

General practitioner and physiotherapist communication: how to improve this vital interaction

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Background: Appropriate communication between general practitioners (GPs) and physiotherapists is vital for providing optimal care. Differing opinions exist as to key inclusion in this communication. This study aims to identify the key components that both GPs and physiotherapists would include in inter-professional communication.

Methods: Qualitative study design, using 14 in-depth, semi-structured telephone interviews. **Results:** Physiotherapists identified relevant past medical history, psychosocial history, yellow flags, anticipated time frame for follow-up and objective measures of current function as the more useful inclusions in written communication. GPs identified the inclusion of a working diagnosis, treatment summary and likely long-term outcomes as the key components to effective communication. **Discussion:** Effective interprofessional communication requires the provision of information that is both succinct and relevant. While there are individual preferences, this study suggests that certain key characteristics exist, and the inclusion of these in interprofessional communication may lead to improved communication and patient outcomes.

Key words: general practice; physiotherapy; communication

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Introduction

Effective communication between primary care providers within a health care system is essential to achieve high-quality patient care (Jones and Jones, 2011). Communication between general practitioners (GPs) and physiotherapists may occur at any time before, during or after patient consultations (Bainbridge and Harris, 2006). There is little consensus, however, as to what constitutes optimal interprofessional communication. In particular there is limited literature describing what vital pieces of information are required by the parties involved (Scaffardi, 1989). This qualitative study explored both the current and desired content and

modes of communication between GPs and physiotherapists. Seven GPs and seven physiotherapists in Australian metropolitan and regional practices completed the interview between March and April 2013.

Methods

This pilot study used a qualitative research design using in-depth, semi-structured telephone interviews. This design was chosen to allow emerging themes to be explored in depth. Sampling was purposive with participants being selected to typify all the physiotherapists and GPs that the lead researcher has worked with professionally. Of the physiotherapists interviewed, two had post graduate qualifications in Musculoskeletal Physiotherapy, one in Neurological Physiotherapy and

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Table 1 GP and physiotherapist demographics

	Years in practice					Gender		Practice Location	
	1–5	6–10	11–20	21–30	Total	Male	Female	Metropolitan	Regional
GP	2	2	0	3	7	3	4	4	3
Physiotherapist	1	3	1	2	7	5	2	3	4

three in Sports Physiotherapy. All GPs are Fellows of the Royal Australian College of General Practitioners. Subject number was determined by continued sampling until thematic saturation was reached (Table 1).

Semi-structured interview questions were compiled through discussion with medical and physiotherapy practitioners. The lead researcher, who no longer works clinically and has no current professional relationships with any interviewee, completed all interviews. New themes that emerged during the interviews were expanded on in future interviews, allowing for a more in-depth discussion of key topics. Thematic coding analysis was used to code and report content exploration of electronic interview transcripts. Ethics approval was granted by the University of Sydney, Human Research Ethics Committee (approval number 2013/021).

Results

The information that GPs sought in communication with physiotherapists was primarily concerned with provisional diagnosis, a summary of treatment to date, rehabilitation goals and expected time frames of management. Feedback as to the appropriateness of physiotherapy as a treatment option was also desired.

For physiotherapists, communication regarding objective measures of pain, movement and disability, relevant past medical history and a time frame for follow up were identified as most important. A greater sharing of information regarding psychosocial issues and previous response to injury was also strongly desired.

It was universally agreed upon by the respondents that written communication was preferred on all occasions except for in an emergency, when telephone communication is appropriate.

Respondents were also in agreement to the fact that communication in dot point form is not only appropriate, but preferred, when communicating in writing.

Sending and receiving appropriate examination findings was important to both GPs and physiotherapists. The inclusion of ‘fancy little physio tests of which I am unsure of their meaning’ is of little help unless there is also a description of the ‘structure that is problematic’ [female (GP2), metropolitan, one to five years experience]. Inclusion of the results of clinical tests was consistently identified as essential, with the desire that this should not be clouded by ‘unnecessary information that I don’t understand’ [female (GP6), metropolitan, 6–10 years experience].

