘to feel free from physical threat, rebuke, or censure, to have secure conditions of employment, to have the emotional demand of work recognised and to work within a supportive culture’ (for staff), and ‘to feel confident in knowledge and ability to provide good care without detriment to personal well-being, to have adequate support networks and timely help when required and to be able to relinquish care when required’ (for family/care partners). Person-centred cultures of care which value health professionals and provide resources for them to meet the demands of person-centred rehabilitation is likely to have a ripple effect for patients and family care.⁷⁴

A person-centred culture of care involves ongoing evaluation of person-centred rehabilitation.^{79,81} If we acknowledge the multidimensional nature of person-centred rehabilitation, we need to carefully consider *how* one evaluates person-centred rehabilitation, and what constitutes a good outcome. This may include the development of dynamic assessments which focus not only on whether person-centred rehabilitation was delivered, but also how it happens, what allows it to happen, what skills are needed and so on.⁹⁹ It may be that evaluations need to move beyond measures as we conventionally understand them, and move towards integrating more qualitative, creative and participatory approaches to evaluating person-centred rehabilitation.¹⁰⁰

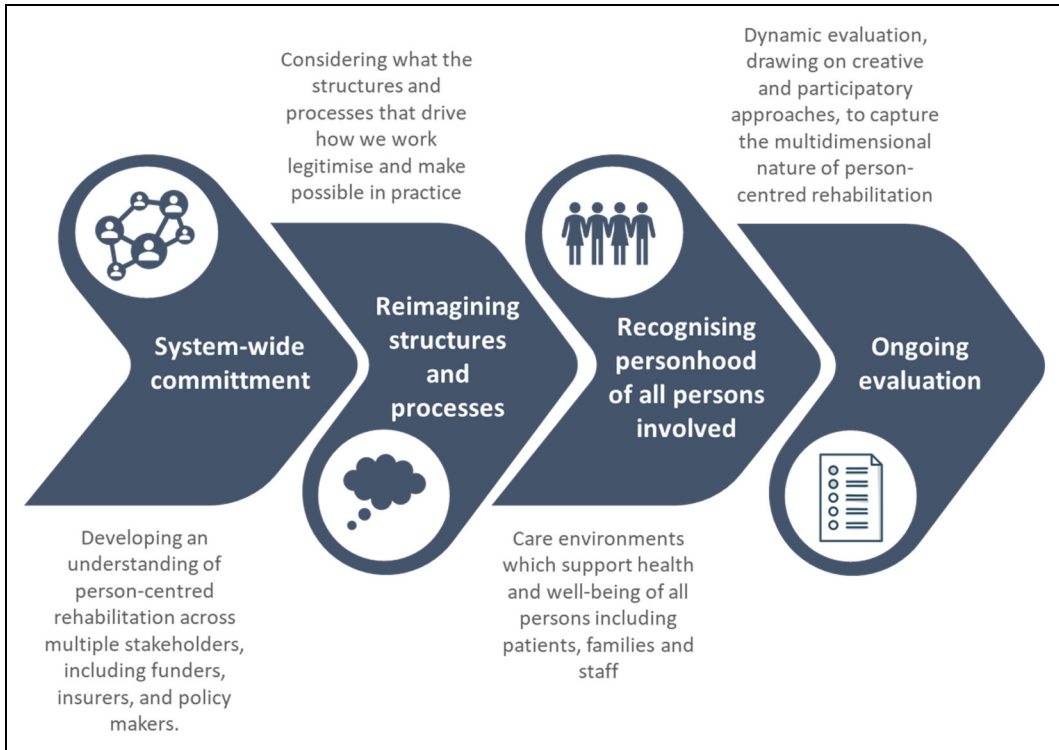


Figure 2. Building person-centred cultures of care.

