Health Communication
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/hhth20

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Joy Goldsmith[a], Elaine Wittenberg-Lyles[b], Brandi N. Frisby[c] & Christine Small Platt[a]
[a] Department of Communication, University of Memphis
[b] Division of Nursing Research and Education City of Hope
[c] Department of Communication, University of Kentucky
Published online: 22 Aug 2014.

Health Communication, 30: 737–745, 2015

ISSN: 1041-0236 print / 1532-7027 online
DOI: 10.1080/10410236.2014.898014

Routledge
Taylor & Francis Group

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Joy Goldsmith
Department of Communication
University of Memphis

Elaine Wittenberg-Lyles
Division of Nursing Research and Education
City of Hope

Brandi N. Frisby
Department of Communication
University of Kentucky

Christine Small Platt
Department of Communication
University of Memphis

Entry-level physical therapists provide clinical care for patients with functional mobility limitations. Their care spans the continuum of settings, disease processes, and diagnoses. Although effective communication skills are required to conduct physical therapy work, there is limited instruction provided in physical therapy education and students receive little exposure to seriously or chronically ill patients. The goal of this study was to assess the effects of communication training for the entry-level physical therapist facing palliative and end-of-life communication with patients/families. A pre–post survey design and narrative writing were used to assess the effect of the COMFORT communication training curriculum provided to doctorally trained, graduating physical therapists. The study demonstrated decreased student apprehension about communicating with dying patients and their families, and a comparison of mean scores reflecting the students' communication knowledge, confidence, and behaviors increased in a positive direction. As students became more willing to communicate, they were also more adept at integrating task and relational messages, as well as assimilating emotional support messages for patients and families. This study shows promise for the feasibility and utilization of the COMFORT curriculum for entry-level physical therapists. Further research should address the integration of COMFORT earlier into physical therapy education, as well as assess evidence of COMFORT communication skills in the clinical context.

For the physical therapist (PT), negotiation, interaction, and communication are directly related to improved treatment outcomes (Oien, Steihaug, Iverson, & Raheim, 2011). Achieving patient adherence comes from the therapist's ability to build confidence and trust by demonstrating clinical listening and empathy (Marshall, Donovan-Hall, & Ryall, 2012; Potter, Gordon, & Hamer, 2003). Patients participating in physical therapy report that a therapist's caring and effective communication influence adherence to treatment recommendations (Cooper, Blair, & Hancock, 2008;

Correspondence should be addressed to Joy Goldsmith, PhD, Communication, University of Memphis, 235 Art and Communication Building, Memphis, TN 38152-3150. E-mail: joy.goldsmith@memphis.edu

Hills & Kitchen, 2007). Satisfied therapy patients are more inclined to experience better quality of life outcomes (Hush, Cameron, & Mackey, 2011).

Evidence shows that communication skills training for clinicians improves (a) the quality of life of patients (Fukui, Ogawa, & Yamagishi, 2011), (b) clinician skills and confidence (Sheldon, 2005), (c) patient satisfaction with information and quality of care (Uitterhoeve, Bensing, Grol, Demulder, & VanAchterberg, 2010), and (d) the effectiveness of communication for all parties. Overall, communication skills training can improve the quality of patient-centered care provided to cancer patients and their families across the continuum of care (Visser & Wysmans, 2010).

Despite strong evidence supporting the importance of communication effectiveness and preparation for the PT, communication training is not a developed area of curricular content in physical therapy education (Chiarelli, Johnston, & Osmotherly, 2013). An absence of cohesion across clinical education components means that opportunities to reinforce and apply psychosocial concepts are lacking. Once in practice, PTs encounter biomedical protocols, continuing education that reinforces a biomedical paradigm, a lack of certainty about key psychosocial dynamics and ways to assess these in a busy practice context, and finally, reimbursement systems that do not prioritize psychosocial aspects of care (Foster & Delitto, 2011). Embedding psychosocial learning into everyday practice for entry-level PTs is a profound challenge. In order for patient-centered physical therapy to be achieved, physical therapist communication education and training is needed that is explicitly inclusive of psychosocial engagement.

