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Title: Physiotherapists' views on their role in self-management approaches: A qualitative systematic review

ABSTRACT

Self-management has been an increasingly important aspect of helping people manage their long-term conditions. The aim of this qualitative review was to synthesise the views of physiotherapists concerning their delivery of a self-management approach. A systematic search was conducted on six electronic bibliographic databases to identify relevant primary studies. Studies were assessed for quality and data extracted. Qualitative data were analysed using thematic synthesis. A total of 1189 studies were identified and screened. Eleven studies met the inclusion criteria. Findings suggest that for self-management approaches to work, physiotherapists believe that patients need to actively participate. Boundaries on who is the expert were blurred at times with some physiotherapists struggling to relinquish control. High quality patient-therapist relationships are required to build trust in order to support patients in the self-management of their long-term conditions. It is also important to consider the competing paradigms in which a service is delivered as this may facilitate or hinder self-management. Seeing patients as people is integral to supporting self-management approaches. Physiotherapists are well placed to support self-management but there is still a need for a cultural and paradigmatic shift in the physiotherapy profession and in some environments, this shift as yet is to be realised.

Keywords: Physiotherapists; Self-management; Qualitative synthesis

INTRODUCTION

Health systems globally have been challenged by the rising burden of chronic illness and long-term conditions (World Health Organisation, 2014). In response, self-management has become an increasingly important aspect of helping people manage with their long-term conditions (Department of Health, 2001; Naylor et al, 2015). With this shift from acute to chronic disease came the understanding that healthcare providers are required to become partners with patients in supporting them to make informed choices about their long-term health and disease management (Lorig and Holman, 2003). Clinicians are now called upon to work with patients to be co-producers of health and self-management is viewed as being inseparable from high-quality care for long-term conditions (Elwyn, 2011; Taylor et al, 2014).

Self-management has been defined as an: "Individual's ability, in conjunction with family, community, and the appropriate healthcare professionals to manage the symptoms, treatment, physical, psychosocial, cultural, and spiritual consequences and inherent lifestyle changes required for living with a chronic disease" (Wilkinson and Whitehead, 2009). It involves consideration of the medical management of a condition (such as taking medication, or the use of an inhaler), role management (involving the maintenance or creation of new meaningful behaviours or roles in life), and emotional management (dealing with the emotional sequelae of a long-term condition such anger, fear, frustration) (Corbin and Strauss, 1988; Lorig and Holman, 2003). Interventions to support self-management are predominantly based on behavioural change theories (Lorig et al, 2006) with the intention of helping patients take the lead in managing their own health and wellbeing.

Despite the fact that the term self-management first appeared in healthcare almost 60 years ago (Loris and Homan, 2003), the evidence of its effectiveness remains equivocal (Sadler, Wolfe, and McKevitt 2014). Some suggest that the evidence for supporting self-management is only moderate due to it being used to describe a wide range of activities from initiatives that

focus on information provision to interventions that target behaviour change and self-efficacy and that combining these leads to a dilution of findings (De Silva, 2011). Different clinical conditions may necessitate varying approaches such as technical structured education for those with diabetes compared to cognitive or behavioural interventions for chronic pain conditions (De Silva, 2011). These range of approaches can make self-management a complex intervention to evaluate (Taylor et al, 2014). No single component of self-management has been identified as more important than any other, however, several core components have been highlighted including education about the condition; psychological strategies to help patients adjust to life with a long-term condition; strategies to support treatment adherence; practical support around activities of daily living and action plans for conditions with marked exacerbations; and social support (Taylor et al, 2014).

A synthesis of over 550 studies to appraise the role of self-management noted that although the findings of individual studies are mixed, the overall evidence suggests that self-management can lead to positive outcomes (De Silva, 2011). In particular, proactive, behaviourally focused self-management approaches, which are designed to increase self-efficacy, can impact positively on patient's clinical symptoms, attitudes, quality of life, and healthcare resource use (De Silva, 2011). However, barriers to self-management from the perspective of patients living with multiple chronic conditions are noted. These include challenges with healthcare professionals around contradictory knowledge, limited access to healthcare providers, and difficulties with medications, such as overreliance on medications and issues related to side effects (Liddy, Blazkho, and, Mill, 2014). To overcome these barriers, patients identified the importance of sharing power and responsibility; they wanted to be able to ask questions of healthcare professionals and seek answers to health concerns (Bardach, Tarasenko, and Schoenberg, 2011). Patients also wanted to be listened to and set mutually agreed goals (Bair et al, 2009). To be able to live well with a long-term condition, it was important for individuals to

stay socially connected and they valued the role of self-care (Stenberg and Furness, 2017). The physical and emotional challenges of living with multiple long-term conditions, such as pain and depression, impacted on patients' ability at times to successfully self-manage (Liddy, Blazkho, and, Mill, 2014).

Therefore, it is evident that a healthcare professional requires a unique skill set to enable the support of self-management strategies. Qualitative reviews have explored the perceptions of health and social care practitioners concerning the delivery of self-management approaches and their experiences of supporting adults with long-term conditions (Morgan et al, 2016; Mudge, Kayes, and McPherson, 2015; Sadler, Wolfe, and McKevitt 2014). Control was a central theme with practitioners expecting patients to have control over their condition and for practitioners to have control over their patients (Mudge, Kayes, and McPherson, 2015). Clinicians who integrated self-management into their practice noted a transformation in their clinical encounters as they moved away from a didactic model of interaction to a partnership approach which valued patient expertise and involvement (Mudge, Kayes, and McPherson, 2015).

