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The patient's perspective of the feasibility of a patient-specific instrument in physiotherapy goal setting: a qualitative study

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Anita Stevens[1,2]
Albine Moser[1,2]
Albère Köke[1,3,4]
Trudy van der Weijden[2]
Anna Beurskens[1,2]

[1]Faculty of Health, Zuyd University of Applied Sciences, Heerlen, [2]Department of Family Medicine, CAPHRI School for Public Health and Primary Care, Maastricht University, Maastricht, [3]Adelante Centre of Research in Rehabilitation, Hoensbroek, [4]Department of Rehabilitation Medicine, Maastricht University, Maastricht, the Netherlands

Background: Patient participation in goal setting is important to deliver client-centered care. In daily practice, however, patient involvement in goal setting is not optimal. Patient-specific instruments, such as the Patient Specific Complaints (PSC) instrument, can support the goal-setting process because patients can identify and rate their own problems. The aim of this study is to explore patients' experiences with the feasibility of the PSC, in the physiotherapy goal setting.

Method: We performed a qualitative study. Data were collected by observations of physiotherapy sessions (n=23) and through interviews with patients (n=23) with chronic conditions in physiotherapy practices. Data were analyzed using directed content analysis.

Results: The PSC was used at different moments and in different ways. Two feasibility themes were analyzed. First was the perceived ambiguity with the process of administration: patients perceived a broad range of experiences, such as emotional and supportive, as well as feeling a type of uncomfortableness. The second was the perceived usefulness: patients found the PSC useful for themselves – to increase awareness and motivation and to inform the physiotherapist – as well as being useful for the physiotherapist – to determine appropriate treatment for their personal needs. Some patients did not perceive any usefulness and were not aware of any relation with their treatment. Patients with a more positive attitude toward questionnaires, patients with an active role, and health-literate patients appreciated the PSC and felt facilitated by it. Patients who lacked these attributes did not fully understand the PSC's process or purpose and let the physiotherapist take the lead.

Conclusion: The PSC is a feasible tool to support patient participation in the physiotherapy goal setting. However, in the daily use of the PSC, patients are not always fully involved and informed. Patients reported varied experiences related to their personal attributes and modes of administration. This means that the PSC cannot be used in the same way in every patient. It is perfectly suited to use in a dialogue manner, which makes it very suitable to improve goal setting within client-centered care.

Keywords: goal setting, patient-specific instruments, client-centered care, patient participation

Introduction

Health care developments toward client-centered care draw attention to individual patient's preferences and treatment goals.[1,2] In physiotherapy, these developments are also considered important and will affect the patient–physiotherapist relationship and mutual expectations.[3–6] To deliver client-centered care, physiotherapists need to identify the treatment goals that the individual patient wants to achieve. This process presupposes active involvement of the patient in the identification of

Correspondence: Anita Stevens
Research Centre: Autonomy and Participation, Faculty of Health, Zuyd University of Applied Sciences, PO Box 550, 6400 AN, Heerlen, the Netherlands
Tel +31 45 400 6364
Email anita.stevens@zuyd.nl

treatment goals and decision making related to treatment. In various studies, the importance and benefits of patients' participation in goal setting to improve the treatment adherence, motivation, and satisfaction of the patient have been considered.[7–13] However, patient involvement in treatment goal setting is not optimal in daily practice.[12,14–16] Due to time constraints, negative attitude, or poor skills from the professional toward involving patients in goal setting, patients are not always aware of their participatory role and may not be fully invited to participate.[10,12,14,16–18] The patient's age, cognitive status, and communication skills are often mentioned as limiting their ability to be involved in goal setting.[10,15,16,18] As a consequence, the goal-setting process is often led by the therapist, with lack of patient involvement and mutual agreement about treatment goals.[10,12,15–17,19,20]

