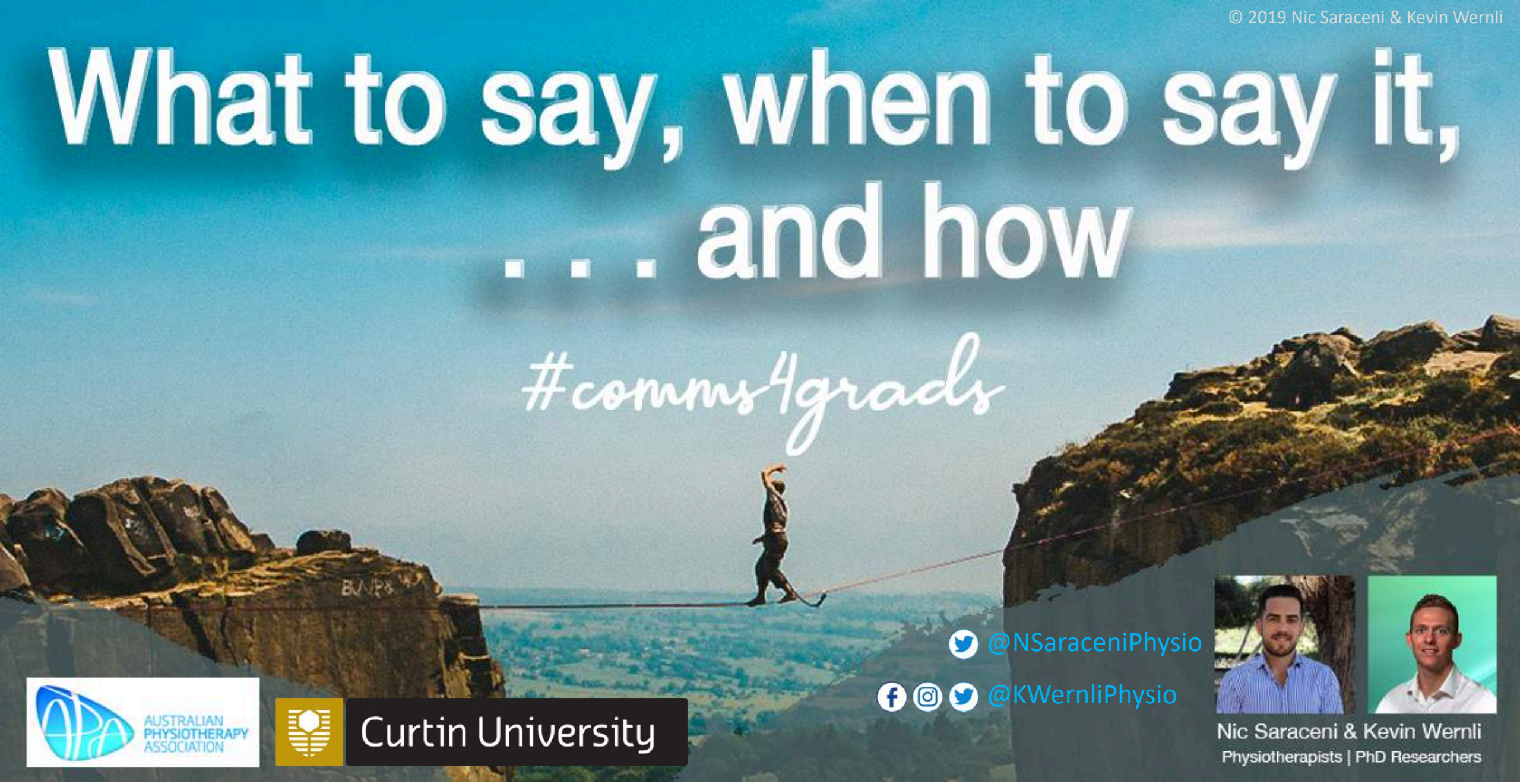
What to say, when to say it, . . . and how

#comms4grads



@NSaraceniPhysio

@KWernliPhysio

Nic Saraceni & Kevin Wernli

Physiotherapists | PhD Researchers

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Curtin University

Link to download slides available at end of lecture

Acknowledgements:

Our supervisory team: Prof. Peter O'Sullivan, A/Prof. Peter Kent, Prof. Anne Smith, Prof. Leon Straker, Dr Leo Ng, Dr Amity Campbell. Dr JP Caneiro, our fellow PhD candidates, the staff from Midland and Body Logic Physiotherapy, and the patients who trust us to help them.

