Communication as a Dynamic Dance: Physiotherapy Clinical Educators' Conceptualisations of Effective Communication in Final Year Physiotherapy Students in New Zealand

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ABSTRACT

Effective communication between the physiotherapist and patient is fundamental to physiotherapy practice. In Aotearoa New Zealand, students must demonstrate "effective communication" to become registered, yet it is unclear what constitutes effective communication. Nor is it clear how clinical educators, who assess students' communication, conceptualise effective communication. This lack of clarity may have implications for how students' competency is supported and assessed. This research explores how clinical educators conceptualise effective communication in final year physiotherapy students in musculoskeletal clinical settings in Aotearoa New Zealand. Guided by Interpretive Description, data were gathered from physiotherapy clinical educators using two data sources: written reflections from watching a pre-recorded student-patient interaction, and semi-structured interviews. Data were analysed using reflexive thematic analysis. Analysis of data from seven clinical educators suggested effective communication to be a dynamic dance, featuring continuous interplay between the physiotherapy student and patient. This primary theme had three subthemes each highlighting a distinct feature of communication: 1) Adapting communication moves in response to patients; 2) Control of the interaction; and 3) Building rapport with patients. Findings indicate communication skill development is complex and evolves over the course of one's professional life. Skill development is also embedded within broader understandings of the role and function of the physiotherapist and, accordingly, supporting students to develop communication competencies requires further attention from educators and researchers alike.

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INTRODUCTION

Communication is an essential component of physiotherapy practice and a growing body of literature exists demonstrating the importance of communication in healthcare (Grenfell & Soundy, 2022; King & Hoppe, 2013; Ong et al., 1995; Umberfield et al., 2019). Effective communication is associated with better health outcomes (Hall et al., 2010; Lang, 2012), treatment adherence (Fuertes et al., 2007), patient safety (Ong et al., 1995), and improved quality of services (Hall et al., 2010; Kurtz et al., 1988). In contrast, ineffective communication in healthcare is a leading cause of unintended patient harm and sentinel events (Krautscheid, 2008; Umberfield et al., 2019). Failure to communicate clearly with patients about their health conditions and treatment choices, and inadequate communication between health professionals can contribute to patient harm (Branch et al., 2021; Dhairyawan, 2024). For instance, communication barriers between healthcare professionals and patients is associated with an increased falls risk (Sullivan & Harding, 2019) while miscommunication between healthcare professionals when ordering or prescribing medication has resulted in dosage errors and drug interactions (Branch et al., 2021). Phillips et al. (2001) found 9.8% of medication errors were fatal in the US.

It has been suggested that "effective communication" is not well understood in physiotherapy (Bright et al., 2018). In healthcare, effective communication has been defined as occurring when "the sender and receiver connect with each other, initially for the common purpose of exchanging information and achieving mutual understanding" (O'Toole, 2020, p. 4), and where there is a sense of reciprocity and shared collaboration (Roter et al., 1987). Yet, research indicates that physiotherapy students in Aotearoa New Zealand perceived communication not as collaborative and responsive but instead as "unidimensional and unidirectional" (Bright et al., 2018, p. 4). Communication was perceived as something done to patients rather than mutually co-constructed with them (Bright et al., 2018). However, collaborative discussions between physiotherapists and patients has been suggested as a hallmark of "expert

physiotherapists" (identified by their physiotherapy colleagues) (Jensen et al., 2000). This potential disjuncture between student and expert clinician understandings and practices of communication supports the need to establish clarity about what constitutes "effective communication" in physiotherapy practice. This may subsequently inform how students can be supported to develop their communication skills.

