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The Effect of the Communication Skills Training on Physiotherapy Education

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Abstract

The purpose of physiotherapy practice is to maximize movement to enable enhancement of functional capability in the life of peoples. The process of effective communication between therapist and patients is the major focus of accomplishing these goals. Two of the established approaches used in health communication are the bio psychosocial model and the patient-centered care which has been advocated to be used as a guide in the physiotherapy practice. In this chapter, with the help of examples of communication in practice that are obtained empirically, we discuss the possible existence of connections between these approaches and communication in physiotherapy and its nature. We derive information about two different qualitative surveys of communicative interactions in primary practice physiotherapy settings. The results of these two studies have shown that physiotherapy clinical communication is put into place and steered by physiotherapists, as well as being flexible and responsive with reference to the needs of a specific patient. Even though communication was systematic and clinically focused, it was indicated that adjustments such as casual conversation, humour and touches were subtle mediating forces. These were communicative adaptations that were dynamic, interpretive and relational that took place in the interaction between a patient and a physiotherapist. These results do not compare with the patient-centered and bio psychosocial approach in descriptions to communication that emphasize how the patient perspective should be mentioned clearly in communication. We have the potential explanations of the perceived gap between communication theory and practice in physiotherapy as discussed in our discussion. Overall, the articles point to the fact that more research should be conducted on reference to

examining the physiotherapy communication processes to produce the interactional theories as a representation and framing of the physiotherapy clinical communication.

Introduction

The one of the established principles and philosophy of the physiotherapy practice is that very foundation and the basis of all the treatment processes is the enhanced theory and the existing evidence (Hills & Kitchen, 2007; Moseley, Herbert, Sherrington & Maher, 2002; Trede & Higgs, 2009). This perfection is also applied to communicative procedures and deliberation thinking necessary to engage in clinical reasoning, and ethical and reflective conversation. All these theories and evidence regarding skills, knowledge, and values incorporated in physiotherapy practice can be basically described as conceptual explanations as to how and why procedures and paradigms of treatment are performed effectively (Reeves, Albert, Kuper, Hodges, 2008). Again, communication theories are meant to provide those in the department of physiotherapy with a means in which to explain how, when, and what format to collect information about a patient and how to provide information, advise, educational materials, and support back to a patient (Schiavo, 2007).

In order to progress the study and technique of health communication when applied to the field of physiotherapy, a combination of an inductive (obtained on the basis of real practice) and deductive (based on a research base or as a philosophical theory) analysis is necessary (Schiavo, 2007). There are four main parts in this chapter. We start with results of a study regarding communication in the patient-physiotherapist encounter in the private practice which was mostly inductively gained. Secondly, we introduce some of the main characteristics of two theoretical methods of communication which have a long history: the patient-centered and bio psychosocial methods. Third, we examine and explain how our empirical results can be linked to these theoretical approaches and why this leads to the following discrepancies. At last, our conclusions emphasize the necessity of theoretically-oriented research on the peculiarities of ideal communication within the physiotherapy practice.

Communication is integral to physiotherapy Practice

In physiotherapy, communication is one of the core professional competencies contained in a physiotherapy code of conduct (Health & Care Professions Council, 2013; Physiotherapy Board of Australia, 2014; WCPT, 2011). The physiotherapist, via the communicative process, opens knocking the door to the life of the client can teach, inspire, empower or dis empower, show empathy or power, express interest and develop trust (Hiller, 2017). The questioning processes of physiotherapists can guide the quantity and nature of information they acquire concerning the situation of the person and situations and promote or hinder the abilities of patients to speak what is important to them regarding their health and wellbeing (Afrell & Rudebeck, 2010).

The communication between therapist and patient is getting increasingly acknowledged as a therapeutic process, due to its ability to have a direct impact on patient outcomes (Hall,

Ferreira, Maher, Latimer, & Ferreira, 2010; Jeffels & Foster, 2003; Klaber Moffett Richardson, 1997). As an example, the impact of specific communicative strategies, including motivational interviewing and counseling, on the results of physiotherapy intervention is becoming an issue of scientific interest (Lonsdale et al., 2012; OSullivan, 2012). Research has also revealed that there is a perception in the minds of patients that one of the major attributes of good physiotherapy is the communicative ability of therapists (Cooper, Smith, & Hancock, 2008; Potter,Gordon & Hamer, 2003).