Several scholars recommend explicit methods to improve both patients' active participation in goal setting and a more focused therapy.[8,9,14,21] Patient-specific instruments can be used to support the goal-setting process.[22] These individualized or personalized measures refer to those tools in which patients indicate personal relevant issues.[23,24] Personalized problem identification is especially important for patients with chronic disorders because they may face multiple problems in daily life and often need long-term treatments. Patient-specific instruments are helpful in client-centered goal setting because patients are actively involved in the identification and rating of their own problems, whereupon individualized treatment goals can be set.[22] Examples of patient-specific instruments are the Patient-Specific Complaints (PSC) instrument in physiotherapy and the Canadian Occupational Performance Measure (COPM) in occupational therapy.[25,26] The PSC resembles the COPM in terms of identifying, prioritizing, and scoring the patient's individual problems, but it differs in the scoring options and the mode of administration. The PSC is similar to the Patient-Specific Functional Scale (PSFS) but differs in the optional activity list. The PSC is frequently used in the Netherlands and it is recommended as a suitable tool in 70% of the Dutch physiotherapy guidelines.[27,28] Internationally, the PSC is also known as the Patient-Specific Approach, Patient-Specific Index, or Severity of Main Complaints Scale.[25,29–31] Despite the extensive dissemination of the PSC in physiotherapy in the Netherlands, its contribution to goal setting in daily practice is not well known.

An important feature for using an instrument in daily practice is its feasibility.[28,32–35] Feasibility refers to the practical use of an instrument by both patients and professionals and can be classified in terms of objective and subjective features.[22,23,36–38] Objective feasibility refers to the characteristics of the instrument itself, such as the time needed, instruction, or availability. Subjective feasibility refers to users' understanding of the instrument and attitude toward its usefulness.[22] Several studies and reviews[25,30,39,40] of the PSC and the PSFS have reported on their validity, reliability, and responsiveness, but information on their feasibility is lacking. Although physiotherapists report on patients' understanding and attitude toward measurement instruments, few studies[28,33] have been carried out to investigate the patient's perspective on this issue. As patient-specific instruments are used to support patient participation in goal setting, the patient's perspective has to be clear. The aim of this study was to get insight into the patient's perspective about the feasibility of the PSC, to optimize its use in daily practice. Our leading research question was "What are the patient's experiences with the feasibility of a patient-specific instrument, the PSC, in the physiotherapy goal setting?"

This study is relevant to improve patient participation in goal setting during their own treatment by the physiotherapist.

Methods

Our methodology was based on the general tenets of naturalistic inquiry, collecting data with observations and semi-structured interviews. We have chosen this approach because we wanted to understand how the individuals constructed their reality within their context and we focused on their subjective and nonquantifiable experiences.[41] Therefore, a qualitative descriptive study design was used to describe the patient's experiences with the use of the PSC.[42,43] The study was carried out in the natural setting of a daily physiotherapy practice in the community.

Setting and participants

Physiotherapy practices in the south of the Netherlands were approached to participate in this study. In these practices, physiotherapists work as independent professionals in the community. The therapists were approached by e-mail with an information letter. After 1 week, they were called and asked for participation. The therapists subsequently approached the patients for participation. Purposeful sampling was used to get various perspectives and rich data and to capture a diversity of experiences. Participants who would benefit our study and who covered a wide range with regard to disorder, age, and sex were selected.[44] The researcher was contacted for final agreement about the inclusion of the patients and

further appointments. All patients were given an oral and written version of the information and allowed to consider their participation for 1 week. Written informed consent was obtained prior to the interview. Ethical approval for this study was obtained from the Medical Ethics Committee of Atrium-Orbis-Zuyd, Heerlen, the Netherlands (approval number: 13-N-18). The inclusion criteria for patients were as follows: suffering from a chronic disorder (eg, reporting complaints for >3 months), being able to communicate in the Dutch language, and preferably consulting the physiotherapist for a new treatment episode. Because we wanted to study the use of the PSC in "real" clinical practice, the physiotherapists were not previously trained to use the PSC in a standardized manner but were encouraged to use it like they always do in order to comply with the naturalistic design.

In total, 20 physiotherapy practices in the south of the Netherlands were approached and 17 agreed to participate. Twenty-three patients were included from 12 different practices and 19 different physiotherapists. From the remaining five practices, no patients who fitted the inclusion criteria for the research period could be selected.

The study population consisted of eight male and 15 female patients aged between 22 years and 80 years (mean: 58.6 years; SD: 15.8 years). The patients had a variety of orthopedic, neurological, oncologic, and lung disorders, such as hip and knee osteoarthritis, low back pain, neck–shoulder complaints, Parkinson's disease, cerebrovascular accidents, cancer, and chronic obstructive pulmonary disease.

