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E.Yu. Vasilyeva

COMMUNICATION AND PATIENT EDUCATION

A MANUAL FOR MEDICAL STUDENTS

PSYCOLOGY AND PEDAGOGY COURSE

Arkhangelsk
2016

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The goals of this manual are to sensitize medical students to how communication and patient education are relevant to clinical practice and to help them acquire basic concepts and skills related to current doctor-patient relationships and health outcomes.

It contains basic information that can be used in training medical students, in supervised group work, presentations and discussions.

The first chapter combines essential basic knowledge about communication. The second chapter is devoted to describing Communication in health and social care. Chapter three describes the basis for Patient education.

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Федеральное государственное бюджетное
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«Северный государственный медицинский университет»
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Е.Ю. Васильева

ОБЩЕНИЕ И ОБУЧЕНИЕ ПАЦИЕНТОВ

Учебное пособие для студентов-медиков

Психология и педагогика

Архангельск
2016

УДК [159.954+37.015.3+61](075)
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Цель учебного пособия состоит в том, чтобы обратить внимание студентов-медиков на проблемы общения и обучения пациентов в реальной практике врача, а также помочь им освоить основные понятия и коммуникативные навыки, относящиеся к теме взаимодействия «врач-пациент».

Учебное пособие содержит материал, который может быть использован в процессе обучения студентов-медиков, в ходе групповой работы, презентациях и дискуссиях.

В первой главе представлена общая информация о процессе общения. Вторая глава посвящена описанию особенностей общения в лечебных учреждениях. В третьей главе представлены основы обучения пациентов.

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FOREWORD

Pedagogy takes place in the second semester of the first year studying in medical university. The course covers everything about communication and patient education through 4 lectures and 8 classes. One of the most easily anticipated questions asked by entering first year medical students is, “When will we get to see patients?” The answer is simple: sooner than you might think. Then, one more question, «Why do medical students study Pedagogy»? The answer is simple: good doctor is a good communicator. Are you good in communication? Do you want to be a good doctor?

This course is divided into two parts. The first 4 weeks of the course (one class a week) begins with an introduction to Communication and peculiarities of doctor-patient communication. In the second four weeks, you’ll gain an understanding of the patient education and teach back method in medical practice.

The goals of these lectures and classes are to sensitize you to how communication and patient education are relevant to clinical practice and to help you acquire basic concepts and skills related to current doctor-patient relationships and health outcomes.

According to students` opinion this course is sometimes entertaining, sometimes refreshing, and sometimes boring, sometimes frustrating. The class enhances a future physician’s understanding of doctor-patient relationships in medicine and the various patients you will be seeing someday (as family practitioners, of course).

This course offers one examination. There are 50 questions and some case-studies on exam. Even though this course serves as a nice “break” between the systems courses, do NOT underestimate the exam! Show up to class, appreciate the material and do your best to apply it.

This course moves quickly and integrates many different topics so it is important to keep up with the information. You will find this is a common theme for all of your medical school classes!

CONTENTS

Introduction

This manual aims to inform medical students about the communication skills for managing doctor- patient relationships and patient education.

It contains basic information that can be used in training medical students, in supervised group work, presentations and discussions.

The first chapter combines essential basic knowledge about communication.

The second chapter is devoted to describing Communication in health and social care.

Chapter three describes the basis for Patient education.

Many US medical resources and case studies are used in this manual for reading and discussions.

Chapter 1: COMMUNICATION: WHAT IS IT?

Health and social care professionals need good communication skills to develop positive relationships and share information with people using services. They also need to be able to communicate well with people's families and/or cares and their own colleagues and other professionals. It is important therefore, if you are considering a career in health and social care, to gain the knowledge, understanding and practical skills needed to develop effective interpersonal skills.

Learning outcomes

After completing this unit you should know: settings

1. What is communication?
2. Verbal communication
3. Listening skills
4. Clarification
5. What is empathy?
6. Non-verbal communication
7. Active listening
8. Communicating in difficult situations
9. Barriers to effective communication
10. Developing effective communication skills

1. What is communication?

http://www.skillsyouneed.co.uk/IPS/What_is_Communication.html

Communication is simply the act of transferring information from one place to another.

Although this is a simple definition, when we think about how we may communicate the subject becomes a lot more complex. There are various categories of communication and more than one may occur at any time.

The different categories of communication are:

Spoken or Verbal Communication: face-to-face, telephone, radio or television or other media. **Non-Verbal Communication**: body language, gestures, how we dress or act - even our scent. **Written Communication**: letters, e-mails, books, magazines, the Internet or via other media.

Visualizations: graphs, charts, maps, logos and other visualizations can communicate messages.

Communication theory states that communication involves a sender and a receiver (or receivers) conveying information through a communication channel.

The desired outcome or goal of any communication process is understanding.

The process of **interpersonal communication** cannot be regarded as a phenomena which simply 'happens', but should be seen as a process which involves participants negotiating their role in this process, whether consciously or unconsciously.

Senders and receivers are of course vital in communication. In face-to-face communication the roles of the sender and receiver are not distinct as both parties communicate with each other, even if in very subtle ways such as through eye-contact (or lack of) and general body language. There are many other subtle ways that we communicate (perhaps even unintentionally) with others, for example the tone of our voice can give clues to our mood or emotional state, whilst hand signals or gestures can add to a spoken message.

In written communication the sender and receiver are more distinct. Until recent times, relatively few writers and publishers were very powerful when it came to communicating the written word. Today we can all write and publish our ideas on the Internet, which has led to an explosion of information and communication possibilities.

The Communication Process

A message or communication is sent by the sender through a communication channel to a receiver, or to multiple receivers. The sender must encode the message (the information being conveyed) into a form that is appropriate to the communication channel, and the receiver(s) then decodes the message to understand its meaning and significance.

Misunderstanding can occur at any stage of the communication process. Effective communication involves minimising potential misunderstanding and overcoming any barriers to communication at each stage in the communication process.

An effective communicator understands their audience, chooses an appropriate communication channel, hones their message to this channel

and encodes the message to reduce misunderstanding by the receiver(s). They will also seek out feedback from the receiver(s) as to how the message is understood and attempt to correct any misunderstanding or confusion as soon as possible. Receivers can use Clarification and Reflection as effective ways to ensure that the message sent has been understood correctly.

Communication Channels

Communication Channels is the term given to the way in which we communicate. There are multiple communication channels available to us today, for example face-to-face conversations, telephone calls, text messages, email, the Internet (including social media such as Facebook and Twitter), radio and TV, written letters, brochures and reports to name just a few.

Choosing an appropriate communication channel is vital for effective communication as each communication channel has different strengths and weaknesses. For example, broadcasting news of an upcoming event via a written letter might convey the message clearly to one or two individuals but will not be a time or cost effective way to broadcast the message to a large number of people. On the other hand, conveying complex, technical information is better done via a printed document than via a spoken message since the receiver is able to assimilate the information at their own pace and revisit items that they do not fully understand. Written communication is also useful as a way of recording what has been said, for example taking minutes in a meeting. (More on Meetings).

Elements of Interpersonal Communication

Much research has been done to try to break down **interpersonal communication** into a number of elements in order that it can be more easily understood. Commonly these elements include:

The Communicators

For any communication to occur there must be at least two people involved. It is easy to think about communication involving a sender and a receiver of a message. However, the problem with this way of seeing a relationship is that it presents communication as a **one-way process** where one person sends the message and the other receives it.

In fact communications are almost always complex, **two-way processes**, with people sending and receiving messages to and from each other. In other words, communication is an interactive process.

The Message

Message not only means the speech used or information conveyed, but also the non-verbal messages exchanged such as **facial expressions**, **tone of voice**, **gestures** and **body language**. Non-verbal behaviour can convey additional information about the message spoken. In particular, it can reveal more about emotional attitudes which may underlie the content of speech.

Noise

Noise has a special meaning in communication theory. It refers to anything that distorts the message, so that what is received is different from what is intended by the speaker. Whilst physical 'noise' (for example, background sounds or a low-flying jet plane) can interfere with communication, other factors are considered to be 'noise'. The use of **complicated jargon**, **inappropriate body language**, **inattention**, **disinterest,** and **cultural differences** can be considered 'noise' in the context of interpersonal communication. In other words, any distortions or inconsistencies that occur during an attempt to communicate can be seen as noise.

Feedback

Feedback consists of messages the receiver returns, which allows the sender to know how accurately the message has been received, as well as the receiver's reaction. The receiver may also respond to the unintentional message as well as the intentional message. Types of feedback range from direct verbal statements, for example "Say that again, I don't understand", to subtle facial expressions or changes in posture that might indicate to the sender that the receiver feels uncomfortable with the message. Feedback allows the sender to regulate, adapt or repeat the message in order to improve communication.

Context

All communication is influenced by the context in which it takes place. However, apart from looking at the situational context of where the interaction takes place, for example in a room, office, or perhaps outdoors, the social context also needs to be considered, for example the

roles, responsibilities and relative status of the participants. The emotional climate and participants' expectations of the interaction will also affect the communication.

Channel

The channel refers to the physical means by which the message is transferred from one person to another. In face-to-face context the channels which are used are speech and vision, however during a telephone conversation the channel is limited to speech alone. (See Effective Speech)

Find more at:

http://www.skillsyouneed.co.uk/IPS/Interpersonal_Communication.html#ixzz2H1Xb2S7I

2. Verbal communication

Effective verbal or spoken communication is dependant on a number of factors and cannot be fully isolated from other important interpersonal skills such as non-verbal communication, listening skills and clarification.

Clarity of speech, remaining calm and focused, being polite and etiquette will all aid the process of verbal communication.

This article is designed to help us think about how we and others communicate verbally, the processes involved and the steps we can take to ensure that verbal or spoken messages are received as intended.

Opening Communication

In many encounters, the first few minutes are extremely important as first impressions have a significant impact on the success of further communication. Everyone has expectations and norms as to how initial meetings should proceed and people tend to behave according to these expectations. If interpersonal expectations are mismatched, communication will not be effective or run smoothly, and negotiation will be needed if relations are to continue.

At a first meeting, formalities and appropriate greetings are usually expected: such formalities could include a handshake, an introduction to yourself, eye contact and discussion around a neutral subject such as the weather or your journey may be useful. A friendly disposition and smiling face are much more likely to encourage communication than a blank face, inattention or disinterested reception.

Reinforcement

The use of encouraging words alongside non-verbal gestures such as head nods, a warm facial expression and maintaining eye contact, are more likely to reinforce openness in others. The use of encouragement and positive reinforcement can:

- Encourage others to participate in discussion (particularly in group work)
- Signify interest in what other people have to say
- Pave the way for development and/or maintenance of a relationship
- Allay fears and give reassurance
- Show warmth and openness.
- Reduce shyness or nervousness in ourselves and others.

3. Listening skills

Listening is the ability to accurately receive messages in the communication process. Listening is key to all effective communication, without the ability to listen effectively messages are easily misunderstood – communication breaks down and the sender of the message can easily become frustrated or irritated.

- Listening is so important that many top employers give regular listening skills training for their employees. This is not surprising when you consider that good listening skills can lead to: better customer satisfaction, greater productivity with fewer mistakes, increased sharing of information that in turn can lead to more creative and innovative work.
- Good listening skills also have benefits in our personal lives, including: a greater number of friends and social networks, improved self-esteem and confidence, higher grades in academic work and increased health and wellbeing. Studies have shown that, whereas speaking raises blood pressure, listening brings it down.

Listening is not the same as hearing. Hearing refers to the sounds that you hear, whereas listening requires more than that: it requires focus. Listening means paying attention not only to the story, but how it is told, the use of language and voice, and how the other person uses his or her body. In other words, it means being aware of both verbal and non-verbal messages. Your ability to listen effectively depends on the degree to which you perceive and understand these messages.

• *"The most basic and powerful way to connect to another person is to listen. Just listen. Perhaps the most important thing we ever give each other is our attention."* Rachel Naomi Remen

We spend a lot of our time listening

Adults spend an average of 70% of their time engaged in some sort of communication, of this an average of 45% is spent listening compared to 30% speaking, 16% reading and 9% writing. (Adler, R. et al. 2001).

4. Clarification

Clarification involves offering back to a speaker the essential meaning, as understood by the listener, of what they have just said, checking that the listener's understanding is correct and resolving any areas of confusion.

The purpose of clarification is to:

• Ensure that the listener's understanding of what the speaker has said is correct.

• Reassure the speaker that the listener is genuinely interested in them and is attempting to understand what they are saying.

As an extension of reflecting, clarifying reassures the speaker that the listener is attempting to understand the messages they are expressing. Clarifying can involve asking questions or occasionally summarising what the speaker has said.

A listener can ask for clarification when they cannot make sense of the speaker's responses. Often, the difficulties a speaker is explaining can be highly complex, involving many different people, issues, places and times. Clarifying helps you to sort these out and also to check the speaker's priorities. Through clarification it is possible for the speaker and the listener to make sense of these often confused and complex issues. Clarifying involves genuineness on the listener's part and it shows speakers that the listener is interested in them and in what they have to say.

Some examples of non-directive clarification-seeking questions are:

"I'm not quite sure I understand what you are saying."

"I don't feel clear about the main issue here."

"When you said.....what did you mean?"

"Could you repeat...?"

Clarifying involves:

• Non-judgmental questioning.

• Summarising and seeking feedback as to accuracy.

Questions

When you are the listener in a sensitive environment, the right sort of non-directive questioning can enable the speaker to describe their viewpoint more fully. Asking the right question at the right time can be crucial and comes with practice. The best questions are open-ended as they give the speaker choice in how to respond, whereas closed questions allow only very limited responses.

Open Questions

If your role is to assist a speaker to talk about an issue, often the most effective questioning starts with 'when', 'where', 'how' or 'why'. These questions encourage speakers to be open and expand on their thoughts. For example:

"When did you first start feeling like this?"

"Why do you feel this way?"

Closed Questions

Closed questions usually elicit a 'yes' or 'no' response and do not encourage speakers to be open and expand on their thoughts. Such questions often begin with 'did you?' or 'were you?' For example:

"Did you always feel like this?"

"Were you aware of feeling this way?"

Questions are generally used for clarifying and should not be asked just for the sake of questioning or to fill in pauses or periods of quietness.

Guidelines for Clarifying

- Admit if you are unsure about what the speaker means.
- Ask for repetition.
- State what the speaker has said as you understand it, and check whether this is what they really said.
- Ask for specific examples.
- Use open, non-directive questions - if appropriate.
- Ask if you have got it right and be prepared to be corrected.

Summarising

A summary involves reviewing what has taken place in the conversation. It is important to keep only to the essential components of the conversation, and it must be given from the speaker's frame of reference, not an interpretation from the listerner's viewpoint. The aim of a summary is to review understanding, not to give explanation, to judge, to interpret or provide solutions.

Summarising should be done at the end of a conversation, although sometimes it may be appropriate midway through as a way of drawing together different threads. At the start of a conversation, it is useful to summarise any previous discussions or meetings as it can help to provide focus. Whilst the summary is likely to be the longest time a listener will be speaking during a conversation, it is important to be as concise and straightforward as possible.

Summary of Clarification

In reflecting, clarifying and summarising, speakers must be allowed to disagree with, and correct, what the listener says. They should be encouraged to express themselves again, if necessary, giving the listener another chance at understanding, and to check understanding until agreement is reached.

Reflecting, clarifying and summarising are all tools used by active listeners to enable them to demonstrate understanding and encourage a speaker to talk openly. It is essential that the listener and speaker both have the same understanding of the discussion and the speaker must have the opportunity to correct the listener's understanding. These are the tools of any good relationship and are important interpersonal skills.

Find more at: http://www.skillsyouneed.co.uk/IPS/Reflecting_Clarification2.html#ixzz2H1Zvpvvk

5. What is empathy?

Empathy is the ability to see the world as another person, to share and understand another person's feelings, needs, concerns and/or emotional state.

Empathy is a selfless act, it enables us to learn more about people and relationships with people - it is a desirable skill beneficial to ourselves, others and society. Phrases such as 'being in your shoes' and 'soul mates' imply empathy - empathy has even been likened to a spiritual or religious state of connection with another person or group of people.

"*I call him religious who understands the suffering of others.*" - Mahatma Gandhi

Being empathetic requires two basic components - **effective communication** and **strong imagination**; shared experiences can also help you to empathise. Empathy is a skill that can be developed and,

as with most interpersonal skills, empathising (at some level) comes naturally to most people. You can probably think of examples when you have felt empathy for others or when others have been empathetic towards you. Imagine a colleague becomes stressed at work due to an unfortunate situation in their personal life; their productivity falls and deadlines are missed. If you were empathetic you might try to relieve work pressures and offer to help out where you could. You could try to imagine how it must feel to be that person and understand why their work commitments were not being met.

Effective Communication

Understanding is the desired outcome or goal in any communication process. Basic understanding is easily achieved but a deeper understanding is the result of effective communication. This involves overcoming the various barriers to communication, being able to express yourself effectively verbally and non-verbally, by active listening and clarification and other interpersonal skills.

Strong Imagination

In addition to effective communication good powers of imagination are required to empathise with others. Everybody sees the world differently, based on their experiences, their up-bringing, culture, religion, opinions and beliefs. In order to empathise with another person you need to see the world from their perspective and therefore need to use some imagination as to what their perspective is based on, how they see the world and why they see it differently from you. Many people find it easier to empathise with people who are closer to them and have more shared experiences and views.

We have all been exposed to news stories of drought and famine in Africa, we can feel sorry for those affected and may be able to help in some way. We hear stories of people walking across the desert to become refugees in a neighbouring country or region, see the pictures of flies buzzing around children with matchstick arms and swollen stomachs, can we emphasise? The information we are receiving via the media is limited and we don't have all the facts. If we have never lived in a desert and have had very few shared experiences with the people in question then our imaginations cannot accurately fill in the gaps of information and enable us to fully empathise. More likely we feel sympathetic or pity for the people concerned.

Empathy is not Sympathy

There is an important distinction between empathy and sympathy. We offer our sympathy when we imagine how a situation or event was difficult or traumatic to another person, we may use phases like, 'I am very sorry to hear that' or 'If there is anything I can do to help…', we feel pity or sorry for the other person. This is how many people would react to the famine example above, there is nothing wrong with sympathy, and it can help to offer closure. Perhaps by sending a donation to a charity to help with the famine we can think, 'I've done my bit' and forget about it. To empathise is to feel how others feel, to see the world as they do. Empathy with the people in the example above would require, for many of us living in the West, a leap of imagination.

Towards Empathy

It may not always be easy, or even possible, to empathise with others but through good communication skills and some imagination we can work towards more empathetic feelings. Research has suggested that individuals who can empathise enjoy better relationships with others and greater well-being through life.

Find more at:

http://www.skillsyouneed.co.uk/IPS/empathy.html#ixzz2H1XHTimS

6. Non-verbal communication

Interpersonal communication not only involves the explicit meaning of words, that is the information or message conveyed, but also refers to *implicit* messages, whether intentional or not, which may be expressed through non-verbal behaviours.

Non-verbal communications include facial expressions, the tone and pitch of the voice, gestures displayed through body language (kinesics) and the physical distance between communicators (proxemics). These non-verbal signals can give clues and additional information and meaning over and above spoken (verbal) communication.

Non-verbal messages allow individuals to:

• Reinforce or modify what is said in words. For example, people may nod their heads vigorously when saying "Yes" to emphasize that they agree with the other person, but a shrug of the shoulders and a sad expression when saying "I'm fine thanks," may imply that things are not really fine at all!

- Convey information about their emotional state.
- Define or reinforce the relationship between people.
- Provide feedback to the other person.
- Regulate the flow of communication, for example by signalling to others that they have finished speaking or wish to say something.

Many popular books on non-verbal communication present the topic as if it were a language that can be learned, the implication being that if the meaning of every nod, eye movement, and gesture were known, the real feelings and intentions of a person would be understood. Unfortunately interpreting non-verbal communication is not that simple. The way communication is influenced by the *context* in which it occurs. For example, a nod of the head between colleagues in a committee meeting may mean something very different to when the same action is used to acknowledge someone across a crowded room.

Interpersonal communication is further complicated in that it is usually not possible to interpret a gesture or expression accurately on its own. Non-verbal communication consists of a complete package of expressions, hand and eye movements, postures, and gestures which should be interpreted along with speech (verbal communication).

The types of interpersonal communication that are not expressed verbally are called non-verbal communications. These include:

- Body Movements (Kinesics)
- Posture
- Eye Contact
- Paralanguage
- Closeness or Personal Space (Proxemics)
- Facial Expressions
- Physiological Changes

Find more at: http://www.skillsyouneed.co.uk/IPS/NonVerbal_Communication.html#ixzz2H1YF928B

7. Active listening

Active listening is a skill that can be acquired and developed with practice. However, this skill can be difficult to master and will, therefore, take time and patience.

'Active listening' means, as its name suggests, actively listening, that is fully concentrating on what is being said rather than just 'hearing'

the message of the speaker. Active listening involves listening with all senses. As well as giving full attention to the speaker, it is important that the 'active listener' is also 'seen' to be listening to them otherwise the speaker may conclude that what they are talking about is uninteresting to the listener. Interest can be conveyed to the speaker by using both verbal and non-verbal messages such as maintaining eye contact, nodding your head and smiling, agreeing by saying 'Yes' or simply 'Mmm hmm' to encourage them to continue. By providing this 'feedback' the person speaking will usually feel more at ease and therefore communicate more easily, openly and honestly.

Listening is the most fundamental component of interpersonal communication skills**.** Listening is not something that just happens (that is hearing), listening is an active process in which a conscious decision is made to listen to and understand the messages of the speaker. Listeners should remain neutral and non-judgmental, this means trying not to take sides or form opinions, especially early in the conversation. Active listening is also about patience - pauses and short periods of silence should be accepted. Listeners should not be tempted to jump in with questions or comments every time there are a few seconds of silence. Active listening involves giving the other person time to explore their thoughts and feelings, they should, therefore, be given adequate time for that.

Active listening not only means focusing fully on the speaker but also actively showing verbal and non-verbal signs of listening. Generally speakers want listeners to demonstrate 'active listening' by responding appropriately to what they are saying. Appropriate responses to listening can be both verbal and non-verbal:

Find more at: http://www.skillsyouneed.co.uk/IPS/active_listening.html#ixzz2H1Z474pV

Effective Listening

Active listening is a very important listening skill and yet, as communicators, people tend to spend far more energy considering what they are going to say rather than listening to what the other person is trying to say. Although active listening is a skill in itself, covered in our articles on listening, it is also vital for verbal communication.

The following points are essential for effective and active listening:

- Arrange a comfortable environment conducive to the purpose of the communication, for example a warm and light room with minimal background noise.
- Be prepared to listen.
- Keep an open mind and concentrate on the main direction of the speaker's message.
- Avoid distractions if at all possible.
- Delay judgment until you have heard everything.
- Be objective.
- Do not be trying to think of your next question while the other person is giving information.
- Do not dwell on one or two points at the expense of others.
- The speaker should not be stereotyped. Try not to let prejudices associated with, for example, gender, ethnicity, social class, appearance or dress interfere with what is being said.

Find more at:
http://www.skillsyouneed.co.uk/IPS/Verbal_Communication.html#ixzz2H1XyZDbn

8. Communicating in difficult situations
http://www.skillsyouneed.co.uk/IPS/communication_difficult_situations.html

Most people want to avoid conflict and potentially stressful situations – this is human nature. People often find it easier to avoid communicating something that they think is going to be controversial or bad, putting off the communication and letting the situation fester. A manager may hold off telling an employee that their standard of work is unsatisfactory. A wife may put off explaining to her husband that she has scratched the car. A child may put off telling their parents that they are struggling with classes at school. Most people can think of times when they have put off having that 'difficult' conversation, most people will also recognise that putting off the difficult conversation alleviates short-term anxiety. However, constantly putting off difficult communication situations often leads to feelings of frustration, guilt, annoyance with oneself, anger, a reduction

in self-confidence and ultimately more stress and anxiety. By following some simple guidelines and using some well-tuned communication skills communicating in difficult situations becomes easier.

There are two distinct types of difficult conversation, planned and unplanned.

Planned conversations are when the subject has been given thought, they are planned as the time, place and other circumstances have been arranged or are chosen for a reason. Planned difficult conversations could include asking an employer for a pay-rise or perhaps telling your parents that you are leaving home to live somewhere else. Although these situations are, by their nature, difficult they are controlled and as long as time has been taken to prepare and think properly about how others may react they can often end up being easier than imagined.

Unplanned difficult conversations however take place on the spur of the moment; these are often fuelled by anger which can, in extreme cases, lead to aggression. Often, after an unplanned difficult conversation we feel a surge of emotion – regret or shame if things didn't go to well or potentially a boost to confidence if they did. After such encounters it is wise to reflect and learn from our experiences trying to find positives and ways of improving future unplanned interchanges.

Certain jobs and roles require difficult communication to be handled professionally, with empathy, tact, discretion and clarity. Some examples are:

Politians often have to communicate bad news, for example, failures in their departments, scandals, not meeting targets etc. As Politians are in the public eye they may be judged by how well they communicate bad news. They will worry about their electorate and the repercussions for their self-image, their political party and their country. It is not unusual for Politians to use 'spin doctors' and 'public relation gurus' who can advise, alleviate personal blame and find positives in potentially bad news.

Doctors and other Health Care Professionals may need to communicate bad or unexpected news to patients and relations of patients, for example, diagnosis and prognosis. Such professionals will have received training and will have worked in practise scenarios to help them to deliver such news effectively and sensitively.

Police and other Law Enforcement Officers may need to communicate

bad news to victims of crime or their family and friends. Such professionals will have received at least basic training in delivering bad news.

Managers in organisations may need to communicate difficult information on several levels, to staff who are underperforming or if redundancies are necessary. Managers may also need to report bad news upwards to directors or board members, perhaps profits are down or some arm of the organisation is failing.

Emotion and Change

There are two main factors that make communication seem difficult: emotion and change**.**

Emotion

People tend to look at emotions as being positive or negative. Happiness is positive and therefore sadness must be negative, calmness is positive whereas stress and anxiety are negative. Emotions are, however, a natural response to situations that we find ourselves in, and the only time that we need to be concerned is when we consistently feel emotions inappropriate to our current situation. Emotions are therefore not positive or negative but appropriate or inappropriate. When faced with unexpected news we may find ourselves becoming upset, frustrated, angry – or perhaps very happy and excited. It is helpful to recognise how we react to things emotionally and to think of different ways in which emotions can be controlled if necessary. Similarly, if we need to communicate information which may have an emotional effect on another person, it is helpful to anticipate what that effect might be and to tailor what we say or write accordingly.

Change

Often difficult conversations are about some sort of change, for example, changes in your job or ways of doing things, changes in finances or health, changes in a relationship. Change is inevitable. Different people handle change in different ways, some respond very positively to a change in circumstances whereas others may only be able to see problems and difficulty at first. If possible it is beneficial to think about the positive side of the change and the potential opportunities that it may bring. It is better for an individual's wellbeing if they are able to embrace change as positively as possible, thus helping to minimize stress and anxiety.

Skills You Need for Dealing with Difficult Conversations:

There has to be a balance between communicating something difficult and being as sensitive as possible to those concerned. The skill set required to do this may seem somewhat contradictory as you may need to be both firm and gentle in your approach. **Recommended skills include:**

Gather Information

Make sure you have your facts straight before you begin, know what you are going to say and why you are going to say it. Try to anticipate any questions or concerns others may have and think carefully about how you will answer questions.

Be Assertive

Once you are sure that something needs to be communicated then do so in an assertive way. We have several pages on assertiveness including, how to be more assertive and recognising why people are not assertive. Do not find yourself backing down or changing your mind mid conversation.

Be Empathic

Put yourself in the other person's shoes and think about how they will feel about what you are telling them; how would you feel if the roles were reversed? Give others time to ask questions and make comments.

Be Prepared to Negotiate

Often a difficult situation requires a certain amount of negotiation, be prepared for this. When negotiating, aim for a Win|Win outcome – that is, some way in which all parties can benefit.

Use Appropriate Verbal and Non-Verbal Language

Speak clearly avoiding any jargon that other parties may not understand, give eye contact and try to sit or stand in a relaxed way. Do not use confrontational language or body language. More on Verbal and Non-Verbal Communication

Listen

When we are stressed we listen less well, try to relax and listen carefully to the views, opinions and feelings of the other person/people. Use clarification and reflection techniques to offer feedback and demonstrate that you were listening.

Try to Stay Calm and Focused

Communication becomes easier when we are calm, take some deep breaths and try to maintain an air of calmness, others are more likely

to remain calm if you do. Keep focused on what you want to say, don't deviate or get distracted from the reason that you are communicating.

Find more at:

http://www.skillsyouneed.co.uk/IPS/communication_difficult_situations.html#ixzz2H1VgWN4l

9. Barriers to effective communication

http://www.skillsyouneed.co.uk/IPS/Barriers_Communication.html

There are many reasons why interpersonal communications may fail. In many communications, the message may not be received exactly the way the sender intended and hence it is important that the communicator seeks feedback to check that their message is clearly understood.

There exist many barriers to communication and these may occur at any stage in the communication process. Barriers may lead to your message becoming distorted and you therefore risk wasting both time and money by causing confusion and misunderstanding. Effective communication involves overcoming these barriers and conveying a clear and concise message. Some common **barriers to effective communication** include:

- The use of jargon, over-complicated or unfamiliar terms.
- Emotional barriers and taboos.
- Lack of attention, interest, distractions, or irrelevance to the receiver.
- Differences in perception and viewpoint.
- Physical disabilities such as hearing problems or speech difficulties.
- Physical barriers to non-verbal communication.
- Language differences and the difficulty in understanding unfamiliar accents.
- Expectations and prejudices which may lead to false assumptions or stereotyping. People often hear what they expect to hear rather than what is actually said and jump to incorrect conclusions.
- Cultural differences. The norms of social interaction vary greatly in different cultures, as do the way in which emotions are expressed. For example, the concept of personal space varies between cultures and between different social settings.