In New Zealand, the Code of Health and Disability Services Consumers' Rights states that consumers have the right to "effective communication", described as being in a "form, language and manner that enables the consumer to understand", as well as "an environment that enables both consumer and provider to communicate openly, honestly, and effectively" (Health and Disability Commissioner, 2023, Section Rights of Consumers and duties of Providers; Right 5:1). In addition, the Physiotherapy Board of New Zealand, the national regulator of physiotherapy programmes and profession, considers communication core to physiotherapy. Physiotherapy practice thresholds detail key competencies within seven roles that physiotherapists must demonstrate to become registered. One of these competencies is "communicator", although interpersonal communication is implicit in other roles (Physiotherapy Board of Australia and Physiotherapy Board of New Zealand, 2023). Examples include "use clear, accurate, sensitive and effective communication to support the development of trust and rapport in professional relationships with the client and relevant others" and "engage in an inclusive, client centred, collaborative, consultative and where relevant culturally appropriate, and responsive model of practice" (Physiotherapy Board of Australia and Physiotherapy Board of New Zealand, p. 15).

Central to these descriptions of communication is the need for adaptive and responsive communication styles. This may be particularly important in New Zealand with its unique demographic. Physiotherapists, including students, often work with people from culturally and linguistically diverse backgrounds that differ from their own. This requires them to express culturally responsive approaches to communication. This may be of particular importance in New Zealand, as there is a legal requirement to uphold the Te Tiriti o Waitangi, which emphasises the importance of culturally responsive and safe behaviours towards Māori (Curtis et al., 2019). In 2022, only 5% of practising physiotherapists were Māori and 1% of practising physiotherapists identified as Pasifika (Physiotherapy Board of New Zealand, 2022). Many Māori and Pacific clients will access services within the Western health system from tauiwi providers; it is critical therefore that such communication and care is culturally safe. As such, there is a need for all physiotherapists to grow and develop their communication skills.

At the time this research was undertaken, there were three physiotherapy programmes. Of these, only two had fourth year students. While communication skills training may be integrated into taught curriculum of these accredited physiotherapy programmes, it is on clinical placement that student communication is practised and assessed in authentic clinical settings. Students undertake clinical placements with local providers in hospital and private practice settings, supervised by clinical educators who are primarily clinicians with an added responsibility of being a student educator. Clinical educators typically attend a training day in preparation for their role as educator and assessor. The clinical educator role includes identifying gaps in practice and providing constructive guidance through formal and informal feed forward and feedback to students, so threshold competencies can be attained. While communication is a physiotherapy practice threshold competency (Physiotherapy Board of Australia and Physiotherapy Board of New Zealand, 2023), research in Australia indicates that clinical educators infrequently comment on communication in physiotherapy student feedback, in contrast to other areas of physiotherapy practice (Woodward-Kron et al., 2012). In practice, clinical educators assess student communication skills by making observational assessments and then applying an evaluative score of the "quality" or "effectiveness" of the skill. In an attempt to improve standardisation and validity in assessments, the Assessment of Physiotherapy Practice tool (APP) (Dalton et al., 2011) was developed. Communication is addressed in two of the seven required competencies: students must communicate "effectively and appropriately" and demonstrate "clear and accurate documentation" (Dalton et al., 2011, p. 1). A Likert scale is used to rate communication from 0 to 4 with 4 indicating an excellent standard for the placement; both verbal and non-verbal communication are included (Dalton et al, 2009). While a list of performance indicators is provided, there remains little detail about these indicators. For instance, there is an ill-defined definition about what "effective" non-verbal communication might look like at an entry level of practice.

While "effective communication" is a professional requirement and right of consumers, it is not clear what constitutes "effective communication" in the clinical environment as interpreted by clinical educators. This knowledge gap prompted the question: How do clinical educators conceptualise effective communication in final year physiotherapy students in Aotearoa New Zealand?

METHODS

Interpretive Description (Thorne, 2016) was utilised in this qualitative study. Consistent with this methodology, a theoretical forestructure was developed, reflecting understandings from personal practice experience, from the literature and from Physiotherapy Board competencies, before commencing data collection. This theoretical forestructure informed the study design, including data collection, sampling decisions, and interview questions. Ethics approval was received from the Auckland University of Technology Ethics Committee (reference number 21/1).

