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Physiotherapists' Treatment Strategies and Delineation of Areas of Responsibility for People With Musculoskeletal Conditions and Comorbidities in Private Physiotherapy Practice: A Qualitative Study

Anna Bernhardt Lyhnebeck^{1,2}  | Mette Bech Risør^{1,3} | Ann Dorrit Guassora¹ | John Sahl Andersen¹ | Søren T. Skou^{2,4} 

¹The Research Unit and Section of General Practice, Department of Public Health, University of Copenhagen, Copenhagen, Denmark | ²The Research and Implementation Unit PROgrez, Department of Physiotherapy and Occupational Therapy, Næstved-Slagelse-Ringsted Hospital, Slagelse, Denmark | ³The Research Unit for General Practice, Department of Community Medicine, UiT the Arctic University of Norway, Tromsø, Norway | ⁴Research Unit for Musculoskeletal Function and Physiotherapy, Department of Sports Science and Clinical Biomechanics, University of Southern Denmark, Odense, Denmark

Correspondence: Søren T. Skou (stskou@health.sdu.dk)

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ABSTRACT

Background: Patients with multiple chronic conditions, for example, musculoskeletal conditions and comorbidities, often receive inadequate and sometimes even contradictory care. Physiotherapists are well qualified to manage patients with musculoskeletal conditions and comorbidities due to their education and experience with rehabilitation; however, it is unknown which challenges they face when treating these patients.

Aim: To identify challenges, treatment strategies, and delineations of areas of responsibility among physiotherapists working in private physiotherapy practice when treating people with musculoskeletal conditions and comorbidities.

Methods: Qualitative study using focus group discussions and participant observations of 13 physiotherapists working in Danish private physiotherapy clinics. Grounded theory was applied to guide the analysis.

Results: Two major themes emerged from the focus groups and the observations (1) The necessity of adapting management to the patients and their treatment trajectory; (2) The dilemma of overall responsibility for coordinating care. The physiotherapists described different elements of adapting their management, including being challenged on time, taking extra care of the patient, and having to adjust to a fluctuating course of treatment. The dilemma in coordinating care concerned whether the responsibility should lie with the physiotherapist, other healthcare professionals, or the patients, and whether to treat only the condition on the referral or to treat all the conditions the patient had.

Conclusion: Physiotherapists use adapted strategies for diagnosing and treating patients with musculoskeletal conditions and comorbidities and are uncertain about the overall responsibility for coordinating care and whether they should focus on the index condition alone or also the other comorbidities the patient has.

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1 | Introduction

The number of patients with more than one chronic condition is increasing (Skou et al. 2022), causing a significant challenge for the healthcare system due to high healthcare utilization (Bähler et al. 2015; Van Oostrom et al. 2014) and poorer clinical outcomes (Marengoni et al. 2011). The management of patients with multiple chronic conditions, for example, musculoskeletal conditions and comorbidities, is challenging for healthcare providers and patients with multiple chronic conditions generally receive inadequate and sometimes even contradictory care (Bartels et al. 2011; Skou et al. 2022). There is still uncertainty on how to handle patients with multiple chronic conditions in the best way (Smith et al. 2021), but it is recommended to apply a patient-centred approach with a multifaceted focus on the patients' needs (Agborsangaya et al. 2013; Bartels et al. 2011; Kernick, Chew-Graham, and O'Flynn 2017; Skou et al. 2022; Smith et al. 2021). Due to physiotherapists' education and experience with rehabilitation, they have a good foundation for handling patients with several conditions (Carlesso et al. 2020). Patients highlight that communication with the physiotherapist is essential, including being involved in the decision-making, individualisation of the treatment, and quick and direct access to physiotherapy (Cooper, Smith, and Hancock 2008; Potter, Gordon, and Hamer 2003).

