CHAPTER 1

Communication and Nursing: Historical Roots and Related Theory

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Practice helps to impress and retain in the memory the knowledge obtained by theory, otherwise forgotten without the practical application. Any one who has been ill knows that the height of good nursing consists principally in what is done for the patient's comfort, outside of the regular orders. A theoretical nurse performs her duty in a perfunctory manner, and may carry out the doctor's orders to the letter; but the patient recognizes there is something lacking, and we know that it is the skilled touch, the deft handling, the keenness to detect changes and symptoms, the ready tact, the patience, the power of controlling her feelings and temper, self-reliance, the kindly sympathy for the sorrowing, and the peculiar power of soothing suffering which can be acquired only by much practice; and a nurse without these attributes, despite her wide theoretic knowledge and teaching, will never be a successful one (Brennan, 2006, p. 191).

In this chapter, the early roots and influences of communications and nursing will be explored. In addition to acknowledging the contributions of those concerned with the subject of patient communication, this text primarily utilizes theories related to patient-centered care, novice to expert development, and reflective practice. These theories will be explored and will form the foundation for the focus of communication practice for the advanced practice nurse. The text will build on basic communication theory and encourage the reader to hone their skills in this area.

Tracing the role and importance of communication theory and practice in nursing requires an amount of speculation and reliance on early nursing curriculum. In order to understand the place of communication theory in nursing practice, we must look to the past and fully explore the early nursing pioneers and those theorists who influenced them. It is also important to remember that nursing, for many decades, was attempting to carve out a clear definition of itself, a scope of

practice in order to take its place as a true profession. Many nursing programs today give only a brief allotment of time to the subject of nursing history. While nursing history, once was a staple in the nursing curriculum as a way to acculturate the new student, over time has been shed and replaced by other content.

The American Association for the History of Nursing (AAHN) has developed a position statement regarding the importance of including nursing history in the curriculum in order to prepare nurses for the 21st century. AAHN recommends that nursing history be included in both undergraduate and graduate curricula and that a separate course in nursing history be part of any doctoral program in nursing (AAHN, 2001). By examining the historical roots of the concepts of patient–provider relationships, and what constitutes nursing care, we can clearly explore the topic of provider communications with patients and families. Without the proper backdrop it might seem like a new idea when, in fact, it has been emphasized by nursing educators and practitioners since the first nurse ministered to the first patient.

EARLY NURSING EDUCATION

Initially, nursing education was based on the apprentice model of education and was designed to meet the service needs of the hospital with which the school was affiliated (Box 1-1). Although not all schools of nursing were affiliated with hospitals, this was certainly the template developed by Florence Nightingale

Box 1-1 Early Development of Nursing Education

1893, formation of The National League for Nursing Education
1917, release of the first standard curriculum for schools of nursing
1918, Goldmark Report, assessing nursing education
1928, *Nurses, Patients, and Pocketbooks* published
1934, *Nursing Schools Today and Tomorrow* published
1936, publication of NLNE *Essentials of a Good School of Nursing* (Effie Taylor, president)
1937, revision of NLNE's curriculum guide

and adopted in the United States. Although there was some variation in early nursing curricula, it is safe to assume that the emphasis was on practical work and service. A typical example is the 1918 curriculum from the University of Texas School of Nursing, the oldest nursing school in Texas and one of the oldest in the Southwest. Established in 1890 as the John Sealy Hospital Training School of Nurses, it was originally organized as an independent school under a board of lay managers. The didactic classroom requirements were as follows (Pope, 1937):

First Year:
- Anatomy and Physiology: 30 hours
- Fever Nursing: 12 hours
- Theory of Nursing: 12 hours
- Bacteriology: 14 hours
- Preventative Medicine: 14 hours
- Materia Medica: 15 hours

Second Year:
- Surgical Nursing: 14 hours
- Medical Nursing: 10 hours
- Gynecological Nursing: 15 hours
- Obstetrical Nursing: 15 hours
- Diatetics:15 hours
- Invalid Cookery: 40 hours

Third Year:
- Pediatric Nursing: 8 hours
- Eye, Ear, Nose, and Throat: 8 hours
- Mental and Nervous Disease: 6 hours
- Theory of Nursing: 20 hours
- Ethics: 6 hours
- Massage: 32 hours.

Total for Three Years: 314 hours

We cannot know for certain what was included in a lecture on the "Theory of Nursing," and it is possible that the topic of patient communication was squeezed into the brief time allocated for "Mental and Nervous Disease." But it is more likely that very little time was devoted to the topic of patient communication. This early curriculum is a typical example of what followed from the 1917 release of the first Standard Curriculum for Schools of Nursing, developed by the National League for Nursing Education. This organization, formed in 1893, during the Chicago World's Fair, was originally the American Society of

Superintendents of Training Schools for Nurses. From its inception, the association made its principal objective the "establishment and maintenance of a universal standard of training." In 1912 the society was renamed the National League for Nursing Education (NLNE).

It was not until after World War I and the influenza pandemic had receded that nursing leaders would take stock of the state of nursing education in the United States. In 1918, a 5-year study funded by the Rockefeller Foundation was initiated and aimed to assess the current condition of nursing education in the United States. Commonly referred to as the Goldmark Report (a member of the committee), this study highlighted the many weaknesses of the apprentice model of nursing education (Dolan, 1983). The Goldmark Report was critical of the relationship schools had with hospitals, the quality of faculty and overall education, and made strong recommendations for change. Unlike the Flexner Report, the equivalent study of medical schools, this report was not made public and, even if some schools closed as a result, the vast majority did not and nothing changed in regard to the model of nursing education. Overall, the sharp criticism in the Goldmark Report did little to make changes in how nursing education was delivered, how schools were organized, or what the nursing curriculum looked like. The financial ties that nursing schools had to hospitals were simply too strong and, thus, the incentive to keep doing business as usual prevailed. Instead of reform, more studies of nursing followed, including *Nurses, Patients and Pocketbooks* (1928) and *Nursing Schools Today and Tomorrow* (1934), both instigated by the American Nurses Association (ANA). Again, the findings reported serious shortcomings on the part of faculty preparation as well as the actual educational programs. Perhaps as a way of addressing these concerns, the NLNE published a specific guide in 1936, *Essentials of a Good School of Nursing*. This guide provided the scaffolding for what was "essential" in nursing and, therefore, nursing curricula. It is interesting to note that among the eight guidelines regarding what a professional nurse should know, number four was:

> *All professional nurses should be able to apply, in nursing situations, those principles of mental hygiene which make for a better understanding of the psychological factor in illness* (National League for Nursing [NLN], 1936).

This criterion may be interpreted as an early remnant of what we have come to understand as nursing diagnosis, or an appreciation of the patients' perspective regarding their illness. It can also be seen as acknowledging the psychosocial aspects of physical illness. Regardless of the interpretation, the criterion points to the necessity of communicating with patients in order to identify and incorporate their perceptions.