BACKGROUND

Physical Therapy and Palliative Care

The patient population increasingly represents an older demographic; as baby boomers experience more sustainable health and life expectancy, they also encounter more illness and health events including strokes, heart attacks, and orthopedic injuries/procedures requiring physical therapy (Bureau of Labor Statistics, 2012). As a result, the employment of physical therapists is expected to increase 39% by 2020 and will largely involve working with patients who are receiving palliative and end-of-life care. As an area of medicine, palliative care is provided to patients who are seriously, chronically, or terminally ill and aims to relieve suffering and improve the quality of life for patients and their families. Exposure to palliative care and its training is limited for physical therapists (Chiarelli et al., 2013). Entry-level professionals report a lack of confidence and preparation in working with this population (Morris & Leonard, 2007). The importance of palliative care to most clinical and demographic populations has been increasingly acknowledged (Brajtman, Hall, & Barnes, 2009; Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010; O'Connor, Fisher, & Guilfoyle, 2006).

Physical therapy contributes to respiratory care, dyspnea, pain control, mobility, and improved positioning to decrease pain (Nelson, Hasson, & Kernohan, 2012). For many people with end-stage disease, protracted and acute symptoms can be treated with physical therapy soft tissue techniques including myofascial release, trigger point therapy, muscle energy techniques, positional release techniques, traditional massage, and deep tissue massage (Pyszora, Wojcik, & Krajnik, 2010). Physical therapists employing palliative care also provide patient and family education specific to physical therapy, such as therapeutic techniques to control pain, digestion, tension, and increase appetite (Pyszora et al., 2010).

The National Consensus Project (NCP) for Palliative Care offers clinical practice guidelines to establish quality standards for the practice of palliative care. NCP's guidelines are expressly intended as an interdisciplinary document and are representative of the inherent interdisciplinary nature of palliative care. Communication and its value to both palliative care and physical therapy are unique in that these specialties present a high frequency of difficult conversations for patients, families, and health care professionals (National Consensus Project, 2013). Given the increasing demand for physical therapy among a growing population that will need palliative care, the development, assessment, and delivery of communication training for physical therapists is critical.

Physical Therapy and Communication

As early as 1983, the American Physical Therapy Association (APTA) invested in understanding the impact of communication education and training skills on physical therapy students. Early evidence demonstrated that as little as 10 hours of instruction in communication skills improved patient communication including responsiveness and decreased the practice of issuing directives to patients (Payton, 1983). The shift to doctoral-level PT preparation in the 1990s was motivated by the increasing need for PTs to care for culturally diverse populations. Explicit integration of social sciences into the curriculum added an additional year of study. Changes in medicine and health care delivery also intensified competency demands for understanding patient/family belief systems (American Physical Therapy Association, 2000; Purtilo, 1993).

In 2009 the American Physical Therapy Association established a consensus of sixteen foundational skills indispensable to a new graduate physical therapist. Within the skills of intervention and education, communication is recognized as central, with a special focus on verbal rapport, interpersonal sensitivity, conflict negotiation, and cultural competence. Key components include eliciting the patient's story and recognizing/adapting to individual differences. Likewise, the Commission on Accreditation in Physical

Therapy Education (2011) declared that physical therapist professional curriculum must include content and learning in communication, training students in expressive, receptive, and culturally competent communication with patients, families of patients, and team members.

