

SECTION ONE

Setting the Stage for Effective Communication

CHAPTER ONE

The First Encounter

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■ CASE STUDY

“Good Morning, Mrs. T. My name is Jay, and I will be your nurse today. We have a full day today with some tests. How about getting washed up now? Is it all right to call you Mrs. T.?”

Mrs. T. is a 76-year-old woman with metastatic lung cancer being cared for by the nurse, Jay. It is her second day in the hospital after developing a fever and cough. She is quiet, giving one-word answers to Jay’s questions. Mrs. T. thinks that Jay is being too aggressive, making her wash up and scheduling tests without asking her permission. Jay is beginning to wonder about why Mrs. T. is reluctant to talk with him.

Later, when he comes in to bring her morning medications, Jay says, “Mrs. T., I have your medications.” She responds, “What am I supposed to do, take those now just because you say so?”

Introduction

In each room, bed, or chair, nurses encounter different people seeking health care. Each time a nurse meets a new person in a healthcare setting, a new relationship begins for both parties. These relationships often develop at vulnerable points, when people seek assessment, treatment, information, and often reassurance about their health. Some interactions will proceed smoothly, with both parties having the same goals for the visit. At other times, the nurse may encounter more challenging situations, such as the one presented in the case study. The nurse’s communication style and responses will establish the framework for future conversations and the implementation of the plan of care. Often, it is the unspoken communication that influences the words to follow. The nurse’s role is to explore and understand both the patient’s needs and the healthcare goals in order to deliver patient-centered care. High-quality communication in health care requires more than words; it requires careful tailoring of communication for the interaction and, most importantly, the person who is the patient.

Terminology

For the purposes of this text, it is useful to define the terms used for the people involved in communication in the healthcare setting. *Patients* are people seeking and/or receiving healthcare services from healthcare providers. While the term “clients” is sometimes used in nursing and communication literature, the term

“patients” will be used in this text because it conveys a level of ethical responsibility to a person in a vulnerable position seeking services.

Healthcare providers are sometimes described in books as “clinicians” or by healthcare profession, such as “doctors” or “nurses.” This text discusses just one type of healthcare provider—nurses.

Patient–provider communication refers to the communication between the patient, family member(s), and provider(s) during visits to receive health care, often involving multiple types of healthcare providers. Much of patient–provider communication is similar across healthcare professions, and improving communication requires an interdisciplinary approach.

The *nurse–patient relationship* is a different type of relationship, as it involves the nurse as a professional healthcare provider communicating with a person seeking health care. Gone are many of the social boundaries that define everyday relationships. Both parties have expectations about how the interaction will proceed and what the outcomes will be. These are different relationships—ones that have the potential to affect both patients and nurses. Communication is a process of mutual influence.

During healthcare visits, patients are often placed in dependent, vulnerable roles. Within a short period of time, they may be required to reveal intimate information about their lives and bodies to people (healthcare providers) they have just met, or they may even undergo painful procedures. For patients to feel respected, cared for, and safe, nurses must create an environment that puts patients at ease, allowing revelation, understanding, and mutual planning to facilitate assessment, treatment, and healing or perhaps peaceful death.

Health care is a fast-paced environment. Time is often short, and quickly establishing these relationships may sound like an impossible task. Nevertheless, good communication is a clinical skill that can be learned. Beginning with basic education, nurses learn the fundamentals of establishing the relationship, basic communication skills, and specific nursing interventions. These professional skills build on previous experiences and begin a lifetime of learning for the professional nurse as both a person and a communicator. After graduation, nurses use their clinical experiences with patients and families to build and refine their own communication style. Each room, chair, and bed brings a unique situation requiring nurses to become flexible communicators.

Communication is a universal word with many meanings. It has been described as a transfer of information between a message sender and a

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message receiver. In nursing, communication entails a sharing of health-related information between a patient and a nurse, with both participants acting as senders and receivers of information. Communication occurs in many ways and may be verbal or nonverbal, written or spoken, culturally appropriate, personal or impersonal, issue specific, or even relationship oriented. It can pertain in a larger sense to public health campaigns and policy issues, or to information on the Internet, or to a single patient's personal experience with a health issue. Human communication is a continuous and dynamic process, with the nurse and patient developing a relationship not only to share information but also to facilitate health, growth, and healing.

