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Practicings of Person-Centred Care in Physiotherapy

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ABSTRACT

This article explores the practices of person-centred care in physiotherapy by adopting a complexity-seeking approach. We acknowledge that person-centred care is contextual and produced through relationships, sociomaterial practices and institutional and organisational settings, thus recognising the agency of more-than-human actors. We draw on the concept of practicings, which refers to a constellation of what is said, materialised, routinised and practised. This framework enables us to explore the complex interplay and interrelatedness of factors that constitute person-centred care across various contexts, transcending micro and macro levels. By conducting a secondary analysis of texts from three qualitative studies from Denmark and Aotearoa New Zealand on person-centred care in physiotherapy, we argue that seemingly disciplinary and governing practices can also be understood as practices of person-centred care. Through the application of the practicings concept, we aim to advance sociological constructs of person-centred care. Focusing on the complex network of co-constituting forces allows for a more nuanced analysis of practices of person-centredness in physiotherapy, with applicability to other similar healthcare settings.

1 | Introduction

Patient-centred or person-centred care (PCC), although a nebulous term, is considered a central value and guiding ethical principle in modern healthcare (Pluut 2016). The focus on person-centred approaches in healthcare has grown over the past decades, and in healthcare, the push to involve patients more actively is driven by the development of medical ethics and increased emphasis on patients' rights (Beauchamp and Childress 1979). From a health professional perspective, person-centred care can be understood as an ethical and relational approach that supports a biopsychosocial model and attempts to address unequal power relations and be respectful of and responsive to the preferences, needs and values of the person who is the recipient of care (Mead and Bower 2000). What constitutes PCC is not always agreed upon and can appear oppositional and contradictory (Liberati et al. 2015). Which elements are prioritised may vary across clinical and organisational contexts and the nature of a condition (Gardner and Cribb 2016; Jesus et al. 2022; McCormack and McCance 2010) and serve a variety of purposes.

Within the field of rehabilitation and, more specifically, physiotherapy, the construction of the 'active' and 'participating' patient has been a prominent ideal for several years (Nicholls 2018; Præstegaard and Andersen 2018). This was prompted by the growing evidence for physical activity as prevention and treatment for a variety of health conditions and has led to interest in how to ensure the active participation of the patient and compliance with the physiotherapist's instructions and guidance—which is often characterised as a 'person-centred approach' (Hansen 2021). Within the clinical research field of physiotherapy, PCC has been examined through various inherent understandings, both empirically through qualitative and quantitative research and through literature reviews (Cheng et al. 2016; Dukhu et al. 2018; Hansen et al. 2022; Wijma et al. 2017). Most of this empirical research is concerned with

exploring PCC on the micro level, focusing on human subjects: patients/clients and/or physiotherapists and the relations between them (Hiller et al. 2015; Kidd et al. 2011; Morera-Balaguer et al. 2021; Pinto et al. 2012; Schoeb and Hiller 2018). Some studies show that practising person-centredness in physiotherapy is challenging (Hiller et al. 2015; Mudge et al. 2014; Ward et al. 2018), but focus only on the local level risks, ignoring broader sociological literature that shows healthcare practices as always situated—historically, culturally and within institutional settings and healthcare systems.

When person-centredness is scrutinised in this narrow way, contexts and nonhuman agency are often neglected (Hansen 2021), and human actors are positioned as primarily responsible for the success or failure of person-centredness in their individual practices. Following Liberati et al.'s (2015) proposal, our main argument is that studying person-centred practices from a practice-based approach, acknowledging both human and nonhuman dimensions, can add important nuance to the critique of these challenges when practising PCC.

We argue that the research approaches applied in physiotherapy are exemplary for research approaches applied in other biomedically informed healthcare practices (Hansen 2021) and that applying a sociological lens is important beyond just understanding the sociology of healthcare practices—it also can and has been used to develop new understandings within a clinical discipline that can change local clinical practices.

In this study, we aimed to not only bring sociological knowledge into the analysis of person-centred practices but also to contribute to the sociological body of knowledge by introducing the analytical concept of 'practicings' (Hansen 2021), which allows us to understand the complex interplay and interrelatedness between factors that constitute PCC across multiple contexts at micro and macro levels.

To situate our study, we first consider sociologically informed research on PCC in rehabilitation practices. When enacted, PCC encompasses a network of practices, interactions, shared meanings, technologies, devices, scripts and physical elements such as spaces and structures that shape healthcare practices (Lydahl 2017; Liberati et al. 2015). In sociological research, the relevance of including context and more-than-human agency in exploring clinical encounters has been emphasised (Gardner and Cribb 2016; Kazimierczak 2018; Lydahl 2017, 2021; May 2007; Pilnick et al. 2009; Rapley 2008). One object of research interest is how technologies, such as professional tools, are co-productive in practices of person-centredness. To take some key examples, Gardner and Cribb (2016) studied how the Canadian Occupational Performance Measure became significant in the distribution and configuration of power relations in a clinical setting in a children's hospital. Similarly, Lydahl (2021) studied how a person-centred protocol not only served as a standardised assessment tool but also became an integral part of the daily person-centred practice in the hospital context where it was used. Both studies highlight how the apparently opposing influences of PCC (as qualitative, humanising and focusing on the unique person) and evidence-based medicine (as quantitative, standardising and seeking to reduce differences) afford person-centred practices when applied and tinkered with by healthcare professionals in their day-to-day work (Lydahl 2021).

