Discharge from Outpatient Orthopaedic Physiotherapy: A Qualitative Descriptive Study of Physiotherapists' Practices

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ABSTRACT

Purpose: To describe the clinical and contextual factors that influence physiotherapists' discharge decision-making processes in outpatient orthopaedic settings.

Methods: The study used a descriptive qualitative design that included three key-informant interviews and two focus groups ($n = 7$) of orthopaedic physiotherapists (total $n = 10$) working in the Greater Toronto Area. Interviews and focus groups followed a semi-structured interview guide that included questions pertaining to participants' discharge decision-making processes, salient contextual factors, and challenges. Data were coded and analyzed for emerging categories and themes using constant comparison techniques and group analyses.

Results: Participants indicated that a combination of *factors* and *strategies* were brought to bear on discharge decision making but that the process changed with clinical experience. Over time, further emphasis was attributed to the patient's role in his or her rehabilitation, and self-management goals were increasingly promoted. Experience affected how therapists conceptualized their roles in discharge decisions and how they negotiated goals with patients.

Conclusions: Discharge decision making is a complex process that requires integrating numerous factors and negotiating with patients. Physiotherapists' decision-making practices evolve with experience and reveal the complexity of implementing models of "client-centred care" in practice. Further research is needed to explore these findings in other settings.

Key Words: discharge planning, outpatient orthopaedics, physiotherapy, qualitative methods

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RÉSUMÉ

Objectif : Décrire les facteurs cliniques et contextuels qui influencent le processus de décision d'un physiothérapeute quand vient le temps de donner congé à un patient en consultation externe en milieu orthopédique.

Méthode : L'étude a eu recours à une structure descriptive qualitative qui a nécessité trois entrevues informatives principales et deux groupes de discussion ($n = 7$) formés de physiothérapeutes en orthopédie (n total = 10) qui travaillent dans la région du Grand Toronto. Un guide d'entrevues semi-structurées comprenant des questions portant sur le processus de décision de donner congé à un patient, sur les facteurs contextuels prédominants et sur les défis propres à de telles décisions fut suivi pour les entrevues et les groupes de discussion. Les données furent codées puis analysées pour que puissent être dégagés les catégories et les thèmes émergents à l'aide de techniques de comparaison constantes et d'analyses groupées.

Résultats : Les participants furent d'avis qu'une combinaison de *facteurs* et de *stratégies* était prise en compte dans la décision de donner congé, mais que le processus évoluait suivant l'expérience clinique. Avec le temps, l'accent était davantage mis sur le rôle du patient dans sa réadaptation, et les objectifs d'autogestion étaient de plus en plus favorisés. Le nombre d'années d'expérience influait sur la façon dont les thérapeutes percevaient leur rôle dans les décisions de donner congé et dans leur manière de négocier les objectifs à atteindre avec les patients.

Conclusions : Les décisions de donner congé sont régies par un processus complexe qui nécessite la prise en compte de nombreux facteurs et une forme de négociation avec le patient. Les pratiques de prise de décision des physiothérapeutes évoluent selon leurs années d'expérience et en disent long sur la complexité liée à la mise en œuvre de modèles de « soins centrés sur le client » dans la pratique courante. Des recherches plus poussées seront nécessaires pour explorer ces constatations dans d'autres cadres de pratique.

Mots clés : méthodes qualitatives, orthopédie en clinique externe, physiothérapie, planification des congés

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INTRODUCTION

Discharge planning is an important part of a physiotherapist's role in providing comprehensive care. Physiotherapists are charged with determining whether and when patient discharge can occur in a safe and timely manner while optimizing physical mobility and independence.¹ Early or poorly planned discharge can result in consequences ranging from patients' not reaching their full rehabilitation potential to serious falls that cause secondary impairments.² In outpatient orthopaedic care, detailed, individualized treatment and discharge planning are essential for good outcomes, and these require knowledge of a wide range of conditions and their expected trajectories of recovery. In this area of physiotherapy practice, however, the decision-making process used by therapists to determine when discharge is appropriate has yet to be explored.

Very few studies have examined the factors health care professionals consider in deciding when to discontinue patient care. While some studies have centred on clinical decision making or discharge planning,^{3,4} the literature tends to focus on resource streamlining or solely on clinical factors. Only a few studies acknowledge and address the complexity of clinical and non-clinical factors that mediate the decision-making practices of individual practitioners.⁵⁻⁷ Studies within the field of physiotherapy have identified clinical outcomes such as balance, muscle strength, pain score, quality of gait and gait aids, previous level of functioning, and range of motion as factoring into discharge decisions.^{2,8} Jette⁹ has described a number of non-clinical factors, including patients' wants and expectations; their motivation to participate in rehabilitation and their support networks; funding constraints; and institutional expectations. In a combined qualitative and quantitative study, Brooks et al.¹⁰ developed a discharge scoring tool to help physiotherapists determine when it is appropriate to discharge patients from perioperative cardiorespiratory treatment. Despite these studies, research examining discontinuation of orthopaedic physiotherapy treatment is sparse and has generally focused on specific inpatient populations such as patients undergoing total hip arthroplasty.^{2,8,11} The factors outlined in these studies are almost exclusively clinical and are specific to the patient population. To the best of our knowledge, there have been no studies specific to the outpatient orthopaedic setting or that consider the range of clinical and non-clinical factors that inform physiotherapists' discharge decision-making processes. Thus, little is known about the factors considered, how they are weighed, or the reasoning used by physiotherapists in deliberating over orthopaedic outpatient discharge decisions.