Participants

Physiotherapists were eligible to participate in the study if they were currently providing clinical education or had provided clinical education in the preceding four years to final year students in musculoskeletal practice contexts within public health services or private practice settings.

Physiotherapists were ineligible if they were employed as clinical educators within university clinics. Both the student and the patient in the stimulus video were approached by the clinic lead and provided with a participant information sheet about the study. After indicating interest in the research, the researcher met with them, provided further information, and answered their questions before obtaining written consent.

Recruitment and sampling

Participants were recruited through professional physiotherapy and rehabilitation networks of the three researchers. Email advertisements were sent via the clinical centre leaders throughout New Zealand. If people expressed an interest in the research, they were invited to contact the primary researcher directly. Those interested in participating were then screened for eligibility and, subsequently, if eligible, were sent a participant information sheet. Purposive sampling was then used with the intent to seek diverse variation across a range of characteristics: workplace, gender, ethnicity, patient populations served, and years of experience (Carpenter & Suto, 2008).

Data collection

After receiving written informed consent, data were gathered through two sources: 1) written reflections of participants about what aspects of effective and less effective communication the student in the stimulus video demonstrated and 2) semi-structured individual interviews. The stimulus video was a 10 min video produced by the first author showing an initial interaction between a final year physiotherapy student and a client with chronic pain. By using a video as stimulus, it was anticipated a range of understandings of effective communication might be elicited. Participants were asked to record their observations of the student's communication skills and, in particular, what they perceived as the student's strengths and any areas where communication development was needed. The researcher reviewed these reflections and then participants took part in an individual interview to probe their reflections further and then to explore their wider experiences and perspectives about student communication. Interviews were semi-structured, with guiding questions informed by the theoretical forestructure of the study (Appendix A). Interviews were completed over 6 months and lasted 50–65 min. They were completed via Zoom (version 5.0.2; San Jose, California, United States) and transcribed verbatim.

Data analysis

Using reflexive thematic analysis (Braun & Clark, 2006), we developed an interpretive account of how clinical educators conceptualised effective communication. Reflexive thematic analysis was chosen for its alignment with Interpretive Description, as it acknowledges the researcher as an active party in constructing the analysis and seeking to generate an interpretive account of patterns within the data (Thompson Burdine et al., 2021). Both the researcher and the data shape one another (Braun & Clark, 2006). The analysis process is depicted in Table 1.

Research rigour

Steps to ensure rigour were framed by Thorne's (2016) methodological guidance. Epistemological integrity is when the research is conducted in a way that is consistent with underpinning epistemology (Thorne, 2016). In this study it was obtained through congruence between the research question, the methodological decisions made, and

Table 1

Data Analysis Steps

Steps	Process undertaken
Familiarisation with the data	Reviewed participants' written reflections of the stimulus video. Found a wide range of opinions on the communication skills of the student, some of which contradicted the others. Listened to and read the transcripts of the interview, making notes of first impressions of the data.
Coding	Coded the data, identifying features relevant to the research question. Codes were semantic (descriptive) and latent (interpretive). Example codes were control and tensions about priorities. Primary researcher did initial coding and this was reviewed by other two researchers.
Initial theme development	After coding, initial themes were constructed by the primary researcher and discussed within the research team. One example of an initial theme was tensions over priorities in care and how that shaped communication approaches.
Theme revision	An iterative and ongoing process of thematic development occurred within the team, returning to the data to revise and refine thematic interpretations as necessary. One main theme with three sub-themes were constructed.
Developing thematic boundaries	Developed thematic boundaries, to ensure each theme was distinct before themes were finalised and named.
Reporting on themes	Once finalised, themes were reported on and were written up with examples of data from the interviews to illustrate.

research conduct. Representative credibility as described by Thorne (2016) refers to the extent to which interpretations authentically reflect the variations and patterns within the data. In this study, it was supported by presenting findings in a manner consistent with an interpretive approach, to illuminate the complexity of the phenomenon under investigation. The primary researcher (CW) completed coding and initial theme development; this was further developed in conjunction with the other two researchers (FB, SM) until the final themes were constructed. According to Thorne (2016), analytic logic (making analytic reasoning apparent) contributes to analytic credibility. This was obtained through reflexivity regarding the researcher's theoretical forestructure. An audit trail captured analytic processes. Data were interpreted into findings to demonstrate analytic decision making. Finally, interpretive authority involves ensuring claims or insights can be traced to patterns in the data and demonstrate reflexivity, which was supported through researcher reflexivity and discussions within supervision to test and defend interpretations.