In a systematic review, general practitioners (GPs) identified four areas where they experienced difficulties in caring for patients with multiple chronic conditions: disorganisation and fragmentation of care, the inadequacy of current disease-specific guidelines, challenges in delivering patient-centred care, and barriers to shared decision-making (Sinnott et al. 2013). However, which challenges physiotherapists working in the primary health sector experience have not yet been identified. Research into the physiotherapists' experiences and choice of treatment strategies as well as their understanding of areas of responsibility may provide new insight into the treatment of patients with musculoskeletal conditions and comorbidities in physiotherapy practice. This will be the first step towards developing guidelines for physiotherapists when treating patients with multiple chronic conditions.

Therefore, the aims of this qualitative study are to identify (1) challenges and treatment strategies among physiotherapists working in private physiotherapy practice when treating people with musculoskeletal conditions and comorbidities and (2) their delineations of areas of responsibility.

2 | Materials and Methods

2.1 | Design

Three focus group discussions (FGD) and 13 days of participant observations with 13 physiotherapists were conducted with physiotherapists working in private practice. Information power was used as a guideline for sample size (Malterud, Siersma, and Guassora 2016). This study was reported according to the COREQ guidelines (Tong, Sainsbury, and Craig 2007).

The study employed a qualitative method, combining three focus group discussions (FGDs) with 13 physiotherapists and 13 days of participant observations to investigate the treatment strategies and areas of responsibility among physiotherapists working in private practice. The qualitative approach was chosen to gain insight into the performance of clinical practice and to gain a comprehensive understanding of the experience of physiotherapists in practice dealing with patients having musculoskeletal conditions and comorbidities. Participant observations were chosen to demonstrate the physiotherapist's clinical practice. To help with the interpretation of observation findings and to describe and discuss the physiotherapist's experiences, all 13 physiotherapists involved in participant observations were invited to participate in focus group discussions (FGDs).

2.2 | Setting and Participants

This study concerns physiotherapists working within the public agreement in private practice. Even though the physiotherapists practice independently, they are part of the primary healthcare system and have to collaborate with both GPs, other healthcare professionals, and municipalities. A substantial part of the patients they treat have been referred by the GPs. The initial consultation with a patient normally lasts 45–60 min and afterwards, a regular consultation lasts 30 min.

The clinics that participated were recruited using purposeful sampling (Palinkas et al. 2015), identifying clinics with high experience with the patient group to ensure information-rich cases. A phone call was initially made and an information letter about the study was sent to five potential participating clinics. The clinics had to be in either the Region of Zealand or the Capital Region in the eastern part of Denmark. Three clinics agreed and two clinics declined to participate in the study. After accepting to participate, all the physiotherapists working in the clinics participated in an information meeting, either online or with physical attendance. The participating physiotherapists had a diverse distribution in age, gender, and work experience. In this study, patients with musculoskeletal conditions and comorbidities were defined by having neck or low back pain or knee or hip osteoarthritis plus a minimum of one of the following conditions: stroke, depression, heart disease that required treatment, or type-2 diabetes. These are common comorbidities among patients with musculoskeletal conditions (Muckelt et al. 2020).

2.3 | Observations and Focus Group Discussions

Observations were conducted based on a guide to learn and understand the diverse perspectives and interplay among the participants (Spradley 1980). Each physiotherapist was observed during a full day of work, including individual consultations and exercise classes. Informal interviews took place during the participant observations. After participant observations, field notes were written. Three FGDs were conducted using a topical interview guide with open-ended

BOX 1 | Patient case.

PATIENT CASE: You are about to have a first-time consultation. From the referral you can read, that the patient is female, she has a referral from the GP, and she is 45 years old. The GP writes that the patient is on sick leave from her job as a kitchen assistant in a kindergarten because of back pain. Furthermore, the GP writes that the patient previously has tried being treated by a masseur and a chiropractor, but this has not helped. The GP recommends that she consult a physiotherapist. The patient informs you that she also has type-2 diabetes and early stages of osteoarthritis in her right knee. You can observe that she is overweight and smell that she is a smoker. During your conversation, the patient further opens up and tells that earlier this year she had stress and now feels depressed from being at home and the growing problems triggered by her issues.