CONE OF EXPERIENCE

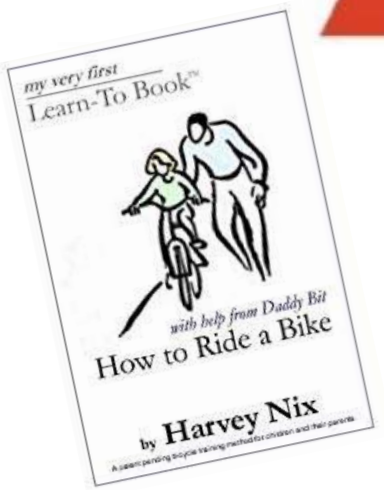
EDGAR DALE

Obsidian LEARNING

PASSIVE LEARNING

ACTIVE LEARNING

	YOU REMEMBER	YOU ARE ABLE TO
~10% OF WHAT YOU READ	READ	DEFINE, LIST, DESCRIBE, EXPLAIN
~20% OF WHAT YOU HEAR	HEAR	
~30% OF WHAT YOU SEE	VIEW IMAGES	
	WATCH VIDEOS	DEMONSTRATE, APPLY, PRACTICE
~50% OF WHAT YOU SEE AND HEAR	EXHIBITIONS	
	WATCH A DEMONSTRATION	
~70% OF WHAT YOU SAY AND WRITE	PARTICIPATE IN HANDS-ON WORKSHOPS	ANALYZE, DEFINE, CREATE, EVALUATE
	DESIGN COLLABORATIVE LESSONS	
~90% OF WHAT YOU DO	SIMULATE A MODEL OR EXPERIENCE A PHENOMENON	
	DESIGN/PERFORM A PRESENTATION/EXPERIMENT	



TO TRY TOMORROW

= you are **Right** to discuss

= you are **Left** out of the discussion

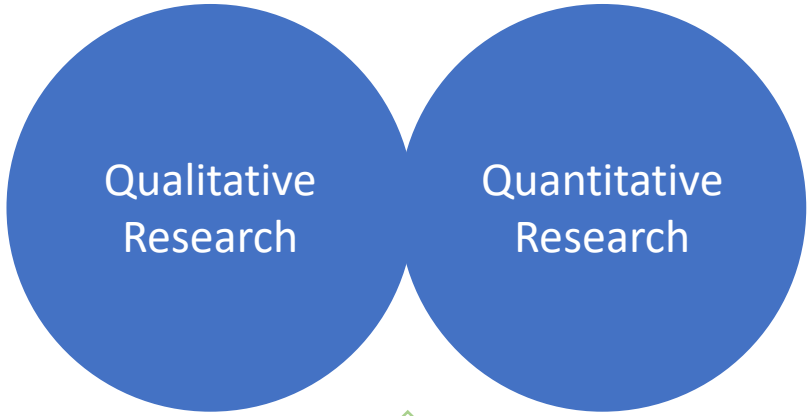
CAVEAT – Applies more to persistent pain