GPs described a desire to be informed of the physiotherapist’s diagnosis. This was seen as an opportunity to ‘test the diagnostic skills’ of the GP [female (GP3), metropolitan, 21–30 years experience] as well as to ensure consistency of diagnosis. ‘If I’m unsure of the diagnosis I would like to know what the physio thinks’ [female (GP4), regional, 21–30 years experience].

The inclusion of a provisional diagnosis was reported to be regularly received in communications from GPs. ‘90% of the time it is just the diagnosis that I receive’ [male (PT4), metropolitan, 11–20 years experience]. Despite this, physiotherapists were less consistent with their desire for written communication from the GP to include a provisional diagnosis. Incorrect diagnosis was seen as a potential barrier to effective patient care. ‘Incorrect or misguided diagnosis is often very unhelpful’ [male (PT2), regional, 21–30 years experience]. A counter theme, however, indicated that high on the list of desired information to be included was the GPs opinion on diagnosis and prognosis.

GPs and physiotherapists value the inclusion of guidance as to an appropriate time frame

for management. This included a time frame within which specific goals could be met, when or if follow-up has been arranged, and what improvements are likely during this time. Combining treatment and follow-up time frames with an overall management plan was preferred as this was seen as a path to optimising patient care. 'This would allow us to get on the same page immediately in terms of the patients, and our own, expectations' [male (PT7), metropolitan, 11–20 years experience].

Both experienced GPs and more recent graduates requested feedback as to whether or not physiotherapy was a suitable treatment option. 'I want to know if physiotherapy is appropriate' [female (GP3), regional, 21–30 years experience]. In line with this a theme developed among physiotherapists to have a clearer idea as to why particular patients were being referred: 'Why they are referring the patient can be lost amongst all the other information' [female (PT6), regional, 1–5 years experience].

Despite the realisation that in practice this can be difficult to do, it was suggested by physiotherapists that information on the psychosocial history and yellow-flags be included in communication. Along with a relevant medical history, 'a psychosocial history is vital' [male (PT1), regional, 6–10 years experience]. This can include previous poor response to injury, previous or current history of lengthy work cover claims, poor attitudes or pain beliefs, and family hardship.

Discussion

Primary health care includes health promotion, disease prevention and illness treatment (Australian Physiotherapy Association Background Paper, 2013). Within this framework primary health care providers, including physiotherapists and GPs, must communicate not only their objective findings, but their expressed desires. Much research has been conducted looking at doctor–patient (Reinders *et al.*, 2011) and physiotherapist–patient communication (Oliveira *et al.*, 2012; Pinto *et al.*, 2012). There is a lack, however, of high-quality research into the communication between GPs and physiotherapists. GPs collaborate with allied health care professionals through referral and feedback letters

(Shortus *et al.*, 2007) and it is common practice for this to include physiotherapists.

There will always be some discrepancy as to what individual practitioners consider vital when discussing a patient's treatment. Certain key criteria, however, have been identified. The consensus is that to improve the interaction between GPs and physiotherapist, written and verbal communication should be succinct, specific and appropriate.

The inclusion of objective measures, including rudimentary range of movement (ROM) scores, allows for a more accurate measure of baseline characteristics. There can be a significant time delay between initial presentation and attendance at follow-up appointments. Communicating the results of clinical assessment allows for monitoring of either improvements or deterioration in the time between presentations at both professions. This may include simple scores of ROM (Hayes *et al.*, 2001) or pain (Carisson, 1983). Documenting these results also allows for pre- and post-treatment comparisons to be made. Keeping the language simple, and limiting the results to easily understandable units (eg, the percentage of lumbar movement or the degrees of shoulder abduction) prevents confusion between therapists and improves overall communication. Reporting 'left sided lumbar spine pain of 5/10 with flexion to the proximal patella' provides appropriate information.