questions to explore participants' underlying perceptions and treatment strategies and allow them to elicit and give in-depth explanations (Krueger and Casey 2000). The interview guide (see appendix) was based on the field notes gathered during the participant observation and evolved around a fictional patient case (Box 1). The patient case was inspired by fieldwork, clinical knowledge, and the study's patient definition. The interview guide involved the following themes: The expectations before meeting the patients, treatment of patients with musculoskeletal conditions and comorbidities, the physiotherapist's role, alliance and cooperation, and organisation. Only the participants, the moderator (AB), and the comoderator (taking notes, AG or JS) were present during the discussions. All participants signed written consent forms and answered a few informational questions before participating in the discussions. The discussions were recorded as an audio file and transcribed verbatim.

AB acted as the lead researcher and conducted the observations at the clinics and acted as a moderator for the FGDs. AB is a female physiotherapist working as a research assistant trained in qualitative methodologies. One FGD was conducted at each of the three participating clinics.

2.4 | Ethics and Data Security

Before observations and FGDs, the lead researcher (AB) informed the physiotherapists about the purpose of the study, anonymity, that consent could be withdrawn at any time and that participation was on a volunteer basis. The study was approved by the Danish Data Protection Agency (file number: 514-0606/21-3000). According to Danish ethical guidelines, qualitative research requires no formal ethical approval. An ID was used to anonymise the participant's names and the clinics. The geographical location of the clinics and individual characteristics of the physiotherapists have also been anonymised.

2.5 | Data analysis

We used an inductive analysis of the data gathered in the participant observations and the FGDs, which was inspired by Kathy Charmaz's interpretation of Grounded Theory (GT) (Charmaz 2006). GT is a comparative, iterative, and interactive method that provides a way to study empirical processes (Charmaz 2006). Inspired by the technique of constant comparison, AB sought to compare the physiotherapist's statements about treating patients with musculoskeletal conditions and comorbidities with statements from other physiotherapists. The analytic process started after all the participant observations and FGDs were conducted. Field notes were included in the analysis and served as data of interaction and practice used together with themes from the FGDs. When analysing the transcripts, we took a flexible and iterative approach using the following process to generate themes from the findings:

1. Getting a total impression by reading the whole text to get an overview.
2. Developing analytic codes from the data concerning the physiotherapist's different strategies when treating patients with musculoskeletal conditions and comorbidities and delineations of areas of responsibility.
3. Establishing categories and sorting the codes correspondingly.
4. Abstracting concentrates from each category and creating themes.
5. Developing memos, analytic notes that explicated and filled out categories.
6. Making comparisons between data and data, data and concept, and concept and concept.

The analysis was conducted by AB and supported by the AG and MR.

3 | Results

A total of 13 physiotherapists (7 men and 6 women, aged 26–60 years) working in private physiotherapy practice participated in the study. Characteristics of the participants are summarised in Table 1. The participant observations consisted of 13 days of observations and a total of 77 consultations. The FGD from clinic A had a duration of 100 and 90 min in clinics B and C.

The physiotherapists reported that they used specific strategies for diagnosing and treating patients with musculoskeletal conditions and comorbidities. First of all, they would need to assess and adapt their usual approach to how the treatment was planned and executed and assess how they best cooperated with the patient. Furthermore, they had learned in their clinical practice that locating the placement of responsibility and coordinating clinical care was a challenge when treating patients with musculoskeletal conditions and comorbidities, demanding

TABLE 1 | Characteristics of the participating physiotherapist.

Characteristics of participants						
ID	Age	Gender	Experience in private practice (years)	Clinic location (region ID)	Clinic ID	
William	36	M	13	1	A	
Frank	60	M	29			
Michael	32	M	8			
Laura	24	F	2			
Karen	45	F	20			
Susanne	52	F	8	1	B	
Karl	27	M	3			
Jan	57	M	20			
Tina	59	F	3			
Ida-Sofie	26	F	1	2	C	
Benjamin	38	M	3			
Helena	30	F	3			
Frederik	26	M	2			

the physiotherapists to address certain tasks and choices towards the healthcare system and the patient.