Halderman and Dagenais (2008) *Spine J.*

INTERACTION

Intervention

@KWernliPhysio



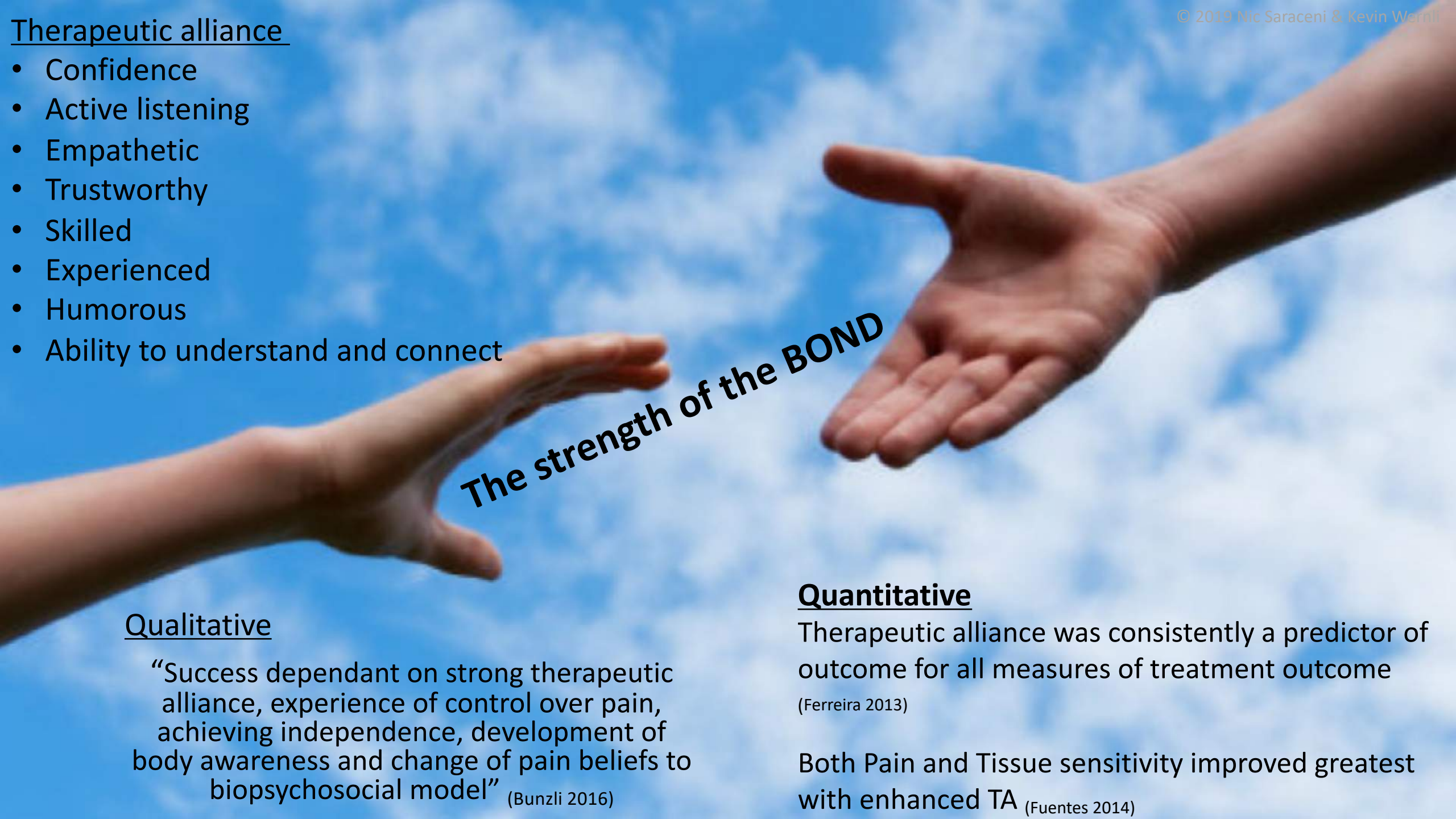
ALLIGNMENT

Patient Voices

Joletta Belton
@MyCuppaJo

Pete Moore
@paintoolkit2

Adrian McGregor
@Adrian30530030



Therapeutic alliance

- Confidence
- Active listening
- Empathetic
- Trustworthy
- Skilled
- Experienced
- Humorous
- Ability to understand and connect

The strength of the BOND

Qualitative

"Success dependant on strong therapeutic alliance, experience of control over pain, achieving independence, development of body awareness and change of pain beliefs to biopsychosocial model" (Bunzli 2016)

Quantitative

Therapeutic alliance was consistently a predictor of outcome for all measures of treatment outcome (Ferreira 2013)

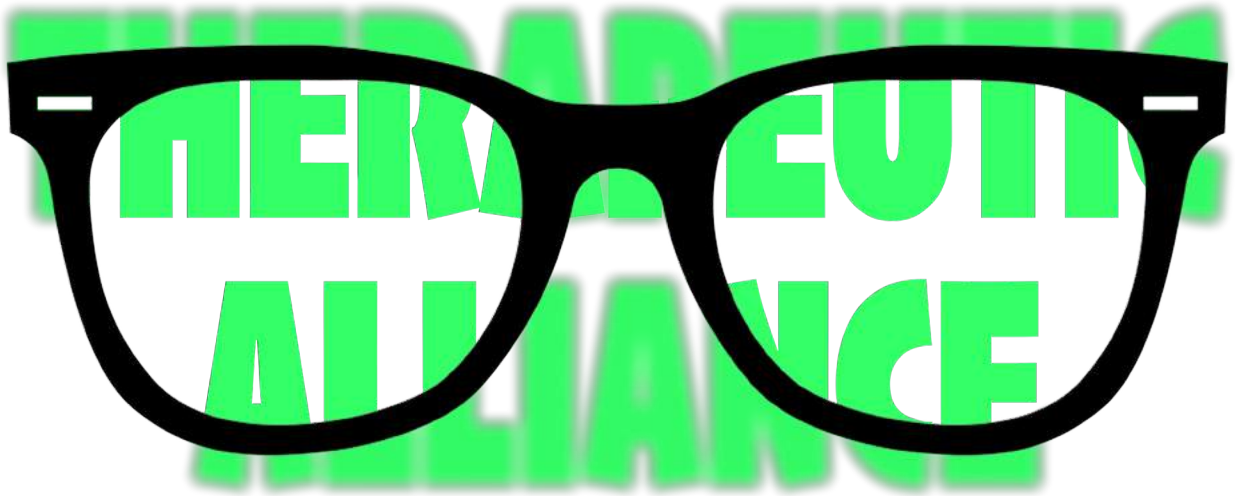
Both Pain and Tissue sensitivity improved greatest with enhanced TA (Fuentes 2014)

