

## **Musculoskeletal clinicians practice behaviour for non-traumatic wrist disorders in the UK: a qualitative study**

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# BMJ Open Musculoskeletal clinicians practice behaviour for non-traumatic wrist disorders in the UK: a qualitative study

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## ABSTRACT

**Objectives** Though non-traumatic wrist disorders (NTWD) are common, little is known about how clinicians direct their management. In this study, we aimed to explore clinical decision-making and practice behaviour in managing those with non-traumatic wrist disorders.

**Design** This is a qualitative study using semi-structured, face-to-face and remote interviews. Interviews were audio-recorded, transcribed verbatim and analysed using thematic analysis

**Setting** UK-based clinicians from across private and public healthcare settings were selected through involvement in a previous online survey.

**Participants** Data were collected from 15 clinicians using semistructured interviews (April–August 2024). Interviews were audio-recorded, transcribed verbatim and analysed using reflexive thematic analysis.

**Results** We analysed the data into five overarching themes. The first theme, 'listening and acknowledging concerns', described the concentration, empathy and attention involved with initial interactions. The second theme, 'What this means to me', described how clinicians interpreted and communicated information about a patient's wrist condition, often co-constructing explanatory narratives with patients through the use, modification or deliberate avoidance of diagnostic labels. Clinicians differed in the value they attributed to specific diagnoses, with some viewing them as essential for guiding management and others favouring function-based explanations.

In the third theme, 'having an honest conversation', clinicians expressed the need to reach a shared and realistic understanding of what was achievable going forwards. The fourth theme, 'managing what matters', reflected the pragmatic sentiment held by clinicians in working towards clear functional goals that really matter to the individual patient. The final theme, 'sitting with uncertainty', encompassed the importance of allowing people to find their own ways of coping and how explaining certain uncertainties may be of value to patients.

**Conclusions** This study provides the first description of UK clinicians' practice behaviour regarding NTWD across professional groups and healthcare settings. The findings reveal that effective care is driven by a sophisticated blend of professional integrity, relational skills and clinical pragmatism, particularly when faced with diagnostic uncertainty and resource limitations.

## STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The use of qualitative methods allowed greater insights into the practice behaviour of clinicians, complementing previous survey and review articles in this area.
- ⇒ Clinical stakeholders from across the non-traumatic wrist disorder care pathway in the UK, representing a range of professional groups and healthcare settings, were interviewed to gain a comprehensive understanding of perspectives on management.
- ⇒ The topic guide for the semistructured interviews was influenced by key questions of importance to a mixed stakeholder group.
- ⇒ A strength of this study was the use of an external auditor to provide evaluation into whether the findings, interpretations and conclusions were supported by the data, and to provide feedback on preliminary findings.
- ⇒ Recruitment was restricted to those who previously had completed an online survey into the management of wrist problems, limiting the representativeness to clinicians engaged in online research.

## INTRODUCTION

Wrist pain is commonly encountered with an annual consultation rate of 58 in 10 000 patients in primary care in the UK<sup>1</sup> and is estimated to affect 6% of the general population in the last week.<sup>2</sup> Non-modifiable associations with wrist pain include the increased age and female sex, and its incidence increases in people who engage in physically demanding occupations and sportspeople where 10% have been found to have short-term pain, and 24% have medium-term pain.<sup>2</sup>

A growing body of work aims to address knowledge gaps identified by a mixed stakeholder group regarding the management of non-traumatic wrist conditions,<sup>3</sup> a group of commonly encountered but poorly understood conditions first identified as a research priority by the Management of Wrist Pain group<sup>4</sup> (online supplemental section 1). Initial studies include scoping reviews of published and unpublished sources<sup>3</sup> and



patient-facing websites,<sup>5</sup> as well as an audit of care pathways and guidelines.<sup>6</sup> Collectively, these reviews indicate that both clinicians and patients lack access to high-quality evidence, clinical guidelines and management resources to support the assessment and treatment of non-traumatic wrist disorders. Consequently, uncertainty exists regarding optimal management approaches and appropriate care pathways.

A subsequent survey of 330 UK-based clinicians from a range of healthcare settings and professional groups provided valuable data regarding current management practices.<sup>7</sup> Key findings were that clinicians encounter these conditions occurring across settings and that their assessment and management confidence increased with clinical exposure. Management methods relied predominantly on non-specific methods which could be applied without requiring a structural diagnosis.<sup>7</sup> Variability was observed between professional groupings and work setting, particularly in diagnostic confidence and confidence in management.

To provide depth and contextual understanding beyond surface-level survey data, the use of qualitative methods was recommended to explore clinicians' decision-making processes and practice behaviours when encountering individuals with non-traumatic wrist disorders (NTWD).<sup>7</sup> This approach has benefit in adding to the knowledge base and enables future stakeholder-based studies to recommend improvements into the package of care available for those with NTWD.

The aim of this study was to explore clinical decision-making and practice behaviours in the management of patients with NTWD. Specifically, we sought to understand how clinicians use clinical reasoning when selecting management options, and to explore their confidence in managing NTWD and their perceptions of the resources available to support care.

