10

Foundations of Interprofessional Communication

Learning Outcomes

After studying this chapter, you will be able to:

1. 1. Explain the essential components of interprofessional communication.
2. 2. Identify appropriate communication tools and techniques to enhance team function.
3. 3. Communicate with team members, patients, families, and community members with respect and clarity.
4. 4. Demonstrate active listening skills in communication with others.
5. 5. Explain the importance of using respectful language in difficult/crucial conversations.
6. 6. Plan and participate in difficult conversations.
7. 7. Communicate the importance of teamwork to others involved in patient-centered care, population health programs, or health-related policy development.
8. 8. Provide timely, sensitive, and instructive feedback to others related to their performance on the team.

Developing competency in interprofessional communication requires moving beyond the basic principles of personal, professional, and therapeutic communication that are fundamental in every healthcare professional's basic role preparation. Competency in interprofessional communication involves specific behaviors and communication skills needed for interprofessional collaboration—those skills that are essential for the accurate, appropriate, and timely sharing of information between those who are involved in a specific healthcare situation. This chapter introduces the basic concepts associated with the Core Competency of Interprofessional Communication (IPEC, 2011; 2016).

Interprofessional communication is an essential component of Interprofessional Collaborative Practice (IPCP), and it is key to team relationships and patient safety. Communication failures have been cited as the leading root cause for medical errors, delays in treatment, and wrong-site surgeries, and the second most frequently cited root cause for operative and postoperative events and fatal falls (The Joint Commission, 2005). Communication breakdown was identified as one of the top three causes in 60% of the healthcare events resulting in unexpected death or permanent loss of function (known as sentinel events) between January 2013 and September 2015 (The Joint Commission, 2015). Clear, accurate, and timely communication positively influences team interactions, organization, and functioning (Essens et al., 2009, as cited by IPEC, 2011, p. 23). Healthcare professionals communicate with a wide variety of people each day, from patients and families to colleagues from their own and other disciplines, to staff and team members with varied educational levels, and to their own family and friends. Each encounter requires adaptation in the type and style of communication used. Professionals need to move fluidly from formal to informal, from professional to laypersons, and from simple to complex communication styles. In each encounter, there is a high potential for unclear or poor communication that may result in misunderstanding. There is clear evidence that both threats to patient safety and lawsuits against healthcare professionals are primarily related to failures of communication (Thistlethwaite, 2012).

To develop competency in interprofessional communication it is necessary to recognize and understand that in interprofessional healthcare teams "communication phenomena are surface manifestations of complex configurations of deeply felt beliefs, values, and attitudes" (Brown & Starkey, 1994, p. 808). This chapter provides foundational content designed to help you understand interprofessional communication within the culture of health care and healthcare teams. Common beliefs, values, and assumptions held by various team members are examined and considered as they affect attitudes toward communication and the interprofessional communication processes and systems in patient care. Other topics covered in this chapter include appropriate communication tools and techniques, guidelines for using respectful language in communicating, and considerations related to having difficult conversations.

Active Learning

Interprofessional Communication

Think about a patient care or population health situation in which you recently participated that involved more than one other healthcare provider, caregiver, or colleague in the wider circle of the situation.

1. 1. Write down at least two areas of shared concerns for team members involved. How did you know these were shared concerns?
2. 2. Did you communicate with any of the other team members about these concerns? If so, which ones? What method(s) did you use to communicate with them?
3. 3. Were there any barriers to this interprofessional communication? If so, what were they?
4. 4. Could the overall outcome(s) of the care situation have been improved by better interprofessional communication? How?

Basics of Interprofessional Communication

The ability to communicate clearly and respectfully is essential to interprofessional collaboration. This section provides an overview of some of the most critical communication skills you will need to participate fully in interprofessional collaboration.

Overview of the Communication Process

To understand the Competency of Interprofessional Communication and its Sub-competencies (IPEC, 2011; 2016), it is necessary to review the basic process of communication. All that ever was or will be accomplished involves communication with others (Adler & Towne,

1978). Communication is an interactive process (Adler & Towne, 1978; Halter, 2014) that begins with a stimulus. This can be a desire to give or receive information or to express a need or emotion on the part of the sender. The sender must translate the stimulus into a message that is verbal, nonverbal, or both. The basic communication process is operationalized in Fig. 10.1.