COMFORT Communication Curriculum

The COMFORT communication curriculum addresses the gap between palliative care education and communication training for physical therapists. A relational and transactional approach to health care training will require communication education and a focus on narrative clinical practice (Wittenberg-Lyles, Goldsmith, Ferrell, & Burchett, 2014). The patient/family experience of serious illness is a context in which narrative theories and methods can inform clinician training as well as health care systems about ways in which quality improvement can be achieved. Therefore, narrative is the primary theoretical foundation of COMFORT communication training. COMFORT unites complementary work in communication studies, nursing, medicine, and interprofessional education to present a theoretically grounded curriculum for teaching communication to interprofessional healthcare professionals. COMFORT is an acronym including C–Communication, O–Orientation and options, M–Mindful presence, F–Family, O–Openings, R–Relating, and T–Team, and is detailed in a volume about communication and palliative nursing (Wittenberg-Lyles, Goldsmith, Ferrell, & Ragan, 2012). Health care professionals are taught to view their communication as both task oriented (providing information, educating) and relational (person-centered, partnership). Narrative communication is introduced as a communication technique to draw out patient/family stories, use the information as a guide in care planning, and provide person-centered messages in difficult communication situations. The use of nonverbal communication is also highlighted to emphasize relational communication strategies.

COMFORT relies on the narrative work of Charon (2004); her work describes narrative in the clinical setting as the principal vehicle to make suffering evident. In her seminal work, Charon (2004) establishes narrative competencies, which include (1) a combination of textual skills (i.e., identifying story, relating to multiple perspectives, recognizing metaphors) (2) creative skills (i.e., interpreting, imagining a variety of endings, building curiosity), and (3) affective skills (i.e., tolerating uncertainty, entering the mood of a story). These competencies are reframed specifically for palliative care within the COMFORT curriculum. First, bearing witness involves relating to others while also honoring their voiced and lived experience (Naef, 2006). Second, a form of active listening called deconstruction will help patients/families address gaps, ambiguities, and conflicting plots (Aloi, 2009). Third, externalization allows the patient/family to include information about their personal life, and helps to incorporate psychosocial communication into a diagnostic assessment (Aloi, 2009). Not only do these three components establish the core theoretical goals of COMFORT, but they advance the primary focus of the curriculum, which privileges the story of the patient and family in the health care interaction in order to more efficiently and effectively address goals of care. With this overarching conceptualization of narrative in clinical interaction, we now underscore features of multiple goals theory and person-centered communication as two points of additional theoretical focus in the physical therapy training described here.

A core axiom of communication is that every message includes both task and relational levels of meaning. While the content or task level of a message is primarily conveyed through words, the relational level is primarily manifested in nonverbal communication. Closely related to this notion of comingled intentions is multiple goals theory (MGT). The essential premise of MGT is that people often want more than one thing when they engage others in an interaction (Tracy & Coupland, 1990). Sometimes these goals are emergent, and sometimes they are known before an interaction begins. COMFORT training is intended to strengthen the PT's ability to identify and assess incongruent patient/family/clinician goals and to develop verbal and nonverbal communication strategies that address those incongruences. Goal identification and strategy development are pivotal in achieving intervention success.

Second, person-centeredness is the "extent to which the perspectives and feelings of distressed others are acknowledged, elaborated and granted legitimacy" and has been empirically validated as a key measurement of emotion support skill (Burleson, 1994, p. 258). Comforting behaviors expressed through supportive messages are termed person-centered messages (PCMs) and have been judged as more supportive and encouraging for those having difficulty addressing their feelings (Jones, 2004). To achieve verbal clarity, one goal of COMFORT is to train PTs to use PCMs that are high in emotional support. Low PCMs deny the patient's and family's feelings. Strategies shared with PTs in COMFORT training incorporated the highest forms of PCMs which include explicitly recognizing and legitimizing the patient's/family's feelings by elaborating on and articulating those feelings (MacGeorge, Gillihan, Sampter, & Clark, 2003).

This innovative curriculum is not a linear guide, an algorithm, a protocol, or a rubric for sequential implementation by clinicians, but rather a set of holistic principles that should be practiced concurrently and reflectively during patient/family care. COMFORT emphasizes the collaborative, reciprocal nature of clinician–patient–family interactions as participants relationally create and adapt to shared requirements, expectations, and desires. COMFORT has been shown to improve clinician self-efficacy, improve attitudes toward communication, and reduce communication apprehension (Goldsmith & Wittenberg-Lyles, 2013; Wittenberg-Lyles, Goldsmith, &

Ragan, 2010; Wittenberg-Lyles, Goldsmith, Richardson, Hallett, & Clark, 2012).