In a nursing setting, McCormack and McCance (2010) also point to the significance of including the context when PCC is being developed and argue that the complex constitution of PCC is underexplored (ibid.). These studies show the significance of understanding the complex conditions under which certain practices emerge and are maintained as 'right', legitimate and sensible, whereas others are marginalised or excluded.

In this study, through secondary analysis of texts generated from three studies across two countries, we examined how PCC practices in physiotherapy are produced through a variety of interacting and co-constituent forces. Analysing these practices as complex events, connected to matters both in and outside the particular situation, reveals how practices of PCC in physiotherapy come in many shapes and forms. Our analysis utilises sociological theories and methods and focuses on the clinical practice setting, highlighting the potential for change in understanding that the analysis opens up. We suggest expanding theoretical approaches by applying the analytical lens of 'practicings' that not only includes contexts but also explores their interrelatedness through transcending micro/macro dichotomies. By applying this lens, we aim to advance the sociological constructs of PCC.

2 | Analytic Lens

We critically explored how physiotherapy practices can be understood as PCC with an ambition to go beyond the prevailing understanding that this is merely produced by human actors. We applied a post-structural framework supplemented with insights from the science and technology studies (STS) tradition, specifically drawing on Mol (2002). Analytically, we employed the theory of subject positions (Davies and Harré 1990), as well as the concepts of 'practicings' (Hansen 2021).

Practices of PCC were understood to be produced at the intersections of human and nonhuman actors. To understand the human interactions, we applied the theoretical approach of positioning theory as proposed by Davies and Harré (1990), which focuses on the reciprocity between discourse, subject, individual and society. According to the theory, human subjects take up positions and are subjectified through the discourses produced in their contexts. The approach allows for an analysis of how positions are offered through discursive practices and thus made available, and thereby how social practices produce accessible subject positions. Positions can be taken up but are negotiated in discursive practice, which is often embedded in unequal relationships between the participants.

Acknowledging that practices are not merely produced through human relations, we applied the concept of 'practicings' (Hansen 2021; Holen 2011; Krøjer et al. 2014; Neidel 2011). This was developed through combining and reading philosophical, ethnographical and anthropological approaches from Foucault (2003, 2013), Mol (2002) and Larkin (2013) through each other. Practicings are to be understood as a constellation of what is

'said/discursively constructed, materialised, routinised and practised' (Højgaard and Søndergaard 2015), thus enabling analysis of how person-centredness is produced through closely intertwined processes that are as much about humans as they are about space, materiality, institutions, and discourses and relations. The concept allows for analytically focusing on the specific encounter and what 'takes place in practice' while simultaneously being able to grasp how this relates to the wider context and power/knowledge relations.

According to Foucault, discursive practice is a useful analytical tool to examine different practices such as criminal justice, medical or psychiatric practice, and the truth regimes established within. '*It is a question of analysing "regime of practices"—practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken-for-granted meet and interconnect*.' (Foucault 2003, 248). When studying practice, Foucault is interested in how the production of truth regimes governs ways of doing things (Foucault 2003) and essentially how subjects govern themselves and each other. Acknowledging this and, at the same time, insisting on regarding practices as produced through multiple interacting relations, we follow Bacchi and Bonham (2014) when they argue that Mol captures and further develops Foucault's concept of discursive practice with the term 'ontological politics', the understanding that there are multiple realities. Mol is concerned with how technologies and materiality can be understood as co-constitutive in daily practices and studies how 'diseases come into being' through processes that 'hang together' across different practices of the hospital (2002). She introduces the concept of enactment, which encompasses more or less verbalised 'doings' and 'practices' that help structure daily life (ibid.). With the concept of enactment and in that regard moving on from Foucault's thinking on discursive practices, Mol suggests a multiplicity of ontology where objects are 'done' and 'enacted', thus existing in multiple versions. The concept of enactment has proven helpful in our situated approach, where we acknowledge the co-constitutive effects of materiality, institutions, spatiality and temporality, and how these form relations with other actors, such as health policies, technologies and clinical guidelines.

In anthropology, Larkin (2013) has addressed such movements and connections through the concept of 'infrastructure'. Infrastructure in this context deals with both systems composed of materiality and the elements such infrastructures mobilise: '*matter that enables the movement of other matter. Their peculiar ontology lies in the facts that they are things and also the relation between things*' (ibid., 329). This concept thus involves a duality, where a technology, for example a digital documentation sheet, can be studied as a technology, but at the same time cannot be theorised as a stand-alone object. When it functions in the health system, it functions in relation to other types of digital health tools and healthcare objectives.

In summary, the concept of 'practicings' can be understood as an expression of how person-centredness is produced through closely intertwined processes that are as much about humans as they are about space, materiality, institutions and wider societal discourses.

3 | Methods

The empirical data for this secondary analysis came from three studies where PCC was a phenomenon of interest. All investigations were conducted in rehabilitation practices in primary care; one study was from Denmark, and the other two were from Aotearoa, New Zealand (NZ) (see overview in Table 1). The context, design and methods of data generation from the original studies are outlined below before discussing our process for selecting both the studies and the specific texts for secondary analysis that contributed to our focus on person-centred practicings. Ethical approval for each of the studies allowed anonymised data to be used for secondary analysis if the aims of the secondary analysis are consistent with the primary aims and purpose, and only anonymised formats were used.