We observed 14 initial consultations and nine second consultations.

The PSC instrument

The PSC[25,39] is an instrument for identifying a patient's main complaints regarding function and for monitoring the course of these complaints over time. The PSC has to be applied in a stepwise process consisting of selecting, prioritizing, and scoring activities. In the first step, the therapist asks the patient an open-ended question: "Which activities do you find important in your life but are difficult to perform due to your health problem?" An additional list with sample activities can be provided to support the recall. Next, the patient has to prioritize and score the activities on a visual analog scale (VAS) or an eleven-point numeric rating scale (NRS): "How difficult was it to perform this activity during the last week?" (0= easy to perform, 10= impossible to perform). The selected activities can be used to formulate the personal treatment goals. Following treatment, the scoring must be repeated to evaluate the therapy.

Data collection

The observations and interviews were conducted from March 2013 until July 2013. The first author observed the consultations and took field notes. The focus of the observation was the process and application of the PSC within the first consultations. In addition, the patient's demographic information was collected during the observation. The first author (AS) conducted the interviews with the patients immediately after the observation, in a private room. The semistructured interview guide consisted of open-ended questions. The concept and dimensions of the subjective feasibility, eg, the experiences of the patients with the instrument, were used to draft the interview guide (sensitizing concepts).[22] The questions included issues regarding the process of administration of the PSC and the usefulness as perceived by the patients.

The field notes of the observation were transcribed directly after the observations. The interviews were audiotaped and transcribed verbatim.

Data analysis

The data were analyzed in the Dutch language. Quotes to illustrate the results from the researcher's field notes and the patient interviews were translated into the English language. The interview data were analyzed with directed content analysis because sufficient knowledge about the concept of feasibility already existed, based on a literature review.[22,45] The two key concepts of subjective feasibility that scaffolded our feasibility framework were as follows: 1) The process of administration comprised the overall process and the scoring. 2) The perceived usefulness was defined as the facet of being useful to facilitate a client-centered approach and comprised issues such as motivation, awareness, and participation.[22] This framework was used in a flexible manner and acted as our initial coding scheme.

The analysis was conducted with 23 observations and interviews. First, we read and reread the interview transcripts and marked the text fragments that suited our research question: "What are the patient's experiences with the feasibility of the PSC in physiotherapy goal setting?" Then, we coded these text fragments based on the initial coding scheme. We used the initial scheme to analyze the first five interviews. Any text that could not be categorized in this scheme was inductively coded and added to the coding scheme. The coding scheme was refined and extended after five analytical sessions with the research team. Coding proceeded until no new codes and themes emerged. This occurred after 15 interviews. We considered this as analytical data saturation.

The remaining eight interviews were used to validate the findings.

The written field notes were used to describe the variations in the use of the PSC and were analyzed separately from the interviews.

During the entire analysis process, qualitative data analysis software (NVivo Version 10; QSR International Pty Ltd, Victoria, Australia) was used to store and manage the data.

Establishing trustworthiness

To guarantee the trustworthiness of the data, multiple measures were taken according to Lincoln and Guba.[41] To meet the criterion of "credibility", three types of triangulation were ensured: investigator triangulation by involving four investigators in the research team; methodological triangulation by using two different methods of data collection, namely, the observation field notes and interviews; and data triangulation by using different data sources, namely, the interviews with different patients and the observations of various patient–physiotherapist interactions. Going back and forth between the analyzed codes-and-themes and the data, during the stepwise analysis, ensured persistent observation. The description of the participants and the setting in this article enabled the reader to make a "transferability" judgment. An experienced qualitative researcher in the team checked whether the analysis process was consistent and in line with the accepted standards for "dependability". "Confirmability" was secured by checking whether the results emerged from the data and by conducting a subsequent analysis. This was partly done in an independent manner, separately, and partly in an interdependent manner in the analytical sessions, with the researchers (AS, AM, AK, TvdW, and AB) with different backgrounds (physiotherapist, nurse, and physician) contributing to the same. Finally, "reflexivity" was ensured by continuously deliberating the researcher's reflections within the research team, cross-checking the progress of analysis, and interpreting the raw and coded data.