## METHODS

### Study design

We conducted a qualitative study involving 15 generalist and specialist clinicians from surgical and rehabilitation backgrounds across a range of healthcare settings

(table 1). All were involved in the provision of care for people with NTWD. Semi-structured and face-to-face and remote interviews were used for data collection. The interview topic guide, opening statement and ice-breaker questions were developed iteratively by the research team and informed by key questions identified as important by a mixed stakeholder group in a previous study.<sup>3</sup> The topic guide included questions that explored the domains of diagnosis, treatment, care pathways and outcomes; what clinicians felt was good and not so good; what they valued in the process; and what they felt could be improved (online supplemental section 3).

Our qualitative team included a PhD student and physiotherapy clinician with 27 years of clinical experience (TGCM), a hand surgeon with over 10 years of clinical experience and qualitative research training (BD), an engineering researcher and PhD supervisor with expertise in design-led and user-centred approaches to healthcare innovation (NH), and two researchers with experience in qualitative research (SM and GP). In line with the Robert Wood Johnson Foundation 'Qualitative Research Guidelines Project',<sup>8</sup> an external auditor (EN), a physiotherapist and recent PhD graduate with qualitative research experience, independently reviewed the analysis to evaluate whether the findings, interpretations and conclusions were adequately supported by the data and provided feedback on preliminary findings.

The principal investigator (TGCM) conducted all interviews and led data analysis in collaboration from BD and SM. TGCM's approach to this qualitative study was grounded in a relativist ontological position, asserting the existence of an external reality that is interpreted through a critical realist epistemological paradigm. Despite having considerable 'insider' knowledge of the clinical specialty, the lead researcher maintained equipoise (neutrality) throughout the process. This was supported through methodological rigour, including verbatim transcription, rigorous checking processes within the thematic analysis and the use of an external auditor. Adherence to the Consolidated Criteria for Reporting Qualitative Research checklist<sup>9</sup> (online supplemental section 2) continued throughout the study.

**Table 1** Professional group and primary work setting of survey respondents (n=15)

| Professional group          | Primary work setting |              |                |                  | Total |
|-----------------------------|----------------------|--------------|----------------|------------------|-------|
|                             | Secondary care       | Primary care | Community care | Private practice |       |
| MSK rehabilitation*         | 3                    | 0            | 0              | 0                | 3     |
| First contact practitioner† | 0                    | 2            | 1              | 0                | 4     |
| Surgeon                     | 3                    | 0            | 0              | 0                | 3     |
| Hand therapist              | 4                    | 1            | 0              | 1                | 5     |
| Total                       | 10                   | 3            | 1              | 1                | 15    |

\*All candidates were physiotherapists (n=3).

†Includes first contact practitioners (n=2), general practitioners (1) and FCP with secondary hand therapy role (1).

FCP, First Contact Practitioner; MSK, musculoskeletal.

### Patient and public involvement

No patients or members of the public were involved in the design, conduct, reporting or dissemination of this research. However, a mixed stakeholder group was involved in the identification of key questions of importance which motivated this research in our previous scoping review.<sup>1</sup>

### Competing interests and funding

In line with International Committee of Medical Journal Editors guidance for competing interests, none of the authors have financial interests with tobacco companies or tobacco-related subsidiary companies or organisations. All other authors have no competing interest to declare.

### Study sample

72 clinicians were invited to participate in this study after choosing to volunteer following their involvement in a preceding online survey of clinicians.<sup>7</sup> Inclusion criteria included healthcare clinicians who contribute to the management of patients with NTWD, specifically surgeons, therapists and primary care clinicians in both public and private healthcare provision (table 1). Exclusion criteria included clinicians based outside the UK and practitioners not actively involved in management of patients with NTWD. Similar studies have been reported with up to 18 participants,<sup>10 11</sup> and our sample of 15 was considered sufficient because no new information was gathered from later interviews. However, Braun and Clarke recently stated the concept of data saturation is incompatible with reflexive thematic analysis.<sup>12</sup> Participants gave informed consent to participate in the study before taking part using an online consent form. No payment was made to participants for their involvement in the study.

### Data collection

Between April and August 2024, TGCM conducted interviews either face-to-face or remotely, according to participant preference. All participants were given a study participant information sheet, followed by the opportunity to ask questions, before agreeing to participate and completing an online consent form. TGCM audio-recorded the interviews and kept a reflexive diary recording field notes and his reflections and interpretations of candidate's responses which were reviewed by SM.<sup>13</sup> Interviews were automatically transcribed and checked for accuracy against the audio-recordings by TGCM. Transcripts were uploaded as Word documents (Microsoft) and organised within NVivo qualitative data analysis software (V.12; QSR International, USA) and anonymised using non-identifiable study codes. Recordings were initially stored on TGCM's institutional laptop and transferred to secure storage at Sheffield Hallam University within 24 hours of completion of the interview.

### Data analysis

Reflexive thematic analysis recommended by Braun and Clarke<sup>12 14</sup> was performed to develop, analyse and

interpret patterns across the qualitative dataset to develop themes relating to participants' practice behaviour. Braun and Clarke's six-step approach was followed: familiarisation with the data; coding; generating initial themes; reviewing and developing themes; refining, defining and naming themes; and producing the final report. Two members of the research team were involved in all six stages of the analysis process (TGCM and BD) with the initial generation of common categories, subcategories and development and clarification of themes led by TGCM and overseen by BD. SM provided cross-checking and feedback on theme development and methodological rigour was further supported by the external auditor (EN).