A skilled communicator must be aware of these barriers and try to reduce their impact by continually checking understanding and by offering appropriate feedback.

Find more at:
http://www.skillsyouneed.co.uk/IPS/Barriers_Communication.html#ixzz2H1UECGsO

A Categorisation of Barriers to Communication

Language Barriers

Clearly, language and linguistic ability may act as a barrier to communication. However, even when communicating in the same language, the terminology used in a message may act as a barrier if it is not fully understood by the receiver(s). For example, a message that includes a lot of specialist jargon and abbreviations will not be understood by a receiver who is not familiar with the terminology used. Regional colloquialisms and expressions may be misinterpreted or even considered offensive. (See our page on effective speaking to help you get your message across).

Psychological Barriers

The psychological state of the receiver will influence how the message is received. For example, if someone has personal worries and is stressed, they may be preoccupied by personal concerns and not as receptive to the message as if they were not stressed. Stress is an important factor in Interpersonal relationships - see What is Stress? and Avoiding Stress for more information. Anger is another example of a psychological barrier to communication.

Physiological Barriers

Physiological barriers may result from the receiver's physical state: for example, a receiver with reduced hearing may not grasp to entirety of a spoken conversation especially if there is significant background noise.

Physical Barriers

An example of a physical barrier to communication is geographic distance between the sender and receiver(s). Communication is generally easier over shorter distances as more communication channels are available and less technology is required. Although modern technology often serves to reduce the impact of physical barriers, the advantages and disadvantages of each communication channel should be understood so that an appropriate channel can be used to overcome the physical barriers.

Systematic Barriers

Systematic barriers to communication may exist in structures and organisations where there are inefficient or inappropriate information systems and communication channels, or where there is a lack of understanding of the roles and responsibilities for communication. In such organizations, individuals may be unclear of their role in the communication process and therefore not know what is expected of them.

Attitudinal Barriers

Attitudinal barriers are behaviours or perceptions that prevent people from communicating effectively. Attitudinal barriers to communication may result from personality conflicts, poor management, resistance to change or a lack of motivation. Effective receivers of messages should attempt to overcome their own attitudinal barriers to facilitate effective communication..

Find more at:

http://www.skillsyouneed.co.uk/IPS/Barriers_Communication.html#ixzz2H1VA1zZH

10. Developing effective communication skills

Effective communication skills are fundamental to success in many aspects of life. Lots of jobs require strong communication skills and socially people with improved communication skills usually have better interpersonal relationships. Effective communication is a key interpersonal skill and by learning how we can improve our communication has many benefits.

Communication is a two way process so improving communication involves both how we send and receive messages.

The list below includes links to other articles at Skills You Need that can help you further improve your communication skills.

Empathise

Empathy is trying to see things from the point-of-view of others. When communicating with others, try not to be judgemental or biased by preconceived ideas or beliefs - instead view situations and responses from the other person's perspective. Stay in tune with your own emotions to help enable you to understand the emotions of others. If appropriate, offer your personal viewpoint clearly and honestly to avoid confusion. Bear in mind that some subjects might be taboo or too emotionally stressful for others to discuss.

Encourage

Offer words and actions of encouragement, as well as praise, to others. Make other people feel welcome, wanted, valued and appreciated in your communications. If you let others know that they are valued, they are much more likely to give you their best. Try to ensure that everyone involved in an interaction or communication is included through effective body language and the use of open questions. (More on body language and non-verbal communication and questioning)

Learn to Listen

Listening is not the same as hearing; learn to listen not only to the words being spoken but how they are being spoken and the non-verbal messages sent with them. Use the techniques of clarification and reflection to confirm what the other person has said and avoid any confusion. Try not to think about what to say next whist listening; instead clear your mind and focus on the message being received. Your friends, colleagues and other acquaintances will appreciate good listening skills.

Be Aware of Others' Emotions

Be sympathetic to other people's misfortunes and congratulate their positive landmarks. To do this you need to be aware of what is going on in other people's lives. Make and maintain eye contact and use first names where appropriate. Do not be afraid to ask others for their opinions as this will help to make them feel valued. Consider the emotional effect of what you are saying and communicate within the norms of behaviour acceptable to the other person. Take steps to become more charismatic.

Treat People Equally

Always aim to communicate on an equal basis and avoid patronising people. Do not talk about others behind their backs and try not to develop favourites: by treating people as your equal and also equal to each other you will build trust and respect. Check that people understand what you have said to avoid confusion and negative feelings. Encourage open and honest feedback from the receiver to ensure your message is understood and to avoid the receiver instead feeding back what they think you want to hear. If confidentiality is an issue, make sure its boundaries are known and ensure its maintenance.

Attempt to Resolve Conflict

Learn to troubleshoot and resolve problems and conflicts as they arise. Learn how to be an effective mediator and negotiator. Use your listening

skills to hear and understand both sides of any argument - encourage and facilitate people to talk to each other. Try not to be biased or judgemental but instead ease the way for conflict resolution.

Find more at: http://www.skillsyouneed.co.uk/IPS/Improving_Communication.html#ixzz2H1ZOPFHt

Just checking

1. What is Communication?
2. What is Spoken or Verbal Communication?
3. What is Non-Verbal Communication?
4. What is Written Communication?
5. What is the desired outcome or goal of any communication process?
6. What are the Elements of Interpersonal Communication?
7. What is listening?
8. What is hearing?
9. What is the purpose of clarification?
10. What is the aim of summary?
11. What are the tools used by active listeners to enable them to demonstrate understanding and encourage a speaker to talk openly?
12. What is Empathy?
13. What does 'Active listening' mean?
14. What are two main factors that make communication seem difficult?
15. Skills you need for dealing with difficult conversations.
16. List some common barriers to effective communication.

Chapter 2: COMMUNICATION IN HEALTH AND SOCIAL CARE

There are several different forms of communication used in a health and social care environment. This unit looks at verbal and non-verbal communication methods. You will gain an understanding of the communication cycle, looking at how to make sure that communication is effective and messages understood at each stage. You will also learn to recognize a range of factors which may create barriers to communication. You will then consider ways in which these barriers may be overcome, including the use of alternative forms of communication.

You will be given the opportunity to observe and discuss communication methods used by professionals – skills which you will practice and refine. You will then demonstrate your communication skills in both one-to-one and group situations.

Learning outcomes

After completing this unit you should:

1. Know different forms of communication
2. Understand barriers to effective communication
3. Be able to communicate effectively

1. Know different forms of communication

Key terms:

Communication – the exchange of information between people

Context – the circumstances in which an event occurs; a setting

Formal – the use of conventional language

Informal – the use of more casual language

In this topic you will learn about why we communicate, why good communication skills are so important within a health and social care environment and the different contexts for communication. We communicate with others all the time, wherever we may be, often without even realizing it and sometimes without intending to. This topic and the following topic will help you explore different forms of communication.

Interpersonal skills are those skills that enable us to interact with another person, allowing us to communicate successfully with them.

Good communication skills are vital for those working in health and social care as they help them to:

- develop positive relationships with people using services and their families and friends, so they can understand and meet their needs
- develop positive relationships with work colleagues and other professionals
- share information with people using the services, by providing and receiving information
- report on the work they do with people.

Contexts

One-to-one communication

One-to-one means one person communicating with another person with no other people joining in. If you walk into a one-to-one job interview, the interviewer may say something like, 'Good morning, my name is … Please take a seat. Did you find us all right?' This is to make you feel relaxed and less nervous so you feel more confident and do your best. If you walked in and they immediately said, 'Sit down. Tell me why you want this job', you would be sitting down and starting to answer questions instantly so would be very on edge. It is the same in any conversation; it is important to create the right feeling by being friendly and showing interest in and respect for the other person. The conversation needs a start, e.g. 'Hi', a middle, when you both discuss what you need to talk about, and an ending, e.g. 'See you later.'

Table 2.1.: **The communication skills needed by people working in health and social care environments**

Using skills for keeping a conversation going	Using listening skills to check understanding	Being able to organize a conversation
Knowing how to ask questions effectively	**Communication skills**	Understanding the communication cycle
Understanding cultural differences	Using non-verbal messages to communicate	Understanding non- verbal messages

Group communication

Group communication is harder because it only works properly if everyone is able to be involved. In most groups there are people who speak

a lot and others who speak rarely, if at all, because they feel uncomfortable speaking in front of a group of people or they are just not interested. Groups work best if there is a team leader who encourages everyone to have a say in turn, rather than everyone trying to speak at once.

Formal and informal communication

Formal communication tends to start with a greeting such as 'Good afternoon. How are you feeling today?' It can be used to show respect for others. Formal conversation is often used when a professional person, such as a health or social care worker, speaks to someone using a service. It is clear, correct and avoids misunderstanding. Communication with a manager is usually formal. A manager is usually more distant from those they manage so that if they need to, for example, issue a formal warning to someone, it is less awkward for both parties than if they are friends.

Informal communication (often used between people who know each other well, like friends and family) is more likely to start with 'Hi, how are you?' and allows for more variety according to the area someone lives in. For example, in some places it is common for people to call other people 'Love' even if they have only just met them. People usually communicate more informally with friends, including those they work closely with on a day-to-day basis.

Just checking

1. What are three features of one-to-one communication?
2. What are three things that help group communication?
3. What is the difference between informal and formal communication? Which would you use with (i) a friend (ii) someone you have not met before but are trying to help in your job as a doctor's receptionist (iii) your manager (iv) a service user?

Forms of communication

This topic looks at different forms of communication. There are three main forms of communication, verbal, non-verbal and the written word. We can also use technology to communicate.

Verbal communication

Verbal communication uses words to present ideas, thoughts and feelings. Good verbal communication is the ability to both explain and

present your ideas clearly through the spoken word, and to listen carefully to other people. This will involve using a variety of approaches and styles appropriate to the audience you are addressing.

Non-verbal communication

This refers to the messages we send out to express ideas and opinions without talking. This might be through the use of body language, facial expressions, gestures, tone of voice, touch or contact, signs, symbols, pictures, objects and other visual aids. It is very important to be able to recognise what a person's body language is saying, especially when as a health or social care worker you are dealing with someone who is in pain, worried or upset. You must also be able to understand the messages you send with your own body when working with other people.

The main elements involved in non-verbal communication.

1. Eye contact
2. Proximity
3. Touch
4. Facial expression
5. Signs, symbols pictures
6. Posture
7. Hand movement
8. Head movement
9. Appearance

Body language – The way we sit or stand, which is called posture, can send messages. Slouching on a chair can show a lack of interest in what is going on and folded arms can suggest that you are feeling negative or defensive about a person or situation. Even the way we move can give out messages, e.g. shaking your head while someone else is talking might indicate that you disagree with them or waving your arms around can indicate you are excited.

Facial expression – We can often tell what someone is feeling by their eyes. Our eyes become wider when we are excited or happy, attracted to, or interested in someone. A smile shows we are happy and a frown shows we are annoyed.

Touch or contact – Touching another person can send messages of care, affection, power or sexual interest. It is important to think about the setting you are in and what you are trying to convey before touching

a person in a health and social care environment. An arm around a child who is upset about something in hospital or a nursery can go a long way to making them feel better but a teenager might feel intimidated by such contact from an older person.

Signs, symbols and pictures – There are certain common signs or gestures that most people automatically recognise. For example, a wave of the hand can mean hello or goodbye and a thumbs up can mean that all is well. Pictures of all forms and objects also communicate messages; an X-ray and a model of a knee joint can more easily communicate to someone needing a knee replacement exactly what is involved.

Written communication

This is central to the work of any person providing a service in a health and social care environment when keeping records and in writing reports. Different types of communication need different styles of writing but all require **literacy skills***. A more formal style of writing is needed when recording information about a patient. It would be unacceptable to use text message abbreviations, such as 'l8er'.

Literacy skills – the ability to be able to present the written word clearly and correctly and to be able to read the written word accurately

Technological aids

Technology is moving so quickly now that we have many electronic aids to help us communicate. For example, mobile phones can be used to make calls but we can also use them to send text messages and emails; and we have computers on which we can record, store and communicate information very quickly and efficiently over long distances. Some aids can turn small movements into written word and then into speech, such as the voice box most famously used by the scientist, Professor Stephen Hawking.

Activity

Imagine you are working in a health centre on a work placement and you have been asked to produce some clear and easily understood information on a poster to help people who need technological aids understand how they work and how they can help them. Research a range of technological aids to communication and produce a poster showing how your favorite works. Include a diagram.

Just checking

1. Explain what is meant by verbal communication.
2. Give three examples of types of non-verbal communication.
3. Describe three examples when signs, symbols and pictures are useful forms of communication.

2. Understand barriers to communication

In this topic you will start to learn about barriers to effective communication, but in order to understand these you first need to understand the different elements that make up communication. This is called the communication cycle and is fundamental to our everyday lives.

This topic and the following ones will help you to understand barriers to effective communication.

The communication cycle

In order to communicate you have to go through a process with another person. This process is called the communication cycle because the process goes round in a circle, as shown in figure.

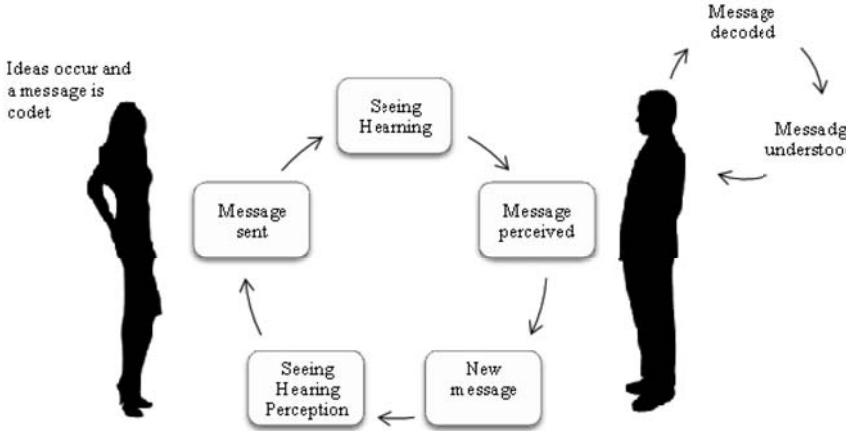

Figure: The communication cycle

• Ideas occur – you think of something you want to communicate. Communication always has a purpose. It might be to pass on information or an idea, or to persuade someone to do something, or to entertain or inspire.

• Message coded – you think about how you are going to say what you are thinking and decide in what form the communication will be, for example, spoken word or sign language. You put it into this form in your head.

• Message sent – you send the message, for example speak or sign what you want to communicate.

• Message received – the other person senses that you have sent a message by, for example, hearing your words or seeing your signs.

• Message decoded – the other person has to interpret what you have communicated; this is known as decoding.

• Message understood – if you have communicated clearly and the other person has concentrated, and there are no barriers to communication, the other person understands your ideas. They show this by giving you feedback, i.e. by sending you a message back.

The communication cycle happens very quickly and subconsciously. We think three times faster than we speak.

These stages of the communication cycle are shown as a list of bullet points rather than numbered because this process is repeated backwards and forwards as long as the conversation goes on. The sender of the message becomes the receiver of a message sent back, the receiver becomes the sender and so on. Each person continues the conversation because they have to check that they have understood what the other person meant. They do this by listening to what the person says and asking questions about it or putting it in their own words and repeating them back, so reflecting what has been said. A conversation can also be called an **interaction***.

**Interaction – when someone or something has an effect on another.*

Things that can go wrong

The person who has the first idea may not make the meaning clear and might assume that the other person is ready and willing to listen to them when they are not. They might also assume that the other person has heard what they said properly and has not been distracted by something else they are interested in. They might have used terms and language that the other person is unfamiliar with or might have started half way through a story assuming that they already knew the beginning. This can lead to

the other person making assumptions as to what they meant, jumping to conclusions and so leading them to talk at cross purposes.

Just checking

1. What are the six stages of the communication cycle?
2. How can someone check that they have understood something that has been said to them?
3. Describe three ways in which things can go wrong in the communication cycle.

Assessment activity

Imagine that you are working for a telephone helpline in the area of health and social care. Examples of these are NHS Direct or Childline. You are going to plan and carry out a one-to-one conversation on an issue of your choosing, and identify the communication skills you have used. It might be that a member of the public is ringing up to ask for advice during a flu epidemic. You can carry out your plan with a partner by giving them a script you have written and telling them which part they are reading. You will record the conversation and you will be assessed on the recording made and your written script.

You need to think about your tone of voice and using the communication cycle properly. Remember, this conversation is taking place on a phone so you cannot see each other.

3. Factors that affect communication

Key terms:

Deprivation – a lack of something

Impairment – a disability

Jargon – technical words used by a professional person as a short way of saying things that are hard for others to understand

Slang – the use of informal words and expressions that are not considered standard in the speaker's dialect or language

Some things stop communication being as effective as it could be. People who work in a health or social care environment need to understand the barriers so they can overcome them. In this topic you will learn about some of these barriers.

It is very important to be able to communicate effectively in a health or social care setting. A service user will not be able to take part in a discussion about their care or planning their future if they do not understand what is being said. Equally, the person providing the service cannot help if they cannot find a way to understand what the service user is trying to ask for.

There are many factors that affect communication. They are:

Sensory deprivation – when someone cannot receive or pass on information because they have an **impairment** to one or more of their senses, most commonly a visual or a hearing disability.

Foreign language – when someone speaks a different language or uses sign language, they may not be able to make any sense of information they are being given by someone trying to help them if that person does not speak their language.

Jargon – when a service provider uses technical language the service user may not understand. For example, the doctor may say that a patient needs bloods and an MRI scan. That can sound very frightening to someone who has been rushed into hospital. It is better if the doctor explains that they need to take some blood to do some simple tests and then explains what a MRI scan is. Understanding the facts can make something seem less scary. Or someone might say "you need to go to the CAB" (which means Citizen's Advice Bureau). This also relates to jargon.

Slang – when a service user uses language that not everyone uses, such as saying they have a problem with their waterworks. This can mean their plumbing system but also means a problem going to the toilet. Sometimes it may be appropriate to use slang with your peers but in normal working with colleagues or service users you should avoid using any language that can be misunderstood or misinterpreted or that might cause offence.

Dialect – when people use different words for everyday objects or feelings depending on the area of a country they come from. In some areas of England people say 'innit' instead of 'isn't it' or 'summat' instead of 'something.' It may cause confusion if someone says, 'A've got a pain in me heed' instead of, 'I've got a headache'.

Acronyms – when words are shortened to initials. There are lots of acronyms in health and social care and they can be very confusing. Sometimes people don't realise that not everyone knows what they mean

and mistakes can be made or people can just feel left out if these terms are not familiar to them. A health care professional might say, "he has those tablets TDS" (which means three times a day).

Cultural differences – when the same thing means different things in two cultures, communication can be difficult. For example, it is seen as polite and respectful to make eye contact when speaking to someone in Western culture but in other cultures, for example in East Asia, it can be seen as rude and defiant. You will learn more about this in Unit 6 Cultural diversity in health and social care.

Distress – when someone is distressed, they might find it hard to communicate. They may not listen properly and so misinterpret or not understand what is being said. They might also be tearful or have difficulty speaking. See also emotional difficulties.

Emotional difficulties – we all have emotional difficulties at times and become upset. You might have split up with your boyfriend or girlfriend or had an argument with someone or you may have had some bad news. The effect can be to not hear or understand what people are saying to you. This can lead to misunderstandings.

Health issues – when you are feeling ill, you may not be able to communicate as effectively as when you are feeling well. This can affect your colleagues and service users. Similarly, people who are being cared for in hospital because of an illness may not be able to communicate in their normal way. Some long-term (chronic) illnesses such as Parkinson's disease or Multiple Sclerosis also affect an individual's ability to communicate and you need to be aware of this if you are working with these people. See also distress and disability.

Environmental problems – when communication is affected by the environment that people find themselves in. For example, someone who does not see very well will struggle to read written information in a dimly lit room. A person who is in a wheelchair may find it impossible to communicate with the receptionist at the dentist's if the desk is too high and above the wheelchair user's head.

Misinterpretation of message – when someone reads a person's body language wrongly. For example, someone with their arms folded and tapping their feet might be impatiently waiting for someone else who is late but you might look at them and assume they are cross with you. This can put you off asking for help.

Just checking

1. Why is it important for people who work in health and social care to understand barriers to communication?
2. Explain how cultural differences can affect communication.
3. How might emotional issues affect communication between a service user and a service provider?

Assessment activity

1. In pairs, choose two of the factors opposite and discuss the ways these could cause problems in a health and social care setting.
2. Four other factors that affect communication are differing humour, sarcasm, inappropriate behaviour and aggression. Think of an example where each of these could lead to a breakdown in communication at the reception desk of an optician.

4. More barriers to communication and ways to overcome them

Key terms:

Aggression – behaviour that is unpleasant, frightening or intimidating
Assertion – behaviour that helps you communicate clearly and firmly

One of the barriers to communication is aggression. In this topic you will learn the difference between being aggressive and being assertive, and how to be assertive. You will also learn some verbal skills to use to check the understanding part of the communication cycle.

Aggression is behaviour that is unpleasant, frightening or intimidating. It takes a variety of forms and can be physical, mental or verbal. It can cause physical pain or emotional harm to those it is directed at. It is caused by a range of factors, such as substance misuse, mental health, a personality problem, fear or an attempt to dominate someone else. People who are aggressive towards other people are often bullies.

Aggression is a form of communication in that it communicates a person's state of mind, such as annoyance. It is also a barrier to communication. Aggression is often emotion that is out of control and it can be destructive. When someone shouts at someone else, the other person can be afraid and will either shout back or shut the aggressive person out. If someone working in a health or social care environment is

annoyed, frustrated or irritated (breathes quickly, shouts, has a clenched jaw and/or rigid body language) the person they are providing a service for may feel dominated, threatened and unable to respond. This will lead to a poorer service being offered due to the breakdown in effective communication.

Assertion is the skill of being calm and firm but not aggressive in the way you communicate with others. It helps you to communicate your needs, feelings and thoughts in a clear confident way while taking into account the feelings of others and respecting their right to an opinion as well.

How to be assertive

You need to plan what you are going to say. Be polite, state the nature of the problem, how it affects you, how you feel about it and what you want to happen. Make it clear that you see the other person's point of view and be prepared to compromise if it leads to what you want. Control your emotions, such as anger or tearfulness and be calm and authoritative in your interactions with others. You need to be clear and prepared to defend your position and be able to say no. This won't cause offence if it is said firmly and calmly. Use questions such as, 'How can we solve this problem?' Use the 'broken record' technique where you just keep repeating your statement softly, calmly and persistently. At the same time, use body language that shows you are relaxed, e.g. make firm, direct eye contact with relaxed facial features and use open hand gestures.

Verbal skills to overcome barriers

When you use your verbal skills effectively, you can help overcome barriers that might be preventing effective communication. Some of the skills you need when communicating verbally, and assertively when need be, with service users:

1. Listening
2. Open questions
3. Summarizing
4. Paraphrasing
5. Closed questions
6. Clarifying

They are useful tools in the checking understanding (message understood) part of the communication cycle.

• Paraphrasing means repeating back something a person has just said in a different way to make sure you have understood the message. For example, someone says, 'I have been sick since Sunday' and you respond by saying, 'You have been unwell for 4 days now then.'

• Closed questions are questions that can be answered with either a single word or short phrase, for example, 'Do you like sprouts?' could be answered, 'No' or, 'No, I can't stand them.' Closed questions give facts, are easy and quick to answer and keep control of the conversation. They are useful as an opening question, such as 'Are you feeling better?' for testing understanding, such as, 'So you want to go on the pill?' and for bringing a conversation to an end, such as, 'So that's your final decision?'

• Open questions are questions that give a longer answer, for example, 'Why don't you like sprouts?' might be answered by, 'I haven't liked the taste or smell of them since I was made to eat them all the time when I was a child…'. Open questions hand control of the conversation to the person you are speaking to. They ask the person to think and reflect, give opinions and feelings. They are useful as a follow-up to a closed question, to find out more, to help someone realise or face their problems and to show concern about them.

• Clarification means to make something clear and understandable. Summarising means to sum up what has been said in a short, clear way.

Just checking

1. Why is aggression a barrier to communication?
2. What is the difference between aggression and assertiveness?
3. Describe three techniques that are useful when checking understanding of something that has been said to you.

5. Overcoming communication barriers

You previously learned about many different barriers to communication and looked at some verbal skills. It is vital to be able to overcome these barriers if people are to receive the care they need. This topic is about how these barriers can be minimised or overcome.

Communication difficulties can isolate a person, making them feel cut off, so it is particularly important in a health or social care environment to overcome these difficulties. Barriers to communication can be minimised in the ways discussed below.

Adapting the environment

This can be done in a number of ways, such as improving lighting for those with sight impairments and reducing background noise for those with hearing impairments. Lifts can be installed with a voice giving information such as when the doors are opening and closing and which floor the lift is on for those who can't see. Ramps can be added, reception desks lowered and signs put lower down on walls, so that people with physical disabilities can access the people and information they need.

Understanding language needs and preferences

Service providers need to understand language needs and preferences of the people they are supporting. They may have to re-word messages so that they are in short, clear sentences, and avoid slang, jargon and dialect as much as possible. They explain details to people who cannot see and encourage them to touch things such as their face. They don't shout at those who cannot hear very well, but use normal, clear speech and make sure their face is visible. They employ a communicator or interpreter for spoken or signed language and show pictures or write messages, depending on what is best for the service user.

Case study

Malik has not been in the UK long. He gets a job as a porter in a hospital but because his English is not very good he does not always understand what the other staff or patients have asked him to do. This has caused one or two arguments and he has come close to being sacked.

1. Suggest what Malik's employer can do to resolve this so that Malik can remain a porter.
2. What can Malik do to help himself?
3. How do you think (i) the patients (ii) staff (iii) Malik feels when communication fails like this?

Using individual preferred language

Most leaflets produced by public bodies such as the health service are now written in a variety of languages so that people who do not speak English can still access the information. If there is a member of staff who speaks the preferred language of a service user they will help translate. However, it is always important to ask a service user what their preferred language is for written and verbal communication.

Timing

It is important to pick the right time to communicate important information to a service user. If, for example, a doctor has just told a patient that they have a life threatening illness the patient needs time to take the information in. If the doctor tells them all about the treatment straight away the chances are that the patient will not really hear much of what is said because they are in shock. It may be better to make another appointment for when the patient has processed the information and is receptive to hearing additional information.

Electronic devices

There are many electronic devices that help overcome barriers to communication. These include:

- **mobile phones** – these are generally affordable and available to the population at large, making them more accessible than computers and far more cost-effective.They have many uses in health and social care. For example, they enable emergency response teams to co-ordinate their efforts, allow a surgical team to contact someone awaiting an organ transplant, gather and send information etc. They are especially important in health and social care in developing countries, where people may live several days' walk from the nearest doctor.
- **telephone amplifiers** – these are devices that amplify, or make louder, the ring tone of a phone so that people who are hard of hearing and maybe use a hearing aid can hear the phone more clearly. They also amplify the volume of the person speaking on the other end by up to 100%. Other devices on telephones include flashing lights so someone who is hard of hearing can see that the phone is ringing.
- **hearing loops** – a hearing loop system helps deaf people who use a hearing aid or loop listener hear sounds more clearly because it reduces or cuts out background noise. At home, for example, you could use a loop to hear sound from your television. You can also set up a loop with a microphone to help you hear conversations in noisy places. In the theatre, a loop can help you hear the show more clearly. A hearing impaired student can wear a loop and the teacher a microphone to help the student hear what the teacher says.

Just checking

1. List three different ways of adapting the environment to help overcome barriers to communication.

2. Why is timing important when giving someone information?

3. Describe how an electronic device such as a mobile phone can help overcome barriers to communication.

4. What ways can the environment be adapted to help people in a wheelchair?

6. Alternative forms of communication

Key terms:

Sign – a posted up notice giving a direction or command

Symbol – something such as an object, picture, written word, sound, or particular mark that represents something else

Sometimes it is not possible to overcome a barrier to communication so an alternative form of communication must be found. In this topic you will learn about alternatives such as sign language, lip reading and Makaton.

Sign language is a language which instead of using sounds uses visual signs. These are made up of the shapes, positions and movement of the hands, arms or body and facial expressions to express a speaker's thoughts. Sign language is commonly used in communities which include the friends and families of deaf people as well as people who are deaf or hard of hearing themselves.

Lip reading

People with normal hearing subconsciously use information from the lips and face to help understand what is being said. Many people misunderstand deafness, thinking that if someone can't hear very well they are being rude or stupid, and this can leave a deaf person feeling very isolated, excluded from everyday activities and conversations, frustrated and lacking in confidence. Lip reading is a technique of interpreting the movements of a person's lips, face and tongue, along with information provided by any remaining hearing. It is used by someone who is deaf or hard of hearing. It is therefore important that you look directly at someone who is lip reading and stand in a well lit area, when speaking.

Makaton is a method of communication using **signs** and **symbols** and is often used as a communication process for those with learning difficulties. It was first developed in the UK in the 1970s and is now used

in over 40 countries around the world. Unlike BSL, Makaton uses speech as well as actions and symbols. It uses picture cards and ties in facial expressions with the word to make the word more easily recognised by those with learning difficulties.

Braille

The Braille system is a method that is widely used by blind people to read and write. Braille was devised in 1821 by Louis Braille, a Frenchman. Each Braille character is made up of six dot positions, arranged in a rectangle. A dot may be raised at any of the six positions to form sixty-four possible combinations and these raised dots are read by touch.

Technological aids

These have already been mentioned in an earlier topic as a way of overcoming barriers to communication. They are also alternative forms of communication.

Human aids

Human aids are people who help people communicate with each other. Examples are:

Interpreters – people who communicate a conversation, whether it be spoken or signed, to someone in a different language they will understand. This is not easy because they not only have to interpret the words or signs but also have to find a way of expressing the meaning of the words clearly.