This study has been designed to determine the effect of COMFORT communication training on doctoral physical therapy students' communication knowledge, confidence, and behaviors regarding communication with palliative appropriate patients. Our research focused on the following questions: Does exposure to COMFORT communication training influence (1) student perception of comfort and confidence in communicating with palliative appropriate patients, (2) perceived comfort level performing communication skills, and (3) the ability for entry-level doctoral physical therapy students to enact narrative practice communication behaviors?

METHOD

Participants

During the final month of a 3-year doctoral program in physical therapy, students received COMFORT communication training as part of a required course named Public Health and Wellness. Previously, students had been exposed to curriculum addressing cultural competence, patient-centeredness, and plain language by clinical faculty. The supporting university's institutional review board approved the study. Participants agreed to participate in this study by providing written informed consent.

Description of the COMFORT Training

Two members of the research team and co-authors of the curriculum delivered a 6-hour COMFORT communication training during regularly scheduled course meeting times. This allotment of time is viewed as substantial in light of the preset curricular demands for the course, as well as the larger program of study. Sixty-four graduating doctoral students in clinical physical therapy were registered for the course. The session began with a brief introduction of palliative and hospice care and the benefits of physical therapy for this patient population. Students received five of the seven modules of the COMFORT curriculum through didactic lecture, video vignettes of real clinical encounters, patients, and caregivers, and short activities that demonstrated communication concepts. Modules M and T (M–mindful presence; T–Team) were not included during the intensive training due to delivery time constraints. Trainers selected these two modules for removal due to their length.

Procedures

Before and after the training sessions, students completed a survey. To measure student perception of comfort with palliative appropriate patients, we assessed their general willingness to communication and communication apprehension with dying patients. We also assessed confidence in communicating using a 5-point interval scale (not confident to very confident) modified to address either comfort or confidence (Sanchez-Reilly, Wittenberg-Lyles, & Villagran, 2007), and collected general demographics. General willingness to communicate was assessed with an attitude measure that consisted of six items measured on a 0–100 scale (McCroskey, 1992). The measure for communication apprehension toward dying persons included 30-item, 5-point interval scales (*strongly disagree* to *strongly agree*) (Hayslip, 1987). Comfort in communicating and communication skills confidence were measured using two 5-item, 5-point interval scales modified to address either comfort or confidence (Sanchez-Reilly, Wittenberg-Lyles, & Villagran, 2007). All scale reliabilities and means at pretest and posttest are reported in Table 1.

To assess behavior, students were asked to complete a reflective writing exercise consisting of six items. Students submitted these responses through their online course portal within 36 hours following the training. First, using three patient/family scenarios in which a psychosocial issue was key, students were asked to identify verbal and nonverbal communication strategies (task and relational) that would be most demonstrative of narrative clinical practice. Second, students were asked to produce three person-centered messages strategies for managing conversations in which patient/family feelings were included. Students were asked to write their response to the scenario using specific language and behavior they would incorporate in the interaction.

Analysis

Mean scores and standard deviations were computed for survey scales, and a repeated-measures multivariate analysis of variance (MANOVA) was performed for all outcome measures.

TABLE 1
Scale Reliabilities, Mean Scores, and Repeated Measures MANOVA Univariate Significance From Pretest to Posttest

Curriculum Outcome Variable	*Pretest α*	*Posttest α*	*Pretest M (SD)*	*Posttest M (SD)*	*p*
Willingness to communicate	.78	.82	59.04 (17.53)	57.83 (20.03)	.83
Comfort with skills	.62	.65	3.68 (0.51)	3.84 (0.48)	.10
Confidence with skills	.65	.70	3.64 (0.52)	3.77 (0.52)	.25
Communication apprehension with dying	.82	.83	2.68 (0.38)	2.57 (0.35)	.18

Coding. To measure communication behavior, six reflective writing responses to case study prompts were assessed for evidence of two COMFORT communication practices taught throughout the five modules: (1) three case prompts for task/relational communication, and (2) three case prompts for verbal response to emotion. The unit of codable response was the student's answer to each of the six case prompts.