## RESULTS

### Professional group and primary work setting of survey respondents

The sample (table 1) predominantly comprised secondary care settings (n=10), with fewer participants from primary care (n=3), community settings (n=1) and private practice (n=1). Professional groupings were spread between specialist surgeons and hand therapists (n=3, n=5) and between generalist musculoskeletal (MSK) practitioners and first contact clinicians (who were comprised of primary care general practitioners and first contact physiotherapists) (n=4, n=3). Clinical experience ranged from 4 to 34 years of post-graduate practice (mean=20.3±9.79 SD).

### Overall results of analysis

The six stages of reflexive thematic analysis enabled an initial 338 statements of interest to be collated, developed into six initial code groupings in phase 2 followed by the generation of 10 initial themes comprising 75 statements in phase 3. These were then refined and named, and through an iterative analytic process across phases 4–6, to reach five overarching themes and seven subthemes derived from 40 core statements which represented the wider data (figure 1, online supplemental section 4).

The sixth 'writing up' stage of the reflexive process finalised the theme titles and consolidated the statements into 34 quotes (figure 2). The first was named 'Listen and acknowledge concerns' and described the concentration, empathy and attention involved with initial interactions with patients. The second theme, 'What this means to me', provided insights into clinical reasoning where clinicians had seemingly divergent opinions about the role of diagnosis in the management of NTWD. The third theme, 'An honest conversation', concerned managing the resource constraints and understanding patient goals. 'Manage what matters' was the fourth theme and reflected a largely pragmatic and function-based approach to managing people with NTWD, while the final theme, 'Sit with uncertainty', reflected the acceptance of ambiguity in outcomes and the importance of knowing when to change approach.