The purposes of this study were (1) to describe the relevant factors that physiotherapists take into account in discontinuing treatment of adults in the outpatient

orthopaedic setting and (2) to explore how these factors mediate the decision-making process.

METHODS

Design

This exploratory study used a descriptive qualitative approach to investigate what physiotherapists consider when discontinuing treatment of patients in an outpatient orthopaedic setting. Because this is a *descriptive* study, the goal was not to generate theory, as in other qualitative approaches (e.g., grounded theory), but, rather, to identify and describe the range of factors that therapists consider in discharge deliberations.¹² According to Sandelowski,¹² qualitative descriptive studies focus on generating a comprehensive summary of practices and events as they occur in people's everyday contexts; this is the method of choice when straightforward description is the study goal.

Data were collected via three key informant interviews and two focus groups with physiotherapists working in outpatient orthopaedic settings. Key informants were interviewed *first* in order to gather expert information that was subsequently used to further develop the focus group guide. Ethics approval was obtained from the University of Toronto.

Participants

To be included in this study, participants had to be registered with the College of Physiotherapists of Ontario and be currently practising in an outpatient orthopaedic setting. For logistical reasons, participant recruitment was limited to the Greater Toronto Area (GTA). Key informants were required to have a minimum of 5 years' relevant experience and were targeted because of their reputations as "experts" in the field. Focus-group participants needed a minimum of 1 year's experience. Potential participants were identified through faculty in the Department of Physical Therapy at the University of Toronto, who were asked to identify therapists whom they considered knowledgeable about the topic area and who would be able to communicate in a reflective manner.¹³ Potential participants were then contacted by e-mail, provided with study information, and invited to participate.

Data Collection

Data collection took place in two phases. In phase 1, three individual, semi-structured key informant interviews were conducted by one of the investigators according to an interview guide. Participants were asked to describe the processes and considerations they used when discontinuing treatment of adults in an outpatient orthopaedic setting. Each interview began with a broad

question: “What do you take into consideration when preparing to discontinue treatment?” Other questions explored the factors, processes, and challenges associated with discontinuing treatment. The interview guide was developed to address the study objectives and was informed by relevant literature and by input from University of Toronto physiotherapy faculty with clinical and methodological expertise. As appropriate to the methods of qualitative inquiry, the interview questions were open-ended and flexible, allowing for newly raised topics to be explored within and between interviews.¹⁴

In phase 2, two focus groups of three and four participants each were conducted by a facilitator and a co-facilitator; the latter was responsible for recording observations of group interactions and speaker order.¹⁵ Focus groups were used because they emphasize social interaction among participants and because findings can be analyzed to understand how participants co-construct their views by sharing and contesting knowledge.¹⁶ Facilitators followed a flexible interview guide developed from the key informant interviews and included probes to encourage interaction and facilitate a discussion of similarities and differences among participants.¹⁷ Sessions began with the same broad question used in the interviews, and participants were then asked to discuss their discharge decision practices and provide details on relevant contextual factors and challenges.

Data Management and Analysis

All interviews were audiotaped, transcribed verbatim, and uploaded into the NVivo qualitative software package (version 2.0, QSR International Pty Ltd, Doncaster, Victoria, Australia) to facilitate data management and analysis. Thematic analysis, as outlined by Braun and Clarke,¹⁸ was used to perform the analysis. First, each member of the six-member study team read all transcripts to form initial impressions. In this stage of *open coding*, individual phrases or paragraphs were examined and labelled with potential descriptive codes, while memos were generated that explored emerging meanings, dimensions, and properties of phenomena.^{19,20} Team members then met to discuss emerging concepts and finalize a coding scheme. Each transcript was coded by two researchers, and comparisons were made before finalizing the codes. Constant comparison was then performed to identify similarities and differences within and between emerging categories and themes.^{21,22} Three case-analysis meetings were held to discuss main themes and impressions, develop explanations, and explore alternative interpretations.²¹

Analytical and Procedural Rigour

Several procedures were used to ensure a trustworthy account of the findings. Credibility was enhanced through the use of *expert* team members and judicious *training*

of junior team members in qualitative methods and analysis. Analytical rigour was achieved through the use of *multiple coders* and ongoing discussion of emerging results at multiple team meetings.²³ These discussions were grounded deeply in the data and were focused on creating the best possible representation of the accounts. *Reflexivity* was achieved through team reflection on possible biases and alternative interpretations that arose during coding and analysis.²⁴ During team meetings, the possible meanings of outliers were examined, negative evidence sought out, and rival explanations debated and explored.²⁴ An *audit trail* that included minutes of team meetings and documentation of analysis decisions enhanced transparency and ensured logical consistency in the interpretations.²⁵ Observational and interpretive field notes were recorded throughout the research process by the research team.