Learn from diverse perspectives of person-centred rehabilitation: An example from Māori culture

Learning from diverse worldviews has the potential to enhance and augment our current understanding of person-centred rehabilitation. Angus Macfarlane, a Māori scholar, argues that when professionals develop understanding and awareness of the knowledge, beliefs, values and traditions that may be produced and perpetuated through ‘mainstream’ culture, they may be more likely to be respectful of and responsive to other cultures and perspectives.¹⁰¹

In New Zealand, Māori practitioners show how Māori perspectives and tikanga (cultural protocols) can be embedded within healthcare. For example, Hinemoa Elder conceptualised paediatric traumatic brain injury as not just an injury to the brain, but an injury to wairua, which she defined as a profound sense of connectivity between Māori and all

aspects of the universe.¹⁰² She developed a framework, Te Waka Oranga, to serve as a practical tool which privileges Māori knowledge and enables families to work in partnership with clinical knowledge.¹⁰³ Similarly, Cameron Lacey, Suzanne Pitama and colleagues have developed the Meihana Model – a framework to guide clinical assessments which incorporates explicit acknowledgement of factors that may affect that journey (such a colonisation, racism, etc.)¹⁰⁴ – and Hui process – a framework to guide clinical interactions which mirrors cultural rituals of encounters.¹⁰⁵

In more recent work, Bobbie-Jo Wilson explored what matters most in the therapeutic relationship for Māori and found a sense of wairua (spirit) and hononga (connection) are fundamental for meaningful interactions for Māori, and that hononga is enabled and enhanced through whaka-papa (genealogy), whānau (relationships), tikanga (cultural protocols), and in an environment

which invites whānau (extended family) to engage as Māori.⁵⁹

A Māori colleague of the first author, Robert Hogg, recently explained how he draws on Mātauranga (Māori knowledge) as gifted to him by his whānau (family) and te reo Māori (Māori language) in his everyday interactions with people.¹⁰⁶ He used the example of 'mokopuna'. The literal translation for 'mokopuna' is grandchild. 'Moko' is typically translated as tattoo, but the deeper meaning is related to imprint. 'Puna' is short for mātāpuna (source, the creator) and tupuna (ancestors). He explained therefore that 'mokopuna' can be translated as 'one who wears the marks of an ancestor'. Drawing from this, whenever he interacts with others, he tries to treat them as if they are an 'ancestor in the waiting' to honour their whakapapa (genealogy).

These examples highlight the potentially intergenerational nature of care experiences and the importance of recognising the cumulative impact of those experiences, whether positive or negative. Putting this into practice would involve looking beyond the person as *individual*, to the person as part of a *collective*. It also highlights the importance of inviting Māori to engage as Māori (rather than requiring them to conform to western ways of being and doing) and acknowledging the tikanga (cultural protocols) of people and places and using that to guide our actions and decisions.

Indigenous perspectives have the potential to challenge and enrich how we think about and practice person-centred rehabilitation. Engaging with and being informed by these perspectives and critically engaging with the cultural and moral assumptions inherent in Eurocentric perspectives may be critical to continued advance in person-centred rehabilitation.

Conclusion

We have provided reflections on the practice of person-centred rehabilitation. This paper is not intended as an exhaustive review of person-centred rehabilitation theory and evidence and so is inherently partial. We have primarily drawn on research

that has been undertaken in rehabilitation settings, rather than on person-centred care more generally. Notwithstanding this, we have provided an overview of the conceptual, practical, and organisational challenges that may hamper meaningful implementation of person-centred practice. We have proposed four key opportunities for the development of person-centred rehabilitation. We hope this will generate debate and contribute to further developments in research and practice to achieve the aspirations of person-centred rehabilitation in contemporary rehabilitation practice.

Clinical messages

- Fixed assumptions about what constitutes person-centred rehabilitation may limit our ability to respond to the needs of persons and families.
- Person-centred rehabilitation may be enabled through person-centred cultures of care at a system level.
- Diverse cultural perspectives can enrich how we think about and practice person-centred rehabilitation.