Secondary analysis of qualitative data is an accepted form of data reuse, allowing for exploration of a topic across datasets and providing an opportunity to apply an alternate conceptual lens than was used in the primary analysis (Heaton 2008). It is an inherent limitation in this type of secondary analysis that the three contributing studies had different primary aims, both to each other and to this study. However, the shared interest in how PCC was practised fitted the intention of the present analysis and aligned with the original ethics applications. Importantly for this study, the texts used for analysis detailed situations within physiotherapy practice, and it was helpful for authenticity that the physiotherapists from whose clinical work the texts were generated were focused on their own practice rather than the sociological research question. The principal researchers from the primary studies were involved in this secondary analysis and thus were able to ensure data integrity and supply relevant contextual information while maintaining participant confidentiality.

The Danish study was a Ph.D. project examining how person-centredness is practised in Denmark. Practice was studied ethnographically through observations of therapeutic encounters and interviews with patients and professionals. The included data are excerpts from observation notes and were chosen because they illustrate, in exemplary ways, how person-centredness is practised in the contexts included in the study (Hansen 2021).

The implementation science project observed physiotherapy sessions in the context of a knowledge translation intervention. This contributed exemplars of common physiotherapist–client interactions within the NZ health system. In this context, physiotherapists run practices that are businesses, but many of the clients are eligible for government-subsidised treatment through a no-fault accident compensation scheme. The specific texts selected were those identified as both typical for the context and interesting illustrations of specific interactions between client and physiotherapist (Kayes et al. 2016).

The text from the men's embodiment experiences in the rehabilitation context was chosen as an example of in-depth observation of a specific context in which there is complex and concentrated work occurring between physiotherapists and their patient. This provided a contrast to the less intensive physiotherapy sessions contributed from the other NZ study and,

TABLE 1 | Overview of the original studies.

	Research context: Context, aim and method of primary study	Selected texts used in this analysis
1.	[Denmark] An ethnographic study in primary care[a] investigating person-centredness in physiotherapy. This study consisted of observations of rehabilitation events in primary care, informal conversations and formal interviews with healthcare professionals and patients.	Five extracts from observations of first and last encounters between a physiotherapist and a client. The National Ethics Committee in Denmark specifies that qualitative studies that do not collect identifiable personal information or biological material do not require approval (J. No. 18-000080). All informants received written information about the study and signed informed consent.
2.	[NZ] An implementation science project applying a multicomponent knowledge translation intervention to facilitate uptake of new ways of working in outpatient musculoskeletal physiotherapy. Practitioners were introduced to specific tools believed to enhance PCC and were supported by knowledge brokers to implement these new skills. Pre- and post-intervention data included qualitative and quantitative data collected 3 months apart.	Three audio recordings of post-intervention clinical encounters (lasting between 20 and 25 min) with $[n = 3]$ participating MSK physiotherapists and consenting (randomly selected) clients. Eligible clients had been receiving treatment from the same therapist for a musculoskeletal condition over two or more sessions. This study was reviewed by the institutional ethics committee AUTEC 15/49. All participants provided informed consent.
3.	[NZ] Exploratory study on the subject of men's embodiment using a mix of interviews and observation data to make sense of the ways that men's bodies are taken up into the rehabilitation process. Interviews were with clinicians and men who had experienced rehabilitation, and the observations were of rehabilitation clinics.	Observation of a treatment session where a man with a spinal cord injury is getting up to stand with the aid of a physiotherapist and a student in a private rehabilitation clinic environment. This study was reviewed by the institutional ethics committee AUTEC 16/242. All participants provided informed consent.

[a]Private physiotherapy practice, rehabilitation centre and community health centre.

therefore, made different aspects of the interacting forces visible (Terry and Hayfield 2025).

3.1 | Analytic Approach

Analysis involved reading transcripts and field notes from the three studies through both 'subject positions' and 'practicings' theoretical lenses introduced above to understand the construction of PCC in physiotherapy practicings. To achieve this, we worked in a collaborative, iterative process that involved re/reading the texts through our analytic lens and then coming together for discussions that would prompt further re/reading and analysis. During this iterative process, a set of analytic focus questions emerged that helped us consistently apply our analytic lenses for these particular texts and relate it back to PCC, which was our key interest. These questions were as follows: (a) What physiotherapist and client/patient subject positions became possible in particular situations, (b) how were these subject positions constituted in practicings and (c) how did those practicings relate to PCC.

We initiated the process by sharing a range of texts from the three studies. These were read individually, before coming together as a group for discussion and collective exploration. We met regularly online, recording our discussions. The recordings, together with the readings, made up the initial analysis and formed the basis for the final choices of nine relevant texts. It was also during this process that we developed the analytic questions described above. The final stage of analysis involved writing analytic essays to capture the developing insights from the discussions that were most pertinent to the analytic questions. This required iterative movements between reviewing recordings of discussions and revisiting the original data, developing and focusing the essays until they were sufficient to integrate into a final report of the findings. Our analysis moved from answering specific analytic questions to a point of coming to a new set of understandings generated from applying lenses of 'subject positions' and 'practicings' to the texts. We present the most pertinent of these new understandings in the Findings section below.