INFLUENCE OF PSYCHIATRIC–MENTAL HEALTH NURSING

It was in the clinical specialty of psychiatric nursing that the concepts and theories of communication and the nurse–patient relationship were to be developed and introduced into the entire discipline of nursing. Most schools of nursing did not offer a separate clinical experience or theory portion focused on psychiatric–mental health until quite late. By 1944 there were still 14 states that had no psychiatric courses in their nursing programs (Kalisch & Kalisch, 2004). The change to having psychiatric nursing included in nursing curricula is credited to the efforts of Effie Taylor. A graduate of Johns Hopkins School of Nursing in 1904, Taylor later studied at Teachers College, Columbia University, and Yale's Department of Public Health. Her career included serving as Associate Principle at Johns Hopkins School of Nursing until 1922, Superintendent of the Connecticut Training School (later named Yale University School of Nursing), and second Dean of Yale's School of Nursing. It was Taylor's interest in *patient-centered* care that led her to arrive at a different model for nursing. Under her leadership, nurses were assigned to specific patients instead of specific tasks, such as dispensing medications or obtaining vital signs for all patients on a floor. Her model was clearly the beginning of what was later referred to as primary nursing. The ability to form a relationship with a patient and family over time, even if during a brief hospitalization, promotes continuity of care. The model also relieves the nurses from being purely task oriented, and places the patient at the center of their work. The patient's emotional and intellectual state was also emphasized in this model of providing care (Church, 1988; Friedman, 1988).

It was Taylor's involvement in professional nursing organizations, however, that allowed her to influence the national scene of nursing curriculum revision. In 1932, Taylor was President of the NLNE and it was during her 4-year term that *A Curriculum Guide for Schools of Nursing* (1937) was being developed. Although this curriculum guide suggested that psychiatric nursing be included in all nursing curricula, the emphasis of the guide was on medical–surgical procedures and skills. The functional nursing model, which originated in the 1930s, was developed by Isabel Stewart and instituted in most hospital schools of nursing in the late 1960s. It stressed procedural expertise without emphasis on the underlying principles, making nursing care rule-based and activity oriented, stressing repetition and neglect of the psychosocial aspects of patient care. Nursing practice in this model was taught without much regard for an intellectual understanding on the part of the clinician of the principles underlying the procedures (Fairman, 2002). In order to address this problem, basic and behavioral sciences were introduced to nursing curricula during the 1950s. Regardless of this shift, according to an NLN report almost a decade later, the integration of basic and behavioral sciences into clinical practice was still problematic (NLN, 1959).

It was clear that a different approach to patient care was needed and an alternative perspective was offered by several nursing pioneers including Hildegard Peplau, Ester Lucille Brown, and Virginia Henderson. Henderson was yet another leader who consistently called for the inclusion of psychiatric nursing into the standard nursing curricula. Henderson reflected on her own early nursing training:

> *Most of my training was in a general hospital where, for the nurse, technical competence, speed of performance, and a "professional" (actually an impersonal) manner were stressed. We were introduced to nursing as a series of almost unrelated procedures, beginning with an unoccupied bed and progressing to aspiration of body cavities, for instance. Ability to catheterize a patient in this era seemed to qualify a student for so-called night duty, where, without any previous experience in the administration of a service, she might have the entire care of as many as 30 sick souls and bodies* (Henderson, 1991, p. 10).

Henderson's career began as a visiting nurse, as was typical during that time, and then progressed to nursing education where she remained at Teachers College, Columbia University, for two decades. It was during this time that she developed and expanded her definition of nursing. She was also influenced by her colleagues at Columbia in the areas of physiology, psychology, and rehabilitation. Henderson brought all of this knowledge and experience to bear as she joined others in the 1937 revision of the NLNE's basic curriculum guide. Henderson tested out her ideas at Columbia during the 1940s in an advanced medical–surgical course that was patient-centered and was organized around nursing situations instead of medical diagnoses. It was a pioneer course, in that students were allowed to provide care under a case assignment system allowing for comprehensive care, including follow-up patient care.

Virginia Henderson was later influenced by Gwen Tudor Will and Ida Orlando Pelletier (*The Dynamic Nurse-Patient Relationship*, 1959) and Ernestine Wiedenback (*Clinical Nursing: A Helping Art*, 1964). She was interested in examining the true nature of nursing and she continued to define the profession, always with an emphasis on the patient. In the presentation of her work, Henderson provided an interesting visual concerning nursing in her depiction of health and medical care in the form a pie graph, assigning wedges of various sizes to members of the healthcare team. She attempted to make the point, whether for the comatose postsurgical patient or the newborn infant, that it was nursing care that played the major role (Henderson, 1991).

Psychiatric nursing leaders emphasized the importance of understanding patient's needs and coined various communication techniques as *validation* and *clarification*. During the 1950s and 1960s, Hildegard Peplau (known as the mother of psychiatric nursing), Brown (a sociologist), and Virginia Henderson were the trio who voiced concern about the discrepancy between what

nurses were taught and what patients needed. They called for a focus on individual patient assessment and care. As a result of their efforts, the patients' *affective experience* regarding their physical problems became an important part of what was considered good nursing care. It was coined *interpersonal care* and was supported by research generated from various applied and social sciences (Fawcett, 2005).

Hildegard Peplau and Her Influences

Hildegard Peplau is credited with identifying and exploring the concept of the nurse–patient relationship. Her contribution was highlighting the importance of the relationship, regardless of clinical setting or population. Although she was a psychiatric–mental health nurse, her belief about this relationship extended to all nurses working with all patients in any setting. The nurse–patient theory is a middle-range descriptive classification theory that focuses on phases of the nurse—patient interaction. Peplau believed that only by understanding the interaction from the *patient's* perspective could the nurse be truly effective. She was less interested in pathophysiology or psychopathology as it was the person-to-person human experience that interested her. Peplau was particularly concerned when someone was "ill" and trying to address issues related to health (Peplau, 1952). Interpersonal relationships formed the "core of nursing" regardless of whether the nurse is engaged in a teaching role or carrying out a technical procedure (Peplau, 1964). Peplau's interpersonal theory is equally applicable for advanced practice nurses as for undergraduate or basic students and, considering the skill required, perhaps even more so. Like the late entry of actual psychiatric nursing theory and clinical rotations in nursing education, psychiatric principles were also late arrivals. Schmahl (1966) conducted a 5-year study of this issue at Skidmore and confirmed that true integration of psychiatric principles, even at this late date, although beneficial, was not the accepted norm in nursing education.

In the mid-20th century objectivity was singularly valued in academic settings and positivistic research was the only path to professional credibility. Nursing was working hard to find a seat at the table and the scientific method and model was adopted in order to secure such a seat. It has been argued that this philosophy may have served to cripple the artistic, nonquantifiable elements of nursing care. Understanding the history of how knowledge development in nursing evolved is critical to freeing nurses from the "conceptual ghetto" identified by Clouser in which members of a profession are "locked into a certain way of seeing the world" (AAHN, 2001).

Creative ways of viewing patient care delivery and educational methods of teaching communication skills require that educators honor more than

quantitative findings and the results garnered from meta-analyses. Communication simulation laboratories are an example of a novel method of teaching communication skills. Simulation has been shown to be an effective adjunct to didactic instruction. Simulation allows students to practice empathetic communication skills, delivering "bad news," and conduct motivational interviewing, which utilizes open-ended questions (Rosenzweig et al., 2008).