Translators – people who change recorded information, such as the written word, into another language. Again, they have to convey the meaning as well as the words.

Signers – people who can communicate using a sign language.

Just checking

1. What do we mean by the expression 'alternative forms of communication'?
2. Explain what Makaton is.
3. What is a human aid? Give three examples.

Assessment activity

1. Do some research to find out the signs for (i) poison (ii) no entry (ii) no smoking (iv) fire exit (v) wet floor. Find at least five more common

signs/symbols that most people will recognise which are used in a health or social care environment of your choosing. Produce an information leaflet for people who are new to the country and have not seen these signs before.

2. Find out what an advocate is then find all the different health and social care services that use advocates and research how they use them.

7. Be able to communicate effectively

Key terms:

Clarification – making something clear and understandable

Empathy – putting yourself in someone else's shoes by sharing and understanding someone else's emotions

Proximity – being near or close to someone or something

In the next topic you will start to learn more skills for effective communication. These include active listening, body language, facial expressions and eye contact. You have already looked at some of these at the beginning of this unit.

Active listening and body language

Listening to people involves more than just hearing what they say. To listen well you need to be able to hear the words being spoken, thinking about what they mean, then thinking what to say back to the person. You can also show that you are listening and what you think about what is being said by your body language, facial expressions and eye contact. By yawning or looking at your notes when someone is talking you give the impression of being bored by what is being said. By shaking your head and frowning you are showing that you disagree with, or disapprove of, what they are saying.

The process of active listening involves:

- allowing the person talking time to explain and not interrupting
- giving encouragement by smiling, nodding and making encouraging remarks such as, 'That's interesting' and, 'Really?'
- asking questions for clarification, such as, 'Can you explain that again please?'
- showing empathy by making comments such as, 'That must be making life really hard for you'

• looking interested by maintaining eye contact and not looking at your watch

• not being distracted by anything else, such as an interruption on your mobile – switch it off or say you will ring back

• summarising to check that you have understood the other person. You can do this by saying, 'So what you mean is …?'

Use of appropriate language

How would you feel if your tutor suddenly started using swear words while they were teaching you? Why would you feel like this? You adjust how you speak depending on who you are with and who is listening to you. Things that are said with a group of friends or at a family gathering might not be understood by others because we use different types of language in different situations. People even unconsciously change their use of dialect depending on who they are speaking to. A person's accent or dialect may become more pronounced when they are speaking to someone from their family or from the area they grew up in.

Tone of voice

If you talk to someone in a loud voice with a fixed tone the person you are speaking to will think you are angry with them. On the other hand, if you speak calmly and quietly with a varying tone the other person will think you are being friendly and kind. So it is important to remember that it is not just what you say, but also the way in which you say it, that matters.

Pace

If you speak really quickly and excitedly, the person listening to you will not be able to hear everything you say. If you keep hesitating or saying 'um' or 'er' it makes it harder for people to concentrate on what you are saying. If you speak at a steady pace, however, you will be able to deliver your message more clearly and the other person will be able to hear every word you say.

Proximity

The space around a person is called their personal space. In a formal situation, such as a doctor talking to a patient, the doctor does not sit close enough to the patient to invade their personal space. In an informal situation, people who are friends or intimate with each other will often

sit closer to each other. People usually sit or stand so they are eye-to-eye if they are in a formal or aggressive situation. Sitting at an angle to each other creates a more relaxed, friendly and less formal feeling.

Just checking

1. State three ways you can show that you are actively listening to a person speaking by what you say in reply.
2. Give three ways you can tell someone is actively listening to you by their use of body language.
3. Explain how your pace and tone of voice can affect how the person you are speaking to understands what you are saying.

8. Skills for effective communication

If you have not heard, or read, and understood a message properly it is impossible to make the best use of the information. This topic looks at the importance of the written word as a form of communication. It also looks at some situations that can arise in a health and social care environment which might lead to communication not being effective.

Written communication

Health and social care workers need to be able to communicate well with the written word. This could be by writing something themselves, such as a letter to refer a service user to a different service, a record of a person's condition and treatment or entitlement to a benefit, or a prescription. This means they need to be able to use different ways of presenting information, such as letters, memos, emails, reports or forms. They need to make their meaning absolutely clear and structure the information well and in an appropriate manner so that mistakes don't happen. It is also necessary to use grammar, spelling and punctuation correctly and writing should also be legible so that the person the information is intended for can actually read it.

It is also important that the language used is appropriate. You probably use text language every day on your mobile but you know not to use it when writing an essay or report. If you were emailing, or writing a letter to, your brother you might start it with the words 'Hi bro' but to someone to apply for a job you would start with either, 'Dear Sir or Madam' or, 'Dear Mr/Mrs …' Care professionals should also not use lots of technical

words, acronyms or jargon if they are writing to someone who will not understand it.

They should read information provided by other care workers thoroughly. They need to be able to identify the main points and be able to find other information from a wide variety of sources. They also need ICT skills to update records and to access information.

Effective communication

Effective communication, including active listening, can be hard work. People who work in health or social care environments tend to enjoy learning about other people and their lives. Things can go wrong, however, if:

- the context is wrong, e.g. the surroundings are unsuitable due to lack of privacy
- the service provider and service user are mismatched. Sometimes communication breaks down because of factors such as age, education level, gender and ethnic background
- a person withholds information because they fear being judged, for example, they have taken illegal drugs
- a person fears that confidentiality will be broken, even though this should never happen, for example, about their sexual orientation
- the service user thinks that the advice given is too vague and has not asked for clarification
- the subject matter is embarrassing, such as talking about sex or intimate body parts
- a person fears they are going to hear bad news so avoids going to a service provider until it is too late to help.

If health and social care workers do not develop good communication skills, the effectiveness of their work will be reduced and things can go wrong. This will not help service users to feel good about themselves and can lead to worse consequences. Remember, it is important to overcome problems such as those listed above, communicate effectively, including checking understanding, so that you get the best out of your interactions with colleagues and service users.

Activity: Doctor, Doctor

1. Read the following conversation:

Doctor: What can I do for you today?

Patient: I've got a pain.

Doctor: What sort of pain is it and where is it?
Patient: It's a shooting pain that goes right down my leg.
Doctor: So the pain is in your leg?
Patient: No, it is in my back but sometimes goes right down my leg.
Doctor: So the pain starts in your back and shoots down your leg?
Patient: Yes.
Doctor: I think you have got sciatica. I'll prescribe you some tablets to take three times a day. Come back and see me in a week if the pain does not improve.

1. Do you think the two people concerned have understood each other?
2. How did the doctor check he had understood the symptoms?
3. Why was it so important that the doctor understood clearly where the pain was and what sort of pain it was?
4. With a partner, role play a conversation between (i) a small child and a nursery nurse (ii) a deaf older person and a care assistant.

2. Draw a mind map to present all the different forms of communication, the barriers to communication, the ways to overcome these barriers and the alternative methods of communication covered in this unit. Each branch should be in a different colour and the mind map should be clear and have only a few words on each large and smaller branch.

3. Take part in a group conversation using all the skills you have learned in this unit. As a group decide on a topic that interests you all, such as whether mobile phones should be allowed in school or college, and discuss it. The conversation will be recorded so you can all watch it back. You should each be aiming to join in equally, contribute but not aggressively, and be mindful of your verbal and non-verbal communication skills. When you watch it back you need to write down what you honestly thought of how well you used verbal and non-verbal skills to communicate effectively with the rest of the group.

Just checking

1. Give five ways of presenting information.
2. How do health and social care workers use the written word?

3. Give three examples of situations where communication can break down and explain why this might happen in these situations.

Assignment tips

Whenever you visit any health or social care environment observe the care workers talking to service users. Make notes of three skills used and the effect on the service users.

Make sure that before you take part in any interactions you plan them carefully. For both your one-to-one and group interaction produce plans that identify:

- the skills you will use
- where the interactions will take place
- any resources you may need, such as a video camera for practising or in role play
- any potential barriers to effective communication.

Suggest any additional skills or factors that could improve communication if you were to repeat the interactions.

Assessment activity

Task 1. Read the text **Bridging The Patient-Doctor Communication Gap** and answer the questions:

1. Has research shown that complaints about doctors usually center on competency rather than communication?
2. What has Research also shown?
3. What are the reasons of difficulties in patient-doctor communication?
4. They say that Patients and Doctors Speak Different Languages. What does it mean?
5. They say that Patients and doctors enter the exam room with drastically different perspectives. What does it mean?
6. They say that 21st century culture, and the Internet in particular, has fundamentally changed the relationship between doctors and patients. What does it mean?
7. How can you efficiently communicate your medical messages with clarity? Give *five CLEAR tips* for making sure that your patients really hear what you're saying:

Bridging the patient-doctor communication gap

https://www.conquerchiari.org/articles/special-topics/special-reports/patient-doctor-communication-gap-Pt-1.html

Just about everyone that goes to a doctor on a regular basis has experienced frustration with a visit at some point in time. Whether you leave the room wondering what the doctor said or found the bedside manner to be lacking, communication between doctors and patients is not always easy. In fact, research has shown that complaints about doctors usually center on communication rather than competency. Research has also shown how important doctor-patient communication is. Effective communication is not only critical to patient satisfaction, but research has shown that effective communication can actually improve patient health outcomes.

While communication is important in every doctor-patient interaction, it becomes critical when dealing with conditions like Chiari and syringomyelia. These complex diseases come with a variety of symptoms, can affect people for the rest of their lives, and there are many controversies surrounding their treatment. As Editor of this publication,

I have heard numerous stories from people expressing frustration with their doctors. This is not to say that the problem lies only with doctors; it takes two for miscommunication to occur and it will take two to correct the problem.

So why is patient-doctor communication such a big problem? In this, the first of three parts on this subject, we take a look at the ingredients that go into this combustible situation.

I believe patient-doctor communication is sometimes difficult for three reasons:

1. Patients and doctors speak different languages
2. Patients and doctors enter the exam room with drastically different perspectives
3. 21st century culture, and the Internet in particular, has fundamentally changed the relationship between doctors and patients

Patients and Doctors Speak Different Languages

Doctors and patients speak different languages, literally. Sometimes when dealing with medical conditions it is necessary to use medical terms. When dealing with Chiari and SM there are a host of technical terms for anatomy, medical procedures, and even symptoms. Doctors spend years learning this language and even specialize in certain dialects. They are immersed it in everyday and like any other language it becomes second nature to them. Because of this, doctors not only use technical terms for things like anatomy, but they tend to use technical terms instead of plain English. For direction they use words like caudal, distal, superior, and anterior. For some doctors, most every sentence will be infused with this type of med-speak, making them very difficult to understand and creating a language barrier that at times can seem as imposing as the Great Wall of China.

This puts patients at an extreme disadvantage and undermines the entire communication process. Common language is fundamental to true communication and understanding. Adding to the language problem is that patients and doctors may have a different understanding of even plain English words, such as success. How does a does a doctor define a successful surgery? Guaranteed it is probably different than a patient would. This last language barrier is a result of patients and doctors entering the room with entirely different perspectives.

Patients and Doctors Enter the Exam Room with Drastically Different Perspectives

To truly understand someone, you must understand where they are coming from and what their perspective is. As human beings, we can not escape the fact that our background, experiences, and emotions will influence how we interpret what is being said to us. The same words spoken by someone to two different people may have entirely different meanings to each of them. Similarly, one person may interpret the same words spoken by two different people differently. Many communication problems can be traced to not understanding someone else's perspective and in the case of patients and doctors, the difference in perspectives is large and varied.

By definition, patients are holistic in how they think about their health and problems with their health. If someone has a chronic condition, like Chiai, it is natural for them to try to trace every little problem back to that condition. Why? Because there is a problem with their body, not their nervous system or their brain. It is also natural for a patient to want or expect a doctor to think about them as a whole and listen as they describe all their symptoms.

The problem is that doctors are trained to be reductionist in their thinking. They are very specialized in their practice and this translates in to the way they think about problems and symptoms. Symptoms are neurological, or orthopedic or some other specialty.

This clash in perspectives can cause problems. A patient may raise a symptom that he feels is connected to Chiari. The doctor may think it isn't and dismiss it out of hand. This strain in communication is amplified by a second difference in perspective.

For patients, a doctor's visit is an emotionally charged event, but doctors approach the situation as caring, but dispassionate and objective professionals. How can a doctor's visit not be emotional for someone with Chiari/SM? These are serious diseases with serious consequences and limited treatment options. Patients have days to think about a doctor's visit and the anticipation of learning test results can be agonizing. On the flip-side, a doctor, even a very caring one, has to remain somewhat dispassionate. Not only to effectively treat a patient (emotion could cloud their judgment), but to protect themselves emotionally. If a doctor

truly got caught up in the intense emotions of every case, they probably wouldn't last too long.

As if that weren't enough, there is a third difference in perspectives between patients and doctors, and that is how they view each other. Unfortunately, if a Chiari patient has been bounced around the medical system, been misdiagnosed, and seen specialist after specialist, they may grow to distrust their doctors. They will go into the meeting guarded and with low expectations. Before you know it, low expectations lead to poor outcomes in a cycle of self-fulfilling prophecies.

Similarly, when some doctors are presented with a situation that is outside the norm (in their experience), they tend to distrust what the patient is telling them. As scientists, doctors are trained to rely on "objective" tests like MRI's and treat patient reports with skepticism. This is apparent in the language that doctors use in their medical records. "Patient complained of headaches. Loss of balance was denied." Words such as complain and deny are not very useful in building a trusting, communicative relationship.

Finally, while this seems strange, doctors and patients may have different goals. Yes, both people want the patient to get better, but there can be subtle differences in how patients and doctors define a successful outcome. For doctors, success in a Chiari surgery may mean that a cine-MRI shows adequate CSF flow or that a syrinx decreases in size. For a patient, that is all well and good, but success really means a return to full, normal function with no limitation. Granted that may not be realistic, but it is difficult for a patient to define anything less than that as a success.

It is easy to see how language differences and differences in perspective can put a strain on the patient-doctor relationship, but perhaps the biggest strain of all is the rise of the 21st century patient armed with the Net.

Twenty-first Century Culture - And The Internet In Particular - Has Fundamentally Changed The Relationship Between Doctors And Patients

The 21st century patient: informed, demanding, and ready to take charge of their own healthcare. Gone are the days of the paternalistic doctor patting patients on the back and saying trust me; in are the days of internet research, shopping around for doctors, joint treatment decision making, and e-mails between doctors and patients. While I strongly

believe that this is in general a good thing, I also think it will take a period of time for this new relationship between doctors and patients to find a natural balance.

First the good news. The 21st century patient is a good thing because patient's should take some level of responsibility for their own care. While we must keep in mind that doctors are highly trained specialists, we as patients should also rely on our own intelligence and feelings to find the doctors we trust and enact treatments we are comfortable with. Because in the end it is our bodies and we have to live with the results.

Now the bad news. Doctors will respond to this shift in different ways. Some will be more willing to accept an active patient who surfs the internet for information and some will be resentful. If a doctor is uncomfortable with a patient trying to exert more control, it will naturally lead to tension in the relationship and effect communication. However, doctors have a right to be suspicious of how patients use the internet and we would be wise to examine the issue objectively (yes, I'm aware of the irony of what I'm about to write).

Estimates place the number of health related web sites at more than 100,000 and growing exponentially. While this can be a treasure trove of information for patients, the quality of the information remains a concern. In addition to containing flat out incorrect information, given the rapid pace of research and medical advances, it can be difficult to keep sites updated with accurate information.

A second problem with many sites is that they offer only brief descriptions of diseases and conditions. In this case, a little knowledge can be a dangerous thing. If a patient thinks they know more than they do about a subject, their communications with their doctor will suffer.

A third problem is that - in my opinion - there is a generally pessimistic and worst case bias in medical information on the web. Just like the evening news, the worst outcomes tend to be reported more than the successes. Having experienced this myself a number of times, I know it is easy to get frightened when researching a new medical condition on-line. I also think that the message boards and chat rooms tend to attract people who are suffering more from their disease than average. Why is this? If someone is diagnosed with a disease and quickly recovers there isn't much incentive to participate in a chat room; chances are they want

to forget about it and move on. This negative bias on the web can lead to heightened concerns for a patient which in turn leads to them being labeled an alarmist and again the communication breaks down.

Clearly, the Internet is here to stay, so both doctors and patients will have to find a way to adapt to the new reality it brings to their relationship.

What's The Solution?

Given the profound difference in language and perspective that exists between patients and doctors and the disruptive force of the Internet, it is no wonder that communication is often frustrating and the patient experience less than ideal. The question is what to do about it? With the stakes as high as they are for Chairi and syringomyelia patients, doing nothing is not an option.

Bridging the Physician-Patient Communication Gap

After a recent trip to the Mayo Clinic in Rochester, Minnesota, I understand the communication gap in a very real way. My father was diagnosed with small cell lung cancer a few years ago and was at Mayo for a checkup when a scan showed a small blotch. This blotch was later determined to be a different type of cancer and the course of action was surgery. My father is now resting comfortably at home during his recovery, but my family's unfamiliarity with the procedures led to many questions.

Luckily, the doctor was gracious with his time and answered every question my mother, brothers, and I had regarding the diagnosis, the surgery, and the recovery. It is a well-known fact that today's medical practices are busy and medical professionals are pressed for time. However, patients and their families must remember to ask questions and get clarity before leaving. This is the most effective way to close the communications gap.

"But the doctor told us last week that dad would live to be 100!" If I had a nickel for every time I heard that phrase when I was a medical investigator at the medical examiner's office I'd be sailing on a private yacht by now.

On countless occasions when investigating a sudden death it would become painfully apparent that the person's demise wasn't that unpredictable after all. Yet, despite the evidence of a medicine cabinet full of cardiac meds and coronary arteries full of plaque, the families I

dealt with would often be flabbergasted to hear that the cause of death was heart-related.

The same confusion can apply to a patient's understanding of a simple lab test or surgical procedure. Why? Because what's commonplace for medical professionals usually isn't as straightforward for patients.

You and your staff are fluent in the language of medicine, but the majority of your patients are not. They take your word as gospel, and even when they have no idea what you're talking about, most people won't question you for fear of appearing to be naïve. Plus, they know you're in a hurry.

The results of medical misunderstandings can be inconvenient at best, disastrous at worst. Every morning, in hospitals around the world, people show up for surgery after eating a full breakfast because they didn't understand the NPO order. That's a costly inconvenience. But more expensive is a life lost over situational semantics.

A misinterpretation that leads a patient to insert a suppository in the wrong orifice is one thing, but one that leads them to repeatedly inject a double-dose of heparin (Drug information on heparin) is quite another. That's what happened to my uncle when he had a DVT. He thought it was okay to play catch-up with his anticoagulant after somehow forgetting a few doses. Though his INR was all over the map, thankfully he suffered no serious consequences. The fact that his thrombus was even diagnosed in the first place was a miracle, because he didn't want to "bother" his physician. He only mentioned his swollen, warm, red calf as an afterthought when he went to get a prescription for a completely unrelated ailment.

The biggest opponent of clinical clarity is time. A busy medical practice simply doesn't provide practitioners with the luxury of explaining every last detail of a diagnosis, test result, or prescription.

How can you efficiently communicate your medical messages with clarity?

Here are **five CLEAR tips** for making sure that your patients really hear what you're saying:

C — Clarify your messages by using lay terms as much as necessary to ensure comprehension

L — Listen carefully to questions and concerns voiced by patients

E — Explain things in a different way if patients are confused by what you've told them

A — Ascertain that patients understand what you've said by asking them to repeat it

R — Recap the conversation in a single "bottom line" sentence

The next time you're tempted to tell someone that they have the heart of a 20-year-old or they're as healthy as a horse, think twice. Patients and their loved ones will take you at your word. Make sure it's accurate.

Task 2.

Read the text **Patient-Physician Communication: Why and How** and make a list of tips **«How to achieve effective communication in the patient-physician relationship».** Be ready to comment on.

Patient-physician communication: why and how
http://www.scu.edu.tw/english/2008/people/wei_da/patient_physican_communication_why_and_how.pdf

Abstract

Patient-physician communication is an integral part of clinical practice. When done well, such communication produces a therapeutic effect for the patient, as has been validated in controlled studies. Formal training programs have been created to enhance and measure specific communication skills. Many of these efforts, however, focus on medical schools and early postgraduate years and, therefore, remain isolated in academic settings. Thus, the communication skills of the busy physician often remain poorly developed, and the need for established physicians to become better communicators continues. In this article, the authors briefly review the why and how of effective patient-physician communication. They begin by reviewing current data on the benefits of effective communication in the clinical context of physicians caring for patients. The authors then offer specific guidance on how to achieve effective communication in the patient-physician relationship.

The manner in which a physician communicates information to a patient is as important as the information being communicated. Patients who understand their doctors are more likely to acknowledge health

problems, understand their treatment options, modify their behavior accordingly, and follow their medication schedules. In fact, research has shown that effective patient-physician communication can improve a patient's health as quantifiably as many drugs -perhaps providing a partial explanation for the powerful placebo effect seen in clinical trials.

The first purpose of this article is to remind physicians of the importance of, and the opportunities for, more effective communications. The second purpose is to offer physicians practical techniques for improved communication with patients.

Why Bother Communicating With Patients?

A Reminder About the Value of Communication

From obtaining the patient's medical history to conveying a treatment plan, the physician's relationship with his patient is built on effective communication. In these encounters, both verbal and nonverbal forms of communication constitute this essential feature of medical practice. Although much of the communication in these interactions necessarily involves information-sharing about diagnosis and therapy options, most physicians will recognize that these encounters also involve the patient's search for a psychosocial healing "connation," or therapeutic relationship. For example, a patient with broken relationships with family, friends, coworkers, or the community in general, will often struggle when describing his illness and symptoms for the first time. That patient's contact with his physician is often a first step toward reconnection. Therefore, it is essential for the physician to listen to patient concerns, provide comfort and healing, and foster the relationship in general. This aspect of the patient-physician relationship is hard to define and, yet, with little doubt, can be found at the heart of any truly therapeutic relationship. This healing aspect also forms the basis for quality health care.

In settings involving the communication of bad news, especially when there is no appropriate biomedical response, the strength of such a therapeutic relationship will be tested, and its value quickly becomes obvious.[19] The physician who can communicate bad news in a direct and compassionate way will not only help the patient cope, but will also strengthen the therapeutic relationship, so that it endures and further extends the healing process.

More broadly and measurably, research into the degree of care used by

physicians in patient-physician communication has been shown to improve patient outcomes. One review of randomized controlled trials on patient-physician communications reported that the quality of communication in the history-taking and management-discussing portions of the interactions influenced patient outcomes in 16 of 21 studies. Outcomes influenced by such communication include emotional health; symptom resolution; function; pain control; and physiologic measures, such as blood pressure level or blood sugar level. The review identified specific elements of effective communication. For example, patient anxiety was reduced in patients whose physicians encouraged questions and also encouraged them to share in the decision-making process. In individual studies, effective communication skills have been correlated to such positive outcomes as adherence to therapy, understanding of treatment risks, and—in some settings— even to a reduced risk of medical mishaps or malpractice claims.

Obviously, improvement in these types of outcomes is a core goal of long-term patient education aimed at managing chronic illnesses (eg, diabetes and asthma). The high perceived value of effective communication in disease prevention, health maintenance, and quality-of-life, in fact, may be precisely why managed care companies have now outsourced these communication-intensive responsibilities to disease management vendors. Such is an indictment of the limited capabilities of individual physicians to provide such long-term and consistent communications. It is also an acknowledgment of the critical nature of direct human communication and support in achieving good medical outcomes. Examples of how direct contact influences medical outcomes are studies that have documented the way in which disease management programs can lower health-related costs, reduce emergency department visits, control chronic disease, and increase patient satisfaction.

How to Communicate with Patients

Reminders for the Busy Physician

Medical professionals debate the best strategies for effective communication, as well as the ability of these strategies to be taught or evaluated objectively. Certainly, each physician must develop his or her own style of communication. At the same time, many professional and academic organizations have now also defined key elements

of communications skills needed by physicians. For example, the Accreditation Council for Graduate Medical Education recommends that physicians become competent in five key communication skills: (1) listening effectively; (2) eliciting information using effective questioning skills; (3) providing information using effective explanatory skills; (4) counseling and educating patients; and (5) making informed decisions based on patient information and preference. Although these and similar lists of recommended patient-physician communication strategies are valid and useful, these tips are frequently found only in academic or specialty journals or on the checklists now used to rate physicians in-training.

To help practicing physicians gain and strengthen an effective and personal communication style, and, thus, improve patient-physician communication and rapport, we have assembled our own list of practical steps. We hope that these tips, based on our years of clinical experience and our reading of the recent literature on patient-physician communication, will remind colleagues that they are more than a passive conduit of medical information for their patients; they are interpreters and shapers of their patients' health and full partners in their patient's long-term health status.

1. Assess What the Patient Already Knows

Before providing information, find out what a patient already knows about his or her condition. Many times, other physicians or health care providers have already communicated information to the patient, which can have the effect of coloring patient perceptions and perhaps even causing confusion when new information is introduced. For instance, a nephrologist may talk about the patient "getting better" based on improving renal function tests, while a cardiologist is focused on the patient's severe, irreversible cardiomyopathy. In other scenarios, patients will come to the physician with preconceived notions about a particular condition, perhaps based on less than-authoritative sources. It is important, therefore, to determine what a patient already understands—or misunderstands—at the outset.

2. Assess What the Patient Wants to Know

Not all patients with the same diagnosis want the same level of detail in the information offered about their condition or treatment. Studies have

categorized patients on a continuum of information-seeking behavior, from those who want very little information to those who want every detail the physician can offer. Thus, physicians should assess whether the patient desires, or will be able to comprehend, additional information. For the physician without advance knowledge of the patient, this level of need will emerge by degrees as the discussion unfolds and as the physician attempts to synthesize and present information in a clear and understandable manner.

As when obtaining informed consent, a standard first step in presenting information to a patient would be to describe the risks and benefits of the procedure and then to simply allow the patient to decide how much additional information he or she wants. However, as suggested elsewhere in this section, this step may require direct questions, strategic silences, and frequent verification that the information is actually being comprehended.

One telling sign of whether the patient is understanding the information is the nature of the questions patients ask; if questions reflect comprehension of the information just presented, a further level of detail may be warranted. If questions reflect confusion, it is advisable that the physician return to basic information. If the patient has no questions or is obviously uncomfortable, this is a good opportunity for the physician to stop the discussion, ask explicitly how much information the patient desires, and adjust accordingly. Continuing to provide further information is not always the best approach.

3. Be Empathic

Empathy is a basic skill physicians should develop to help them recognize the indirectly expressed emotions of their patients. Once recognized, these emotions need to be acknowledged and further explored during the patient-physician encounter. Further, physicians should not ignore or minimize patient feelings with a redirected line of inquiry relentlessly focused on "real" symptoms. Patient satisfaction is likely to be enhanced by physicians who acknowledge patients' expressed emotions. Physicians who do this are less likely to be viewed as uncaring by their patients.

4. Slow Down

Physicians who provide information in a slow and deliberate fashion allow the time needed for patients to comprehend the new information.

Other techniques physicians can use to allow time include pausing frequently and reinforcing silence with appropriate body language. A slow delivery with appropriate pauses also gives the listener time to formulate questions, which the physician can then use to provide further bits of targeted information. Thus, a dialogue punctuated with pauses leads to deeper comprehension on both sides.

One study found that physicians typically wait only 23 seconds after a patient begins describing his chief complain before interrupting and redirecting the discussion. Such premature redirection can lead to late-arising concerns and missed opportunities to gather important data.

As a side note, patient satisfaction is also greater when the length of the office visit matches his or her previse expectation. In situations involving the delivery of bad news, the technique of simply stating the news and pausing can be particularly helpful in ensuring that the patient and patient's family fully receive and understand the information. Allowing this time for silence, tears, and questions can be essential.

5. Keep it Simple

Physicians should avoid engaging in long monologues in front of the patient. Far better for the physician to keep to short statements and clear, simple explanations. Those who tailor information to the patient's desired level of information will improve comprehension and limit emotional distress.[35] Again, physicians should be sure to ask whether patients have any questions so that understanding can be checked and dialogue promoted. It is wise for the physician to avoid the use of jargon whenever possible, particularly with elderly patients.

An important fact for physicians to keep in mind is that, in the United States, between 20% and 40% of individuals between 60 and 80 years of age have not attained a high school diploma. In patients of all ages, a physician cannot assume the understanding of treatment risks that are described with percentages or numbers. Such "low numeracy skills" of patients require that physicians take special care in outlining the relative risks of diagnostic procedures and treatments.

6. Tell the Truth

It is important to be truthful. In addition, it is important that physicians not minimize the impact of what they are saying. For example, euphemisms may soften the delivery of sad information but can be extremely misleading and create confusion.

Saying that a patient has "gone" or has "left us," for example, could be interpreted by an anxious family member as meaning that the patient has left his room to have a radiologic film taken or to undergo a test. Alternatively, physicians who use "D" words (eg, dying, died, dead), when appropriate, effectively communicate the circumstance and minimize confusion.[38]

7. Be Hopeful

Although the need for truth-telling remains primary, the therapeutic value of conveying hope in situations that may appear hopeless should not be underestimated. Particularly in the context of terminal illness and end-of-life care, hope should not be discouraged.

For example, in situations such as the imminent death of a patient, hope can be conveyed to the family by assuring them that therapy can be effective in allaying pain and discomfort. Thus, even when physicians must convey a grim prognosis to a patient or must discuss the same with family members, being able to promise comfort and minimal suffering has real value.

8. Watch the Patient's Body and Face

Much of what is conveyed between a physician and patient in a clinical encounter occurs through nonverbal communication.

For both physician and patient, images of body language and facial expressions will likely be remembered longer after the encounter than any memory of spoken words.

