

Manipulating practices

A critical physiotherapy reader

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CHAPTER 13

Communication in physiotherapy: challenging established theoretical approaches

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Abstract

Physiotherapy practice aims to optimize movement in order to improve functional abilities within peoples' lives. Effective communication between patient and therapist is central to achieving these aims. The biopsychosocial model and patient-centred care are two established approaches to health communication and are promoted as frameworks to inform physiotherapy practice. In this chapter, we use empirically derived examples of communication in practice to explore whether and how these approaches are related to communication in physiotherapy. We draw data from two separate qualitative studies of communicative interactions in primary practice physiotherapy settings. Findings from these two studies demonstrated that physiotherapy clinical communication is structured and physiotherapist-directed, and is adaptive and responsive

to the needs of the individual patient. Although communication was structured and clinically orientated, findings suggested that adaptations such as casual conversation, humour, and touch acted as subtle mediating forces. Such communicative adaptations represented dynamic, interpretive, and relational components occurring in patient-physiotherapist interactions. These findings contrast with descriptions of patient-centred and biopsychosocial approaches to communication which focus on how communication should explicitly include the patient's perspective. Our discussion provides possible explanations for the apparent discrepancy between theory and practice of communication in physiotherapy. Taken together, the studies highlight a need for further research examining physiotherapy communication processes to generate interactional theories that both represent and frame physiotherapy clinical communication.

Introduction

A recognised tenet and philosophy of physiotherapy practice is that all aspects of treatment are grounded in and guided by relevant theory and available evidence (Hills & Kitchen, 2007; Moseley, Herbert, Sherrington & Maher, 2002; Trede & Higgs, 2009). This ideal extends to the communicative processes and deliberative thinking required for clinical reasoning, and ethical and reflective communication. Theories and evidence about skills, knowledge, and values inherent in physiotherapy practice provide conceptual explanations of how and why procedures and treatment paradigms work (Reeves, Albert, Kuper & Hodges, 2008). Similarly, theories of communication in physiotherapy should help practitioners to clarify how, when, and in what format, to obtain information from a patient and how to give information, advice, educational material, and support back to the patient (Schiavo, 2007).

To continue to advance understanding and practice in health communication applied to physiotherapy, a mix of inductive (derived from actual practice) and deductive (derived from a research base or philosophical theory) analysis is required (Schiavo, 2007). This chapter has four main sections. We begin by presenting findings from research about communication occurring in the private practice patient-physiotherapist encounter that were largely inductively derived. Second, we present key features of two established theoretical approaches to communication: the patient-centred and biopsychosocial approaches. Third, we analyse whether and how our empirical findings relate to these theoretical approaches and discuss likely reasons for the resultant discrepancies. Finally, our conclusions highlight the need for theoretically-driven work regarding the specifics of optimal communication in physiotherapy practice.

Communication is integral to physiotherapy practice

Communication is included as one of the core professional competencies in physiotherapy codes of conduct (Health & Care Professions Council, 2013; Physiotherapy Board of Australia, 2014; WCPT, 2011). Through their communicative interactions, physiotherapists can educate, motivate, empower or disempower, express empathy or authority, demonstrate interest, and build trust (Hiller, 2017). Physiotherapists' processes of questioning can direct the amount and type of information they obtain about a person's condition and circumstances and facilitate or impede patients' capacities to express what matters to them about their health and wellbeing (Afrell & Rudebeck, 2010).

The process of communication between therapist and patient is increasingly recognised as therapeutic in itself, because of its

potential to directly influence patient outcomes (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010; Jeffels & Foster, 2003; Klaber Moffett & Richardson, 1997). For example, there is growing research interest in the effects of particular communicative techniques, such as motivational interviewing and counselling, on outcomes of physiotherapy treatment (Lonsdale et al., 2012; O'Sullivan, 2012). Studies have also shown that patients perceive that therapists' communicative capacity is a pivotal characteristic of good physiotherapy (Cooper, Smith, & Hancock, 2008; Potter, Gordon & Hamer, 2003).

