



Patient-centered care in musculoskeletal practice: Key elements to support clinicians to focus on the person

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ABSTRACT

Musculoskeletal rehabilitation, including physiotherapy, needs to move towards a broader biopsychosocial understanding of musculoskeletal conditions and the delivery of high-value care for people with persistent pain conditions, in which a patient-centered approach is a key feature. However, it has been reported that clinicians experience difficulties with integrating patient-centered care principles into their clinical practice. Based on a focused symposium about patient-centered care for patients with musculoskeletal conditions, held during the online 2021 World Physiotherapy Congress, the purpose of this article is to share key elements of the content of this symposium with a wider audience, aimed at enabling clinicians to enhance patient-centeredness in their current practice. These key elements include establishing meaningful connections, deciding together and self-management support. Moreover, challenges on patient-centered care in low/middle income countries will be discussed and recommendations to implement patient-centered care in clinical practice will be provided.

1. Introduction

Musculoskeletal pain conditions are one of the leading contributors to disability worldwide (Vos et al., 2020). Pain conditions are influenced by multiple interacting factors, including genetics, psychological, social and biophysical factors, comorbidities and lifestyle and are often resistant to current treatments (Hartvigsen et al., 2018; Lewis and O'Sullivan, 2018). Musculoskeletal rehabilitation, including physiotherapy, needs to move towards a broader biopsychosocial understanding of musculoskeletal conditions and the delivery of high-value care for people with persistent pain conditions (Lewis and O'Sullivan, 2018; Lewis et al., 2021; Lin et al., 2019), in which a patient-centered approach is a key feature.

Patient-centered care is characterized by regarding the patient-as-person, a biopsychosocial perspective, sharing power and responsibility, and therapeutic alliance (Paul-Savoie et al., 2018). In such an approach, establishing meaningful connections, shared decision-making, self-management support, and patient-centered

communication are essential components. However, it has been reported that clinicians experience difficulties with integrating patient-centered care principles into their clinical practice (Dukhu et al., 2018; Hall et al., 2018; Hutting et al., 2020; Mudge et al., 2014). A focused symposium about patient-centered care for patients with musculoskeletal conditions was held during the online 2021 World Physiotherapy Congress, aiming to enhance physiotherapists' patient-centered approach to practice and better equip them to support people with musculoskeletal pain conditions. The purpose of this article is to share key elements of the content of this symposium with a wider audience, aimed at enabling clinicians to enhance patient-centeredness in their current practice.

2. Establishing meaningful connections for patient-centered care

A connection is a link between people who have something in common or have acknowledged one another in some way (Miciak et al.,

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2019). It has become a ubiquitous term given the varied ways people interact (e.g., social media) and may not indicate the linkage's meaning. However, connections within clinical interactions should be meaningful. A meaningful connection is one in which patients and clinicians feel seen, heard, and appreciated and is developed through professional and personal acknowledgements that bring them closer together (Miciak et al., 2019). Establishing meaningful connections is a component of the therapeutic relationship (McCabe et al., 2021; Miciak et al., 2019). Therapeutic relationship has been positioned as integral to patient-centered care (Bright et al., 2012), with better quality relationships associated with improved clinical outcomes, patient satisfaction, and adherence (Babatunde et al., 2017; Hall et al., 2010; Hush et al., 2011; Kinney et al., 2020; Stagg et al., 2019). Further, relational ruptures could result in poor outcomes and increased drop-out rates (Safran and Kraus, 2014).

Clinicians should intentionally establish connections with patients given the potential impact. Considering the clinical interaction's dynamic nature, there are three ways clinicians can consciously form connections that align with patient-centered care: acknowledge the individual; use the body as a pivot point; and give-of-self (Miciak et al., 2019). To *acknowledge the individual*, clinicians verbally and non-verbally meet patients as equals, validate their experiences, and individualize treatment. *Using the body as a pivot point* leverages the clinician's ability to clarify physical problems and solutions, facilitate patients' connection to their bodies, and use touch to bridge a gap. *Giving-of-self* is the extra investment therapists put toward helping patients when its needed, inside and outside of the clinical interaction. Ultimately, therapists are more likely to provide patient-centered care by taking a deliberate and responsive approach to forming connections. Table 1 provides verbal and non-verbal examples of how to cultivate connections.