RESULTS

Participant characteristics

Seven participants from around New Zealand were interviewed. Table 2 presents participant characteristics.

Four participants were clinical educators in private practice and three were clinical educators working in public hospitals. Six of the seven participants had more than five years' clinical experience, with 80% having more than 10 years' clinical experience. Participants reported they worked with patients with a diverse range of ethnicities including New Zealand European, Māori, Samoan, Chinese, and Indian patients. To protect participant anonymity, pseudonyms have been used and ethnicity and geographical location have not been stated.

Constructed themes

Communication as a dynamic dance

One primary theme, "Communication as a dynamic dance" was constructed from the data. This "dance" occurred between the physiotherapy student and the patient. Three core features of communication were expressed in each of the subthemes. The first subtheme was "Adapting communication in response to individual patient needs and to the clinical context". This subtheme describes how students were expected to adapt their communication in response to what the patient shared and how they presented moment by moment, as well as to the clinical context and physical environment. The second subtheme, "Control of the therapeutic encounter", describes how educators expected students to use communication to maintain control of the interaction. The third subtheme, "Building rapport with patients", described the various ways clinical educators expected students to make a connection with the patient while remaining professional.

Adapting communication in response to individual patient needs and to the clinical context

Clinical educators indicated that communication needed to be responsive to the individual patient needs and to the clinical context to be effective. They suggested verbal and non-verbal communication need to be "on the move" (Cam). For example, educators expected students to read both the patient and the clinical situation, make a judgement in the moment about what actions were needed, and then adapt their communication as necessary. The most common examples of communication adaptations related to sharing clinical information with patients, such as adapting the language they used from "jargon to lay language" (Amanda), or if a patient could not understand the student's instructions, they needed to "adapt the way they gave instructions" (Gordon). Educators suggested students needed to be able to "take complex information and convey it simply and succinctly" (Ann). Some educators expected students to adapt their communication to the age and personality of the person, with two suggesting it was important to mirror the client's communicative approach (Ann and Tina).

Clinical educators appeared to most readily reflect on communication in the context of taking a case history, suggesting the "pace [of the interview] and frequency of questions" (Sally) needed to be responsive and varied to suit the person. One characteristic of less effective

Table 2

Participant Characteristics

Participant pseudonym	Gender	Workplace	Location[a]
Cam	Male	Public	North
Ann	Female	Public	North
Sally	Female	Public	North
Amanda	Female	Private	South
Tom	Male	Private	South
Gordon	Male	Private	South
Tina	Female	Private	South

Note. 'Private' refers to participants working in private practice; 'Public' refers to Health New Zealand - Te Whatu Ora (i.e., the government-funded healthcare system).

[a] North and South indicate on which island participants were based.

communicators was those who simply ran through a list of questions in a linear non-responsive manner. Ann gave an example of a student "bombarding" a patient with rapid-fire questions, commenting she perceived that the client appeared to disengage, something the student failed to notice and, therefore, did not attempt to remedy by changing their communication. Students were also expected to have flexibility to change the session plan in response to what the patient shared. For example, Sally recounted an instance of a client telling a student her husband had died a week ago, reporting that the student continued with her pre-determined list of questions, asking how the client's hip pain was. While, in this instance, the educator described modelling the response she felt was appropriate, clinical educators often appeared unsure of how to teach students to be adaptive and responsive to a multitude of situations they may face.