In juxtaposition to an emphasis on procedures and techniques, an exciting new model of care has developed that is primarily concerned with the *patient* as the focus. It has been dubbed patient-centered, and one could ask who else should be at the center, if not the patient? It is also important to place all interventions within the context of the nurse–patient relationship. An interesting and disturbing study of this relationship suggests that educational/occupational status continues to be a source of power for nurses within this relationship and patients may feel powerless when dealing with their provider (Oudshoorn, Ward-Griffin, & McWilliam, 2000). The authors recommend that nurses reflect on and change the disempowering aspects of the nurse–client relationship in order to improve home-based palliative care. Mok and Chiu (2004) studied the nurse–patient relationship in the context of palliative care and found that the presence or absence of a trusting relationship was paramount. In this study nurses became "part of the family" as well as providers of care and, because of the trust from patients and families, they were more capable of providing holistic care, to demonstrate their understanding of patient suffering, and to provide comfort measures in an intuitive manner. Based on trust, the goals of both nurse and patient could be achieved along with demonstrated caring and a sense of reciprocity in the relationship. This quality of relationship has demonstrated positive effects in regard to improvement of both physical and emotional issues, illness adjustment on the part of the patient, and ultimately effective pain management and a positive death experience. In addition, as a result of this approach, the nurse can experience a sense of satisfaction and enrichment as a result of being in a relationship with another human being that has genuine meaning.

PATIENT-CENTERED CARE

> *Effective patient care requires attending as much to patient's personal experiences of illness as to their diseases* (Stewart et al., 1995, p. 27).

The model of patient-centered care is founded on the work of Carl Rodgers, Balint (1957), and Neuman and Young (1972) who adapted the model for nursing. Patient-centered care means embracing the concept of patient and family collaboration. This collaboration can be accomplished in a variety of ways,

including actively seeking patient and family participation in decision making and teaching patients self-management skills. Patient-centered approaches emphasize the clinician's style of communication, the use of empathy, and the ability to manage the emotional reactions of patients.

A Commonwealth Fund survey found that most patients, between 30 and 80%, reported that their needs during a primary care visit were not met. This was attributed to less-than-optimal communication between patient and clinician, inadequate time for patients to talk, and exclusion of patients from decision making (Epstein, Mauksch, Carroll, & Jaen, 2008). There is ample evidence that patients desire both more information as well as more involvement in medical decision making (Coulter, 1997).

Research on training healthcare providers in this area reveals that clinician's patient-centeredness results in improved patient communication, clarification of patient concerns, and greater patient satisfaction (Lewin, Entwistle, Zwarenstein, & Dick, 2001). During the medical interview, Barrier and Jensen (2003) refer to the "essential functions" of gathering information, building a relationship, and educating the patient. Merely asking the question "What else?" was found to be linked to an improvement in health outcomes, patient compliance, and patient satisfaction, as well as a reduction in malpractice suits.

The value of a caring relationship with patients continues to be important to advanced practice nurses particularly because of the tension created when productivity concerns dominate a clinical setting, such as in primary care (Green, 2004). Advanced practice nurses are called on to coordinate care between patients and multiple providers as well as teach patients effective resource utilization, including use of the Internet for seeking medical information and in assisting in overall communications with healthcare providers.

Various models of care exist that address the challenges of the time constraint inherent in the primary care setting and yet stay true to the conceptual framework of patient-centered care (Box 1-2).

Focus Protocol

Epstein et al. (2008) propose a series of steps to be followed in primary care in an effort to set an agenda in a collaborative fashion with a patient. The steps involve:

1. Ask about *all* of the patient's concerns
2. Develop a working agenda
3. Sort through the patient's concerns and prioritize
4. Structure the office visit with the previous steps in mind

Box 1-2 Nursing Education Models

Name	Authors	Description
Patient-centered care Focus protocol Three function approach Four habits approach	Carl Rodgers, Neuman & Young Epstion et al. AACH, Mayo Clinic Frankel, Stein, & Krupat	Collaboration between patient, family, healthcare team Establish agenda with patient Gather information, build relationship, educate patient Invest in the beginning, elicit patient perspective, empathize, invest in the end
Family-centered care	Institute for Family-Centered Care	Importance of family as support network and healthcare advisors; core concepts: dignity and respect, information sharing, participation, collaboration
Nurse–patient theory	Hildegard Peplau	Focus on phases of nurse–patient relationship
Patient-centered approach	Univ. of Western Ontario	Six components (see Box 1-3)
Patient-centered care model	Picker Institute	Discover needs and concerns of patients/family to provide better health care
Reflective practice	Donald Schon	Reflection-in-action
Clinical practice development model	Patricia Benner	Seven domains of expert care; beginning of phenomenology

In addition to guiding the office visit, the authors suggest that clinicians communicate with patients before a visit, either utilizing online forms or written materials that ask patients to list their concerns and invite them to participate in the visit by preparing questions ahead of time. This strategy will save time during the actual visit and help both the patient and clinician to accomplish the goals for the visit.

The Three Function Approach

The American Academy on Communication in Healthcare (AACH) has developed institutional workshops for physicians, the "three function" approach for effective physician–patient communication, developed at the Mayo Clinic. They cite the statistic that, according to a Commonwealth Fund survey, more than 30% of respondents reported leaving a doctor's office without getting an answer to an important question. Half reported that the doctor did not discuss the emotional aspects of their illness, including coping skills or strategies.

The three functions are:

1. *Information gathering*: allowing patients to tell their story and using prompts that assure the whole story is elicited, thereby setting an agenda for the clinical visit.
2. *Relationship building*: using PEARLS, or

   Partnership
   Empathy
   Apology
   Respect
   Legitimization
   Support

3. *Patient education*: using "tell and ask," a combination of providing information and then asking about specific patient concerns *before* advancing to another piece of information.

Four Habits Approach

Frankel, Stein, and Krupat (2003) developed four habits of physician–patient communication that has been taught at Kaiser Permanente since 1996. The habits are:

1. *Invest in the beginning*: start with open-ended questions and then prioritize the patient's concerns.
2. *Elicit the patient's perspective*, including their thoughts on etiology as well as concerns and expectations for care.
3. *Demonstrate empathy*.
4. *Invest in the end*: frame the diagnosis in terms of the patient's original concerns and inquire about patient satisfaction.

The original model of patient-centered care is now also referred to as "family-centered" care. The Institute for Family-Centered Care defines this

model as an approach to planning, delivering, and evaluating health care that is based on "mutually beneficial partnerships" among patients, families, and providers regardless of setting or specific patient population related to age or clinical condition. The Institute for Family-Centered Care is a nonprofit organization founded in 1992 whose mission is to advance the understanding and practice of patient- and family-centered care. The shift from the patient to the family acknowledges the central place families have in a patient's support network and honors the importance of families as advisors and partners when improving clinical care and systems of delivering that care. The Institute for Family-Centered Care also notes that people most dependent on hospital care and use of the healthcare system are also often most dependent on families. This population includes the very young, the very old, and those with chronic conditions. The Institute identifies the "core concepts" patient- and family-centered care as:

Dignity and Respect
Information Sharing
Participation
Collaboration

These core concepts require active listening on the part of healthcare providers, and a nonjudgmental approach. Information is shared in a timely, complete, and accurate manner in order to allow patients and families to make decisions about health care. Participation is encouraged and supported and patients and families are asked for input in regard to wider institutional, policy, and program issues. Williamson (2005) notes that it is often difficult to distinguish between policies that are withheld because of the clinician's personal or clinical views and those that represent the rationing of services. Because of this, the following suggestions are offered for the provider in order to preserve the clinical relationship and to support the patient's autonomy.

1. Offer easy access to institutional and clinical policies and guidelines that may affect the patient.
2. Make available unwritten policies.
3. Decide how to make available to patients any policies that are unwritten.
4. Consider discussing with patient groups how to offer information about policies that may be distressing to patients.