Two studies of communication in physiotherapy

Results in the studies offered in this chapter are based on two PhD projects (Delany, 2005; Hiller, 2017) which provided an exploration of the way physiotherapists communicate with their patients. The investigation was carried out separately (twelve years later). Both also gathered audio-tapped one on one interaction of communication between patients and physiotherapists in primary treatment practice of Australia. Despite the part of these studies being published (see Hiller, Guillemin, & Delany, 2015; Hiller, 2017; Delany, 2005), the results of the research were not assembled before.

The study 1 (carried out in 2005), examined the way physiotherapists inform their patients and secure their informed consent to treatment (Delany, 2005). The material included seventeen transcription of audio taped treatment sessions and interviews with the included physiotherapists. The communication was recorded and analyzed in interpretation methodology (Packer & Addison, 1989). It concentrated upon how ethic of the communication being discriminatory of a patients autonomy in the private practice setting is represented by the communication in the field of physiotherapy.

Study 2 (which was held in 2016) was aimed at describing the process of communication in practice and comparing the results with the accepted methods of healthcare communications (Hiller et al., 2015; Hiller, 2017). Based on the same interpretivist framework, study 2 applied the element of ethnographic and grounded theory approaches to this study and included observations and audiotapes of 52 patient-physiotherapist meetings. Data were analyzed inductively, that is, using procedures of transcription, data coding, memo-writing, and concept mapping outlined by Braun and Clarke (2007) and Charmaz (2006).

Both studies received ethics approval by the Human Research Ethics Sub-committee at the University of Melbourne: ethics ID DPH 1/2003 (study 1) and ethics ID 1238974 (study2).

Both studies had their subjects acquiring informed consent. The two studies used the same approach although their purposes were different. The authors met a number of times to compare and contrast results of both studies. The trends of communication that we observed in our analysis of the findings demonstrated strikingly similar patterns of the communications that take place in the course of the physiotherapy practice at a private level. Such patterns consisted of:

- Reproducible and reproducible communiqué frameworks that shift

during stages of the therapeutically session;

- a general attitude of prescriptiveness of the therapist

dominance of the agenda of the physiotherapist;

- an intensity of responsiveness and readiness to adapt to the person

patient to enable him/her to understand and connect with him/her.

Compared to the theme of study 1 that read structured communication: building fences, the theme indicated the same trend of communication that took place during patient-physiotherapist interactions. The bio medically oriented information in the communication has been steered by physiotherapists and followed the same pattern as outlined by Jones, Jensen and Rothstein (1995). One characteristic of the systematic approach was finding information systematically to come up with hypotheses. It is to go on to test those hypotheses. The words employed in the approach were objective and precise to the extent that sometimes they would be comprised of short closed questions by the therapist and short answers by the patient. This communicative method stands also to be credited with the following has been identified in the other descriptions of the communicative and cognitive activities in clinical reasoning presented by other authors (Jensen, Shepard & Hack, 1990; Parry, 2004; Talvitie & Reunanen, 2002).The structured pattern is evident in the following example:

Physiotherapist: What sort of pain?

Patient: Um, it's like a sharp pain.

Physiotherapist: Is it there all the time?

Patient: No. Umm.

Physiotherapist: So it just comes back?

Patient: Sort of when I twist, when I'm twisting or moving.

Physiotherapist: Twisting and moving?

Patient: Yeah.

(Study 1, treatment encounter 5)

An overall message of expertise, authority, and certainty was conveyed through the physiotherapists' structured communication.

There was also a corresponding, but largely unstated assumption that the patients would comply with the therapist's agenda.

This pattern is demonstrated in the following example:

Physiotherapist*:* Alright. Then. You have come to the movement… test. So I would like to look at your middle back first.

Patient: Mmm.

Physiotherapist: If you would like to put your hand like this.

Right. Is there any pain?

Patient: No.

Physiotherapist: Okay. Try and keep your elbows together, and

try to point it up towards the ceiling. That's good.

Patient: I'm feeling it sort of now.

Physiotherapist: Try and go a bit further. There, okay?

Patient: Yep.

Physiotherapist: How about trying to touch your opposite shoulder with your elbow. Does that still hurt?

Patient: No, that feels fine.