3.1 | Challenges and Treatment Strategies

3.1.1 | Theme 1: Adapting Their Approach

There was a general agreement among the participants that it was necessary to assess and adapt their approach when treating patients with musculoskeletal conditions and comorbidities. A physiotherapist working in private practice with a large uptake of patients with chronic conditions expressed his relation to these patients in this manner:

If this is the case, that when they enter the room, and we find out that there are these things present, then I will simply lower the level of ambition a bit.

(Frank)

The physiotherapists used the term lowering the level of ambitions, not as giving the patient a lower level of care, but as a way of articulating that it was not possible to diagnose and treat a patient with multiple conditions in the same way as treating and diagnosing a patient with a single condition. With this term, they implied that they needed to adapt their ambition towards how fast it would be possible to see improvement in the treatment and assess how much of a burden one could place on the patients with multiple chronic conditions. This entailed that the physiotherapists had to actively adapt the treatment and the cooperation from the beginning to fit the individual patient with multiple chronic conditions. These adaptations came from clinical experience and previous patient cases.

Many mentioned that they experienced that patients with musculoskeletal conditions and comorbidities did not have the same level of energy or resources as patients with a single condition. Resourceful patients would typically receive effective treatment earlier on and have the opportunity to actively

participate in their recovery. Conversely, they had experienced patients with musculoskeletal conditions and comorbidities who usually did not have the same level of possibility to actively participate in their recovery. This could be due to complex disease history, complex symptoms, or lower levels of health literacy. This meant that the physiotherapist had to work innovatively and closely with the patient to figure out how best to adapt the treatment course to the individual patient in order to provide the best possible care. Some of the physiotherapists explained that even though the guidelines suggested it, they would not instruct patients with musculoskeletal conditions and comorbidities to do exercises at home. For some of the patients, this would be too demanding, instead, they agreed that the patient should participate in a class at the physiotherapy clinic. By doing this, the physiotherapists could lower the treatment burden for the patients, and individually adapt the treatment to the patient's resources.

3.1.1.1 | Being Challenged by Time. Several of the participants claimed that time was one of the most challenging elements when treating patients with musculoskeletal conditions and comorbidities. A physiotherapist with 5 years of experience at a private clinic explained:

It makes our time less – the half-hour set aside feels like a quarter because everything just takes longer.

(Michael)

Michael shows how he would like the patient to do an exercise at home. The patient is still in doubt and repeats the exercise several times.

(Field note from participant observation)

This quote and field note illustrate that the allocation of time when treating patients with musculoskeletal conditions and comorbidities is different from treating patients with a single condition. Several of the physiotherapists expressed the challenge of time as a frustrating element, both for themselves as

health professionals, and also for the patients. Because many patients with musculoskeletal conditions and comorbidities often had complicated disease histories, some of the participants described that it could take a much longer time for a patient with musculoskeletal conditions and comorbidities to experience a positive effect of the treatment, therefore prolonging their course of treatment. This could create dissatisfaction and even distrust between the physiotherapist and the patient. Because many patients with musculoskeletal conditions and comorbidities had a high demand for repeated information, other physiotherapists also described that they felt they did not have very much time with the patients to perform actual physiotherapy, like instruction exercises or conducting manual therapy. This left the physiotherapist with the sensation of not being very efficient in their consultations.

Many of the physiotherapists also felt they were challenged on time by the need they felt patients with musculoskeletal conditions and comorbidities had for extra care in the consultation. An experienced female physiotherapist gave an example of this if a patient with musculoskeletal conditions and comorbidities cancelled an appointment. In this case, she predicted that she needed to contact the patient herself and make a new appointment because otherwise there was a big risk of the patient not making a new appointment and thereby terminating the treatment. This added to the burden of treating patients with musculoskeletal conditions and comorbidities and required the physiotherapists to be extra attentive.

For many of the physiotherapists, the time perspective and the need for added attention meant they had to adjust their treatment to a new level of what was possible to accomplish in a consultation.