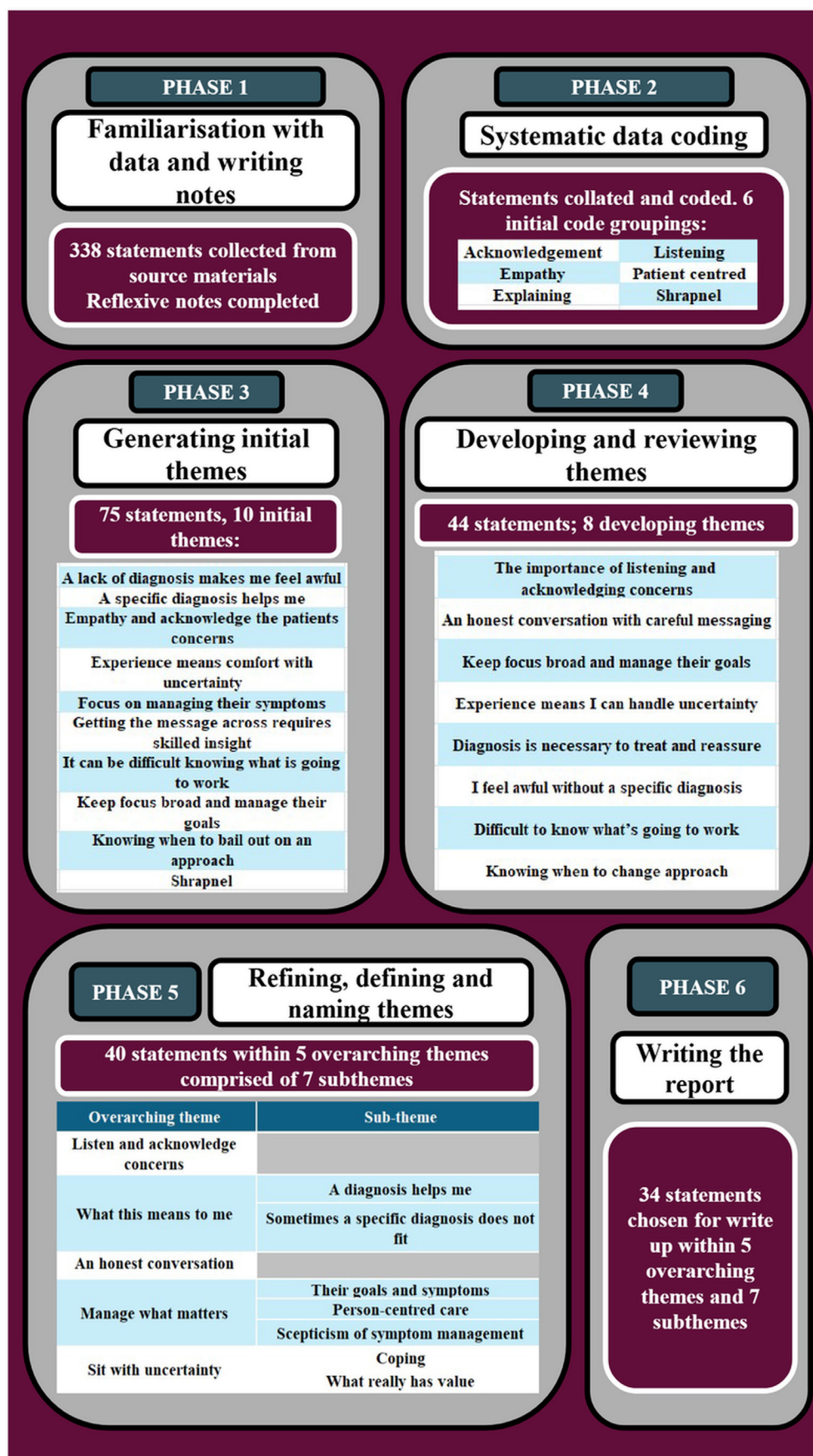


**Figure 1** Summary of coding tree using six-stage reflexive thematic analysis.

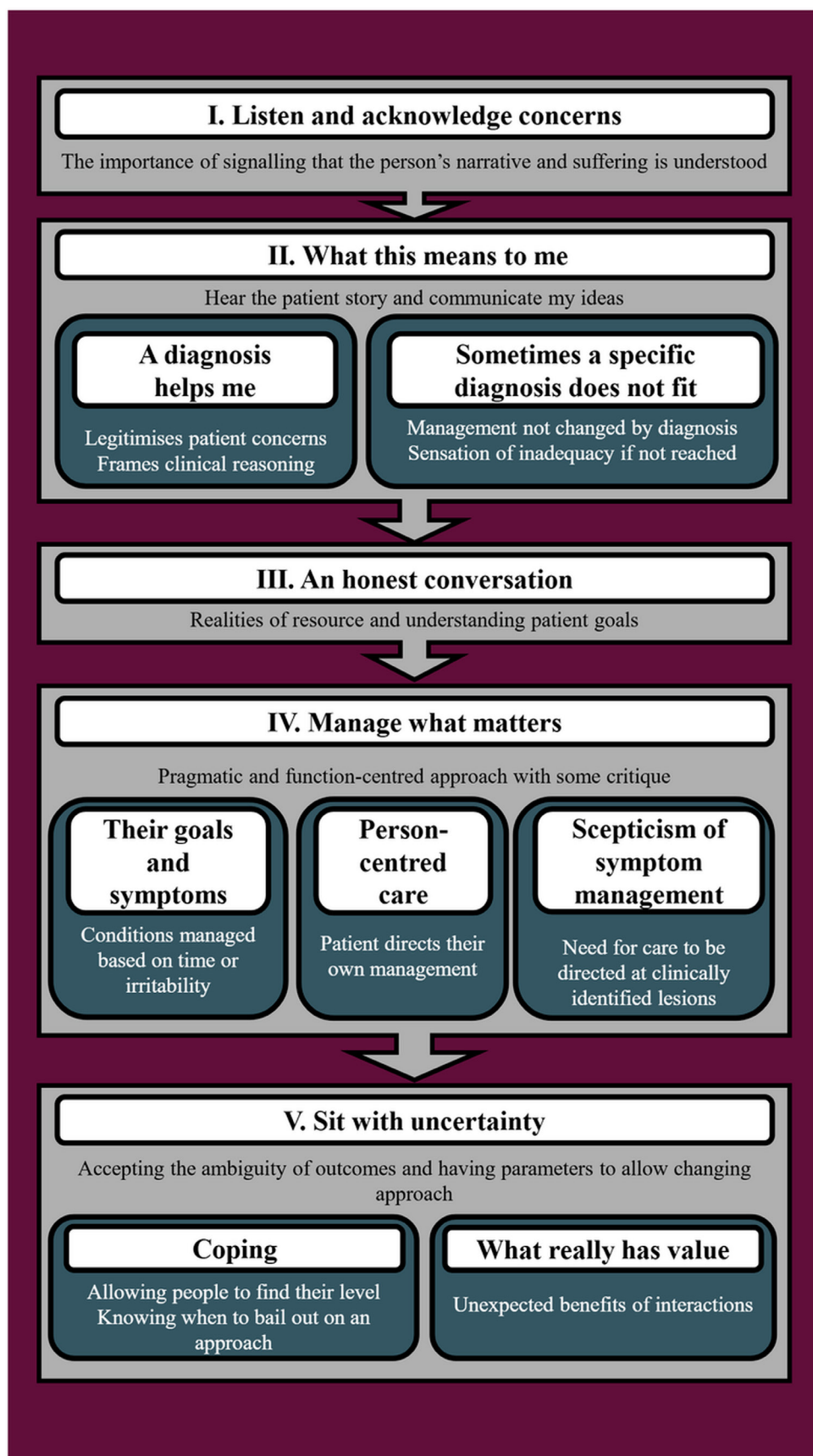


**Figure 2** A conceptual storyline of themes (I–V) and subthemes demonstrating practice behaviour in NTWD. NTWD, non-traumatic wrist disorders.

### Listen and acknowledge concerns

This theme describes clinicians' belief that allowing patients to express their experiences and understanding was central in establishing the trust-based relationship necessary for effective clinical practice. By signalling that the person's narrative and suffering is understood, clinicians establish a safe space for disclosure: "If I distil it down to one thing, they need to feel like they've been taken seriously." (P5, Surgeon).

Listening was seen as more than a technique used to show empathy, as the patient's perspective about their condition was seen as a crucial part of the knowledge gathering, and to allow the establishment of trust and the creation of the conditions for patients to engage meaningfully in their care.

If they have a serious problem, establishing trust from the outset is crucial. My patients are part of the team; I need them to feel comfortable enough to share important history details, allow me to examine them and engage in shared decision-making. They must trust me to follow through with the agreed management whatever it is (P5, Surgeon)

Furthermore, the data highlighted a crucial distinction for patients with non-traumatic wrist problems presenting with greater complexity. For these individuals, the therapeutic value of feeling heard and having things explained frequently outweighed the demand for immediate or 'definitive answers':

The more complex the patient, the more they seem to value being properly listened to and having things explained. Early in my career, I thought patients always wanted an answer, but we don't always have all the answers. (P9, General physiotherapist)

This suggests that for complex cases, validating the experience of uncertainty through deep listening is, in itself, a primary component of care, allowing the clinician-patient relationship to remain intact even when a complete solution is unavailable. The collective accounts frame listening as the essential pre-condition that shifts the patient-professional dynamic from prescribed and passive care to a model of active care and a person-centred partnership.