3. Deciding together: shared decisions in musculoskeletal practice

Shared decision-making involves mutuality, combining the skills of healthcare professionals, with the patients' experience (Spatz et al., 2017). Shared-decision making considers the person's context, knowledge, needs, values and goals (Lin et al., 2020). The process is complex, with no universal definition or single model. Indeed, in a recent systematic review, 40 shared decision-making models were identified, with 53 different elements including: patient preferences; mutual respect; and listing options (Bomhof-Roordink et al., 2019). The core components of shared decision-making are presented in Table 2.

Clinicians can enhance their shared decision-making abilities through self-awareness and adopting a goal-oriented approach. Empirical work by Vermunt et al. (2018) resulted in a 3-level model for goal setting: 1) symptom- or disease-specific goals (to obtain relief from symptoms); 2) functional goals; and 3) fundamental goals (drawing on a person's values, hopes and priorities in life). Vermunt et al. (2018) recommend setting goals at all three levels, *starting* with fundamental

Table 1
Clinical examples of establishing meaningful connections.

Ways of establishing connections	Clinical examples of establishing connections
Acknowledge the Individual	- sit at the patient's level - affirm expressions of emotion or personal disclosures - adapt home programs by considering patients' unique circumstances
Use the body as a pivot point	- provide clear explanations of assessment findings - cue patients to their bodies to develop awareness - carefully handle the patient's affected body region
Giving-of-self	- share a part of your life or experience, as appropriate - speak with patients' other care providers

Table 2

The core components of shared decision-making (after Elwyn and Charles, 2009).

Identifying and clarifying the issue
Identifying potential solutions
Discussing options and uncertainties
Providing information about the potential benefits, harms and uncertainties of each option
Checking that patients and professionals have a joint understanding
Gaining feedback and reactions
Agreeing a course of action
Implementing the chosen treatment
Arranging follow-up
Evaluating outcomes and assessing the next steps

goals. These drive the discussions about function and symptom-specific goals, and ensure that decisions are genuinely made together.

Despite its complexity, shared decision-making can be measured using scales like the OPTION tool (Elwyn, 2003). Originally developed for general practice, this tool has generic phrasing that can be applied to any clinical setting. It measures 12 clinician behaviours on an ordinal scale, each scored from 0 ('the behaviour is not observed') to 4 ('the behaviour is observed and executed to a very high standard'), and summed to give a percentage (see Table 3). The higher the score, the greater the skills displayed, and 60% is generally accepted as the minimal level of competence. In a systematic review of 29 international studies (mainly involving cancer, diabetes and depression), the mean OPTION score was 23% (range 9–37%) (Couët et al., 2015) and UK physiotherapists in primary care scored 24% (range 10–44%) (Jones et al., 2014) and 5% among self-employed, Flemish physical therapists (Dierckx et al., 2013).

4. Self-management support in patient-centered care

Self-management support can be defined as interventions that aim to equip patients with skills to actively participate and take responsibility in the management of their persistent condition to function optimally (Jonkman et al., 2016). In self-management, goal setting, (shared-)decision making, problem solving, managing pain and emotions, action planning, and forming partnerships are important skills (Barlow et al., 2002; Hutting et al., 2019; Jonkman et al., 2016; Kongsted et al., 2021; Van de Velde et al., 2019).

Physiotherapists are ideally positioned to support people in their self-management (Hutting et al., 2019) and ideally, these topics should

Table 3

The 12 behaviours in the OPTION scale (Elwyn, 2003).