It is also important to recognize that the patient-physician encounter involves a two-way exchange of nonverbal information. Patients' facial expressions are often good indicators of sadness, worry, or anxiety. The physician who responds with appropriate concern to these nonverbal cues will likely impact the patient's illness to a greater degree than the physician wanting to strictly convey factual information. At the very least, the attentive physician will have a more satisfied patient.

Conversely, the physician's body language and facial expression also speak volumes to the patient. The physician who hurriedly enters the examination room several minutes late, takes furious notes, and turns away while the patient is talking, almost certainly conveys impatience and minimal interest in the patient. Over several such encounters, the patient may interpret such nonverbal behavior as a message that his or her

visit is unimportant, despite any spoken assurances to the contrary. Thus, it is imperative that the physician be aware of his or her own implicit messages, as well as recognizing the nonverbal cues of the patient.

9. Be Prepared for a Reaction

Patients vary, not only in their willingness and ability to absorb information, but in their reactions to physician communications. Most physicians quickly develop a sense for the various coping styles of patients, a range of human reactions that has been categorized in several specific clinical settings.

For instance, a certain percentage of individuals will meet almost any bad medical news in a nonemotional, stoic manner. The physician, however, should not interpret this nonreaction as a lack of patient concern or worry. In some cases, these same individuals go on to exhibit distress by other means (eg, an increased reporting of physical symptoms, additional nonverbal communication of pain, or other behaviors aimed at gaining the attention of the treatment team).

At the other end of the emotional spectrum, the sizable proportion of patients with mild or diagnosable depression and/or anxiety will likely react to bad news with frank displays of crying, denial, or anger.

A small percentage of patients who have difficulty forming a trusting relationship with a physician may react to bad news with distrust, anger, and blame. For such patients, establishing a lasting bond of trust with their physicians can be extremely difficult, and although all attempts to communicate should be made, unsettled feelings on both sides are to be expected.

In responding to any of these patient reactions, it is important to be prepared. The first step is for the physician to recognize the response, allowing sufficient time for a full display of emotions. Most importantly, the physician simply needs to listen quietly and attentively to what the patient or family are saying. Sometimes, the physician can encourage patients to express emotion, perhaps even asking them to describe their feelings. The physician's body language can be crucial in conveying empathic concern in these encounters.

The patient-physician dialogue is not finished after discussing the diagnosis, tests, and treatments. For the patient, this is just a beginning; the news is sinking in. The physician should anticipate a shift in the patient's sense of self, which should be handled as an important part of

the encounter - not as an unpleasant plot twist to a physician's preferred story line.

Conclusion

Simple choices in words, information depth, speech patterns, body position, and facial expression can greatly affect the quality of one-to-one communication between the patient and physician. To a large degree, these are conscious choices that can be learned and customized by the physician to fit particular patients in clinical situations.

***Communication traps to avoid*:**

1. Using highly technical language or jargon when communicating patients
2. Not showing appropriate concern for problems voiced by patients
3. Not pausing to listen to the patient
4. Not verifying that the patient has understood the information presented
5. Using an impersonal approach or displaying any degree of apathy in communications
6. Not becoming sufficiently available to the patient

Tips

These skills are not wholly formed on graduation from medical school or completion of medical residency. Strengthening one's communication skill set **takes time and ongoing practice.** A reminder of the most fundamental elements of communication, as found in this article, may be helpful and lead to more productive patient-physician encounters and better overall clinical outcomes.

Task 3. Patient-doctor communication: the fundamental skill of medical practice
http://simidchiev.net/fid/Dissert/Patient_Doctor_Comm.pdf

Activity. Read the text and define basic elements of the medical interview.

Describe how to handle the initial encounter, conduct the interview, to respond to the patient, how to educate, negotiate and collaborate with the patient and close the interview.

Introduction. The first visit for a patient is a crucial encounter that can either lead to the development of a therapeutic patient-doctor relationship or end in dissatisfaction on both sides and the search for another care provider. The medical interview goes well beyond the capture of medical information in order to make a diagnosis. It is the building block upon which the physician's relationship with the patient is constructed. The interview is filled with opportunities for patients to share information about themselves and for the physician to get to know the patient, so that the patient becomes a person, not just a medical problem. By understanding the patient, who they are, and the expectations that they have of the doctor, the doctor can formulate the appropriate medical judgments for that particular patient, as well as derive satisfaction from healthy patient-doctor relationship.

Patient-doctor communication is the verbal and non-verbal processes through which a doctor obtains and shares information with a patient, thereby developing a therapeutic relationship. While communication with a patient may seem straightforward and intuitive, an effective patient-doctor interaction can be quite challenging. It is up to the doctor to find out about the patient and their medical issues regardless of how difficult or complex the patient's history may be. Only when the doctor understands the patient in his or her own context, can the physician provide good care.

All patient-doctor interactions are influenced by the expectations of both parties. If the doctor has unfair expectations of the patient, or the interaction is affected by bias or unfair judgment, then an effective relationship will never develop. Likewise, if the patient's expectations of the doctor are not met, the patient will not develop enough respect or trust for the physician to accept his/her suggestions. The patient must feel at all times that they are treated with respect. Doctors expectations of their patients should be fair, unbiased and without judgment.

Common expectations patients have for their physicians are:

Primary Expectations-

- Clinical Competence

Secondary Expectations-

- Professional
- Respectful
- Polite

- Sincere
- Interested
- Effective Communication Skills-Verbal and Non-Verbal

Behaviors that satisfy these expectations, as well as serve to develop rapport with the patient are: being well groomed, addressing the patient by name, introducing oneself, developing an agenda, avoiding judgmental behaviors, appropriate eye contact/ facial expressions and posture.

Communication Skills-

Basic Elements found in the medical interview/interaction with the patient.

Initial Encounter-

The First Impression- the most important one that occurs!

The patient, in the first few moments, will decide if he/she will feel comfortable with the doctor and most of this first impression is made not on what the doctor says, but how he/she says it and how he/she interacts with the patient

Table 2.2

Be Prepared-know who the patient is before you walk through the door	Don't fumble for a name after you are in the room. Never call a patient over the pediatric age group by their first name without permission, it is disrespectful
Make eye contact with the patient, shake hands, and introduce yourself	Indicate your role to the patient. If you are a medical student, make sure the patient knows that and does not assume you are the one in charge of their care. You cannot assume that the patient will know who you are.
Set the patient at ease and build rapport	Most patients will be nervous meeting the doctor for the fist time. If appropriate, you can consider an initial inquiry into non-medical areas of lift to assist in developing a relationship with them as a person.
Have a seat	Where you are positioned relative to the patient is important. It is intimidating to the patient for you to stand over them. The patient should not have to look up to you to make eye contact.
Let the patient tell their story	Ask the patient to explain why there are here.

Conducting the interview

As the patient explains the chief complaint and the history of the present illness, you can question the patient using the following skills and techniques

Table 2.3

Use open-ended questions	This is done to obtain general information *("Tell me more about…" "Describe the pain for me…")*
Direct/closed-ended questions	Used as a follow up to open-ended questions *("Did you experience…," Does the pain go anywhere?")*
Avoid leading questions	Leading questions may suggest to the patient the desired answer
Ask one question at a time	Presenting more than one question is confusing and inconsiderate
Keep the interview organized and use transition statements	Try not to jump around from one topic to another. The patient should be able to understand what the purpose of any question would be. Transition statements summarize and enable you to proceed. If you do forget some questions under a particular category or line of questioning, it's okay to go back as long as you use a transition statement so the patient knows where you are going
Learn about the patient and his/her family	Do this formally and informally, during the course of the interview when discussing social and family history but also through an ongoing conversation with the patient. *(What activities does the patient participate in? What, if any stressors exist that may be contributing to the patient's medical concern? What sources of support could be utilized when developing a treatment plan?)*
Encourage the patient to ask questions	This will further develop trust and enhance your relationship with the patient
Listen Accurately to the Patient	It is often necessary throughout the course of the interview to verify what you have heard from the patient and elaborate on it. It is okay to repeat, rephrase, or paraphrase what the patient has said *("...so you have had this pain for three weeks now and is really has you worried')* This tells the patient that you are listening and understand what he/she is saying

Responding to the Patient

How you respond to the patient throughout the course of the interview will determine not only how much information you will elicit, but will also form the core of your ongoing working relationship with the patient. You will often have an opportunity to provide the patient with **empathy**,

a key component of rapport building. Without empathy, the patient will never develop any trust that you understand and sympathize with their situation.

Table 2.4

Pay attention to the clues, both verbal and non-verbal, from the patient that they may not be relating to the whole problem.	Verbal-It is often difficult for patients to disclose personal information about themselves or problems they may be experiencing. When the patient does reveal sensitive information, take a moment to explore what they have told you *(i.e. You mentioned you feel overwhelmed. Can you tell me more about that?)*.
	Non-Verbal-The patient's body language may be telling you something different from what the patient is saying. It is appropriate to point discrepancies to the patient and elicit their understanding about their causes. For example, if you are interviewing a patient that is very fidgety, you can say, *"You seem quite nervous. Can you tell my why you might be anxious?"*
Avoid judgmental language or behaviors	As the patient's physician, you must put aside your own beliefs and values and refrain from projecting them onto the patient. The medical problem or issue is not about you, but about the patient and their beliefs system and you need to understand it from their perspective
Provide Encouragement	Praising patients also strengthens the patient-doctor relationship. Offer them praise (e.g.*…."It sounds like cutting back on smoking has been difficult for you, but I'm glad to hear you have not given up trying"*)
Build Partnership	This entails offering your support and that of other health professionals when appropriate
Be aware of your non-verbal cues	Being attentive, making eye contact, and providing positive cues will encourage the patient to be open with you. Your body language should show that you are engaged, do not sit back in the chair, rather lean forward and pay attention.

Educating, negotiating and collaborating with the patient

Once all the information is collected from the history, physical exam, and other testing, it is time to explain to the patient what you believe the problem to be and what the next steps should be. You need to explain this to the patient in language they can understand.

Table 2.5

Avoid the use of medical jargon or abbreviations	Unexplained medical jargon can have a negative effect on the conversation's equilibrium.
Ascertain that the patient understands the information you have provided.	You can do this by involving them in the conversation, not just talking AT them. Assessing the patient's understanding can be done in a non-condescending way by simply asking, *"What will you tell your family about today's visit?*
Elicit the patient's feeling or concerns about the information	(e.g.…*"What thoughts do you have about this so far?)* and respond appropriately
Collaborate with the patient	Although you can explain your recommendation, do not assume that the patient will automatically agree with you. The plan needs to conform to the patient's understanding, belief system and values
Discover potential barriers	You, as the physician, must be sensitive to the patient's concerns and must explore any reason why they would not be comfortable with a given plan (e.g.…*"What obstacles/factors would prevent you from being able to comply with this plan?"*)

Closing the interview

At the end of the interview, it is important for you to establish that both you and the patient understand what occurred and what the plan is going to be

Table 2.6

Summarize the encounter	Do this for the patient and to get their agreement of their summary
Answer the patient's questions	The patient should leave knowing that all of their concerns have been addressed
Confirm partnership	The patient needs to be able to depend on the fact that you will be there in the future for them.
Provide your initial thoughts	In any given situation, you may need to discuss the plan with your supervising physician. However, if appropriate you should provide the patient with your initial opinion
Discuss next steps	This could include a discussion with your supervising physician. Or, in the future set up a follow-up appointment or at the very least welcome that back to see you again.

These basic elements of the medical interview, handling the initial

encounter, conducting the interview, responding to the patient, educating, negotiating and collaborating with the patient and closing the interview all construct the paradigm known a as patient-doctor communications. Performed well and in earnest, the patient is likely to reward your effort with their honesty, trust, respect, loyalty and confidence and much more. This exchange of mutual respect and understanding will pave the road to a long and satisfying professional relationship.

Task 4

1. Read the text **Communicating with Your Doctor** and be ready to help your peer to build an effective partnership with a doctor (may be you make a presentation or booklet or smth. else).
2. Be ready to visit a doctor (make some notes).

Communicating with your doctor
https://www.ucsfhealth.org/education/communicating_with_your_doctor/

The relationship with a doctor is a very personal one, built on communication and trust. In choosing a doctor, the "chemistry" between the two of you must work. You must be able to trust, confide in and tell your doctor about your health problems, including all symptoms. Your doctor, in turn, should listen to you, give you options and feedback and have your best interest in mind.

Here are some things you can do to help build an effective partnership:

Be Organized

Doctors are busy, so you need to know how to get the most from their limited time with you. This means that you must be organized and focused on the issues you want to address.

Think in advance about the questions you want answered. Write down and prioritize those questions, highlighting the main three or four you want to discuss. Send a list of the questions to your doctor in advance, if you think that would be helpful.

Keep Good Records

Provide your doctor with good, accurate information about your symptoms and medications so he or she has the necessary tools to

accurately diagnose your condition and prescribe appropriate treatment**.** A list of medications and supplements you are taking, recent symptoms and the dates at which they occurred, any recent tests and names of other doctors you are seeing can be useful information to share with your doctor.

The better you are able to communicate your needs and concerns, the better your doctor can respond.

Set the Tone

Let your doctor know how much or how little you want to participate in the decision-making process and whether you want very detailed information about all treatment options or just general information. Inform your doctor of any cultural beliefs that may affect your treatment choices or preferences**.**

Be Assertive

There is virtually nothing more important than your health. Just as you would not buy a car without asking questions, don't be afraid to ask your doctor questions. If your concerns are not addressed to your satisfaction, be assertive. Let your doctor know that you still have questions and ask if an additional appointment can be set up, whether the appointment can be extended or if there are other staff members who can address your questions.

Be Understanding

Balance assertiveness with respect and understanding**.** Although it's important to let your doctor know your needs or if you are dissatisfied, it's equally important to voice appreciation for positive aspects of your communication and treatment. Keep in mind that many of your questions can be addressed by a nurse, a social worker or by the staff at….

Know How to Keep in Touch

Before you leave, find out the best way to keep in touch between office visits, whether through the nurse, via email or by leaving messages at the front desk.

Before Your Visit

Take a list of specific questions to your appointment, making sure to list the most important ones first.

Familiarize yourself with your medical history, so you can convey it concisely to your doctor. Writing out a brief synopsis to give a new doctor can be helpful and save time.

Keep a diary to track your symptoms and concerns. Convey these clearly to your doctor.

List medications you are taking with their dosages. Tell your doctor about any medication changes.

During Your Visit

Tape-record your visit or bring a pencil and notebook to take notes. You also may bring a trusted friend or relative to take notes for you.

Keep your discussion focused, making sure to cover your main questions and concerns, your symptoms and how they impact your life.

Ask for clarification if you don't understand what you have been told or if you still have questions.

Ask for explanations of treatment goals and side effects.

Let your doctor know if you are seeing other doctors or health care providers.

Share information about any recent medical tests.

Let your doctor know how much information you want and if you have religious or cultural beliefs that affect your treatment.

Stand up for yourself or have a friend or family member advocate for you if your concerns are not addressed.

Balance assertiveness with friendliness and understanding.

Case study

PATIENT ASSESSMENT OF DOCTOR PROFESSIONALISM AND INTERPERSONAL COMMUNICATION

Please take a few minutes to provide feedback for your doctor who has been helping with your medical care. Use the back of the form for comments.

RATING SCALE HOW WAS THIS DOCTOR	Poor	Fair	Good	Very Good	Excel-lent	Unable to evaluate
1. Telling you everything; being truthful, upfront and frank; not keeping things from you that you should know	1	2	3	4	5	#
2. Greeting you warmly; calling you by the name you prefer; being friendly, never crabby or rude	1	2	3	4	5	#

RATING SCALE HOW WAS THIS DOCTOR	Poor	Fair	Good	Very Good	Excel-lent	Unable to evaluate
3. Treating you like you're on the same level; never "talking down" to you or treating you like a child	1	2	3	4	5	#
4. Letting you tell your story; listening carefully; asking thoughtful questions; not interrupting you while you're talking	1	2	3	4	5	#
5. Showing interest in you as a person; not acting bored or ignoring what you have to say	1	2	3	4	5	#
6. Warning you during the physical exam about what he/she is going to do and why; telling you what he/she finds	1	2	3	4	5	#
7. Discussing options with you; asking your opinion; offering choices and letting you help decide what to do; asking what you think before telling you what to do	1	2	3	4	5	#
8. Encouraging you to ask questions; answering them clearly; never avoiding your questions or lecturing you	1	2	3	4	5	#
9. Explaining what you need to know about your problems, how and why they occurred, and what to expect next	1	2	3	4	5	#
10. Using words you can understand when explaining your problems and treatment; explaining any technical medical terms in plain language	1	2	3	4	5	#

Communication skills and doctor patient relationship
Task 4.

Please read the article entitled "Communication skills and doctor patient relationship" by Prof. Samuel YS Wong and Prof. Albert Lee, complete the following self-assessment questions.

http://www.fmshk.org/database/articles/607.pdf

Questions 1-10: Please answer T (True) or F (False)

1. Good doctor patient communication was shown to have a positive impact on health outcomes.

2. Improvements in doctors' communication skills were shown to be associated with increases in the emotional distress of patients.

3. Better doctor patient communication was shown to be associated with better control of chronic diseases.

4. Patient-centred visits are associated with more diagnostic tests and referrals in the subsequent months.

5. Low compliance with prescribed medical interventions is associated with reduced medical costs.

6. The doctors' attitudes towards their patients, their ability to elicit and respect the patients' concerns, the demonstration of empathy and the development of patient trust are the key determinants of good compliance with medical interventions.

7. Effective doctor-patient communication is highly associated with increased patient satisfaction.

8. Doctors' satisfaction with their professional life are associated with greater patient trust and confidence.

9. Communication problems are important factors in medical litigation.

10. Adequate research has been done to evaluate doctor-patient relationship and doctor-patient communications.

Communication Skills and Doctor Patient Relationship

Having good communication skills is essential for doctors to establish good doctor patient relationship. Not surprisingly, many undergraduate and postgraduate medical education and training programmes have made the attainment of good communication skills a core requirement. With the increase in demand from patients who value doctors who are patient centred (who spend time and listen to them), together with the rise of consumerism in medicine, health service research on doctor patient relationship has become an important area of interest for both medical researchers and administrators alike. In this paper, a brief review will be presented to illustrate and provide some evidence for the importance of effective communication in health care delivery. The recognition of the importance of doctor patient relationship and communication in medicine

has particular relevance for primary care physician whose discipline has long focused on the importance of the doctor patient relationship quality health care delivery.

Improved health, functional and emotional status

Good doctor patient communication has been shown to have a positive impact on a number of health outcomes in previous studies. In a study that explored the effects of communication-skills training on the process and outcome of care associated with patient's emotional distress, improvement in physicians' communication skills was shown to be associated with a reduction in emotional distress in patients (Roter et al, 1995). In a review of 21 randomised controlled trials and analytic studies on the effects of physician-patient communication on patient health outcomes, the quality of communication in both history taking and discussion of the management plan was found to be associated with health outcomes (Stewart, 1995). Better doctor patient communication was shown to be associated with better emotional and physical health, higher symptom resolution, and better control of chronic diseases that included better blood pressure, blood glucose and pain control. More recently, in a study conducted on 39 randomly selected family physician offices and 315 patients, Stewart et al (2000) showed that the degree of patient-centred communication was associated with less discomfort, less concern and better mental health in patients. Moreover, in terms of reduction of utilisation of health services, it was shown that patients who perceived that their visits had been patient centred received fewer diagnostic tests and referrals in the subsequent months. In another study that investigated physician interaction styles and perceived health services quality by patients, Flocke et al (2003) performed a cross- sectional study looking at 2881 patient visits of 138 family doctors and categorised physicians' interaction styles into 4 categories: person-focused, biopsychosocial, biomedical, and high physician control by the use of a primary care instrument. They showed that physicians with a person- focused interaction style with patients were associated with the highest reported quality of care by patients, while physicians with the high control styles were associated with the lowest reported quality of care.

Compliance with medical treatment

Low compliance with prescribed medical interventions is an important problem in medical practice and it is associated with substantial medical

cost including increased hospital admissions. It also creates an ongoing frustration to health care providers (Melnikow, 1994). Finding ways to improve compliance is of interest to both health service administrators and physicians. To this end, the doctor patient relationship may have an important role to play. It has been shown that doctor's attitude towards his patients, his ability to elicit and respect the patients' concerns, the provision of appropriate information and the demonstration of empathy and the development of patient trust are the key determinants of good compliance with medical treatments in patients (DiMatteo, 1994; Safran et al, 1998). Furthermore, training doctors to improve their communication skills could potentially be cost-effective as it increases compliance which in turn improves the overall health of patients (Cegala, 2000).

Improved Patient Satisfaction

Effective doctor patient communication is shown to be highly correlated with patient satisfaction with health care services. In a study (Jackson, 2001) involving 500 patients who were seen by 38 primary care clinicians for physical symptoms, aspects of patient doctor communication such as "receiving an explanation of the symptom cause, likely duration, and lack of unmet expectations" were found to be the key predictors of patient satisfaction. In another review of 17 studies (Lewin, 2002) by the Cochran Library that was conducted to study the effects of interventions directed at health care providers to promote patient- centred care, training health care providers in patient- centred approaches was shown to impact positively on patient satisfaction with care. Patient satisfaction is an important area that deserves our attention because dissatisfaction with health care services can result in litigation against doctors by patients, unnecessary health care expenditure due to repeated visits, both could be very costly for the health care system.

Improved clinician satisfaction

Although much emphasis has been put on the importance of effective communication and good doctor patient relationship in affecting patient health outcomes and satisfaction, physician satisfaction with their professional life can also be an important determinant of a good doctor patient relationship. In a study conducted in the outpatient division of a teaching hospital, it was shown that physician's satisfaction with their professional life was associated with greater patient trust and confidence

in their primary care physicians (Grembowski D, 2004). It seems that physicians who are themselves more satisfied may be better able to address patient's concern (Hall, 1990). It has been suggested that physicians who are satisfied with their professional life may have more positive effect, which may in turn affect their communication with patients which then affect patient satisfaction (Hall, 1988). The exact mechanism for how physician satisfaction is could be affected by a third confounding factor such as one's personality attribute that related to patient satisfaction is not known, although authors have suggested that both relates to both empathic and communication skills. How these are related await further research (Roter, 1997).

Reduces Medical Malpractice Risk

In a study that explored plaintiff depositions to study reasons that instigate patients to file malpractice claims against doctors, Beckman et al (1994) identified relationship problems between doctor and patient being an important factor in 71% of depositions. These problems of relationship between doctor and patient included "deserting the patient", "devaluing patient and/or family views", "delivering information poorly" and "failing to understand the patient and or family perspective". Not surprisingly, the authors concluded that the patient's decision to litigate against doctors is often associated with a perceived lack of caring and collaboration in health care delivery in doctors. Similarly, in a study conducted by Hickson et al (1992) to examine factors that prompted families to file malpractice claims against doctors following perinatal injuries, it was shown that communication was an important factor that was related to these malpractice claims. The same authors also found that physicians who had been sued frequently were also the ones who received frequent complaints regarding the interpersonal care that they provided for patients, even by patients that never sued (Hickson et al, 1994). The complaints from these patients included "a feeling of being rushed", "being neglected" and a lack of explanations for tests performed. In another study that investigated similar issues which was conducted on primary care physicians, Levinson et al (1997) d e m o n s t r a t e d s i g n i f i c a n t d i f f e r e n c e s i n communication behavior of "no-claims" versus "claims" primary care physicians. They found that no- claims primary care physicians used more statement of orientation (educating

patients about what to expect and the flow of the visit), and tended to use more facilitation (soliciting patients' opinions, checking understanding, and encouraging patient to talk). All these studies highlighted the importance of communication and the role of a good doctor patient relationship in buffering against patients' dissatisfaction with heath services and complaints. As malpractice claims are increasing in Hong Kong over the last several years, this area will become an important topic for health administrators, physicians and health service researchers.

Conclusion

Good doctor patient communication is important and has multiple impacts on various aspects of health outcomes. The impacts included better health outcomes, higher compliance to therapeutic regimens in patients, higher patient and clinician satisfaction and a decrease in malpractice risk. To improve doctor patient relationship is a particularly important issue for family physicians. One of the four founding principles of family medicine adopted by the College of Family Practice of Canada is that "the patient-physician is central to the role of the family physicians" (CFPC, 2000), family physicians around the world thus should make an initiative to make themselves the advocates for improving doctor patient relationship in medical care. Extra effort to improve communication and relationship with patients would help to reduce complaints, improve compliance and reduce unnecessary investigation. To this end, family medicine academics should take the first step to study this area of medicine which is currently under- researched.

Activity: Make some sentences (5-7) to show correlation between doctor patient relationship and health outcomes, using grammar construction **the…..the.**

- The better doctor patient relationship the higher patient satisfaction.
- The higher patient satisfaction the more……
- The……..the…….

Questions for discussion:

1. Why good doctor patient relationship is so important in medicine?
2. Why do patients value patient centered doctors? What does it mean?
3. What do studies show us about good doctor patient communication? (one example)

4. What are the key determinants of good compliance with medical treatments in patients?

5. Why is patient satisfaction an important area for doctors?

6. Do studies show correlation between doctor patient communication and patient satisfaction?

7. What is Hall`s suggestion about physicians who are satisfied with their professional life and improved clinical satisfaction?

8. Are relationship problems between doctor and patient an important factor of the patient's complaints? What do these problems of relationship include?

9. What multiple impacts on various aspects of health outcomes does doctor patient communication have?

10. How can we to reduce complaints and to improve compliance?

Questions for final control

1. Explain the importance and the opportunities for doctors more effective communications with their patients (350 signs).

2. Offer practical techniques for improved communication with patients (6-8).

Cases

Read the following scenarios. For each of them, explain briefly:

- what are the barriers to effective communication
- how these barriers could be overcome.

1. Salvo is a patient in the medical ward of a large District General Hospital. His diabetes has got worse and he has now lost his sight. Salvo finds this very distressing and tends to stay close to his bed for fear of getting lost in the ward. He is becoming worried that he will not be able to get to the toilet in time on his own.

2. Edith is 56 years old and has recently suffered a stroke. This has left her paralysed down her right-hand side and she is unable to speak. Edith cannot put her thoughts into words or understand words that are written down. She can understand some of what is said to her. You have been asked to find out what meals Edith would like to choose from next week's

menu. You have been given a printed menu that patients normally fill in themselves.

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Chapter 3: PATIENT EDUCATION

The importance of health teaching as a part of medical practice has been recognized for years.

If physicians are legally and professionally expected to teach and are committed to this role, they must be well prepared.

This course is designed to provide medical students with guidelines and techniques that will help them become more knowledgeable and confident in providing health teaching.

Information is adapted from a book «Patient Teaching into Practice» http://www.euromedinfo.eu/providing-age-appropriate-patient-education.html/

Learning outcomes

After completing this chapter you should know:

1. The growing need for patient teaching and purposes of patient education
2. The Theoretical Basis of Patient Education
3. Developing an effective teaching style & Using adult learning principles
4. Providing Age-Appropriate Patient Education
5. Process of Patient Education
6. Impact of Culture on Patient Education
7. Helping Patients Who Have Low Literacy Skills
8. Resources for Patient Education and choosing effective patient education materials

1. The growing need for patient teaching and purposes of patient education

Patient education is one of the most crucial aspects of medical practice.

Table 3.1

Purposes of Patient Education
• To increase patient's and family's understanding of the patient's health status, health care options, and consequences of options selected

Purposes of Patient Education
• To encourage patient, family participation in decision making about health care options • To increase the patient's and family's potential to follow the therapeutic health care plan • To maximize patient and family care skills· • To increase the patient's and family's ability to cope with the patient's health status and prognosis and outcome • To enhance the patient's and family's role in continuing care • To promote a healthy patient lifestyle *Source: Adapted from: Lorig, K. (1996). Patient Education: A Practical Approach. Thousands Oaks, Calif.: Sage Publications, xiii-xiv.*

Through skills-oriented teaching, patients learn:

- how to change dressings,
- give and manage their own medications,
- perform exercises,
- participate in activities that increase independence and functioning.
- Through health teaching aimed at changing health behaviors, patients learn how to prevent disease and promote health.

Table 3.2

Characteristics of a Patient Self-Management Model
• Learning how to manage the physiological and psychological consequences of the health care problem • Learning how to solve problems and make decisions about health care management • Learning how to prevent further disease and promote health • Learning how to become a partner with health care professionals *Source: Adapted from: Lorig, K. (1996). Patient Education: A Practical Approach. Thousands Oaks, Calif.: Sage Publications, xiii-xiv.*

The results of patient teaching:

- symptoms lessen,
- anxiety decreases,
- readmission rates decrease,
- quality of life increases,
- knowledge of disease and treatment expands.

2. The theoretical basis of patient education

Learning outcomes

After completing this unit you should know:

1. Theories used for patient teaching: the Health Belief Model, self-efficacy theory, locus of control theory, cognitive dissonance theory, diffusion theory, stress and coping theory, and adult learning theory.

2. Rules and strategies that can help us find answers for patient learning and motivation, and help predict the consequences of specific health education interventions.

Introduction

The goal of patient teaching is to influence behavior change, yet changing habits is extremely difficult for most of us. Health care providers ask patients to make enormous changes in their lives in order to prevent disease and promote health. For example, we ask diabetic patients to lose or maintain weight by staying on a diet 365 days a year, every year, for life. Diabetic patients must also carefully control their intake of dietary fat and cholesterol to decrease their increased risk of heart attacks and stroke. Constant and accurate self-monitoring of blood glucose is required by finger sticks and urine testing. Exercise is part of the treatment as well, but it must be planned to avoid causing elevations or severe drops in blood glucose levels. In addition, the patient must inject insulin several times a day or take oral medications. Self-management of diabetes is very complex, yet we ask ordinary people to take on all these tasks and, at the same time, carry on their normal life of work, school, and social relationships.