RESULTS

Sample

Ten physiotherapists, eight women and two men, participated in either a key informant interview ($n = 3$) or a focus group ($n = 7$). Further information on participant demographics can be found in Table 1. The three key informant interviews ranged from approximately 45 to 60 minutes, and the two focus groups were 70 and 80 minutes long respectively, for a total data set of approximately 5 hours.

Findings

Six primary themes emerged from the data; these fall into the two broad categories of *factors* and *strategies*, as well as one cross-cutting theme. *Factors* were elements that consistently informed the decision-making processes used by physiotherapists. Two main factors were identified: *physiotherapist experience* and *funding source*. Three *strategies* for approaching discharge decisions were identified: *facilitating self-management*, *negotiating patient goals and managing expectations*, and *using objective findings*. *Patient education* was identified as a cross-cutting theme that was both a factor and a strategy. No apparent differences emerged in the current study that could be attributed to participant-specific profile. Age, gender, practice profile, and typical patient profile appeared to have no effect on the findings.

Each of the six primary themes is discussed below. All participant names are pseudonyms, and each is identified as either a key informant (KI) or a participant in focus group 1 or 2 (FG1 or FG2).

Factors Affecting Discharge Deliberations

Physiotherapist Experience

A highly prevalent theme that emerged across the accounts was the influence of a physiotherapist's experi-

Table 1 Demographics for Physiotherapists Participating in Either Focus Groups or Key Informant Interviews ($n = 10$)

		<i>All Participants</i>	<i>Focus-Group Participants</i>	<i>Key Informants</i>
Age (years)	Mean	44.4	48.6	49.7
	Range	30–62	30–62	48–51
Gender	Male	2	2	0
	Female	8	5	3
Experience (years)				
Total years practising	Mean	18.65	15.62	27.33
	Range	1.5–41	1.5–41	25–29
Total years practicing in outpatient orthopaedics	Mean	15.65	14.07	24.33
	Range	1.5–35	1.5–35	22–29
Clientele (number of therapists primarily treating each client group*)				
Funding	Private	6	4	2
	Public	5	3	2
	Workplace Safety and Insurance Board (WSIB) / motor vehicle accident insurers (MVA)	3	2	1
Diagnostic group	Sports injury	7	5	2
	General orthopaedics	9	6	3
	Postoperative	3	2	1
	Specialty population**	2	1	1

* Numbers exceed number of participants because of multiple patient populations in workplace setting.

** Specialty populations not specified for reasons of confidentiality.

ence on treatment decisions and discharge planning. The term “experience” is used to refer to repeated exposure to similar circumstances over time and how the participants related this ongoing exposure to interrelated changes in their knowledge, prediction, confidence, clinical judgment, and clinical practice proficiency:

For the cases that it's less obvious ... how long do you actually keep the person on treatment? How long can you expect [physiotherapy] to be making a noticeable change? ... For those long-standing things that are [going to] take time, when is it OK to discharge the person, and leave them with their exercises, and feel confident that you've done your due diligence, and that you've done everything for them? I think that's kind of an experience thing. (Alice, KI)

Participants suggested that knowledge and clinical practice proficiency are gained through the practice of physiotherapy. Concurrently, they stated that a therapist's ability to recognize and effectively treat a myriad of clinical conditions and to predict an appropriate timeframe for the expected recovery improves. As a result, confidence in one's discharge decision-making skills may increase:

I think just having more experience, that probably in the first number of years that I was working ... with fracture patients, not necessarily knowing if people had gotten as far as one can expect with that type of injury, that maybe I kept people on a little bit longer. Whereas now I, you know, can anticipate what I'm hoping they'll be able to

achieve and recognizing a little bit sooner, so I think with experience, that'll help you recognize and be a little bit more confident that the time is right. (Alice, KI)

Participants noted that discharge discussions with patients had been much more difficult when they were new graduates and became less challenging as they gained knowledge, an understanding of clinical presentations, and experience in clinical practice over time. In particular, the ability to determine the course of therapy and predict a timeframe for discharge proved highly challenging when, as novice physiotherapists, they felt they had not yet developed sophisticated understandings of the expected treatment trajectories and/or outcomes for many orthopaedic conditions:

When I first graduated I was not confident at all, I think because I didn't know, I didn't have a good sense of [the client's] prognosis ... I think just seeing many, many people over the years you kind of get an idea and just reasoning through tissue healing ... also paired with the fact that I think I am more confident saying to the patient, “You are not going to get better” or “You are going to get better at a certain time.” (Hank, FG2)

Confidence in their ability to treat a patient effectively aids physiotherapists in better managing the course of treatment and discharge. Hank, in the comment reproduced above, suggests that a practitioner's confidence in his or her clinical skills increases as he or she gains experience.