4 | Findings

The analytic findings are organised into two sections: PCC within norms of functionality and potentiality and PCC within government. Each section discusses a form of person-centred practicing made possible in the construction of certain physiotherapist subject positions, and the subsections are analytic discussions of these subject positions. Subject positions afforded certain types of practicings of PCC—each enabled some forms of PCC and excluded others. These subject positions were shaping, and also being shaped by, the various constituting forces producing PCC. Specific subject positions are indicated in the reporting using hyphenated descriptors (physio-as-...). Examples provided are intended to illustrate specific points, although they always contain elements of other aspects, because both the section categories and the various subject positions are constructs that cross each other at many points.

Physiotherapist subject positions ranged from collaborator in problem-solving functional difficulties, to participant-enabler in significant physical acts, to humanising interpreter of prescribed systems (and also part of the system). The subject positions of the physiotherapist were a mechanism by which the physiotherapist's governance role was made 'natural' and taken-for-granted. These

subject positions were produced at the intersections of the following:

- How the role of a physiotherapist is constructed within texts that govern their practice and how this relates to the broader social construct of the profession.
- What position the physiotherapists occupy within clinic organisational systems, and how this is embedded within institutional logics.
- The construction of the physiotherapist–client relationship within those systems and how these relationships are produced through discursive and co-constructive sociomaterial practices and power relations.

Language used to describe the recipients of physiotherapy varied across the different contexts that the texts were drawn from. In reported examples, we have retained the word (or English equivalent) that is the norm for each context. Generally, this is 'client' or 'patient'.

4.1 | Person-Centred Care Within Norms of Functionality and Potentiality

Services provided in physiotherapy often consist of training and exercises that support the patient in improving their physical function to achieve or strive for a particular norm. In the analysed texts, this goal was often implicit rather than verbalised—a normalisation discourse was naturalised and enacted from the subject position of physiotherapist-as-knowledgeable-professional (see next section). This could also be articulated as a potentiality discourse (reproduced in various ways in the different texts): Patients must commit themselves to becoming 'more normal' or becoming a better version of themselves. Within a discourse of potentiality, the expert physiotherapist takes up the position of facilitating the enablement of the patient to fulfil the goal of becoming more normal, and it is taken-for-granted that this becoming helps people to improve their lives. Within this context, this can, to some extent, be understood as practices of PCC. In the case of the standing exercise described below, the activities might have to do with blood circulation, which is crucial to health and longevity, although this is never explicitly explained because it is drawn from professional training which is taken-for-granted as a key factor in this situation. The logic of the PCC being practised here is not articulated—but is present in the practices in the context of knowledge that is implicitly brought through from that professional training.

4.1.1 | Physio-as-Normaliser-and-Potentiator

Physiotherapists take up a subject position as 'enhancers of normalisation' to support a patient in improving function, thus constructing practicings of PCC. Enactments of this can sometimes look bizarre when viewed from outside taken-for-granted professional discourses. In the following example from a NZ private practice, practicings of PCC are constituted through several interacting elements: discourses of normal physical function and materialities such as the harnesses, the wheelchair and the abled-bodied physiotherapists.

> Tony's injury wasn't new, he had been in a chair for 2–3 years at the time of the observation. When talking about his tasks for the day, his nervousness increased, but he spoke about being excited. Standing was a major milestone for him to reach. He repeatedly affirmed throughout the lead up to standing that this is what he wanted to do, and it was a part of his trajectory to improvement 'I am really excited about this'. [..]

> In preparation for the stand, harnesses were pulled out and attached, to the overheard beam, but primarily to the bodies of Tony and PT Pam (lead physiotherapist). Tony's nervousness visibly increased, and he was doing reassuring self-talk. The physiotherapists responded to this by affirming him and his progress to this point but proceeded to go about preparation in a continuous, business-like fashion.

> Safety was emphasised, but language of comfort and togetherness was used as well [..]. There was a flurry of talk and activity, and Tony was pulled upward into the stand [..], but then Tony, standing at 6"5 for the first time in a couple of years, immediately demanded he sit down, but the wheelchair had been moved away from the standing area. PT Pam moved straight into 100% soothing ('You're doing great …' 'this is good …' 'just breathe …'), but Tony's agitation only increased. She asked Tony if he definitely wanted to sit down, and he responded with a keening wail [..]. The communication between physiotherapists at this point was difficult as PT Pam was focused intently on engaging Tony, using soothing words, emphasising her closeness, telling him to focus on her. PT Michaela finally got the chair and positioned it near Tony, and PT Pam eased him back.

A discourse of potentiality is present, and norms of the ideal body as being an upright, standing body permeate the event. The physiotherapists position themselves within these hegemonic discourses of normalisation, not questioning if Tony needs to be performing as an 'abled-bodied person'. This was reinforced by Tony's initial enthusiasm for the standing project, and thus, both the physiotherapists and Tony were subjectifying through these discourses.

Within physiotherapy discourses, promoting physical functions such as standing can be a form of care aimed at improving, for example, blood circulation, so practicings of PCC are enacted through underlying potentialisation and normalisation discourses. Care is also enacted through sociomaterial practices: applying harnesses (as a kind of 'normalisation technology'), the physiotherapists' supporting bodies and the wheelchair. All, however, constitute Tony's body as wanting. This constellation

of complex, interacting forces intersects with hegemonic health political discourses of striving to become as self-managing and independent as possible. Indeed, physiotherapists themselves were often constructed as role models of physically capable human beings who can literally and/or metaphorically stand with their patients. In this way, the body of the physiotherapist becomes part of *both* 'PCC within norms of functionality and potentiality' and also 'PCC within government'. For the former, it is the representation of 'normal' and the enabler of the body of the client. For the latter, the body itself enacts the subject position of physiotherapist-as-knowledgeable-professional within the governing complex.