Acknowledgements

The authors would like to thank their colleagues and collaborators who have contributed to their thinking over the years. Both authors recently collaborated with colleagues on a scoping review and thematic synthesis of evidence on person-centred rehabilitation.^{9,26} Our connection through this scoping review led to the development of a joint symposium presentation at the 2020 American Congress of Rehabilitation Medicine focusing on person-centred rehabilitation. In preparation, we had the privilege of engaging in a series of in-depth and challenging discussions about person-centred rehabilitation while we debated, synthesised, and reconciled our thinking on the topic for the purpose of presentation. We both benefited deeply from this rich, collegial debate and discussion. This formed the starting point for this paper. We would like to thank the reviewers and Professor Derick Wade for his detailed feedback on our drafts and for challenging us to further refine and improve the accessibility of the ideas presented in this paper. NK would also like to acknowledge past, present and associate members of the Centre for Person Centred Research (<https://cpccr.aut.ac>).

nz/) for ongoing debate and discussion on the topic of person-centred rehabilitation; and her colleague Robert Hogg, Associate Dean for Māori Advancement in the Faculty of Health and Environmental Sciences at Auckland University of Technology, for sharing insights from mātauranga and Te Ao Māori.

Author contributions

The conceptual ideas presented in this paper were jointly developed by both authors. NK wrote the first draft of the paper, with CP contributing in a substantive way to further developing the writing. Both authors worked together to revise and refine the draft in response to feedback.


Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

ORCID iD

Nicola M Kayes  <https://orcid.org/0000-0002-2747-667X>

References

- World Health Organisation. Rehabilitation: key for health in the 21st century. In: *World Health Organisation rehabilitation 2030: a call for action*; 2017: 2.
- Mills J-A, Cieza A, Short SD, et al. Development and validation of the WHO rehabilitation competency framework: a mixed methods study. *Arch Phys Med Rehabil* 2021; 102: 1113–1123.
- World Health Organisation. *Rehabilitation competency framework*. Geneva: World Health Organisation; 2020.
- CARF International. *CARF International 2021*. Available from: <http://www.carf.org/>.
- Entwistle VA, Cribb A, Watt IS, et al. “The more you know, the more you realise it is really challenging to do”: tensions and uncertainties in person-centred support for people with long-term conditions. *Patient Educ Couns* 2018; 101: 1460–1467.
- Gibson BE, Terry G, Setchell J, et al. The micro-politics of caring: tinkering with person-centered rehabilitation. *Disabil Rehabil* 2020; 42: 1529–1538.
- Mudge S, Stretton C and Kayes N. Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disabil Rehabil* 2014; 36: 457–463.
- Naldemirci Ö, Lydahl D, Britten N, et al. Tenacious assumptions of person-centred care? Exploring tensions and variations in practice. *Health* 2016; 22: 54–71.
- Jesus TS, Papadimitriou C, Bright FA, et al. Person-centered rehabilitation model: framing the concept and practice of person-centered adult physical rehabilitation based on a scoping review and thematic analysis of the literature. *Arch Phys Med Rehabil* 2022; 103: 106–120.
- Mudge S, Sezier A, Payne D, et al. Pilot trial of the living well toolkit: qualitative analysis and implications for refinement and future implementation. *BMC Health Serv Res* 2020; 20: 69.
- Terry G and Kayes N. Person centered care in neurorehabilitation: a secondary analysis. *Disabil Rehabil* 2020; 42: 2334–2343.
- Papadimitriou C. Becoming en-wheeled: the situated accomplishment of re-embodiment as a wheelchair user after spinal cord injury. *Disabil Soc* 2008; 23: 691–704.
- Papadimitriou C. ‘It was hard but you did it’: the co-production of ‘work’ in a clinical setting among spinal cord injured adults and their physical therapists. *Disabil Rehabil* 2008; 30: 365–374.
- Papadimitriou C, Clayman M, Mallinson T, et al. What does shared decision making look like in chronic disability care? Adapting a conceptual process model of SDM to better serve PM&R. *Arch Phys Med Rehabil* 2020; 101: e155.
- Papadimitriou C and Cott C. Client-centred practices and work in inpatient rehabilitation teams: results from four case studies. *Disabil Rehabil* 2015; 37: 1135–1143.
- Papadimitriou C and Stone DA. Addressing existential disruption in traumatic spinal cord injury: a new approach to human temporality in inpatient rehabilitation. *Disabil Rehabil* 2011; 33: 2121–2133.
- Gibson BE. Parallels and problems of normalization in rehabilitation and universal design: enabling connectivities. *Disabil Rehabil* 2014; 36: 1328–1333.
- Gibson BE, Carnevale FA and King G. “This is my way”: reimagining disability, in/dependence and interconnectedness of persons and assistive technologies. *Disabil Rehabil* 2012; 34: 1894–1899.
- Papadimitriou C. From dis-ability to difference: conceptual and methodological issues in the study of disability. In: Toombs SK (ed.) *Phenomenology and medicine. Handbook in bioethics and the philosophy of medicine series*. Dordrecht: Kluwer Academic Publishers; 2001, pp.475–492.
- Todres L, Galvin K and Dahlberg K. Lifeworld-led healthcare: revisiting a humanising philosophy that integrates emerging trends. *Med Health Care Philos* 2006; 10: 53.
- Todres L, Galvin KT and Holloway I. The humanization of healthcare: a value framework for qualitative research. *Int J Qual Stud Health Well-Being* 2009; 4: 68–77.