Not only did educators want students to consider the messages they were conveying to the patients through their verbal and non-verbal communication, but they also expected them to attend to the messages the physical environment conveyed and make adaptions. This included their positioning in relation to the patient, considering variables such as eye contact and being at the same level of the patient. These appeared to reflect considerations around power, rapport, and client safety. They also expected students to attend to the messages the physical environment conveyed and make adaptions. For instance, Cam described a gym commonly used by disabled people, which had "posters of able-bodied people on the walls" and "physiotherapists in sporty attire", which could potentially make a patient feel uncomfortable before they even started. Clinical educators appeared to consider students had some responsibility for adapting the physical environment, even though aspects of this were designed by the service and were in place before the students had arrived on placement.

There was an expectation of students adapting their communication to so-called "professional" communication. Clinical educators described a range of indicators of professional and unprofessional communication, something they considered was commonly conveyed through non-verbal communication, stating that students need to become aware of their body communication and the messages it conveyed to patients. It appeared easier for clinical educators to identify examples of inappropriate communication. For instance, one educator suggested that "tucking their legs up under them while interviewing a patient" was not professional (Cam), while being distracted by their phones during sessions was also disapproved of (Gordon). Colloquial language, evident in terms like "bro" and "mate" (Amanda) was also deemed inappropriate or unprofessional. Professional communication was seen to be important for conveying their emerging identity as a physiotherapist.

There appeared to be an expectation that students would not simply adapt to the client's communication needs, but they would seamlessly shift between communication approaches to achieve their therapeutic objectives. This is part of the dynamic dance to change moves frequently to achieve the balance of what is needed from both the therapist and the client's perspective. One educator, Cam, described this as moving between "patient-centred communication and therapist-centred communication". Patient-centred communication was described as letting the patient tell their story while therapist-centred communication was described as using closed questions to "nut down on things" (Cam) and get the information they needed. Educators described a range of communication behaviours that might reflect using both patient-centred and therapist-centred communication. One commented on students needing the ability to be person-centred but also drive the agenda and get the information they need (Cam). Others commented on students needing to have the ability to "structure things" and keep to the "agenda" (Ann) but also be able to "empathise with the human in front of them" (Ann), to be "immersed in the person" (Gordon) and "ride along with the person on their journey" (Sally). Educators in this study appeared to expect students to be able to move between these approaches seamlessly. However, they struggled to articulate how students could be supported to develop this flexible communication.

Being able to adapt and respond to patients was valued by all educators; however, there was little evidence of educators proactively preparing students to be adaptive in the ways they described as important. Educational approaches participants described appeared to be reactive, occurring after noticing communication breakdowns, or observing communication that occurred in ways other than what the educator perceived as "effective". For instance participants sometimes had to step in when students failed to make important adaptions. Educators recognised that many students appeared to find it challenging to adapt to individual patients and contexts, describing their communication as "not natural" (Ann), "robotic and wooden" (Sally), and "somewhat forced or abrupt" (Cam), but educators considered this complex skill evolved with time.

Control of the therapeutic encounter

Educators deemed it important that students were in control of the therapeutic encounter through their communication. This reflected a view that the primary goal of an initial interaction was reaching a diagnosis. As such, asking the "right questions" (Ann) and keeping the person on the "right track" (Tom) were viewed as core communication skills. Educators considered control could be demonstrated by knowing how to "kindly cut someone off" (Tina), "bring someone back to the space if they talked about something too far away" (Sally), by using "closed ended questions" (Ann), and by "summarising what had been said" (Ann). "Signposting" (Ann) (using verbal clues to signal a change in direction of the interview) was also described as a way to maintain control. Losing control was considered a risk as it could mean the student did not have enough information to reach a diagnosis or plan assessments and interventions (Amanda). While all educators agreed it was important that students display attentiveness through the use of non-verbal communication, caveats still existed in relation to the type of information they required students to gather. "Effective communication" meant gathering the information that was pertinent to the person's injury and diagnosis.