4.2 | Person-Centred Care Within Government

Currently, in Danish and NZ contexts and many other jurisdictions worldwide, physiotherapists derive their widespread legitimacy from state endorsement as health professionals (Nicholls 2018). To retain that legitimacy, their practice is situated within the reciprocal expectations of that privilege—registration to practice is regulated by law. This requires that professional bodies govern what is appropriately within the scope of practice—which in physiotherapy explicitly incorporates a person-centred approach. In addition, physiotherapists are employed by organisations that administer limited state funding for health-focused interventions. Prior scholarship has illustrated that within public health systems in neoliberal capitalist countries, professionals are both governed themselves and participate in the governance of those they are there to help (Cummins et al. 2022; Holmes and Gastaldo 2002). In this study, we show that through the lens of practicings, there were many instances where this participation in governing health resources could be interpreted not just as a form of control but as a type of *person-centred care* with its own logic. While this could also be understood from the perspective of biopolitics—governing the individual as a method of care of a population; in our study, we also saw instances where governing the individual could be understood as care of the person.

Physiotherapists in our study were subject to this type of governance of their practice and, as follows, participated in governing physiotherapist-led interventions: who the interventions were for, what they were for and how they were done. The subject positions we discuss in this section relate to how PCC is produced *within* the governmental milieu of physiotherapists and their clients. These are to be understood as overarching subject positions, which supported and/or made other physiotherapist subject positions possible.

4.2.1 | Physiotherapist-as-Knowledgeable-Professional

Physiotherapist-as-knowledgeable-professional is a subject position that shapes possible actions and practices of PCC. Indeed, the legitimacy of the physiotherapist is tied up in their ongoing construction as knowledgeable and competent, so it matters a lot that this construct is maintained. In some analysed texts, the physiotherapist's skill-knowledge was constructed as very much a standard package—predictable and utilisable by systems. We see this as forms of institutional infrastructures that mobilise clinical guidelines and health political aspirations of productive and abled-bodied citizens. There also seemed to be an association between a construction of the physiotherapist as the conveyor of a skill-knowledge 'package' and more explicit construction of clients as governable units to fit into a biopolitical system. This came through in texts from both countries. In these examples, the physiotherapist was a cog in the system, and the client was a unit to be governed—as such, both were heavily governed, but in the neoliberal way where they govern each other through a web of relations.

The following example from Denmark describes a situation from a community health centre that offers rehabilitation to maintain levels of physical function or post-surgery rehabilitation. Susan had completed the standard rehabilitation programme provided by the centre after knee replacement surgery but, at this point, had not achieved what she or PT Thomas wanted.

> Thomas tells Susan that he knows he already promised to extend her rehabilitation by a few weeks, but he will still need to test her.

> 'We're going to measure you,' PT Thomas says. He brings his open laptop and sits down. He looks at the laptop screen and Susan's record. He reads aloud, 'Your goal was to get back to your usual activities. How's that going?'. 'It's better. I can walk, but I have a bit of a limp', Susan replies. Thomas agrees and looks at the laptop. He finds a measuring tape and a goniometer[1] [...]. He repeats several measurements here and there on Susan's leg and summarises the outcomes of his examinations; 'You could bend 54° and stretch to 15° when you started. Now it is 95/10. The surgeon will be satisfied, but he'll want you to be able to bend 110°. My extension of your course of rehabilitation has been justified. It's quite fair to add six sessions more'.

The subject position as 'knowledgeable-professional' is made possible by PT Thomas' predecided result of the examination and is confirmed by his use of professional measuring technologies. These are not just innocent materialities but co-constituting the correct outcome of the intervention. Interacting with the organisational procedures represented by the digital documentation systems and the immanent power of the (absent) surgeon, PT Thomas' position is legitimised and left unchallenged as the one who defines what is going on, how it is done and why. In this situation, we see PCC come through when the unsatisfactory measurements and lack of achieving goals are constructing openings for Susan to continue the rehabilitation programme and 'to get back to [her] usual activities'. The physiotherapist is drawing authority from his biomedical knowledge, and the hegemony of biomedicine is apparent in the way the governmental complex is organised.

In contexts where the governance of health is situated more with the physiotherapy practice (rather than the physiotherapist as a cog in an explicit broader system), physiotherapist-as-knowledgeable-professional allowed for a construction of PCC as something like 'teamwork'. When this happened, the client

subject position was as a person living their life and working through what they have come to the physiotherapist about. The physiotherapist subject position was person and knowledgeable professional—the latter legitimised by their professional role and the place of their profession in healthcare governance. In this interaction, PCC was enacted in the form of coming together to make the problem better. In this context, we observed more explicit participation of discourses that construct a 'good client'. Here, the 'good client' was an active subject position—the client who values and enacts the physiotherapist's recommendations. This 'teamwork' variety of PCC also came into a particular sort of relationship with the concept of 'scope of practice'. The physiotherapist's expertise could only be utilised if their part in the 'team' stayed within the bounds of the agreed physiotherapy skill-knowledge, which is governed by law. However, these 'scope of practice' boundaries needed to be enacted within an interaction which resembled more of a meeting of two people (not simply clinician and patient).

