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RESEARCH ARTICLE

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Physiotherapists' views and experiences of health literacy in clinical practice

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Abstract

Objective: Using a qualitative design, this study aimed to explore the experience of physiotherapists' supporting patient health literacy in clinical practice, gain an understanding of their conceptualisation of health literacy, and make recommendations for improving health literacy support in clinical practice.

Methods: Convenience sampling via social media was used to recruit eight participants who were all physiotherapists practicing in the United Kingdom. Semi-structured interviews took place on Zoom during the second Covid-19 lockdown. Interviews were audio-recorded, transcribed, coded, and thematically analysed to uncover physiotherapists' views on health literacy, experiences of supporting patients with health literacy and opinions and recommendations for practice.

Results: Of the eight participants, five were female and the mean years of clinical experience as a qualified physiotherapist was 5.8. Four main themes were identified: physiotherapists' conceptualisation of health literacy, identification of health literacy and skills required to support patients, training and barriers to providing health literacy-sensitive care and recommendations for improvement.

Conclusion: The findings highlighted that physiotherapists identified a patient's health literacy abilities by picking up tacit clues throughout their consultations and they pre-dominantly viewed health literacy as the ability to read, write and communicate effectively. They reported having a limited exposure to health literacy training and recommended raising awareness and education as key to improve practice.

KEYWORDS
health literacy, long-term conditions, physiotherapy, qualitative research

1 | INTRODUCTION

Health literacy represents the personal knowledge and skills that are acquired through daily activities, social interactions, available resources and organizational structures that enable individuals to access, understand, appraise and use information to enable good health for themselves and their communities (Nutbeam & Muscat, 2021). In the United Kingdom (UK) 7.1 million adults read at or below the age of an average nine-year-old (Health Education England, 2022). A recent UK study found that 52% of participants

had limited health literacy, highlighting that many people will have difficulties understanding and engaging with health information (Protheroe et al., 2016). Limited health literacy has been linked to older adults and those with lower educational attainment and income (Schaffler et al., 2018). The impact of limited health literacy has been well documented: it is associated with reduced adherence to prescription medication (Miller et al., 2016), difficulty understanding written medical information and communicating with healthcare professionals (Green et al., 2014), and a poorer ability to self-manage chronic conditions (Mackey et al., 2016). Furthermore, self-management support is important enable people to manage their musculoskeletal condition (Hutting et al., 2022). Physiotherapists play a key role in supporting the self-management of musculoskeletal conditions because they often discuss health information with people to help them make informed decisions about their health (Briggs & Jordan, 2010). However, current self-management strategies for musculoskeletal conditions are often poorly communicated, and effective clinician communication that supports self-management is needed to ensure that health messages can be understood and utilised by people with different levels of health literacy skills (Adams et al., 2019). Health literacy strategies, such as the use of plain language, can facilitate improved patient-practitioner communication, which is important to improve the care and outcomes for people with limited health literacy (Green et al., 2014). Current research on the use of health literacy strategies in healthcare has predominantly focused on medical or nursing professionals (Cafiero, 2013; Güner & Ekmekci, 2019; Rowlands et al., 2020). There is limited research into how physiotherapists support patient health literacy. This study aims to explore physiotherapists' views and experiences of health literacy in clinical practice.

2 | METHODS

2.1 | Overview

In this qualitative study, physiotherapists were interviewed about their experience of supporting patient health literacy in consultations. They were invited to discuss their views on health literacy and their experiences supporting patient health literacy in their practice. This study was approved by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee (ERN_21–1087).

3 | METHODOLOGICAL APPROACH

An experiential qualitative approach was taken through inductive thematic analysis due to the desire to focus on the participants' point of view and health literacy experiences in clinical practice. This methodology was chosen because it prioritises participants views (Braun and Clarke, 2013). The methodological orientation used was a contextualist perspective because it assumes that truth can be accessed through language and emerges from context and how individuals create meaning (Madill et al., 2000). Therefore, the study sought to understand the meaning participants ascribe to the phenomenon of health literacy, and to understand its 'reality' in clinical practice.