Interestingly, therapists suggested that as they gained practical experience, their clinical judgment improved and they were better able to balance a manual therapy approach with one focused on helping patients achieve independent self-management and patient education:

As a new grad, my expectation was that I was going to go out and use these hands-on skills with every patient ... I think where I've changed is to be able to realize what population needs those skills because—I'm not saying that those skills are bad, they're very very useful, but what populations need those skills? And what patients are going to get better without them? (Catherine, FG1)

Catherine's and others' comments suggest that, with experience, therapists develop a better understanding of their patients' needs and how best they can assist them. Participants contrasted this to their earlier focus on their own skills and a lesser emphasis on how patients participate in therapy.

All participants were asked what they believed would help new graduates with discharge planning and decision making. Therapists struggled with this question and suggested that proficiency primarily comes with experience. However, two important suggestions were offered. The first was providing new graduates with a period of formal mentorship with an experienced physiotherapist. Participants believed that there would be great value in having the opportunity to share experiences and thus develop confidence in working through the discharge process with patients. The second suggestion stressed the importance of ongoing consultation with colleagues outside of formal mentorship arrangements. Participants did not, however, suggest a time-frame within which formal mentorship should occur, and they were aware that because of time constraints, these options may not always be feasible.

Funding Source

Patients' source of funding for treatment was identified by participants as a key influence not only on therapists' treatment and discharge planning but on clients' engagement in therapy. Four participants noted that funding source and how it may influence treatment is one of the first considerations that physiotherapists must take into account with new patients. For example, participants stated that patients relying on limited extended health benefits and those who pay out of pocket can sometimes afford only a limited number of treatments. Similarly, funders such as the Workplace Safety and Insurance Board (WSIB) and motor vehicle accident insurers (MVA) may impose limitations on the type and amount of treatment funded. For some participants, the influence of funding arrangements on the discharge process was associated with a sense of diminished professional autonomy:

... it's when someone else is making the decisions that's so frustrating. It's like my treatment plan is now being dictated by funding and someone else is deciding that the person has met certain goals that I disagree with. (Jessica, FG2)

Type and amount of funding may have a negative influence on patients' engagement in therapy. In cases of third-party payers such as MVA, participants reported that patients do not necessarily expect that they need to participate actively in their therapy:

When people are being funded elsewhere they have expectations that their needs are going to be met, sometimes they don't have a lot of expectations for themselves that they hold ... Some [patients with MVA coverage], not all, but some are really into passive treatment, they just go, you know, "fix me." (Ivan, FG2)

Ivan's comment implies that some of these patients want to be "fixed" and are not necessarily willing to do what is required for them to recover. Ultimately, this phenomenon has posed a challenge for participants both in how they approach treatment and in how they initiate the discharge process.

In participants' accounts, there seemed to be a notion that out-of-pocket or limited extended health benefit payments can complicate the discharge process by forcing therapists to terminate treatment too early or by forcing patients to self-discharge due to lack of funds. Debra noted this in relation to patients who have private insurance coverage:

[I've learned] to ask "what's your coverage like?" ... otherwise they spring it on you, "Oh, I only have \$200, I can only come for three visits" ... [and] I'd been planning for eight ... because I often would just have patients stop coming. (Debra, FG1)

Seven of the 10 participants agreed that the best way to deal with this issue is to initiate early and open dialogue with patients regarding their funding situation. They suggested that if they discover early on that there is a limitation of funds, they will then have ample time to adjust their treatment plan accordingly.

Participants further noted that some patients are unwilling to pay even when they clearly have the means to self-fund beyond what their insurance covers. In response to these discussions, Ivan noted, "I think people have a certain sense of entitlement to, about health care in Canada ... they don't want to pay [for health care]." He went on to suggest that free health care is expected and that people are simply not "willing to invest in their health as they would for their car."

An interesting point that arose related to how limits in available funding sometimes facilitate the discharge process:

I think that whether the patient is paying or there is a third-party payer, I think it kind of forces you to be ... analyzing and thinking about how long should this person be on treatment. (Brenda, KI)

Brenda's statement seems to suggest that funding limitations, although often a hindrance to care, can at times aid physiotherapists in improving efficiency by ensuring that patients are moved through treatment to discharge in a timely manner.