Physiotherapist: Elbows out like this. Try to turn. Anything?

Patient: No.

(Study 1, treatment encounter 8)

Physiotherapist: How have you been since last week?

Another theme of communication in study 1 was that of communication breaks or as they referred to as gaps in the (communication) fence.

These were termed as mini differences in the organized conversation going on between patient and therapist. Physiotherapists used different protocols like watching and pausing to listen so that to sense the level of comfort, engagement and the reactions of patients in the course of treatment. Small alterations in communication like the open questions approach were employed to fit the interaction with the unique patient and to provide a chance to the patient to implement their agenda. Physiotherapists, nevertheless, hardly ever questioned the patients in direct terms of their opinion or perception, and they dominated all the loopholes and modifications of the communication fence.

One of these gaps can be shown in the example below. It had an open question put by the physiotherapist followed by a space where the patient would write the answer. The characteristic feature of this extract is pauses implying that the physiotherapist was listening and encouraging the patient to give details.

Patien*t*: Well after my workout with you, that night it was terrible, I got home and I, before I went to bed, I did those…the exercises and might have done it too much, I'm just not sure…um, you know…and that was a bad night, but then the night before last I found I could lie on my side…. And whenever I think of it I'm doing my tummy pulling,
but I found that very difficult to do…. I'm thinking of it.

Physiotherapist: Good….

Patient: You, know. I'm thinking of my posture a lot more too.

Physiotherapist: Well done. It will probably get easier to do it when you're doing activities as well and I guess it's, as much as anything it's almost on the return from bending over that you need to draw the tummy in to support the spine.

(Study 1, treatment encounter 14)

The procedure of the developing the holes in the fence by manipulating the routine

structure appeared to reflect one of the methods of creating an opportunity to speak more, on the part of the patient. It was a method which is widely applicable among research participants.

In study 2 also two main themes were frame. The physiotherapist led communication was a theme communicating that many processes of communication were led by physiotherapists. It was observed that physiotherapists made their treatment session follow a pattern, which featured a simple introduction, the discussion of presenting problem, physical examination, treatment and teaching followed by a conclusion. In this framework of interaction, physiotherapists also steered the conversation by starting it up in their speech, asking mainly closed questions, also interrupting or digressing in communication and communicating in biomedical language. Furthermore, almost every decision was communicated in a treatment episode, except in the case of physiotherapists. These included: objectives of treatment, nature and level of treatment, at home exercise programs, and at what time patient is expected to resume his/her next appointment. Figuratively speaking, the physiotherapist in the next passage formulated goals and decisions regarding exercises the patient underwent, home regimen and the time he was supposed to come back and carry on treatment.

Physiotherapist: So your goals for me mainly are –to add another day of walking.

Patient: Yeah.

Physiotherapist: Continue doing the exercises.

Patient: Yeah.

Physiotherapist: Um… and… yeah and we'll touch base in the new year and see how your back is feeling then. And I also want you to keep an eye on how the mornings are going.

Patient: Yeah.

(Study 2, treatment encounter 40)

A regular emphasis on pain and set of biological aspects of patient conditions has also been introduced in the physiotherapist-led communication theme. The given example is that of repeated posing of closed questions by a physiotherapist regarding pain.

Physiotherapist: When I press is there any pain here?

Patient: It was no very much.

Physiotherapist: Nothing much? What here?

Patient: Nup.

Physiotherapist: Now that, is pain?

Patient: Oh, a bit, not very much.

Physiotherapist: But, when I touch here it hurts?

Patient: Yep (a bit aggrieved).

Physiotherapist: It is the muscle then.

Study 2, treatment encounter 1 (Study 2, treatment encounter 1)

These transcript excerpts also indicate how the communication was controlled by physiotherapists as all questions and discussions were made by them with patient usually giving brief answers.

The second major theme of study 2, which was fitting to establish rapport, identified numerous aspects of communication that went on between patients and physiotherapists that responded to the needs of specific patients- and seemed to be oriented to the need to establish rapport. As an example, the touch was adapted by changing hand placement of the therapist, rhythm as well as pressure of the therapist during manual treatment. As shown in the next transcript e.g. touch of the physiotherapist changed in accordance with a response of a patient.

Patient: Ha ha ha ha (laughing)… Ohhh that hurts badly
ah he (in a pained expression). So um.