Shared decision-making behaviour
<i>The clinician ...</i>
1 Draws attention to an identified problem as one that requires a decision making process
2 States that there is more than one way to deal with the identified problem
3 Assesses patient's preferred approach to receiving information to assist decision making
4 Lists 'options', which can include the choice of 'no action'
5 Explains the pros and cons of options to the patient
6 Explores the patient's expectations (<i>or ideas</i>) about how the problem(s) are to be managed
7 Explores the patient's concerns (<i>fears</i>) about how problem(s) are to be managed
8 Checks that the patient has understood the information
9 Offers the patient explicit opportunities to ask questions during decision making process
10 Elicits the patient's preferred level of involvement in decision making
11 Indicates the need for a decision making (<i>or deferring</i>) stage
12 Indicates the need to review the decision (<i>or deferment</i>)

Scoring: 0 = The behaviour is not observed; 1 = A minimal attempt is made to exhibit the behaviour; 2 = The behaviour is observed and a minimum skill level achieved; 3 = The behaviour is exhibited to a good standard; 4 = The behaviour is observed and executed to a high standard.

be integrated in the support provided by physiotherapists or other musculoskeletal clinicians. However, qualitative research showed that the way clinicians currently address self-management in people with musculoskeletal pain conditions, such as low back pain, is not optimal, because self-management skills were generally not addressed sufficiently and a biopsychosocial perspective was lacking (Hutting et al., 2020). Moreover, clinicians perceive self-management as challenging, for example because it may not be culturally acceptable or expected by the patient (Lewis et al., 2021).

As the characteristics are largely the same across musculoskeletal conditions (Caneiro et al., 2019), a focus on generic self-management skills is very important (Hutting et al., 2019). Such an approach is in line with a recently-proposed model consisting of building self-efficacy, coaching to engage in exercise and a healthy lifestyle, education regarding the biopsychosocial contributors to musculoskeletal conditions, and strong clinical alliance (Lewis et al., 2021). Moreover, a self-management approach can also be valuable for people with acute or subacute conditions. Therefore, a self-management approach is recommended as an overall approach in contemporary physiotherapy for people with musculoskeletal pain conditions. Recommendations to provide self-management support in people with musculoskeletal conditions are provided in Table 4. In such an approach, all the important characteristics of patient-centered care are included, therefore, we believe that investing time to help patients develop skills and confidence in self-management is essential to deliver patient-centered care.

5. Challenges on patient-centered care in low/middle income countries

In numerous high-income countries, health systems are moving toward meaningful implementation of patient-centered approaches (World Health Organization, 2010). However, implementation of patient-centered care remains a challenge, especially in low- and middle

income countries across the world. For example, the majority of African countries are unable to meet the basic requirements for good healthcare systems. Poor governance and human resource challenges are linked to ineffective integration of services in resource-limited nations (Oleribe et al., 2019). Three major challenges identified are inadequate human resources, inadequate budgetary allocation to health, and poor leadership and management (Oleribe et al., 2019), which also has an effect on the implementation of patient-centered care.

African countries, and other low- and middle income countries, can adopt and or follow aspects of the implementation of patient-centered care in other countries. An example is the framework for patient family centered-care developed in an Australian Community hospital (Frakking et al., 2020). This framework consists of three essential core components: 1) the experiences of the consumers and staff, considered the center and focus of care; 2) key elements leadership, environment, service delivery, engagement and learning; and 3) overarching fundamental values of being heard, respected, valued and supported by staff and consumers at all levels of in the organization (Frakking et al., 2020).

An educated patient is an empowered patient. The appropriate strategy is to empower patients through patient education which enhances their autonomy and encourages them to become full partners in their care, as opposed to objects of clinical interventions or entities whose values or attitudes need to be shaped and changed through education (Jotterand et al., 2016). Feasible solutions to these issues require sufficient health literacy. However, low health literacy is a significant problem in many low- and middle income countries because of the low levels of general literacy and poorly resourced and functioning health systems (Meherali et al., 2020).

6. Implementing patient-centered care in clinical practice

Patient-centered care incorporates the patient's perspective as part of the therapeutic process. In practice, clinicians need to communicate in a manner that creates an adequate conversational space to elicit the patient's agenda (i.e. understanding, impact of pain, concerns, needs, and goals), which guides the clinical interactions. This approach encourages greater partnership in management (Cowell et al., 2021; Lin et al., 2020).