Results

The results present the observed use of the PSC, the analyzed feasibility themes, and a new theme that emerged, namely, patient attributes.

The observed use of the PSC

The written field notes from the observations revealed that the PSC was used at "different moments" of the consultation and it was applied in "different ways". During the first consultations, the PSC was integrated in the history taking or administered immediately after the physical examination. In this case, the patients were asked about their daily activity problems in a dialogical manner, as a natural part of history taking.

When the PSC was administered after the physical examination or in the second consultation, it was used as a separate questionnaire. In most of these cases, the identification of problem activities was not always explicitly linked to the previous identified problems. In some observations, the earlier revealed problems were summarized and used to fill in the PSC.

In many cases, a printed-paper version of the PSC was used and, in some cases, it was applied on the computer. Both the NRS and VAS were used for "scoring". The subject of scoring varied among the perceived burden, the difficulty in performance, and the amount of pain.

The "activity list" was used in almost half of the consultations, and this took about 2–10 minutes.

The "patient's involvement" in choosing their own problem activities varied. Some physiotherapists gave the patient the time and opportunity to read and select activities from the whole list. In other cases, the patient's involvement was limited, and the physiotherapist asked the patients to restrict their selection to three activities:

> Field note: The PSC is administered at the beginning of the 2nd consultation on paper. Physiotherapist asks the patient to name three important activities he cannot perform anymore, or is impaired, due to his complaints. Then he asks him to score the magnitude of his limitation on a scale from 0 to 10. Physiotherapist explains the means of the score and then the patient scores the activities. [Male, 51-years-old, frozen shoulder]

Sometimes, the physiotherapist took the lead and preselected the activities for the patient:

> Field note: The PSC is used in the first consultation, during history taking. It is introduced as a form that has to be filled in. Physiotherapist turns the computer to the patient and shows her the activity list. The patient does not really look at the screen; I wonder if she can see it. Physiotherapist selects activities from the list and asks the patient if she has problems with these activities. During this conversation he is constantly looking at the screen. He reads the activities and the patients answers "yes" or "no". She cannot read and choose for herself. [Female, 65-years-old, sacroiliac joint blockade]

The physiotherapist informed the patient about the PSC and explained its purpose, such as its necessity for treatment, potential goals, or evaluation. In other cases, no reason or purpose of the PSC was given. In some cases, the patients

were actively involved in the process of administration and were asked to fill in the forms or to score on the computer themselves, but in most other cases, this was done by the physiotherapist himself/herself.

Feasibility themes

The stepwise analysis of the interviews confirmed the two main feasibility themes, namely, the perceived ambiguity with the process of administration and the perceived usefulness (Table 1). The process of administration consisted of three subthemes: the identification of problem activities, the use of the activity list, and the scoring. The perceived usefulness was identified for both the patients (awareness, motivation, and informing the physiotherapist) and the physiotherapists (for determining treatment). Additionally, several patient attributes that seemed to influence the perceived experiences with the PSC were identified: attitude, role preference, and health literacy (Table 1).

Perceived ambiguity with the process of administration

Patients expressed a certain ambiguity in their experiences with the process of administration of the PSC. This perceived ambiguity covered a broad range of experiences, such as emotional and supportive, as well as a type of uncomfortableness. In general, patients judged the overall administration of the PSC as "pleasant" and "client-focused." They had different experiences with the identification of problem activities. Those who had been able to explain their main complaints during history taking had "no difficulties" in recalling problem activities. Others found it "difficult" to talk in terms of activities. This was a special issue in patients with pain complaints. For them, pain was the dominant complaint. They were either not aware of activity problems or activity problems were not perceived as important:

> Yes, that [identifying activities] was very difficult, because I often have constant pain in all the things I do. [Female, 64-years-old, low back pain]

Others had difficulties with the identification of problems because it forced them to focus on future activities. This "confronted" them with a future vision that they might not be able to perform some activities again because of their progressive disorder, such as cancer. Some patients had problems in prioritizing the three most important activities because, for these participants, all activities were perceived to be important.