Physiotherapists regularly work with individuals who have long-term conditions and seek to promote independence (Chartered Society of Physiotherapy, 2019). Self-management strategies are important in physiotherapy practice, which routinely incorporates the use of self-efficacy strategies, supported goal setting, active adaptive coping, and active patient involvement (National Health Service Education for Scotland, 2012). Therefore, this review sought to build on the work of broader studies which explored the views of health and care practitioners regarding self-management (Morgan et al, 2016; Mudge, Kayes, and McPherson, 2015; Sadler, Wolfe, and McKevitt, 2014) by examining the views of physiotherapists. The aim of this study was to explore the views of physiotherapists concerning their delivery of a self-management approach. The new knowledge generated from this review will provide insight into the barriers

and enablers to implementing self-management approaches within physiotherapeutic encounters to inform future practice.

METHODS

Information Sources and Search Strategy

This review followed a systematic review protocol (PROSPERO reference number CRD42019131242). A search was carried out on the following electronic bibliographic databases: AMED, Academic Search Premier, CINAHL Complete, MEDLINE, PsycINFO, SPORTDiscus with full text to identify relevant primary studies. Reference lists of eligible studies were hand searched. No date limits were applied, and the final search was carried out 21 March 2019. The search was limited to peer-reviewed papers, published in English. A Boolean search strategy was employed to search the databases using key concepts and their alternatives (physiotherapist* OR “physical therapist*” AND "self manag*" or "self?manag*" or "self?care" or "self care").

Eligibility Criteria and Study Selection

Since the aim of this review was to explore the views of physiotherapists concerning their delivery of a self-management approach, qualitative or mixed-methods studies with a substantive qualitative component were sought. The inclusion and exclusion criteria outlined in Table 1 were developed based on the population (physiotherapists), phenomena of interest (views concerning delivery of a self-management approach) and context (physiotherapy practice) and was used to screen papers. Papers were initially screened for eligibility by CK using their title and abstract. Studies were included if they contained participants who were physiotherapists or physical therapists with qualitative data on their perceptions, views, experiences, or beliefs regarding their role in the delivery of self-management approaches. Where it was difficult to determine if a paper met the inclusion criteria based on title and abstract, they underwent full-text screening.

Search results were handled using an excel spread sheet to facilitate an audit trail and article screening. Full-text articles were independently reviewed by CK and SC. Discrepancies regarding eligibility for inclusion were resolved by discussion and consensus with CC and JW. Studies were excluded if it was not possible to distinguish the views of physiotherapists from the views of others. This was carried out to ensure that only the views of physiotherapists were included in the synthesis.

Included studies were critically appraised for quality by CK and MT through the use of the Qualitative Findings Critical Appraisal Scale using an excel spreadsheet (Pearson, 2004). Discrepancies were resolved by discussion and consensus with the review team. Studies were not excluded based on their quality appraisal as studies with lower quality may still yield valuable insights and as such was included in the synthesis (Noyes et al, 2008). The methodological quality of included papers is reported to allow the reader to make an informed judgement about the credibility or trustworthiness of the findings, and transferability or relevance of the research findings to other settings (Tong et al, 2012).

Data Extraction and Synthesis

The framework for data synthesis was Thomas and Harden's (2008) method of thematic synthesis. The findings sections of each study were imported verbatim into QSR International NVivo 12 and were coded line-by-line in the first open coding phase. The second stage of synthesis involved the free codes being organised into related areas to construct descriptive themes. These first two stages sought to stay as close as possible to the primary studies. In stage three, analytical themes were generated which went beyond the data of the original studies to generate interpretive constructs in relation to the research question being addressed in this synthesis.

Data were initially coded by CK before other members of the review team (MT and SC) independently cross-checked sections by comparing the initial codes, descriptive themes, and analytical themes generated to the text and research question. This process of cross-checking led to valuable discussions which helped in refining themes (Barbour, 2001). The process of theme development can be seen in table 3. The authors sought to follow the statement on enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) as a methodological guide (Tong et al, 2012).

RESULTS

Study Selection

A total of 1189 studies were identified through the search strategy. Eleven studies met the inclusion criteria. Figure 1 shows the process of study selection based on the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (Liberati et al, 2009). Quality appraisal results for each included study are shown in table 2. For ease of comparison across studies, a total quality scored has been noted. However, caution should be used with interpreting these as an equal weighting cannot be assumed for each of the quality criteria. Overall, studies were of moderately high quality with 10 of the 11 studies meeting at least 7 of the 10 quality criteria. The main limitations were a lack of reporting of the influence of the researchers on the research and the philosophical perspectives used.

Study Characteristics

The research studies included in this review employed a range of data collection methods, including focus groups, semi-structured interviews, and observations. The included studies analysed their qualitative data using a range of approaches including thematic analysis, grounded theory, framework analysis, and content analysis.

Study sample sizes ranged from two to 100 participants, although participant age and gender were reported sporadically. Only one study (Solvang and Fougner, 2016) detailed participant age, with a range of 30-65 years. Of the seven studies which detailed participant gender (Cooper et al, 2017; Cowell et al, 2018; Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014; Robinson, Newton, Jones, and Dawson, 2014; Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014; Solvang and Fougner, 2016), a total of 92 females and 25 males were recorded. The experience of the participants was from a number of healthcare settings, including primary, secondary clinical, outpatient, community, acute, rehabilitation, and stroke units. Physiotherapists reported managing a range of long-term conditions, including stroke survivors, chronic obstructive pulmonary disease, chronic lower back pain, and older persons in falls prevention programmes. The majority of studies were based within the UK (Cooper et al, 2017; Cowell et al, 2018; Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014; Robinson, Newton, Jones, and Dawson, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Wilson, Kendall, and Brooks, 2006). The remaining studies were based in the Netherlands (Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014; Visse et al, 2010), Norway (Solvang and Fougner, 2016) and New Zealand (Crowe et al, 2010). Table 4 provides an overview of the included studies.