3.1.1.2 | Having to Adjust to a Fluctuating Course of Treatment. Several of the physiotherapists described how they through clinical practice had come to expect patients with musculoskeletal conditions and comorbidities to have a fluctuating course of treatment. A physiotherapist working in a large clinic in a major city put it this way:

Again then definitely think there will be more bumps in the road – it is not possible just to assign them to a class with expected good effect over time and then everyone is happy.

(Benjamin)

These fluctuations could be detected in the planning of the patient's treatment. Some of the physiotherapists described that it could take several attempts before the correct treatment plan was found because there was a substantial risk of the patients with musculoskeletal conditions and comorbidities reacting to the treatment. Therefore, the physiotherapists needed to stop the treatment, reassess, and then try again. A male physiotherapist explained it like this:

I also usually call it noise – so I think there is a little more noise in the course of treatment compared to others.

(William)

These elements of interference could make it more challenging for the physiotherapist to diagnose the patient correctly and plan the course of treatment. It was expressed that these fluctuations contributed to the need to lower the expectations of the treatment because they could not move as quickly in the treatment plan as when treating patients with less complex treatment courses. An experienced physiotherapist claimed that the more challenging path for the patients with musculoskeletal conditions and comorbidities was not synonymous with the patients and the physiotherapists not reaching their goal for the rehabilitation; it just demanded more time, more adjustments, and a different strategy.

3.1.2 | Theme 2: Two Sides of Responsibility

3.1.2.1 | The Responsibility of Coordinating Care.

Since patients with musculoskeletal conditions and comorbidities frequently experienced complicated and time-consuming treatments, a discussion on where to place the overall responsibility of coordinating care arose. Several of the physiotherapists believed it was necessary to take on this responsibility themselves. A physiotherapist explained:

When I mean control I mean, that it is us who must take the responsibility rather than the patient.

(William)

Many patients with musculoskeletal conditions and comorbidities may have year-long continuous treatment in private physiotherapy practice, allowing the patient and the physiotherapist to develop a very close relationship. Some of the physiotherapists, like William, explained that due to the close collaboration and relationship with the patients, they felt they needed to take on the responsibility of coordinating care, instead of leaving the responsibility to the patients where it could become too big a burden. Others advocated that it should not be the physiotherapists that shoulder this responsibility. A physiotherapist working in a major city gave this advice:

We just have to give some of that responsibility from us otherwise we do not have time to concentrate on what is our core service which is physiotherapy.

(Frank)

Those physiotherapists felt they should instead hand off some of the responsibility and concentrate on their core competencies. They expressed that the responsibility of managing care should stay where it always had been, with the GPs. About half of the physiotherapists advocated that it should be the patients themselves that had the responsibility of managing and coordinating their own care. A female physiotherapist with many years of experience in treating patients with chronic conditions explained:

On the contrary, I would say that it is the patient who must be primarily responsible, otherwise two years will pass and then the patient has the same problem.

(Karen)

These physiotherapists believed that if the patients carried the responsibility, it would allow them to take action on what they thought was relevant, thereby giving them a way to take charge of their own bodies and treatments and evoking a sense of empowerment.

3.1.2.2 | The Clinical Responsibility. The analysis showed that within the physiotherapist's framework of treatment, there was a disagreement about whether the physiotherapists were responsible for treating all the chronic conditions the patients had or if they simply should treat the one they were referred to. One physiotherapist only thought it was possible to treat patients with musculoskeletal conditions and comorbidities if you included all their conditions. He put it this way:

We cannot separate it from each other – (...) if you have to be treated by me then we have to deal with all of it – I must admit because I will not succeed with any parts of it if I separate it.

(Frank)

Frank and some other participants did not think it was possible to execute their treatment if they did not embrace all the conditions the patients had. These participants accepted that it was not possible to separate the patient's different conditions and therefore had to adapt their treatment to this.