22. Hammell KRW. Client-centred practice in occupational therapy: critical reflections. *Scand J Occup Ther* 2013; 20: 174–181.
23. Hammell KW. Client-centred practice: ethical obligation or professional obfuscation? *Br J Occup Ther* 2007; 70: 264–266.
24. Latimer T, Roscamp J and Papanikitas A. Patient-centredness and consumerism in healthcare: an ideological mess. *J R Soc Med* 2017; 110: 425–427.
25. Jesus TS, Bright F, Kayes N, et al. Person-centred rehabilitation: what exactly does it mean? Protocol for a scoping review with thematic analysis towards framing the concept and practice of person-centred rehabilitation. *BMJ Open* 2016; 6: e011959.
26. Jesus TS, Bright FA, Pinho CS, et al. Scoping review of the person-centered literature in adult physical rehabilitation. *Disabil Rehabil* 2019; 43: 1–11.
27. Darlow R and Williams W. *Person and Whānau centred care: model for physiotherapy in Aotearoa, New Zealand*. New Zealand: Physiotherapy New Zealand; 2018.
28. McCormack B and McCance TV. Development of a framework for person-centred nursing. *J Adv Nurs* 2006; 56: 472–479.
29. Gzil F, Lefevre C, Cammelli M, et al. Why is rehabilitation not yet fully person-centred and should it be more person-centred? *Disabil Rehabil* 2007; 29: 1616–1624.
30. Leplege A, Gzil F, Cammelli M, et al. Person-centredness: conceptual and historical perspectives. *Disabil Rehabil* 2007; 29: 1555–1565.
31. Waters RA and Buchanan A. An exploration of person-centred concepts in human services: a thematic analysis of the literature. *Health Policy* 2017; 121: 1031–1039.
32. Wade DT. What is rehabilitation? An empirical investigation leading to an evidence-based description. *Clin Rehabil* 2020; 34: 571–583.
33. Beach MC and Inui T. Relationship-centered care research network. Relationship-centered care. A constructive reframing. *J Gen Intern Med* 2006; 21: S3–S8.
34. Kokorelias KM, Gignac MAM, Naglie G, et al. Towards a universal model of family centered care: a scoping review. *BMC Health Serv Res* 2019; 19: 564.
35. Bamm EL and Rosenbaum P. Family-centered theory: origins, development, barriers, and supports to implementation in rehabilitation medicine. *Arch Phys Med Rehabil* 2008; 89: 1618–1624.
36. Söderbäck M, Coyne I and Harder M. The importance of including both a child perspective and the child's perspective within health care settings to provide truly child-centred care. *J Child Health Care* 2011; 15: 99–106.
37. Ellis-Hill C, Pound C and Galvin K. Making the invisible more visible: reflections on practice-based humanising lifeworld-led research – existential opportunities for supporting dignity, compassion and wellbeing. *Scand J Caring Sci* 2021; 36: 1037–1045.
38. Wagner AK, Boninger ML, Levy C, et al. Peer review. *Am J Phys Med Rehabil* 2003; 82: 790–802.
39. Jesus TS, Papadimitriou C, Bright FA, et al. The person-centered rehabilitation model: framing the concept and practice of person-centered adult physical rehabilitation based on a scoping review and thematic analysis of the literature. *Arch Phys Med Rehabil*. 2022; 103: 106–120.
40. Gibson BE, Fadyl JK, Terry G, et al. A posthuman decentring of person-centred care. *Health Sociol Rev* 2021; 30: 292–307.
41. Levack WM, Dean SG, Siegert RJ, et al. Navigating patient-centered goal setting in inpatient stroke rehabilitation: how clinicians control the process to meet perceived professional responsibilities. *Patient Educ Couns* 2011; 85: 206–213.
42. Levack WMM, Siegert RJ, Dean SG, et al. Goal planning for adults with acquired brain injury: how clinicians talk about involving family. *Brain Inj* 2009; 23: 192–202.
43. Siegert R, McPherson K and Taylor W. Toward a cognitive-affective model of goal-setting in rehabilitation: is self-regulation theory a key step? *Disabil Rehabil* 2004; 26: 1175.
44. Hersh D, Worrall L, Howe T, et al. SMARTER goal setting in aphasia rehabilitation. *Aphasiology* 2012; 26: 220–233.
45. McPherson KM, Kayes NM and Kersten P. MEANING as a smarter approach to goals in rehabilitation. In: Levack W and Siegert R (eds) *Rehabilitation goal setting: theory, practice and evidence*. Boca Raton: CRC Press/Taylor & Francis; 2014, pp. 105–122.
46. Bright FAS. *Reconceptualising engagement: A relational practice with people experiencing communication disability*. Auckland: Auckland University of Technology, 2015.
47. Bright FAS, Kayes NM, Cummins C, et al. Co-constructing engagement in stroke rehabilitation: a qualitative study exploring how practitioner engagement can influence patient engagement. *Clin Rehabil* 2017; 31: 1396–1405.
48. Bright FAS, Kayes NM, Worrall LE, et al. A conceptual review of engagement in healthcare and rehabilitation. *Disabil Rehabil* 2015; 37: 643–654.
49. Kayes NM, Cummins C, McPherson KM, et al. Developing connections for engagement in stroke rehabilitation. *Brain Impair* 2022; 23: 42–59.
50. Bishop M, Kayes NM and McPherson KM. Understanding the therapeutic alliance in stroke rehabilitation. *Disabil Rehabil* 2021; 43: 1074–1083.
51. Kayes NM, Cummins C and Kersten P. *Connection and collaboration in rehabilitation: a measure of therapeutic relationship*. 2021.
52. Kayes NM, Cummins C, Theadom A, et al. What matters most in the therapeutic relationship in neurorehabilitation? 30th Conference of the European Health Psychology Society and British Division of Health Psychology 'Behaviour change: making an impact on health and health services'; Aberdeen, Scotland, 2016.