Theoretical Background

Human communication is multidimensional and has been studied by researchers from many disciplines, including nursing, medicine, psychology, social work, and pastoral care. Watzlawick, Beavin, and Jackson (1967) describe communication as occurring on two levels: the relationship level and the content level. The relationship level refers to how the two participants are bound to each other. The content level refers to the words, language, and information that are exchanged by the participants. The two levels are inextricably bound, and the content is relayed more effectively in healthy relationships. The opposite occurs in strained relationships—that is, the content of the message is not clearly relayed or heard because of struggles within the relationship.

Relationships between patients and healthcare providers such as nurses influence communication and care. This section reviews four models of communication with applicability to nurse–patient communication in the healthcare setting. While not distinctly nursing theories, each contributes to the understanding and provides theoretical frameworks for communication models and some components of nursing theory (see the chapter titled *The Nurse as a Person: Theories of Self and Nursing* for more on nursing theories). The models to be discussed are as follows:

- Health Belief Model
- Orlando's theory of the deliberative nursing process
- Rogerian model
- Social information processing models

The Health Belief Model

The Health Belief Model (Rosenstock, 1974) focuses on the patient's perspective on health communication. This model has been influential because it explains how the patient's beliefs may predict the adoption of healthy behaviors. Certain variables or modifying factors can influence a patient's beliefs, including demographic characteristics such as age, sex, and ethnicity; perceived threats; and cues to action (e.g., advice, advertising, or illness in a family member). When applying the Health Belief Model, cues to action are incorporated into interventions to optimize their effectiveness in changing behaviors. For example, young adolescents are more susceptible to cigarette advertisements (*cues to action*) and peer pressure (*age-related variable*) than are middle-aged adults. Therefore, advertising campaigns to stop adolescents from smoking may be more effective if they involve posting videos of students placing body bags in front of the corporate headquarters of tobacco companies on YouTube rather than providing handouts for parents at the pediatrician's office. In contrast, a diagnosis of lung cancer in a family member (*cue to action*) would be more apt to influence a middle-aged adult to quit smoking than it would a teenager. Communication at the nurse–patient level should be geared toward understanding patients' perceptions of their health and utilizing interventions that are appropriate for their demographic characteristics.

Orlando's Theory of the Deliberative Nursing Process

Nursing communication affects patient outcomes such as anxiety, adherence to treatments, and satisfaction with care. Ida Jean Orlando's theory of nursing process describes nurses' reactions to patients' behavior as generating a perception, thought, and feeling in the nurse and then action by the nurse.

Orlando's theory of the deliberative nursing process describes communication between nurses and patients in terms of three concepts: the "patient's behavior," the "nurse's reaction," and the "nurse's activity." The patient sends a cue in the form of a behavior—that is, "patient's behavior." The "nurse's reaction" is the nurse's response to the "patient's behavior." Two types of nurse responses are defined in Orlando's theory: a "nonobservable response" consisting of a thought, perception, and feeling, and an observable "nurse's activity" as the final action/response to the "patient's behavior." Orlando further described the "nurse's activity" as being "automatic" or "deliberative nursing process." The "deliberative nursing process" allows nurses to identify the patient's needs and help the patient—that is, to be of

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Nurses develop communication skills that build on a lifetime of experience and continue to grow throughout their professional careers



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help. Orlando's theory emphasizes that effective nursing practice is the result of the nurse's nonobservable reaction (perception, thought, and/or feeling), followed by the nurse's observable actions (activity) to the "patient's behavior."

In Orlando's theory, nurse–patient interaction involves reciprocity, making the relationship dynamic and collaborative. According to Orlando, the nurse confirms his or her perception, thought, and feeling with the patient for validation prior to selecting the activity. Deliberative actions are seen as more effective, but the process of self-reflection, the assessment of self-efficacy, and the role of peer evaluation/support are not clearly identified in the theory.

Rogerian Model

The Rogerian model describes the role of the relationship between the healthcare provider and the client or patient. Carl Rogers (1951) described the therapeutic relationship as central to facilitating healthy adjustment in the

client. Communication is client centered because the patient is the focus of the interactions. The helper or healthcare provider communicates with empathy, positive regard (or respect), and congruence (or genuineness) to facilitate client adjustment to the circumstances and movement toward health. Although originally created for psychotherapists, the Rogerian model has proved useful for nursing and the establishment of the therapeutic nurse–patient relationship.