### What this means to me

This theme captures the clinician's role in co-creating the injury narrative with the patient, a process heavily mediated by the use, or the intentional avoidance, of a specific diagnostic label. Our reflexive approach presented diagnosis to be a boundary object, providing a shared point of reference even though clinicians interpreted and applied the concept in contradictory and sometimes conflicting ways. For some, discovering the specific pathoanatomical structure is a necessary tool for targeted, effective treatment, while for others, it is a potential barrier to honest communication and patient progress from a function-based approach.

### Subtheme: a diagnosis helps me

For clinicians holding this perspective, a structural diagnosis serves a vital multifunctional role extending beyond clinical categorisation. Primarily, this involves clinical efficacy and targeting of treatments where a lesion-based diagnosis is viewed as an essential guide for intervention:

Unless we get the structure that could be causing the problem right, we may not be targeting our treatment to solve the problem...I think it's really important if we can narrow it down to a specific cause to make our treatment effective. (P7, Hand therapist)

This reasoning suggests that a diagnostic label provides necessary precision to focus management and justify therapeutic choices. For some clinicians, this belief is so strong that the absence of a clear diagnosis can undermine the legitimacy of non-specific rehabilitation: "If you don't have a diagnosis, it's a bit pointless doing physiotherapy" (P6, Surgeon). Beyond guiding treatment, specific diagnoses perform broader functions for both the clinician and the patient. For one clinician, reducing symptoms to a diagnostic classification is seen to serve as a crucial validation tool: "sometimes patients have a perspective that because nobody has given them a diagnosis, people are not acknowledging that they have a real problem." (P7, Hand therapist). Critically, diagnosis performs a narrative and social function for the patient. A clear label provides a meaningful framework that helps patients reach understanding and ownership of their condition in a way which is relatable to their support networks:

Some patients really value a clear diagnosis because it helps them understand what's happening, [to] communicate it to family and friends, and legitimise their condition (P15, GP)

A specific diagnosis is highly valued by some clinicians for its advantages, which can be viewed as having both direct and non-specific, psychosocial effects. The application of diagnosis for patient validation and as a narrative and social vessel is a prime example of its non-specific utility.

### Subtheme: sometimes a specific diagnosis does not fit

The alternative perspective challenges both the realism and necessity of reducing diagnosis to an anatomical structure, especially in complex or highly symptomatic NTWD. In acute presentations, "it's impossible to narrow it down to a structure" (P7, Hand therapist), and this was expressed as affecting the clinicians confidence: "Oh no, I don't know what is going on, this is awful- everything is irritable" (P13, Hand therapist).

The consternation associated with failing to reach specific diagnosis and the fortitude required to overcome the anxiety associated with diagnostic uncertainty was expressed. As one clinician reflected, "It is frustrating when the patient says, 'I just want to know what's wrong,' and you're like, 'I would too,' but we might not know." (P13, Hand therapist). Nevertheless, building

confidence in managing diagnostic uncertainty was seen as desirable, and something that develops over time and exposure, with experienced clinicians having the confidence to state “I don’t know” (P13, Hand therapist). This transparency, rather than the label itself, is framed as the key to successful therapeutic relationships “Explain that there might not be a diagnosis and be confident in being honest.” (P8, Hand therapist).

The overarching argument against attempting a specific diagnosis was an acknowledgement that the therapeutic strategy was unlikely to be altered in many clinical scenarios. Rehabilitation was cited as being pragmatically prescribed based on severity, irritability or time, related to the functional limitation of the patient, and remains largely independent of the specific diagnosis:

We just want people to get better, and the names we’ve given things are not always helpful...[if] the main treatment is we’re going to offload it, and they don’t need to know how many tendons you have. (P12, Surgeon)

Furthermore, some clinicians cautioned that diagnosis can be used inappropriately as a “mask” by the “inexperienced to give authority” (P12, Surgeon), suggesting that reliance on a label may sometimes obscure genuine clinical uncertainty.

The negotiation between these two viewpoints underscores the central conflict in modern MSK care for non-traumatic wrist conditions: balancing the desire for certainty and legitimisation, important to both patients and therapists, with the clinical reality of complexity and uncertainty.

### An honest conversation

This theme moves beyond the initial steps of listening and diagnosis, focusing on the crucial phase of therapeutic boundary setting and expectation management. Clinicians described navigating the realities of the resource at their disposal alongside the nature of the patient’s condition. The core function of the theme appears to be facilitating the patient’s changing perspective from seeking a definitive cure to pursuing a path of realistic adaptation and self-management.

Clinicians recognised a professional duty to clearly articulate the resource constraints of their setting (including the limits of National Health Service Patient and Public Involvement for care and accessibility of services) and confronting the limitations of the modalities available, stating: “once I realise there might be limits to hand therapy, it’s about explaining that to the patient.” (P13, Hand therapist). This included acknowledging when further intervention may yield diminishing returns or when the symptom presentation is minor and long-standing: “Are you happy with the natural order of things? Are you willing to wait this out?” (P1, Generalist physiotherapist).