Physiotherapist: Far too gentle (hands were seen to soften and go slow)
in response).

Patient: Thank… You are [name of physiotherapist] yes. Ah he
he. It is just that, my, my um, my muscles feel sensitive…. As I have said I
unless I had the confidence with you of coming back at all.
and I know it hurts in the end that it is better in the long run you know.
Hehehehe.

Physiotherapist: Oh (little smile).

Study 2, treatment encounter 17

In line with this, a form of a caring touch like touching the shoulder patient was also seen to have been used by physiotherapists as a form of adaptation which gave the sense of being understood. It also was observed that physiotherapists: altered their positions in the body, to mirror and suit that of their patients; used eye contact usage and loss frequently and dependant on the consideration of their patient; used their casual, conversational tone with their patients; and used humour. In their turn, patients modified their interaction in accordance with the physiotherapists and achieved it by employing body positions, nodding their heads and, most importantly, humour, as a way to show their involvement and role in the situation.

These communicative means were also actively involved in the treatment talks between patients and physiotherapists along with the physiotherapist-directed elements of the communication process.

The parallels are to be noted between the way therapists should speak with their patients in these two studies, considering that in both studies the communication methods between therapists and patients were studied in terms of behavior and a certain degree of manipulation, although the general focus of the studies was different with the first study being carried out ten years before the second. The governed themes namely, structured communication: building fences and physiotherapist-led communication have illustrated a communication style, which is controlled by the therapist and which has been depicted in other studies as well. Specifically, the

results of the study in Denmark and the United Kingdom showed that little to no involvement of patients in decision-making is applied by physiotherapists during the treatment sessions (Dierckx, Deveugele, Roosen, & Devisch, 2013; Jones et al., 2014).

It has been proven in other studies of communications that physiotherapists are the chief movers of the goal-setting process (Parry, 2004); talk more than twice as much as patients (Roberts & Bucksey, 2007); communicate with closed questions (Cruz, Moore, & Cross, 2012; Opsommer & Schoeb, 2014); and they majorly talk about (Opsommer & Schoeb, 2014).
inhibit inclusion of the patient view (Josephson &Bulow, 2014; Opsommer &Schoeb, 2014); and prevent information on pain and knowledge of clinical state (Cruz et al., 2012; Opsommer &Schoeb, 2014).

Communicative dominance in the case of physiotherapists is duly filled by another strong finding of adaptation (study 2) and gaps in the fence (study 1). These revelations indicate that subtle communicative strategies can also be taking place in countries of the world such as the United States patient-physiotherapist encounters. Although the physiotherapist is the leader in the interaction, the interaction includes the dynamic and interpretive and relational elements. Although the ordering of the communication is structured through the clinical orientation of the communication, which acts to manage the overall course of the communication, there are some mediating forces here.

These forces or influences involve the use of conversational casual and humour, the use of touch not only in an attempt to provide a form of therapy, but also to express interest, care and attention. In these two studies, the analysis of their results described physiotherapy communication as an amalgamation of structured, directed, negotiated and adapting interactions. However, additional studies are required to look into the explanations that therapists have of these styles and their influence to the patients.

Another study has also drawn attention to another point, silent, yet receptive, in physiotherapy communication during clinical practice (Bjorbaekmo & Mengshoel, 2016; Tasker, Loftus, & Higgs, 2011; Thornquist, 1991). Tasker and colleagues (2011) describe the role of casual conversation and active listening in creating responsive relationships between the patient and the physiotherapist in the community aspect. The overall communication presented by physiotherapists is also highly responsive as it is evident in the article by the authors Bjorbaekmo and Mengshoel (2016) who explained the nature and effect of touch in the therapeutic context.
Thornquist (1991) explained how physiotherapists would use eye gaze to show their interest in every patient and to make the continuous changes in both the positioning of the patient and physiotherapists during physiotherapy consultations. Together with our findings, these findings confirm that there is an adaptive and responsive element of the language of patient-physiotherapist communication. According to Tasker and her co-authors (2011), this responsiveness establishes a relationship, a rapport between the patient and therapist. Other than these studies where the authors made a certain purpose out of the communication by

therapists, the issue this chapter is trying to find out is the relationship between our empirical findings and major approaches to healthcare communication.