3.1 | Participants

Eight UK-based physiotherapists were recruited who all provided rehabilitation and support for people with long-term conditions in a variety of specialities (this included musculoskeletal, community and respiratory care). A convenience sampling strategy was used by promoting the research on social media and by the first author asking physiotherapy contacts known to her to circulate the link. An interview was scheduled with those who provided informed consent to participate in the study. One participant completed a consent form but dropped out prior to the interview due to work commitments. The recruitment was stopped when data analysis highlighted that sufficient insight had been achieved and information redundancy was reached because nothing new became apparent (Saunders et al., 2018).

3.2 | Procedure

A pilot interview was conducted and the data from this was included in the analysis. Semi-structured interviews were conducted on the secure online meeting platform Zoom to circumvent social restrictions caused by the coronavirus pandemic. Zoom was chosen as it has been shown to be feasible and acceptable for collecting qualitative interview data for healthcare research (Archibald et al., 2019). A semi-structured interview guide was developed by the first author with insight from the research team, and included questions about health literacy (e.g., their definition of the concept, how they identify health literacy levels, strategies used to support health literacy, and any barriers or facilitators to this) (Table 1). Interviews were conducted by the first author, who wrote field notes after the interviews to document her decision making. The first author is a physiotherapist who received training in qualitative methods as part of her MRes study and is a member of the professional group being interviewed, which can affect the researcher's assumptions and perceptions and influence the way the researcher is perceived by participants (Chew-Graham et al., 2002). The first author therefore employed several reflexive strategies, including introducing herself as a physiotherapist in the interviews to highlight her insider perspective and making field notes after the interviews to question her assumptions and document decision making. Interviews were audio-recorded and transcribed, and participants were anonymised using pseudonyms and removing any reference to places or names. Interviews lasted between 20 and 53 min. Written consent was obtained from all participants in the form of an online consent form prior to the interview.

3.3 | Data analysis

The analysis team consisted of three researchers: the lead author (a physiotherapist) and two senior researchers from a nursing professional background with experience in qualitative and quantitative research. Thematic analysis of the data from the interview transcripts was conducted following the process documented by Braun and Clarke (2013). The first author read and re-read the transcripts and then completed line-by-line inductive coding using the comment function in Microsoft Word. The initial codes were shared and checked by all other team members. The first author then identified patterns in the data and grouped them together to generate potential themes. A codebook was used to document the analytical process and to help make connections between themes. These themes were then discussed with the research team and the themes and subthemes were refined throughout this process, and during the write up of the results.

4 | RESULTS

The demographic characteristics of the participants are included in Table 2. Thematic analysis led to four themes being identified: physiotherapists' conceptualisation of health literacy, identification

TABLE 1 Interview topic guide.

Opening	To start with, I'd like to ask about your career as a physiotherapist. Can you tell me about your job role?
	(Demographic questions—job title, area of physiotherapy, years worked as a physiotherapist, age, how would you describe your gender and ethnicity?)
Health literacy views discussion	What does the term health literacy mean to you? (What do you think the implications of low health literacy are?)
	What do you think physiotherapists need to do to support patients with low health literacy?
	What skills do you think patients need to access, understand and use health information to make decisions about their health?
Health literacy experiences discussion	What is your experience of identifying patients with low health literacy levels?
	(Barriers? Facilitators?)
	What is your experience of working with patients with low health literacy?
	(What made you think that they had a low level of health literacy?/Did any difficulties arise in the consultation?/How did you resolve these difficulties?)
	What did you do to support the patient regarding their health literacy?)
	What is your experience of working with patients with a high level of health literacy?
	(What made you think that they had a good level of health literacy?/What was your experience of working with them?/What did you do to support the patient regarding their health literacy?)
	What recommendations would you suggest to improve a patient's level of understanding in physiotherapy sessions?
	What would you suggest to help other physiotherapists manage patient health literacy?
	If the way patient health literacy is managed was to improve, what is needed?
	(Did you get any training on health literacy in your undergraduate course?)
Closure	Is there anything else you would like to add? Ask me?

TABLE 2 Participant demographics.