The honest conversation serves as a therapeutic intervention in itself, reframing the patient’s experience towards

acceptance and adjustment. Clinicians consciously avoid negativity, instead adopting a positive outlook that emphasises the potential for living well despite the condition: “rather than saying, ‘Oh, it just won’t get any better, so deal with it’, it’s more about going, ‘You know, this is something you can live with and adjust to’.” (P13, Hand therapist). This shift from problem elimination to functional co-existence is a hallmark of managing chronic or persistent symptoms.

Finally, this theme reinforces the core importance of the clinical encounter highlighting the non-specific therapeutic power of simply paying attention. Despite the emphasis on limits, the very act of having an honest, attentive conversation, regardless of the specific treatment offered, holds intrinsic therapeutic value: “there’s a huge value in just someone paying attention to your problem.” (P12, Surgeon). This highlights that the quality of the interaction is often the most significant non-specific effect in the patient’s experience, overshadowing the perceived complexity of the management strategy.

### Manage what matters

The fourth theme represents the practical application of the clinician-patient partnership. The intervention strategy is targeted towards the patient’s functional goals rather than pathological structures alone. This theme illustrates a strategic shift in focus from disease to person, acknowledging that in many complex cases, therapeutic success is defined by functional adaptation and symptom modulation, rather than anatomical resolution. The theme is characterised by a fundamental divergence in clinical philosophy between an advocacy for patient-driven, symptom-focused management versus ongoing professional scepticism about the predictive power of non-specific approaches.

#### Subtheme: their goals and symptoms

A subtheme comprising a pragmatic, function-centred approach where treatment efficacy is measured by symptom control and goal attainment was developed. For highly irritable or non-specific presentations, clinicians emphasised symptom management over diagnostic precision: “I’d focus on managing symptoms over specific diagnosis with high irritability” (P13, Hand therapist). This approach accepts the current limits of diagnostic certainty and focuses on immediate relief and functional improvements.

Some clinicians recognised the risk of clinical drift, where practitioners prioritise the objective, measurable problem over the patient’s subjective reality. One hand therapist admitted being “caught out working on the objective problem rather than what mattered to the patient” (P13, Hand therapist), highlighting the tension between measurable findings and the patient’s priorities.

A function-centred approach suggested by one therapist where “we don’t have a diagnosis, but we’re going to try this, it might be beneficial” (P13, Hand therapist) implies the principles of management can be effective without targeting a pathoanatomical structure for a trial period. This requires the patient to be “engaged, understands what’s going on, knows the limitations” (P7,



Hand therapist), making the clinical encounter a shared venture with both parties having agency.

### *Subtheme: person-centred care*

Person-centred care emerged not just as an ethos, but as the mechanism of management. The clinician's role is framed as presenting options and facilitating a choice, effectively transferring a degree of agency and ownership to the patient, demonstrated by the statement "I very much involve them in the decision; these are your options [...], 'what type of treatment do you want to take part in?'" (P8, Hand therapist). Clinical behaviour such as this transforms the passive receipt of care into active participation. The ultimate measure of successful intervention is its capacity "to help patients achieve their own goals, their own expectations" (P7, Hand therapist). This reinforces the idea that the treatment plan must be customised to the patient's life context and desired outcomes.

### *Subtheme: scepticism of symptom management*

Concerns about the limits and efficacy of non-specific, symptom-focused approaches, particularly regarding predictive uncertainty and the specificity argument, were grouped in this subtheme. Scepticism was evident, stemming from the challenge of prognosis in the absence of a clear structure-based diagnosis and concerns about failing to identify those who may benefit from specific management at an early stage.

it's going to be difficult to isolate the patients who are going to get better with nonspecific management- When we come across a patient the very first time, who is going to get better and who is not going to get better, who needs the specific intervention and who doesn't, in a very early stage (P7, Hand therapist)

This highlights the professional pressure to work efficiently, to triage accurately and to accept the clinical responsibility for the overall well-being of the patient but also highlights a confidence that specific management should be the default position while placing the onus on others to identify those suitable for non-specific care.

The specificity argument serves as a necessary check against over-reliance on the non-specific effects of the encounter. Some clinicians voice caution that therapeutic effectiveness cannot be attributed solely to rapport or time, underscoring a continued belief in the power of specific, targeted intervention. One hand therapist noted that they were "... sceptical that empathy or time are the only things that makes a patient better" (P7), reflecting on value placed on management and underlying clinical reasoning.

### *Sit with uncertainty*

This final theme captures the complex, endpoint reality of clinical practice where even the most structured and person-centred approaches yield unpredictable outcomes. This requires the clinician to move from the active planning phase to a posture of reflective observation and humility. Our

interpretation of the data highlights the reliance on patient resilience for long-term success, coupled with the necessity of clinical judgement to determine when to pivot from a generic management pathway to a specialist one.

### *Subtheme: coping*

Here, the patient's capacity for coping is linked with the clinician's responsibility to set parameters for safe, time-limited generic care, recognising when escalation is necessary. "I see horrendous conditions that people manage to cope with" (P11, Generalist Physiotherapist) reflected clinician's deep belief in the patient's inherent capacity to cope and adapt to symptoms and functional limitations, often drawing inspiration from observing individuals with significant disability:

most people can cope with most things in life, even injury and disability. Working in disabled sports, I see what people miraculously achieve. (P11, Generalist Physiotherapist)

However, this resilience is dependent upon the process of engagement, specifically, involving the patient in a 'shared decision-making process' to foster ownership and prevent blame if the outcome is suboptimal.