Model of Social Information Processing

Models of social information processing provide useful constructs that are applicable to how nurses learn to respond to patients. The Crick and Dodge model (Crick & Dodge, 1994) is a circular depiction of the emotional and cognitive processes involved in learning to respond to social cues. At the core of the model is a database of memories, acquired social rules, and social knowledge and schemas. When applied to nursing, this database may include previous social experiences in the personal and professional spheres, formal education in communication skills, and role expectations, including ethical and legal ramifications, societal expectations, and professional mandates of nursing. Nurses learn to develop their professional communication skills by regulating arousal (i.e., nurses controlling their internal reactions to patient communication, particularly during difficult conversations), developing self-efficacy (confidence), deciding on responses, and finally enacting a response that helps both patient and nurse attain their goals. Nurses adapt to their roles as professional healthcare providers by learning effective methods of responding to patients and developing confidence to communicate confidently in a variety of patient situations.

Summary

Communication is the sharing of information between individuals. It is also a dynamic and reciprocal process, affecting each person in the relationship. The communication process is influenced by the information to be shared and the structure of the relationship.

In health care, theoretical frameworks provide a basis for understanding nurse–patient communication. The Health Belief Model is useful in understanding why patients adopt or change health behaviors. Orlando’s theory describes the nursing process in terms of nurses’ reactions to patients’ behaviors as generating a perception, thought, and feeling in the nurse and then action by the nurse. The

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communication is influenced by perceptions and judgments made by both the patient and the nurse (Sheldon & Ellington, 2008). The Rogerian model describes a patient-centered model for nurse–patient relationships. In this model, nurses use empathy, congruence, and positive regard/respect to establish a therapeutic relationship with the patient. Social information processing models provide useful constructs for exploring how nurses learn to respond to patients, including regulation of their internal reactions. These selected models demonstrate the dynamic process of healthcare communication and the fundamental components of nurse–patient communication.

Case Study Resolution

In the case study, Mrs. T. has certain perceptions about the nurse, Jay, and his role as her nurse. Jay is unsure about her reactions when he discussed her scheduled testing and morning care. Using a Rogerian approach, the nurse could explore Mrs. T.’s perceptions of the situation and offer suggestions about ways to incorporate her goals into the plan of care. What should have been a beginning to their relationship has become more challenging because certain parts of messages are missing, and the relationship is not well established. Perhaps Jay could respond, “Mrs. T., it can be difficult to be a patient. You haven’t had much time to yourself since we scheduled these tests.” Or perhaps he could give her more control over her day: “When would you like me to bring your medicine?” He could also acknowledge her underlying concerns: “You sound upset this morning. Tell me more about what’s going on.”

Whatever approach Jay takes is essential to establishing goals that are respectful of the patient and acknowledge her concerns regarding this experience. The lack of understanding on both sides can be minimized by effective communication and will lay the foundation for future interactions and optimal nursing care.

EXERCISES

Break into groups of three. Each person in the group has a role: a nurse, a patient, or an observer. Each person in the group will role-play in one role for 5 minutes. Pick one of the following scenarios:

- A 17-year-old boy with a seizure disorder who is not taking his medications regularly
- A 49-year-old man with a 2-pack-a-day smoking habit for 35 years who has bronchitis

- A 20-year-old woman with a chlamydial infection and a new sexual partner
- A 77-year-old woman with a recent transient ischemic attack and dizziness who does not like using a cane
- A 7-year-old boy who broke his wrist skateboarding and was not wearing protective gear

Begin the role-play with a greeting from the nurse and the initial assessment. Role-play for no more than 5 minutes. As the “nurse,” begin the encounter with the appropriate introductions and assess the reason the “patient” has sought health care. As the “nurse,” try to assess the “patient’s” problem and arrive at mutually set goals. The “observer” will assess the “nurse’s” actions.

After each role-play, the observer will begin the discussion with the group. Use the following questions to assess the interactions:

1. Did the nurse begin the relationship in a warm, respectful manner?
2. Did the nurse solicit the patient’s perception of the situation?
3. Did the nurse make judgments about the patient’s behavior?
4. Was the nurse empathetic to the patient’s feelings about the situation?
5. Did the nurse ask the patient’s opinion about possible interventions?
6. Did the nurse incorporate the patient’s health beliefs into the plan of care?

Rotate the roles and pick a new patient scenario two more times so each person in the group has the opportunity to role-play each role.

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