Strategies for Approaching Discharge Decisions

In addition to the factors outlined above, participants described three primary *strategies* that they use to engage patients in the decision-making process and prepare them for discharge: self-management, goal negotiation, and use of objective findings. These strategies provide insight into what constitutes a "successful" versus an "unsuccessful" discharge for participants. As discussed below, a "good" or "successful" discharge is most often associated with the patient's having both achieved his or her goals and having the knowledge and skills to self-manage his or her condition.

Facilitating Self-Management

Patient self-management was identified as important to the discharge process and was discussed by all participants along two dimensions: first, as a goal of or endpoint to therapy that should be achieved; and, second, as a strategy used to facilitate discharge. These two dimensions of self-management, as both goal and strategy, were closely intertwined in participants' accounts. The term "self-management" was used by participants to refer to patients' ability to successfully monitor their condition and address their symptoms following discharge from a physiotherapist's care. As Erica (KI) noted, "they have the skills, the education, and the tools to be able to carry on by themselves and to know when they need help." Patients' active participation in treatment, both during and outside of physiotherapy sessions, throughout their recovery was discussed as a strategy to facilitate an earlier discharge but also as a means of increasing patients' ability to self-manage their conditions. Catherine (FG1) reinforced this point by noting the importance of "introducing the patient to the concept of self-management and that they are an integral part of their treatment." Although therapists noted that they value other treatment goals, promoting independent self-management clearly emerged as a consistent discharge objective, regardless of patient diagnosis and of whether or not patients sought treatment with this goal in mind (this is discussed in more detail below under "Negotiating Patient Goals and Managing Expectations").

In participants' accounts, *patient education* was closely tied to self-management and to achieving what therapists perceive as a successful discharge:

I think earlier on in my practice, I put a lot of onus only on me. I need to get them discharged because of what I do and patient education is sort of an adjunct, but I think it's the primary thing. So that is what I base my decision [to discharge] on: so if they understand, so if I can sort of, minimize their, or optimize or maximize their understanding of what's going on, I find that the discharge comes easier. (Hank, FG2)

This comment suggests that Hank's appreciation of the value of patient education as an integral part of treatment increased with time and experience and illustrates how the emphasis he places on this aspect of care has changed over time. Ensuring that patients are knowledgeable about their conditions and able to self-manage has helped him to facilitate discharge planning.

Participants' notions of self-management endpoints varied significantly depending on patient population. For example, Alice (KI) discussed self-management of acute conditions in terms of engagement in lifelong healthy behaviours, such as maintaining an adequate level of generalized flexibility and strength, and contrasted this with the self-management of chronic conditions, where the likelihood of reaching a symptom-free state is uncertain. She stressed that chronic patients need to have both the capacity to cope when symptoms are present and the ability to recognize that a completely symptom-free life may not be feasible. Challenges likely to impede success were reported to be particularly aligned with the nature of a patient's condition. All participants agreed that chronic conditions present a greater challenge to discharge than those that are acute in nature:

I think it really depends on your patient population. If you are dealing with acute cases it's so much more straightforward. As you go past the 6-month mark, 1-year mark ... it becomes increasingly more difficult. (Ivan, FG2)

Ivan and others' comments suggest that level of chronicity markedly influences the amount of time and effort needed to educate patients and help them get to the point of self-management and discharge.

Additionally, two participants linked patients' personalities and individual expectations of physiotherapy with the ability to self-manage successfully. This was especially the case for patients with complex or chronic conditions. It was suggested that these patients are more likely to develop a "dependency" on treatment that makes them reluctant to discontinue physiotherapy care:

Patients with chronic conditions are like peeling layers, and you don't know what you're going to get or where it's going to take you. Sometimes it can take a month or two to really understand everything that's underlying their condition. They are also more likely to become dependent on you as well. (Alice, KI)

Negotiating Patient Goals and Managing Expectations

Helping patients to set achievable goals emerged as a key strategy for managing treatment and discharge expectations. Participants suggested that goal setting can be influenced by patient-specific factors such as personality, values, or individual circumstances. Gina (FG1) gave the example of competitive athletes who typically aim for a quick return to sport and ultimately desire full resolution of their injuries, in contrast to less active or elderly individuals, who may strive to diminish symptoms and return to previous functional activities such as pain-free mobility. Alice (KI), who works primarily with what she considers “elite” patients—that is, privately paying clients from a high-income demographic—compared her private patients to hospital patients, stating that “they’re demanding clients ... they set higher goals than when you’re in a hospital.”