The patient-centered model is a natural for the profession of nursing, which utilizes a biopsychosocial model, and the foundational element of the nurse–patient relationship. In this model, the provider reaches an understanding of the patient's illness by placing themselves in the patient's shoes, a technique stressed by Carl Rodgers. As clinicians, we cannot assume that we know what meaning the illness

holds for a patient or family. It is dangerous to lump patients and families together and to generalize from our past experiences. No matter how expert or seasoned the clinician is, it is critical that the provider does not make assumptions, no matter how similar the patient may be to past patients they have treated. Patients and families are unique, and require a suspension of judgment and a willingness to enter the patient's world. This may be accomplished by being attentive to the patient's ideas, expectations, feelings, and conducting discussions regarding the effect of illness on their ability to function on a day-to-day basis. It demands that the provider set aside an image of what *they* would be feeling or thinking if they experienced a particular diagnosis or treatment option. This strategy requires the clinician to identify the subtle and not so subtle cues that the patient or family provides during a clinical encounter. Utilizing the patient-centered approach in the clinical setting might lead to a variety of questions, including:

What is the patient's understanding of the illness?
What does the patient believe caused it?
What are his or her expectations of the provider?
What are his or her feelings?
What are his or her fears?

Toombs (1992) has stated that all patients want to be understood, appreciated, and recognized. In order to meet these needs, clinicians must avoid attending to only the superficial words that patients present and must be willing to dig deeper. Instead of quickly categorizing patients according to specific diagnostic criteria, providers must understand the person at a deeper level. This model requires that the clinician place the initial symptoms in a very *personal* context and avoid making judgments and assumptions. It requires the ability and the willingness to truly listen. Stewart et al. (1995) refers to this process as "responding to suffering." This process requires a departure from responding only to physical complaints and concerns. It demands seeing the patient as a complex person, who lives within a complex system that is dynamic, and as someone capable of affecting one's own health status. It assumes that the patient arrives to the consultation with a set of ideas concerning their illness. A patient's symptoms have meaning for them and this will probably only be revealed *if* the clinician directly inquires about this *meaning*. Therefore, specific questions need to be posed to patients and families that elicit this information. Patients and families also experience understandable fears about symptoms or illness. This is another area that may remain underground and unexplored if not directly asked by the clinician. It is important not to assume you know what a patient is feeling about *any* aspect of their health or illness. "Tell me about your feelings" is much preferred to "You must be feeling anxious." The clinician may have an intuitive feeling about what the

patient or family is feeling, but it is more effective to not lead the conversation in any specific direction. Patients and families that are trying to please or who are easily influenced will sometimes agree with a leading statement rather than contradict a clinician. The theory and practice of "active listening" will be further explored in chapter 4.

Patient-Centered Approach

A specific patient-centered approach, contrasted to the medical-centered approach, has been developed at the University of Western Ontario (Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986). The model consists of six components, see Box 1-3.

This model is particularly well suited in the setting of primary care and, specifically, family practice. It incorporates the clinician's exploration of both the patient's disease and dimensions of the illness experience, including feelings about being ill, a patient's ideas about what ails them, the impact of the problem on their daily functioning, and their expectations of what should be done. This model also emphasizes a holistic approach and, therefore, is particularly well

Box 1-3 Six Components of University of Western Ontario's Patient-Centered Care Model

Explore both the disease and the illness experience: differential diagnoses; dimensions of illness, including feelings and expectations	Prevention and health promotion: health enhancement, risk reduction, early disease detection, ameliorating effects of disease
Understand the whole person: the person includes life story, personal and developmental issues; the context includes family or anyone else affected by the patient's illness	Enhance the relationship: characteristics of a therapeutic relationship, sharing power, caring and healing relationship, self-awareness, transference and countertransference
Find common ground in regard to management: problems and priorities, treatment goals, clarification of roles of provider and patient	Realism: time, resources, team building

Stewart et al., 1995, p. 25

suited from a nursing perspective. An additional component of the model is the search for establishing common ground with a patient or family in regard to the management of health and illness, thus incorporating health promotion and prevention. Also central to the model is an emphasis on the patient–provider relationship and a requirement that the practice be realistic.

Studies that have focused on the benefits of the patient-centered model have reported better patient satisfaction (Roter, 1989), better provider satisfaction (Roter et al., 1997), fewer malpractice complaints (Levinson, Roter, Mullooly, Dull, & Frankel, 1997), and, contrary to popular belief, the approach does *not* increase the time of a typical office visit (Roter et al., 1997). Although this model was developed to address what the authors considered a troubled physician–patient relationship, it is a useful model for advanced practice nurses and graduate level healthcare providers.

Question Builder

The Agency for Healthcare Research and Quality (AHRQ), part of the US Department of Health and Human Services, has developed a tool for assisting patients in preparing for a visit to a healthcare provider. This tool is referred to as Question Builder, and it aims to help the patient clarify the purpose of the visit, by asking:

Did your clinician give you a prescription?
Are you scheduled to have medical tests?
Did you recently receive a diagnosis?
Are you considering treatment for an illness or condition?
Did your clinician recently recommend surgery?
Are you choosing a health plan?
Are you choosing a clinician?
Are you choosing a hospital?
Are you choosing long-term care?

After choosing a category, the patient is guided through a series of relevant questions that are useful to address during a clinical visit. For example, for patients considering treatment for an illness or condition, the questions are:

What are my treatment options?
What do you recommend?
Is the treatment painful?
How can the pain be controlled?
What are the benefits and risks of this treatment?

How much does this treatment cost?
Will my health insurance cover the treatment?
What are the expected results?
When will I see results from the treatment?
What are the chances the treatment will work?
Are there any side effects?
What can be done about them?
How soon do I need to make a decision about treatment?
What happens if I choose to have no treatment at all?

Lang, Floyd, and Beine (2000) explore the presence of clues that patients present during a routine office visit that are often missed. These clues relate to how patients perceive their illness and arrive in a variety of forms, including:

Direct statements about the impact of an illness
Expressions of feelings about the illness, including nonverbal expressions
Attempts to explain symptoms, without naming an illness
Repetition of ideas about an illness
Asking loaded questions
The presence of another person during the visit
Interruptions of the clinician by the patient
Scheduling a routine visit without a specific presenting complaint
Resisting a recommendation
Expressing dissatisfaction with previous care
Sharing a personal story during a visit

Utilizing a patient-centered approach begins with the first utterance by the clinician, "What brings you to the clinic today?" and the follow-up response to the patient's answer to the question. The clinician will choose to only focus on the symptoms that are reported or will venture into the world of ideas, feelings, and functional aspects that are related to the presenting complaints. How often in the traditional medical model is the patient asked about what *their* thoughts about the symptoms or illness are? Michael Crichton, better known for his thriller novels rather than his medical skills, wrote about his dissatisfaction with the traditional medical approach during his clinical rotations at Beth Israel Hospital during his final year at Harvard Medical School in the 1960s (Crichton, 1988). He decided, during his rotation on the cardiac unit, to ask patients who had experienced a heart attack what ideas they had about *why* they had suffered a cardiac event. He reports that patients quickly responded to the question with various theories, and Crichton marveled at the fact that this question was not part of the interview process he was taught to conduct. The patients were typically middle-aged men who had various thoughts about the