Participant	Gender	Ethnicity	Age	Area of physiotherapy practice	Job title	Years of experience
1	Male	White British	26	Community	Senior urgent response physiotherapist	3.5
2	Male	White British	26	Respiratory	Senior respiratory physiotherapist	4
3	Female	White British	48	Community	Senior urgent response physiotherapist	2
4	Female	White British	27	Community	Highly specialist community physiotherapist	6
5	Female	White British	38	Community (private practice)	Highly specialist community physiotherapist	15
6	Female	White British	33	MSK/Pelvic health	Senior MSK and pelvic health physiotherapist	7
7	Male	Asian British (Indian)	26	MSK	Senior MSK physiotherapist and first contact practitioner	4
8	Female	Asian British (Indian)	26	MSK/Orthopaedic	Senior MSK and orthopaedic physiotherapist	5

of health literacy and skills required to support patients, training and barriers to providing health literacy-sensitive care, and recommendations for improvement. The themes are discussed below with the anonymised participant quotes to highlight the findings.

Theme 1. Physiotherapists' conceptualisation of health literacy

Health literacy was primarily conceptualised as having functional literacy skills, including the ability to read and comprehend information. This was linked to enabling individuals to access and use health information to improve their own knowledge of their condition:

> To me it's a patient's understanding of healthcare and whether that's kind of their understanding of their condition or the kind of, patient pathway, the NHS, the treatment. So yeah, to me it's all to do with patients' kind of understanding and I guess it incorporates kind of…their ability to kind of read and write (P8)

Alternatively, some participants viewed health literacy as an interactive phenomenon, requiring social and cognitive skills. This was because they felt it required patient-practitioner collaboration to facilitate effective communication and education:

> Health literacy, to me, is kind of a two-way interaction between a healthcare provider and the patient. And it's trying to pitch the health literacy point you're trying to get across to the patient in a manner in which it can be absorbed and digested and interpreted. Which is an art [laughs] (P6)

The *'art'* of providing information highlights that the participant perceives a professional responsibility to tailor information to the individual. The patient is viewed as an active participant in this process because they need to be able to express themselves to the physiotherapist to build rapport. This effective exchange is perceived as integral to developing health literacy. Participants described from their own experiences that patients with limited health literacy were more likely to find this interactive aspect of health literacy difficult, impacting health outcomes:

> Whereas when somebody doesn't share that or possibly doesn't know how to share it or how to explain that information and then you're kind of thinking 'right, where do I start' and you're trying to sift through all the information to work out what that patient means. It can just be a longer process (P3)

Several participants commented that they assumed that their patients would be able to read and write. Having adequate health literacy skills was perceived as the norm, and they did not often consider the patients' abilities:

> It often gets overlooked, that you assume that someone is competent with reading and writing (P6)

This may suggest that these patients' health literacy abilities are overlooked and underserved in clinical consultations as there is not always an awareness of their health literacy needs.

Theme 2. Identification of health literacy and skills required to support patients

None of the participants reported using formal methods to identify patient health literacy. It was commented that *"we don't use a specific outcome measure"* (P1). Patient health literacy was identified by *"instinct"* and *"previous experience to make a judgement"* (P2). This suggests that identification of health literacy is developed through experiential learning in clinical practice. Participants picked up on tacit clues in the consultation to help build a picture of the patients' health literacy levels. This included verbal clues, such as their ability to explain their situation and the language they used to achieve this. It also included non-verbal clues, such as body language and ability to fill out paperwork related to the appointment:

> It'd be things like they would be able to tell me like the purpose of the visit, why I'm here and they'd be able to understand our service and be able to talk to me about it (P1)

> [on identifying health literacy] "I mean a lot of time I think yeah body language and like language really is the main thing I will go based on" (P7)

These quotes suggest that participants infer their patients' health literacy levels through their communication and interaction as part of their consultations in clinical practice. Participants reported that a facilitator to this was if patients were *"more open and willing to communicate"* (P8) and *"in a receptive state, they have to be willing and want to learn"* (P2), again highlighting that the patient is an active participant within the consultation. Most participants echoed this, commenting that communication was the "*key*" way to support patient health literacy as ""*that's how we're going to help people to learn*" (P1). However, participants reflected that they felt pressure to ensure they communicated tactfully with patients with variable health literacy:

> You don't want the patient to turn round and say 'oh, you're calling me stupid'. It's such a fine, tricky communication balance (P2)

This highlights the tension between building rapport and challenging incorrect health beliefs and explaining health concepts simply, without being patronising. Participants also reported that having *"patience"* and *"taking time to explain"* (P3) also helped facilitate effective support. Several participants also reported that they checked understanding throughout the consultation by using teach

back, a health literacy communication strategy to confirm patient understanding by asking the patient to repeat back what has been explained to them (Anderson et al., 2020), though they did not call this technique by that name:

> You constantly have a responsibility to check that they're following what you're saying. And there's no good saying or getting to the end and then going in your last minute before you pull the curtain 'is that all right?' (P6)

Getting the patient to repeat what has been discussed in their own words can support patient health literacy by identifying knowledge gaps and enabling the opportunity for further clarification. As well as teach, another communication skill that was consistently identified as a facilitator to support patient health literacy was using plain language:

> Speak to them and be aware of your communication and keeping it clear, simple sentences and reiterate stuff (P5)

This indicates that participants break down information into manageable chunks and prioritise key health messages to avoid overloading the patient with information.

Theme 3. Training and barriers to providing health literacy-sensitive care

Physiotherapists frequently stated that their exposure to formal health literacy training was limited throughout their career:

> I can't remember any specific training about health literacy if I'm honest (P1)

> I do think that that training is sometimes lacking or not taking as seriously as it should be (P4)

As a result, participants reported that they did not feel confident in their knowledge of health literacy, with one participant stating that [they knew] "*so little about the subject at the moment*" (P2). Participants identified that limited health literacy was a problem for many of their patients but were not always confident that they were addressing this effectively.

> I'm sure there's probably more that we can do that we're not doing. It is a real problem [health literacy] for a lot of our patients now (P8)

> [on health literacy] It's something I haven't specifically looked into or learnt about, or looked at the research into, but it's something that kind of comes up in day-to-day clinical practice (P5)

This suggests that health literacy impacts on physiotherapy consultations but is currently not routinely taught about at an undergraduate level or once qualified.

The most common barrier to providing care that was responsive to health literacy levels was a lack of time. Participants reported that in their clinical settings, there was sometimes not enough time to explain information to patients in the detail they would like:

> I think the big thing is time because….I think we all want to help patients with low health literacy, but in a rushed NHS setting, do we really get the time to explain things to patients? But we should because there's such a big effect on their treatment and the treatment outcomes (P8)

Participants recognised that if the information given was rushed it could impact treatment outcomes, with patients more likely to present again with the same problem. This was described as a *"vicious cycle"* or a *"revolving door"* (P7) with patients more likely to *"come back and they're more likely to be chronic as well"* (P5).

Theme 4. Recommendations for improvement

The first recommendation was to increase awareness of health literacy in the physiotherapy profession through training. Most participants discussed that health literacy training should focus on optimising effective patient-practitioner communication in consultations. Participants felt that this would help support patients by providing patient-centred care:

> I think that needs to be a bit more of an emphasis on actually…just improving the consultation style…and identifying what's really and truly important to the patient, and not just their back or knee pain (P7)

> What I find universities can lacking in, is in terms of how you can communicate and adapt your communication with patients. You know, it would be good if we had more education on that prior to placements or our first jobs, because then that would help better prepare us as healthcare professionals and help us to improve our clinical practice (P1)

A participant suggested that health literacy training could be successfully facilitated by working with professional bodies to champion health literacy and incorporate it into professional standards for practice:

> I just don't think there's an awareness of it [health literacy]. So, I think you'd either have to, perhaps work with their professional bodies to make it more of a standard for each of the relevant professions or work with specific organizations and embed it within their

> statutory mandatory training, appraisal process, etc, something like that (P4)

The second recommendation was to take an organisational approach to health literacy and make service provision more flexible. This was seen as important to allow physiotherapists to spend more time supporting patients, particularly those with limited health literacy. Participants felt that having more autonomy over their workload would enable them to be able to support patient health literacy more successfully:

> [a] different amount of appointments…can significantly improve it…because [then] I have more time, I can spend more time actually talking to them and trying to get them around it, to educate them a bit a bit better (P7)

Participants felt that organisational support to offer different lengths of appointments would help them address patients' health literacy needs. This was seen as more efficient in the long-term, reducing healthcare costs by facilitating self-management and reducing repeat admissions or referrals for the same complaint.