Two studies of communication in physiotherapy

The studies presented in this chapter draw from two PhD projects (Delany, 2005; Hiller, 2017) that examined how physiotherapists communicate with their patients. The studies were independently conducted (12 years apart). Both collected audio-recordings of the one-on-one communication between patients and physiotherapists in primary practice treatment settings in Australia. Although some aspects of these studies have been published (see Hiller, Guillemin, & Delany, 2015; Hiller, 2017; Delany, 2005), the research findings have not previously been combined.

Study 1 (completed in 2005) investigated how physiotherapists provide information to their patients and obtain their informed consent to treatment (Delany, 2005). The data comprised seventeen transcripts of audiotaped treatment encounters and interviews with the participating physiotherapists. Recording and analysing the communication was conducted using an interpretivist methodology (Packer & Addison, 1989). The focus was on how physiotherapy communication in the private practice setting

reflects the ethical ideal of communication that respects a patient's autonomy.

The aims of study 2 (completed in 2016) were to describe communication occurring in practice and to compare findings with established approaches to healthcare communication (Hiller et al., 2015; Hiller, 2017). Drawing from the same interpretivist framework, study 2 used aspects of ethnographic and grounded theory methodologies and incorporated observations and audio-recordings of 52 patient-physiotherapist consultations. Data were analysed inductively with steps involving transcription, data coding, memo-writing, and concept mapping described by Braun and Clarke (2007) and Charmaz (2006).

Ethics approval for both studies was granted by the Human Research Ethics Sub-committee at the University of Melbourne: ethics ID DPH 1/2003 (study 1) and ethics ID1238974 (study 2). Informed consent was obtained from all participants in both studies. These two studies had similar methods but different aims. We, the authors, met several times to compare and contrast the findings of each study. Our analysis of these findings highlighted strikingly similar patterns of communication occurring in physiotherapy private practice. These patterns included:

- A consistent and repeatable structure of communication transitioning through phases of the treatment session;
- an overall tone of directiveness on the part of the therapist, and prominence of the physiotherapist's agenda;
- a level of responsiveness and preparedness to adjust to the individual patient to facilitate understanding and build rapport.

Table 1 presents the key themes derived during analysis of the audio-recorded observational data from each study that are then explained in the text.

Table 1: Findings from studies of physiotherapy communication

Study	Theme	Explanation and interpretation
Study 1 (2005)	Structured communication: “building fences”	<ul style="list-style-type: none"> • Content and focus was consistent across treatments • Consistent and recognisable communicative structure that correlates to descriptions of clinical reasoning patterns • Physiotherapists communicated as an authoritative, problem-solving and/or helping figure • Assumption from the therapist that the patient will comply • The metaphor of building a fence represents the idea that the therapist was separate to the patient as evidenced by a clear and consistent pattern and structure to their communication
	Gaps in the fence	<ul style="list-style-type: none"> • Gaps existed in this communicative structure • Physiotherapists attended to cues from each patient by watching and listening during conversations • Intuitive reasoning or personal judgement was used by physiotherapists to respond to individual patients
Study 2 (2017)	Physiotherapist-led communication	<ul style="list-style-type: none"> • Physiotherapists provided a consistent structure • Physiotherapists provided communicative direction • Physiotherapists made decisions • Content consistently focussed on physical aspects and pain
	Adapting to build rapport	<ul style="list-style-type: none"> • Physiotherapists intuitively adjusted elements of communication for individual patients, including: <ul style="list-style-type: none"> - Body language and eye contact - Touch - Casual conversation - Humour • Our interpretation was that communication was often adapted in order to build rapport with patients

The theme “structured communication: building fences” from study 1 depicted the consistent patterns of communication occurring in patient-physiotherapist encounters. Physiotherapists directed the biomedically focused content of communication and used a consistent structure as described by Jones, Jensen, and Rothstein (1995). A key feature of the structured approach was methodically gathering information to form hypotheses, and to continue to test those hypotheses. The language used in this approach reflected objectivity and precision and often included short, closed questions from the therapist with similarly short responses from the patient. This communicative approach has also been found in other authors’ descriptions of the communicative and cognitive processes of clinical reasoning (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)

A second theme about communication in study 1 was the idea of communication breaks, or “gaps in the (communication) fence”. These were described as subtle gaps in the structured communication occurring between patient and therapist. Physiotherapists incorporated strategies such as watching and pausing to listen in order to perceive patients' level of comfort, engagement and reactions during treatment sessions. Subtle changes in communication, such as the use of open questions, were used to tailor the interaction to the individual patient and to allow an opportunity for the patient to incorporate their agenda. Physiotherapists, however, rarely directly asked the patients for their opinion or perception, and they controlled almost all the gaps and adjustments in the communication fence.

