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RESEARCH ARTICLE

The advanced practitioners' perspective. Exploring the decision-making process between musculoskeletal advanced practitioners and their patients: An interpretive phenomenological study

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Abstract

Introduction: Advanced practice roles for allied health professionals continue to expand and provide key services within pathways of care for patients with musculoskeletal conditions. Despite the extensive utilisation of these roles and previously reported high patient satisfaction, little is understood about how these practitioners interact with their patients and the factors that influence decision-making conversations.

Study: A qualitative study utilised Interpretive Phenomenological Analysis (IPA) to explore the decision-making process occurring between Advanced Practitioners (APs) and their patients in a musculoskeletal service. AP data were collected through focus groups and analysed using IPA methodology.

Conclusions: Advanced practice decision-making is a complex process and APs exhibit a range of styles, from paternalistic to shared decision-making. APs may have a personal preference, but exhibit the ability to flex between styles in consultations. Multiple themes emerged from the data that influenced the decision-making process, including AP staff understanding the importance of patient expectations and the complex factors that influence patient interactions. It is important that clinicians have an awareness of the multiple factors that contribute to the decision-making process.

KEYWORDS
advanced practice, communication, decision-making, musculoskeletal, physiotherapy, patient expectation

1 | INTRODUCTION

Advanced Practitioners (APs) from an allied health professional (AHP) background play a vital role in delivering modern healthcare. Government policy in the United Kingdom has highlighted the importance of AP roles across a range of specialties (Department of Health, 2014; NHS, 2017). In musculoskeletal (MSK) practice, the AP role is well established, as the first Extended Scope Practitioner (ESP) roles appeared in the United Kingdom over 30 years ago (Byles & Ling, 1989). APs have now expanded into many aspects of MSK

practice: secondary care orthopaedics (Aiken et al., 2008), Emergency Departments (McClellan et al., 2012), rheumatology (Caffrey et al., 2019), paediatrics (Mír & O'Sullivan, 2018) and primary care MSK services (Moffatt et al., 2018).

Developments in the United Kingdom have seen a change in recommended title from ESP to AP, to reflect the changes in scope of practice and the advanced practice framework (Chartered Society of Physiotherapy, 2016). This paper will use the term AP throughout.

The evidence supporting the effectiveness of APs has expanded, with numerous research reports and systematic reviews supporting the role (Desmeules et al., 2012; Kersten et al., 2007; Thompson et al., 2017). Much has focused on reporting patient satisfaction (Kennedy et al., 2010; Razmjou et al., 2013) and diagnostic and management choice alignment with medical colleagues (Desmeules et al., 2013; MacKay et al., 2009).

There has been very little research reporting on the relationship between APs and their patients (Thompson et al., 2017), particularly exploring the way APs and their patients interact and make decisions. Historically patients had a more passive role in consultations and the balance of power rested with the clinician (Charles et al., 1999; Taylor, 2009). Over time, this position has changed and with the emergence of person-centred care, which encourages health professionals to work collaboratively with patients (The Health Foundation, 2014), the importance of the patient's role in decision-making has been recognised (Stenner et al., 2016). Decision-making, as a shared process between the patient and their clinician, is recommended (The Health Foundation, 2014), following assessment and discussion regarding risks and benefits of appropriate management options. Undertaking shared decisions with patients provides increased patient empowerment and autonomy and improves the patient experience, with a reduction in complaints (Jones et al., 2014).

Decision-making evidence in physiotherapy practice is limited, although what evidence exists describes a predominantly paternalistic process (Dierckx et al., 2013). Where shared decision-making is implemented by MSK physiotherapists, there is evidence of it being poorly performed (Jones et al., 2014).

A more effective understanding into physiotherapy decision-making is required, particularly in advanced practice settings, as there is a lack of evidence in this important area of clinical practice. Findings can then influence education and training of APs to enhance their ability to undertake effective patient consultations. This paper presents the results from a research study exploring the decision-making process between MSK APs and patients.

2 | METHODOLOGY

A phenomenological and hermeneutic enquiry method, Interpretive Phenomenological Analysis (IPA) (J. A. Smith, 1996), was selected to frame the study. IPA is an important method for analysing and understanding patient–clinician interaction (Biggerstaff & Thompson, 2008), as it enables the collection of rich data to elucidate the complexities of advanced practice and patient decision-making, whilst also ensuring findings can be grounded in participant experiences.