Task communication and relational communication were demonstrated in these materials, and three levels of content were shared with students that exemplified (a) a complete lack of task/relational content, (b) a presence of task or relational content, and (c) the most superior communication, which included both task and relational communication features. These levels translate directly into the coding scheme for analysis of the responses. Similarly, four levels of performance were identified in the delivery of COMFORT to teach verbal response to emotions (i.e., [1] denial, [2] cursory recognition, [3] explicit awareness, and [4] pursuit of needs). See Table 2 for coding levels, descriptions, and features.

Two members of the research team first independently coded 10% of the data; once effective interrater agreement reached 80%, the two researchers each independently coded half of the remaining data set. Cohen's kappa revealed good interrater reliability (.774). In total, 246 message strategies were coded.

TABLE 2
Coding Levels and Descriptions

Level	*Feature*	*Description*
Task (Teach, Advocate, Educate, Coordinate) and Relational (Nonverbal Manifestation, and Acknowledgment of Relationship) Response		
1	No presence of task or relational	Student PT either ignores communication in response and relational opportunities or expresses dismissal
2	Task or relational communication	Student PT creates a message which includes at least one task or relational message feature
3	Task and relational communication	Student PT creates an explicit response that underscores one task feature and one relational feature
Verbal Response to Emotion		
1	Denial/disconfirmation/ deflection	Student PT ignores patient/ family emotion opportunity
2	Cursory recognition	Student PT produces automatic, script-like response, with minimal recognition and either changes or abandons the topic
3	Demonstrates explicit awareness	Student PT produces explicit communication that the patient/ family have shared a legitimate and unique challenge
4	Pursues emotions and needs	Student PT explicitly engages patient/family challenge and extends the conversation with inquiry

RESULTS

Overall, 64 students completed the curriculum and pre- and postsurvey, and 41 students completed the reflective writing exercises (with two students only completing three of the six items). The majority of students were female (72%) with an average age of 25.86 years, ranging from 23 to 36 years old. One student did not provide an age. With the exception of one student who identified as Hispanic, all participants were Caucasian.

We sought to determine whether physical therapy students' exposure to the COMFORT curriculum would influence (a) student comfort with palliative appropriate patients by raising willingness to communicate and lowering apprehension about communicating with the dying, (b) perceived comfort level with performing communication skills, and (c) the confidence level for performing communication skills from pretest to posttest. Although the changes from Time 1 to Time 2 were not significant [$\Lambda = .86$, $F(1, 50) = 1.56$, $p = .19$, $\eta_p^2 = .15$], the direction of mean change from pretest to posttest supported increased comfort level, increased confidence level, and decreased apprehension about communicating with the dying. However, the changes in means from pretest to posttest did not show movement toward increased willingness to communicate.

Communication behaviors were assessed through responses to reflective exercises. Table 3 provides an overview of coding categories, examples from the data, and frequency of coding.

Student scores for application of task and relational communication averaged 2.15 out of 3.0. Almost half of the students (48%) were able to apply either task or relational communication concepts, with one-third (33%) accomplishing integration of both task and relational communication features in their described communication with patient/family. For verbal acknowledgment of patient/family feelings, students averaged 2.63 out of 4.0. The majority of student verbal communication strategies involved a cursory recognition and awareness of patient/family feelings (29%). About one quarter of students (24%) achieved full integration of feelings into communication strategies, while 15% were not able to acknowledge feelings in any manner in the clinical case scenario.