The example below demonstrates one of these gaps. It included an open question from the physiotherapist that was then followed by space for the patient to answer. This extract is characterized by pauses that suggest the physiotherapist was listening and encouraging the patient to elaborate.

Physiotherapist: How have you been since last week?

Patient: 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 process of creating gaps in the fence by adjusting the routine structure seemed to represent a way of providing a space for the patient to speak more. It was a technique commonly used by participants in the study.

Two central themes were also developed in study 2. The theme “physiotherapist-led communication” encapsulated how physiotherapists directed many aspects of communication. Physiotherapists were observed as creating a consistent structure to the treatment session that involved an initial greeting, conversation about the presenting problem, physical assessment, treatment and education, and finally, closure. Within this structured interaction, physiotherapists further directed the communication by initiating conversation, asking predominantly closed questions, sometimes interrupting or redirecting communication, and using biomedical language. In addition, physiotherapists made almost all decisions that were communicated during treatment encounters. Such decisions included: goals of treatment, type and amount of treatment, home exercise programs, and when the patient should return for

their next appointment. As an example, in the following extract, the physiotherapist set goals, and made decisions about the patient's exercises, home activities, and when he should return for further 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)

The physiotherapist-led communication theme also incorporated a consistent focus on pain and biological aspects of patient conditions. The following example demonstrates a physiotherapist repeatedly asking closed questions about pain.

Physiotherapist: Pain here when I touch?

Patient: Not much, no.

Physiotherapist: Not much? What about here?

Patient: Nup.

Physiotherapist: Is that pain now?

Patient: A little bit, not much.

Physiotherapist: But if I touch here there is pain?

Patient: Yep (*slightly pained*).

Physiotherapist: Okay, it's the muscle.

(Study 2, treatment encounter 1)

These transcript extracts also demonstrate how physiotherapists directed the communication by initiating all questions and conversation, with the patient generally providing short responses.

The second central theme from study 2, “adapting to build rapport”, depicted many elements of communication occurring during patient-physiotherapist encounters that were responsive to the needs of individual patients – and appeared to be aimed at developing rapport. For example, touch was adapted through adjustments in therapist hand positions, rhythm, and pressure during manual treatment. In the following transcript example, the physiotherapist’s touch adapted to the patient’s cues.

Patient: Ah he he he he (*laughing*)... Ohhh that’s really sore (*in a pained expression*) ah he. So um.

Physiotherapist: Very gentle (*hands observed to soften and slow in response*).

Patient: Thank... Yes you are [name of physiotherapist]. Ah he he. I just know my, my um, muscles are sensitive.... As I said I wouldn’t come back if I didn’t have full confidence with you... and I know in the end it feels better in the long run you know. Ah he he.

Physiotherapist: Ah (*slight smile*).

(*Study 2, treatment encounter 17*)

In addition, a form of “caring” touch, such as a rubbing the patient’s shoulder, was observed to be incorporated by physiotherapists as an adaptive form of communication that conveyed empathy.

Observations also established that physiotherapists: changed their body positions to reflect and accommodate those of their patients; engaged or disengaged eye-contact regularly, depending on perceived patient comfort; engaged in casual, social conversation with patients; and incorporated humour. Patients, in turn, adjusted their communication in response to physiotherapists, using their body positions, head nodding and notably, humour, to demonstrate their engagement and position within the encounter.

These communicative tools were dynamically included in treatment encounters between patients and physiotherapists in conjunction with the physiotherapist-led aspects of communication.