> If you consider the whole picture and the time, the resources, the cost of money, you're probably cheaper and more efficient to actually spend more time, more number of treatments sessions, rather than the bare minimum to get them out the door so the numbers look good for audits, and you know, as I say, they come back (P5)

This shows that there is no 'one-size fits all' approach to supporting patient health literacy, though participants recommend that more time would enable them to meet the patients' health literacy needs more effectively.

5 | DISCUSSION

This study sought to explore physiotherapists' views on health literacy and their experiences of health literacy in clinical practice. The findings show that the interviewed physiotherapists had different definitions of health literacy and identified patient health literacy levels through tacit clues in the consultation. However, some assumed patients had functional literacy skills in their consultations, and others were reticent to ask directly about health literacy levels in case of causing offence. Barriers to health literacy support were a lack of time to explain health information and limited exposure to health literacy training. Participants highlighted that the use of communication strategies, training and raising awareness of health literacy in the physiotherapy profession could contribute to improving health literacy support for patients.

The first theme highlighted that the participants had different conceptualisations of health literacy. Recent research shows that health literacy is often conceptualised and interpreted inconsistently, risking missing information that could be important to the initial understanding of the concept (Urstad et al., 2022). The participants in this study focused on functional health literacy, which is common in clinical settings (Brooks et al., 2020; Lambert et al., 2013). This is a risk-based approach, where an individual's literacy capabilities need to be managed within a clinical consultation rather than a set of skills that can be developed (Nutbeam, 2008). Participants reported that they did not routinely ask about health literacy because of a fear of causing offence. This reflects the stigma associated with limited health literacy, and research has shown that individuals with limited health literacy often conceal their difficulties (Easton, et al., 2013; Mackert, et al., 2019). Physiotherapists need to be aware of this and encourage patients with limited health literacy to access and engage with healthcare professionals (Protheroe et al., 2012). Several participants viewed health literacy as interactive, incorporating the psychological and social requirements for effective health literacy skills. This broader view of health literacy highlights the intersection between literacy, cognitive and social skills to engage in health-related activities. Participants recognised that limited health literacy could impact communication and shared decision making, creating disparities in participation and care outcomes. Supporting patients to develop their health literacy skills can improve self-management of long-term health conditions and may have a marked improvement for those in lower socio-economic groups who may find self-management more difficult (Gibney et al., 2020).

The second theme highlights that participants learned experientially how to identify health literacy, often through verbal and non-verbal cues in the consultation. Participants used strategies such as plain language (to improve accessibility of health information) and teach back (to check patient understanding and test the accuracy of their communication). Research on prioritising health literacy and clear communication practices for healthcare professionals has also found that teach back and avoiding medical jargon were the most important priorities (Coleman et al., 2013). Both these techniques are also recommended by Health Education England (2022) to improve accessibility to health information. A cluster control pilot intervention study by Toibin et al. (2017) evaluated the effect of a health literacy communication intervention called *Ask me 3* in two primary care physiotherapy clinics over a five-week period. *Ask me 3* focuses on using plain language, visual models and teach back to facilitate understanding. Outcomes were measured by a questionnaire on clinician communication and participation. No statistical difference was found between the outcome measures of the two groups. Health literacy improved significantly ($p \leq 0.01$) and *Ask me 3* was perceived as easy to use, inexpensive and facilitated clear communication. Future research should focus on testing the intervention over a longer follow-up period to understand if health literacy communication strategies facilitate a sustained change to clinical practice.