Data collection involved qualitative interview techniques (King & Horrocks, 2010), and data were collected from the APs via focus groups, to encourage participant discussion and deepen the richness of the data (Barbour, 2007). The focus groups took place at a local university and each group lasted approximately 60 min. A focus group topic guide (Figure 1) was created to provide a framework for questions related to decision-making during a patient consultation. The topic guide was developed considering the aims of the study and personal reflection of the AP role by the main researcher. Using personal reflection in formulating topic guides is a recommended process to developing more effective questions (King & Horrocks, 2010). During development, the topic guide was reviewed by the other members of the research team and an AP clinician, with feedback aiding the final content and question order. The focus group was independently facilitated and moderated, to support researcher reflexivity (Barbour, 2007), by a research physiotherapist (not associated with this study), who was trained to lead focus groups.

A purposive sampling strategy was employed to ensure participants had prior experience of the phenomena being studied and is a recommended approach for IPA research (Pietkiewicz & Smith, 2014; J. Smith et al., 2009). APs were recruited from one NHS Trust's community-based MSK service via invitation letters sent through a gatekeeper. Twelve APs accepted an invitation to take part and nine were available to attend one of two focus groups that were organised. The inclusion criteria required clinicians to be holding an AP role in a MSK service. A relatively small sample size is recommended for IPA research to allow for the collection of detailed data, in-depth analysis and interpretation (Pietkiewicz & Smith, 2014). Focus groups were audio recorded and interview transcripts were transcribed verbatim using Express Scribe software (NCH Software).

Data analysis was conducted within the IPA framework described by J. Smith et al. (2009). The stages of this process require multiple reading of the interview transcripts, initial note taking to explore content at a descriptive level, developing emerging themes through more in-depth analysis, considering connections across themes and the development of superordinate themes. As the data came from focus group discussion, an additional level of analysis was undertaken to ensure content contributing to the development of themes could be attributed to individual AP experiences. The other three members of the research team provided scrutiny throughout the data analysis phase ensuring this was appropriately conducted, by reviewing transcript analysis and discussing how emergent themes were shaped into superordinate themes. This ensured a sensitivity to context and appropriate level of rigour existed within the date analysis process (Yardley, 2015).

3 | RESULTS

The data were collated from focus group interviews with nine APs working in an MSK service covering both community and secondary

Main questions are listed with sub questions below each one in case the discussions require further prompting.

1. Ask each participant to introduce themselves and how many years of AP experience they have

2. What does being an advanced practitioner mean to you?
   - How would you see the AP role compared to your previous clinical roles?
   - Do you approach things differently in this role?

3. Can we now talk about the consultation. How does this look?
   - Where do you see the role of the patient in the consultation?
   - How do you feel about your role in a consultation?

4. How do you arrive at a management plan?
   - What do you feel about your role / the patient's role in this process?
   - What is your experience of this? – where easy / where difficult
   - How do you decide what to do?
   - What drives this process?

5. How do you feel about making decisions in your role?
   - As an example if considering to directly list a patient for a surgical procedure? Or considering referral of a patient for orthopaedic opinion who you think requires surgery.
   - How do you manage these feelings?

6. How do you perceive risk in this process (decision making) in the context of patient safety? (governance)
   - Have these feelings changed with experience?
   - How do you think this change has happened? (or not)

7. Does anyone have anything else they wish to add about the topics we have discussed?

FIGURE 1 Advanced Practitioner focus group topic guide

care clinics. Seven of the APs had a background as physiotherapists, whereas two APs had podiatry backgrounds. Five of the APs had been in an advanced clinical role for more than 6 years, whilst the other four participants had between 1 and 5 years' experience. Table 1 details the characteristics of the APs who took part in the study.

Table 2 details the superordinate themes arising from analysis of the interview data. The first two themes; decision-making and AP: patient relationship and communication, directly relate to decision-making processes during consultations. The remaining three themes relate to factors that emerged as influencing and underpinning AP decision-making.

In IPA analysis, the superordinate themes represent the strongest clusters of themes emerging from the data (J. Smith et al 2009). Each superordinate theme will be considered and illustrated with direct quotes from the focus groups.