Others advocated that they thought it was important to keep the focus on the condition with which the patient was referred. They did not think that physiotherapists had the qualified competencies to embrace all the different conditions patients with musculoskeletal conditions and comorbidities could present with. A male physiotherapist working at a large private clinic gave this advice:

Now we must also remember that we are physiotherapists, and there are some things that doctors must treat and some things that psychologists must treat in psychiatry.

(Frank)

These participants thought that physiotherapists should embrace only the issues that they were educated about, such as issues within the musculoskeletal area. They thought that it was improper to take responsibility for areas typically related to other professions, such as medicine and psychology, because they did not think that physiotherapists had the professional capabilities for treatments in these areas. See Supporting Information S1 for additional quotes.

4 | Discussion

Our study indicates that physiotherapists used specific strategies for diagnosing and treating patients with musculoskeletal conditions and comorbidities. This involved assessing and adapting their usual diagnosis and treatment. It also involved reflections on where to place the responsibility of coordinating care and the consideration of whether to treat all the conditions the patient

with multiple chronic conditions presented with or to focus on an index condition.

To our knowledge, this is the first study to investigate the physiotherapists' challenges, treatment strategies and delineations of areas of responsibility for treating patients with multiple conditions. The physiotherapists highlighted their need to adjust the care to the individual patient, as recommended by the NICE guidelines, and adapt their approach towards the patient and the treatment. The physiotherapists accepted that the patients needed more time to process information and instructions and anticipated that they needed supervision instead of home exercises. This is in agreement with a previous qualitative study of healthcare professionals, demonstrating that patient-centred care contributes to the well-being of patients with multiple chronic conditions when it is based on the individual patient's wishes, needs, and abilities (Kuipers, Nieboer, and Cramm 2021b). Previous studies have focused on other parts of primary care, such as how GPs work, and found similar organizational structures in health care to be a challenge when treating patients with multimorbidity (Sinnott et al. 2013). The GPs also found that insufficient consultation time could lead to suboptimal approaches for the patient group. This is the first study to demonstrate how physiotherapists from private practice work with patients with musculoskeletal conditions and comorbidities and how they work patient-centred by adapting their approach including working with time management, taking extra care of the patient, and adjusting to a fluctuating course of treatment.

The physiotherapists in our study were challenged in terms of implementing a patient-centred care approach due to organizational barriers such as available time with the patients. These findings agree with Kuipers et al. (Kuipers, Nieboer, and Cramm 2021a) who have described how patient-centred care for patients with multiple chronic conditions is 'easier said than done.' They identified difficulties in achieving mutual understanding between patients and healthcare professionals, a lack of training and education of new skills in the healthcare professionals, and a challenge in time pressure and conflicting financial incentives (Kuipers, Nieboer, and Cramm 2021a). All these barriers pose a true challenge in effective and sustainable patient-centred care for patients with multiple chronic conditions in physiotherapy as well as primary care. In October 2018, The Richmond Group of Charities published the findings of an in-depth ethnographic research project describing how it feels to live with multiple chronic conditions and the challenges people face in accessing the care and support they need (The Richmond Group of Charities 2023). The report highlighted that people with complex conditions were left with a feeling of fragmented and uncoordinated care. A consequence of uncoordinated care is that the patients feel that they are being sent from one specialist to another, their consultations are overlapping, and they are forced to explain their medical history repeatedly with the risk of receiving contradictory care (Bower et al. 2011; Noël et al. 2005). Adding to the findings in our study, this highlights the importance of coordinated and comprehensive care with lower levels of ambition that is needed to successfully treat patients with multiple conditions (Skou et al. 2022).