Qualitative Synthesis

Thematic synthesis of the included studies led to five themes that were important from the perspective of physiotherapists in regard to their role in the delivery of self-management approaches. These themes will be presented with direct quotes taken from the participants of the included studies.

Focus on Active Patient Participation

The focus on active patient participation theme was defined from the viewpoints of physiotherapists that for self-management approaches to work they were aware that they would need to "…always try and get people actively involved. Looking after themselves" (Crowe et al, 2010, p. 1482). In particular, the attitude or expectation of the patient towards physiotherapy was perceived to be important in determining whether patients would be willing to adopt self-management approaches (Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014; Solvang and Fougner, 2016). For example, patients who had a particular expectation or preference for 'hands on' physiotherapy were perceived to be more difficult to engage in active self-management strategies: "These patients also expect treatment to be by the therapists' use of hands on soft tissue. This way of providing treatment, however, is not the way physiotherapists work." (Solvang and Fougner, 2016, p. 595).

For the patients who did not wish to engage in self-management approaches, physiotherapists felt there was little they could do to change this:

> *"You can talk to them till you're blue in the face and explain why, but if they don't want to be there and they're not really interested, then there's not really a lot you can do."*
> *(Robinson, Newton, Jones, and Dawson, 2014, p. 383).*

In terms of supporting active participation, physiotherapists reported using a range of strategies. This included practical approaches such as writing down the exercises, exercise diaries, and visual reminders (Robinson, Newton, Jones, and Dawson, 2014). This would indicate a professional compliance model of care which runs contrary to the principles of self-management since the aim of the therapists was more often to:

"monitor and track adherence levels rather than to support the older person to play an active role in managing their treatment programme." (Robinson, Newton, Jones, and Dawson, 2014, p. 384).

Taking an individualised approach to patient goal setting was perceived to be an important aspect of helping patients actively self-manage their conditions (Cowell et al, 2018; Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014; Robinson, Newton, Jones, and Dawson, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Solvang and Fougner, 2016). However, it was felt that those with cognitive impairment following a stroke for example, or those with vascular dementia might struggle with active self-management strategies (Robinson, Newton, Jones, and Dawson, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014; Solvang and Fougner, 2016). The level of social support available to a patient was viewed as having an impact on a person's ability to actively participate in self-management (Norris, Jones, Kilbride, and Victor, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014).

Targeting individual factors was viewed as more likely to engage the patient and therefore having listening and communication skills were central to self-management and agreeing collaborative goals:

I think it's just got to be really, really patient specific. I think you need to sit and spend your time listening to all the factors involved in that particular patient's back pain to find an approach that's tailored to them and then I think you've really got to get them on board to buy into whatever the best approach you feel is for them. (Cowell et al, 2018, p. 116).

However, the notion of getting the patient "on board to buy into whatever the best approach you feel is for them" is again focusing on a professional compliance model which does not align with self-management approaches.

The Physiotherapist as the Expert

The theme of the physiotherapist as the expert expresses the views of physiotherapists as having a professional authority and a desire to be in control. This professional authority created an uneven power structure that was suggested to stem from professional training with the expectation that as professionals they held the necessary knowledge (Norris and Kilbride, 2014). In one instance, prior to any specific self-management training, stroke physiotherapists noted that although they were committed to helping patients, they were most often comfortable when they were in control and could dictate to patients (Norris and Kilbride, 2014).

> *Therapists for some reason I think when they're qualified they have this unerring belief that they are now the professional, they know everything, and that from their professional standpoint they get to almost dictate if you will to clients, to patients, about what they think should be happening. (Norris and Kilbride, 2014, p. 34).*

Interestingly, after self-management training, the perspectives of these same therapists had shifted to placing a greater emphasis on the agenda of stroke survivors. Physiotherapists had a fear of losing control either through the increased risk that came with patients self-managing their condition, a fear of doing nothing through not meeting measurable goals (as determined by the therapists) or through a lack of time since self-management approaches were deemed to be more time consuming. In addition, self-management was not their highest priority (Norris and Kilbride, 2014).

This sense of being an expert and a desire to remain in control was similarly noted in the context of rehabilitation for patients who are at risk of falling (Robinson, Newton, Jones, and Dawson, 2014). Therapists felt that older people should be supported in taking responsibility for their health, however, they as therapists had a conflicting desire to keep control of the treatment (Robinson, Newton, Jones, and Dawson, 2014). If their advice was rejected by patients it was

predominantly viewed as a threat to their professional identity and a sense that they had failed: "you feel like you've failed, and maybe you have, I don't know" (Robinson, Newton, Jones, and Dawson, 2014, p. 384).

Physiotherapists working with those with long-term conditions recognised that the patient is the expert in their condition, but they are the expert in their therapeutic skills: "they might be experts but what we're expert in is our skills" (Wilson, Kendall, and Brooks, 2006, p.809). Stroke therapists, whilst viewing themselves as the expert felt that their role was "to guide and support people rather than dictate" (Sadler, Wolfe, Jones, and McKevitt, 2017, p. 5). Education was seen as being an important aspect in helping patients work out where they would like to get to (Sadler, Wolfe, Jones, and McKevitt, 2017; Solvang and Fougner, 2016).