TABLE 1 AP characteristics

			Years AP experience	
AP	**Gender**	**Profession**	**0–5 years**	**6+ years**
AP01	Male	Physiotherapy	x	
AP02	Female	Physiotherapy		x
AP03	Female	Physiotherapy		x
AP04	Female	Podiatry	x	
AP05	Male	Physiotherapy		x
AP06	Female	Physiotherapy	x	
AP07	Male	Physiotherapy		x
AP08	Female	Podiatry	x	
AP09	Male	Physiotherapy		x

Abbreviation: AP, advanced practitioner.

TABLE 2 Data superordinate themes

AP data superordinate themes
Decision-making
AP:Patient relationship and communication
Role development and reasoning
Clinical governance
Internal and external influence

Abbreviation: AP, advanced practitioner.

3.1 | Decision-making

APs describe decision-making as a complex process, which encompass both reaching a diagnosis and management plan, from often multifaceted presenting symptoms, or in the actual making of the decision itself.

> AP09 *It seems that the complexity of the case, the medical comorbidities is probably the difficult thing, but, but a big contributor to the difficult decisions.*

In addition to the complexity, the making of a decision for some APs also carries a certain amount of emotional weight and personal consideration, which links to the enhanced role that APs undertake.

> AP09 *I just think its you know…a massive…that question to me has been a massive journey to have confidence in my decisions but I think its quite an individual question as some people could be very confident you know it depends how you're made up doesn't it you know. Every decision I make is wrong till proven otherwise and that's always the way I have been and er but I can understand its very different for other people.*

There is a spectrum of decision-making that runs from a more paternalistic style to a shared process. The APs described different views and positions on how decision-making occurs in their practice. The following quotes point towards a more collaborative and shared process between the AP and their patients. The APs see their role as providing knowledge and informing patients about their options. Patients are partners in the process and supported to make decisions appropriate to their own circumstances.

> AP02 *I think their [patients] role is foremost. I think we should be helping them to make their decisions on how they should manage their problems.*

> AP07 *Coming up with a clinical reason to do something or not to do something. Most of us work through that with the patient. The patient. Put them in a position where they can make a decision.*

Other APs describe a more paternalistic style of processing and reaching decisions about their patients. This can involve more pre-emptive thoughts from a patient's referral information, which informs how the AP considers directing the patient and what the AP feels is the most appropriate care decision.

> AP01 *I find that process actually starts on paper cos if you think about it you read a referral you're already starting to make decisions …. so when they come in actually you've already got you know, actually in my mind some diagnoses in mind so that you're questioning becomes quite focused and closed so you will almost ask things for affirmation that yes that's…so you're almost forward reasoning.*

In the quote below the AP is providing choice, but potentially making an assumption over the patients ability to assimilate that information and then as the clinician, directing the patient to what they (the clinician) feel is the most appropriate course of action, but this may not be taking fully into account the patients views and wishes.

> AP04 *We give patients the choice but you are kind of giving people choice who doesn't have all the information and knowledge you have so you have a responsibility to influence if that's the right word, or direct with some degree of education towards what maybe the most appropriate.*

A level of clinical intuition was mentioned that develops with experience in this more advanced role and supports decision-making. APs can therefore reach a point where they feel they have the confidence to offer decisions and act upon them autonomously, without seeking peer support.

> AP09 *I think personally I've sort of come to the, where I have accepted you know we are sort of human in our decision-making and er we will make errors and er we try our best for patients and I'm probably a lot more comfortable with that now than I was four years ago and beyond before we started.*

Decision-making, when considered alongside patient expectations and the wider responsibilities of the AP role, is an area that may well create a degree of stress for clinicians as can be seen from the quote below

> AP02 *It was scary to start with and it has you know it's been a steep learning curve. I've learnt an awful lot in that time because I've had to and erm now I feel a lot more comfortable making those decisions.*

3.2 | AP:Patient relationship and communication

It was vital to build a relationship with patients through effective communication, as this aids the gathering of clinical information and supports the decision-making process. In clinical practice, AP and patient contacts can be quite brief and there is a need to quickly build rapport, typically in one or two consultations.

> AP09 *I'm a big believer in the sort of kindness and good compassionate care and that they should feel comfortable, they should immediately buy into that professional relationship that you are building up and er have the freedom to explore and not feel time pressured. Those sorts of things.*

The communication process is complex, but APs facilitate active patient involvement in the consultation to support the decision-making process. Although as can be seen from the quote below, APs can face dilemmas over trying to practice shared decision-making over being more leading and paternalistic.