53. Kayes NM and McPherson KM. Human technologies in rehabilitation: 'who' and 'how' we are with our clients. *Disabil Rehabil* 2012; 34: 1907–1911.
54. Kayes NM, McPherson KM and Kersten P. Therapeutic connection in neurorehabilitation: theory, evidence and practice. In: *Evidence-based neurology: management of neurological disorders: an evidence based approach*. 2nd ed: Chichester: BMJ Books/John Wiley and Sons, 2015, pp. 303–318.
55. Lawton M, Haddock G, Conroy P, et al. Therapeutic alliances in stroke rehabilitation: a meta-ethnography. *Arch Phys Med Rehabil* 2016; 97: 1979–1993.
56. Lawton M, Haddock G, Conroy P, et al. People with aphasia's perception of the therapeutic alliance in aphasia rehabilitation post stroke: a thematic analysis. *Aphasiology* 2018; 32: 1397–1417.
57. Lawton M, Sage K, Haddock G, et al. Speech and language therapists' perspectives of the therapeutic alliance construction and maintenance in aphasia rehabilitation post-stroke. *Int J Lang Commun Disord* 2018; 53: 550–563.
58. Miciak M, Mayan M, Brown C, et al. The necessary conditions of engagement for the therapeutic relationship in physiotherapy: an interpretive description study. *Arch Physiother* 2018; 8: 3.
59. Wilson BJ, Cummins C, Bright FAS, et al. 'The Wairua first brings you together': Māori experiences of meaningful connection in neurorehabilitation. *Brain Impair* 2022; 23: 9–23.
60. Søndena P, Dalusio-King G and Hebron C. Conceptualisation of the therapeutic alliance in physiotherapy: is it adequate? *Musculoskel Sci Pract* 2020; 46: 102131.
61. Bright FAS and Reeves B. Creating therapeutic relationships through communication: a qualitative metasynthesis from the perspectives of people with communication impairment after stroke. *Disabil Rehabil* 2020; 44: 1–13.
62. Pinto RZ, Ferreira ML, Oliveira VC, et al. Patient-centred communication is associated with positive therapeutic alliance: a systematic review. *J Physiother* 2012; 58: 77–87.
63. Sezier A, Mudge S, Kayes N, et al. Development of a toolkit to enhance care processes for people with a long-term neurological condition: a qualitative descriptive study. *BMJ Open* 2018; 8: e022038.
64. Sullivan N, Hebron C and Vuoskoski P. "Selling" chronic pain: physiotherapists' lived experiences of communicating the diagnosis of chronic nonspecific lower back pain to their patients. *Physiother Theory Pract* 2021; 37: 973–992.
65. Cosgrove J and Hebron C. 'Getting them on board': musculoskeletal physiotherapists conceptions of management of persons with low back pain. *Musculoskel Care* 2021; 19: 199–207.
66. Horler C, Hebron C and Martyn K. Personalizing education: the clinical reasoning processes of physiotherapists using education for the treatment of people with chronic low back pain. *Physiother Theory Pract* 2020; 38: 1–10.