The activity list was frequently perceived as "supportive" for problem identification. The examples on the list reminded patients of activities they did not think about at first.

> You can see what they mean […] to me it's difficult to explain and when you see it written down, then you will not forget things […]. [Male, 56-years-old, low back pain, knee arthrosis]

Others said that the use of a prescribed list "tempted" them to select activities from the prestructured list instead of considering their own problems. One patient found the list "incomplete" because certain activities she liked to engage in were missing. One patient found the use of the activity list "boring" because the physiotherapist used it in a checklist manner and each activity was read and checked out loud.

Patients made various statements regarding the scoring of the selected activities. The meaning of the score, ranging from 0= "easy to perform" to 10= "impossible to perform", was "clear" to all patients. Three main difficulties with scoring were mentioned: the subjectivity of scoring, the quantification of their burden, and scoring their fluctuating performance.

Table 1 Results of the analysis

Feasibility themes			Patient attributes
Perceived ambiguity with the process of administration		**Perceived usefulness**	
Pleasant	Difficult	For the patient	Attitude toward questionnaires
Client focused	Uneasy	Awareness of functioning	Role preference
Supportive	Confronting	Motivation	Active role
Valuable	Tempting	Providing information	Passive role
Clear	Incomplete	For the physiotherapist	Health literacy
	Boring	Treatment planning	
	Unsure	Evaluation	
	Fear of judgment	Tailored therapy	
		Client-centered approach	
		Not useful	

> Scoring is always difficult, because it is not constantly 7 or 3. So you should take the average score, but I choose the worst score, because I know there are moments in which it's really the worst. [Male, 56-years-old, knee arthrosis]

Others perceived "uneasiness" in scoring their performance due to time delay in experiencing their physical problem such as pain complaints. For instance, they were "unsure" what to score when problems arose after, instead of during, certain activities and as a consequence, they could not perform these activities any more. Patients expressed different perceptions about scoring. Not all perceived the "added value" of an abstract number and preferred to rely on their subjective experience. In the case of a progressive disease, such as cancer, one patient found it "difficult" to calculate the expected decrease in the score over time. He was aware that his deterioration in function will affect the perspective of his burden. Another patient hesitated to fill in a score because she "feared" that the physiotherapist would judge the severity of her problem as being too low to justify treatment by the physiotherapist:

> Is a score of 6 seriously enough to come here? Don't they think you have to come here with a score of 9 or 10? [Female, 56-years-old, low back pain]

Usefulness of the PSC

The patients found the PSC useful for themselves as patients, as well as being useful for the physiotherapist. Most patients perceived the PSC as being useful for themselves because they became more "aware of their own functioning". They felt stimulated to think about how they perform their activities in daily life by explicitly naming and writing down their problem activities:

> It can be an eye opener to write it down. This is different than just telling to someone. You confront people when it is written on a paper. So I think it can work very good to create awareness in people. [Female, 46-years-old, neck–shoulder complaints, asthma]

Some patients felt "motivated" by seeing the effectiveness of the therapy reflected in an improved score during evaluation later in the treatment process. Others felt motivated by the PSC because they realized that the therapy would be directed toward a meaningful activity and that they would be able to regain a desired function or reperform a desired activity again:

> In my opinion you are directed in a direction you want to. You have to work on your own problems and this stimulates you to do anything and go for it […]. [Male, 56-years-old, knee arthrosis]

Patients often mentioned that the PSC was useful to "provide information" to the physiotherapist about the problems they encounter every day, while performing routine activities, such as getting out of the car, walking – and especially, walking stairs, doing the laundry, and so on, thereby creating a full picture of themselves. They felt encouraged to explain their personal thoughts and perception about their problems and why these were important to them. The subsequent scoring helped them to express and make the magnitude of their limitations explicit to the physiotherapist:

> I think you can create image for the physiotherapist what your problems really are and how big they are. [Female, 22-years-old, cruciate ligament injury]

The patients also perceived the PSC useful for the physiotherapist, "to make a treatment plan" and "to evaluate" the success and results of the therapy. The selected activities were expected to provide the physiotherapist with a starting point for therapy and "tailor the therapy to the patient's needs". Some patients mentioned that the PSC could "support a client-centered approach" by establishing a mutual agreement regarding the treatment goals and treatment plan:

> I think that it's important for him [the physiotherapist], so he can see whether we are on the same track. Hmm, whether our goals are close by or distant. This [the PSC] can act as a sort of registration point; here we have to adjust our treatment. [Male, 64-years-old, stroke]

Some patients assumed the PSC was useful but they could not explain why.