meaning of their illnesses when asked "Why did you have a heart attack?" Although the young medical student worried that the question might anger some patients because it implied a sense of control, he found that instead of anger, patients would validate that they had been thinking about just that question. The stories that patients told were of various events that had literally broken their hearts. They were stories of lost love, rejection, and events in which their hearts had been "attacked." It led the young medical student to the conclusion that the relationship between mind, heart, and illness was underappreciated in his medical education. Although Michael Crichton left medicine, once his book *Andromeda Strain* was sold to be made into a movie, his experiences speak to the notion of understanding the meaning of a symptom or illness for the patient. Levenstein, McCracken, McWhinney, Stewart, and Brown (1986) make a clear distinction between *disease* and *illness* when developing the foundations of the patient-centered model. The disease is what we try to categorize and find a code for reimbursement purposes. It is helpful in terms of communicating with other healthcare professionals to use this frame. This view may drive treatment choices and tell us something about prognosis and recovery. It may say something about etiology and inform us in regard to what is to be expected in future. However, it is not in any way individual or personal. It does not take into account the many variables that we know play a part in how the course of treatment will proceed. In addition, this view helps clinicians distance themselves from patients. Some may prefer it as a method because it is generalized and perhaps even cut and dry. It is not plagued by the messiness of all of the unique variables that the concept of illness brings to mind. Whereas a disease is a concept of something outside of the person, an illness is a lived experience that is very much a part of the person. No two will be the same, and the onus is on the healthcare provider to attempt to uncover the nuances that make the patient's perspective clear. A natural curiosity and humility is required with this approach, and it directly competes with the authoritative expert posture of the clinician who, once pouncing on a diagnosis, has all of the information and answers. Although pathophysiology is important, it is simply not enough. It places the emphasis on cells and physiology, not on the person. Mishler (1984) refers to turning away from a scientific, detached posture to one that pays attention to the social context, the meaning of an illness event, and the subsequent affect on personal goals as a "lifeworld" approach. Asking a patient what most concerns them, how it is disruptive to their life, and how they think you can be helpful is useful when following this approach.

In writing about the various stages of illness, Reiser and Schroder (1980) identified three stages: awareness, disorganization, and reorganization. This is similar to human response to trauma or a disaster. It would seem logical that a

clinician needs to place any communication in the context of this process. For example, to give copious direction initially, when the patient is struggling with new information, seems foolish. Initially, patients would expect to be in some form of denial, an expected defense mechanism that is unconscious. Patients will typically be highly ambivalent about knowing too much, while wanting the truth at the same time. Another struggle involves a wish to be cared for and a desire to maintain independence. If symptoms persist, issues of a diminished sense of control are predictable. In disorganization, patients regress and may relate to their provider as a parental figure. They may be cranky, demanding, and irritable. Others may become withdrawn, sullen, and lose hope. This difficult stage requires sensitivity on the part of the clinician if they hope to be effective. Finally, in the third stage, a patient seeks a new understanding in the face of illness. Social support plays an important role as does the relationship with the healthcare provider.

Challenges to patient-centered care (Holmes, Cramer, & Charns, 2003) include the fact that a certain treatment requested by a patient or family may not be supported by evidence-based practice. Some clinicians may not be comfortable with patients and families who are fully engaged with their care, preferring a more traditional passive patient role. Not all patients or families will be confident in their right to be involved in treatment decisions or have confidence in their opinions, leading to discomfort in regard to fully participating with healthcare providers. In addition, healthcare providers may be leery for patients and families to know too much, fearing litigation.

THE PICKER INSTITUTE

> *"Understanding and respecting patient's values, preferences and expressed needs is the foundation of patient-centered care."*
>
> —Harvey Picker

A patient-centered care model was also developed in 1984 at the Picker Institute, by Harvey and Jean Picker, as a result of their personal experience with the healthcare system. The Institute has the goal of improving healthcare delivery from the perspective of paying attention to patient's needs and listening to the concerns of patients and family members. This not-for-profit organization led the movement to develop a scholarly approach to discovering the needs and concerns of patients and families in order to assist healthcare professionals. Researchers developed new performance measurement tools after finding that the tools available at the time, aimed at measuring patient satisfaction, did not truly measure patient preference. The Picker Institute believes

that patients' views and experiences are "integral" to the effort to improve patient care. The principles that guide this patient-centered approach include:

Physical comfort and a safe environment
Empathy and emotional support
Involvement of family and friends
Fast access to reliable health advice
Effective treatment delivered by trustworthy staff
Continuity of care
Involvement in decisions and respect for patient preferences

The original survey utilized at the Institute was aimed at answering the following questions:

What do patients want?
What do patients value?
What helps or hinders their ability to manage health problems?
What aspects of care are most important to patients and families?

The Institute has further refined the survey in order to address the results of the original Picker survey and addresses the following areas:

Access: including time spent waiting for admission or time between admission and allocation to a bed in a ward
Respect for patient's values, preferences, and expressed needs: including the impact of illness and treatment on quality of life, involvement in decision making, dignity, needs, and autonomy
Coordination and integration of care: including clinical care, ancillary and support services, and "front-line" care
Information, communication, and education: including clinical status, progress and prognosis, facilitation of autonomy, self-care, and health promotion
Physical comfort: including pain management, help with activities of daily living, surroundings, and hospital environment
Emotional support and alleviation of fear and anxiety: including treatment and prognosis, impact of illness on self and family, financial impact of illness
Involvement of family and friends: including social and emotional support, involvement in decision making, impact on family dynamics and functioning
Transition and continuity: including information about medication and danger signs to look out for after leaving the hospital, coordination and discharge planning, and clinical, social, physical, and financial support

The Picker survey is analyzed by the creation of 40 "problem scores," which indicate the presence or absence of problems. These are then summarized into "dimension scores" according to theme. More than 8000 patients, family members, and healthcare providers were involved in the original research. In addition to uncovering invaluable information about what areas of care most mattered to patients and families, the survey used a new approach: that of asking patients and families to report on their experience of health care instead of the typical patient satisfaction rating survey. Now this method of measuring performance, from the perspective of the patient and family, is considered a standard. Today the Picker Institute surveys are utilized not only in the United States, but also in Great Britain, Sweden, Germany, and Switzerland. The surveys provide patient experience measurement services to the healthcare industry and sponsors education and research in the area of patient-centered care.

An example of information derived from the Picker survey is a study about the harmful effects and ethical and political implications of withholding information from patients about organizational policies (Williamson, 2005). This practice of withholding information can undermine patient autonomy and repress their political voice. These results underscore the connection between offering patients and families access to policies and ethical clinical practice.

REFLECTIVE PRACTICE

> *When nurses welcome patient's feelings, respect their wishes, and honor their need for self-expression, they help patient's choose options that are in their best interest* (Appleton, 1994, p.103).

It was an educator, Donald Schön (1987), who first introduced the concept of reflective practice as a process that taught teachers how to hone their skills. Schön's work grew out of what he called a "crisis of confidence" in teaching when there existed the pressure for a better educated populace in the face of increasing competition and Asian imports. He was interested in "reflection-in-action" or what teachers did in classrooms. Reflection-in-action is a response based on improvisation, and it is artistic. It often is initiated when the practitioner is surprised, and then puzzled, and then responds with an on-the-spot experiment based on an understanding of what is occurring. It requires thought about the surprise and an awareness of looking at or reflecting while doing. It leads to new ways of behaving if the experiment brings a positive result. The practitioner can then store the experience for future use in similar situations. Schön called

it "thought turning back on itself." He likened it to jazz and good conversation, where neither is wholly predictable. Schön also confessed that teaching students to do something he did well was indeed challenging unless he reflected on *how* he did the thing, or observed himself at least mentally. He warned that theories only take one so far when trying to teach.