Theories that explain human behavior change serve as guidelines for teaching. Theories are a generalized set of rules that can help us find answers for patient learning and motivation, and help predict the consequences of specific health education interventions. The more you know about educational theories, the more tools you will have for building strong, effective patient education interventions. Theories that can be applied to patient education come from the disciplines of communication, organizational development, sociology, psychology, and adult education. Theories used for patient teaching include the Health Belief Model, self-

efficacy theory, locus of control theory, cognitive dissonance theory, diffusion theory, stress and coping theory, and adult learning theory.

The Health Belief Model

The Health Belief Model helps explain why individual patients may accept or reject preventative health services or adopt healthy behaviors. Social psychologists originally developed the Health Belief Model to predict the likelihood of a person taking recommended preventative health action and to understand a person's motivation and decision-making about seeking health services. The Health Belief Model proposes that people will respond best to messages about health promotion or disease prevention when the following four conditions for change exist:

- The person believes that he or she is at risk of developing a specific condition.
- The person believes that the risk is serious and the consequences of developing the condition are undesirable.
- The person believes that the risk will be reduced by a specific behavior change.
- The person believes that barriers to the behavior change can be overcome and managed.

The first condition in the Health Belief Model is perceived threat. If the person does not see a health care behavior as risky or threatening, there is no stimulus to act. For example, a 59 year old woman who sunbathes every day who doesn't believe that she is at risk of skin cancer will continue to sun bathe. There are two types of perceived threats: perceived susceptibility and perceived severity. Susceptibility refers to how much risk a person perceives he or she has; severity refers to how serious the consequences might be. To effectively change health behaviors, the individual must usually believe in both susceptibility and severity. This is one reason that many people "get religion" after they have been diagnosed with cancer, heart disease, or diabetes. Because both susceptibly and severity are a clear and present danger, people who have previously resisted or put off behavior change finally give up smoking, stop drinking, lose weight, or start an exercise program. Individuals must also have the expectation that the new behavior will be beneficial; they must feel that barriers to change do not outweigh the benefits and that they can realistically accomplish the needed changes in behavior.

Unfortunately, for many desirable health behaviors, the barriers are immediate and the benefits are long-range. For example, it's difficult to pass up eating a piece of chocolate cake with the hope that you will not have heart disease or cancer in the future. From this perspective, it is not hard to see why it is so difficult to get patients to change behaviors.

Knowing what aspect of the Health Belief Model patients accept or reject can help you design appropriate interventions. For example, if a patient is unaware of his or her risk factors for one or more diseases, you can direct teaching toward informing the patient about personal risk factors. If the patient is aware of the risk, but feels that the behavior change is overwhelming or unachievable, you can focus your teaching efforts on helping the patient overcome the perceived barriers.

Patient Education: Self-efficacy

Self-efficacy refers to the extent of an individual's belief in his or her abilities. Because self-efficacy is based on feelings of self-confidence and control, it is a good predictor of motivation and behavior. Research has shown that health care professionals can have an impact on self-efficacy and that changes in self-efficacy are associated with changes in behavior. Some examples of ways to enhance a patient's self-efficacy include:

- Skills mastery
- Modeling
- Social persuasion

Skills mastery refers to the technique of breaking down skills to be learned into very small, manageable tasks so that it is likely the task will be done successfully. People are more likely to adopt a health behavior if they think they will be successful in doing it. Thus, interventions should increase confidence by giving patients many little "successes" in the process of behavior change.3 Alcoholic Anonymous programs take advantage of self-efficacy principles when they encourage participants to take one small step "to promise not to drink today."

Modeling is a self-efficacy technique by which the patient becomes aware of seeing someone else with a similar problem. Support groups and patient groups such as the Arthritis Foundation's self-help course and the American Cancer Society's Reach to Recovery Program are based on modeling. When using modeling, try to match patients with models

who are as much like them as possible in terms of age, sex, ethnic origin, and socioeconomic status. It's important to avoid using superacheiving people who have overcome problems in a dramatic manner. Although such people are inspiring, they are not always the best models if the patient perceives their achievements as unrealistic.

Social persuasion refers to individual efforts to influence behavior. One aspect of persuasion that is particularly effective is to urge and encourage the patient to do slightly more than he or she is now doing. When using this strategy, strive to make teaching goals short-term and realistic, and not much beyond what the patient believes he or she can realistically accomplish.

The way the health care professional presents teaching content can have a major impact on increasing self-efficacy. If the patient feels overwhelmed by the amount of material to be learned or the complexity of tasks involved, he or she will be less likely to be willing to try new skills.

In addition to breaking down information into realistic segments, it's helpful to emphasize the similarity of the new task to be learned to something the patient is already successful at doing by explaining and reinforcing that the task can be learned one step at a time or by having other patients who have learned the new skills meet with the patient. To build self-efficacy, the first step is to divide a complex task or complex into subtasks that appear easy to the patient. The second step is to offer feedback/reinforcement after each step. Providing enough time for the patient to practice new skills helps build self-efficacy. Examples of repetitions that build self-confidence are practicing insulin injections, demonstrating how to use adaptive equipment, or showing how to select low-sodium foods from a menu. Recognizing and rewarding the patient for accomplishing subtasks are important to help build the esteem that is the basis of self-efficacy. Recognition is particularly important for patients without much education or who have literacy problems. Over their lifetimes, these individuals have often "guessed wrong" and are therefore more likely to have low self-confidence that they can perform the tasks you are asking of them. A sincere statement such as "Good, you're beginning to get the idea," or "You're doing well" from a nurse or other healthcare professional or even a positive response from a computer-aided instruction can help immensely.

Related theories of Patient Education

Locus of control theory

Locus of control theory describes the extent to which people believe they are in control of their own health. This theory proposes that people who believe they are in control of their own health status are more likely to change behaviors in response to health information than people who don't believe they have such control. Individuals who believe or feel that their health is in the hands of God or fate or the physicians (external control) are less likely to take preventive healthy actions. People who feel that they are in charge of their health condition (internal control) are more likely to adopt healthy behaviors. Locus of control theory is especially relevant for patients with limited education and low literacy skills. If they have had difficulty understanding health care instructions, they may feel that managing their own health is beyond their understanding. Nurses can assist patients with an external locus of control by encouraging use of social support systems and by helping them believe they have the ability to control health events and by helping them improve their decision making skills.

Cognitive dissonance theory

The basis of cognitive dissonance theory is that a high level of unhappiness or dissonance is a stimulus for behavioral change. A person's readiness to change is based on feeling sufficiently unhappy with the present health care status. Most people don't feel good when they keep doing things they know are unhealthy. For example, a person who is fully aware that smoking is unhealthy and wants to quit would likely suffer some cognitive dissonance (mental discomfort) when realizing he or she is opening the third pack of cigarettes of the day.

The basis of cognitive dissonance theory is that people want to reduce discomfort and return to a more comfortable state.

Health care professionals using cognitive dissonance theory might deliberately increase the patient's discomfort about a desired behavior or allow the patient to choose an unhealthy option that increases discomfort.

Educational strategies based on cognitive dissonance theory are useful in getting a patient to make a decision to stop an unhealthy behavior or to add a healthy behavior and to maintain the new behavior once the

decision has been made. After patients have made a healthy decision, reinforcement is needed to keep them from regressing.

Diffusion theory

Diffusion theory refers to the observation that some people will try new behaviors more readily than others will.Understanding and using diffusion theory is particularly appropriate when teaching individual patients and family members and when educating a community, as those people who are more willing to adopt change can influence others. The first individuals within a family group or a community to try out and adopt new ideas are innovators who are secure enough to feel comfortable in making a change. These people may serve as models or change agents for others who follow. The next group to adopt the change is known as early adopters. Both innovators and early adopters tend to make decisions based on rational thinking and experiences. To persuade these people to change a health behavior, your message needs to be logical and must include the reason for the change and proof of results.

Those individuals who are willing to change later-the late adopters-are likely to be more conservative and less secure. Late adopters are motivated more by social influences such as local organizations and friends than by rational thinking. Health information heard at a neighborhood party is likely to have more influence on late adopters than advice from a health expert seen on television.

Health care professionals can use diffusion theory to help influence individuals within a group or community. The initial target for the health care message is the innovators and early adopters in the group. These people may be political figures, teachers, or sports figures. When early adopters have made the desired behavior changes, the message may be revised to stress social influences for the desired behaviors.

Stress and coping theory

Coping refers to an individual's constantly changing cognitive and behavioral efforts to manage specific external or internal demands that the person senses are stressing his or her physical and psychological resources. A person's coping abilities change over time in response to new situations. Both personal and situational factors influence the amount

of stress perceived and coping efforts. Personal factors are those things the individual brings to the situation, such as his or her personal life experiences. Situational factors refer to how the person perceives and interprets each unique situation.

People cope with health care problems in a variety of ways. Some examples include:

- Escape-avoidance
- Distancing
- Exercising self-control
- Positive reappraisal
- Finding social support
- Learning problem solving skills

Escape-avoidance is a coping strategy by which a person denies a problem exists. This strategy may work in the short term, but is not a useful long-term coping strategy. Distancing is a strategy in which people separate themselves from the problem and convince themselves that their condition is so unique that they cannot benefit from the experience of others. Another method of coping is exercising self-control. Individuals who use self-control as a coping strategy gain control by participating in self-care and being active in decision making. Positive reappraisal is a coping strategy in which a person focuses on what one can do, rather than dwelling on what can't be done.

Some people seek social support when they feel they cannot cope effectively on their own. Importantly, there is growing evidence that giving support, i.e., being helpful to others, may be as important as receiving support. Nurses should consider using patients who are more confident and skilled in performing health care tasks to help others as a means of increasing coping by participating in a helper role. Problem solving is one of the most useful strategies available to people to cope with illness.

Appraisal-focused coping refers to efforts a person makes to define the meaning of a situation and can take the form of problem-focused coping or emotion-focused coping. When using problem-focused coping, a patient deals with the reality of a situation by modifying the source of the threat or handling the consequences of the problem. A person engaged in emotion-focused coping focuses on managing the emotions aroused by

an event. For example, a 58-year-old woman has just been diagnosed with breast cancer. Her first response is emotion-focused coping. She shares her diagnosis with her family and close friends and begins to openly seek emotional support from them. At the same time, she begins to develop some problem-focused coping strategies by obtaining information from the Internet about breast cancer diagnosis and treatment options.

Learning domains

Learning is a process that involves behavior change. Domains or categories of learning help guide and direct teaching and learning. The three learning domains described briefly, are:

- Cognitive domain: knowledge and understanding of facts, concepts, and principles
- Psychomotor domain: physical skills
- Affective domain: attitudes, values, and beliefs

The cognitive domain involves using mental processes to recall, apply, and evaluate facts and information. Cognitive learning involves learning new facts or concepts, and building on or applying past knowledge to new situations. An example of learning in the cognitive domain would be a diabetic patient who is able to state the signs of hypoglycemia and hyperglycemia, or is able to plan an appropriate diet. When teaching a patient factual information, use teaching strategies such as discussion, programmed instruction, written information, videotapes and audiotapes, and computer assisted instruction.

The psychomotor domain involves the physical skills that a person needs to perform a procedure or technique. Psychomotor learning includes the development of manipulative or physical skills, ranging from simple movements to complex actions. A diabetic patient who learns how to operate blood glucose monitoring equipment or to inject insulin is acquiring psychomotor skills. Strategies to help a patient learn psychomotor skills are demonstration and return demonstration and practice drills.

The affective domain involves attitudes, beliefs, and values that influence behavior. Affective learning includes values, religious and spiritual beliefs, family interaction patterns and relationships, and personal attitudes that affect decisions and the problem-solving process. Learning

in the affective domain involves a change in attitudes or emotions that will affect behaviors. Discussion, simulations, and role-playing are teaching strategies used to teach in the affective domain. The nurse uses all three domains, depending on what is to be taught. To learn or change a health behavior, the patient may need to learn in all three domains. The nurse's role is to select a combination of content from the three domains that is appropriate to meet individualized patient teaching goals.

Activity: case study

Case 1. You are GP. Your patient is not going to give up smoking and start an exercise program after he has been diagnosed with heart disease. You see that he is unaware of his risk factors for this or more diseases. What strategy do you need to help him?

Case 2. You are GP. Your patient is not going to stop drinking and lose weight after he has been diagnosed with diabetes. Your patient is aware of the risk, but feels that the behavior change is overwhelming. What strategy do you need to help him?

Case 3. You are GP. Your patient is not going to give up drinking after he has been diagnosed with heart disease. You see that he thinks he will not be successful in doing it. What strategy do you need to help him?

Case 4. You are GP. Your patient is not going to take a drug after he has been diagnosed with heart disease. You see that he believes that his health is in the hands of God or fate. What strategy do you need to help him?

Case 5. You are GP. You see that your patient is not able to plan an appropriate diet after he has been diagnosed with a diabetic. What strategy do you need to help him?

Case 6. You are GP. You see that your diabetic patient should learn to inject insulin. What strategy do you need to help him?

Just checking

1. What is the goal of patient teaching?
2. Why do nurses and doctors need theories in patient education?
3. What theories are used for patient teaching?

3. Developing an effective teaching style

Learning outcomes

After completing this unit you should know:

- How to develop an effective teaching style
- How to use adult learning principles
- Characteristics of an excellent teacher.

Your teaching style refers to the personal way in which you interact with a patient to provide teaching. Nurses and doctors who are effective teachers usually have a teaching style that includes establishing and maintaining a helping relationship, being an active listener, and knowing how to ask effective questions.

There are *several techniques* you can use to help establish and maintain the helping relationship that is foundation of the teaching-learning partnership.

Show your respect for the patient as an individual by making sure that you treat each patient as a unique and worthwhile human being. Establish and maintain a helping relationship. Help the patient develop confidence in your concern and abilities.

Demonstrate that you accept the patient for who he or she is. Be sincere-make sure your words and actions match. For example, if you say that you will be back in 15 minutes to give the patient pain medication, do so, or let the patient know how long you might be delayed. This type of communication lets the patient know that he or she can depend on you to keep your word.

To become an active listener, start by maintaining eye contact to let the patient know you're interested in what he or she says and that you intend to pay attention. Look for nonverbal messages while you listen to verbal messages, and assess whether or not the patient's nonverbal behavior is consistent with what he or she is saying. If not, inquire further into what the patient's concerns are.

Don't allow interruptions, such as speaking before the patient is finished, or answering a call or pager. Such interruptions may result in the patient deciding you are too busy to attend to his or her needs.

Respond to the patient's questions and concerns in a warm, empathetic manner that encourages continued dialogue.

To use questions effectively, use open-ended rather than closed or simple "yes/no" questions. For example, asking a patient, "Do you know how to take your medication" is a closed question that will not yield much information. The open-ended version of this question is "Can you tell me in your own words how you should take your medication?" Asking a patient, "How did you sleep last night" is another example of an open ended question that gives the patient the opportunity to provide details about his or her sleep pattern that are important for you to know.

Nurses may also inadvertently ask questions that patients perceive as intimidating. For example, a nurse learns on a return outpatient visit that the patient has not followed the instructions he or she was given. If the nurse asks, "Why didn't you follow the doctor's instructions," the patient may feel intimidated and limit further communication with the nurse. A less intimidating version of the same question that is likely to keep communication going is "Can you tell me what stopped you from following the doctor's instructions?"

Using adult learning principles

Your adult patient will probably want to exercise self-direction. Adults like to make their own decisions and have their decisions respected. Therefore, listen to what patients believe they need to learn and how they feel they would best learn it.

Make your teaching realistic. Adults usually want what they learn to have an immediate practical value, to meet a perceived need, and to fit their budget and time constraints. If you don't make the relevance of what you're teaching evident, the patient may not pay attention.

Give patients credit for their life experiences and invite them to share what they know. Acknowledge that the patient may have strong and stressful feelings about being in a learning situation.

Many adults have good or bad feelings associated with prior learning. Your patient may have had poor experiences with authority figures such

as teachers or may have a lifetime love of learning. Observe the patient's reaction to different learning situations and try to determine his or her comfort level with teaching and learning. Correct any mistakes the patient makes in a sensitive way. If corrections are needed, make them tactfully, pointing out what the patient understands or performs correctly first; then correct what he or she misunderstands or performs incorrectly.

Relate new ideas to current knowledge. Adults learn best and retain more when they can connect what they're learning to something they already know. From your assessment, you have a picture of the patient's work situation, hobbies, and interests. Try to tie your teaching into your what your patient is already comfortable with.

Remember that conflicting information slows learning. If your patient has seen you do a procedure one way and another nurse does it another way, he or she may be confused about how to proceed. It is ideal to have teaching done by the same person; however, when this isn't realistic or possible, focus on the key points and stress that there can be adaptations to tasks and procedures.

Recognize that learning can cause anxiety. The procedures you teach may seem routine to you, but to your patient, they're unusual and quite possibly frightening. Allow enough time for learning and practice, and encourage the patient and family to actively participate. Provide a comfortable physical and emotional learning environment.

The following are the 4 Cs-the characteristics of an excellent teacher:

- Confidence
- Competence
- Communication
- Caring

Having *confidence* means that you know how to select what to teach, how to prepare an effective teaching plan, and how to arrange an appropriate learning environment. Nurses who are confident teachers are experts about how to select the main points of information that are most important for the patient to learn.

Being *competent* means that you ensure the patient's safety during teaching sessions and you provide the patient with written instructions that are individualized for his or her care, including letting the patient know what to do if problems arise.

Being a *good communicator* means that you know how to give clear directions, how to use simple pictures or models for instruction, and that you are able to explain information in words the patient understands. Nurses who are good communicators know how to both speak and listen well. They are not concerned with impressing the patient and family with how much they know. Instead, they get to the point and involve the patient by finding out what the patient already knows. They stop and ask questions to make sure the patient understands the instructions. They are comfortable talking to the patient's family and involve them in the teaching plan. They often use a "show and tell" approach. They are comfortable talking to the patient's family and involve them in teaching.

Being a *caring teacher* means that you demonstrate empathy, you are sensitive to the patient's concerns and needs, you ensure adequate time so that the patient doesn't feel pressured or rushed, and you provide continuous support and encouragement. Nurses who are caring teachers have the ability to put themselves in the patient's shoes and consider how the patient might feel. They understand the patient's concerns about safety, pain, appearance, and financial costs, and they help the patient address these concerns. They are encouraging and provide enough time for the patient to be successful.

Just checking

1. What does teaching style of effective teachers include?
2. Describe techniques you could use to help establish and maintain relationship that is like foundation of teaching-learning partnership.
3. Give a short characteristic of adult patients. What do they want, have and like?
4. List and comment on characteristics of an excellent teacher.

4. Providing age-appropriate patient education

Learning outcomes

After completing this unit you should know:

- Why you must consider the patient's age and developmental level
- Teaching pre-school children
- Teaching school age children

- Teaching adolescents
- Teaching young adults
- Teaching adults in midlife
- Teaching older adults

Introduction. To provide effective patient teaching, you must consider the patient's age and developmental level. Knowing your patient's developmental level will help you select the most effective teaching strategies. The three developmental areas you will be assessing are the patient's physical maturation and abilities, psychosocial development, and cognitive capacity.

Specific developmental issues characterize each age group. Infancy is the time from birth to the first 12 to 18 months of life. During this time, the infant is totally dependent on others to meet basic needs. The toddler period is the time from when a child begins to walk until around 3 years of age. The years between 2 and 3 are a significant time for physical and emotional development. Motor development progresses significantly, and the child begins to have a degree of physical and emotional independence while still maintaining a close relationship with the primary family unit. During the pre-school period-generally between ages 3 and 6-a child shows increasing interest in and involvement with his age group peers. Most pre-schoolers are able to relate to their peers and have beginning social interactions with many people. From 6 to 12 years of age, the interests of school age children turn away from their immediate family to the wider world. The school age child has enough maturity to begin to relate to other people as individuals. Adolescence is characterized by the onset of puberty and is associated with a significant amount of personal exploration. Adolescence ends when the young person demonstrates his or her readiness to assume full financial, emotional, and social independence. In Western societies, this usually occurs between 18 and 21 years of age.

During young adulthood-from approximately 21 to 39-individuals focus on selecting an occupation or career, choosing and learning to live with a partner, and starting and raising a family. During middle adulthood, individuals work at establishing themselves in a marriage and mature in their career choice. Most middle-aged adults between ages 40 and 65 begin

to face adjustments to physiological changes that occur with maturity. Older adults must make adjustments to decreased physical strength, a declining health status, retirement from the work force, reduced income, decreasing independence, and the deaths of spouse, siblings, friends, and self.

Psychologist Jean Piaget's work on cognitive development is a useful guide in knowing what teaching approach to take for teaching infants, toddlers, pre-schoolers, school aged children, and adolescents. Table 3 reviews Piaget's life stages as they relate to children's concepts of health and illness.

Table 3.3

Piaget's Life Stages and Children's Concepts of Health, Illness
• *Infant/toddler-Sensorimotor stage:* The infant or toddler has no perception of illness and little understanding of health and illness concepts • *Pre-schooler-Preoperational stage:* The pre-schooler perceives illness as changes in behaviors; is not able to explain the cause of illness; may see illness as a form of punishment. • *School-age children-Concrete operations stage:* Are able to describe illness in terms of multiple symptoms; view disease transmission primarily resulting from physical contact with source, e.g., "catching a cold from someone else." • *Adolescents-Formal operations stage:* Adolescents are able to acknowledge that their personal actions contribute to health and illness, and understand many dimensions of illness and treatment, internal organs/processes that may affect health/illness, and the influence of psychological processes in health and illness *Source: Whitman, N.I. (1998). "Developmental characteristics." In: Boyd, M.D., et al. Health Teaching in Nursing Practice: A Professional Model, 3rd ed. Stamford, Conn: Appleton & Lange, 136.*

Teaching parents of infants

It is important to teach parents that infancy is a time of rapid growth and development. New parents may misinterpret many normal aspects of infant development as a deviation from the norm. It is important to emphasize that development does not occur at the same rate for all infants. Unless new parents are aware of this, they may experience considerable anxiety when comparing their infant to others who may be developing more quickly.

Teaching parents about normal infant development, as well as the range of individual differences, can relieve unnecessary anxiety. Other

typical topics for infant development teaching include the need for immunizations, infant stimulation, infant feeding, and safety issues, and teething.

Teaching toddlers

Between 18 months and 3 years of age, the young child rapidly gains language skills and begins to demand increased autonomy. Nurses can help parents learn what behaviors to expect and how to effectively manage behavioral issues.

Child safety is an extremely important area to teach parents of toddlers. Young parents may be unaware of safety hazards and may need help in learning ways to childproof their home.

Toilet training also occurs at this age. By teaching various ways to toilet train, and by continuing to emphasize individual rates of development, nurses can help parents toilet train children with realistic expectations and lessened stress. Although toddlers are unable to reason and may take many things literally, they are capable of some degree of understanding when they have medical tests or procedures. The nurse's approach to the toddler should be calm, warm, and matter of fact.

Planning health teaching for an infant and toddler is primarily directed toward the parents. As separation from parents often causes anxiety, parents should be included in patient care whenever possible. It is helpful for one nurse to establish a relationship with the child and family and to be consistently involved with learning activities. Reading stories and involving the young child using pictures, dolls, and puppets can stimulate learning. Because young children have no real sense of time, health teaching must occur in close proximity to the time of any event to which the teaching relates. Children this age have a very limited ability to attend to information, so plan teaching in very brief (two- to five-minute) sessions.

Teaching pre-school children

Teaching children about procedures to be done should be a routine part of interacting with pre-school children. Keep in mind, however, that the pre-school child has limited reasoning abilities, so it is not helpful to explain in any detail the purpose of a procedure. Explanations should be simple and matter of fact.

Most preschool children fantasize and are quite vulnerable to fear of pain and bodily harm. It is important for the nurse to help children to express their fears and to deal with them openly.

Teaching topics for parents of pre-school children include understanding the importance and role of play, dealing with sexual curiosity, beginning school adjustment, and handling eating and sleeping problems.

Remember that the preschool age child is just beginning contact with the larger outside word. To avoid overwhelming the preschooler with choices, give the child no more than two or three. For example, "Would you rather look at the pictures about the test you will be having or have me show your dolly about the test?" is a choice preschoolers can make. Parents continue to provide support for this age group and can be helpful participants in the teaching-learning session. The use of play, active participation, and sensory experiences work well for this age group. Physical and visual stimuli are better than verbal ones since the language ability of the preschooler is limited.

Teaching school age children

School age children between age 6 and 12 are capable of logical reasoning. They should be included in the patient education process whenever possible, and especially before procedures that affect them.

Explain procedures, as well as the reasons for them, in a simple, logical way, and with confidence and optimism. You should also plan to spend considerable time teaching the parents of school age children. In addition to teaching them about the child's illness and treatment plan, parents may also need information about problems common in this age group, such as behavior disorders, hyperactivity, learning disorders, and enuresis. Any of these problems may produce stress for the child and family and may require extensive teaching to enhance both the parents' and child's understanding of the condition and methods to manage the problem.

Whatever stage of childhood the young patient is in, it is important to keep the child's developmental stage in mind and to encourage parents to foster the child's normal development despite limitations that may be imposed by illness. Table 4 outlines principles that are useful for teaching pre-school and school age children.

Table 3.4

Principles for Teaching Pre-Schoolers And School Age Children
• Children learn best through their senses; choose learning activities that stimulate many senses • Learning activities should be interesting and meaningful; select activities that create enthusiasm and interest • The child's learning is enhanced through the use of concrete materials; teaching should move from the concrete to theabstract as appropriate • Consider the child's developmental level, experiences, interests, and abilities • When possible, give the child something to keep or to take home • Activities such as games, role playing, showing items and objects, using puppets and artwork, and telling stories and reading books are appropriate for this age group *Source: Hooper, J.I. (1998). "Health education." In: Edelman, C.L.,& Mandle, C.L. Health Promotion Throughout the Lifespan, 4thed. St. Louis: Mosby, 222-227.*

Teaching adolescents

Adolescence is a distinct stage that marks the transition between childhood and adulthood. Adolescents are capable of abstract reasoning. Although you may still include the family in education, adolescents themselves are a major focus of teaching since they have considerable independence and are, consequently, in more control of the degree to which recommendations will be carried out.

Adolescents have many important developmental tasks to achieve. They are in the process of forming their own identity, separating themselves from parents, and adapting to rapidly changing bodies. Bodily changes at puberty may cause a strong interest in bodily functions and appearance. Sexual adjustment and a strong desire to express sexual urges become important. Adolescents may have difficulty imagining that they can become sick or injured. This may contribute to accidents due to risk taking or poor compliance in following medical recommendations. Because adolescents have a strong natural preoccupation with appearance and have a high need for peer support and acceptance, health recommendations that they view as interfering with their concept of themselves as independent beings may be less likely to be followed.

As sexual adjustment and strong sexual urges characterize this age, the nurse may do significant teaching about sex education and contraception. In addition to teaching adolescents about why and how their bodies are changing, the nurse is also in a good position to dispel misconceptions young patients may have about sexual development or sexual behavior.

Teaching adolescents about sexuality requires a special sensitivity and understanding. Respect for the patient's modesty, privacy, and opinions are critical to establishing an atmosphere of openness and trust. In addition to sex education, other important patient teaching areas are alcohol and drug abuse and general health measures, such as the importance of good nutrition and exercise as the basis for life-long health.

Regardless of the topic, health education for adolescents is more effective when the nurse establishes trust by respecting the adolescent's needs, shows empathetic understanding, and answers questions honestly.

Patient teaching for adolescents should take the form of guidance rather than lecturing. Nurses who gain credibility with an adolescent patient establish themselves as the teen-ager's advocate rather than representatives of the parents. The nurse may increase health teaching effectiveness by including the family. The nurse can give guidance and support to family members that can help them understand and respect adolescent behavior. Parents should be encouraged to set realistic limits for adolescents while still allowing them to become increasingly responsible for their own health care management.

To the extent possible, children of all ages should be included as much as appropriate for their age level in the teaching process. With the exception of adolescents, however, in most instances it is the child's parent or parents who will be supervising the degree to which the treatment regimen or recommendations for prevention are followed. Therefore, the nurse conducting patient teaching must establish rapport not only with the child as a patient but with the parents as well.

In preparation for teaching both the child and parent, the nurse should assess the quality of the relationship between parent and child. Some parents are open and honest with their children and foster independence. Other parents provide structure and guidance while allowing the child latitude to make some choices of his or her own. Still other parents are less flexible and allow their children little participation in the process. In other instances, parents provide little structure or guidance, enforcing no rules and essentially abandoning the child emotionally.

The approach to patient teaching the nurse takes in each of these situations differs depending on each unique parent-child relationship. It is important to remember that instead of judging the relationship, the nurse should use whatever relationship exists as a starting point for teaching.

Teaching young adults

The developmental tasks of young adults include establishing and managing a home, becoming established in an occupation or career, and starting a family. All of these changes can be sources of stress. Health teaching topics that the nurse may become involved in include stress reduction, health maintenance and promotion, and for some young adults, marital adjustment, prenatal teaching, and child-rearing practices.

When teaching young adults who are preparing to be parents, the nurse should focus on normal physical and emotional changes associated with pregnancy, sexual activity during pregnancy, preparation for the newborn, diet counseling, preparation for the parenting role, and the process of birth, including procedures during labor, delivery, and the postpartum period.

Important nursing activities for young adults include teaching risk factors for future disease, teaching how to alter lifestyles to decrease risk, and finding opportunities for health promotion in the many types of settings where nurses work with young adults.

Teaching adults in midlife

Midlife serves as a transition period between young adulthood and later years. During middle adulthood, many individuals have reached the peak in their careers. Because people at mid-life are often confronted with recognizing their own physical changes and their parents' declining health, middle aged people may become especially aware of their own goals and values and their own mortality. This realization may either motivate the person to follow recommendations more closely or, if the prospect of mortality is especially threatening, to deny illness or abandon health promotion and prevention practices. During this period, nurses can clarify misconceptions about menopause for both women and men. Patients in this age group are also often open to learning about risk factor reduction for future disease.