A few patients experienced the PSC as "not being useful". They had no idea of any relationship with the upcoming treatment and did not perceive it useful to themselves:

> I don't think that it has anything to do with my treatment. [Female, 76-years-old, hip arthrosis, tendinitis]

> I don't think it has anything to do with me, but with the one who treats me. [Female, 78-years-old, neck–shoulder arthrosis]

One patient even thought that the PSC was solely intended for this study, ie, for research purposes only.

Patient attributes

A new theme, patient attributes, emerged from the data, which might have influenced the patient's experiences with the PSC. We defined this theme as the way the patients presented themselves in their individual manner.

Patients expressed different "attitude toward questionnaires". Some appreciated filling in questionnaires because

they found them interesting and appreciated the focus on their individual complaints. In general terms, most patients did not mind filling in a questionnaire (ie, activity list) and were willing to do so. Some patients disliked questionnaires at all or found the PSC boring, especially in cases when questionnaires were used mechanically by the physiotherapist as an agenda that had to be worked through. Most patients had previous experience with questionnaires, while others did not. Some patients were surprised and did not expect to fill in a questionnaire.

The patient's "role preferences" varied considerably. Some patients found it very important to take on an active role. They appreciated the opportunity to influence the physiotherapy program and appreciated the PSC because they felt that their concerns were heard.

> Sometimes, one [professional] might say, you have to do this or that, whereas it feels different to me as a patient. I appreciate the opportunity of having influence, because it doesn't work otherwise. I like to communicate about that. [Female, 28-years-old, neck–shoulder complaints]

Other patients preferred a more passive role, letting the physiotherapist taking the lead. They viewed the PSC as a tool of the physiotherapist and therefore only relevant to the therapist. Some thought that it was the physiotherapist's job to decide the therapy goals:

> I think it [setting treatment goals] has to come from her [the physiotherapist] […] I leave her the initiative. [Male, 74-years-old, stomach cancer]

"Health literacy" seemed to be a relevant patient attribute. We defined health literacy as the patient's skills in understanding the therapy process and their own health status as influenced by their profession, earlier experiences, and their cognitive capacities. Patients with a professional background in health care were more often more health literate and were interested in monitoring their own health status with an instrument such as the PSC:

> This [the PSC] makes it realistic and measurable and I like being busy with such scientific things. [Female, 47-years-old, breast cancer]

Earlier experience with physiotherapy made the patients more aware of the whole process.

The patient's cognitive capacities had an influence on the feasibility. Some patients, such as patients with neurologic disorders or older patients, did not fully understand the questions:

> Honestly, I don't overlook all the ins and outs or how it works, because of my limited capacity of thinking. [Male, 64-years-old, stroke]

Others were unaware of the purpose of these questions and its relevance to their own therapy:

> I don't know what happens with all these questions and activities, I don't know if it would make any difference to me. [Female, 65-years-old, knee arthrosis]

Discussion

The patient's experiences with the feasibility of the PSC seemed to be strongly related to the mode of administration and the patient attributes. Patients with a more positive attitude toward questionnaires, patients who preferred an active role, and health-literate patients appreciated the PSC and felt facilitated by it. Other patients, who lacked these attributes to varying degrees, did not fully understand the PSC's process or its purpose, and this resulted in leaving the physiotherapist to take the lead. These patients could not identify any relationship between the process and results of the PSC and their own treatment.