An area that physiotherapists did not perceive themselves to be expert in was the area of self-management. A gap in knowledge was identified by several therapists in that they noted they did not have the necessary skills to explore self-management strategies with patients (Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014). This was highlighted as a lack in pre-registration physiotherapy training with its focus on physiology and diagnosing conditions rather than on supporting individuals in making choices:

> *After completing our basic training at the school of physiotherapy, we thought our work would focus on diagnosis – if you know what I mean. But we work with a person and that person has a life, a family and a history. That's where the challenge lies. (Solvang and Fougner, 2016, p. 597).*

Valuing the Quality of the Patient-Therapist Relationship

This theme reflects the views of physiotherapists on the value of a high-quality patient-therapist relationship in supporting self-management. Valuing the quality of this relationship was seen as

being central to collaborative working with patients and empowering patients in their self-management.

Part of this patient-therapist relationship was developed through communication and importantly, listening to a patient (Visse et al, 2010). It was this listening which helped the therapists understand the patient's challenges and helped develop a personalised, tailored approach which supported patient engagement (Cowell et al, 2018; Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014). Understanding the cultural background of patients was especially important for physiotherapists utilising self-management approaches in working with those from minority ethnic backgrounds:

> *"…for me it's allowed me to learn what's important for their culture. So you know having goals around getting to church and um . . . volunteering for church, and the kind of foods that they like to eat and what time of day they like to eat. So I'd say it's helped me to understand their culture more..." (Norris, Jones, Kilbride, and Victor, 2014, p. 2258).*

In order to facilitate self-management, some physiotherapists spoke about their role as being a guide or coach such that they would work collaboratively to share decision-making. This positive patient-therapist relationship was viewed as a prerequisite for success in helping patients self-manage (Sadler, Wolfe, Jones, and McKevitt, 2017). The therapists on occasion needed to be someone that the patients could lean on and work with to achieve an agreed goal (Solvang and Fougner, 2016) and a strong patient-therapist relationship was necessary to enable this supportive role. Having a good patient-therapist relationship supported motivation and patient engagement such that they were able to achieve their goals as part of the self-management process (Cowell et al, 2018; Sadler, Wolfe, Jones, and McKevitt, 2017; Solvang and Fougner, 2016; Visse et al, 2010). Trust was also important in developing a high-quality relationship and

promoting self-management since "successful patient engagement was deemed to be contingent on a trusting therapeutic relationship…" (Cowell et al, 2018, p. 116).

Competing Paradigms

This theme reflects the challenges experienced by physiotherapists based on the competing paradigm of their practice environment. For example, in an acute hospital setting the highest priority was dictated by the hospital with its focus on safety, assessment, and early discharge. Acute stroke units tended to reinforce a sick patient model with high pressure to discharge patients quickly. In this context, patients did not have to think about their own self-management because there was someone there to help them:

> *When they're in the hospital and the hospital is looking after them, the hospital is dealing with all the problems, they don't necessarily have to think about that [self-management] as much as when they are actually having to put on a pad, to put on a splint which can be difficult for some people. (Physiotherapist 7, stroke unit) (Sadler, Wolfe, Jones, and McKevitt, 2017, p. 6).*

A number of physiotherapists perceived that self-management was further limited in the acute stroke rehabilitation context by the competing paradigms of other members of the multi-disciplinary team who in some instances tended to provide care for patients rather than promoting independence: "…the first who takes away independence are the nurses who put a bed pan below a patient instead of helping them to go to the toilet" (Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014, p. 1749).

The biomedical model and culture of the in-patient hospital environment was perceived by physiotherapists to be the problem and blamed for these challenges. This was because it perpetuated the passive patient role where patients were passive recipients of care: "…they're on your patch and they have to play the patient role, sick role...I don't think it is even sick role...but

they're very vulnerable but also passive" (Norris and Kilbride, 2014, p. 34). Keeping patient's passive was seen as helpful by some physiotherapists as it meant they could continue with a therapist centred agenda; others perceived that the in-patient environment meant that patients had no choice but to be passive recipients (Norris and Kilbride, 2014).

If self-management approaches are to become embedded then, as one physiotherapist stated, there may need to be a shift in perspective away from biomedical models:

> *I think that in general we are focussed to treat within medical-technical frameworks, but when you talk about self-care…self-management, then it is not directly related to that framework. So you should think from another perspective and that is more a social framework. (Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014, p. 1749).*

The increased focus on targets and reduced staffing levels led to time and service constraints. This affected therapy time which was perceived by therapists to be a barrier to enabling self-management approaches (Norris and Kilbride, 2014; Robinson, Newton, Jones, and Dawson, 2014; Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014)

On a more practical note of resourcing, physiotherapists from rural locations bemoaned the lack of referral options for patient's post-discharge, which would facilitate ongoing self-management through exercise such as walking groups or exercise classes: "We do signpost to what's available, but I do tend to find in a small rural area, there's not the same facilities as there might be in [City name]" (Cooper et al, 2017, p. 141).

Physiotherapists felt that the community setting was more conducive to self-management approaches (Robinson, Newton, Jones, and Dawson, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014; Solvang and Fougner, 2016). This was because physiotherapists perceived that in their own environment patients would be more likely to discuss what was important for them. Understanding the patients' environment and how they interact with it may help steer towards a more person-centred approach to

supporting self-managing in their home environment (Sadler, Wolfe, Jones, and McKevitt, 2017; Solvang and Fougner, 2016).