We explored potential relationships between perceived comfort and confidence and students' ability to identify helpful communicative behaviors and enact desirable communicative behaviors. Only students' willingness to communicate was positively associated with students' ability to identify helpful and not helpful behaviors, such that as students became more willing to communicate, they were also

TABLE 3
Communication Behaviors of PT Students Post COMFORT Training

Communication Behavior	*Examples From Data*	*n*	*%*
Task and relational communication			
No course concept applied	Support. Provide other educational outlets for personal use. "We are all going to die eventually, even the baby that was just born down in the nursery, but . . . he's not a goner yet, and we are going to do everything we can to keep him here."	22	17.88%
Presence of task or relational communication	It is best to use any strategy that will be perceived as nonjudgmental. Allowing him to fully express these thoughts and not cutting him off is very important. Maintaining a look of interest and facing him while he is talking will be beneficial.	60	48.78%
Presence of both task and relational communication	Make sure to give them the bad news . . . show that you care. Let them share their emotions about the situation. Re-author to help widen the view beyond the illness and help patient/family accept their current condition. Use person-centered messages to show support. Maintain eye contact while patient discusses concerns.	41	33.33%
Verbal acknowledgment of patient/family feelings			
Neglects patient/family's feelings	Fever . . . is one of the strategies as to how the body fights infection. A rise in body temperature also signals an increase in production of WBCs, these cells fight infection too.	19	15.44%
Cursory recognition of patient/family's feelings	Your sister is a strong individual. While there is a possibility she may overcome her cancer again, she also may not. It is our job to make sure that regardless of what happens, we have a plan to make sure she can enjoy her life.	38	30.89%
Demonstrates awareness of patient/family's feelings	I know you're not feeling well, but exercise has been shown to increase kidney functions as well as improve function overall. Let's make the most of today. Then you can go home and rest. Ok?	36	29.26%
Shows integrated engagement with patient/family's feelings	What do you mean exactly that "you don't know why you are going through this"? Do you have more specific questions about your care that I could answer? I'd be glad to take all the time we need to discuss these issues with you.	30	24.39%

more adept at identifying helpful behaviors in the vignette ($r = .48$, $p = .003$).

To explore the impact of the training session, we used discrepancy scores to investigate whether changes in comfort, confidence, and willingness to communication from pretest to posttest would predict students' ability to identify helpful behavior and enact desirable communication behaviors. The multiple regression was not significant, $F(6, 17) = .80$, $p = .59$. Notable to these outcomes is that data could not be matched as results are based on aggregates of attitudinal variables as well as aggregates of the learning that our participants experienced.

DISCUSSION

The COMFORT curriculum addresses areas of narrative clinical communication education including empathy, listening, patient perspective, late hospice referrals, and conflict (Cobbe & Kennedy, 2012; Cooper et al., 2008; Foster & Delitto, 2011; Frymark, Hallgren, & Reisberg, 2009). Results in the direction of improved confidence and decreased anxiety in this pilot study demonstrate the COMFORT curriculum as a promising way to improve entry-level PT training, thus enabling therapists to provide improved psychosocial care by integrating task/relational and person-centered messages into clinical communication. COMFORT training was a feasible way of introducing communication skills curriculum into preexisting physical therapy classroom coursework and structure, and was accomplished expeditiously. These findings lend evidence to further test the curriculum among professional as well as first-year student PTs.

Physical therapy students in this project were exposed to psychosocial communication material that diverged from their years of biomedical preparation. Repeated exposure to ideas, a systematic engagement of psychosocial concepts, and deliberate integration of communication anxiety awareness would likely increase receptivity to the COMFORT curriculum. As these students were only hours away from completing course work, they were likely experiencing feelings of being "finished." However, this could present an opportunity to impact entry-level therapists as they are literally on the brink of working independently without the support of preceptors. The co-presenters entered into an existing class in which the classroom climate and rapport/connectedness

were already established. Participant demographics include little diversity of age, ethnicity, or sex. While these statistics are representative of the PT student population in this geographic region, a more diverse sample would likely produce varied outcomes to those in this study. Finally, including the M (mindfulness) and T (team) aspects of the COMFORT curriculum when time constraints allow may improve overall outcomes associated with the communication education training PTs demonstrate.