Schön encouraged both the novice as well as the seasoned professional to actively engage in a process of reflecting on one's experiences and then applying the knowledge to future encounters. He argued that reflection-on-action was intellectual work requiring verbalization. He eloquently spoke of the separation of research and practice in the modern university that has little tolerance for artistry, messiness, and nontechnical problem solving. "The challenge to the professional schools, I think, is this challenge of educating for artistry. Helping people become more competent in the indeterminate zones of practice, as carrying out processes of reflection-on-action and reflection ON reflection-in-action" (Schön, 1987). Schön called on various professional schools to pick up the gauntlet, including athletics, arts, architecture, music, and dance and nursing. He believed in a "reflective practicum" whose main feature is a situation in which people learn by *doing*; with others involved in the same activity in a virtual world, students can run experiments cheaply and without great danger. "They don't have to actually go out and build a building to learn about designing a building. And they don't have to go out and kill a patient to learn what the carotid artery is. And they can actually go back and do it again, and they can control the pace of the doing. I believe, the experience of students in any reflective practicum is that they must plunge into the doing, and try to educate themselves before they know what it is they're trying to learn. *The teachers cannot tell them*" (Schön, 1987, p. 12).

Initially implemented in colleges of education, reflective practice is a natural fit for many healthcare disciplines. Like Benner's continuum model, Schön's model is based on different levels of practice. The popular portfolio utilized for both admission and graduation requirements in many fields are an example of the homage paid to the theory of reflective practice.

Reflective Practice and Nursing

Awareness of personal and professional values enhances clinical judgment for the advanced practice nurse (Chase, 2004). These values include openness, courage, persistence, and loyalty to patients. Reflection is the path to understanding one's beliefs and values. Although educators struggle to find ways to incorporate reflective writing in the curriculum, once accomplished, student writing improves over time (Epp, 2008).

Although there are several models for reflective practice in nursing, Johns (2007) defines and describes reflection as:

> *Reflection is being mindful of self, either within or after experience, as if a window through which the practitioner can view and focus self within the context of a particular experience, in order to confront, understand and move toward resolving contradiction between one's vision and actual practice. Though the conflict of contradiction, the commitment to realize one's vision, and understanding why things are as they are, the practitioner can gain new insights into self and be empowered to respond more congruently in future situations within a reflexive spiral towards developing practical wisdom and realizing one's vision as a lived reality. The practitioner may require guidance to overcome resistance or to be empowered to act on understanding* (p. 2).

In other words, reflection involves intuition, perception, and cognition based on a lived experience with a patient in order to understand ourselves and how we may practice more effectively. Johns has outlined a model that incorporates various ways of knowing. It calls for the practitioner to first recall the interaction in one's mind and then focus on one part of the experience that seemed to be significant. Then the practitioner focuses on what others were feeling and why, and then how they were feeling and why. Next, the clinician thinks about what exactly they were trying to achieve in the interaction and how effective they were. The clinician asks what the consequences were for the patient, others involved, and for them. Following this, the practitioner looks inward and asks what factors influenced how they felt, thought, and behaved. What knowledge informed or might have informed? They then assess how the behavior matches up with their value system, prior similar experiences, and how they might be more effective in future. Alternative actions are considered in terms of consequences for the patient, others, and self. Finally, the practitioner assesses how they now feel having gone through the prior set of questions (Johns, 2005).

Role play and reverse role play are methods used to facilitate the process of reflection by simulating Socratic dialogue (Todd, 2005). Students can either be in diads or a triad. In the latter configuration, students take the role of patient or nurse, and the third person's role is to observe, offer technical prompts, and help guide the interaction.

Homework assignments are an integral part of reflection. This can be in the form of a reflective journal which records clinical practice situations that line up with classroom activities and theory. In a reflective journal thoughts and affect can be explored alongside behavior in order to lead to increased self-awareness and be used as a guide for future practice. A reflective journal assists clinicians in identifying specific learning experiences as well as recording professional growth as the clinician moves from novice to expert. Jasper (2003)

has clarified that the connection between reflective writing and learning occurs because writing helps to:

Order our thinking
Develop analytical skills
Develop critical thinking skills
Develop creativity
Identify and clarify the limits of understanding

In addition to these, Moon (1999) has identified the purposes of keeping a journal:

Encourage metacognititon
Enhance problem-solving skills
Serve as a form of self-expression
Increase participation in one's own learning
Enhance personal development
Enhance self-empowerment
Foster communication and interaction in a group
Support planning and progress in scholarly projects

Kim (1999) has developed a method of inquiry meant to assist clinicians in being critical thinkers who are reflective in regard to their practice. The phases of this inquiry include a descriptive phase, a reflective phase, and a critical phase. Practitioners develop descriptive narratives that are used to promote self-awareness and new knowledge as a result of reflection. Finally, a critique of practice leads to new learning and a change in practice. The goal is to learn to identify good versus ineffective practice, to generate knowledge from practice, and to change or correct ongoing practice. There is value to allowing students to utilize reflective writing with some distance from the actual clinical encounter, including both actual patients and the clinical site. In one model, Web journaling provides the opportunity for faculty and students to dialogue about clinical situations, and can raise the awareness of both students and faculty in regard to the learning needs of the students and their evolving understanding of their patients (Cohen & Welch, 2002). Because this method is Web-based, students are encouraged to utilize the Internet for information. Faculty guide students in the use of the information, with particular patients under specific circumstances. Use of this model over several courses may reinforce the value of both reflective journaling as well as self-directed learning.

Web journaling **is a practice that incorporates the principles of journaling, reflective practice, and encouraging students to be self-directed.**

THE WORK OF PATRICIA BENNER

> *A complex social practice such as nursing requires attentive caring relationships with patients and families, professional commitment to develop practical knowledge, astute clinical judgments across time about particular patients and families, and good collaborative relationships with others on the health care team* (Benner in Haag-Heitman, 1999, p. 17).

Patricia Benner's work on the attributes of expert practice has served to guide all advanced practice (nurse practitioners, clinical specialists, nurse-midwives, and nurse anesthetists) to common ground in regard to what constitutes advanced practice. In describing "expert," Benner identified seven domains: the helping role; the teaching–coaching function; effective management of rapidly changing situations; diagnostic and patient monitoring role; monitoring interventions and regimens; ensuring quality in healthcare practices; and organizational competencies. It was Fenton (1983) who applied these domains in order to further clarify advanced or graduate nursing practice. Brykcyznski (1989) studied nurse practitioners in outpatient care settings and added a domain related to ambulatory care. Studies focusing on advanced practice nurses' communications styles, which enable health promotion and disease prevention, are in the early stages (Berry, 2006).

In discussing clinical decision making for the advanced practice nurse, Smith (2006) suggests the following approaches:

Understand the meaning that patients attribute to their health.
Learn about the patient's lived social world, support system, and role responsibilities.
Along with the patient, note personal and social health obstacles and facilitators.
Determine the patient's preference for and ability to participate in healthcare decision making and health management.
Mutually set health goals and priorities.
Identify and treat patients in crisis, transitions, and times of loss.
Know the patient's spiritual framework.

These previously listed approaches require the development and building of a relationship with patients, and this can only be accomplished through effective therapeutic communication.

> *The art of nursing is the art/act of the experience-in-the-moment. It is the direct apprehension of a situation, the intuitive and embodied knowing that arises from the practice/praxis of nursing. Art arises from the immediate embodied*

> *grasp of the situation, the tools or instruments with which the artist works, and the intuitive knowing of what is to be created in the act* (Chinn, 1994, p. 24).