Responses to the stimulus video provided more nuanced insight into the clinical educators' perspectives and demonstrated that there was a wide diversity in the way educators perceived effectiveness in communication. Some educators felt the student in the stimulus video "lost complete control of the session" (Gordon) and there was "a risk the patient took over the session" (Tina). They felt the student needed to "take control" (Tina), "get back to the agenda" (Gordon), and "was at risk of not getting enough information" (Tina). Yet others praised the student's responsiveness, referring to the way the student did not impose "a structure on the patient" (Sally) and instead "used really open-ended questions and gathered information as she listened" (Cam), commenting that she "never lost control" (Sally). Despite the different opinions about what constituted control, control was considered necessary by all educators to enable a diagnosis to be made in a timely manner.

Building rapport with the patient

Educators valued students who were able to build and maintain connections or rapport with their patients, while appearing professional. Rapport was said to be built using a combination of verbal and non-verbal communication. Several educators described the importance of "using humour" (Sally), "banter about family" (Ann), "sport" (Cam) and "remembering what a person had shared and asking about it next time" (Ann) to build connections with the patient. This was thought to help show they were viewing them as a person and not just a number. The use of non-verbal communication was also considered important in building rapport. When listening to a patient share their story, educators valued students who could "mirror the patient's body posture" (Ann), "show eye contact" (Tom), "nod to clarify understanding" (Ann), and "sit still with appropriate body posture" (Sally), which Sally said would demonstrate they were "riding along with the patient on their journey" and maintaining connection.

When asked to describe students they considered less effective communicators, educators described them using terms such as "nervous" (Ann), "struggling to get past yes or no questions" (Cam), "lacking in rapport" (Ann), "awkward" (Sally), and "robotic" (Sally), or as "over communicators who just talk and talk and talk" (Tina). In contrast, more effective communicators were described as "good at listening" (Tom), "responsive to patients" (Sally), "relaxed and friendly" (Tina), "able to use a conversational tone" (Cam), and "not interrupting too much" (Amanda). Being able to show empathy was also considered part of developing rapport. It appeared that students who presented as confident in themselves, and in their physiotherapy knowledge, were considered to more easily build connections with patients. Only one educator talked about ways she supported students to develop rapport; however, she noted that if the student was less attuned to interpersonal communication, this was more challenging to support. This suggests educators may require support as to how to best support students who are struggling to build rapport with patients.

DISCUSSION

This study aimed to understand how clinical educators conceptualised effective communication in final year physiotherapy students. Clinical educators envisioned communication between a student and their patient to be like a dynamic dance. Educators wanted students to be able to build rapport with their patients using a range of communication approaches, to continually adapt their communication to the patient and what was happening, while maintaining control of the interaction so they could reach a diagnosis. However, the study also highlighted the lack of consensus among educators about what constitutes effective communication.

There was consensus from all study participants that students need skills to build rapport with their patients, a concept supported by existing research (Allen & Roberts, 2017; Kidd et al., 2011; Peiris et al., 2012). What is less well documented in physiotherapy literature to date, compared with medical literature (Carrard & Mast, 2015; Verheijden et al., 2022), is the need for therapists to adapt their communication to patient preferences and needs, and indications of what adaptions might be appropriate in different circumstances. For instance, Epstein and Street (2007) argue there is not one universally agreed way to communicate and a clinician's ability to monitor and deliberately adapt their communication to meet the need of their patients is essential. Adaptive communication is also evidenced in physiotherapy regulatory documents. The Physiotherapy Board of New Zealand Threshold Competencies (2023) states students must be able to "adapt their written, verbal and non-verbal communication to reflect the language proficiency, comprehension, impairments, age and health literacy of the client and relevant others" (Physiotherapy Board of Australia and Physiotherapy Board of New Zealand, 2023, p. 17). Yet what is unknown is how students learn how to "adapt" and "respond" to the unique needs of clients. This research suggests that while there are a variety of ways physiotherapy students need to, and are expected to, adapt their interpersonal communication, there is currently a lack of clarity and consistency in the way this is taught and supported.