The third theme emphasised that a lack of time due to high workloads was identified as a barrier to providing health literacy support in clinical practice. This is a common barrier in healthcare settings and justifies the importance of developing and implementing health literacy interventions that can improve health literacy support in the context of the current health system (Baumeister et al., 2021). Physiotherapists reported a lack of knowledge and limited exposure to training, hindering their confidence in their ability to support patient health literacy. They recommended that training should focus on communication strategies to support health literacy. Training may lead to a better ability to recognise the variability in health literacy needs, facilitating a more nuanced response to health literacy support (Berens, 2018). Health literacy training is a relatively underdeveloped area of healthcare professional education, and it is unclear when is best to deliver training or over what time period (Saunders et al., 2019). A recent multi-centre, pre-post intervention study of health literacy and communication training programme for healthcare professionals found improvements in self-rated health literacy competencies at 6–12 weeks, particularly in communication skills to support self-management (Kaper et al., 2019). Further research is needed to ascertain the effect of health literacy training interventions and could also focus on profession specific health professionals, as there may be variation across different professionals and healthcare settings.

The final theme recommended that physiotherapy services could be improved to be more responsive to health literacy. Participants suggested that having managerial support, flexibility in service delivery and health literacy embedded at an organisational level would be beneficial to assist with this. The results from this study suggest that improving physiotherapists' experience of delivering health literacy support requires both an individual and organisational approach because of the multi-factorial nature of the concept. This is supported by Khorasani et al. (2020), who found that organisational health literacy is not usually integrated into healthcare systems. Beauchamp et al. (2017) tested the Ophelia (Optimising Health Literacy and Access) approach to enable health organisations to identify and support health literacy. It was reported that both organisational and staff practice changes were required for successful implementation. This is because improving organisational responsiveness to health literacy may also lead to improvements in workplace culture and leadership, which in turn could improve individual physiotherapists' ability to use health literacy strategies effectively (Trezona et al., 2017).

6 | LIMITATIONS

This qualitative study is the first to generate an understanding of physiotherapists' views and experiences of health literacy, although there are important limitations to consider with its design. Time constraints and social restrictions caused by the pandemic were a limitations for data collection. This meant that the first online pilot interviews were included in the final analysis. Another limitation was that most of the sample were in their twenties, White British and senior physiotherapists. They also all worked in physical health settings. More time would have enabled purposive sampling to conduct interviews with physiotherapists of varying ages, ethnicities, experience levels and who worked in different practice settings. The relationship of the interviewer also being a physiotherapist may have meant that only those with an interest in health literacy took part or that they found it more difficult to talk openly to a fellow professional about the topic. However, an insider perspective can help make sense of the participants accounts, facilitate a deeper understanding of the phenomenon of health literacy, and explore the processes that occur in clinical practice (Carnevale et al., 2008).

7 | CONCLUSION

This study considered physiotherapists' views and experiences of health literacy in clinical practice. This is an area with limited research and has uncovered a gap in physiotherapy education about health literacy. The physiotherapists in the study identified that their exposure to learning about health literacy was limited at all stages of their career. Health literacy training was cited as having the potential to improve their knowledge and confidence. Participants recommended that their practice could be developed by improving communication in consultations to better support patients. At an organisational level, a commitment to embedding health literacy principles through flexible service provision was reported as a potential facilitator. The strength of this study is that the recommendations for practice in this study come from physiotherapists who provide care and are therefore uniquely placed to identify the opportunities and challenges to supporting patient health literacy. This should drive future research to implement and develop interventions to raise awareness of health literacy and support physiotherapists to deliver health literacy support to their patients.

AUTHOR CONTRIBUTION

Study concept and design: Joanna Simkins, Dr Richard Breakwell, Dr Kanta Kumar. *Ethics process:* Joanna Simkins, Dr Richard Breakwell, Dr Kanta Kumar. *Analysis and interpretation of results:* Joanna Simkins, Dr Richard Breakwell, Dr Kanta Kumar. *Draft manuscript preparation:* Joanna Simkins, Dr Richard Breakwell, Dr Kanta Kumar.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of the study are available from the corresponding author on reasonable request.

ETHICS STATEMENT

This study was approved by the University of Birmingham Research Governance Committee (ERN_21–1087) and digitally informed consent was collected for each interview participant.

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