Benner believed that in order to study caring, the personal and cultural meaning must be examined. Her work provides grounding for the method of phenomenology. She cautioned that because the work of nursing was "contextual," "temporal," and "relational" that the usual task analyses of the work would not be sufficient or accurate. She spoke of *experiential learning* and *practical wisdom* as a more appropriate guide for nursing practice. By using a developmental and interpretative approach, nursing becomes "visible" both to the nurse, who has reflected on their practice, and to the larger organizations, which can validate the work. Benner's methodology of studying novice to expert was observational and narrative in nature. In her role as educator, Benner requires first-person experience narratives of her students. These clinical narratives, a form of reflective practice, are meant to encourage learning about new practice or even clinical errors (Benner in Haag-Heitman, 1999).

In the final stage of Benner's clinical practice development model, the expert practitioner is guided by intuition and a skill derived from and grounded in experience. Their practice can be described as "flexible," "innovative," with a "confident self-directed" approach to clients (Haag-Heitman, 1999). The expert is able to identify their own personal values and place them in context, thereby not interfering with the patient or family and their decisions regarding care. Caring is characterized by being fully present with the patient, "being with" as opposed to "doing to." It requires active listening, understanding the meaning for the patient and family of the current situation. Care also means providing hope offered in the context of a trusting relationship. Only within such a relationship can the provider act as patient advocate, assist in making choices, and truly empower patients and their families.

Clinical intuition or forethought is the ability to make sense of the clinical situation by recognizing patterns and similarities. It means anticipating difficulty and early intervention and an ability to prioritize. Delegation and decisive action are components of this skill, and it requires clear and convincing communication skills in order to explain to colleagues the basis of opinions (Haag-Heitman, 1999).

> *We stand on the threshold of developing knowledge of the art of nursing and aesthetic knowing in nursing. Breaking new ground is difficult because the ways we have learned to think, to practice, to be, stifle creativity and devalue ways of knowing closely associated with women. As nurses engaged in the process of developing experiential criticism have reflected time and again, moving to new awareness of nursing practice as an art opens remarkable possibilities for the future* (Chinn, 1994, p. 37–38).

IMPLICATIONS FOR ADVANCED PRACTICE NURSING

> *Essential to high-quality clinical judgment is the ability of the nurse practitioner to form a link between patient's life experiences, their problems, and the full range of diagnostic and therapeutic choices available to achieve a range of possible outcomes. The nurse practitioner must be expert at eliciting the true patient story and in recognizing patterns presented in the data* (Chase, 2004, p.15).

Jensen (2006) urges advanced practice nurses to honor a different model of patient care, one that acknowledges the contributions of nursing rather than simply adopting the medical model. She stresses that it is not the activities themselves, but rather *how they are carried out* that will differentiate advanced practice nursing from physicians.

The most recent definition of nursing involves protection, promotion, and optimizations of health, prevention of illness, and alleviation of suffering. This is to be accomplished via the processes of diagnosis and treatment and advocacy (ANA, 2003). It is hard to imagine how any of these goals can be accomplished without solid communication skills.

Advanced practice nursing includes clinical specialists, nurse practitioners, nurse anesthetists, and nurse-midwives, and is defined by the ANA scope and standards of practice (2003) as a preparation for specialization, advancement, and expansion of practice. Four common functions of these diverse groups include patient care, educator, researcher, and consultant (Hameric, Spross, & Hanson, 2004). Again, all of these roles require communication skills and one could argue that the complexity of the healthcare system, as well as the expanded scope of practice, require advanced communication knowledge and skills. Advanced practice nurses are leaders in organizations and mentors to other healthcare professionals. There also exists real tension regarding who are the legitimate leaders of a healthcare team that will continue to evolve within the context of an aging population and a nursing shortage. Yet, whether in the clinical arena with families or involved in organization consulting, the advanced practice nurse will need to be a facile and skilled communicator.

The National Association of Clinical Nurse Specialists (NACNS) has described the spheres of influence of the clinical specialist as patients/clients, nurses, and organizations and systems (NACNS, 2004). These spheres of influence form the foundation for the development of core competencies for this group of advanced practice nurses. Communication skills clearly form the basis of functioning in all three spheres.

As the international supply of physicians continues to fail to keep up with demand, and the shifting tide of patient care away from hospitals and into the community advances, the role of advanced practice nurses is increasingly seen as an

answer to the question of who will provide care, particularly in the primary care setting. In an attempt to study "nurse–physician substitution" in primary care, a meta-analysis ranging from 1966 to 2002 was done. In all, over 4000 articles were screened and 25 articles were chosen as best relating to inclusion criteria. The analysis found that "no appreciable differences" were discovered between doctors and nurses in regard to health outcomes, actual care, and resource utilization and cost (Laurant, Hermens, Braspenning, Grol, & Sibbald, 2004). In five studies nurses were responsible for initial contact care for patients needing "urgent consultation." In these studies, nurses not only provided longer consultations and more information to patients, but had a higher patient satisfaction grade. In four studies the nurses worked with patients with chronic illnesses and no significant differences were found between doctors and nurses in regard to patient care or financial considerations. The authors concluded that advanced practice nurses can indeed be called on to provide high-quality patient care across the spectrum.

Early studies called the difference between nurse practitioners and physicians "indistinguishable" (Sox, 1979; Stewart et al., 1995), and recent research supports the fact that patients report greater satisfaction regarding care when treated by nurse practitioners. In addition, findings suggest that patients also report receiving longer visits and significantly more information about their illnesses (Hooker, Potts, & Ray, 1997; Kinnersley et al., 2000; Venning, Durie, Roland, Roberts, & Leese, 2000; Horrocks, Anderson, & Salisbury, 2002). In one study, nurse practitioners spent twice as long with their patients and both patients and clinicians spoke more (Seale, Anderson, & Kinnersley, 2005). In addition the nurses talked "significantly more" than general practitioners about treatments and how to apply or carry out treatments. There was also evidence that the nurse practitioners were more likely to discuss social and emotional aspects of patients' lives, discuss the likely course of the patient's condition and side effects of treatments, and use humor.

A recent article in an online journal addressed the issue of communication for nurse practitioners (Katz-Wliner & Feinstein-Whittaker, 2008). The authors, a corporate communication trainer and a speech-language pathologist, offer the following "tips" for effective communication in a clinical encounter:

1. Pay attention to identifying yourself when entering the room, make eye contact, and introduce yourself by name and title.
2. Listen to your patients, attending to both verbal and nonverbal communication without interruption.
3. Avoid using medical jargon and ask patients to repeat all instructions or information in order to assure their understanding of what you are trying to communicate.

4. Speak slowly and clearly.
5. Provide written instructions in regard to any treatment as well as information regarding future appointments and additional resources.
6. Be respectful at all times.
7. Speak directly to the patient, not to family members about the patient, no matter what age the patient.
8. Be professional at all times.
9. Adhere to confidentiality.
10. Be culturally sensitive in your care.

While these authors mention the lessening of "risk exposure," decreased attrition, and decreased patient dissatisfaction as advantages with this approach, they also stress the overall goals of improved patient care and increased image of the clinical practice as well.

COMMUNICATION EXERCISES

1. Patient-Family-Centered Approach

Pair off as patient and provider: 30 minutes.

Provider:

Conduct an initial assessment utilizing four concepts related to the patient-Family-Centered approach.

Patient:

At the end of the interview try to identify which concepts your provider stressed in the course of the interview.

Discussion:

How does a focus on patient-centered care differ from other assessments you have conducted?
What experiences, as a patient at the receiving end of this approach, were of value?

Were any difficulties encountered, either as patient or provider?

What are the obstacles for implementing this approach in a clinical area?