Seeing Patients as People

This theme reflects the views of physiotherapists that if patients are to be successful at self-managing then they need to be viewed as people (Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014; Sadler, Wolfe, Jones, and McKevitt, 2017; Solvang and Fougner, 2016; Visse et al, 2010). Physiotherapists were aware that they needed to understand that they had to view patients holistically as people with personal biographies, within the context of their lives and their environment.

> *The lived life of the patient and the life they have lived with the affliction. The lived life in their environment can sometimes be the thing we should work with, as opposed to what we find out about their bodily problem. (Solvang and Fougner, 2016, p. 597).*

When patients were viewed as people, both emotional and mental health were deemed to be as important as the physical challenges experienced. Physiotherapists needed to develop an integral view of the mind-body connection to help patients self-manage their conditions because the physiotherapists "noticed that there is a very strong connection between someone's physical and mental or emotional state" (Visse et al, 2010, p. 365). This was important because, for example, in stroke rehabilitation, community physiotherapists noted that patients needed to be supported in managing the longer-term consequences of having a stroke, including the psychological and emotional effects as well as the immediate physical effects of the stroke:

> *"…self-management it's not just talking about more physio, but more holistically. They've got to manage post stroke, how they are feeling in relation to activities, but also their mood, their future, what medication they may be on as well. So it's kind of the bigger picture" (Sadler, Wolfe, Jones, and McKevitt, 2017, p. 5).*

Some physiotherapists expressed that the key to seeing patients as people was in listening to patients and finding out about their histories and life stories. This was not necessarily a new practice for therapists but was felt to be "key to the process of rehabilitation itself" (Norris and Kilbride, 2014, p. 35). This was perceived to be important in helping set individualised goals, which promoted engagement (Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014).

DISCUSSION

The aim of this review was to explore the views of physiotherapists concerning their delivery of a self-management approach. This knowledge is important in understanding barriers and enablers to implementing self-management approaches with patients in the context of physiotherapy practice. This study has four contributions to make to how best to support patients in the self-management of their conditions.

Firstly, this review has highlighted that from a self-management perspective, where patients and physiotherapists are partners (Lorig and Holman, 2003), it is important to raise the question of 'who is the expert?' Findings from this study suggest that some physiotherapists view themselves as the experts leading to attitudes and behaviours akin to professional authority and a desire to control. In some instances, physiotherapy advice rejected by patients was perceived as a threat to professional identity. This is echoed in the broader healthcare context where in traditional models of practice, the clinician is positioned as the expert and as such leads to them being in a position of authority over the patient (Mudge, Kayes, and McPherson, 2015). This type of thinking does not align with self-management approaches where clinicians and patients work together in sharing decision making (Elwyn, 2001).

Some physiotherapists were willing to acknowledge the patient was an 'expert' in the knowledge of their condition but believed that as a physiotherapist they were the expert in

therapeutic skills. Beliefs about who is the expert and shared expertise appeared to be important in promoting collaborative working, trust and a positive patient-therapist relationship. This collaborative bond between patient and therapists, also known as therapeutic alliance (Krupnick et al, 1996), has been shown to be facilitated through prioritised goals, autonomy, support and motivation (Babatunde, MacDermid, and MacIntyre, 2017). This has implications for practice and the authors suggest that it would be important for therapists to reflect on where their expertise lies, what expertise the patients bring to therapeutic encounters and who is in control. A recently coined term, 'mansplaining', a portmanteau of man and explain, is typically used to describe men speaking to women in a patronising manner (Bridges, 2017). If physiotherapists do not reflect on the shared expertise between patient and therapist, there is a risk of assuming control and of 'physiosplaining' in therapeutic encounters, patronising individuals with significant lived experience, thus hindering the facilitation of a positive patient-therapist relationship, which is vital for self-management.

Secondly, it is important to consider how self-management is conceptualised by physiotherapists, as this will determine how it is implemented in practice. If self-management is characterised by whether someone adheres to their exercises or not, then physiotherapists may have missed the point of supporting people in self-management. After all, self-management is based on supporting patient empowerment so that they can make their own decisions whilst partnering with physiotherapists, not on a model of compliance (Holman and Lorig, 2000; Sadler, Wolfe, and McKevitt 2014). This was exemplified in the study by Robinson, Newton, Jones, and Dawson (2014), who in the context of falls rehabilitation noted that strategies such as exercise diaries, writing down exercises, visual reminders and outcome measures were more often used to monitor exercise adherence rather than to support a person in playing an active role in self-management. Self-management is not synonymous with exercise adherence, although an aspect of self-management may include exercise and indeed the keeping of diaries. Rather, self-

management also includes the psychological and social aspects of living with a long-term condition (Newman, Steed, and Mulligan, 2004; Sadler, Wolfe, and McKevitt 2014). The authors would suggest that promoting adherence to exercise is not getting to the heart of supporting people in the self-management of their long-term conditions as this would be a reductionist and narrow approach to self-management.

Narrow and broader approaches to supporting self-management have been documented by Morgan and colleagues (2016). Narrow approaches of support focus on helping people *manage their condition well* and include aspects such as disease or symptom control. Broader approaches seek to support people in *managing well with their condition*, with an approach that includes quality of life goals such as maintaining social roles, exercising autonomy, finding meaning as well as physical health. The two conceptualisations of narrow and broader practitioner approaches to support are important in the context of understanding physiotherapists' views of self-management and thus how they engage in promoting active patient involvement. It is clear from the findings that physiotherapists can reconceptualise their understanding of self-management through education, therefore perhaps the idea of confidence and competence is important. Within a new conceptualisation, do therapists have the depth of skills and agility in application that is key to facilitating individuals to manage well with their condition, such as those found in coaching and behavioural change? As highlighted by Hartley (2019), the role of the physiotherapist needs re-imagining when working with people with long-term conditions to ensure physiotherapists evolve to stay contemporary in approach to support the changing needs of people with long-term conditions.