PATIENT-CENTERED CARE

- Individualised based on patient preferences
- Shared decisions
- Effective communication
- +/- Explicit discussion of patient centered care

Lin 2019

Objectives:



- Provide clarity on tools that may enhance therapeutic alliance
- Learn from peers through observation, discussion, interaction and role-play.

The acronym:

L.P the **BES** student from **PER** had to **DPFR**

What do you take out of this 60 second interview

L P the B E S student from P E R had to D P F R

SUBJECTIVE

LISTEN

- The first minute is crucial
- It shapes the rest of the session
- Listen actively throughout (eye contact, nodding, facial expression, posture, body language)

Consider:

Try to really engage/listen for first 45seconds without interrupting.

LPBES student from PER had to DPFR

SUBJECTIVE

Let's see how long it takes for Kevin to interrupt…

- First interruption: 7 seconds
- Then interrupted twice more within 36 seconds
- Patient looses train of thought

Consider:

TO TRY TOMORROW

Try to really engage/listen for first 45seconds without interrupting.

LPBES student from PER had to DPFR

SUBJECTIVE

PROBLEM

- Activity limitation>aggravating factors
- Shifting emphasis from pain to impact of pain (problem/s)
- Focus of Physiotherapy session becomes goal orientated
- What are ways to ask the questions that shift the focus?

"Can you tell me 1-3 key tasks/activities that you are unable to do because of this problem?"
"If your pain improves what would you be doing?"
"How would your life look differently if you had less pain?"
"What activities do you find annoying because of your pain?"