The following example is from a NZ private practice and shows this version of physiotherapist-as-knowledgeable-professional, illustrating the 'teamwork' construct. The client and PT Brenda spent much of their session in friendly banter and sharing personal information; however, when it came to creating an action plan, the tone of the session changed:

> PT Brenda now situates the injury in the rest of life, including mundane but meaningful activities. She inquires if the client is still able to put her socks on? The client expresses reservations about previously enjoyed activities, which prompts the physio to probe for ideas for increasing activity generally.

PT Brenda: So what would you like to do?

Client: Ah ahm, I don't know—knitting? no

PT Brenda: Don't laugh. I knit

Client: No [laugh]. What do I want to replace it with? Probably swimming would be the nearest thing. What I got from mountain biking was a complete switch off from everything, and swimming, I could do the same.

> PT Brenda then tries to find ways to encourage the client to take up swimming to strengthen the leg and lose weight. The client is somewhat hesitant with many excuses. PT Brenda tries to lock in a specific event at the pool and manage any barriers to participation to overcome the client's hesitation. The client attempts to push the relationship and asks, 'What time do you want to meet me down there? [both laugh]'. PT Brenda makes light of this and continues to negotiate buy-in with specific times, number of repetitions and points about correct technique.

In this example, the physiotherapist constructed the relationship and therefore the treatment as 'teamwork', both encouraging the client to generate ideas that fit with their life and inserting professional expertise to legitimise the suggestion of swimming. The implication is that the client would take up the subject position of 'good client' by participating in this teamwork. However, the client, by their ironic response, performed resistance by challenging the physiotherapist's commitment to the activity they have agreed 'together'. Although the interaction between physiotherapist and client appears more casual and friendly than in the previous example, the helping relationship that the physiotherapist occupies is still very much subject to the bounded knowledge-authority of the physiotherapist, governed by the physiotherapist's scope of practice and also the discursive binary of clinic (where the physiotherapy–client relationship belongs) versus community (where people live their lives). The 'scope of practice' construct therefore necessitates boundaries within person-centred practicings because the physiotherapist cannot legitimately offer what is outside of their scope of practice. To pay attention to the person without *simultaneous* attention to scope of practice is actually a threat to their ability to enact PCC. As such, here 'teamwork' turned into something more like a negotiation.

It was apparent how the physiotherapist-as-knowledgeable-professional subject position and these constructs that govern it very often constrained the orientation to the patient or client. There was a very narrow 'script'—and because of the constraints, even normal interpersonal conversation often resulted in disconnect because the physiotherapist could not engage in that conversation and also stay 'on the job'. The effect was 'missing' each other, getting lost or extreme 'small talk'.

We also observed interpretation of what is offered in conversation to fit assessment criteria. Physiotherapists would steer away from asking assessment questions directly, but there was also little scope to engage in genuine interpersonal conversation when the focus was on mining what was shared for assessment-related information. This could be seen as a tension between a person-centred intention to connect with the person in front of them and competing governing forces of professional training and assessment guidelines. The possibility of speaking across each other increased under these circumstances. The extract below from the Danish context illustrates an instance where a patient was invited to talk about his experiences of limitations in everyday life. Still, the full meaning (and perhaps what mattered most to the patient) in the interaction was 'missed' because PT Anna is focused on extracting relevant information to assess eligibility for interventions they can offer.

> Hans is an older man with multiple diseases, such as post-cancer sequelae, heart failure, and severe arthritis leading to balance- and walking impairments, and he needs a walker to get around. The situation follows a conversation and testing session with PT Anna. Now, they're attending an interdisciplinary meeting where the purpose is to agree on a rehabilitation plan for Hans.

> The occupational therapist joins the meeting a little too late and is busy, and PT Anna summarises what she has talked to Hans about. 'We talked about how

> you would like to walk the stairs. But I would like to adjust that goal a little. You mustn't fall again [...] Hans, if you were to rank your wish on how much you want to be able to manage the stairs, what would it be on a scale from zero to ten?'. Hans looks at her for a long time. [Researcher notes to herself: I think he seems perplexed]. Hans answers, 'But as I told you, it's essential because the shower is in the basement, so there's no choice'. 'Oh, then it has to be 10', the occupational therapist replies. PT Anna asks, 'and if you were to rank how much you believe in it. What would it be?' Hans answers, 'There's not much to discuss because I must get to the basement to shower. So, it would have to be ten again'.

This extract illustrates the sort of situation discussed above. The patient is talking about navigating his life—essentially a continuation of the conversation they were having prior. However, the physiotherapist has 'switched', and her side of the conversation is now driven by assessment. Assessment criteria and processes have emerged as a primary actor at this turn in the conversation, enacted by the physiotherapist. Although this can all be linked to the person-centred practicing of the physiotherapist, it has produced a disconnect and a perplexing situation for the patient—which is a disruption of PCC. This shows competing forces in the relationship where there is an invitation to relate to people's lives alongside a force that must draw the interaction towards standardised assessment in order to be able to advocate for them regarding eligibility for services. This latter force is discussed in more detail in the next section.

4.2.2 | Physio-as-Authorised-to-Be-Concerned-With-Eligibility

Physiotherapists often became involved in making available the subject positions that would render their clients eligible for physiotherapist-led interventions. Limited access to services was allocated according to need, where the need was linked to potential gains, particularly those gains related to 'functional' improvement that could enable productive citizenship (rather than simply addressing functional limitations). Physiotherapists also represented the funding contracts in their interactions with clients, albeit in indirect and complex ways. A practice of 'PCC' *within* these governance roles involved a process of interpellation into 'eligible' subject positions, including shaping the contract requirements known to the physiotherapist into eligible-for-physiotherapy subject positions that somewhat represented the needs and desires of the person they were with—in turn, (re)enacting their role in the governmental system. We saw this happen in different ways in different encounters.