> AP06 *You've got to try to facilitate, sort of getting the information out of them rather than encouraging them down a road you've got to let them, its letting them tell you their story rather than er rather than er fitting their story to your questions if that makes sense…and that is a difficult thing to do.*

Developing rapport and effective communication helped APs recognise and understand patient's expectations. APs see managing expectations as a key factor and felt patients often arrived at consultations with high expectations given their specialist role. Arriving at decisions that patients supported required this understanding.

> AP04 *I think sometimes the patient's expectations of our appointments are higher, they have greater, because they have usually been elsewhere, we are sometimes the first point of contact after a GP but many of our patients have been elsewhere and they come and have a level of expectation for what we can do and our role is to make sure they leave knowing options, what is possible, not possible, hopefully taking them to a point where they have made a decision and are happy with where it is going from there on in.*

The above quote also points toward the APs having the ability to flex, when appropriate between both paternalistic and shared styles of decision-making. This shows APs can potentially react within, or between consultations to the dynamic nature of the patient relationship and utilise what they feel is the most effective decision-making style in that interaction.

3.3 | Role development and reasoning

APs see themselves as specialists and have extended their practice into areas that were previously undertaken by medical colleagues. A significant part of the role is in patient diagnosis, and there is an increase in the accountability they face and the complexity of decisions that they consider.

> AP06 *Increased responsibility over patient care….responsible for a diagnostic element to patient care.*

> AP07 *It's having an advanced extended clinical role, so taking on some of the jobs that used to be done more by the medical profession.*

The APs recognise a broader remit to the role and consider the balance between practicing within a medical model and utilising a broader perspective on management options gained from their previous AHP experience.

> AP01 *There's a greater medical understanding from being an AP. So as a physiotherapist you're… the frameworks in which you work are very much physiotherapy frameworks and moving to an AP role you start to have a much deeper understanding of medical frameworks and understanding of things like blood tests and interpretation of imaging and being able to piece all of those things together.*

> AP09 *That's er the thing about AP work. We do work in a diagnostic paradigm. Its much more towards the biopsychosocial model but you know you can't ignore the medical model with these patients because we are entirely accountable er for diagnostics*

As AP staff develop into the role, they become more confident in their own abilities and rely less on referring to peers and medical specialties for decisions.

Skills such as clinical reasoning are seen to be enhanced and develop.

> AP02 I think your clinical reasoning gets a lot better you know you have to think quickly all the time.

The APs understand the increased responsibilities that are part of this role and can reflect on this and come to accept this new level of clinical practice. For some practitioners, this is a personal journey to enable them to gain confidence in their own abilities and allow them to manage the levels of decision-making required.

> AP06 *You get more confidence the more experienced you are.*

> AP09 *Cos you have to push those boundaries cos that's a responsibility we have and er it took a long time for me to make that decision [ ] we are going further down that expert continuum, you become more aware of situations and appropriateness of interventions [ ] I just think it's you know…a massive…that question to me has been a massive journey to have confidence in my decisions.*

3.4 | Clinical governance

All APs in the study had the ability to place their patients directly onto surgical waiting lists for certain orthopaedic surgical procedures, without the patient requiring a medical Consultant appointment. This was carried out within specific local clinical pathways agreed between the MSK and orthopaedic service. They all recognised the need to be competent and aware of their own scope of practice in all aspects of their roles, but particularly in relation to this 'direct listing' for surgical procedures.

> AP09 *You've got to have an awareness of risk and risk assessment in multiple contexts, er I think just talking about AP work in general then you really just need to have a good sense of self governance.*

Even though APs are seen to develop confidence in their clinical decision-making skills, they still value the availability of a support network including their peers. This provides a safety net and the chance to offload after stressful consultations. It is important to consider this alongside the findings within the role development theme above, that as APs develop more autonomy with experience, there are still situations where access to a peer support network is beneficial.

> AP07 *I think some of our confidence comes from working in a team and working with our peers. So although we sometimes make our decisions independently we are making the same decisions as other practitioners at the same level as us and we do case discussion and we get feedback from consultants we work with about patients we may have managed and that improves your confidence and your ability to make those decisions independently within a particular remit.*

3.5 | Internal and external influence

APs provided data showing other influences impacting upon their role and decision-making. External influences came from service pathways, relationships with peers and medical colleagues and the impact from external partners.