Discussions of how therapists weigh and integrate patient-stated goals generated some interesting findings. All participants in some way stated that attainment of patient-defined goals was a guiding principle in their practice. As Gina (FG1) said, “When I do an assessment, I take their goals, and let them reach their goals. Then they’re discharged.” However, these kinds of statements often seemed to be presented as a habitual response to the general question of discharge criteria posed by the interviewer. When probed about the details of treatment and discharge decisions or asked to provide examples, participants often made little or no mention of patient goals. This discrepancy may be attributed to an expectation embedded in current health care discourse, such that participants reproduced the accepted “right answer” to questions about clinical decision making. It also reveals the complexity of decision making and suggests that therapists must balance respecting patients’ wishes with numerous other factors, including expected prognosis and funding limitations. Participants suggested that they must often negotiate goals with their patients, particularly when patients set what therapists see as “unrealistic” goals, that is, goals that they perceive to be unachievable based on the patient’s clinical presentation:

I think you should be looking at what the patient’s expectations are, because sometimes ... the patient sets unrealistic expectations that are not achievable. So we need to put that into the mix as well. (Catherine, FG1)

Participants discussed the role of education and ongoing dialogue in helping patients to set achievable goals. It was apparent in these discussions that they felt that as therapists gain experience, they become more proficient in educating patients on their diagnosis and prognosis and, ultimately, in helping patients differentiate between achievable and unrealistic goals:

I go by what they want to get back to, when they want to do that, and correlating that with their prognosis ... if this is something that has been going on for 10 years, I’m not going to be able to completely diminish pain. (Ivan, FG2)

Most participants agreed that early education is imperative in managing patient expectations:

I think to be realistic from the beginning, very early on in treatment, in terms of what you’re going to be providing in terms of service or treatment. What the timelines are that you’re going to be looking at them ... and what would be your criteria for not continuing treatment. (Catherine, FG1)

Back then versus now, I think we never had the emphasis on discharge planning from the first visit ... It felt so open-ended back then and so vague. [Now], it feels like everyone’s on board from day 1 and there aren’t any surprises ... It’s not carved in stone, but at least it’s discussed, so that there shouldn’t be any surprises. (Francis, FG1)

Early and ongoing dialogue was also said to provide emotional support to patients during what can be personally difficult and fearful times and to better prepare them for eventual discharge:

... it’s actually educating the patient, reassuring the patient, explaining why you feel that they can continue on their own, they’re not being abandoned. (Brenda, KI)

Participants noted that discontinuation of treatment sometimes arouses fear and anxiety in patients who are concerned about their ability to self-manage without relying on a therapist. Participants suggested that early education and ongoing dialogue may also help therapists to understand each patient’s unique needs and circumstances and to individualize care. An exception to this was Gina (FG1), who works in a private setting and primarily treats general orthopaedic patients. Gina noted that she has found discussing discharge with patients often raises their level of fear and increases their reluctance to “let go”; she therefore chooses not to discuss the process too far in advance of discharge.

Use of Objective Findings

Objective findings include the range of tools and measures that therapists use to quantify patient progress, such as visual analogue scales, goniometry, and standardized outcome measures. From the data, it emerged that objective findings serve at least two purposes in the discharge process: first, as a way to educate patients on their progress; and, second, as a means of recognizing treatment plateaus. The former use, however, was much more prevalent in participants’ accounts.

Participants reported that objective findings are excellent tools that can be used to educate patients on their progress. For slowly progressing patients with chronic conditions, objective findings were said to be particularly important for a timely and successful discharge, because they can be used to demonstrate incremental progress to patients who have not noticed their improvements. Consequently, objective findings are used to motivate patients to continue to participate actively in physio-

therapy. In the course of an exchange about how participants use objective measures to maximize the potential for functional recovery, Hank (FG2) commented,

You have to have a full conversation with them and say, "You took a walk yesterday, how long did you go for? Well, initially you couldn't walk." You have to point ... those things out and then that really helps with discharge ... some people will say, "But I still have pain," then you say, "You are here [functionally]" ... you can convince them that they are better functionally, even though they have pain.

Hank's contribution to the focus group made it clear that his intention in this comment was not to minimize or ignore patients' pain but, rather, to illustrate how he uses objective measures to help motivate patients who may be focused on their pain without recognizing other improvements.

Objective findings are also used to recognize when patients have reached a plateau in treatment. Participants identified two types of plateaus: the functional maximum patients reach through therapy and a temporary plateau that requires adjustment of the treatment plan. Therapists described three primary courses of action that they undertake when a plateau is reached: the patient is referred elsewhere; the treatment plan is adjusted; or the patient is discharged from the therapist's care:

When they plateau, it might just be time for a change in the direction of treatment ... or they need to go back to the doctor, they need to look at other therapy options ... you know, being referred on. (Brenda, KI)

Participants stated that with experience, they were more able to recognize effectively when a plateau has been reached and to differentiate between a "maximum function" plateau and a temporary plateau. This was attributed to increased exposure to specific patient populations and to the development of an enhanced familiarity with their expected treatment progression.