The similarities in how therapists communicate with their patients derived from these two studies are significant, given that they were conducted a decade apart and with different overall study goals. The themes “structured communication: building fences” and “physiotherapist-led communication” highlight a therapist-controlled communication style that has also been captured in other studies. For example, research from Denmark and the United Kingdom demonstrated that decisions within treatment sessions are made by physiotherapists with minimal patient involvement (Dierckx, Deveugele, Roosen, & Devisch, 2013; Jones et al., 2014). Other communication research has shown that physiotherapists drive goal-setting processes (Parry, 2004); talk twice as much as patients (Roberts & Bucksey, 2007); use closed questions (Cruz, Moore, & Cross, 2012; Opsommer & Schoeb, 2014); focus predominantly on pain and understanding the clinical condition (Cruz et al., 2012; Opsommer & Schoeb, 2014); and limit incorporation of the patient perspective (Josephson & Bülow, 2014; Opsommer & Schoeb, 2014).

The communicative dominance of physiotherapists, however, is complemented by another strong finding of “adaptation” (study 2) and “gaps in the fence” (study 1). These findings suggest that nuanced communicative approaches are also occurring within patient-physiotherapist encounters. Despite being led by the physiotherapist, the interaction contains dynamic, interpretive, and relational components. While the structured clinical orientation of the communication acts to control the overall direction of the communication, there are subtle mediating forces at work. These forces or influences include the use of casual conversation and humour, and the use of touch not only as a form of therapy,

but also to convey interest, care, and attention. The findings of these two studies portrayed physiotherapy communication as a combination of structured, directed, negotiated, and adaptive interactions. There is, however, a need for further research to examine therapists' explanations of these styles and their impact on patients.

Other research has similarly highlighted an often tacit, but responsive aspect in physiotherapy clinical communication (Bjorbaekmo & Mengshoel, 2016; Tasker, Loftus, & Higgs, 2011; Thornquist, 1991). Tasker and colleagues (2011) explain how casual conversation and active listening are used to develop responsive relationships between patient and physiotherapist in the community setting. The responsive nature of physiotherapists' communication is also clearly demonstrated in the work of Bjorbaekmo and Mengshoel (2016) who describe the types and impact of touch in the therapeutic encounter. Thornquist (1991) described physiotherapists' use of eye gaze to convey interest in each patient and to inform the constant adjustments made to both patient and therapists' body positions in physiotherapy consultations. In conjunction with our results, these findings affirm that an adaptive, responsive component exists within patient-physiotherapist communication. Tasker and colleagues (2011) emphasise that this responsiveness creates a human connection, or rapport, between patient and therapist.

Unlike these studies where the authors attributed a particular purpose to therapists' communication, the key question this chapter seeks to address is how our empirical findings relate to, or are represented by, prominent approaches to healthcare communication. In the second half of this chapter, we detail some of the main features of patient-centred and biopsychosocial approaches to enable this analysis.

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

In physiotherapy, as in other healthcare professions, patient-centred and biopsychosocial approaches are established as the guiding frameworks for how practitioners and patients should communicate with their patients (Pinto et al., 2012; Sanders, Foster, Bishop & Ong, 2013). A biopsychosocial approach to healthcare is premised on the idea that poor health or physical dysfunction is not only grounded in a physical problem, but is influenced by a person's feelings, their ideas about health and events and circumstances in their lives (Engel, 1977). Extrapolated to health communication, a biopsychosocial approach requires a practitioner to incorporate biological, social, and psychological factors when assessing, diagnosing, providing treatment, and interacting with their patient (Engel, 1978; Epstein et al., 2003). Each of these three inter-related components of communication should be purposefully included and integrated within clinical interactions. Roter and colleagues (1997) described biopsychosocial communication as evidenced by a practitioner including more social talk and fewer practitioner questions in order to achieve some balance between psychosocial and biomedical content. More recently, Smith and colleagues (2013) suggested that the use of open-ended questions illustrates this approach in practice.