> AP09 *Your decisions are very accountable aren't they?…. You know accountable to and very closely aligned to our medical and surgical colleagues.*

> AP09 *We have er governance from CCG and commissioners about what we can do with certain conditions and patients and er and that provides some sort of framework.*

Internal influences revolved around perceived pressures, the increase in role responsibility and how this played on AP thoughts and previous levels of experience and the confidence of individuals to act in some situations.

> AP01 *First point is its (the role) quite scary. When I first started doing it erm I, I as a physio without that background it was it did weigh on me a lot for a long time erm you know.*

> AP05 *It's a learning curve as well. [ ] I suppose your experience affects the way you manage them and the decisions that you make.*

4 | DISCUSSION

This research provides new evidence and contributes understanding to the complex and fluid decision-making process that occurs between APs and patients. Prior research into how physiotherapists make decisions shows a predominance for paternalistic decision-making (Dierckx et al., 2013; Jones et al., 2014; Stenner et al., 2018), whereas this research showed MSK APs using a broader range of decision-making styles. APs in this study illustrated the dilemmas that can exist in relation to how decision-making is approached and sometimes switched their own style within or between consultations. It may be that particular practitioners have a preferred style of decision-making, although having the flexibility to move between styles, represents the APs having a more sophisticated 'tool-box' that they can call upon.

For APs in this study who did favour a paternal style, this appears to be associated with their perception of their role as a specialist, possessing the knowledge (and power) to make decisions. A similar hierarchical system of decision-making authority has been prevalent in medical professions (Holm, 2011). It maybe that these APs have always favoured a clinician led style of decision-making, but it may have also been influenced by AP training alongside medical colleagues and experiences of working in secondary care consultant led clinics.

The move towards integrated patient centered care models considers effective decision-making as a collaborative venture (The Health Foundation, 2014). A number of the APs in this study utilised this approach, even though they are often focused on seeking a diagnosis and describe working within medical models of practice.

HEE (2020a) see the holistic nature of AP practice as providing a clear benefit to patients. With an AHP background, some of the APs in this study may possess experiences and be exhibiting a more inclusive clinical outlook that supports a shared decision-making approach. This broader holistic scope of an APs' practice could help to explain previously reported high satisfaction with AP care (Kennedy et al., 2010; McClellan et al., 2006; Razmjou et al., 2013).

Communication and interpersonal skills play a vital role in the decision-making process (Hoffmann et al., 2020). APs in this study discussed examples of effective communication and facilitating patient relationships, despite busy clinical roles with pressure from limited consultation time. This is important to recognise, as previous research provides limited evidence in the area of patient interaction. It has been shown in this study to contribute to explaining decision-making preferences and may lead to more positive patient satisfaction. Therapeutic relationships between APs and their patients have to develop quickly, given contact with patients is often limited (Evans et al., 2020; Jakimowicz et al., 2017). Appointment time pressure can influence how APs feel (O'Keeffe et al., 2016) and could impact upon AP reasoning and pressure to make decisions (Langridge et al., 2015).

Consultation time constraints may influence some APs to use more paternalistic decision-making practices and may explain some of the descriptions seen of 'forward reasoning' before patients attend. In this way, APs are seen to lead communication in order to efficiently use consultation time for information-gathering and reach a diagnosis. But there is a dichotomy here between the AP leading communication due to time demands and ensuring decision-making is genuinely collaborative. With the COVID-19 pandemic leading to many AP services delivering care in a more virtual consultation format (Gilbert et al., 2021), it is important clinicians ensure they maintain active patient involvement in decisions about their care. If APs have effective communication strategies, then shared discussions regarding risks and benefits can help answer patient's questions and support subsequent decision-making (Politi et al., 2013) in both face to face and virtual consultations.

APs were able to utilise listening skills and consider the importance of patients' expectations within a consultation and as part of decision-making conversations. Patient expectations can influence their experiences of AP appointments (Coyle & Carpenter, 2011). These findings provide important evidence that factors, such as patient expectations are indeed considered by APs during patient contacts and influence decision-making. Having awareness and acting upon patient preferences and expectations plays an important role in supporting shared decisions (Hoffmann et al., 2020). Acknowledging and reflecting on patient expectations may be another factor underpinning high levels of satisfaction seen in previous AP research (Desmeules et al., 2013; Kennedy et al., 2010; McClellan et al., 2006).