Teaching older adults

Health promotion is an important activity throughout the life span. Older adults are not too old to stop smoking, start exercising, or change their diets. One of the greatest challenges is to dispel misconceptions about health promotion among older adults.

It is important for the nurse to understand normal physiological changes that occur with age and to know how to adapt teaching strategies to accommodate for normal aging changes.As chronic illnesses become more prevalent after the fifth or sixth decades of life, a majority of health teaching for older adults focuses on illness and disease management.

Older people are often coping with varying types of loss, including the loss of a spouse, life-long friends, and individual physical capabilities. It is important to interact with each elderly patient as a unique individual, capable of learning and changing.

Patient teaching for older people should be delivered with the same enthusiasm and conviction with which it is provided to younger patients. In addition to specific disease issues or treatment recommendations, many older adults are interested in sexuality and aging, exercise, nutrition, and other topics related to preventing illness and promoting quality of life. The older patient's barriers to independence should be assessed to help him or her find ways to maximize strengths and promote independence. The nurse is often in an excellent position to help patients follow medical recommendations by providing information, considering patients' individual needs, building an awareness of community services that can help lessen social isolation, and helping them maintain their independence.

Learning capacity usually remains at an efficient level well into the 80s. In fact, the inability to absorb new information may be the first indication of a subclinical disease process in an aging person. Instead of using stereotypical modifications, such as shorter sessions or a slower pace, make sure to assess each older person individually. Although ill elderly learn with difficulty, many older people require no modification in teaching strategies. It is important to give all older learners a chance to show their inquisitiveness and lifelong experience.

Assessing learning needs for the older adult

During all phases of the teaching-leaning process (including assessment, planning, implementation, and evaluation), you should focus your attention not just on the existing medical problem, but also on the potentially numerous functional and psychosocial problems that are common to old age. A detailed history is a critical part of the assessment. If the patient is not a reliable informant, a family member or significant

other should be included. Besides the medical history, a comprehensive social history can identify potential problems with the home environment, support systems, financial resources, and various stresses that may be contributing to the medical problem. An accurate diet history is especially important if the patient is being placed on any kind of diet restriction. It is good practice to ask the elderly patient to bring in all medications, both prescription and over-the-counter, for complete evaluation.

With advancing age, there is a corresponding normal decline in sensory function, including vision, hearing, and touch. Two-thirds of the frail elderly have vision and hearing deficits. In addition, there is a normal decline in physical dexterity and endurance. Eighty percent of people over 65 have some form of chronic disease. The effects of chronic diseases, together with the normal changes that occur with aging, may impede learning.

Doing a psychosocial assessment also yields important information about the patient's ability to follow a recommended treatment plan. There are many reasons why an elderly patient may not follow a treatment plan. The patient may not see that the medical regimen is pertinent to his or her well-being. The patient may simply not choose to make lifestyle changes and instead choose to continue long-standing habits and patterns. The patient may choose not to accept a new treatment regimen based on his or her perceptions of quality vs. quantity of life. Finally, the patient, although willing, may be unable to carry out treatment recommendations. The single most important issue in health care management for many people of advanced age is that of personal resources, including the presence of a support person or caregiver in the home, adequate finances, availability of transportation, and a safe and accessible home environment.

The following patient situations illustrate these issues:

- A 67-year-old patient with a new diabetic diet had received days of planned teaching. When asked what she would make for breakfast the day after she returned home, she said that she planned to make her husband and herself a big plate of sausage, gravy, and biscuits. In this situation, the nurse did not probe deeply enough to learn what foods she usually prepared and whether she intended to change her cooking habits.
- A 69-year-old patient was discharged home after demonstrating step by step daily dressing changes from healing burns on his lower legs.

When the patient returned to clinic visits, the burns were not healing as expected. It was then learned that he had no plumbing in his home and no access to a bathtub. Obviously, everyone assumed that the patient had bathing facilities and that if he did not, he would tell them.

- A 74-year-old patient was admitted for control of her diabetes. She was not able to correctly draw up and give insulin because of functional hand limitations due to arthritis. The patient stated that she was confident that her 80-year-old sister, with whom she lived, was all the support she would need. However, the home health nurse found on the first home visit that the sister was blind. This situation shows the importance of verifying that an adequate support system is in place.

Teaching strategies to consider for older adults

Consider using specific teaching techniques when providing health teaching for older people. Some elders have increasing difficulty understanding complex sentences, are less proficient than younger people in drawing inferences, and have problems with motor tasks.

Present new information at a slower rate than you do for younger patients. Speak in a low tone of voice and allow enough time for the patient to assimilate and integrate conceptual material. Allow plenty of time for the assimilation and integration of conceptual material, and emphasize concrete rather than abstract material.

It is important to reduce environmental distractions, both to compensate for any age-related hearing loss and to help the patient with attention and concentration. Group teaching may help some elderly patients increase their health-related problem solving abilities.

When suggesting lifestyle changes, be aware that many elderly patients are cautious and may not make changes easily. The implications for patient teaching are that we must take more time in teaching and that we should deliver the educational materials in small increments so that the material can be integrated.

In order for the teaching-learning plan to be effective, it must be individualized to fit the needs and lifestyle of the older patient, and in order for goals to be mutually acceptable, the patient must participate actively in goal setting.

The ability to comply with expected behavioral changes depends heavily on the changes being perceived as important by the patient, the

changes being able to fit into the patient's lifestyle, and the availability of adequate resources.

In planning patient teaching for an elderly person, goals must be must be individualized not only in accordance with what the patient needs, but with what he or she chooses to do. For example, an 84-year-old patient with COPD and the nurse may agree that to be less short of breath is a goal. The nurse can then plan a teaching program designed to help the patient feel less breathless and can tie interventions such as pursed lip breathing, exercise, activity planning, medications, and nutrition to this one goal.

Compensating for impairments that interfere with learning

If the elderly patient has impaired vision, use adequate diffused light, and avoid having the older patient face a direct source of light. If the patient has prescription glasses, make sure they are being worn, and use large print for labels and instructions. To compensate for hearing loss, use a low-pitched voice, speak clearly and slowly, and face the patient while talking.

Encourage the patient who has a hearing aid to use it. Ask the patient questions to verify that he or she has understood what you have said, and give written information as backup to what you've presented orally.

To compensate for limited endurance, keep teaching sessions short-no more than 10 to 15 minutes-and schedule them to allow the patient rest as needed.

During the teaching of any activity or skill, the pace must be set by the patient.

Remember that musculoskeletal and nervous system limitations result in joint stiffness and reduced reaction time. These changes affect the performance of simple tasks such as opening a medicine bottle, as well as complex tasks such as transferring from chair to bed. Never rush the older person and do not set time limits on task performance.

With advancing age, a person's memory is better for information that is heard than it is for information that is seen. Therefore, an older person is more likely to remember information he or she hears than information that he or she reads. To increase learning for a patient with memory loss, repeat the message frequently, and question the patient regularly to

determine the level of retention. Pay particular attention to the language you use. Select clear, simple, terminology, and talk on the patient's level. Some elderly patients are highly educated and will prefer that you use and explain medical terminology; others will prefer that you keep interactions short and simple. Be sure to avoid making assumptions about terms, and help the patient problem solve what to do if instructions can't be followed for any reason. For example, if a patient is taking a medication "before meals," what happens if the patient doesn't eat-should the drug be taken anyway or skipped until before the next meal?

Keep in mind that return demonstrations are important for elderly patients to ensure that they are able to do psychomotor skills independently. For example, one patient was given instructions for an inhaler, but was not asked to do a return demonstration and didn't know that the cover should be removed from the inhaler before using it. As a result, she didn't get the intended therapeutic effect from inhaled medication. Another patient was discharged home in a wheelchair. The physical therapist showed his elderly wife how to do a car to wheelchair transfer, but never asked her to return demonstrates. When they arrived home, the wife was unable to help the patient out of the car, nor was she able to manage and manipulate the wheelchair in the home because she had never had the opportunity to practice these techniques.

Help your older patients and their families with information about how to obtain resource information. Some older patients can access Internet Web sites on their own as sources of health information. In other instances, children and grandchildren may wish to take on the task of locating resource materials on the Internet.

Conclusion

In order to plan and implement individualized approaches to health teaching, the nurse must take age and developmental level into account.

When working with children, you must assess cognitive and psychosocial development. This will influence the level of the teaching strategies chosen and help identify whether parental or peer involvement would facilitate learning.

If psychomotor skills are part of the learning need, you must determine whether the child has enough physical maturation to realistically perform the skill.

When assessing an adult, emphasis on the developmental stages is different than when assessing a child.

The average adult possesses cognitive capacities to learn, so assessing the precise level of cognition becomes less important. Is important to assess current knowledge about the content area. Assess physical skills by focusing on past experience with skills and the adult's feelings about manipulative competencies. This helps to determine the amount and type of practice that will be needed to master psychomotor skills.

Assessment of older adults needs to focus on the physical changes experienced by a given individual. Psychosocial assessment is also important in working with adult age groups. In working with the elderly patient, you may feel overwhelmed trying to teach a patient and family when the frail elderly person may have multiple medical problems and more than 10 medications, and is dependent in several activities of daily living. Yet these patients and families need the most education and support you can provide. Through careful assessment of developmental factors, selection of teaching strategies that are age-appropriate, and compensation where needed to overcome normal deficits seen with aging, you can plan and implement effective patient teaching.

Activity: case study

Case 1. Teaching parents of infants (an example)

«I am Mr. Greenfield, a chief of the hospital. We will open the school for parents of infants. Give me a plan of sessions including typical topics for infant development teaching. What teaching methods and teaching materials will you use»?

Short characteristic of the age group	Typical topics for infant development teaching	Teaching methods
Infancy is the time from birth to the first 12 to 18 months of life. During this time, the infant is totally dependent on others to meet basic needs.	Teaching parents about: • the need for immunizations, • infant stimulation, • infant feeding, • safety issues, • teething. • normal infant development	Teaching methods • Small group discussions and support groups • Demonstration and return demonstration • Role-playing • Programmed instruction Teaching Materials • Pamphlets and brochures

Short characteristic of the age group	Typical topics for infant development teaching	Teaching methods
		• Posters and flip charts • Videos and closed circuit television • Computer – assisted instruction – Internet, CDs • Transparencies

Case 2. Teaching toddlers

«I am Mr. Greenfield, a chief of the hospital. You know that there is a school for parents in our hospital. The next session we plan to teach parents of toddlers. Give me a plan of session to teach parents of toddlers. Pay attention to typical topics for teaching toddlers. Think about teaching methods and teaching materials».

Short characteristic of the age group	Typical topics for teaching toddlers	Teaching methods

Case 3. Teaching pre-school children

«I am Mrs. Green. Unfortunately, I missed your class in the school for parents. I have a son of 4 ages. He used to fantasize and is quite vulnerable to fear of pain and bodily harm. Would you be so kind to tell me briefly what topics I should focus on teaching my son? What stimuli are better - physical and visual stimuli or verbal ones»?

Short characteristic of the age group	Typical topics for parents of pre-school children include	Teaching methods

Case 4. Teaching school age children

«I am Mrs. Kristy. My son is 10. He has many problems, such as behavior disorders, hyperactivity and enuresis. All these problems have produced stress for the family. Our family needs extensive teaching to

enhance both the parents' and child's understanding of the condition and methods to manage the problem. Tell me, please, what principles for Teaching School Age Children does our family need»?

Short characteristic of the age group	Typical topics for school age children	Teaching methods

Case 5. Teaching adolescents

«I am Mrs. Green. My son is 14. Bodily changes at puberty have caused his strong interest in bodily functions and appearance. I feel his strong desire to express sexual urges. There is no rapport in the family and I am lack of competence to tell him about why and how his body is changing and about sex education and contraception. Who can help me»?

Short characteristic of the age group	Typical topics for Teaching adolescents	Teaching methods

Case 6. Teaching young adults

«I am Mrs. Green. This is my husband. We are preparing to be parents and would like to know typical topics for teaching young adults who are preparing to be parents».

Short characteristic of the age group	Typical topics for teaching young adults	Teaching methods

Case 7. Teaching adults in midlife

«I am Mrs. Green. I am 50 now. I am afraid of menopause. Where can I get information about it and risk factor reduction for future disease»?

Short characteristic of the age group	Typical topics for adults in midlife	Teaching methods

Teaching older adults

Case 8. Teaching older adults

You are the physical therapist. You ask your college to answer the question «What did you do wrong in the next case»? - «I showed patient`s elderly wife how to do a car to wheelchair transfer. When they arrived home, the wife was unable to help the patient out of the car, nor was she able to manage and manipulate the wheelchair in the home. So she called to the chief of the department and accused me in low competence».

Short characteristic of the age group	Typical topics for teaching older adults	Teaching methods

Just checking

1. What do you must consider to provide effective patient teaching? Why?
2. List specific developmental issues of each age group.
3. Is teaching approach for teaching infants, school aged children and young adults one and the same? Why?
4. Describe teaching strategies to consider for older adults.

5. Process of patient education

Learning outcomes

After completing this unit you should know:

- Assessing learning needs
- Developing learning objectives
- Planning and implementing patient teaching
- Evaluating patient learning
- Documenting patient teaching and learning

Introduction

The process of patient teaching refers to the steps you follow to provide teaching and to measure learning. The steps involved in the teaching-learning process are:

- Assessing learning needs
- Developing learning objectives
- Planning and implementing patient teaching
- Evaluating patient learning
- Documenting patient teaching and learning

Assessing learning needs

Your first step in the process of patient teaching is assessing the patient's learning needs, learning style, and readiness to learn. Assessment includes finding out what patients already know, what they want and need to learn, what they are capable of learning, and what would be the best way to teach them.

Begin the process by interviewing the patient.

First, find out more about the patient as an individual and what his life is like. Questions you might ask include:

- Tell me what an average day is like for you
- How has your average day changed since you've been sick?
- What do you like to do in your spare time?
- Tell me about your family
- Tell me about your work

Second, start assessing the patient's learning needs. Questions you might ask include:

- What are you most concerned about?
- What are your goals for learning how to take care of yourself?
- What do you feel you need to know to achieve your goals?
- What specific problems are you having?
- What do you know about your condition?
- What are you most interested in learning about?
- How will you manage your care at home?

Third, find out what the patient's learning style is so you can match teaching strategies as closely as possible to the patient's preferred learning style. Questions you might ask to determine the patient's learning style are:

- What time of day do you learn best?
- Do you like to read/what types of books or magazines do you enjoy reading?
- Would you prefer to read something first, or would you rather have me explain information to you?
- Do you learn something better if you read it, hear it, or do it hands on yourself?

Forth, gather information about the patient's readiness to learn. Questions you might ask include:

- How do you feel about making the changes we've discussed?
- What changes would you like to work on now?
- Are there any problems that would prevent you from learning right now?

After you've talked with the patient, interview the family. Conversations with the patient's family can fill in missing information, change your understanding of what you've heard from the patient, or affect your view of what the patient's home situation might be. Do family members ask to be present during teaching, and when teaching occurs, do they actively participate? Do they seem supportive of the patient's need to change health behaviors and to learn new tasks and skills?

You can also consider using checklists and questionnaires to obtain information about learning needs, learning style, and learning readiness. Written materials also help you determine the patient's literacy level and ability to understand written information. Confer with other health care team members. Each health care team member has valuable information about the patient and his or her learning needs and abilities. Collaborating with others who care for the patient can give you-and them-a better picture, allowing all of you to design more effective teaching strategies.

Determining learning needs, preferred learning style, and learning readiness are all requirements included in the Joint Commission on Accreditation of Health Care Organizations (JCAHO) standards for patient and family education. This part of the process begins when an individual, either the patient or the nurse, identifies a need for the patient to learn a new skill or to know more information. If the patient identifies the need-"What exactly will this operation involve?" or "Or how will I handle this when I go home?" he or she is already demonstrating

motivation to learn. If you, rather than the patient, identify the need, your job will be not only to deliver the information in such a way that the patient is able to understand it, but also to demonstrate to the patient why the information is important.

In some instances, there are differences between the patient's and the health professional's view of the need to know. The health professional may perceive the need for information when the patient does not. For example, a pharmacist tries to give the patient information when filling a prescription. The patient's response is: "Oh, I don't need to know that-I trust my doctor. Whatever he ordered is fine. There's no reason I should know all the details." In this example, the best approach may be for the pharmacist to start with why the information is important and explain that the physician depends on the patient to know the information.

Determining learning style involves assessing how patients learn best, when they learn best, and how able they are to learn what they need to know. Finding out whether the patient learns best by hearing, reading, or hands-on learning is relatively straightforward. However, factors such as the patient's educational and literacy levels also need to be considered. Sometimes patients and families may seem uninterested in learning because they don't know what to ask or don't yet realize that they will need information. For example, family members of a patient with a stroke may have never known anyone else with a stroke and thus may have no idea of what to plan for or what to ask. In some instances, nurses and other health professionals may take it for granted that patients have a better understanding of their condition and treatment than they actually do.

During the acute phase of an illness, patients are dependent on health care professionals. Dependency may be a realistic and necessary condition because of physical and psychosocial demands caused by the illness. Available energy is invested in coping with the physiological and psychosocial demands of the illness and the person's focus may be on survival. Readiness to learn, therefore, is limited. Not only is energy diminished, but other distractors such as pain and fatigue are usually present. Learning needs at this time usually focus on diagnostic tests and treatments. These needs are considered short-term learning-the material being learned relates to the present situation and once the situation is over, it is usually no longer necessary to retain it. As the person recovers

and independence increases, he or she progresses to the post-acute or resolution stage of illness.

For most patients, an improving physical condition and the desire to return to normalcy acts as an incentive to learn how to recognize, prevent, and manage complications. Due to short hospital stays, much of the patient's learning readiness for management and prevention of further problems will take place in an out-patient or a home setting.

Developing learning objectives

The second step in the patient education process is to develop learning objectives. To develop objectives, you need to define the outcomes you and the patient expect from the teaching-learning process. Unlike goals, which are general and long-term, learning objectives are specific, attainable, measurable, and short-term. For example, for a newly diagnosed diabetic patient, the overall learning goal may be to learn how to maintain blood glucose levels between 70 and 150 mg/dl at all times. Reaching such a goal may be overwhelming unless it's broken down into specific, short-term behavioral objectives that lead up to the overall goal. For this patient, an objective such as "After this session, the patient will be able to list five symptoms of hypoglyemica" is one step on the way to the larger goal.

A simple and practical way of developing learning objectives is to start with the words WHO, DOES, WHAT, HOW, and WHEN. For example, the objective "The patient will list five signs of hyperglycemia by time of discharge" could be broken down this way:

- WHO - the patient
- DOES - will list
- WHAT - five signs of hyperglycemia
- HOW - accurately or by stating out loud
- WHEN - by discharge

Make sure in writing objectives that you use action words that are measurable such as *list*, *state*, *explain*, and *demonstrate*. Avoid using terms that cannot be measured or observed easily, such as understand or appreciate.

Planning and implementing teaching

The next step in the process is to plan and implement an individualized

teaching plan. Your teaching plan should include what will be taught, when teaching will occur, where teaching will take place, who will teach and learn, and how teaching will occur. Deciding what will be taught is a decision you and the patient need to make together. Although you begin as the content expert, your goal is to make your patient as competent as he needs to be to manage his or her own health care needs. Start by looking at the information that the patient needs to know and distinguish between what the patient "needs to know" and what is "nice to know." Start with the "need to know" information and let the patient select where he or she wants to start.

Plan when you will teach, taking the length of hospital stay or number of home health visits available into account. Let the patient tell you what works for him or her and offer as many options as are realistic. Does the patient prefer mornings or have more energy in the evening? Does he or she like short sessions or longer, more in-depth sessions? As you implement your plan, assess how quickly the patient can learn information. During teaching sessions, ask the patient to tell you when he or she is tired and watch for signs of fatigue such as yawning, inability to concentrate, or inattentiveness. Keep teaching sessions relatively short-generally no more than 30 minutes and possibly as short as five minutes. Plan on being able to grab those precious "teachable moments" when the patient is ready to learn-even when it means throwing your planned timetable out the window.

Plan where you will teach, including considering both comfort and privacy. If the patient may become upset or you must ask intimate questions, find an empty room, wait until the patient's roommate has left for a while, or use an empty treatment room or office. Whatever setting you use, make sure you try to limit distractions and interruptions. Plan who will teach and who will learn. Will you be the primary teacher or will other health care professionals be involved? Former patients who have been through a similar experience can be helpful. You may be teaching people other than the patient, such as a spouse, another caregiver, or a friend or neighbor.

Plan how you will teach. Use data from your assessment about the patient's preferred learning style to select the method. Remember that global learners like to understand the big picture first and work down to

the details. Linear learners want the details first and then expect a bigger picture to emerge. As an example, when teaching a global learner how to do home blood glucose monitoring, you might start with the overall purpose of monitoring and then go on to details. If your patient is a linear learner, start with the first procedure that patient needs to know to operate the machine and end with the bigger picture. If your patient indicated on the assessment that he or she is a visual learner, select teaching materials that involve reading, writing, and watching visual media such as videotapes and slides. Auditory learners need to hear information via spoken explanations and audiocassettes, and they may remember information better in pamphlets if they hear it read aloud. Tactile learners must touch, manipulate, and perform a task to learn. Tactile learners often remember more when they can touch and handle equipment, and they may recall written information best by underlining or highlighting. Table 5 shows some of the teaching methods and materials you may use, depending on the patient's preferred learning style and which methods and materials are most appropriate for specific situations.

Table 3.5

Examples of Methods and Materials
Teaching methods • One-on-one sessions • Small group discussions and support groups • Demonstration and return demonstration • Role-playing • Games • Programmed instruction **Teaching Materials** • Pamphlets and brochures • Posters and flip charts • Videos and closed circuit television • Computer – assisted instruction – Internet, CDs • Audiocassettes • Transparencies • Models *Source: Boyd, M.D. (1998). "Strategies for effective health teaching." In: Boyd, M., et al. Health Teaching in Nursing Practice, 3rd ed. Stanford, Conn.: Appleton & Lange, 201-228.*

Whenever possible, select interactive teaching methods that use as many senses as possible. Keep in mind that patients remember approximately 10 percent of what they read, 25 percent of what they hear, 45 percent of what they see, 65 percent of what they hear and see, 70 percent of what they say and write, and 90 percent of what they say as they perform a task.

Evaluating teaching and learning

Evaluation, the last phase of the teaching process, is the ongoing appraisal of the patient's learning progress during and after teaching. The goal of evaluation is to find out if the patient has learned what you taught.

Here are some ways you can evaluate learning:

Observe return demonstrations to see whether the patient has learned the necessary psychomotor skills for a task.

Ask the patient to restate instructions in his or her own words.

Ask the patient questions to see whether there are areas of instruction that need reinforcing or re-teaching.

Give simple written tests or questionnaires before, during, and after teaching to measure cognitive learning.

Talk with the patient's family and other health care team members to get their opinions on how well the patient is performing tasks he or she has been taught.

Assess physiological measurements, such as weight and blood pressure, to see whether the patient has been able to follow a modified diet plan, participate in prescribed exercise, or take antihypertensive medication.

Review the patient's own record of self-monitored blood glucose levels, blood pressure, or daily weights.

Ask the patient to problem solve in a hypothetical situation.

Documenting patient teaching

Your documentation of patient teaching should take place throughout the entire teaching process. Documentation is done for several purposes. Documentation promotes communication about the patient's progress in learning among all health care team members. Good documentation helps maintain continuity of care and avoids duplication of teaching.

Documentation also serves as evidence of the fulfillment of teaching requirements for regulatory and accrediting organizations such as the JCAHO, provides a legal record of teaching, and is mandatory for obtaining reimbursement from third party payers. Documentation of patient teaching can be done via flow-charts, checklists, care plans, traditional progress notes, or computerized documentation. Whatever the method, the information must become a part of the patient's permanent medical record. Table 6 shows suggestions on what to document and how.

Table 3.6

Documenting Patient Teaching
What to document • The patient's learning needs • The patient's preferred learning style and readiness to learn • The patient's current knowledge about his or her condition and health care management • Learning objectives and goals as determined by both you and the patient • Information and skills you have taught • Teaching methods you have used, such as demonstration, brochures, and videos. • Objective reports of patient and family responses to teaching • Evaluation of what the patient has learned and how learning was observed to occur **How to document** • Record the patient's name on every page of your documentation. • Include the time and date on all entries. • Sign each entry. • Write in black or blue ink, for legal and reproduction purposes. • Write legibly. • Be accurate and truthful when discussing facts and events. • Be objective-don't show personal bias or let others influence what you write. • Be specific. • Be concise-record information succinctly, without compromising accuracy. • Be comprehensive-include all pertinent information. • Record events in chronological order. *Source: Rankin, S.H., & Stallings, K.D. (1996). Patient Education: Issues, Principles, Practices, 3rd ed. Philadelphia: Lippincott-Raven, 233-236.*

Activity: case study

Case study: Make a process of patient education

You are GP. You have been asked by the chief of the department to make a process of patient education for a newly diagnosed diabetic

patient. She is 45 years of old business - woman. She is too busy to get knowledge about diabetic and risk factors. You see that she has to change her behavior to prevent bad consequences. You should make a process of this patient education.

Assessing learning needs

Steps	Questions
Find out more about the patient as an individual and what his life is like	
Assessing the patient's learning needs	
Find out what the patient's learning style is	
Gather information about the patient's readiness to learn	
Interview the family	

2 Developing learning objectives

- Who - ?
- Does -?
- What -?
- How - ?
- When - ?

3 Planning and implementing teaching

Questions	Answers
What will be taught	
When teaching will occur	
Where teaching will take place	
Who will teach and learn	
How teaching will occur	

4 Evaluating teaching and learning (ways to evaluate learning)

Case study 2.

Role-player's brief (for GP)

You have a newly diagnosed diabetic patient. She is 39 years of old. Make an a**ssessment:**

what patient already knows,

what she wants and needs to learn,

what she is capable of learning,

what would be the best way to teach her.

Role-player's brief

You are Ms Kay Trench, a 39-year-old primary school teacher.

You are single now. But you are going to be married in 6 months. You love children and plan to have three.

You currently live with your parents and three brothers and you are close to your family.

You have not taken any regular medication except in the last 3 months.

You have noticed some weight change but have always been chubby. You have not noticed any symptoms.

You smoke, and drink alcohol socially on occasions.

You are worried about the result of the diagnostic.

You are extremely upset about learning of the diabetes, especially when you are to be married and plan to have children.

You don`t know how to plan an appropriate diet.

You don`t know how to inject insulin

Prompt questions

What are the consequences of the diabetes, doctor?

Why has this happened to me?

Is there no way for me to have children in the future?

What are the risks of the hypoglycemia or hyperglycemia?

What are the risks and side-effects of radiotherapy?

Just checking

1. How many steps are there in the teaching-learning process? What are they?

2. What does assessment include? How many steps? What are they?

3. What steps does planning and implementing teaching include?

4. What teaching methods and teaching materials can you use in patient education?

6. Impact of culture on patient education

Learning outcomes

After completing this unit you should know:

1.Impact of culture on patient education

- How culture influences health beliefs
- Doing a cultural assessment
- Cultural negotiation
- Using interpreters in health care
- Non-English speaking patients
- A model of care for cultural competence.

2. Helping patients who have low literacy skills

- Helping patients who have low literacy skills: introduction
- Designing low literacy materials

1. Impact of Culture on Patient Education

Introduction

Culture refers to characteristic patterns of attitudes, values, beliefs, and behaviors shared by members of a society or population. Members of a cultural group share characteristics that distinguish them from other groups. Cultural differences will affect the receptivity of a patient to patient education and willingness to accept information and incorporate it into his or her lifestyles. It is important to remember that every patient education interaction has a cultural dimension.

Culture is a way of living, thinking, and behaving. Culture is learned within the family and guides the ways we solve problems and live our daily lives. Ethnicity is closely related to culture, although ethnicity usually refers to a particular cultural group or race that interacts and has common interests. Often there is as much diversity within ethnic groups as between them. For example, Hispanics are often classified as an ethnic group; however, there are enormous differences between Spaniards, Cubans, and Mexicans.

Culture includes many elements, including language, customs, beliefs, traditions, and ways of communicating. Another way of defining culture is to describe is “as the way things are done around here.”

Cultural competence refers to a set of congruent behaviors, attitudes, and policies that enables nurses and other health care professionals to work effectively in cross-cultural situations. As you acquire increasing cultural competence, you become more effective in helping patients of many cultures.

How culture influences health beliefs

All cultures have systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient education as having cultural relevance for them can have a profound effect on their reception to information provided and their willingness to use it. Western industrialized societies such as the United States, which see disease as a result of natural scientific phenomena, advocate medical treatments that combat microorganisms or use sophisticated technology to diagnose and treat disease. Other societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed disfavor of powerful forces. *Cultural issues play a major role in patient compliance.* One study showed that a group of Cambodian adults with minimal formal education made considerable efforts to comply with therapy but did so in a manner consistent with their underlying understanding of how medicines and the body work.

Asians/Pacific Islanders are a large ethnic group in the United States. There are several important cultural beliefs among Asians and Pacific Islanders that nurses should be aware of. The extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honor of the family are more important than those of individual family members. Older family members are respected, and their authority is often unquestioned. Among Asian cultures, maintaining harmony is an important value; therefore, there is a strong emphasis on avoiding conflict and direct confrontation. Due to respect for authority, disagreement with the recommendations of health care professionals is avoided. However, lack of disagreement does not indicate that the patient and family agree with or will follow treatment recommendations. Among Chinese patients, because the behavior of the individual reflects on the family, mental illness or any behavior that indicates lack of self-control may produce shame and guilt. As a result, Chinese patients may be reluctant to discuss symptoms of mental illness or depression.

Some sub-populations of cultures, such as those from India and Pakistan, are reluctant to accept a diagnosis of severe emotional illness or mental retardation because it severely reduces the chances of other members of the family getting married. In Vietnamese culture, mystical beliefs explain physical and mental illness. Health is viewed as the result of a harmonious balance between the poles of hot and cold that govern bodily functions. Vietnamese don't readily accept Western mental health counseling and interventions, particularly when self-disclosure is expected. However, it is possible to accept assistance if trust has been gained.