To be able to carry out this analysis we have, in the second half of this chapter, described some of the key characteristics of patient-centered and bio psychosocial approaches.

Key features of biopsychosocial and patient-centred theoretical approaches to communication

The patient-centered and bio psychosocial models in physiotherapy, just like in any other form of healthcare profession, have been adopted as the defining element in how the practitioners should interact and communicate with their patients (Pinto et al., 2012; Sanders, Foster, Bishop & Ong, 2013). The concept of healthcare of a bio psychosocial approach is based on the belief that ill health, or physical incompetency is not really based on a physical issue only, but also as a result of the emotions as well as a component of a person, his or her ideas of health and things and situations occurring in his or her life (Engel, 1977). Applied to health communication, the bio psychosocial approach obliges a practitioner to consider biological, social, and psychological data during assessment, diagnosis, treatment, and communication with his or her patient (Engel, 1978; Epstein et al., 2003). All these three inter-related components of communication are to be deliberately selected and incorporated in clinical interactions. Roter and associates (1997) referred to bio psychosocial communication by referring to it in that practitioner incorporated more social talk and minimum practitioner questions in a bid to attain some form of balance between biomedical and psychosocial information. In more recent years, Smith and colleagues (2013) implied the application of open-ended questions as the demonstration of such approach.

Bio psychosocial approach has much relation to the patient-centered approach of communication. General characteristics are that communication is overtly utilized in discharging of information as well as responsibility, lower down the perceived power disparities, and include the requirements and insights of individual patients (Bensing, 2000; Mead & Bower, 2000). In a patient-centered approach, communication is employed to show respect of, and inclusion of, individual knowledge and experience of each patient (Bensing, 2000; Byrne & Long, 1976). In order to be patient-centered, it seeks to use communicative devices to invite and integrate the narrative nature and the experiences of the patient into the context of informing and constructing the encounter (Epstein & Street, 2011). The patient-practitioner relationship is considered as an alliance and the care is a joint decision. The particular communication specificities are the use of open-ended and non-direct requesting questions; addressing and discussing emotional components of the experience of a person; not interrupting the patients (Epstein & Street, 2011; Grol, de Maeseneer, Whitfield, & Mokkink, 1990; Mead & Bower, 2000; Smith, Fortin, Dwamena & Frankel, 2013; Winefield, Murrell, Clifford, & Farmer, 1996).

Conclusions

This chapter contrasted physiotherapy communication in the physiotherapy treatment encounter with the two popular theoretical approaches to healthcare communication: bio

psychosocial model and patient-centered care. These two pioneering methods stressed on the significance of decentralizing the power vested in the practitioner (provider) to the patient and the necessity to integrate the viewpoint and inclination of each patient in the process of communication. We did not find such focuses in our studies, carried out in the sphere of physiotherapy private practices. Rather, our results proved that regardless of physiotherapists being receptive and willing to consider a specific need and concern of a patient, the prevailing style of interacting appeared to be the practitioner-centered one. Even though the physiotherapy profession embraces the notions of patient-centered And bio psychosocial (National Physiotherapy Advisory Group, 2009; Physiotherapy Board of Australia, 2014), our results indicate that the attitude of therapists towards care, treatment, communication (in the primary practice location) is entrenched.

They are biomedical inspired. In the present chapter, we have attempted to provoke deeper thought and discussion and an interest in physiotherapy communication to be theorized.

The characteristics, aims, and styles of physiotherapy communication must be explained and analyzed in details to investigate the possibility of the bio psychosocial or patient-centered approach or another approach which will take into consideration the specificity of the communicative purposes of the physiotherapy treatment. Such results raise some questions that should be answered based on future research. Such questions are: How is physiotherapy communication applied to instruct, inspire, embolden, debilitate, show compassion, power, humility and interest in assorted clinical scenarios? What do patients say about the effectiveness of physiotherapy communication strategies? Which kind of theory of communication can be discussed? Contextualize and justify the involvement of communication within the physiotherapy professional practice?

Other opportunities arising out of the comparison in theory and practice of communication communicated in this chapter by physiotherapy educators is how other theories on behavioral and social sciences (several of which are addressed in this book, see also

The goals and strategies of communication may be framed and elucidated according to the concepts suggested by Schiavo, 2007).

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