When asked to identify the *main* factor to consider when discharging a patient, participants reported that a single primary criterion cannot be isolated:

That is so hard to say, what the main one is, I think all those [factors] come into play. I think it varies so much per patient ... to some degree it is a bit of a mystery. (Ivan, FG2)

This last passage is particularly revealing in describing how participants struggled to identify and isolate the discrete factors and strategies they use in their discharge deliberations. Nevertheless, the findings revealed that therapists do share common strategies toward discharge that are affected by similar factors, albeit in different ways, for different patients and settings.

DISCUSSION

The study results provide insight into the relevant factors taken into account by physiotherapists during discharge planning, highlight their complex interrelatedness, and illuminate the primary role of experience in shaping therapists' discharge decision-making processes and practices. Participants reflected on how, over time, they have become less focused on using tools and techniques learned academically and have incorporated knowledge gleaned from clinical experience into the processes of discharge planning and negotiation of goals.

Our findings parallel those of other research that has shown the influence of physiotherapists' experience on their clinical reasoning processes. Jensen et al., in their grounded theory work examining the development of expert physiotherapy practice, showed that experienced therapists "were much more focused on the knowledge they had gained learning from patients in their practice than on knowledge gained from traditional academic content areas such as anatomy, biomechanics, or pathology."^{26(p.37)} They demonstrated that as therapists gained experience and reflected on their practices, they became proficient at listening closely to patients, interpreting signs and symptoms, analyzing what worked and what did not, and applying their previously gained knowledge to the unique situation of each patient.

In this study, experience also factored into the weight attributed to the patient's role in his or her rehabilitation. Self-management of one's condition, both throughout the course of therapy and following discharge, is taught to physiotherapy students as part of their formative training. However, the findings indicate that the scale of its significance becomes much more apparent to therapists as they accrue clinical experience. Other research has shown that self-management is a critical component of discharge planning in other areas of orthopaedic practice,^{27,28} as well as in neurological and cardiorespiratory physiotherapy.^{29,30}

The intricacy of discharge decision making and the numerous factors and strategies revealed in the study highlight the challenges therapists face in providing "patient-centred care." Models of patient-centred care emphasize health professionals' duty to attend to individual patients' particular needs, circumstances, and stated preferences and to involve them in decision making.^{31(p.1-15),32} While this approach is frequently advocated in health care, our data reveal the complexity of achieving these goals in practice. Providing patient-centred care requires more than simply asking about and honouring patients' stated wishes. Participants in the study described negotiating with patients regarding reasonable and achievable treatment goals, using education and dialogue to co-determine goals that remain consistent with patients' needs and values.

These negotiation approaches described by participants have a number of parallels with *shared decision-making* models described in the literature.³³ Shared decision making emphasizes mutual participation through the sharing of knowledge and expertise. Within this framework, the practitioner's expertise is said to rest in his or her knowledge and experience of diagnosis, treatment, and prognosis, while the patient's expertise lies in knowledge of the contextual facts of his or her own personal situation, including experience of illness, values, aspirations, and available supports. As the participants noted, through the promotion of early and open dialogue, patients and practitioners can work together to determine achievable goals. Nevertheless, the findings also suggest that, regardless of years of experience, participants generally place less emphasis on patients' expressed preferences and desired goals of treatment when planning discharge than on objective clinical findings and their understanding of the typical course of treatment. As part of the goal-setting process, therapists rely on their knowledge of clinical presentations and on their clinical experience, whether broad or limited, to influence patients' choices and modify what they perceive as unrealistic expectations. This is not necessarily inappropriate or unwelcome to patients, but it does reveal a gap between the rhetoric of patient-centred care and the complexity of actual practice. Physiotherapists must therefore take care not to influence decision making unduly, to listen to their patients' needs and concerns, and to engage in ongoing dialogue to deliver patient-centred care.³³ Further research is needed to determine which processes best support patients' decision-making needs in the outpatient setting and, ideally, lead to mutually agreed discharge goals.

Although these results suggest that gaining experience is central to the development of clinical reasoning, participants suggested that this could be augmented and accelerated through guidance from more senior therapists in the form of structured mentorship. According to Godges,³⁴ structured mentoring helps novice physiotherapists accelerate their professional growth and, ultimately, their ability to provide optimal patient care. In addition, mentorship has been shown to benefit newly graduated therapists working in private practice³⁵ and to aid in the professional development of expert physiotherapists.²⁶ These kinds of structured mentorship programmes are available to novice Canadian physiotherapists. The Canadian Physiotherapy Association (CPA) has recently launched the CPA Mentorship Program, which includes an online "mentor matching" service for members across the country.³⁶ The programme allows CPA members to partner with volunteer mentors to share knowledge and experience and aid in mentees' professional development. CPA states that the programme's "simple and flexible design allows mentors and mentees to determine the scope and nature of

their professional relationship, whether it be to develop career, clinical or professional issues."³⁶ Such a design can accommodate a wide range of learning styles and objectives and may therefore be a promising option for novice practitioners to receive guidance when planning a patient's discharge.