Furthermore, promoting adherence or compliance with rehabilitation has been described in terms of the task orientations of physiotherapists (Terry and Kayes, 2019). An alternative perspective relates to the role of the therapist as someone who enhances efficacy and autonomy through the rehabilitation process (Terry and Kayes, 2019). This suggests that a broader question

could be raised not of how self-management is conceptualised, but how the role of a physiotherapist conceptualised. Thus, the authors challenge physiotherapists to consider whether they view themselves as task orientated in their rehabilitative encounters or focused on promoting efficacy and autonomy; the latter being aligned to the premise of self-management.

Thirdly, moving beyond the way in which a physiotherapist conceptualises their role, this study has highlighted challenges around the competing paradigms of the context in which physiotherapy services are delivered and the impact this can have on physiotherapists in supporting patients in self-management. The breadth of physiotherapists' perspectives relating to self-management appear to have been influenced by the paradigm of the clinical environment. For example, in the acute setting, physiotherapists were less likely to encourage self-management as they dictated and controlled the therapy, while in the community setting there appeared to be a partnership approach that was more holistic in nature, taking account of psychological and social factors. Thus, the paradigm or worldview of the environment in which therapy is delivered could be a contributing factor in whether self-management is promoted or hindered.

Modern healthcare has been said to be influenced by two main paradigms: biomedical practice and person-centred practice (Hughes, 2004). Self-management comes from the ontological framework of person-centred approaches of empowerment and shared decision making (Anderson and Funnell, 2005), whereas traditionally, physiotherapy as a profession has aligned itself with biomedical models of healthcare underpinned by positivist paradigms (Wiles and Barnard, 2001). The adoption of biomedical paradigms by the founders of modern physiotherapy was important in establishing the legitimacy of the profession in bringing them closer to the medical practitioner and gaining public trust (Nicholls and Gibson, 2010). The introduction of the biopsychosocial model in the 1970s (Engel, 1978) challenged the biomedical

discourse of dualism and reductionism by offering a more holistic alternative (Borrell-Carrio, Suchman, and Epstein, 2004).

The physiotherapy profession has adopted a paradigmatic shift towards a biopsychosocial model of care which considers the patient as a whole including their social, cultural and environmental context (Sanders, Foster, Bishop, and Nio Ong, 2013). The challenge for physiotherapists is how to balance collaborative patient-therapist approaches that encourage self-management, within positivist healthcare services of efficiency and economic limitations which tend towards the biomedical paradigm, especially evident in acute hospital environments. Although there are challenges to self-management in this biomedical acute environment, this could in fact provide an opportunity for physiotherapists to rise to the challenge and realise a shift from hierarchical practitioner-patient relationships towards more person-centred, collaborative approaches. This would be important because the quality of the relationship between the patient and health care professional has been noted as an important factor in fostering self-management practice (Sadler, Wolfe, and McKevitt 2014).

Furthermore, there are calls to move away from seeing biomedical approaches and person-centred care as dichotomous but rather on a continuum (Mudge et al, 2020; Terry and Kayes, 2019). Adopting a view of person-centredness as a continuum would encourage an understanding that improvements are possible (Mudge et al, 2020; Terry and Kayes, 2019). This view would help physiotherapists make small, incremental changes within biomedical healthcare environments, towards approaches that support the empowerment of patients in actively self-managing their long-term conditions such as seeking to involve patients in decision making or seeing patients as people and collaborative partners.

Finally, physiotherapists and patients need to have a shared understanding of how psychological and social aspects can contribute positively to self-management. For self-management approaches to be effective, physiotherapists must see patients as people. Some

physiotherapists in this current study viewed this whole person approach, which aligns with the biopsychosocial paradigm, as integral in supporting people in the self-management of their long-term conditions. Central to this was listening to patients' life stories to help develop collaborative goals. The notion of taking a holistic, empowering approach towards physiotherapy rehabilitation and seeking to involve the patient directly in their own care is not new knowledge (Nicholls and Gibson, 2010; Pratt, 1989). However, for some this became a stronger feature of their clinical practice after specific training in self-management approaches (Norris, Jones, Kilbride, and Victor, 2014; Norris and Kilbride, 2014). This suggests that there are benefits in ensuring physiotherapists are trained in self-management approaches, an area in which physiotherapists felt they lacked expertise.

Like other clinicians (Mudge, Kayes, and McPherson, 2015), physiotherapists face challenges in supporting patients in the self-management of their long-term conditions. Ultimately, physiotherapists are well placed to facilitate self-management, however, challenges remain.

This review raises a number of implications for practice and future research. First, reflective practice is an important part of being a physiotherapist and, as such, qualified physiotherapists are encouraged to reflect on their role. The following questions might be a helpful starting place. Where do the boundaries of expertise lie between the patient and therapist? Do physiotherapists view their role as task oriented or focused on promoting patient autonomy? Do physiotherapists view their philosophy of practice of self-management from a narrow perspective of helping people manage their condition well, or is it broader where they see their role as helping people manage well with their condition? What is the healthcare paradigm of the environment in which they work and what can they do to move closer to approaches which empower collaborative relationships between themselves and their patients? Do they view

patients as people? The answers to these questions may lead to very different types of physiotherapy practice.