67. Jones F, Livingstone E and Hawkes L. 'Getting the balance between encouragement and taking over' – reflections on using a new stroke self-management programme. *Physiother Res Int* 2013; 18: 91–99.
68. Mudge S, Kayes N and McPherson K. Who is in control? Clinicians' view on their role in self-management approaches: a qualitative metasynthesis. *BMJ Open* 2015; 5: e007413.
69. Norris M and Kilbride C. From dictatorship to a reluctant democracy: stroke therapists talking about self-management. *Disabil Rehabil* 2014; 36: 32–38.
70. Bright FAS, Boland P, Rutherford SJ, et al. Implementing a client-centred approach in rehabilitation: an autoethnography. *Disabil Rehabil* 2012; 34: 997–1004.
71. Turner-Stokes L. Politics, policy and payment – facilitators or barriers to person-centred rehabilitation? *Disabil Rehabil* 2007; 29: 1575–1582.
72. Eisenberg NR. Post-structural conceptualizations of power relationships in physiotherapy. *Physiother Theory Pract* 2012; 28: 439–446.
73. Moore L, Britten N, Lydahl D, et al. Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scand J Caring Sci* 2017; 31: 662–673.
74. Brown DJ. *The meaning of careful: how putting people before process will deliver outstanding results and transform our healthcare*. United Kingdom: HCV Publishing, 2009.
75. Donabedian A. Evaluating the quality of medical care. *Milbank Mem Fund Q* 1966; 44: 166–206.
76. Soundy A, Smith B, Butler M, et al. A qualitative study in neurological physiotherapy and hope: beyond physical improvement. *Physiother Theory Pract* 2010; 26: 79–88.
77. Bright FAS, Kayes NM, McCann CM, et al. Understanding hope after stroke: a systematic review of the literature using concept analysis. *Top Stroke Rehabil* 2011; 18: 490–508.
78. Bright FAS, Kayes NM, McCann CM, et al. Hope in people with aphasia. *Aphasiology* 2013; 27: 41–58.
79. McCormack B, Dewing J and McCance T. Developing person-centred care: addressing contextual challenges through practice development. *Online J Issues Nurs* 2011; 16: 3.
80. Jones F, Gombert-Waldrone K, Honey S, et al. *Using co-production to increase activity in acute stroke units: the CREATE mixed-methods study*. Southampton: NIHR Journals Library, 2020.
81. Naldemirci Ö, Wolf A, Elam M, et al. Deliberate and emergent strategies for implementing person-centred care: a qualitative interview study with researchers, professionals and patients. *BMC Health Serv Res* 2017; 17: 527.
82. Bruschini M, Carli A and Burla F. Burnout and work-related stress in Italian rehabilitation professionals: a comparison of physiotherapists, speech therapists and occupational therapists. *Work* 2018; 59: 121–129.
83. Murray G, Hart T, Doyle A, et al. There's no cure for brain injury: work-related stress in brain injury rehabilitation professionals. *Brain Inj* 2019; 33: 1442–1448.