Communicating with the physiotherapist the specific anatomical region of concern can be more important than including a specific, and perhaps misleading, provisional diagnosis. This allows the physiotherapist to provide further diagnostic tools without contradicting information provided by the general practitioner or 'challenging' the referring doctor's clinical opinion. Discrepancies exist in the diagnosis of many of the most common musculoskeletal disorders and conflicting 'diagnosis' by treating health professionals may reduce the patient's confidence with the providers involved. Managing unrealistic patient expectations can be made simpler by consistent, rather than conflicting, statements. For example, the communication may state 'left lumbar spine pain (5/10) radiating to the left posterior thigh with flexion to the proximal patella' rather than providing a specific diagnosis such as 'lumbar muscle sprain with sciatica'.

Accurately predicting the time course of healing of any one of the myriad of musculoskeletal

complaints is a difficult undertaking. Discussion of anticipated treatment and recovery time frames, however, provides the patient and treating clinicians with opportunities to explore goal setting and to manage expectations. Goal setting is a crucial component of complex and chronic musculoskeletal injury management (Parry, 2004). The physiotherapists surveyed expressed a desire to have timeframes specified not as to when total resolution of symptoms will have occurred, but as to when the GP expects significant improvements to be made. If this is not practical then a time at which, if improvements are not made, that further management options or investigations be sought is equally beneficial. Specifying this in the initial consultation, and including it in subsequent communication, improves the likelihood of appropriate follow-up and allows specific goals to be set. If the physiotherapist is aware of the date of review they may also be able to ensure the patient is reminded to attend the follow-up appointment. This also gives the physiotherapist adequate warning so as a written reply can be provided to the referring GP in a timely manner.

The contribution of psychosocial factors to individual patient recovery is well documented (Hill *et al.*, 2011). It can be a challenge for both physiotherapists and GPs to include appropriate insight into the psychosocial parameters of the patient in written communication, without compromising patient confidentiality or trust. The physiotherapists in this study, however, clearly desired a more forthright understanding of the psychosocial background, and in particular issues that may influence injury management and return to work. This was on the understanding that the GP may have had a more long-term professional relationship with the patient, for this doctor–patient relationship creates the key element for identifying relevant psychosocial factors (Crawford *et al.*, 2007). Any information on previous response to injury, previous work-cover claims, family hardship, passive attitudes to rehabilitation, depression or anxiety can be immensely beneficial to the physiotherapist. While some of these components can be summated with stratification according to patient prognosis (low, medium, or high risk) according to pre-ordained criteria (Hill *et al.*, 2011), inclusion of detailed and specific psychosocial factors pertinent to individual cases may significantly improve communication.

While it was recognised by respondents that certain elements of this can be difficult to include in written communication, any attempt to do so has the potential to improve patient outcomes. Simply stating that the patient ‘had a similar episode of low back pain which required nine months to return to work’ or ‘the patient is fearful of further damage’ provides insight into the likelihood of response to injury and rehabilitation. The patient may not always be forthcoming with information which, if provided by the GP, may prove critical for management of yellow-flags. Early identification of these factors allows treatment to be directed appropriately from the outset.

Any study of individuals within a profession will reveal contrasting desires and behaviours. This study is limited by the small sample size which does restrict the ability to extrapolate the results into health care practice. While this study has highlighted certain key points on which communication may be based, it is recommended that a discussion be had with any professionals whom the GP regularly communicates with. This provides clinician-specific information on what is generally most sought after in terms of patient information. This would account for individual variations, and may provide an opportunity to feedback other relevant information.

The results of this study indicate that further analysis of the preferred communication content between general practitioners and a range of allied health providers is warranted. The themes identified in this study shall be used as the basis of a much larger, quantitative study. This will allow a more rigorous assessment of current and desired communication practices. A significantly larger study would likely include practitioners with a broader range of experiences and be more truly representative of the Australian health care workforce. This may lead to more effective coordination of health services which may in turn lead to more cost effective service provision and better patient outcomes.

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Conflicts of Interest

None.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional guidelines on human experimentation (University of Sydney Human Research Ethics Committee approval number 2013/021) and with the Helsinki Declaration of 1975, as revised in 2008.

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