Second, physiotherapists did not perceive themselves to be experts in self-management and felt that they lacked knowledge in this area. This is hardly surprising given the focus in pre-registration education on the number of hours spent on anatomy, biomechanics, and pathology as opposed to psychosocial factors (Darnell, 2007). It is suggested that approaches to supporting patients in the self-management be taught explicitly as part of pre-registration training to equip the future workforce with the skills needed to support patient empowerment. The authors would suggest that pre-registration physiotherapy programmes also build in opportunities for students to consider the type of physiotherapist they wish to become. This should include opportunities to develop a philosophy of practice which is regularly reviewed and aligned with the concepts of person-centred care and self-management approaches within a biopsychosocial framework. This would be important in challenging assumptions of professional authority (Mudge, Kayes, and McPherson, 2015; Norris and Kilbride, 2014) and help student physiotherapists see patients as people. Longitudinal research studies which track students in how they develop their philosophy of practice and skills in supporting self-management would add new knowledge in terms of optimal pedagogic approaches to teaching self-management.

Study Limitations and Strengths

The main limitation of this systematic review is the diverse contexts of studies, with four related to physiotherapists who work with stroke patients; three in the context of low back pain; two with those who worked with patients with a wide range of long-term conditions; one with falls rehabilitation physiotherapists, and one with respiratory physiotherapists. It could be that different types of patients need different self-management approaches. For example, stroke survivors might have cognitive limitations or severe physical disabilities and as such low ability

to care for themselves, while individuals with back pain might have more resources for self-management. Having said this, the diversity could also be seen as a strength since it considers the views of physiotherapists from a wide range of patient populations. The included studies were from the UK, the Netherlands, Norway, and New Zealand, offering an international perspective on the views of physiotherapists.

As there were no date limits applied to the search strategy, it is important to be mindful of the fact that over time, the healthcare context in which self-management takes place can change and therefore, so may the views of physiotherapists in relation to this. The robustness of the review might have been affected by only one reviewer (CK) conducting the initial screening of articles by title and abstract which could have resulted in errors being made. However, the validity of the review was strengthened by having full-text screening, quality appraisal, and data analysis carried out by two reviewers. The studies included in this review were limited to those published in English, grey literature was not included, citation tracking was not used to locate further articles, and experts in the field were not consulted. This may have led to the exclusion of some relevant studies.

CONCLUSIONS

This study sought to synthesise the views of physiotherapists on their role in the delivery of self-management approaches with a view to understanding how self-management approaches can be optimised within a physiotherapy practice setting. Findings suggest that for self-management approaches to work, physiotherapists believe that patients need to actively participate. Boundaries on who is the expert were blurred at times with some physiotherapists struggling to relinquish control. High quality patient-therapist relationships are required to build trust in order to support patients in the self-management of their long-term conditions. It is also important to consider the competing paradigms in which a service is delivered as this may facilitate or hinder

self-management. Finally, seeing patients as people is integral to supporting self-management approaches. Self-management has been an increasingly important aspect of helping people manage their healthcare needs and physiotherapists are well placed to support self-management. However, there is still a need for a cultural and paradigmatic shift in the physiotherapy profession and the findings of this review suggest that in some environments this shift as yet is to be realised.

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Table 1. Inclusion and exclusion criteria for eligibility.

Inclusion criteria	Exclusion criteria
• Focus on the perceptions, views, experiences, or beliefs of physiotherapists or physical therapists regarding their role in the delivery of self-management. • Primary research with a qualitative or mixed-method (where the qualitative data can be extracted) study design. • English language studies published in a peer-reviewed journal.	• Perceptions, views, experiences, or beliefs of patients, carers, or others. • If it is not possible to distinguish the physiotherapists views from the views of others. • If the focus was not on the physiotherapists' role in the delivery of the self-management approach, (e.g. focused on the views of the intervention rather than the self-management approaches). • Grey literature and systematic reviews. • Quantitative study design.

Table 2. Quality appraisal of included studies

Criteria	Cooper et al, 2017	Cowell et al, 2018	Crowe et al, 2010	Norris et al, 2014	Norris and Kilbride 2014	Robinson et al, 2014	Sadler et al, 2017	Satink, et al, 2014	Solvang and Fougner, 2016	Visse et al, 2010	Wilson et al, 2006
1. There is congruity between the stated philosophical perspective and the research methodology	Y	N	U	Y	Y	Y	U	Y	U	Y	U
2. There is congruity between the research methodology and the research question or objectives	Y	Y	Y	Y	Y	Y	Y	Y	Y	U	Y
3. There is congruity between the research methodology and the methods used to collect data	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4. There is congruity between the research methodology and the representation and analysis of data	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5. There is congruity between the research methodology and the interpretation of results	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6. There is a statement locating the researcher culturally or theoretically	U	N	N	U	N	Y	Y	N	N	N	N
7. The influence of the researcher on the research, and vice-versa, is addressed	N	Y	N	Y	Y	Y	N	Y	Y	N	N
8. Participants and their voices are adequately represented	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body	Y	Y	Y	Y	Y	Y	Y	U	Y	N	Y
10. Conclusions drawn in the research report appear to flow from the analysis or interpretation of the data	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total number of items with Y response	9	8	7	9	9	10	8	8	8	6	7