Russian immigrants frequently view U.S. medical care with a degree of mistrust. The Russian experience with medical practitioners has been an authoritarian relationship in which free exchange of information and open discussion was not usual. As a result, many Russian patients find it difficult to question a physician and to talk openly about medical concerns. Patients expect a paternalistic approach-the competent health care professional does not ask patients what they want to do, but tells them what to do. This reliance on physician expertise undermines a patient's motivation to learn more about self-care and preventive health behaviors.

Although Hispanics share a strong heritage that includes family and religion, each subgroup of the Hispanic population has distinct cultural beliefs and customs. Older family members and other relatives are respected and are often consulted on important matters involving health and illness. Fatalistic views are shared by many Hispanic patients who view illness as God's will or divine punishment brought about by previous or current sinful behavior. Hispanic patients may prefer to use home remedies and may consult a folk healer, known as a curandero.

Many African-Americans participate in a culture that centers on the importance of family and church. There are extended kinship bonds with grandparents, aunts, uncles, cousins, or individuals who are not biologically related but who play an important role in the family system. Usually, a key family member is consulted for important health-related decisions. The church is an important support system for many African-Americans.

Cultural aspects common to Native Americans usually include being oriented in the present and valuing cooperation. Native Americans also place great value on family and spiritual beliefs. They believe that a state of health exists when a person lives in total harmony with nature. Illness is viewed not as an alteration in a person's physiological state, but as an

imbalance between the ill person and natural or supernatural forces. Native Americans may use a medicine man or woman, known as a shaman.

As can be seen, each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices differ from those of the traditional American health care culture. Unfortunately, the expectation of many health care professionals has been that patients will conform to mainstream values. Such expectations have frequently created barriers to care that have been compounded by differences in language and education between patients and providers from different backgrounds.

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making.

Cross-cultural variations also exist within cultures. Strategies that you can use in working with patients from different cultures as displayed in Table 3.7.

Table 3.7

Strategies for Working With Patients In Cross-Cultural Settings
• Learn about the cultural traditions of the patients you care for. • Pay close attention to body language, lack of response, or expressions of anxiety that may signal that the patient or family is in conflict but perhaps hesitant to tell you. • Ask the patient and family open-ended questions to gain more information about their assumptions and expectations. • Remain nonjudgmental when given information that reflects values that differ from yours. • Follow the advice given by patients about appropriate ways to facilitate communication within families and between families and other health care providers. *SOURCE: Mc Laughlin, L., & Braun, K. (1998). "Asian and Pacific Islander cultural values: Considerations for health care decision-making." Health and Social Work, 23 (2), 116-126.*

Doing a cultural assessment

Data obtained from a cultural assessment will help the patient and nurse to formulate a mutually acceptable, culturally responsive treatment plan. The basic premise of the cultural assessment is that patients have a right to their cultural beliefs, values, and practices, and that these factors should be understood, respected, and considered when giving culturally competent care. The first step in cultural assessment is to learn about the meaning of the illness of the patient in terms of the patient's unique culture. Table 3.8 shows questions to ask during a cultural assessment.

Table 3.8

Questions to Ask During a Cultural Assessment
• What do you think has caused your problem? • Why do you think it started when it did? • How severe is your illness? Will it have a long or short course? • What kind of treatment do you think you should receive? • What are the most important results you hope to get from this treatment? • What are the chief problems your illness has caused for you? • What do you fear most about your illness?
Source: Rankin, S.H., & Stallings, K.D. (1996). Patient Education: Issues, Principles, Practices, 3rd ed. Philadelphia: Lippincott-Raven, 69.

By asking the patient and family these questions you can obtain valuable information needed for a teaching plan. It is important to remember that the patient's personal interpretation of the illness experience is more significant than your view of the disease. Health care providers should teach from a position of mutual understanding and collaboration rather than trying to impose traditional Western or Eastern medical practices that are unlikely to be effective.

The next step in cultural assessment is to determine how embedded the patient is in his or her traditional culture. Cultural embeddedness refers to how aligned the patient is with the native culture. The extent of the patient's cultural embeddedness has a major influence on health care teaching. Table 9 shows some characteristics of cultural embeddedness.

Table 3.9

Characteristics of Cultural Embeddeness
• How recently did the patient immigrate? • Was the immigration voluntary or involuntary? • Did the patient live in intermediate countries before coming to …? • What country did the patient immigrate from and how different is that culture from this culture? • Who does the patient associate with? • What type of neighborhood does the patient live in? • Does the patient follow traditional dietary habits? • Does the patient wear native dress? • Does the patient leave his neighborhood to participate in the larger culture? • Does the patient use folk medicine or use the practices of a native healer? • Does the patient come from an urban or rural area in the native country?
Source: Rankin, S.H., & Stallings, K.D. (1996). Patient Education: Issues, Principles, Practices, 3rd ed. Philadelphia: Lippincot-Raven, 70-72.

The nurse should also inquire about the process of immigration for the individual patient. For example, what country did the patient immigrate from and how different is the native culture from American culture? Does the patient associate with friends primarily or exclusively from his or her same ethnocultural group? Because moving to a new country and culture is stressful, it is common for newly arrived immigrants to associate only with people with whom they feel comfortable and secure-people who share their own native culture. It is important to remember than the greatest influences on reactions and responses to health care treatment and management may be very unfamiliar to nurses.

Frequently, when immigrants arrive in a new country, they live in an ethnically homogenous neighborhood with people from their same cultural group. Within a generation, immigrants often move to other areas of a city. In the United States, it is possible for immigrants to remain in a community in which the native language is the primary language spoken and newspapers are in this language. A patient who is embedded in the original culture may not have much contact with the predominant cultural group and may present a greater challenge in patient teaching.

Does the patient have traditional dietary habits and wear traditional dress? Traditional dietary habits are often maintained for many generations, while traditional dress is usually given up sooner unless it

is also closely associated with religious beliefs. For example, the dress of Muslim women represents their religious beliefs. Traditional dietary habits should be acknowledged, respected, and incorporated into patient teaching plans. Traditional dietary habits of native peoples are often healthier than U.S. eating habits because there is little use of processed foods or overuse of animal fats. In fact, modifying the patient's native dietary pattern may make a disease like diabetes easier to manage than if the patient ate a typical U.S. diet.

Does the patient live exclusively within his own cultural neighborhood or does he venture out into the larger cultural American experience? Patients whose daily lives are spent within their own culturally defined neighborhoods are usually more culturally embedded than patients who leave the neighborhood are.

Does the patient use folk medicine or engage the services of a traditional healer? Is the patient from an urban or rural area in the country of origin? Immigration from a rural area is associated with less exposure to and knowledge about Western medical practices and the American health care system. This is especially true of rural immigrants from Asian, African, and South American countries.

Knowing the patient's degree of cultural embeddedness helps the nurse to know where to start negotiating with the patient and his or her family to achieve health care goals. Patients who are highly embedded in the native culture are traditional individuals totally committed to their original cultures. People who are less embedded and more acculturated value open communication and ideas from both cultures. Bicultural individuals can move easily between both cultures.

The nurse may observe tension between acculturated children who want older members of the family to take advantage of Western medical practices and older members of the family who wish to follow traditional remedies. The challenge for the nurse in this situation is not to become involved in the transgenerational struggles, but to respect the two positions and allow opportunities for teaching that recognize the importance of both generations.

Cultural negotiation

Once assessment is done, cultural negotiation can take place in terms of agreeing on a treatment regimen that is acceptable to both patient and

provider. The goal of cultural negotiation is to join Western and non-Western beliefs in a way that helps the patient achieve a healthy outcome. For example, a dietitian can use Chinese beliefs about cold (yin) and hot (yang) foods to plan a diabetic diet that is both acceptable to the patient and that helps the patient maintain an appropriate blood sugar level.

In participating in cultural negotiation, nurses can use other health care providers who are from the patient's own cultural group. However, it is important to remember that, if there is a large gap between the beliefs of providers and patients, and if providers are westernized, they may distance themselves or look down on those who hold traditional beliefs. When this happens, the care providers cease to be therapeutic, even though they share a common cultural heritage. It is important to remember that language alone does not ensure cultural understanding. Patients and care providers from the same country may come from different class and social structures and may not always communicate effectively.

The nurse must know when and how to present material so that it respects cultural values. At times, patients are encouraged to learn new ways of approaching care, or when necessary, are helped to accept mandated changes, such as altering parenting skills to change more abusive child rearing practices to those legally acceptable in this culture.

Using interpreters in health care

Language is the foundation for effective nurse-patient relationships and is important for interpersonal and cross-cultural communication. Being able to communicate with a patient is vital for obtaining an accurate and comprehensive patient and family assessment, formulating and implementing a treatment plan, determining the effectiveness of nursing care, and evaluating outcomes of care. As result of dramatic demographic changes in the United States, nurses are increasingly faced with the challenge of communicating with the patient who cannot speak English or speaks English with limited proficiency.

There are important differences between a translator and an interpreter. A translator is a person who can speak English and the patient's native language. However, the translator often does not have equal fluency in both languages and may lose important cultural nuances and meanings. In contrast, an interpreter is a professionally trained person who interprets the

meaning of words and phrases from the health care provider's language to the patient's language and provides the same services on behalf of the patient to the health care provider.

Non-English speaking patients

It is helpful to learn a few words of the patent's language, such as good morning and thank you.

Taking the time to learn a few polite expressions shows an interest in the patient's language.

When you speak to the patient or an interpreter, use standard everyday English. Avoid slang expressions that may not be understood or may be misinterpreted by the patient or the person interpreting.

Use simple words and phrases that are to the point and easily translated. However, using simple words does not mean the same thing as using simplistic words.

Avoid talking to the patient or the interpreter as if they were children. Complete an entire sentence and then allow time for the interpreter to translate. When you stop in mid-sentence, the interpreter may not be able to understand the context of the entire sentence and may provide a confusing or inaccurate translation. Avoid giving long explanations. When the interpreter needs to interpret long speeches, he or she may try to make a synopsis of what you're saying or forget part of the full thought you wish to communicate.

The cultural implications of topics as death, sexuality, childbirth, and women's health are frequently poorly understood by health care professionals, and such topics should be probed with care and respect.

Be careful about making jokes or using humor to convey an English thought into another language. Remember that what is humorous in one language or culture may not be funny in another. What you may consider funny may, in fact, by considered offensive when it is translated. Know the language skills of the interpreter so that you have confidence that both you and the patient are having your ideas translated accurately. While the interpreter is translating what you have said to the patient, position yourself so that you are looking at the interpreter. Keep in mind that the patient is able to read your nonverbal messages. Look at the interpreter, smile occasionally or nod your head in agreement.

If you look through the patient's chart or gaze out the window while the interpretation is proceeding, you may send signals to the patient that you are not interested in the interaction. Table 3.10 shows methods of interpretation:

Table 3.10

Methods of Interpretation
• "Getting by" • Ad hoc interpreters • Volunteer interpreters • Professional interpreters • Telephone language services • Web services
Source: Villarruel, A.M., Portillo, C.J., & Kane, P. (1999). "Communicating with limited English proficiency persons: implications for nursing practice." Nursing Outlook, 47(6), 262-270.

Getting by refers to using facial expressions and gestures, or using a few key words or phrases in the target language. For example, a nurse who "gets by" in Spanish may be able to communicate about a patient's leg pain by understanding the words pierna for leg and dolor for pain. In addition to using a few words in the target language, the nurse may obtain information about the patient's pain by pointing to an area of the body, making grimaces as if in pain. "Getting by" has both advantages and disadvantages. This method allows the nurse to communicate with the patient immediately without having to wait for an interpreter. "Getting by" is effective when only basic information needs to be exchanged. It is often used in emergencies or when no one can be found who speaks the patient's native language. However, the amount and complexity of information that can be obtained is limited, and there is a danger of miscommunication. For example, if the patient is complaining of chest pain, knowing just a few words of the target language will not allow you to assess important aspects about the quality and timing of the pain that may be vital in making a correct diagnosis. Nurses also may use the "getting by" method because they feel that other methods are inconvenient. Sometimes we may also overestimate our basic skills in the target language.

An *ad hoc interpreter* is anyone available who speaks both languages, such as the patient's friends or roommates. Using ad hoc interpreters

has distinct advantages and disadvantages. In addition to being readily available, ad hoc interpreters often share the patient's cultural background and can serve as sources of cultural information between the patient and the health care team. Disadvantages of using ad hoc interpreters include compromising the patient's right to privacy and relying on someone without training as an interpreter. Due to lack of training or experience, ad hoc interpreters may leave out important words, add words, or substitute terms that make communication inaccurate. An example of this involves a young non-English speaking patient who comes to the emergency room with a long and detailed account of an acute episode of flank pain, nausea, and vomiting. The friend with her is used as an ad hoc interpreter. The interpreter tells the health care team that the patient has had back pain, but adds that she complains about back pain frequently. The interpreter also says that the patient has been vomiting, but states that in her opinion, it may be the flu because the patient's husband was vomiting from what appeared to be the flu a few days ago. Thus, through omissions, additions, and opinions, an acute episode of kidney stones could be interpreted as a condition of less importance.

Volunteer interpreters can include the patient's family and health agency employees who are bilingual. Health care professionals and administrators often think that using family and friends as interpreters is more cost-effective than using other methods of translation. However, strong anecdotal evidence suggests patient care and level of satisfaction are negatively affected by this method. Family and friends are not bound by any code of conduct. They may interpret, editorialize, or deliberately withhold information that they feel is embarrassing or that may upset the patient or health care provider. Family members are probably the least desirable source of translators because they may filter what the health care provider is trying to tell the patient. They may also "edit" what the patient is trying to tell the health care provider. Using family members as translators also puts undue stress on both the patient and family member. Because of the high possibility of misinterpretation, don't use a minor child as an ad hoc interpreter except in an emergency.

Volunteer interpreters, usually drawn from a health care agency's own workforce, can offer several advantages. The cost to use employee volunteers is low, and because the volunteer works in a health care

setting, he or she is usually familiar with health-related terminology and procedures. Using volunteer interpreters instead of family or friends lets patients maintain their privacy and control the nature and amount of information shared with family members and friends. Using volunteer interpreters also has some disadvantages. Not all facilities provide training, and the educational, health care, and language backgrounds of bilingual staff who serve as volunteer interpreters vary widely. As a result, they may inadvertently commit errors or violate patient confidentiality. Another disadvantage is that the volunteer interpreter's own work obligations may limit his or her availability.

Professional interpreters have excellent bilingual language skills and are bound by a code of conduct. Such individuals are usually contracted for directly or work with an interpreter agency. However, professional interpretation services are expensive, often costing between $50 and $100 an hour. They may also be unavailable on weekends or holidays or not be able to come in on short notice in an emergency. Some very large hospitals are able to employ professional interpreters or cultural mediators. A cultural mediator not only provides interpretive services, but also interprets cultural and social circumstances that may affect the patient's care.

*Using a telephone language lin*e, an off-site interpreter communicates through a speakerphone or hand held phone. AT& T Language Line Services and Pacific Interpreters Inc. can provide access to interpreters in more than 140 languages, 24 hours a day, seven days a week. Language line interpreters receive training in medical interpreting and are tested for linguistic competency and knowledge of medical terminology. They also sign a code of ethics statement that protects the patient's confidentiality. Agencies contracting with telephone language lines may pay a monthly fee plus a per-minute rate or just a per-minute rate. Such services are particularly useful in scarcely populated areas where there are few other options for interpretation other than the patient's immediate family or close friends. A disadvantage of language line interpretation is that the interpreter must depend on oral language alone. The interpreters cannot see the patient's body language or facial expressions and must depend solely on the content and tone of the conversation. In addition, this type of interpretation is difficult to do when teaching patients how to use equipment or perform a skill.

Written materials and educational programs

There are several issues to consider when translating written materials from English into other languages. Although the natural tendency is to translate materials directly from English into the target language, direct translation doesn't always consider cultural influences and literacy limitations. The words used in an English version may not be appropriate for people of another culture. Keep in mind that many patients don't read well in either English or their native language. It is helpful to ask an interpreter to talk with a sample of the intended population to determine if the instruction needs to be in that language or whether a simplified version in English, which includes lots of illustrations, could meet their needs just as well. If you are designing written materials, have several members from the culture work with you in the overall design and approach. Often, graphics, diet lists, and procedures do not translate with the same meaning in other languages. If you don't have access to other members of the cultural group, look for community resources. A number of community services are becoming available to meet specific translation needs. For example, some churches and community agencies offer translation services.

Ways to communicate when you don't speak the patient's language:

Use pictures, synthetic body models, and demonstrations with actual equipment to get your message across.

Use simulations to show what you are trying to communicate.

Use audiotapes made in the language(s) of your patient population to present routine information such as admission procedures, room and unit orientation, or preoperative procedures.

It's important that the patient has understood what you are communicating. After giving information verbally instead, test the patient's comprehension by asking him or her to show, draw, or communicate with gestures what he or she is supposed to do. Ask the patient to repeat the feedback if there is hesitancy or body language shows uncertainty. Because some patients come from cultures that are very different from ours, it is important not to make assumptions that the patient knows what to do. Some of the most ordinary requests that we make in the health care system are not within the experiences of other cultures. For example, when a non-English patient who failed to fill a prescription was asked

why he didn't take it to be filled, he replied that the prescription was still in his car because he didn't know what to do with it. He had never had a prescription before and had never been to a pharmacy.

Assess who should be included in patient teaching. The assumption in traditional American culture is that each person manages his or her own health care. However, in other cultures the critical decision making is influenced by others, e.g., the godmother, priest, or an outside group such as a council of elders; in those instances, the target audience broadens to include not only the patient but also the significant decision makers. Patients of other cultures also need to be taught to expect health professionals to ask questions about health history. Sometimes patients from other cultures may feel that if the nurse and physician have to ask so many questions, they aren't very competent.

A model of care for cultural competence

The term culturally competent care refers to nursing care that is sensitive to issues regarding culture, race, gender, and sexual orientation. Cultural competence is a process in which the nurse strives to achieve the ability to effectively work within the cultural context of an individual, family, or community from a diverse cultural/ethnic background. Campinha-Bacote proposes a culturally competent model of care that includes cultural awareness, cultural knowledge, cultural skill, and cultural encounters. The components of this model are:

- Cultural awareness
- Cultural knowledge
- Cultural skill
- Cultural encounter

Cultural awareness is the process by which the nurse becomes aware of, appreciates, and becomes sensitive to the values, beliefs, life ways, practices, and problem-solving strategies of other cultures. During this process, you examine your own biases and prejudices toward other cultures as well as explore your own cultural background. Without becoming aware of the influence of one's own cultural values, we have a tendency to impose our own beliefs, values, and patterns of behavior on other cultures. The goal of cultural awareness is to help you become aware of how your background and your patient's background differ.

Cultural knowledge is the process by which you seek out and obtain education about various worldviews of different cultures. The goal of cultural knowledge is to become familiar with culturally/ethnically diverse groups, worldviews, beliefs, practices, lifestyles, and problem-solving strategies. Some of the ways you can acquire knowledge are by reading about different cultures, attending continuing education courses on cultural competence, and attending cultural diversity conferences. The next step, cultural skill, involves learning how to do a competent cultural assessment. Nurses who have achieved cultural skill can individually assess each patient's unique cultural values, beliefs, and practices without depending solely on written facts about specific cultural groups. It is extremely important to remember that each patient you care for, whether born and raised in the United States or not, is a member of a specific cultural group that affects his or her health care beliefs. Therefore, cultural assessments should not be limited to specific ethnic groups, but conducted with each individual patient. Cultural encounter involves participating in cross-cultural interactions with people from culturally diverse backgrounds. Cultural encounter may include attending religious services or ceremonies and participating in important family events. However, it is important to remember that although we may have several friends of different cultural groups, we are not necessarily knowledgeable about the group as a whole. In fact, the values, beliefs, and practices of the few people we encounter on a social basis may not represent that specific cultural group which you provide nursing care for. Therefore, it's important to have as many cultural encounters as possible to avoid cultural stereotyping. Madeleine Leininger, who has done pioneering work in the influence of culture on health care, suggests two guiding principles that nurses can use in caring for patients from many diverse cultures. The first is to maintain a broad, objective, and open attitude about each patient. The second is to avoid seeing all patients alike. By following these principles, we can open ourselves to learning about the way others view health and illness and form relationships that are therapeutic.

Just checking

1. What is Culture? List some definitions of Culture.
2. What elements does Culture include?

3. What is a role of Cultural issues in patient compliance?

4. Do cultural differences affect patients` attitudes about medical care?

5. List strategies for working with patients in cross cultural settings.

6. What is the challenge for the nurse and a doctor in the situation of cross-cultured settings?

7. What are important differences between a translator and an interpreter?

8. List some ways of communication with non-speaking English patients.

9. What are the ways to communicate when you don't speak the patient's language?

10. Describe a model of care for cultural competence. Comment on this model.

11. List two guiding principles that nurses and doctors can use in caring for patients from many diverse cultures.

7. Helping patients who have low literacy skills

Introduction

Did you know that half of the patients and families you teach every day won't be able to understand many of your written teaching materials? The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Hospital Association's Patients' Bill of Rights require that patients have current information about their diagnosis, treatment, and prognosis in terms that patients and families can understand. JCAHO Patient and Family Education Standards specify that health care professionals consider their patient's literacy, educational level, and language in providing health care instruction. Health organizations are now scored on how well their patients understand the safe and effective use of medications and medical equipment, potential food-drug interactions, and when and how to obtain further treatment. Patients are also being discharged home sicker and quicker than in the past, and patients and families are expected to assume more responsibility for health care. Therefore, they must be able to read and understand the health care information we provide them.

However, literacy experts tell us that many of our written patient

teaching materials don't match our patients reading abilities. Patients struggle to understand discharge instructions, consent forms, handouts, and labels on prescription and over-the-counter medications. Many cannot understand important health-related letters or medical forms. Failure to understand directions may lead to missed appointments, noncompliance, and in some cases, disability and death.

Designing low literacy materials

When designing written patient teaching materials, you can use specific techniques to produce materials for patients with low literacy skills.

First, choose short, common words rather than medical terms. For example, use pill instead of medication, eat instead of consume, and weigh instead of measure.

Second, make sure sentences are short-about 10 words in length and written in the active voice. Instead of saying: "Most health care experts believe it is advisable for you to take this medication consistently," write: "You must take these pills every day."

Third, paragraphs should be short and should present one important issue.

Fourth, make the materials easy on the eyes. Type font size should be between 10 and 14 points. Avoid using capital letters, which are harder to read than lowercase letters. Larger fonts are helpful for elderly people and for others with impaired vision. Keep the right margin jagged and not justified (lined up evenly). Reading text is easier when the right margin is not justified because the jagged right edges help distinguish one line from another. Fifth, when describing a procedure, such as giving insulin or taking a pill, place illustrations next to the related ideas in the text.

If you have already purchased or designed materials that are not at the appropriate grade level, you can make them more readable by highlighting points that patients must know, such as how many pills to take, when and how to take them, what symptoms they should call about, and what phone number to call.

Additional tips for teaching patients with low literacy skills include:

• Set realistic objectives. Choose only one or two objectives per teaching session and make sure the objectives state exactly what behaviors are expected. Try to make the objective relevant for the patient, such as

"to help you be able to go back to work by getting your blood sugar under control."

• Focus on behaviors and skills. Having the patient be able to show you how to position himself or herself to prevent a pressure sore is an example of a measurable skill.

• Present the context first, then give new information. Provide the context of the instruction-the part the patient already knows-first. In Teaching Patients With Low Literacy Skills the authors suggest writing "Vegetables with many nutrients are carrots, broccoli, etc.," rather than writing "Broccoli, carrots, sweet potatoes, peas, spinach, cabbage, beets, and squash have many nutrients." In this last example, the reader must remember the entire list with no framework or context. By the end of the sentence, it is likely that a poor reader will have forgotten all or most of the items.

• Break up complex instructions. Separate complex instructions into smaller parts. For most people, even those with high literacy skills, three to five items at a time is a reasonable limit.

• Make educational sessions interactive. Make educational instructions interactive by having the patient do, write, say, or demonstrate something in response to your teaching. Interaction strategies greatly assist recall and the patient's ability to carry out directions successfully.

Don't be reluctant to use these techniques with patients who read well. Literacy experts have found that simplifying written materials seems to appeal to everyone-patients with low literacy skills as well as the highly literate.

Just checking

1. What specific techniques you should use designing written patient teaching materials for patients with low literacy skills?
2. List additional tips for teaching patients with low literacy skills.

8. Resources for patient education

Objectives - after completing this module, you will be able to:

• Choose effective patient education materials

• Select materials for Patient Education

- Use one or more of the teaching tools in Patient Education

Teaching resources provide patients and families with important information. Many voluntary organizations and government agencies provide patient teaching materials at no cost to health care professionals and consumers. Resources for patient teaching range from traditional printed material to interactive Web sites. Helping patients and families locate health information and evaluate its accuracy and usefulness are vital parts of the nurse's patient teaching role.

Increasingly, health professionals will face the issue of patients' bringing their own health information to appointments, often from the Internet. Use of the Internet as a primary source of medical information is expected to grow significantly in the near future. The Internet is attractive to both patients and health professionals for a number of reasons. It is a high-speed, entertaining medium that allows users to search at their own convenience. Communication is anonymous, and service provider charges are usually reasonable. The challenge for patient educators is not only to take advantage of consumer education offered by the Internet, but also to reduce the potential damage of erroneous information.

Patients can obtain information from four different sources over the Internet-Web sites, newsgroups, listservs, and bulletin boards. Web sites connect the user to a homepage that has links to a great deal of printed information. Newsgroups are Internet-based forums for the exchange of information on specific topics. Listservs are mailing lists designed to serve the needs of groups of people who want to exchange information on a common topic of interest. Bulletin boards offer a number of services for patient education and counseling that patients can use from home. Bulletin boards make it possible to provide information and interpersonal support to a variety of patient populations in a cost-effective way. By using the Internet, patients and families can share information and solve problems of common interest without having to arrange time to attend face-to-face support groups. They also allow participants to ask questions and receive answers from health professionals. Electronic bulletin boards also provide access to a library of expert information on health care problems. This easy accessibility reduces the time needed to search for health information or wait for materials to be sent by mail.

It is helpful to advise patients that an Internet site with the designation "edu" for educational institution and "org" for organization are generally reliable. "Com" or commercial sites may be put on the Internet by anyone-patients should be taught to carefully evaluate "com" sites by looking at how current the information is, who the sponsors are, and to whom the site has links. The potential for health quackery exists on the Internet; by helping patients become educated consumers, nurses can help prevent them from being misled by inaccurate or even dangerous information.

Three strategies health care professionals can use to incorporate the Internet into health care are to

- Develop Internet sites to point patients to reliable information.
- Advocate for endorsement of sites by professional organizations.
- Act as intermediaries between patients and the Internet.

Choosing effective patient education materials

https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000455.htm

Once you have assessed your patient's needs, concerns, readiness to learn, preferences, support, and possible barriers to learning, you will need to:

- Make a plan with your patient and his or her support person
- Agree with the patient on realistic learning objectives
- Select resources that fit the patient

The first step is to assess the patient's current knowledge about their condition. Some patients need time to adjust to new information, master new skills, or make short- or long-term lifestyle changes.

Getting Started

Your patient's preferences can guide your choice of education materials and methods.

- Find out how your patient likes to learn.
- Be realistic. Focus on what your patient needs to know, not on what is nice to know.
- Pay attention to the patient's concerns. The person may have to overcome a fear before being open to teaching.
- Respect the patient's limits. Offer the patient only the amount of information they can handle at one time.

- Organize the information for easier comprehension.
- Be aware that you may need to adjust your education plan based on the patient's health status and environmental factors.

Basic Priorities

With any type of patient education, you will likely need to cover:

- What your patient needs to do and why
- When your patient can expect results (if applicable)
- Warning signs (if any) your patient should watch for
- What your patient should do if a problem occurs
- Who your patient should contact for questions or concerns

Patient Education Resource Options

There are many ways to deliver patient education. Examples include one-on-one teaching, demonstrations, and analogies or word pictures to explain concepts.

You can also use one or more of the following teaching tools:

- Brochures or other printed materials
- Podcasts
- YouTube videos
- Videos or DVDs
- PowerPoint presentations
- Posters or charts
- Models or props
- Group classes
- Trained peer educators

Selecting Materials

When selecting materials:

- The type of resources that a patient or support person responds to varies from person to person. Using a mixed media approach often works best.
- Keep your assessment of the patient in mind. Consider factors such as literacy and culture as you develop a plan.
- Avoid fear tactics. Focus instead on the benefits of education. Tell your patient what to pay special attention to.
- Be sure to review any materials you plan to use before sharing them with the patient. Keep in mind that no resource is a substitute for one-on-one patient teaching.

In some cases, it may not be possible to get the right materials for your patients' needs. For example, it may be hard to find materials on new treatments in certain languages or on sensitive topics. Instead, you may try having a discussion with the *patient on sensitive topics or creating your own tools for the patient's needs.*

Just checking

1. Describe different sources where patients can obtain information.
2. List strategies which health care professionals can use to incorporate the Internet into health care?
3. What are the ways to deliver patient education?

CONCLUSION

Creating Effective Patient Education in Your Practice

Patient education program in your practice may seem time-consuming at first, but once in place, it can save you time and trouble. And you don't have to start from scratch – there are many materials available to get you started. So you should:

- Talking with Your Patients
- Using Print Materials
- Creating Your Own Print Materials
- Obtaining Informed Consent
- Communicating with Non-English Speaking Patients
- Using Your Allied Health Staff
- Patient Education on the Internet

Talking with Your Patients

Good communication with your patients is the cornerstone of effective patient education. In one study, patients were asked about the most important aspects of receiving bad health news. This is what they said was important to them:

The doctor takes time to answer all of their questions.

