

Communication Skills

Effective symptom control is impossible without effective communication. Moreover, the success of many clinician–patient relationships depends on our ability to communicate effectively. Effective communication is about conveying information to others clearly and unambiguously. It is also about receiving the information that others are sending. In fact, communication is successful only when both the sender and the receiver understand the same information as a result of the communication (Figure 2.1).

Clinicians need good communication skills to diagnose and treat disease, to establish and maintain a therapeutic relationship, and to offer information and educate. Good communication ensures good working relationships, increases patient satisfaction, increases patient understanding of illness and management, and improves patient adherence to treatment. Good communication can also increase job satisfaction for staff and has similar effects on reducing stress. In a palliative care setting, important and potentially difficult discussions are frequently necessary with patients who have active, progressive, far-advanced disease (Figure 2.2) [1].

Requirements for Effective Communication

Effective communication requires that information is:

- clear,
- concise,
- correct,
- complete,

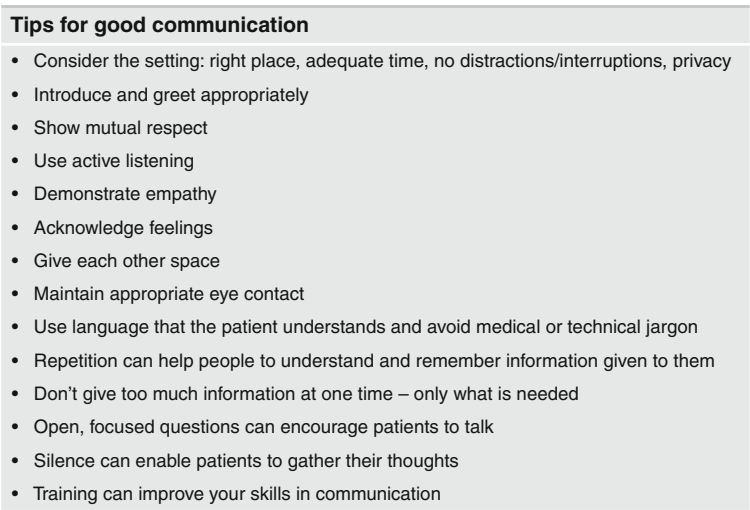


Figure 2.1 Tips for good communication

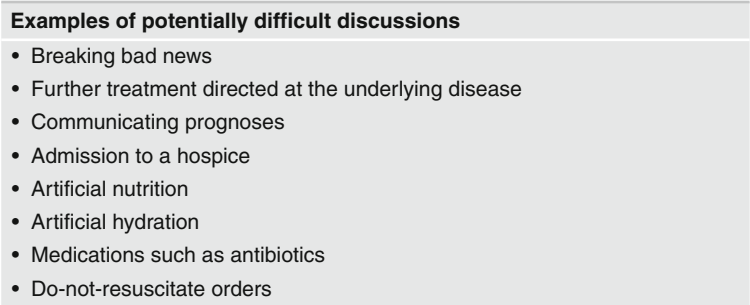


Figure 2.2 Examples of potentially difficult discussions. (Doyle and Woodruff [1])

- courteous, and
- constructive.

Both verbal and non-verbal communication should be congruent. It is sometimes quoted that words are only 7% of the total communication package, whereas tone carries 38% and body language 55% of the overall picture [2]. Congruence is when the words, tone of voice, and body language all convey the same message. Positive body language displays an

interest in what the person is saying. For inconsistent messages, or incongruent communications, body language and tonality are probably a more accurate indicator of emotions and meaning than the words themselves.

Throughout the process of communication it is essential to acknowledge that, as healthcare professionals, we have our own agendas, beliefs, and values that can affect the way in which we respond and act with others. Where possible it should be conveyed to the patient and family that they are important and that the aim is to help them. There are many ways to do this [3], and the process should be comfortable and natural. Key characteristics of the process include:

- warmth,
- genuineness,
- empathy,
- acceptance,
- respect,
- dignity,
- trust,
- caring, and
- beliefs and values.

In responding to patients, it is advisable to avoid the following:

- exclamations of surprise, intolerance, or disgust,
- expressions of over-concern,
- moralistic judgments, criticisms, or impatience,
- being defensive and getting caught up in arguments,
- making false promises, giving flattery or undue praise,
- personal references to your own difficulties,
- changing the subject or interrupting unnecessarily, and
- speaking too soon, too often, or for too long.

Verbal Communication

Verbal communication refers to the use of the spoken word to acknowledge, amplify, confirm, contrast, or contradict other verbal and non-verbal messages. Key components of verbal communication include sound, words, speaking, and language (Figure 2.3).