The pragmatic use of generic or non-specific management is supported by the crucial caveat of knowing "when to 'bail out' on that generic approach" (P5, Surgeon). This reflects a sophisticated understanding of triage while balancing the cost-effectiveness of a general approach initially with the ethical responsibility to recognise a lack of progress or signs that warrant specialist intervention. This decision-making, often based on duration of symptoms or severity, is necessary to prevent a small group of patients from receiving inadequate or delayed care:

Do we want to go down the specialist route right from the beginning when we don't necessarily need that intervention for every single patient? But there is also a little group of patients who could possibly get worse if they don't get the right information at the right time. (P7, Hand therapist)

### *Subtheme: what really has value*

This subtheme captures the therapeutic impact of the clinical relationship itself, which often surprised the clinician. In recalling reflections of clinical encounters received from patients, it was recognised that the effectiveness of care is not solely attributable to the specific technical intervention. Instead, the non-specific effects, the quality of the interaction, attention and respect are often the primary determinants of patient satisfaction and perceived value:

Patients often thank you for the most unexpected reasons, not always for giving them an effective treatment. (P15, GP)

While effective treatment is useful, its' not the only thing (P14, FCP)

The ethical and practical bedrock upon which all specific treatments rest was frequently raised by the participants. One

surgeon observed, “I am sure that if somebody treats you poorly, you’re not going to respect what they have to say” (P12), crystallising the idea that poor relational quality can affect the therapeutic potential of even technically competent care.

This final theme shifts the clinician’s success metrics from symptom eradication to facilitation of patient coping and resilience, highlighting that the human elements of respect, honesty and attention ultimately underpin all clinical outcomes.

## DISCUSSION

NTWD have been found to pose a significant clinical challenge due to their diagnostic opacity, the absence of established clinical guidelines and resource limitations that impede evidence-based care with knowledge gaps identified around practice behaviour.<sup>3 4 15</sup> We aimed to examine how clinicians from different settings and backgrounds employ clinical reasoning when selecting management options, exploring their confidence and assessing their satisfaction with the resources available. Our findings do not support reasoning based on silos of profession or clinical setting, but instead provide a rich, nuanced understanding of how these complexities are navigated, revealing practice underpinned by professional integrity, pragmatism and a deep appreciation for the patient’s role in their own recovery. Five themes collectively describe the transition from initial encounter to long-term adaptation: establishing relational trust, negotiating the injury narrative, setting realistic boundaries, actioning functional goals and accepting outcome uncertainty.

The primacy of honesty and professional integrity was threaded throughout the clinician accounts, beginning in our first theme ‘Listen and acknowledge concerns’. Listening transcended mere empathy to become an act of conferring epistemic authority to the patient, recognising their perspective as containing serious and necessary knowledge about their condition. This relational foundation was deemed critical, particularly for complex presentations, ensuring the patient felt ‘taken seriously’ and thus enabling their full engagement in shared decision-making. This approach differs from traditional paternalistic models of healthcare, which have been criticised for being overly reactive and condition focused.<sup>16</sup> Involving the individual as an active partner in their care is consistent with person-centred care which aligns with the biopsychosocial model of care and is a primary commitment of the NHS long-term plan,<sup>17 18</sup> indicating a responsiveness to fundamental shifts in healthcare delivery.

This commitment to honesty was rigorously tested by the theme ‘An honest conversation’. Here, integrity required clinicians to explicitly set therapeutic boundaries, communicating the realities of available resources and the limits of intervention. By pivoting the goal from definitive cure to realistic adaptation, clinicians implicitly acknowledged the poor evidence for the methods of management at their disposal and demonstrated that therapeutic success often required

managing expectations with transparency, rather than offering false certainty.

However, although valuing person-centred approaches and understanding the limitations of the methods of assessment and management at their disposal, a number of practitioners held biomechanical reasoning as a lens to view their practice and strongly advocated for this. The theme ‘What this means to me’ revealed this divergence, although silos of reasoning were not found to be solely based on professional group or clinical setting. The tension between ‘A diagnosis helps me’ and ‘Sometimes a specific diagnosis does not fit’ highlights the practical challenges posed by NTWD, where anatomical pathology often fails to correlate with symptom presentation, and the ways in which management is altered by reductive reasoning is unclear.<sup>4 19–25</sup> It is possible that the strong conviction towards specific diagnosis and management reflects the historical reliance on biomedical reasoning and the orthopaedic model, and the structure of secondary care management for wrist and hand conditions which tends to be specialist-led. Critics argue attempting to use biomedical reasoning as the primary driver for non-traumatic MSK conditions has fuelled overmedicalisation of non-harmful conditions, resulting in overdiagnosis and the diversion of limited resources towards low-value treatments based on fixing pathoanatomical structures.<sup>26–31</sup> The downstream effects of this have led to an increasing financial and societal burden of non-traumatic MSK problems that is of significant concern to policy makers and governments alike.<sup>32–34</sup> This study highlights the tension between the specific ‘biomedical’ approach and the more pragmatic patient-centred non-structure specific approach. Clearly the devil lies in the detail, fitting with the ‘sitting with uncertainty’ and it may be that the real expert skill in managing these complex disorders is in how one blends a degree of both approaches in a way this fits with the individual patient and the best evidence. Balancing nonspecific versus specific reasoning is the art of clinical practice, and evidence can only chip away to resolve uncertainties in a rather slow and cumbersome manner.