The study and practice of palliative care may be confronting and emotionally challenging for students, and such condensed academic modules might not be the most effective means to produce responsiveness in PT characteristics including attitude and emotional engagement (Chiarelli et al., 2013). However, it has been suggested that a greater impact on the emotional preparedness may be gained by gradual immersion via clinical palliative care placements within the construct of a course based on palliative care (Moriarty, McKinlay, & Tanne, 2006).

Although this study found that COMFORT training positively impacted student perceptions and self-efficacy, further research is needed to determine whether these perceptions significantly influence communication skills performance. Importantly, the need for the PT to communicate effectively despite cultural differences and patient and family health literacy levels has been noted in recent research (Chiarelli et al., 2013; Kumar & Jim, 2011; Oien et al., 2011). Student willingness to communicate is an important variable in this process, and attitudes to fortify the communication role of the PT when providing physical therapy should be more clearly defined.

The only other study on physical therapy student learning and communication training in America found similar results suggesting students were positively affected by communication training intervention (Ross & Haidet, 2011). Physical therapy students experiencing palliative care placements during their professional education have noted the opportunities for interprofessional learning, a deepening understanding of the spiritual and creative needs of patients, enacting a patient-centered philosophy of care, and gaining a greater understanding for the physical therapist's role within the palliative care team (Morris & Leonard, 2007).

PRACTICAL IMPLICATIONS AND CONCLUSION

Most physical therapy postgraduate training emphasizes didactic conferences, short courses, and workshops that fortify the biomedical emphasis foregrounded in their entry-level training (Foster & Delitto, 2011). COMFORT has established its utility in improving practice learning for interprofessional disciplines, including PTs (Wittenberg-Lyles et al., 2010; Wittenberg-Lyles et al., 2012). Many therapists experience little to no support from other interprofessional team members as they work to engage psychosocial factors contributing to patient and family health and pain control. Interprofessional education incorporating a variety of methods, shared interprofessional posts, and clinical partnerships can be facilitated with the COMFORT curriculum (Wittenberg-Lyles, Goldsmith, Ferrell, & Burchett, 2014; Goldsmith & Wittenberg-Lyles, 2013; Wittenberg-Lyles, Goldsmith, Richardson, Hallett, & Clark, 2012; Wittenberg-Lyles et al., 2010). A focus on patient/family perspective in physical therapy education/training would offer an alternative to traditional and siloed training patterns (Foster & Delitto, 2011).

PTs play a large role in educating patients, families, and health care teams, as well as collaborating with other health care professionals and care services. Developing communication curriculum that will enable PTs to learn holistic communication strategies to practice with patient and family, as well as interprofessionals, is critical. Additionally, the rapidly growing area of physical therapy practice will take place in palliative and hospice care across nursing homes, home health settings, ambulatory care centers, and other inpatient care settings. Current research shows evidence that a majority of dying hospice patients receiving physical therapy in the last week of life (Cobbe & Kennedy, 2012).

Current training programs do not adequately prepare graduating physical therapists to meet the psychological, physical, and developmental needs of their largest group of patients: the aged and dying. In fact, most PTs refer their patients to other professionals instead of engaging conversations about fear, anxiety, and spiritual distress (Oakley, Katz, Sauer, Dentz, & Millar, 2010). All PTs lack formal training in communication at the end of life (American Physical Therapy Association, 2011), and COMFORT was designed specifically to address difficult communication about chronic, terminal illness and prognosis with patients and families in a palliative care setting. Additionally, barriers to physical therapy referral for palliative and end-of-life patients are formidable and require a better interprofessional understanding of team member roles (Blaney, Lowe-Strong, Campbell, Allen, & Gracey, 2010; Eyigor, 2010). The aging and expanding population of Americans with comorbidities and the model of interprofessional team care secure the role of the physical therapist in palliative and end-of-life care.

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