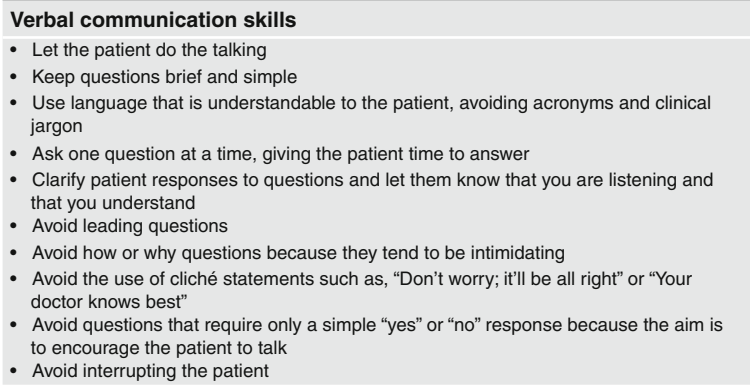


Figure 2.3 Verbal communication skills

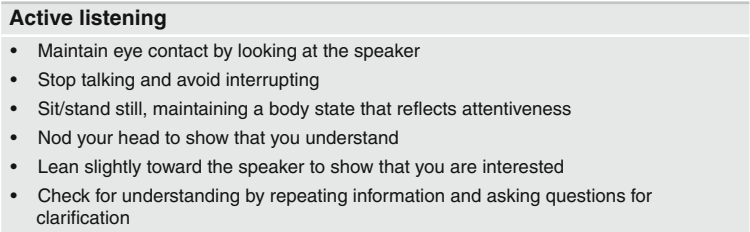


Figure 2.4 Active listening

Listening

One of the skills required for communication is to listen. Listening means not only hearing what is being said, but also attempting to understand what lies behind the spoken words. Effective listening therefore requires a continuous, determined effort to pay attention to the speaker (Figure 2.4).

Open Questions

Open questions can be answered in any manner and do not direct the respondent or require him or her to make choices from a specific range of answers. They are an essential way of finding out what the patient is experiencing and so help to tailor a support system for the patient. In contrast

to open questions, directive (restricts to a predetermined answer), closed (requires the patient to respond yes or no), leading (puts words into patient's mouth), or multiple (questions in quick succession without allowing response from patient) questions are less helpful. For example:

- “How are you feeling?” versus “I suppose you’re feeling tired after your treatment.”
- “Tell me about your relationship with your partner” versus “Do you have a good relationship with your partner?”
- “What concerns you most about your illness?” versus “Are you concerned that your illness is getting worse?”
- “What has been most difficult about this illness for you?” versus “You must be finding the illness difficult?”

Silence

Silence is a technique for facilitating dialogue between a patient and clinician. If the patient is speaking, do not talk over him or her. Waiting for the patient to stop speaking before replying is a simple, but often ignored, rule most likely to give patients the impression that they are not being listened to. Silences also have other meanings. Often a patient falls silent when he or she has feelings too intense to express in words. A silence, therefore, means that the patient is thinking or feeling something important, not that he or she has stopped thinking. If you need to break the silence, a helpful way to do so is to say: “What were you thinking about just then?” or “What is making you pause?” Silence also gives the clinician time to think and assimilate what has been said.

Non-verbal Communication

Non-verbal communication is the process of communicating through gesture, body language or posture, facial expression, and eye contact (Figure 2.5) [4]. Speech may also contain non-verbal elements including voice quality, emotion, and speaking style, as well as rhythm, intonation, and stress. Other techniques can involve:

- acknowledgment/facilitation,
- encouragement,
- picking up cues,

Using posture to communicate	
S	Sit square to the patient
O	Open to the patient
L	Lean in toward the patient
E	Eye contact with the patient
R	Relax

Figure 2.5 Using posture to communicate. (Data from Egan [4])

Reasons for poor communication	
Patients	Language barriers
	Fear of getting upset/emotional
	Tiredness/illness
	Feeling like a burden/taking up too much time
	Consider staff too busy or not interested
Staff	Language barriers
	Not knowing what to say
	Fear of dealing with strong emotions
	Not knowing enough

Figure 2.6 Reasons for poor communication

- reflection,
- clarification, and
- empathy.

Barriers to Effective Communication

Poor communication and information giving are some of the most common causes for complaints. This may be as a result of factors related to either the patient or the healthcare professional (Figure 2.6).

Recognizing the barriers is the first step to effective communication (Figure 2.7). Remember too that the interpersonal gap is the difference between the backgrounds, education, religious beliefs, and history of each party and how clearly each understands the other.

Effective communication, both verbally and non-verbally, is an essential element of any generalist or specialist clinician’s management strategy, “seek first to understand, then to be understood” [5]. Gain an understanding of the patients’ fears, expectations, hopes, and concerns,

Barriers to good communication

- Lack of time
- Lack of privacy
- Uncertainty
- Embarrassment
- Collusion
- Maintaining hope
- Anger
- Denial

Figure 2.7 Barriers to good communication

where they are ‘coming from.’ It is only through a common understanding of the problem that a common solution can be explored with both the patient and the family.

Further Reading

Rungapadiachy DM. Interpersonal communication and psychology for health care professionals: theory and practice. London: Butterworth Heinemann; 1999.

References

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4. Egan G. The skilled helper: a problem-management and opportunity-development approach to helping. 9th ed. Pacific Grove: Thomson Brooks/Cole; 2007.
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