Developing self-confidence was seen to help APs overcome anxieties that may surface when considering advanced decision-making and the associated potential risks. This links to the reporting of an emotional experience in the way APs develop and manage decision-making in their practice (Langridge et al., 2016). Relationships with peers and medical colleagues was seen to support how APs consider decisions and offer management choices and previous AP studies have highlighted some form of clinical mentorship as key to the development of AP practice (Stevenson et al., 2020).

Operational issues are external influences that also seem to influence AP clinical practice and MSK service pathways, where commissioning decisions can impact upon availability of care, particularly where pre-surgical criteria are required (British Orthopaedic Association, 2016). In this environment, it is more difficult for AP staff, as gatekeepers, to balance the complexities of decision-making with the needs and expectations of patients and the availability of resources.

In this study, the AP cohort showed a clear awareness of clinical governance. Governance is a key aspect of AP practice and maps to clinical practice capabilities as part of the four pillars of Advanced Clinical Practice (ACP) in the ACP framework (NHS, 2017). The APs in this study worked within a community MSK service and had extensive responsibilities, including radiological interpretation and the ability to directly list for orthopaedic surgery. Governance was robustly supported through peer networks and clinical decisional support from medical colleagues in associated specialties such as orthopaedics and radiology. This support, alongside AP staff clearly demonstrating self-awareness and reflection on their own practice, meets recommended advanced practice frameworks (NHS, 2017) when APs are dealing with complex decision-making.

Within this type of qualitative study, it is recognised that the research is focused upon an in-depth exploration of a particular group of clinicians in a specific service, therefore care should be taken in generalising the results to other settings. However, it would not be unrealistic for APs to consider the results in relation to their own practice.

5 | CONCLUSION

This study shows APs in MSK practice favour a range of styles from paternal to shared decision-making and can flex between styles within and between consultations. They understand the vital role of developing an effective clinical relationship with their patients and have awareness of the complex influences on their practice, such as patient expectations, communication and clinical governance. Integrating the findings of this study into AP education and training would enable APs to better understand the factors surrounding patient encounters and decision-making. With the publication of the framework for advanced practice (HEE, 2020a), the First Contact Practitioner Roadmap (HEE, 2020b) and the development of the Advanced Practice Academy in the United Kingdom, it is vital that existing APs and those who will enter this training pathway develop the knowledge and skills required to engage effectively with their patients in complex settings to deliver high quality patient centred care.

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CONFLICT OF INTEREST

None of the authors possesses any conflicts of interest in relation to the content of this paper.

ETHICAL APPROVAL

Ethical approval for the study was granted by the NHS Research Authority with REC reference 15/YH/0049 and IRAS project ID 164795 and through York St John University Research Ethics Committee.

AUTHOR CONTRIBUTIONS

Jonathan Thompson was lead investigator of this research study and took the primary role in writing and editing the research paper reporting on the study findings. The three co-authors listed were significantly involved in the research study itself through developing methodology and data analysis. All three co-authors provided content within the article through writing and re drafting sections and the editing process.

DATA AVIALABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

Aiken, A., Harrison, M., Atkinson, M., & Hope, J. (2008). Easing the burden for joint replacement wait times: The role of the expanded practice physiotherapist. *Healthc Q*, *11*(2), 62–66. Retrieved from http://www.longwoods.com/product/19618

Barbour, R. S. (2007). *Doing focus groups*. SAGE.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, *5*(3), 214–224.

British Orthopaedic Association. (2016). *Rationing of elective orthopaedic procedures by clinical commissioning groups*. Retrieved from London, British Orthopaedic Association.

Byles, S., & Ling, R. (1989). Orthopaedic out-patients—A fresh Approach. *Physiotherapy*, *75*(7), 435–437. Retrieved from http://ezproxy.yorksj.ac.uk/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=1989097261&site=eds-live

Caffrey, A., Smart, K. M., & FitzGerald, O. (2019). Physiotherapist-led triage at a rheumatology-based musculoskeletal assessment clinic: An 18-month service evaluation of activity and outcomes. *ACR Open Rheuma*, *1*(4), 213–218.