N, no; U, unclear; Y, yes

Table 3. Table of theme development

Stage 1: Open coding	Stage 2: Descriptive themes	Stage 3: Analytical themes
Importance of individualised approach and goal setting Patients should be encouraged to take control and responsibility Poor cognition Best patients Expert patient Little could be done to encourage those who did not wish to participate Older people poorly motivated Patients responsible for own functional decline Patient response to self-management Patient inexperience in self-management Patient specific barriers to self-management Self-efficacy Patient treatment preferences Patient views of physiotherapy Patients want to please the physiotherapist Dependence on professional support Personal responsibility of the patient	Attitude of the patient	Focus on active participation
Communication Education Functional approaches	Strategies to promote exercise adherence	
Medical model Changes in service delivery Environmental constraints to exercise or rehabilitation Lack of onward options MDT in self-management Phase of illness Acute versus community Resistance to patient self-management Stages of rehabilitation Time Vulnerability of patients	Constraints to service delivery	Conflicting paradigms

Mind body connection Whole person approach Life world	Mind body connection	Seeing patients as people
PT desire to remain in control Uneven power structure Therapeutic control Personal views impact on professional role Relinquishing control Risk in self-management	PT desire to remain in control	Physiotherapist as the expert
PTs require skills or training	PTs require skills or training	
Trusting therapeutic relationship Therapeutic alliance Empowering patients Collaboration Ownership Lack of trust in patient testimony Listening to patients PT needs to be able to motivate PT views on who is motivated	Trusting therapeutic relationships	Valuing the quality of the patient-therapist relationship social
Supportive social environments Socio cultural background	Socio cultural background	

Table 4. Overview of included studies

Study	Patient groups	Context	Data collection methods	Aims
Cooper et al, 2017	Older persons with chronic lower back pain	Setting: United Kingdom – primary care 13 National Health Service Physiotherapists (11 female). Experience cannot be determined from details given.	Focus groups and semi-structured interviews	To explore the perceptions of patients, physiotherapists, and potential peer mentors on the topic of peer-mentoring for self-management of chronic low back pain following discharge from physiotherapy.
Cowell et al, 2018	Non-specific chronic low back pain	Setting: United Kingdom – primary care 10 National Health Service Physiotherapists (3 female) who had 3-14 years' experience working in the musculoskeletal field.	Semi-structured interviews	To explore the perceptions of physiotherapists' in primary care in England adopting a biopsychosocial approach to managing non-specific chronic lower back pain patients.
Crowe et al, 2010	Chronic low back pain	Setting: New Zealand – primary care 15 Healthcare professionals including physiotherapists. Exact number of physiotherapists not stated. Gender/Experience cannot be determined from details given.	Semi-structured interviews	To investigate how healthcare professionals perceive their role in facilitating self-management.
Norris, Jones, Kilbride, and Victor, 2014	Stroke survivors	Setting: United Kingdom – rehabilitation (acute and community) 12 physiotherapists (10 female) who had been qualified between 2-36 years.	Semi-structured interviews	To explore the experience of healthcare professionals in using an individualised self-management approach with stroke survivors from minority ethnic backgrounds.
Norris and Kilbride 2014	Stroke survivors	Setting – United Kingdom – rehabilitation (acute and community) 7 physiotherapists (6 female) who had been qualified between 7-36 years.	Semi-structured interviews	To present the views of trained therapists about the utility of a specific self-management approach in stroke rehabilitation.

Robinson, Newton, Jones, and Dawson, 2014	Older persons at risk of falls	Setting: United Kingdom – rehabilitation (hospital and community) 17 physiotherapists (14 female) who had been qualified between 1-28 years.	Focus groups	To involve older people and physiotherapists in the development of acceptable strategies to promote uptake and adherence with an exercise-based falls prevention programme.
Sadler, Wolfe, Jones, and McKevitt, 2017	Stroke survivors	Setting: United Kingdom – inpatient stroke unit and community 13 physiotherapists with between 1-7+ years' experience in stroke rehabilitation. Gender not stated.	Semi-structured interviews	To explore physiotherapists' views of self-management, focusing on what self-management means and factors perceived to enable and hinder self-management after stroke.
Satink, Cup, de Swart, and Nijhuis-van der Sanden, 2014	Stroke survivors	Setting: The Netherlands – primary care and private practice 4 physiotherapists. Gender/experience not stated	Focus groups	To explore allied healthcare professionals' perceptions and beliefs regarding the self-management of stroke survivors and their knowledge and skills regarding stroke self-management interventions.
Solvang and Fougner, 2016	Patients with a "wide range of health problems"	Setting: Norway – sports clinics, orthopaedic rehabilitation and a rehabilitation hospital 12 physiotherapists (11 female) with between 7-37 years' experience.	Focus groups	To gain an understanding of how physiotherapists in practice understand their interactions with patients during the treatment process.
Visse et al, 2010	Chronic Obstructive Pulmonary Disease	Setting: The Netherlands – centre for people with Chronic Obstructive Pulmonary Disease 2 lung physiotherapists (four interviews in total). Gender/experience not stated.	Semi-structured interviews	To evaluate a Chronic Obstructive Pulmonary Disease programme and examine the possibilities to enrich the notion of self-management.
Wilson, Kendall, and Brooks, 2006	Long-term conditions	Setting: United Kingdom – community, primary, and secondary care settings 32 physiotherapists. Gender/experience not stated.	Focus groups and semi-structured interviews	To explore how patient expertise is viewed, interpreted, defined and experienced by patients and healthcare professionals, to analyse how patient expertise is promoted and enabled through the self-management process.

Figure 1. Flow chart of study selection