The patient-centred approach to communication is closely related to the biopsychosocial approach. Overarching features are that communication is explicitly used to share information and responsibility, reduce perceived power differences and incorporate the needs and perspectives of individual patients (Bensing, 2000; Mead & Bower, 2000). Within a patient-centred approach, communication is used to demonstrate respect for, and inclusion

of, each individual patient's knowledge and experience (Bensing, 2000; Byrne & Long, 1976). Being patient-centred requires the use of communicative strategies to elicit and incorporate the patient's narrative and experiences to inform and shape the encounter (Epstein & Street, 2011). Decisions about care are shared and the patient-practitioner relationship is viewed as a collaborative alliance. Specific communicative features include the use of open-ended and non-directive questions; including and responding to emotional aspects of a person's experience; and avoiding interrupting patients (Epstein & Street, 2011; Grol, de Maeseneer, Whitfield, & Mokkink, 1990; Mead & Bower, 2000; Smith, Fortin, Dwaamena & Frankel, 2013; Winefield, Murrell, Clifford, & Farmer, 1996).

Does communication in physiotherapy practice align with the biopsychosocial and patient-centred approaches?

Physiotherapy literature and codes of conduct suggest physiotherapists should aspire to incorporate biopsychosocial and patient-centred approaches into their clinical communicative practice (National Physiotherapy Advisory Group, 2009; Physiotherapy Board of Australia, 2014; Pinto et al., 2012; Sanders et al., 2013). One interpretation of the research findings presented in this chapter is that this may not be explicitly and purposefully happening. The findings demonstrated a distinct communicative focus on the biomedical aspects of a patient's presenting problem: therapists paid little overt attention to psychosocial aspects of their patients' condition or experience. Physiotherapists also controlled the communication by using closed questions, initiating conversations, interrupting patients and making decisions. These physiotherapist-directed styles of communication and the biomedical focus align more closely with practitioner-centred and biomedical

approaches than biopsychosocial and patient-centred approaches to health communication. Documented communication features of a patient-centred approach such as open questions, minimal interruptions, and shared decision making (Bensing, 2000), were not overtly incorporated into observed physiotherapy treatment encounters. Other scholars of physiotherapy communication have also reached similar conclusions about the predominance of communication that represents biomedical and practitioner-centred approaches (Cruz et al., 2012; Josephson, Woodward-Kron, Delany, & Hiller, 2015; Opsommer & Schoeb, 2014).

The data did, however, demonstrate the presence of adaptive or responsive communication. This style of communication is closer to a patient-centred approach because it involves adjusting to the perceived needs of the individual patient, although these adaptations did not derive from the patient's perspective. Rather, the key function of adaptive communication seemed to be instrumental, that is, to build rapport between patient and therapist. This focus distinguishes adaptive communication from a patient-centred approach where the communication content and direction should draw from the patient's stated needs. Touch and other forms of non-verbal communication were prominent features of adaptive communication (particularly in study 2), and are not documented as features of biopsychosocial or patient-centred theories.

Why is there a discrepancy between communication theory and communication in practice?

Research demonstrates that physiotherapists find biopsychosocial and patient-centred approaches difficult to implement in practice (Mudge, Stretton, & Kayes, 2013; Sanders et al., 2013; Singla, Jones,

Edwards, & Kumar, 2015). Studies have shown that physiotherapists recognise and acknowledge the need to incorporate patients' perspectives and psychosocial factors and understand broad features of both patient-centred and biopsychosocial approaches (Hiller, 2017; Sanders et al., 2013; Singla et al., 2015). Despite this awareness, however, how to practically integrate these elements remains elusive, and physiotherapists' "fall back" position is to focus on biomedical aspects of a patient's presenting condition (Mudge, Stretton, & Kayes, 2013; Singla et al., 2015). The challenge of practical translation of these models resonates with previous critiques. For example, Cooper and colleagues (1996) suggested that there has been little theorisation regarding how the three domains within the biopsychosocial model might be integrated, including how they are relate to and influence each other, and whether they are regarded as equally valuable for each health encounter. Other authors have stated that the biopsychosocial approach is an ideology and a vision for practice, rather than a clear clinical method (Epstein & Borrell-Carrio, 2005; McLaren, 1998). It is left to the health practitioner to determine how to include and combine each of the biological, social, and psychological dimensions.