This study provided further insights into the complexities of clinical communication, demonstrating that "effective communication" is not simple to define, and nor is it universally understood. Study findings reinforced that effective communication is dynamic. Each clinical interaction depends on how both the patient and the student co-construct the content and context of the encounter (White & Danis, 2013). This suggests such interactions cannot be reduced to a set of rules about the right thing to do or say, but that they need to be responsive. Mescouto et al. (2022) propose an approach that can help physiotherapists better attend to such responsiveness and build collaborative interactions with patients. They suggest this can be done by reflecting on practice, being comfortable with silence, and making space for more holistic care. Our research highlights the need for such practical guidance. Study findings support recommendations by Salmon and Young (2011), who argue there should be an emphasis on developing

skilled communicators, rather than simply teaching discrete communication skills. While there is value in learning specific skills such as questioning and active listening, skilled communicators can integrate these skills and use them to navigate unique situations, make sound judgements, and develop their own personal style (Salmon & Young, 2011), all features that clinical educators in this study valued.

Clinical educators in this study placed a strong emphasis on student control of sessions, although there were differing viewpoints about what constituted control. It appeared control was important so that physiotherapists could enact their professional agenda, which, in the context of musculoskeletal practice, was centred on making a provisional diagnosis. It would appear the notion of control is linked to wider philosophical approaches to physiotherapy, which see the role of assessment as reaching a clinical diagnosis (Jiandani & Mhatre, 2018). However, some participants in this study advocated for students to be able to shift between a patient-centred and a therapist-centred approach, suggesting a more balanced approach to communication was needed, in which control was shared and which could see students follow the lead of patients. Hiller et al. (2015) and more recently, Verheijden et al. (2022) argue that communication may work best when clinicians move between therapist-centred communication, which focuses on therapist agendas and timeframes, and patient-centred communication, which focuses more on the patient's perspective and the psychological and social aspects of injury and care. While educator participants in our research acknowledged there is a need to incorporate both these approaches, as reflected in the metaphor of the dance of communication, there was still an implicit perspective that, ultimately, control and gaining the information the therapist needed was most important.

Clinical educators have a vital role to play in providing suitable and supportive learning in authentic clinical environments where students can develop and evolve their communication skills (Woodward-Kron et al., 2012). Participants rarely expressed their approach to teaching communication skills in relation to known health communication frameworks such as patient-centred communication. Hiller et al. (2015) also found that physiotherapists rarely reference or acknowledge any communication models. Furthermore, while not specifically asking participants about learning theories in this study, clinical educators did not refer to or acknowledge any learning theories or approaches used to frame student learning or refer to knowledge gained in clinical educators' training. Learning theories and approaches differ from each other in the way they understand the purpose and nature of knowledge and what it means to learn (Baker et al., 2021). If clinical educators are unfamiliar with these, they are less likely to facilitate optimal education irrespective of the clinical context (Baker et al., 2021). While there is a need to better support clinical educators in how to support students to develop their communication competencies, we suggest this is also an area where students need explicit instruction within their university curriculum, with White (2025) arguing this must include opportunities for learning, feedback, and reflection guided by experienced educators who draw on communication theory and evidence to guide teaching.

Future research

Further research is needed to better understand how to define effective communication and make the concepts visible to students, clinical educators, and lecturers, without oversimplifying what is inherently complex. Further research is needed to determine how educators can best facilitate the nuances of effective communication within the clinical environment, determine assessment modalities to assess these nuances, and provide detailed feedback to students.

Study strengths and limitations

This research offers novel insights into understandings of communication in New Zealand. Methodology facilitated this through use of simulated videos and interviews. As the first study in this area, it provides useful insights for practice and future research. However, we acknowledge that the sample was somewhat heterogenous, lacking ethnic diversity. Having participants from varied ethnicities and cultural backgrounds may have broadened conceptualisations of effective communication. This could give insights for physiotherapy students about what is valued by different groups of people regarding communication. While our sample size was small, our findings provide sufficient information and context for readers to consider transferability to their own practice contexts.