What changes might you consider for another interview with this approach?

Switch roles and repeat.

2. Patient Understanding of Their Illness

Pair off as patient and provider: 30 minutes.

Provider:

In the process of your interaction with this patient you need to explain a complicated diagnosis, treatment regime, and prognosis.

Patient:

You have just been told of a difficult and complicated diagnosis. You have many questions about treatment as well as fear about your life expectancy. You have a high school diploma and struggled with a learning disorder since grade school. Attempt to communicate your concerns with your clinician as you seek information about your illness.

Discussion:

Debrief the interaction from both the position of the provider and the patient. Explore both the process and the content of the interview, noting any areas when the dialogue became challenging. Share with one another the perspective of patient and provider, while trying to focus on helping a patient understand their illness.

Switch roles and repeat.

3. Patient Expectations

Pair off as patient and provider: 30 minutes.

Provider:

Prepare an initial opening that elicits what the patient is expecting from today's visit.

Patient:

This is the first time seeing this clinician, and you are somewhat reticent. When responding to the question of what you are expecting from the visit, be indirect and somewhat passive. Do not give elaborately detailed responses. Make your provider use their communication skills to draw you out. As the interview unfolds, and you become more comfortable with your provider, you begin to be more open with him/her.

Discussion:

Debrief this interaction from the perspective of how well the patient's expectations were elicited and then addressed.
What were the challenges and successes?

Identify communication techniques that were most useful in this exercise.

Switch roles and repeat.

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4. Patient Fears

Pair off as patient and provider: 30 minutes.

Provider:

You are seeing a patient for an annual exam; there are no presenting complaints that you are aware of.

Patient:

You have come to your annual visit with your provider with a serious concern that is particularly embarrassing to you. You are hoping that you will not have to directly express this issue, but that your clinician will ask you about it.

Discussion:

Explore how successful the provider was at uncovering the patient's concerns. What communication techniques were utilized in order to clarify the issues and then deal with the patient's emotional state?
What were the challenges of this exercise?

What learning or insight did you derive from this exercise?

Switch roles and repeat.

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5. Patients and Etiology

Pair off as patient and provider: 30 minutes

Provider:

You are seeing a patient who presents with what you have diagnosed as poison ivy. You quickly come to realize that your patient sees this very differently. Use your communication skills to delve into this issue.

Patient:

You have searched the Internet regarding a rash you have developed. You have read both medical sites and blogs discussing rashes and have come to think you have a rare condition that, according to what you have read, is often missed by primary care providers. You are hopeful your provider will listen to your hypothesis.

Discussion:

Debrief this interaction, from the position of patient and provider.
What were the points of tension and how were they dealt with?

Share with one another what it was like to try and communicate your position.

What insight was gained from the exercise? How might you use this understanding in a clinical setting?

Switch roles and repeat.

6. Novice to Expert

Pair off as two providers.

Take turns sharing with one another and identify which stage of professional development you have reached.

Discuss where on the continuum you have reached as a staff nurse and as an advanced practice nurse.

Explore the experience of moving from the role of staff nurse to that of an advanced practice nurse.

What have been the challenges?

What have been the positive aspects of this transition?

7. Nurse–Patient Relationships

Pair off as two providers.

Take turns identifying your personal qualities that facilitate the nurse–patient relationship.

Which qualities do you find most challenging when caring for patients?

Share an experience that best illustrates your ability to engage in a therapeutic relationship with a patient or family.

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8. Reflective Practice

Pair off as two providers.

Review the process of reflective practice using a recent clinical event with one another.

Discuss the value of reflective practice in this scenario.

Explore what insights you gained as a result of engaging in reflective thinking about the clinical encounter.

JOURNALING EXERCISES

The unreflective life is not worth living.

—Socrates

Journals have begun to be assigned to students as a method of facilitating reflective practice. Reflection-in-action, as described by Schön (1987), is considered by many to be the cornerstone process of journaling. They are a useful tool for both students and faculty alike for delving more deeply into focused topics. Journaling and role playing, utilized together, can be powerful reinforcers of new learning and promoting critical thinking (Andrusyszyn & Davie, 1997; Halva-Neubauer, 1995). Journaling allows one to bring to conscious awareness new insights and knowledge. The act of reflecting on one's practice cannot help but influence interactions with future patients. Reflective journaling is not simply a matter of recording the events of a day. It requires that the writer identify and examine the underbelly of an experience. What was unclear or confusing? What further questions were generated as a result of the experience? What additional information is needed in order to clarify a confusing aspect of the issue? In these series of journal entries, students will be encouraged to look within in order to increase their self awareness as effective and therapeutic communicators. They will be encouraged to bridge theory and practice with their own personal attributes. Some of the exercises will cause discomfort, but growth rarely occurs where there is no stirring of uneasiness. The value of journaling stems from the fact that it can illuminate contradictions as well as misconceptions. Educational research suggests that active reflection is needed if true transformational learning is to occur. Benefits of journals include clarifying the connections between new knowledge and previous knowledge; examining relationships between what is being learned and the outside world; reflecting on personal goals; sorting out experiences; solving problems; enhancing reflective thinking; enhancing metacognition; improving problem solving and critical thinking; facilitating self-exploration, personal growth, and values clarification; and synthesizing ideas, experiences, and opinions after didactic instruction (Hiemstra, 2001; King & LaRocco, 2006).

1. Nursing History

Discuss your present level of knowledge in regard to nursing history.

What is the relevance of nursing's journey to current practice?

Identify an historical issue that seems to be resurfacing in health care today. What were the lessons of history that can inform today's leaders?

Identify an historical issue that is longstanding and has not reached resolution in nursing.

What are the implications of these historical issues in the current healthcare environment?

Research one of these issues further and prepare to present it in class.

2. The Nurse–Patient Relationship

Discuss what aspects of the relationship you feel most prepared for at this stage of your career.

Your ability to be successful in personal relationships is correlated with your ability to form meaningful nurse–patient relationships. Agree or disagree? Why?

What are the messages you have received in your training regarding patient relationships?

Have you witnessed the nurse–patient relationship as a priority in the clinical settings you have worked?

What interferes with the nurse–patient relationship in your opinion?

What steps can you take to improve in this area?

3. Patient-Centered Care

Discuss your familiarity with this approach before you read this text.

What do you think of the practicality of this approach?

Discuss the challenges of implementing this approach.

What has been your experience with collaborating with patients and families?

Explore the idea that providers lose some power or control when they work in a more collaborative fashion with patients and families.

4. Novice to Expert

Discuss where you see yourself on Benner's continuum of novice to expert.

What implications does Benner's work have for your clinical practice? Be specific.

As you approach the role of an advanced practice nurse, what are the aspects of the role that relate to Benner's theory?

If you are a seasoned clinician returned to graduate studies, how do you see yourself relating to the Benner model?

Do your years of experience mean that you are not a novice as an advanced practice nurse?

Discuss what issues this raises for you.

Does Benner's model match your observations of peers or colleagues?

5. Reflective Practice

Do you consider yourself an introspection person by nature?

What are the challenges of attending to clinical interactions in a thoughtful and reflective manner for you?

What is your experience with keeping a journal?

What do you see as the advantages and drawbacks of keeping a journal of your clinical encounters?

Write about a clinical encounter that you found yourself mentally reviewing long afterward.

Describe the process of "rethinking" how you behaved and responded in this scenario.

What are the implications for future clinical encounters derived from this experience?

Develop and identify goals for yourself as a reflective practitioner.

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