Regardless of the diagnostic narrative, pragmatism rules in management. Even those who highly valued a specific diagnosis (for its role in treatment targeting and patient legitimisation), the ultimate management strategy shifted towards a function-centred approach. The clinical imperative was to get the patient moving forwards, regardless of the full certainty of the label. This pragmatic, goal-directed management style shows that clinical effectiveness is ultimately measured by functional gain and symptom modulation, not diagnostic precision.

The final themes powerfully underscore that clinical help is limited and finite. Through ‘Sit with uncertainty’, clinicians acknowledged hard-to-predict outcomes and the significant contribution of non-specific effects to patient outcomes. Interviewees were often surprised by ‘What Really Has Value’ to the patient, frequently attributing success not to technical interventions but to the intrinsic therapeutic value of attention, respect and time. This has resonance with other qualitative work where people who seek help for long-term musculoskeletal conditions often understand they are

unlikely to improve through the primary effect of the rehabilitation interventions used, but is worthwhile overall because of what they had learnt and the progress they had made.<sup>35</sup>

These findings reinforce a crucial, sobering observation: Ultimately, most of the time, people cope on their own. Clinicians recognised that their involvement, while vital for initial guidance and symptom management, represents a limited phase in the patient's life journey with their condition. Effective practice, therefore, requires recognising when to 'bail out' generic care but also recognising when the primary work of adaptation must be carried out by the patient. The explicit acknowledgement that the persistent problem is the patient's, not the clinician's, is vital to maintaining professional objectivity and preventing the clinician from placing their own need for certainty or success ahead of the patient's need for guidance and eventual self-reliance.

In conclusion, effective management of NTWD appears to rely less on a rigid biomedical model and more on the clinician's ability to maintain high ethical standards through honest communication, pivot pragmatically towards functional goals and humbly acknowledge the profound resilience and coping capacity of the patient.

### Strengths and limitations

We employed a qualitative study design to explore clinical stakeholders' experiences and perceptions of the current management of non-traumatic wrist disorders. Qualitative research is inherently interpretive, with the aim of generating meaningful understandings of phenomena rather than achieving reliability, validity or objectivity as defined by quantitative paradigms. From this epistemological position, subjectivity and interpretation are considered methodological strengths. Accordingly, our analytic focus centred on developing credible and contextually grounded interpretations of participant accounts. The aims of the study may be overly specific to fully support an inductive approach; however, the alignment of results with the original aims and subquestions was achieved in general terms, although detailed insights regarding specific management options and participants' satisfaction were limited by the data obtained from the interviews.

Several strategies were used to enhance the trustworthiness of the findings. The semistructured interview topic guide was informed by priority questions identified by a mixed stakeholder group and by findings from previous work in a wider research programme.<sup>3 5 7</sup> Recruitment of a diverse sample of clinical stakeholders supported the transferability of the findings across settings. An external auditor contributed an independent perspective, strengthening the rigour and criticality of analytic processes. Nonetheless, as participants were recruited from clinicians who had previously volunteered through a survey, it is possible that those less engaged with research activities may hold alternative or additional views. Credibility was further supported through regular team debriefing and data meetings, which were used to challenge, refine and extend interpretive insights.

### CONCLUSION

This study provides the first description of UK clinicians' practice behaviour regarding NTWD across professional groups and healthcare settings. The findings reveal that effective care is driven by a sophisticated blend of professional integrity, relational skills and clinical pragmatism, particularly when faced with diagnostic uncertainty and resource limitations.

### Practice implications and insights

The five themes, 'Listen and acknowledge concerns', 'what this means to me', 'an honest conversation', 'manage what matters' and 'sit with uncertainty', map a clear, person-centred pathway that prioritises the quality of the clinical encounter over reliance on a specific diagnostic label. Diagnosis remains a contested area. While some clinicians seek diagnostic certainty for targeted treatment, the majority employ a pragmatic, function-centred approach. They accept that the therapeutic value of the clinical encounter (eg, validation and attention) often outweighs that of specific targeted interventions, reinforcing that clinical success is frequently defined by functional adaptation rather than anatomical resolution.

The widespread commitment to honesty and shared decision-making is critical. Clinicians actively manage expectations by communicating the realities of resource limitations, thereby empowering patients to assume ownership of their condition and pursue realistic adaptation when a full cure is unavailable.

This deeper understanding of clinical decision-making and practice behaviour is valuable within an evolving healthcare landscape, where non-specific and complex musculoskeletal presentations are increasingly common in primary and secondary care.

### Future directions

Ultimately, the study underscores the fundamental reliance on the patient's coping capacity and resilience. The clinician's role is not to eliminate the problem, but to act as a facilitator for self-management, setting the conditions for the patient to eventually manage their condition independently.

Future studies into NTWD would benefit significantly from stakeholder involvement (patients, policy makers and clinicians) to collaboratively identify improvements to the future package of care offered, ensuring that services effectively align with the patient-centric, pragmatic approach observed in these findings.

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