The below is a quote from a situation from the Danish context. Karl and his wife are having an initial consultation with the physiotherapist (PT) Julie. She introduces the terms for receiving rehabilitation, stating that Karl can join exercise classes for 3 months if he has lost function. PT Julie then enquires about their everyday life to determine what physical impairments Karl has that would legitimise a rehabilitation programme, thus making him eligible for physiotherapy intervention.

> What are you spending your time with now?" With a glance at her laptop, PT Julie asks, 'Can you easily get around at home?' 'Uh ..., easily get around at home?' Karl replies, indicating with his tone of voice that he does not understand what she means. 'Yes, I mean; can you move around the house without using anything, a cane or walker or something?' 'Yes, I find it hard to walk up and down stairs' [..]. PT Julie continues to inquire about the walking difficulties and sums it up; 'Here, we usually create an individual programme that you must do and which we (the physiotherapists) make. And then we'll help refine or change it'.

The subject positions are constituted through multiple interacting relations, including the immanent power relation of the encounter. In the case of Karl seeking help from PT Julie, the power dynamics are produced by their respective positions as patient or physiotherapist, but also the setting itself matters. Here, the power relation materialises through elements such as PT Julie's (clinical) clothing, the laptop that, requiring Julie's attention, inserts the organisational guidelines into the centre of the encounter and Julie's state authorisation that legitimises the physiotherapist subject position to be concerned with Karl's functional impairment. Through her inquiry, PT Julie is searching for possible alignments between Karl's physical challenges and the organisational requirements that must be met to be eligible for rehabilitation in this context—a relation that re-enacts and asserts institutional logics while also being a practicing of PCC. The 'individual programme' as a technology in the system of eligibility and governance interacts with the structural power of rehabilitation systems to produce a situation where Karl is obviously subject to PT Julie's assessment, but at the same time she is attempting to engage with his life situation to shape it into eligibility criteria, enacting PCC *within* government.

In another situation from a NZ private practice, PT Lara is treating a client with extensive shoulder pain who has had no progress so far. In the endeavour to construct the patient as eligible for treatment, PT Lara insists on focusing on the physical impairment, changing focus from the pain (pain being what mattered to the patient). The physiotherapist works on reassuring the client that she knows what it takes to improve the situation, whereby she positions herself as an expert. This enables the PT to reframe the client's complaints from being a problematic lack of recovery to being a situation PT Lara can assist in improving, thus producing a form of PCC within the scope of practice that PT Lara can legitimately offer.

> PT Lara proceeds to 'do expertise' by explaining the reasons for the ongoing pain, how the client's condition is typical, and that there are good protocols in place to see improvement. She engages in a detailed and technical explanation of the biomechanics but intermingles this with recommendations in colloquial terms ('heaps and heaps of rest and ice, OK?'). She also

> highlights the progression on an ultrasound that the surgeon hasn't pushed for.

This activity appears to reassure the client that PT Lara knows what she is talking about and can be taken seriously.

> PT Lara then locates improvement within a self-management rubric: 'But the main thing is that you are keeping up with the [pendulum], and the shoulder pull back because if you can keep the shoulder in a more optimal position, then that's really going to help you in the long term getting those goals ... I would not want to not wash my hair ... that's where it's really good to have that idea that the pendulum is going to feed into you being able to do all of those things. So even though it only seems like a really small goal and a small exercise: you go like how does this work into the big picture: it's going to keep the capsule clear'.

This is followed by PT Lara watching the client doing the prescribed exercise to check she is using the correct form.

The practicings seem to be about reassuring the client that self-management is the primary mechanism for improvement, rather than who (what professional group) is caring for her and what the scans and other markers, such as pain, are suggesting. By observing the exercise and pairing her own professional expertise with a discourse constructing agency of the client to self-manage, PT Lara is able to lead the client into recognising she has been 'obviously overdoing it', which has likely led to increased pain, and that it can be adjusted—allowing the client to be better cared for as a person with agency. At the same time, the pain experienced in the body, which has been a key participant in the power relations to this point, is backgrounded by bringing forward the agency of the client to enact change using the expertise of the physiotherapist—again, legitimised through professional training and state registration, re-enacting the governmental relation.

5 | Discussion

Our analysis discusses two key aspects of PCC: PCC within norms of functionality and potentiality and person-centred care within government. We show how these practicings of PCC are produced through physiotherapist subject positions made possible by various constituting forces.

PCC within government comes through as governing both the individual client and the physiotherapist, understood as a cog in a wider system. Person-centred approaches have been criticised for adopting a conceptualisation of the patient as a political subject who, instead of being a vulnerable person in need of care, becomes a consumer of healthcare services and an active person responsible for their own health (Cribb and Gewirtz 2012; Pedersen and Kjær 2017). In that conceptualisation, person-centredness is a governing technology that preserves the patient's engagement and active participation (Kjær and Reff 2010), making the healthcare professionals a part of the infrastructure that enables this. In this study, however, we show that despite biomedical logics and broader societal discourses of individual responsibilisation being clearly present, caring for the person is coming through as well. This happens, for example, when the physiotherapist works around the funding contracts or institutional guidelines to construct subject positions for their client to be eligible for a treatment they see the client needs. Or when the physiotherapist constructs a client's choice of services to align with professional knowledge, then uses this knowledge to legitimise the needs of the client. Or when the physiotherapist utilises a measuring tool to meet the demands of the surgeon and as a legitimation of extending the rehabilitation course. The care is indeed shaped by forces that construct its boundaries, but importantly, it also takes on a creative power in relationship to those forces.