LP the BES student from PER had to DPR

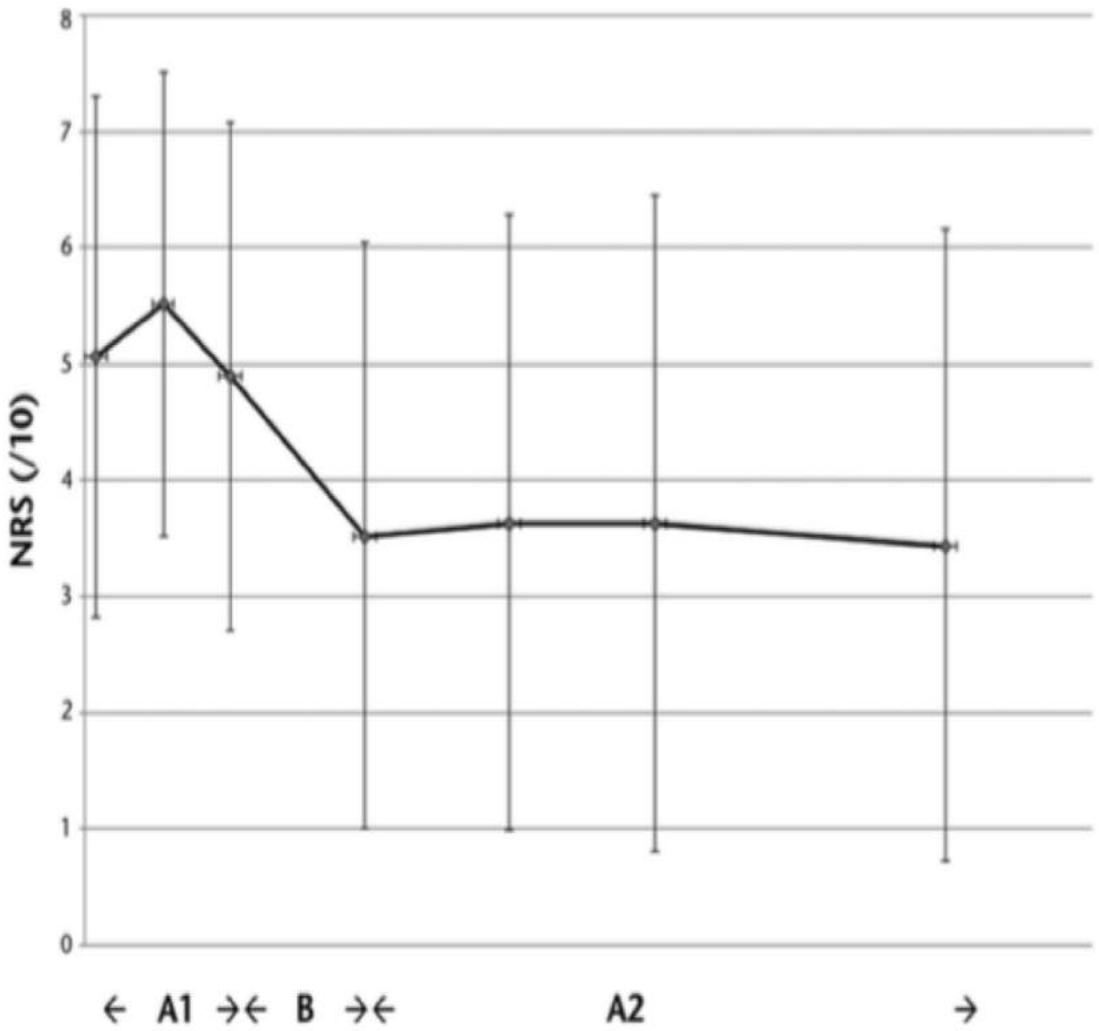


Figure 3.
Mean (SD) pain intensity (numeric rating scale [NRS] scores) across the 3 phases of the study (A1, B, and A2).