84. Peter KA, Hahn S, Schols JMGA, et al. Work-related stress among health professionals in Swiss acute care and rehabilitation hospitals—a cross-sectional study. *J Clin Nurs* 2020; 29: 3064–3081.
85. Tabaj A, Pastirk S, Bitenc Č, et al. Work-related stress, burnout, compassion, and work satisfaction of professional workers in vocational rehabilitation. *Rehabil Couns Bull* 2014; 58: 113–123.
86. Bateman EA and Viana R. Burnout among specialists and trainees in physical medicine and rehabilitation: a systematic review. *J Rehabil Med* 2019; 51: 869–874.
87. Sinclair S, Raffin-Bouchal S, Venturato L, et al. Compassion fatigue: a meta-narrative review of the health-care literature. *Int J Nurs Stud* 2017; 69: 9–24.
88. Restall G, Ripat J and Stern M. A framework of strategies for client-centred practice. *Can J Occup Ther* 2003; 70: 103–112.
89. Lautermilch A. Care work: dreaming disability justice by Leah Lakshmi Piepzna-Samarasinha. *J Liter Cult Disabil Stud* 2022; 16: 121–124.
90. Palmer SC, Gray H, Huria T, et al. Reported Māori consumer experiences of health systems and programs in qualitative research: a systematic review with meta-synthesis. *Int J Equity Health* 2019; 18: 163.
91. Hansson SO and Fröding B. Ethical conflicts in patient-centred care. *Clin Ethics* 2020; 16: 55–66.
92. Gibson BE. *Re-forming rehabilitation. Rehabilitation: a post-critical approach*. Boca Raton: CRC Press, 2016.
93. Carman KL, Dardess P, Maurer M, et al. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health Aff* 2013; 32: 223–231.
94. Stumberg J. Person-centered medicine from a complex adaptive systems perspective. *Eur J Pers Cent Healthc* 2014; 2: 85.
95. Austin W, Bergum V, Nuttgens S, et al. A re-visioning of boundaries in professional helping relationships: exploring other metaphors. *Ethics Behav* 2006; 16: 77–94.
96. Molloy E and Bearman M. Embracing the tension between vulnerability and credibility: ‘intellectual candour’ in health professions education. *Med Educ* 2019; 53: 32–41.
97. Nolan MR, Brown J, Davies S, et al. *The senses framework: improving care for older people through a relationship-centred approach*. Sheffield: University of Sheffield, 2006.
98. Seligman M. PERMA and the building blocks of well-being. *J Posit Psychol* 2018; 13: 333–335.
99. McCormack B. Person-centred care and measurement: the more one sees, the better one knows where to look. *J Health Serv Res Policy* 2022; 27: 85–87.
100. Cribb A and Woodcock T. Measuring with quality: the example of person-centred care. *J Health Serv Res Policy* 2022; 27: 151–156.
101. Macfarlane AH. “Other” education down-under: indigenising the discipline for psychologists and specialist educators. *J Educ Altern* 2012; 1: 205–225.
102. Elder H. Indigenous theory building for Māori children and adolescents with traumatic brain injury and their extended family. *Brain Impair* 2013; 14: 406–414.
103. Elder H, Kuaka TW and Oranga TW. Working with Whānau to improve outcomes. *Aust N Z J Fam Ther* 2017; 38: 27–42.
104. Pitama S, Robertson P, Cram F, et al. Meihana model: a clinical assessment framework. *N Z J Psychol* 2007; 36: 118–125.
105. Lacey C, Huria T, Beckert L, et al. The Hui process: a framework to enhance the doctor–patient relationship with Māori. *N Z Med J* 2011; 124: 72–78.
106. Hogg R. AUT Faculty of Health and Environmental Sciences Forum. 2021.