Finally, the study revealed some rather surprising results with respect to the role of funding in discharge planning. Limitations in funding both helped and hindered therapists' treatment and discharge decisions. It was anticipated that participants would identify certain sources of funding as a constraint on the amount of therapy they could provide to individual patients and perhaps as precipitating what they might see as a premature discharge. For example, through an examination of Canadian trends in financing of physiotherapy services, Landry et al.^{37,38} found that budgetary constraints within the public health care sector have decreased both patients' access to services and physiotherapists' professional autonomy. Landry et al. suggested that in instances where funding is provided through third-party payers, "providers are increasingly being shifted from payments based on volumes to capped payments, which also affects the physical therapists' willingness (or ability) to provide services."^{37(p.263)} The authors further proposed that this may be putting pressure on physiotherapists to choose between providing what is deemed necessary and in the client's best interest and providing what is permitted by the funder.

Not unexpectedly, the study participants reflected these concerns in their discussions, stating that funding restrictions on number of treatments or other limits placed on their professional autonomy were generally seen as hindrances to providing quality care. What we did not anticipate were participants' comments on how funding limitations could also have a positive impact by forcing physiotherapists to be more selective in their treatment methods and to increase the efficiency of care delivery. Another interesting influence of funding arrangements was their effect on patients' expectations: participants suggested that while most patients are willing to assume the costs of their physiotherapy care, others seem reluctant to pay for their therapy. Participants attributed these behaviours to Canadian cultural expectations of free health care and expressed frustration that patients who can afford therapy are averse to personally covering the costs. However, instances of patients' unwillingness to pay were presented as exceptions to the norm rather than as a common occurrence.

Although the study findings are based on a relatively small sample of Canadian physiotherapists recruited from a single urban area, the results are likely relevant to physiotherapists in other geographical areas who practise under similar funding and delivery mechanisms. Further investigation with a larger sample across different provinces is needed. Additionally, although no clear

differences emerged in the current study that could be attributed to participants' age, gender, typical patient profile, or source of funding, these comparisons might be interesting in future research with a larger sample. Lastly, while this study explored physiotherapists' perspectives on discharge decision making, research investigating patients' perspectives on discontinuation of treatment is needed to address how best to meet patients' needs.

CONCLUSION

The results of the present study reveal that a combination of factors and strategies are considered by physiotherapists in discharge planning in the outpatient orthopaedic setting. Our findings emphasize the importance of clinical experience in shaping physiotherapists' processes, practices, and priorities in discharge decision making. Participants suggested that experience has modified their use of objective findings to educate patients, the emphasis they place on self-management, and their practices in negotiating patient goals and managing expectations. However, our findings suggest that their perspectives on the use of these strategies evolve over the course of their careers. Funding source also played an important role in discharge planning, including perceptions of professional autonomy, efficiency, and patient expectations. Further investigation into these effects is warranted. For example, little is known about the function of funding models in mediating power relations among patients, therapists, funders, and other gatekeepers or about the concomitant effects on the delivery and quality of patient care. In addition, our results suggest that providing patient-centred care requires a complex balance of multiple factors and open patient-therapist interactions.

KEY MESSAGES

What Is Already Known on This Subject

Few studies have been conducted that examine the factors considered by health care professionals when discontinuing patient care. Studies within the field of physiotherapy have identified clinical outcomes and non-clinical factors (e.g., balance, pain score, quality of gait, patients' wants and expectations, and funding constraints) as factoring into discharge decisions.^{2,8,9} However, the factors outlined in these studies are focused on specific patient populations. To the best of our knowledge, there have been no studies that consider the range of clinical and non-clinical factors that inform physiotherapists' discharge decision-making processes specific to the outpatient orthopaedic setting. Thus, little is known about physiotherapists' considerations and reasoning in deliberating outpatient orthopaedic discharge decisions.

What This Study Adds

The study results provide insight into the relevant factors taken into account by physiotherapists during discharge planning, highlight their complex interrelatedness, and illuminate the primary role of experience in shaping therapists' discharge decision-making processes and practices. Our findings emphasize the importance of clinical experience in shaping physiotherapists' processes, practices, and priorities in discharge decision making. Participants suggested that their clinical experience has modified their use of objective findings to educate patients, the emphasis they place on self-management, and their practices in negotiating patient goals and managing expectations. Their perspectives on the use of these strategies have evolved over the course of their careers. Funding source also plays an important role in discharge planning, including perceptions of professional autonomy, efficiency, and patient expectations.

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