Similarly, some critiques of patient centred care suggest it is a "fuzzy concept" that is poorly defined and therefore difficult to operationalize (Bensing, 2000, p. 21; Nolan et al., 2004). The patient-centred approach was derived from an impetus to shift away from medicalization toward individual personalization of medical care for each patient (May & Mead, 1999). Pulvirenti and colleagues (2011) suggest that if care is to be defined by a patient rather than by the health professional, patients will need active support and empowerment from practitioners. Interactive components of patient centred care have been specified as: validation of the patient's experience, consideration of their broader context, working towards mutual understandings between the health

professional and patient and taking a partnership approach to the therapeutic encounter (Stewart et al., 2003). These more specific components, however, were not visible in the data presented in this chapter and have not been actively translated to physiotherapeutic theories that capture how to communicate with patients.

A second explanation for why there may be a discrepancy between communication theory and practice is that the physiotherapy profession has focused on generating evidence and aligning their clinical practice techniques and outcomes of treatment with biomedical constructs (Chipchase et al., 2006). This biomedical and “practitioner as expert” focus, has permeated physiotherapy communication research which demonstrates that physiotherapists predominantly practice in a practitioner-centred manner. It is possible that physiotherapists have neglected to consider strategies that might help them understand the individual patient perspective and achieve psychosocial aspects of communication (Sanders et al., 2013; Singla et al., 2015).

A further possible reason for the discrepancy between communication practice and theory in physiotherapy is that both the patient-centred and biopsychosocial approaches were originally developed for medicine. A psychiatrist, Engel (1978), first formally described the biopsychosocial approach. He challenged the biomedical perception within medicine and proposed that social and psychological aspects of each patient be incorporated into medical practice and communication alongside the biological content (Engel, 1978).

Despite the obvious similarities between medicine and physiotherapy as healthcare professions aiming to alleviate pain and other symptoms, aspects of physiotherapy communicative practice differ considerably from its medical counterpart. For example, physiotherapists use touch as a responsive and central communicative tool (Nicholls & Holmes, 2012), and this is notably different from medical

practice. Used as a form of communication in physiotherapy, touch can assist understanding, perception of, and preparation for movement; demonstrate care; and form a core part of treatment and education (Roger et al., 2002). In physiotherapy, touch establishes a physical relationship that has been described as a sensitive, responsive, and expressive bodily conversation (Bjorbækmo & Mengshoel, 2016; Poulis, 2007; Roberts & Bucksey, 2007).

The significance of touch and other types of physiotherapy-specific communication, including extensive education and advice, and the reliance on active patient involvement (Poulis, 2007), means that any discussion and analysis of communication in physiotherapy should include these interactional dimensions.

Conclusions

This chapter has compared physiotherapy communication as it occurs in physiotherapy treatment encounters, with two common theoretical approaches to healthcare communication: the biopsychosocial model and patient-centred care. These two established approaches emphasise the importance of shifting traditional provider authority from the practitioner to the patient and the need to incorporate each patient's perspective and preferences within communication exchanges. These focuses were not evident in our studies, conducted in physiotherapy private practice settings. Instead, our findings demonstrated that despite physiotherapists being responsive and open to include a patient's individual needs and concerns, the dominant model of interaction was a practitioner-centred approach. Although the physiotherapy profession supports the ideals of patient-centred and biopsychosocial approaches (National Physiotherapy Advisory Group, 2009; Physiotherapy Board of Australia, 2014), our findings suggest that therapists' approaches to treatment and

communication (in the primary practice setting) are firmly grounded in biomedical models of practice.

Our aim in this chapter has been to stimulate further debate and discussion and promote an interest in theorising physiotherapy communication. The features, goals, and styles of physiotherapy communication need to be thoroughly described and analysed to examine possibilities for physiotherapy-specific adaptation of biopsychosocial or patient-centred approaches, or alternative approaches that capture the distinct communicative goals of physiotherapy treatment. The findings lead to questions that future research should address. These questions include: How is physiotherapy communication used to educate, motivate, empower, disempower, express empathy, authority, humility, and interest in a range of clinical situations? How effective are physiotherapy communication strategies according to patients? What type of communication theory could frame and support the practice of communication in physiotherapy professional practice?

The comparison between communication in theory and in practice in this chapter also provides opportunities for physiotherapy educators to consider how other behavioural and social science theories (many of which are discussed in this book, see also Schiavo, 2007) might be used to frame and clarify the goals and strategies of communication.

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