CONCLUSION

This study has highlighted how clinical educators in Aotearoa New Zealand conceptualise effective communication in musculoskeletal physiotherapy. "Effective communication" was conceptualised as a dynamic dance between the physiotherapy student and the patient, but one in which the student is ultimately in control. Yet it is also clear that communication is complex and supporting students to develop their communication competence is also complex. This study also demonstrated that communication practices are shaped by broader perspectives of physiotherapy practice. Educators need support to make expectations about adaptive and responsive communication visible to students both in practice and in assessment. We are in the early days of developing the evidence base for communication in physiotherapy. While there is a need for more research and robust education, there is also a need to recognise the crucial role clinical educators have in supporting communication and to provide them with support and education to equip and empower them in their role supporting students in clinical practice contexts.

KEY POINTS

1. Effective communication is an essential element of physiotherapy practice, yet what constitutes effective communication is not well understood and agreed on.
2. Clinical educators conceptualise communication as dynamic and requiring continuous adaptation, yet it is not known how to support the development of such responsive communication.

3. The diverse opinions about effective communication could make it difficult for students to know what is expected of them, and for educators to assess communication competence.
4. Communication competence was seen as a continuum with a view that skills are likely to evolve over the course of one's professional life.

DISCLOSURES

Funding was received from Auckland University of Technology. No conflicts of interest exist that may be perceived to interfere with or bias this study.

PERMISSIONS

Ethical approval was obtained from the Auckland University of Technology Ethics Committee (reference number 21/1).

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CONTRIBUTIONS OF AUTHORS

All authors conceived the design of the study. CW was the primary researcher and undertook all the interviews and completed the research in fulfilment of her MPhil, supervised by FB and SM. All three authors contributed to data analysis, writing and editing this manuscript.

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Appendix A

LIST OF INDICATIVE QUESTIONS FOR THE INTERVIEWS

Video review

- What elements of effective communication did you observe in the student–patient interaction?
- What elements of less effective communication did you observe?
- What feedback would you give this student? Anything else?
- How would you scaffold this student's learning regarding communication skills?
- What would you expect in this student's reflection after the session about communication?
- Have you had students with similar communication skills? How did you scaffold them?

Understanding effective communication

There is a lack of consensus in the literature about what constitutes effective communication.

- When you look for effective communication what key features would you be looking for? Anything else?
- Can you think of any non-verbal features of effective communication you might look for?
- Can you think of a student who displayed poor communication skills? What behaviours did you notice in that student?
- Can you think of a student who displayed average communication skills? What would that look like?
- Can you think of a student who showed outstanding communication skills? What did that look like? What kind of behaviours did they demonstrate?
- Can you think of a scenario where communication was lacking and caused some concern for the patient? What happened? If I was sitting next to you, what might I have seen? What did the communication look like? Were you able to help the student further develop? What was helpful in doing that?
- How do students demonstrate professional communication?
- Does the APP assessment tool capture your perception of effective communication?
- How do students explore patients' experiences of their injuries/illness?
- Why do you focus on the subjective first and then the objective, etc.?

Ability to adapt to patients' needs

The Physiotherapy Board of New Zealand says a physiotherapist should be able to adapt communication appropriately.

- What does this mean to you when working with students? Anything else?
- Can you tell me about an average final year student? Were they able to adapt their communication to the needs of the patient? In what ways?
- Have you had a student with poor ability to adapt his/her communication? What behaviours did they show?
- What behaviours might you see in a student who was good at adapting communication?

How does culture have an impact on effective communication?

- How would you expect a student to adapt their communication to be culturally responsive?

How do you support a student's communication skills while they are on placement?

- What resources to you use to support students with communication?
- Do you feel you have had enough training to support effective communication?
- Is there anything you think would be useful to help support students with communication skills?