K. O'Sullivan 2014

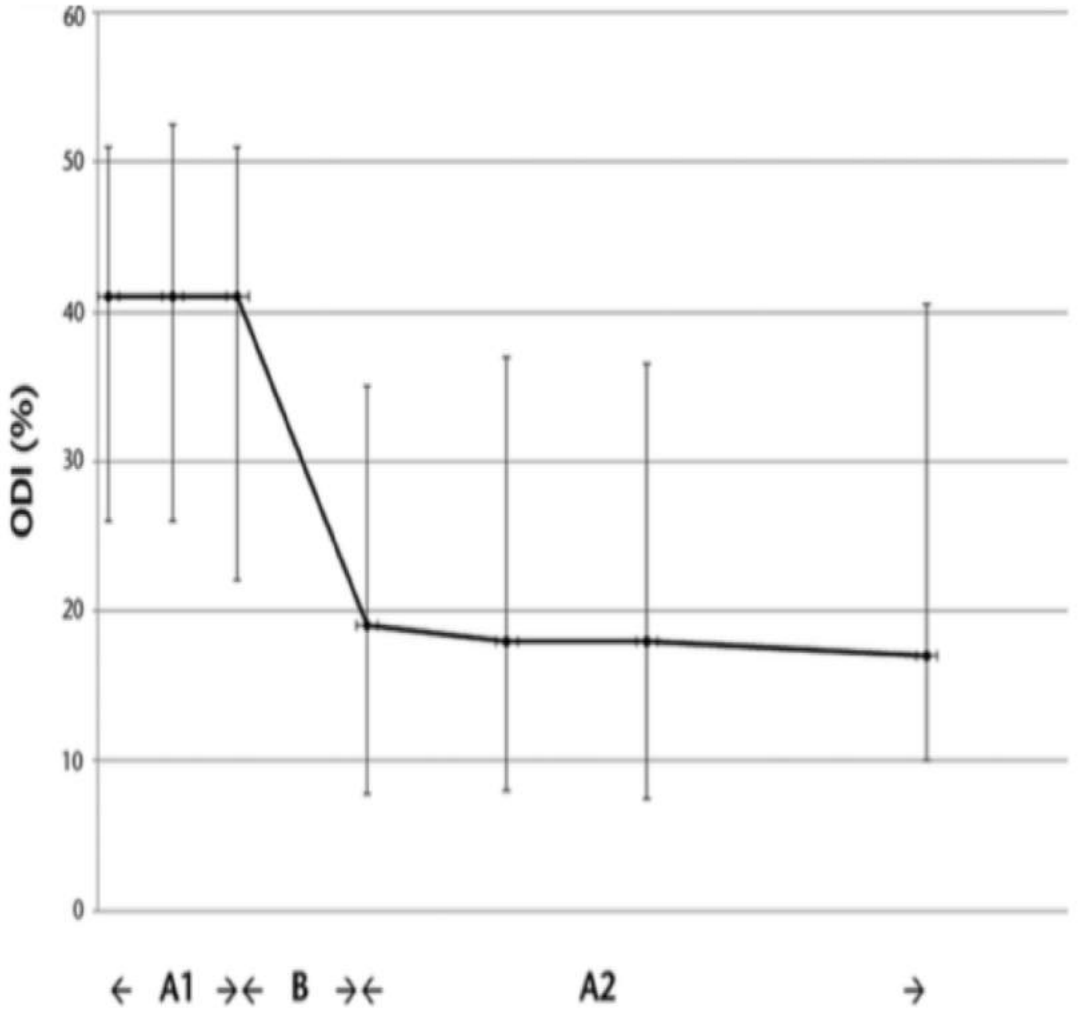


Figure 2.
Median functional disability (Oswestry Disability Index [ODI] scores) across the 3 phases of the study (A1, B, and A2). Error bars represent interquartile range.

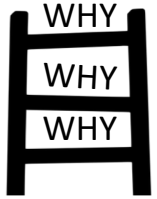
Caneiro 2018

LPBES student from PER had to DPFR

SUBJECTIVE

BELIEFS

- We want to understand the patients perspective of:
  - Why do they believe they have pain?
  - What do they believe pain means?
  - What do they believe an increase in pain means?



- Why?
  - Behaviours' are often secondary to belief (example: limping)

What if the patient says:
"You tell me, you're the expert"?
Consider: "You are the expert on you, you've lived with this for X months/years, I've only known you for X minutes. I will definitely tell you what I think after I have a clear understanding of your history and have done a thorough assessment"

- Beware the backfire: ⚠CAUTION
- "*Beliefs don't change with challenge, they change with experience or evidence*"
- Refrain from correcting beliefs during subjective, save it until post assessment, ideally with lived experience or in vivo evidence.

TO TRY TOMORROW

Get to the *why* (the 1-3 key beliefs of why they think they hurt).
Consider: "What is your understanding of why you hurt?" or "Why hasn't this got better?"

LPBES student from PER had to DPFR

SUBJECTIVE

EXPECTATIONS

- Alignment between patient and therapist
- If there is a mismatch - address it
- Goal setting
- Scans – The elephant in the room - (Around 90% think they need a scan) Lim 2019

Patient

- Diagnosis – OA/painful knee
- Goal: Back to running
- Expectation: Massage

Physio

- Diagnosis – OA/painful knee
- Goal: Back to running
- Expectation: Educate/Exercise

Consider: “What are you expecting from Physio?

LPBES student from PER had to DPFR

Expectations for massage

LPBES student from PERR had to DPFR

Activity:

How do you address expectations for massage?

LPBES student from PER had to DPFR

Consider: Tight muscles analogy – we want to understand **why** they feel tight

LPBES student from PER had to DPFR

SUBJECTIVE

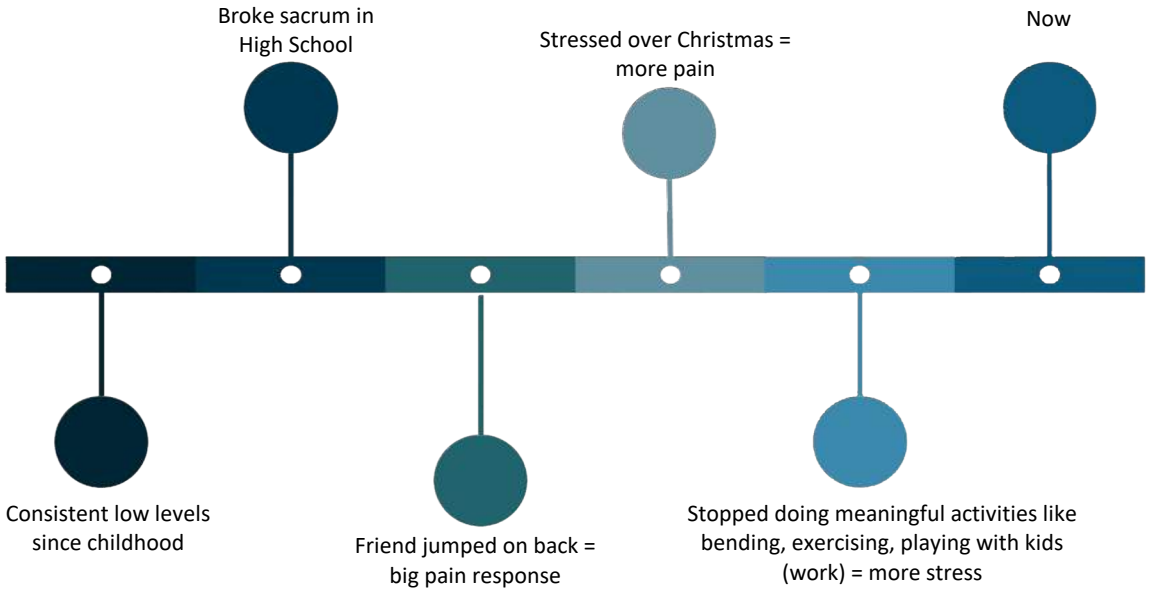
SUMMARY

- Patients think being heard is important. The best way to ensure they are being heard is to recite a brief summary of their story.