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Social Science & Medicine*, *49*(5), 651–661.

Chartered Society of Physiotherapy. (2016). *Advanced practice in physiotherapy*. Chartered Society of Physiotherapy:

Coyle, A., & Carpenter, C. (2011). Patient experiences of their clinical management by extended scope physiotherapists following attendance at an orthopaedic clinical assessment service. *The International Journal of Person Centred Medicine*, *1*(3), 1–8. Retrieved from http://www.ijpcm.org/index.php/IJPCM/article/view/114

Department of Health. (2014). *NHS five year forward view*. Department of Health

Desmeules, F., Roy, J.-S., MacDermid, J. C., Champagne, F., Hinse, O., & Woodhouse, L. J. (2012). Advanced practice physiotherapy in patients with musculoskeletal disorders: A systematic review. *BMC Musculoskeletal Disorders*, *13*(1), 1–21. https://doi.org/10.1186/1471-2474-13-107

Desmeules, F., Toliopoulos, P., Roy, J.-S., Woodhouse, L. J., Lacelle, M., Leroux, M., Girard, S., Feldman D. E., & Fernandes J. C. (2013). Validation of an advanced practice physiotherapy model of care in an orthopaedic outpatient clinic. *BMC Musculoskeletal Disorders*, *14*, 162–171. https://doi.org/10.1186/1471-2474-14-162

Dierckx, K., Deveugele, M., Roosen, P., & Devisch, I. (2013). Implementation of shared decision making in physical therapy: Observed level of involvement and patient preference. *Physical Therapy*, *93*(10), 1321–1330.

Evans, C., Pearce, R., Greaves, S., & Blake, H. (2020). Advanced clinical practitioners in primary care in the UK: A qualitative study of workforce transformation. *International Journal of Environmental Research and Public Health*, *17*(12), 4500.

Gilbert, A. W., Booth, G., Betts, T., & Goldberg, A. (2021). A mixed-methods survey to explore issues with virtual consultations for musculoskeletal care during the COVID-19 pandemic. *BMC Musculoskeletal Disorders*, *22*(1), 245. https://doi.org/10.1186/s12891-021-04113-y

HEE. (2020a). *Advanced practice*. Retrieved from https://www.hee.nhs.uk/our-work/advanced-clinical-practice

HEE. (2020b). *First contact practitioners and advanced practitioners in primary care (musculoskeletal): A Roadmap to practice*. Health Education England

Hoffmann, T. C., Lewis, J., & Maher, C. G. (2020). Shared decision making should be an integral part of physiotherapy practice. *Physiotherapy*, *107*, 43–49.

Holm, S. (2011). Final responsibility for treatment choice: The proper role of medical doctors? *Health Expectations*, *14*(2), 201–209. https://doi.org/10.1111/j.1369-7625.2011.00673.x

Jakimowicz, M., Williams, D., & Stankiewicz, G. (2017). A systematic review of experiences of advanced practice nursing in general practice. *BMC Nursing*, *16*(1), 6. https://doi.org/10.1186/s12912-016-0198-7

Jones, L., Roberts, L., Little, P., Mullee, M., Cleland, J., & Cooper, C. (2014). Shared decision-making in back pain consultations: An illusion or reality? *European Spine Journal*, *23*(1), 13–19.

Kennedy, D. M., Robarts, S., & Woodhouse, L. (2010). Patients are satisfied with advanced practice physiotherapists in a role traditionally performed by orthopaedic surgeons. *Physiotherapie Canada*, *62*(4), 298–305.

Kersten, P., McPherson, K., Lattimer, V., George, S., Breton, A., & Ellis, B. (2007). Physiotherapy extended scope of practice - who is doing what and why? *Physiotherapy*, *93*(4), 235–242. Retrieved from http://ezproxy.yorksj.ac.uk/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2009745448&site=eds-live

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. SAGE.

Langridge, N., Roberts, L., & Pope, C. (2015). The clinical reasoning processes of extended scope physiotherapists assessing patients with low back pain. *Manual Therapy*, *20*(6), 745–750.

Langridge, N., Roberts, L., & Pope, C. (2016). The role of clinician emotion in clinical reasoning: Balancing the analytical process. *Manual Therapy*, *21*, 277–281.