Despite the impact patients with multiple chronic conditions have on the healthcare system, most healthcare systems are

organised within a single-disease framework that does not account for multiple chronic conditions (Barnett et al. 2012; Boeckxstaens and de Graaf 2011; Salisbury et al. 2011). Qualitative studies in the field suggest that both patients and health care providers find this single-disease framework inconvenient, inefficient, and unsatisfactory (Bower et al. 2011; Noël et al. 2005; Smith, O’Kelly, and O’Dowd 2010). Another consequence of this is that the patients may be confused about overall responsibility for their care (Doessing and Burau 2015), and they become more vulnerable to organizational fragmentation (Barnett et al. 2012) and lack of coordination of care, which becomes even worse with more conditions (Maeng et al. 2012). Our findings among physiotherapists confirm the presence of this challenge by heterogeneous views on where to place the responsibility of managing care for patients with musculoskeletal conditions and comorbidities and whether to focus on one or all conditions that the patient has.

4.1 | Methodological Considerations

The lead researcher would introduce herself as a colleague when presenting herself in the clinic and initiating the FGDs as she is a former physiotherapist working in private physiotherapy practice. The strength of this approach was easily gaining the physiotherapists’ trust and seamlessly integrating into the clinic’s daily routines. Additionally, it was beneficial for guiding the FGD towards clinically relevant topics and for understanding and appreciating the physiotherapists’ work situations and perspectives. However, a potential weakness in this clinical position could lead to ‘blind spots’ for the lead author, hindering sufficient reflective view. To address this, the author group ensured a research team with various professional backgrounds and consistently posed questions throughout the research process. Furthermore, some physiotherapy participants might feel inclined to respond to the FGD in a manner that they perceived the lead researcher would prefer. This inclination could potentially lead to participants providing answers that were pleasing or aligned with the lead researcher’s expectations. The participants in the FGDs were recruited from the same physiotherapy clinics. In certain FGDs, clinic owners also took part, introducing an asymmetrical power dynamic among the participants. This raised concerns regarding whether all participants felt comfortable expressing their opinions freely. The presence of clinic owners, who inherently hold authority within the clinic setting, could influence the willingness of other participants to voice dissenting opinions or provide critical feedback. To mitigate this, the lead researcher tried to foster an open and non-judgemental atmosphere during the FGDs, encouraging participants to express their genuine opinions and experiences freely. While it could have been valuable, we did not involve patients in the development of the patient case or the interview guide. However, the current study was conducted alongside another study interviewing and observing patients with musculoskeletal conditions and comorbidities recruited from the same clinics as where the physiotherapists in the current study worked. As the author group of the two studies were the same and since they were conducted simultaneously in time, knowledge from one study helped inform the analyses and interpretation of the other study and vice versa.

5 | Conclusion

Physiotherapists often experience having to work towards goals in smaller steps when treating patients with musculoskeletal conditions and comorbidities. They felt that they achieved less with these patients within the regular timeframe, and patients often did not have a lot of resources to invest in their own treatment. Furthermore, treatment plans often had to be revised to fit fluctuating illness. Physiotherapists sometimes experience taking treatment coordination responsibility. Physiotherapists did not agree about who should have the responsibility for coordination or if they should treat only what the patient had been referred for or include related issues.

Supporting physiotherapists in recognising difficulties and responsibilities in their care for patients with multiple chronic conditions is important, thereby taking a step towards improving the health and care of this population and the development of patient-centred care. It is unknown what kind of expectations, barriers, and special needs the patients have about physiotherapists in private practice. Such knowledge is needed to better understand the population and develop effective care strategies and guidelines in the future.

Author Contributions

Study conception and design: Lyhnebeck, Risør, Guassora, Andersen, Skou. Recruitment of participants: Lyhnebeck. Acquisition of data: Lyhnebeck. Analysis and interpretation of data: Lyhnebeck, Risør, Guassora, Andersen, Skou. Drafting the article or revising it critically for important intellectual content: Lyhnebeck, Risør, Guassora, Andersen, Skou. Final approval of the article: Lyhnebeck, Risør, Guassora, Andersen, Skou. All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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Conflicts of Interest

Dr. Skou has received personal fees from Munksgaard, Nestlé Health Science, and TrustMe- Ed, all of which are outside the submitted work. He is the co-founder of GLA:D, a not-for profit initiative hosted at the University of Southern Denmark aimed at implementing clinical guidelines for osteoarthritis in clinical practice. None of the other authors have any conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.