- "Mirror communication"

- Mini summaries after key points:
  - "Is it fair to say that…"
  - "Let me just clarify…"

- Timeline



TO TRY TOMORROW

Consider:
Asking permission to summarise what you've heard.
Ask: "Is there anything you'd like to add that you think is important?"

LPBES the student from PER had to DPFR

Listen (really listen): Let them finish their story, it might take a minute

Problem: identify 1-3 key activity limitations

Beliefs: identify 1-3 pertinent beliefs – get to their why

Expectations: align what they think they need to what you do

Summary: recap timeline in your own words, give opportunity for patient to add then proceed with clarity

Now what do you take from the interview?

LPtheBES

LPBES student from PER had to DPFR

OBJECTIVE

PROBLEM

- Assess those 1-3 key activity limitations you identified in the subjective
- Patients Agenda vs Your Agenda Cowell 2016

Problem List

Patient	Therapist
I can't bend	PPIVMs
I can't lift kids	PPAIVMs
I can't work	Muscle length
	NTPT
	Motor Control
	Palpation
	etc. etc.

TO TRY TOMORROW

Consider:
"These are the 1-3 challenges you mentioned to me before, I want to look and help you with them?"

LPBES student from PER had to DPFR

OBJECTIVE

EXPERIENTIAL LEARNING

- People don't argue with their own data
- Before lecturing ask:
  - "What does that tell you?"
  - Or "What does that mean?"
- A powerful way to shift beliefs or shape advice
- Fear avoidant physio's (Darlow 2016)

"Tell me and I forget,
teach me and I may remember,
involve me and I learn"

TO TRY TOMORROW

Consider:
Before lecturing, see if you can educate with experience.

LPBES student from PER had to DPFR

OBJECTIVE

REFLECTIVE QUESTIONING

Patient's interpretation:

"That I've done something bad"

- What do you interpret from the following palpation assessment?

We think one thing…
It may not be remotely close to what the patient is thinking, but you never know unless you ask.
Don't assume.

TO TRY TOMORROW

Consider:
"What does that mean to you?" or "How do you make sense of this?"

LPBES student from PER had to DPFR

MANAGEMENT

The Kieran O'Sullivan Test

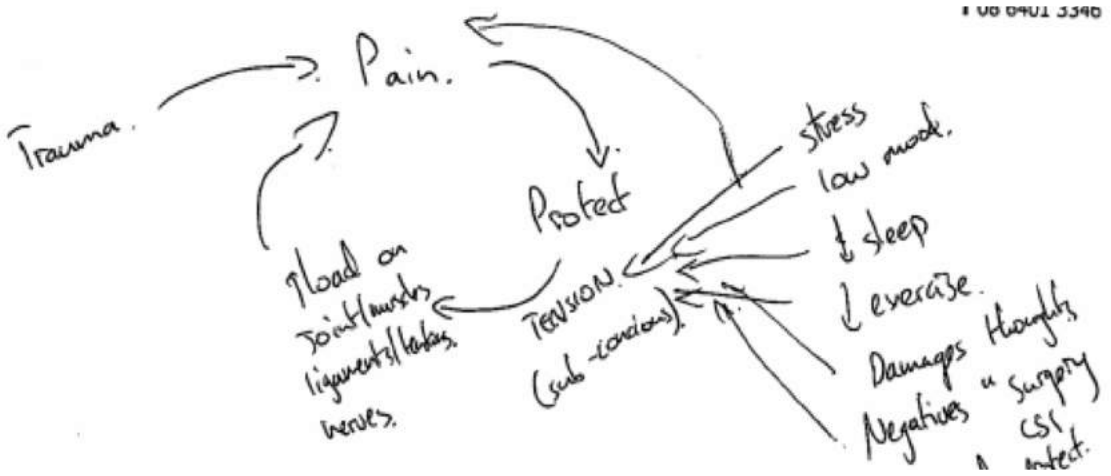
"Ask your patient to describe how they will explain your consultation findings to their family, or significant other, when they get home"

- Dr Kieran O'Sullivan

KiwerniPhysio

DIAGNOSIS

- Put it together (or even better let them put it together)
- The understanding of the contributing factors (under a BPS model)
- Focus on modifiable factors (even better if you can use their own experience/data/language)
- Clear, consistent and legitimate (Lim 2019 and Bunzli 2016)



TO TRY TOMORROW

Consider asking:
"So what have you learnt about the things that might be contributing to your pain today?"