Mír, M. Ó., & O'Sullivan, C. (2018). Advanced practice physiotherapy in paediatric orthopaedics: Innovation and collaboration to improve service delivery. *Irish Journal of Medical Science*, *187*(1), 131–140.

MacKay, C., Davis, A. M., Mahomed, N., & Badley, E. M. (2009). Expanding roles in orthopaedic care: A comparison of physiotherapist and orthopaedic surgeon recommendations for triage. *Journal of Evaluation in Clinical Practice*, *15*(1), 178–183. https://doi.org/10.1111/j.1365-2753.2008.00979.x

McClellan, C. M., Cramp, F., Powell, J., & Benger, J. R. (2012). A randomised trial comparing the clinical effectiveness of different emergency department healthcare professionals in soft tissue injury management. *BMJ Open*, *2*(6), e001092. https://doi.org/10.1136/bmjopen-2012-001092

McClellan, C. M., Greenwood, R., & Benger, J. R. (2006). Effect of an extended scope physiotherapy service on patient satisfaction and the outcome of soft tissue injuries in an adult emergency department. *Emergency Medicine Journal*, *23*(5), 384–387. Retrieved from http://ezproxy.yorksj.ac.uk/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edsbl&AN=RN187650493&site=eds-live&scope=site

Moffatt, F., Goodwin, R., & Hendrick, P. (2018). Physiotherapy-as-first-point-of-contact-service for patients with musculoskeletal complaints: Understanding the challenges of implementation. *Primary Health Care Research & Development*, *19*(2), 121–130.

NHS. (2017). *Multiprofessional framework for advanced clinical practice in England*. NHS

O'Keeffe, M., Cullinane, P., Hurley, J., Leahy, I., Bunzli, S., O'Sullivan, P. B., & O'Sullivan, K. (2016). What influences patient-therapist interactions in musculoskeletal physical therapy? Qualitative systematic review and meta-synthesis. *Physical Therapy*, *96*(5), 609–622.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7–14.

Politi, M. C., Dizon, D. S., Frosch, D. L., Kuzemchak, M. D., & Stiggelbout, A. M. (2013). Importance of clarifying patients' desired role in shared decision making to match their level of engagement with their preferences. *BMJ*, *347*, f7066. https://doi.org/10.1136/bmj.f7066

Razmjou, H., Robarts, S., Kennedy, D., McKnight, C., MacLeod, A. M., & Holtby, R. (2013). Evaluation of an advanced-practice physical therapist in a specialty shoulder clinic: Diagnostic agreement and effect on wait times. *Physiotherapie Canada*, *65*(1), 46–55. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2011929497&site=ehost-live&scope=site

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, *11*(2), 261–271. https://doi.org/10.1080/08870449608400256

Stenner, R., Palmer, S., & Hammond, R. (2018). What matters most to people in musculoskeletal physiotherapy consultations? A qualitative study. *Musculoskeletal Science and Practice*, *35*, 84–89.

Stenner, R., Swinkels, A., Mitchell, T., & Palmer, S. (2016). Exercise prescription for non-specific chronic low back pain (NSCLBP): A qualitative study of patients' experiences of involvement in decision making. *Physiotherapy*, *102*(4), 339–344. https://doi.org/10.1016/j.physio.2015.08.005

Stevenson, K., Bicker, G., Cliffe, S., Kemp, J., Menon, A., Hall, E., & Ryan, S. (2020). Development, implementation and evaluation of a bespoke, advanced practice musculoskeletal training programme within a clinical assessment and treatment service. *Musculoskeletal Care*, *18*(2), 204–210.

Taylor, K. (2009). Paternalism, participation and partnership-The evolution of patient centeredness in the consultation. *Patient Education and Counseling*, *74*(2), 150–155.

The Health Foundation. (2014). *Person centred care made simple. What everyone should know about person centred care*. The Health Foundation.

Thompson, J., Yoward, S., & Dawson, P. (2017). The role of physiotherapy extended scope practitioners in musculoskeletal care with focus on decision making and clinical outcomes: A systematic review of quantitative and qualitative research. *Musculoskeletal Care*, *15*(2), 91–103.

Yardley, L. (2015). Demonstrating validity in qualitative psychology. In J. Smith (Ed.), *Qualitative psychology. A practical guide to research methods* (3rd ed., pp. 257–272). SAGE.

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