Patient-centered communication requires attention to *what* we communicate and *how* we communicate across the entire clinical interaction including interview, examination, and management planning (Lin et al., 2020). Clinicians need to be open, reflective, aware and responsive to verbal and non-verbal cues, and demonstrate balance between engaging with the patient (e.g. eye gaze) and writing/typing notes during the interview (Cowell et al., 2018; Edmond and Keefe, 2015; O'Keeffe et al., 2016).

During the examination, the clinician encourages patient involvement and facilitates disclosure of beliefs, fears and concerns. This is a collaborative learning process that promotes self-efficacy and ultimately self-management. The clinician then designs a personalized management plan that addresses key contributing factors (e.g. sleep, stress, activity levels) and that is considerate of the patient's context. Patients are included in this process, which involves clear and transparent discussion about the benefits of high-value care and limitations of low-value care. Clinicians can provide resources to reinforce health messages provided during the sessions. To support patient care and minimize the potential for mixed messages, ongoing communication with the patient and other healthcare professionals is encouraged.

A roadmap outlining key actions to implement patient-centeredness in clinical practice has been outlined in detail elsewhere (Caneiro et al., 2019). This includes: screening for serious pathology, health co-morbidities and psychosocial factors; adopting effective communication; providing positive health education; coaching and supporting patients towards active self-management; and facilitating and managing co-care (when needed).

To implement patient-centered care, clinicians need to reflect on

Table 4

Recommendations to use self-management support in people with musculoskeletal conditions.

Therapeutic alliance	- focus on therapeutic alliance, which consists of collaborative goal setting, shared decision making and building a strong therapeutic relationship (Bordin, 1979; McCabe et al., 2021; Miciak et al., 2018; O'Keeffe et al., 2016). - support patients to identify their goals, based on their values and preferences (Beattie et al., 2016; Caneiro et al., 2019; Hutting et al., 2019; Kongsted et al., 2021).
Coaching	- use coaching to facilitate behaviour change, a healthy lifestyle, and building self-efficacy (Beattie et al., 2016; Caneiro et al., 2019; Hutting et al., 2019; Kongsted et al., 2021).
General self-management skills	- support patients to obtain general self-management skills aimed at problem solving, decision making, using resources, action planning, self-tailoring, self-monitoring, and creating partnership (Barlow et al., 2002; Hutting et al., 2019; Jonkman et al., 2016; Kongsted et al., 2021; Van de Velde et al., 2019).
Specific knowledge, skills, tools	- provide support (knowledge, skills, tools) with regard to the patient's (biopsychosocial) barriers, needs and achievement of their goals, also after the initial treatment period has ended (using digital support, booster or review sessions). - topics can include: dealing with and acceptance of pain, disability, exacerbations, emotions, fatigue, and stress; physical barriers to recovery (i.e. load management and a graduated exercise program of adequate dosage), lifestyle factors (i.e. physical activity, sleep, weight control, nutrition, relaxation); unhelpful cognitions and misconceptions; (work) participation (including communication, ergonomics, assertiveness, social support) (Caneiro et al., 2019; Hutting et al., 2019; Kongsted et al., 2021).

their own beliefs and practice. The use of peer review or self-video recording of clinical encounters, and self-reflective questions such as 'Do I communicate effectively with patients?', 'Do I feel equipped to explore my patients' beliefs and emotional responses to pain?', 'Is my consult long enough to implement this approach?', can be insightful in this process.

Although there are several obstacles to implementing a patient-centered approach (Briggs et al., 2018), we believe change is needed now. Initiatives to change how we care for people with persistent musculoskeletal pain should involve clinicians, patients, educators, professional organizations, the research community, funders and policy-makers (Lewis et al., 2021), as they have a shared responsibility and are dependent of each other. We contend that a global effort (Briggs et al., 2021) will be necessary to achieve change.

Declaration of competing interest

None.

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