The doctor is honest about the severity of their conditions.

The doctor gives them enough time to ask all of their questions.

The doctor gives them his or her full attention.

• Quality is more important than quantity. In a study on the doctor/patient relationship, patients who were satisfied after a visit tended to overestimate the time their doctor actually spent with them. In contrast, patients who were dissatisfied complained that the doctor seemed in a hurry, even when visits were long.

• Spending more time with patients may also reduce the likelihood of malpractice claims. Although poor treatment outcome is the primary cause of malpractice actions, poor communication actually is at the root of about 75 percent of cases. A good physician-patient relationship might deter patients from suing even in situations where medical error causes a problem.

Using Print Materials

A study from the Journal of Hypertension showed patients quickly forget about 40 percent of what physicians tell them. To overcome this problem, give patients written explanations of their conditions and treatments. For e[ample, in the field of ophthalmology, physicians have a unique challenge when choosing written patient education materials. Not only do you need to look for materials containing trusted content, but you also have to make sure the materials are suitable for people with visual impairments. When choosing printed materials, consider the following:

Font styles and sizes. Choose materials with font sizes large enough for people with visual impairments to adequately see and read the information. Avoid materials with busy font styles, all capital letters or italics.

Use of illustrations and images. Use illustrations to complement textual descriptions. This helps patients gain a clearer idea of what is occurring in their eyes.

Use of color. Choose materials with colors that have good contrast and are easy on the eyes. Dark text on light backgrounds (black on white) is easier to read than light text on dark backgrounds (white on black).

Tone and clarity. Use materials that present information in a clear and understandable manner using a pleasant, friendly and respectful tone.

Literacy Levels. Forty-four percent of people age 65 and older read at about the fifth grade level or less. Another 30 percent read between the fifth- and eighth-grade levels. For older adults, choose easy-to-read materials written in plain language, familiar words and short sentences.

Creating Your Own Print Materials

When creating your own patient education materials, you should have one goal—to make the information easy to understand. The following tips will help make your materials more effective:

- Keep your sentences short, but not choppy.
- Use personal pronouns (you, your) to make your patients understand how the information applies to them.
- Use bold print to emphasize important terms and information.
- Use bullets for important list items.
- Use active verbs to illustrate effect. «Laser surgery reduces the risk of blindness» is more effective than «To reduce the risk of blindness, laser surgery is recommended.»
- Avoid using technical terms and language.

Using Video/DVD in the office as a marketing tool

Video is often more effective than traditional patient education methods in increasing short-term retention of information. One study found that using video followed by brief individual counseling actually saved physicians time without sacrificing knowledge when compared with prolonged individual counseling.

Video should be used, however, as a supplemental part of your patient education process. Even the most well produced videos will not be effective educational tools if your patients do not have the opportunity to discuss the content with you and ask questions.

Academy patient education videos feature real patients talking openly about their feelings and experiences. This helps viewers to relate to the patients in the videos and have a better understanding of their treatment options.

Videos and DVDs can also be effective marketing tools for your practice. In Academy-produced patient education videos and DVDs, prospective patients considering elective procedures will see:

- real patient testimonials clear, easy-to-understand animated graphics illustrating the procedures; and informed consent information regarding the benefits and risks of the procedures.Videos and DVD presentations are the most comprehensive way prospective patients can preview the surgical experience. Viewing videos or DVDs can help to alleviate misconceptions, concerns and inhibitions.

Communicating with Non-English Speaking Patients

Your patients may speak English but not read it well, especially if the information is new or complex. If your patients do not read English well, but read in their native language, you should use translated materials. If they cannot read their own language well, try alternative teaching tactics such as translated videos and/or counseling.

Even though your patients may read English, they still may prefer learning in their native language. Patients who are not comfortable with English may be less likely to read the material, even if it is important. The Center for Medicare Education recommends asking specific questions to determine language preferences, including:

Do you get your information from English newspapers or non-English newspapers?

Do you «think» in English?

When you read or hear something in English, do you understand it in English, or do you translate it in your mind into another language?

Can you understand complex or technical information in English, or would you rather read and talk about it in your native language?

Gauging your patients' needs will improve their and your level of understanding about their conditions and reduce the potential for adverse or unexpected results.

Beyond Language Differences: Learn more about increasing cultural competency in your practice to improve patient education, communication and compliance.

Learn more about Cultural Competency.

Using Your Allied Health Staff

Your allied health staff is an important component to patient education in your practice. Your staff members often have the first and last contact with your patients during a visit. This means the patient's first and last impression of your practice is affected by the communication they receive from your staff. The ability to gain the patient's trust and respect will aid both you and your staff in gathering necessary information for diagnosis and treatment and will help ease the patient's concerns.

Patient Education on the Internet

There are thousands of Internet sites devoted to every imaginable

health topic. Unfortunately, the information often is incomplete and requires a high reading level to understand. Patients relying on Internet content to make health decisions, including whether to seek care, could be negatively influenced by deficiencies of the information provided. It is nevertheless a fact that patients will use the Internet to access information regarding their health. There are several things you can do to counteract the possible negative effects of the Internet on patient education.

1. **Give your patients the information they're looking for.** Ask your patients if their questions have been adequately answered, and make sure they have printed or written copies of important explanations and instructions. Encourage your patients to talk about conflicting information they find.

2. **Recommend reliable Internet sites.** When directing your patients to reliable information on the Internet, consider the following:

The source of the information. Find Web sites produced by or affiliated with organizations you trust. Try to find several Web sites and not rely on only one source.

How often the information is updated. The Web sites should be professionally managed to ensure that the information is kept current at all times.

ACTIVITY

Read the principles for patient teaching and discuss it with your peers.

Principles for Patient Teaching

http://medicine.osu.edu/sitetool/sites/pdfs/ahecpublic/HL_Principles_for_Patient_Teaching.pdf

1. You cannot avoid teaching. You are teaching with every contact you have with the patient in your words, actions, and nonverbal behavior. You can choose to teach well or teach poorly.

2. Teaching is caring.

Teaching is the part of caring that stays with a patient and his or her family long after all physical contact has stopped. The impact of teaching is often delayed and the results are usually not seen by the health care provider while the patient is in the hospital.

3. Assess patient knowledge.

Adults learn best what they want to learn and what is an immediate concern or problem for them. Assess what the patient knows and what experience or exposure he or she has had to the topic. Try to determine what is most important to the patient and start teaching at that point.

Have the patient determine, or agree with, what is to be covered in a teaching session.

4. A teaching session includes an introduction, body and conclusion.•

Introduction:

Identify yourself, your purpose, and involve the patient in establishing the goal for the session. This serves as an advanced organizer and will help bring past knowledge into active memory. Identify what you anticipate the patient will be able to do by the end of the session (expected outcome). For example, "When we finish discussing exercise, you should be able to identify

types of activity you would like to do at home."

Body:

During this phase of the session. Information is presented, with patient involvement, and time for rehearsal and problem-solving should be planned. Use simple handouts that convey main points.

Conclusion:

Start the conclusion by asking the patient to do what was stated in the expected outcome. Offer precise and positive reinforcement for even small achievements. Offer other resources for reinforcement or further information. End the session on a positive note, stressing what the patient CAN do.

5. Focus on self-management.

Self-management is the goal that is emphasized for a person with chronic illness. The progress toward this goal is not only positive, and usually involves regression with progress. To reach the goal, the patient needs knowledge, skills, values, life-style changes, and support.

6. Teach what and the how first.

Don't start with the why. Wait until the patient asks for more information about "why." A detailed explanation of the why may block further learning because of its complexity and difficulty to relate it to current knowledge. Teaching the "what and how" involves more practical

information that a patient can use immediately. Start with what the patient needs to know to safely manage the illness at home and how to fit management into his or her lifestyle.

7. Keys to effective teaching and learning:

Individualize by determining what is essential, realistic and achievable information within your given time frame. Using examples the patient can relate to, links new information to old learning.

Relate to specific lifestyle by framing discussions around the individual's age, gender, occupation, marital status, cultural considerations, etc. Making the information meaningful and relevant to the patient's lifestyle and current situation enhances learning.

8. Use small time blocks for teaching.

A typical teaching session should be 5 –10 minutes. Don't try to teach everything at once. Teach one concept or skill per session and avoid too much detail. If a skill is complex, break it into logical steps and teach part of it in a session. This time frame helps reduce patient fatigue and loss of interest or attention. Focused information can be more easily sorted and stored in memory than multiple bits of information.

9. Rehearse, Rehearse, Rehearse!

Rehearsal promotes learning and memory and should be encouraged for both skills and information. For skills rehearsal, talk through the steps and demonstrate then have the patient practice. Verbal rehearsal requires the patient to synthesize and apply information to their situation. Ask the patient to problem-solve anticipated problems or situations they may have. This increases confidence in their ability to perform the required care. Ask them to rate their level of confidence in performing the care on a scale of 0 (no confidence) to 10 (total confidence). If they rate 7 or below, help your patient problem-solve as to why they lack confidence.

10. Allow the patient to talk.

Have the patient talking as much as you do in every teaching session. Active participation and involvement is vitally important to learning. Use open ended then probing questions. When asking a question, allow "wait" time. Give the patient an opportunity to form an answer before rephrasing the question or providing the answer. Provide feedback on specific behaviors to correct, improve, or reinforce them.

Just checking

1. What should you do to create effective Patient Education in Your Practice?
2. How can you make communication with Non-English Speaking Patients?
3. «Quality is more important than quantity». Comment on this statement.
4. List the principles for patient teaching.

The Teach-Back Method in medical practice

Objectives - after completing this unit, you will be able to:

- Define teach-back and its purpose
- Describe the key elements for using teach-back correctly
- Use teach-back in the clinical setting

Teach-back and its purpose

The Challenge

- Research shows that patients remember and understand less than half of what clinicians explain to them.
- Most patients have difficulty understanding information given to them by health care providers. (Ley, 1988)
- Patients remember and understand less than half of what their providers explain to them. (Rost, 1987)
- Ninety-eight percent of medical errors are communication-related. (AMA, 2007)
- Patients say the healthcare environment can make it hard to tell a provider they do not understand. (IOM, 2004)
- Patients with limited literacy say they feel shame and hide their limited reading ability from others. (Parikh, 1996; Wolf, 2007)

How Patients Feel

- Patients may have negative feelings and emotions related to their limited reading ability or limited understanding.
- The health care environment can make it hard for patients to tell us they don't read well or do not understand.

- They hide this with a variety of coping techniques.

The Right to Understand

Patients have the right to understand healthcare information that is necessary for them to safely care for themselves, and to choose among available alternatives.

Healthcare providers have a duty to provide information in simple, clear, and plain language and to check that patients have understood the information before ending the conversation.

What is the solution?

Patient safety advocates and others call for adoption of the following health literacy principles with all patients since you can't tell by looking who doesn't understand.

Use plain language

Focus on the most important messages

Always check for understanding using teach-back

One of the easiest ways to close the gap of communication between clinician and patient is to employ the "teach-back" method, also known as the "show-me" method or "closing the loop."

Teach-back: Why do I use it? What is it? How do I use it? When do I use it?

Teach-back is…

Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.

NOT a test of the patient, but of how well ***you*** explained a concept.

A chance to check for understanding and, if necessary, re-teach the information.

A way to make sure you—the health care provider—explained information clearly. It is not a test or quiz of patients.

Asking a patient (or family member) to explain in their own words what they need to know or do, in a caring way.

A research-based health literacy intervention that improves patient-provider communication and patient health outcomes. *Schillinger, 2003*

Creates an opportunity for dialogue in which the provider gives information, then asks the patient to respond and confirm understanding *before* adding any new information.

Re-phrase if a patient is not able to repeat the information accurately.

Ask the patient to teach back the information again, *using their own words*, until you are comfortable they really understand it.

If they still do not understand, consider other strategies.

Additional Points

Do not ask yes/no questions like:

"Do you understand?"

"Do you have any questions?"

For more than one concept:"Chunk and Check"

Asking for a Teach-back - Examples

Ask patients to demonstrate understanding, *using their own words*:

"I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?"

"What will you tell your husband about the changes we made to your blood pressure medicines today?"

"We've gone over a lot of information, a lot of things you can do to get more exercise in your day. In your own words, please review what we talked about. How will you make it work at home?"

Tips. Suggested Approaches When Using Teach-back.

"I want to be sure that I explained your medication correctly. Can you tell me how you are going to take this medicine?"

"We covered a lot today about your diabetes, and I want to make sure that I explained things clearly. So let's review what we discussed. What are three strategies that will help you control your diabetes?"

"What are you going to do when you get home?"

10 Elements of Competence for Using Teach-back Effectively

1.Use a caring tone of voice and attitude.

2.Display comfortable body language and make eye contact.

3.Use plain language.

4.Ask the patient to explain back, using their own words.

5. Use non-shaming, open-ended questions.

6.Avoid asking questions that can be answered with a simple yes or no.

7. Emphasize that the responsibility to explain clearly is on you, the provider.

8.If the patient is not able to teach back correctly, explain again and re-check.

9.Use reader-friendly print materials to support learning.

10.Document use of and patient response to teach-back.

l

Keep in mind:

This is not a test of the patient's knowledge: This is a test of how well you explained the concept. Patient understanding is confirmed when they explain it back to you. It can also help the clinic staff members identify explanations and communication strategies that are most commonly understood by patients.

Use with everyone: Use teach-back when you think the person understands and when you think someone is struggling with your directions.

Teach to all staff: All members of the practice staff can use it to make sure their communication is clear.

Try the teach-back method:

Start Slowly. Initially, you may want to try it with the last patient of the day.

Plan your approach. Think about how you will ask your patient to teach-back information based on the topic you are reviewing. Keep in mind that some situations will not be appropriate for using the teach- back method.

Use handouts. Reviewing written materials to reinforce the teaching points can be very helpful for patient understanding.

Clarify. If patients cannot remember or accurately repeat what you asked them, clarify your information or directions and allow them to teach it back again. Do this until the patient is able to correctly describe

in their own words what they are going to do, without parroting back what you said.

Practice. It may take some getting used to, but studies show that once established as part of a routine, it does not take longer to perform.

Track Your Progress

Assess results of the teach-back method with staff and patients.

The Teach-Back Self-Evaluation and Tracking Log provide a method for staff to document their experience using the teach-back method. Encourage staff to use the logs, and hold a discussion about their experience. This will allow people to share teach-back strategies that worked best. In addition, it is helpful to ask patients if they find the teach-back interaction positive and helpful during the patient encounter.

Assess how often the teach-back is used.

A few weeks after first trying the teach-back, track how many clinicians or staff members are using it. Have each individual keep a log of when and how it was used over the course of a few days (table)

Table 3.11

Care Team Member:_____

Date: Observer:

_____Time:

Did the care team member…	Yes	No	N/A	Comments
Use a caring tone of voice and attitude?				
Display comfortable body language, make eye contact, and sit down?				
Use plain language?				
Ask the patient to explain in their own words what they were told to do about: • Signs and symptoms they should call the doctor for? • Key medicines? • Critical self-care activities? • Follow-up appointments?				
Use non-shaming, open-ended questions?				
Avoid asking questions that can be answered with a yes or no?				

Did the care team member…	Yes	No	N/A	Comments
Take responsibility for making sure they were clear?				
Explain and check again if the patient is unable to use teach-back?				
Use reader-friendly print materials to support learning?				
Document use of and patient's response to teach-back?				
Include family members/caregivers if they were present?				

Activity

Questions to Consider

1. What are specific topics or directions you commonly discuss with your patients that you can use the teach-back method with?

Ideas: Insulin injections, inhalers, medication changes, chronic disease self-care, colonoscopy preparation

2. How can you phrase your teach-back questions? Brainstorm and discuss how you can ask questions for the scenarios above.

Testimonial

"I decided to do teach-back on five patients. With one mother and her child, I concluded the visit by saying 'So tell me what you are going to do when you get home.' The mother just looked at me without a reply. She could not tell me what instructions I had just given her. I explained the instructions again and then she was able to teach them back to me. The most amazing thing about this "ah ha" moment was that I had no idea she did not understand until I asked her to teach it back to me. I was so wrapped up in delivering the message that I did not realize that it wasn't being received." -*resident physician, pediatric office*

Brainstorm and discuss how you can ask questions for this scenarios.

Case study

Case 1.

After explaining a plan, ask the patient to tell you the plan in his

own words. Make some questions (3-5) to confirm that your patient understand what you are explaining.

You had appendicitis operation. Tomorrow you will be discharged from the hospital. Two days later, you will come to the hospital to remove the stitches. You should not lift heavy objects. You should avoid exercise and stress. You should wear a bandage. You cannot wash before the stitches will be removed.

Case 2.

After explaining a plan, ask the patient to tell you the plan in his own words.

You have a peptic ulcer disease. Today you are discharged from the hospital. You should have an appropriate diet. You should not eat fried, salty and spicy dishes. You should stop smoking and alcohol. You need to take two antibiotics twice a day. You should make gastroenteroskopiyu six months later.

Case 3.

After explaining a plan, ask the patient to tell you the plan in his own words. Make some questions (3-5) to confirm that your patient understand what you are explaining.

You have a sore throat. You should take antibiotics twice a day for five days. You should gargle every three hours. You should receive physiotherapy. You should drink plenty of water.

Case 4.

After explaining a plan, ask the patient to tell you the plan in his own words. Make some questions (3-5) to confirm that your patient understand what you are explaining.

You have cystitis. You should take antibiotics twice a day for five days. You should observe the thermal regime. You should pass urine analysis n a week. You need to see a doctor after that.

Case 5.

After explaining a plan, ask the patient to tell you the plan in his own words.

Make some questions (3-5) to confirm that your patient understand what you are explaining.

You have a broken leg bones. You will be put in plaster. Within three months, you are advised to limit physical activity. After the plaster will be removed, you should do gymnastics and exercise therapy.

Just checking

1. Define teach-back and its purpose.
2. List 10 Elements of Competence for Using Teach-back Effectively.
3. Give 2-3 examples asking for a Teach-back.

Final control

Questions and case studies for the unit «Patient education»

1. The goal of patient teaching
2. The results of patient teaching
3. The essential points of patient education
4. Theories used for patient teaching include
5. How to build self-efficacy (strategy)?
6. How to direct teaching toward a patient if a patient is unaware of his risk factors for one or more diseases?
7. How to help a patient who is aware of the risk, but feels that the behavior change is overwhelming or unachievable?
8. How can you assist patients with an external locus of control?
9. How many steps are there in the teaching-learning process? What are they?
10. What does assessment include? How many steps? What are they?
11. What steps does planning and implementing teaching include?
12. What teaching methods and teaching materials can you use?
13. How to develop an effective teaching style: several techniques
14. List adult learning principles.
15. List characteristics of an excellent teacher.
16. A model of care for cultural competence.
17. Strategies for Working with Patients in Cross-Cultural Settings.
18. List ways to communicate when you don't speak the patient's language.
19. Define teach-back and its purpose.
20. List 10 Elements of Competence for Using Teach-back Effectively.
21. Give 2-3 examples asking for a Teach-back.
22. List the principles for patient teaching.

Case. You are the physical therapist. You ask your college to answer the question: What did I do wrong in the next case?

«I showed patient`s elderly wife how to do a car to wheelchair transfer. When they arrived home, the wife was unable to help the patient out of the car, nor was she able to manage and manipulate the wheelchair in the

home. So she called to the chief of the department and accused me in a low competence.»

Case. I am Mrs. Green. This is my husband. We are preparing to be parents and would like to know typical topics for teaching young adults who are preparing to be parents.

Case. I am Mr. Greenfield, a chief of the hospital. We will open the school for parents of infants. Give me a plan of sessions including typical topics for infant development teaching. What teaching methods and teaching materials will you use?

Annex - Glossary

The definitions were taken from the following sources:

- *Educational handbook for health personnel*. Geneva, WHO, 1998, 6th ed.
- *Targets for health for all*. Copenhagen, WHO Regional Office for Europe, 1985.
- *Glossary in managing programmes for leprosy control*. Geneva, WHO, 1994.

A

Active learning: learning in which the learner is active and gradually becomes responsible for his own learning

Activity (educational): what a learner does to acquire or improve a given *competency* with the (direct or indirect) help of a teacher, preferably on the basis of a contract between teacher and learner. (See *contract*)

Activity (professional): a group of acts and *tasks* (with a common purpose) performed by an individual.

Attitude: the internal disposition reflected by one's behaviour with respect to persons, events, opinions and theories

B

Behaviour: the manner of conducting oneself in relation to one's environment

C

Certifying evaluation: a judgment based on measurement or assessment of learner *performance*, used to justify decisions regarding advancement in the educational process, or the award of an academic qualification, credit or other certification of *competence*

Chronic diseases: diseases that cannot be cured but may be controlled by the cumulative effect of medication, physical therapy, psychological support and *therapeutic patient education* (the term *chronic disease* is synonymous with *long-term disease*)

Communication: a process by which information and feelings are exchanged between individuals through a common system of language or signs

Competency (or competence): the professional ability required to carry out certain functions. A recognized aptitude to perform a specific act. *Competence* is a potential which is realized at the moment of *performance*

Competency profile: see *professional profile*

Compliance (comply): the way in which a patient follows a prescribed treatment. It includes regularity of controls and visits to health care facilities

Constraints: fixed factors (social, political, cultural, financial, technical) imposed by the environment on a given sys- tem, which cannot be re- moved, and which influence the achievement of objectives. See also *obstacles*

Contract (educational): description of an agreement reached between a student and a teacher on competencies to be acquired by the student with the help of the teacher

Contract (with patients): description of an agreement reached between patients and health care providers on what the patient is expected to do, with the help of the health care providers, in order to manage his disease and treatment

Coping: skill and way of attempting to meet, adjust, or adapt in order to overcome personal problems, difficulties and challenges

Cost: an amount to be paid for

something. It refers not only to money but also to pain, grief, effort, loss of quality of life, etc.

Curriculum: a group of *educational activities* to be experienced by a student, designed to achieve selected learning objectives

E

Educated patient profile: a list of actions that patients should be able to perform in order to manage their treatment and prevent avoidable complications while maintaining or improving their quality of life

Education: action or process facilitating the formation and development of a person's physical, intellectual, sensorimotor and affective characteristics

Educational diagnosis: the first step of the educational process. It is a systematic, comprehensive, iterative col lection of information by the health care provider concerning the patient's bio-clinical, educational, psychological and social status. This information is to serve as a basis for the construction of an individualized therapeutic education programme

Educational objectives: see *learning objectives*

Educational needs assessment: see *Educational diagnosis*

Effectiveness: capacity to produce the desired result

Efficiency: capacity to produce the desired result at the least cost

Empathy: the capacity to participate in another person's feelings

Evaluation: a judgment of value, based on measurement; in education it provides the basis for decision-making

F

Formative evaluation: a judgement based on measurement of the progress or gains made by the learner. The teacher must not use it for a *certifying evaluation*

Function (professional): abroad area of competencies, a group of activities (with a common purpose) that a per- son performs to fulfill his role in society

H

Health beliefs: ideas or conceptions patients may have about their state of health or disease

Health care provider(s) (or health personnel): all personnel engaged directly or indirectly in health care tasks (pro- motive, preventive, curative and rehabilitative) within the health system. For example, with reference to chronic diseases, it refers to nurses, medical doc- tors, physiotherapists, dentists, nutritionists, chiropodists, teachers, psychologists, etc.

Health care-provider education: educational process helping health care providers ac- quire the competencies relevant to their *professional profile*

Health demand: the extent to which a type of health care or service is demanded by the patient or the population

Health needs: the extent to which a type of health care or service is needed, as judged by health professionals, with due consideration of the health of the population. *Felt needs* are those needs that correspond to *demands*

Health team: a group of individuals who share a common goal and common *objectives*, determined by patients' *needs*, to the achievement of which all members of the team contribute, in accordance with their individual *competencies*, and in co- ordination with the *functions* of others

I

Implementation: putting a *programme* into action; doing the work to be done

Implementation plan: outline of *activities* expected to achieve defined *objectives*

Interprofessional approach: members of different health professions working together, sharing common goals

Intersectoral approach: educational process whereby learners take into consideration the health sector and all other sectors of social and economic community development and organization that affect health

L

Learner-centred approach: an educational process which puts the learner at the centre of the picture. It describes what the learner intends (or is in- tended) to learn (i.e. *learning objectives*), relevant *l***e***arning activities* and *self-evaluation* instruments

Learning: a process resulting in some modification, relatively permanent, of the learner's way of thinking, feeling or doing

Learning objectives: statements describing what a learner should be able to do at the end, and as the result of a period of learning, which he or she could not do beforehand (also called *educational objectives*). They can be *general*, *intermediate* or *specific*, corresponding respectively to a *professional function*, *activity* or *task*

Lecture: in its conventional form, a lesson given orally by a teacher, with virtually no active student participation.

Level of performance (acceptable): criterion of a specific learning objective (see *specific learning objective*)

Lifestyle: a person's particular way of life ; habits used to cope with life and ease social contact; shaped by patterns of interpersonal interaction and social learning that interrelate with and are determined by the social environment

Locus of control: (psycho- logical theory – Rotter, J.B., 1954). Refers to the amount of personal control over the environment which individuals believe they possess. *"I can anticipate difficulties and take action to avoid them*" (*internal* locus of control). *"I think people are the victims of circumstances beyond their control"* (*external* locus of control)

M

Management: the actions necessary for the preparation of *plans*, their *implementation*, the *evaluation* of results and the re-planning stage

Medical chart: see *Patient chart*

Motivation: what causes a person to act in a particular way

Multiprofessional education: *learning activities*, with inter- action as an important goal, shared by learners of different health professions during certain periods of their education

N

Networking: action of working together, in order to be more efficient, concerning members of different professions. See also *teamwork*

O

Objective: in management terms, a statement of purpose or a condition/situation desired in some stated future

Objectives (learning): see *learning objectives*

Objectivity: the extent to which independent and competent examiners agree on what constitutes an *acceptable level of performance*

Obstacles: impediments that must be overcome to achieve objectives. In contrast to constraints, obstacles can be re- moved, by-passed or over-come. See also *constraints*

P

Patient-based education: an educational process in which the patient is one of the essential learning resources

Patient-centred approach: a process that puts the patient at the center of the picture. It is concerned with patients' opinions, concepts, ideas and feelings as well as their biological state. This approach should not be used only for chronic- disease patients: all patients deserve it

Patient-centred education: see therapeutic patient education

Patient chart: usually called "medical chart". It is a collection of information (usually on paper) reported by health care providers concerning the patient, including main complaint, history of the illness (anamnesis), and physical and other findings, laboratory results etc. In a multiprofessional patient-centred approach each patient should have a single chart in which the periodic contributions of all health care providers concerned are recorded

Patient's competencies: see *educated patient profile*

Patient education: see *therapeutic patient education*

Performance: accomplishment of an act (*task*). An individual result obtained from carrying out a task, depending largely on level of *competence* and on *motivation*

Prerequisites: conditions, including experience and *competencies*, which must be present before a task can be performed

Prerequisite level: level of *competence* required from a learner in order to begin an *educational activity*

Problem (health): difference between current and desired health conditions, or between actual and expected results, which causes concern to the patient or the population as a whole

Problem-based learning: a process whereby a learner uses, from the beginning of the learning activity, a *problem* as a stimulus to discover what information is needed to understand and help in the resolution of the problem

Problem-solving approach: see *problem-based learning*

Professional profile: a list of *functions* and *activities* corresponding to a given profession. Also called *job description*

Profile: see *professional profile* or *educated patient profile.*

Programme (educational): a series of planned and coordinated

educational activities that a learner is to experience with the assistance of teachers

R

Reformulation (ing): expressing in other words what a person said

Relevance: quality of being appropriate to and consistent with the object pursued. In this glossary it is the quality of conformity with the *health needs* of the patient

Resources: the sum of total manpower, finance, facilities, technology, legislation and materials (supplies and equipment) available for rendering a service

S

Self-evaluation: process by which learners directly obtain information on their progress or gain in competence (see also *formative evaluation)*

Self-management: what patients decide to do in order to manage their treatment and prevent complications

Skill (professional): a learned ability to perform an act competently. It may be an intellectual skill (cognitive), an inter- personal-communication skill (affective) or a practical skill (sensorimotor)

Specific educational objective: an objective derived directly from a *professional task* and with the following qualities: unequivocal, feasible, observable and measurable. Well formulated, it should include: the act corresponding to the expected competency, ex- pressed by an active verb; the *content* specifying the subject in relation to which the act is to be performed; the *conditions*, describing the *resources* avail- able to perform the act; and a *criterion* for the *acceptable level of performance*.

Strategy(ies): approach(es) to solving a *problem* by achieving stated *objectives* while taking account of *resources*, *obstacles* and *constraints*

System approach: an approach that considers the elements of a problem as an interdependent whole

T

Task, professional: a measurable action derived from the segmentation of a *professional activity*

Teacher-centred approach: in conventional education, a process

describing what teachers do (number, length and content of lectures), as distinct from a *learner-centered approach*

Teaching: interactions between teacher and learner, under the teacher's responsibility, designed to bring about expected changes in the learner's behaviour

Teamwork: a process including coordinated action aimed at solving problems, carried out by two or more persons jointly, concurrently or sequentially, formally or informally. It implies commonly agreed goals; respect for, and a clear aware- ness of, others' roles on the part of each member of the team; adequate human and material resources; effective leadership and provision for evaluation

Teamwork competence: the ability to work as colleagues rather than in a superior-sub- ordinate relationship

Therapeutic patient education: *educational activities* essential to the management of *pathological conditions*, man- aged by health care providers duly trained in the field of education, designed to help a patient (or a group of patients and their families) to manage their treatment and prevent avoidable complications, while keeping or improving their quality of life.

What is specific about it is that it produces a therapeutic effect additional to that produced by all other interventions (pharmacological, physical therapy, etc.)

V

Validity: the extent to which an instrument measures what it is intended to measure

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