LP the BES student from PER had to DPR

MANAGEMENT

PRESCRIBE THE PROBLEM

- Sam (patient with knee pain during cycling) audio from
  Clam shell king *Try everyday?* *Best advice*

THE physio matters PODCAST

- The majority of your patients, will not do your exercises Belcon et al (1984) *Arthritis Rheum*
- To help motivate, try aligning the exercise with the problem identified in LP and assessed in PER.
- It should clearly align with their goals.
- Reps/sets in hands of patient (**tolerable** during and 24-48hrs after – **does not have to be pain free**)
- Habit program vs exercise program

TO TRY TOMORROW

Consider after exercise prescription:
"Why are you doing these exercises again?"

MANAGEMENT

Flare-Up Plan

- Safety of a mechanic in car on long road trip
- Case Study x
- Persistent knee pain, Diagnosis OA, 55 years, non-exerciser,
- Has just done 3 months of exercise rehab, pain from 5/10 walking 3km initially
- Now able to complete long 2hr trail walk with friends on Sundays with mild post exercise pain

- What are the components to address before you let them go about if their pain was to become worse again? (ie the flare-up plan)

LPBES student from PER had to DPFR

MANAGEMENT

Flare-Up Plan

- Normalise a return of pain (without nocebo)
- Understand it is unlikely damage
- Understand their contributors to pain
- Know how to get back in control
- Contact me if stuck

TO TRY TOMORROW

Consider:
Giving your patient a written plan if their pain worsens

LPBESS student from PER had to DPFR

MANAGEMENT

RESOURCES

- People have a working memory capacity of 3-5 new pieces of information (and it's usually not what you want them to retain) Cowan (2010) *Curr Dir Psychol Sci*
- Provide key points in written/handout form.
- Ask if they'd like more information about why they hurt, or stories of people in a similar situation.
- Our top 5 resources are (links to these are in the resources folder):

Kevin:

- FXNL Media: Persistent Pain in 5 mins and Imaging
- Back Pain – Separating fact from fiction – Prof Peter O'Sullivan
- Jamie E's story – PainHealth
- Load vs Capacity – RunningReform
- Runners and cyclists have healthies discs paper (Nature and ACSM)

Nic:

- Exercise and Pain Video – Pain Health
- 23.5 hours – Dr Mike Evans
- Pain in Children – Midland Physio website
- Joe Rogan and Matt Walker podcast #1108 – Why we sleep
- Why does back pain persist – Body Logic Physiotherapy website
- Massive disc prolapses resolve paper – Benson 2010

TO TRY TOMORROW

Consider:
Ask permission to provide supporting research that helps explain why your patient hurts and what they can do about it.

LPBES the student from PPER had to DPFR

CONSIDER:

LISTEN: Try to really engage/listen for first 45 seconds without interrupting.

PROBLEM: "Can you tell me 1-3 key tasks/activities that you are unable to do because of this problem?"
"If your pain improves what would you be doing?" "How would your life look differently if you had less pain?"
"What activities do you find annoying because of your pain?"

BELIEFS: Get to the *why* (the 1-3 key beliefs of why they think they hurt).
"What is your understanding of why you hurt?" or "Why hasn't this got better?"

EXPECTATIONS: "What are you expecting from Physio?

SUMMARY: Asking permission to summarise what you've heard. "Is there anything you'd like to add that you think is important?"

PROBLEM: "These are the 1-3 challenges you mentioned to me before, I want to look and help you with them?"

EXPERIENTIAL LEARNING: Before lecturing, see if you can educate with experience.

REFLECTIVE QUESTIONS: "What does that mean to you?" or "How do you make sense of this?"

DIAGNOSIS: "So what have you learnt about the things that might be contributing to your pain today?"

PROBLEM: "Why are you doing these exercises again?"

FLARE-UP PLAN: Giving your patient a written plan if their pain worsens

RESOURCES: Ask permission to provide supporting research that helps explain why your patient hurts and what they can do about it.

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Further Resources:

PODCAST: www.kevinwernli.com/LevelUp

Communication Quiz: www.lowbackpaincommunication.com

QR code for brief feedback quiz – link to slides and resources at end of quiz

Or go to:
Tiny.cc/CommunicationQuiz

Questions?