Similarly, PCC within norms of functionality and potentiality might, at first pass, be perceived only as a disciplining practice enacted through sociomaterialities and hegemonic health political discourses about self-management (Hansen 2021). However, our analytic lens showed that these practicings also produce care for the person through the very same mechanisms of improving physiological functions—and although these effects are in tension, at the same time they are not separate from one another. Sociological studies that have explored the sociomaterial complexities of PCC by looking at how specific technologies affect or change practice echo some of the tensions and interactions identified in our study. Lydahl (2017) studied the complexity of introducing a standardised model of PCC into healthcare at a Swedish hospital by applying a material-semiotic approach. That study showed how a technology such as a particular model compels healthcare professionals to negotiate the tensions between a standardised procedure and the specific situation—demonstrating that they remain creative, rather than simply becoming script-followers. Jensen and Vabø (2024) explore how another standardised tool, the Canadian Occupational Performance Measure, calls for tinkering, translation and editing of the assessment protocol in the specific context, concluding that it is extremely difficult to make the principles of person-centredness from a tool entirely compatible with the concrete practice situation. Like the findings of this study, these studies also illustrate how PCC is always relational, and the relationships are not just person-person but also person-procedure-tool-training-discipline and so on. Gardner (2017) introduced the notion of 'the broad clinical gaze', which relates to the idea that the body is no longer the only site of interest during diagnostic or treatment procedures—this interest has broadened out to include social and other aspects that relate to the person. Similar to how our study discusses 'PCC within norms of functionality and potentiality', however, Gardner shows that this broadened clinical gaze is still normative and may constitute a form of disciplinary power. A focus beyond the body does not automatically mean that healthcare professionals are enabled to see beyond normative constructs: This is a limitation of PCC in the same way that it is a limitation of body-centred care. This can be seen as a counterpoint to the creative forces that enable person-centred advocacy within governance and, indeed, are equally important to attend to.

6 | Conclusion

From a sociology of health perspective, this study contributes to the literature illustrating how sociological theories and methods

can be applied to produce a more nuanced understanding of practices within healthcare beyond the usual scope of clinical research. Importantly, sociology can potentially influence healthcare practices by providing new ways of seeing what is going on and thus opportunities for important shifts.

In this study, we applied the analytical concept of practicings and asked how PCC is practised in physiotherapy to expand the understanding of the complexity healthcare professionals are faced with when working within person-centred approaches. We found that including co-constituent forces of both human and nonhuman agents in the analysis enables a more nuanced and in-depth understanding of how person-centred care is produced. Applying the concept of 'practicings', we brought into analysis the agency of materialities such as technologies, clothing and laptops and the significance of the infrastructures that mobilise policies and clinical guidelines. This highlighted how physiotherapists navigate their daily practices with the aim of doing good and caring for their clients and how they do this within the complexities of the milieu in which they must operate. Through the findings, we have shown how the theoretical lenses of practicings and subject position have the potential to advance sociological constructs of PCC as encompassing practices that may not be instantly recognisable as person-centred.

As such, to advance PCC, we propose a stronger focus on these tensions between two dominating trends in healthcare: PCC, which emphasises the individual subjective experience, and standardisation, which emphasises objectivity with the aim of improving efficiency and equity (often also with a view to changing unhelpful normative constructs). We suggest that it is important to make space for healthcare professionals to navigate these competing demands, which lead to a range of different practicings of PCC. In order to do this well, it is vital we seek to make visible how PCC actually emerges in these complex negotiations (rather than make assumptions), as this offers important information about the effects of institutional structures, health policy framings, normative discourses and key technologies on the people they exist to help.

Author Contributions

Louise Søgaard Hansen: conceptualization (lead), data curation (equal), formal analysis (equal), investigation (lead), methodology (lead), writing – original draft (lead), writing – review and editing (equal). **Joanna Fadyl:** conceptualization (equal), formal analysis (equal), methodology (equal), writing – original draft (equal), writing – review and editing (equal). **Christine Cummins:** conceptualization (equal), data curation (equal), formal analysis (equal), investigation (equal), methodology (equal), writing – original draft (supporting), writing – review and editing (equal). **Gareth Terry:** conceptualization (equal), formal analysis (equal), investigation (equal), methodology (equal), writing – review and editing (supporting). **Nicola Kayes:** formal analysis (equal), investigation (equal), writing – review and editing (supporting).

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Ethics Statement

This study presents a secondary analysis, the intent of which aligned with the ethics approvals of the original studies. The principal researchers from the primary studies were involved in this secondary analysis and thus were able to ensure data integrity and were able to supply relevant contextual information while maintaining participant confidentiality.

Consent

The authors have nothing to report. This study presents a secondary analysis of data from three original studies with individual patient consent forms.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data supporting the findings are available on request from the corresponding author but are not publicly available due to privacy or ethical restrictions.

Permission to Reproduce Material From Other Sources

No material from other sources has been reproduced.

Endnotes

[1] A professional instrument that measures the angle of the joint.

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