The study was carried out in a natural setting, namely, the physiotherapy practice in the community, and the therapists were prompted to use the PSC as they would normally do it. The choice of this approach constitutes a methodological advantage because the patient's experiences were based on large practice variations, and observing this variety in numerous consultations enabled us to examine its "real-world" use from the patient's perspective. As our aim was to study the patient's experiences about the feasibility of the PSC in the process of goal setting, we observed the use only in the initial assessment. Therefore, we cannot present results about the whole goal-setting process, including evaluation. To overcome this lack of data, we could have used a series of in-depth case studies with a smaller sample. We provided a rich description of the context to enable researchers to make a sound transferability judgment.[41] We included primarily patients with chronic illnesses and long-term problems because we assumed these patients to benefit the most from the PSC. Thus, no conclusions can be made for patients with acute disorders. The perspective of the interviewer, who is a physiotherapist herself and an expert in the PSC procedure, might have influenced the observations and questioning of the patients. Nevertheless, we compensated for this by involving a research team with various backgrounds and expertise, as recommended by Lincoln and Guba.[41]

To reflect on the feasibility of similar patient-specific instruments in facilitating client-centered goal setting, we compared our results with studies on the COPM and the Self-Identified Goals Assessment instruments.[26,46] In these studies, patients appreciated the client-focused

administration of both these patient-specific instruments, similar to the PSC.[46–48] They also experienced similar problems with the process of administration. The patient's difficulty of talking in terms of activities is confirmed by Rochmon et al[49] in a study about the use of the COPM. The fact that the meaning of the NRS score (0= easy to perform, 10= impossible to perform) was clear for our patients is similar to the observation in other studies,[46,49] but in contrast to one study[50] were some patients who accidentally inverted the scale and assigned better performance to a higher score. Patients found it difficult to score their fluctuating performance and to quantify their burden, which is similar to the findings in other studies.[46,49–51] This might be explained by the fact that patients did not understand the scoring, or because they were not well informed. The experienced uncomfortableness and fear of judgment was also previously recognized and might be based on power inequality between patient and physiotherapist.[50] Patients perceived patient-specific instruments as being useful in increasing their awareness in terms of functioning, comparable with previous studies.[46,49–52] Some of these studies also mentioned the usefulness in helping the therapist to design the upcoming treatment, ie, to formulate the treatment goals and treatment plan, as well as to evaluate the treatment.[46,51,52] Professionals often indicated that using instruments or questionnaires is less suitable in the case of patients with communication and/or cognitive problems.[22] This resonates partly with the observations in our study. The reason for this might be that the physiotherapist does not fully adapt his communication skills to the patient's needs and preferences. Additionally, our patients presented themselves with different role preferences, such as their expectation that the physiotherapist would set the goals. This role preference was also identified in other studies.[5,15,18,53,54] One might conclude on this issue that patients who are very cooperative, as in our study, sometimes show submissive behavior and this might be related to their age group or their belonging to an older generation.

Our empirical data confirm that before patient-specific instruments are implemented in daily practice, their feasibility should be considered, especially from the patient's point of view. In this study, we refined the concept of feasibility with the patient's experiences and the perceived ambiguity of the process of administration, as well as the perceived usefulness for both patients and physiotherapists. Good feasibility is not a stand-alone quality of an instrument but depends on the individual patient, the health care professional, eg, the physiotherapist, as well as their mutual relationship.

Conclusion

We conclude that the PSC may be a feasible tool to support patients' participation in the physiotherapy goal setting. However, in daily practice, patients are not always fully involved and informed about its intended use, and physiotherapists do not always integrate the PSC in their whole diagnostic and therapeutic process. We learned that patients reported varied experiences regarding the feasibility of the PSC related to their personal attributes and mode of administration. This observation teaches us that the PSC should preferably not be applied in a dogmatic manner. A patient-specific instrument such as the PSC is perfectly suited for use in a dialogue manner, to improve goal setting within client-centered care.

Implications for clinical practice and future research

To improve practice, health care professionals should explicitly inform their patients about the purpose of an instrument and the patients' possible contribution toward therapy. The use of the instrument should be fully integrated in their physiotherapy diagnostic and therapeutic process and not be used as a separate instrument, unrelated to the individual care context. Moreover, health care professionals should tailor the use of the instrument to the skills, needs, and preferences of each individual patient to improve a client-centered approach.

Further research is required to explore the physiotherapist's experiences regarding the use of the PSC in the goal-setting process and how it can support patient participation in goal setting. In addition, future studies about the clinical use of measurement instruments should always explore the patient's experiences and preferences in order to work in a client-centered manner.

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