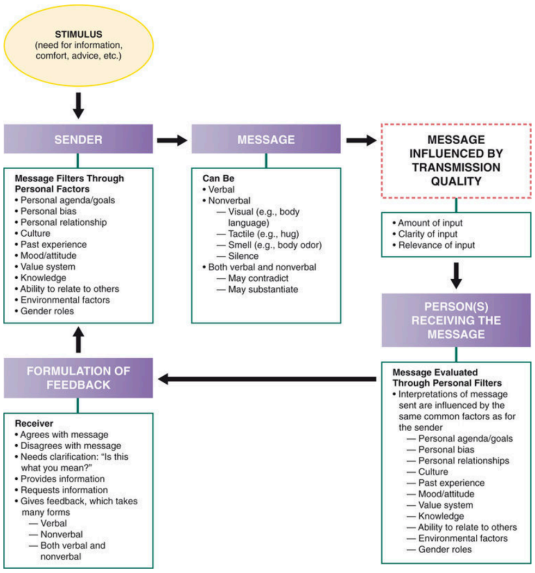

FIG. 10.1 The communication process source: operational definition of communication. (Data from Ellis, R., & McClintock, A. [1990]. *If you take my meaning*. London: Arnold. In Halter, M. [2018]. *Varcarolis' foundations of psychiatric-mental health nursing* [8th ed.]. St. Louis, MO: Saunders Elsevier.)

The next step in the communication process is to send the desired message to the intended receiver. There are several ways to send a message. Verbal communication is communication in words. It can be spoken or written. For example, a verbal message can be sent electronically as a text, email, voice recording, or an entry in the electronic health record. It can be spoken via telephone or in person. Nonverbal communication consists of body language such as position, gestures, eye contact, or touch. We also communicate using symbols such as pictures, graphics, or manual signs as used in American Sign Language (ASL).

Once a message is sent, the receiver must interpret its meaning and respond by acting and/or providing feedback to the sender. The sender will then convey feedback to the receiver and so on. Communication is effective when the sender's meaning is accurately interpreted by the receiver (Adler & Towne, 1978; Halter, 2014). This does not always occur. The process of communication within the wide circle of healthcare team collaborators can go wrong during any step of the process, and each method of communication requires specific skills and safeguards (Thistlethwaite, 2012). For this reason, it is important to think about exactly what you want to communicate, to whom, and in what manner. It is essential to get feedback from the receiver to make sure that your message was understood in the way in which you intended. This is true regardless of the person, or people, with whom you want to communicate.

There are many factors that affect communication. Some of these factors can obstruct or distort communication at any point in the process by causing inaccurate formulation of the message, inaccurate or improper transmission, or inaccurate interpretation by the receiver. These factors include personal, environmental, and relationship factors (Halter, 2014). Cultural differences must also be taken into consideration. An example of inaccurate interpretation by the receiver occurring is when two healthcare professionals are communicating. The first professional uses his or her professional culture (e.g., jargon) to formulate the message, and the second professional uses his or her professional culture as a filter through which to interpret the message. Without a common ground of understanding, the message may be misinterpreted.

After any communication exchange, it is important to make sure your message was clearly received and understood. A simple tool that can be used for confirming that you have explained things in an understandable manner to patients or others is the teach-back method. To use this method, simply ask the person to state, in his or her own words, his or her understanding of what you have explained to the person. If this process uncovers any misunderstandings, you will have the opportunity to clarify your message and recheck the person's understanding again. In instances when you have large amounts of information to convey, you can use the chunk-and-check method. Using this method, you can "chunk" out the information you need to provide in small segments and have the person "teach" it back at shorter intervals to ensure his or her understanding (AHRQ, n.d.).

Personal Factors

Personal factors that can affect communication include the sender's and receiver's emotional state, mood, or response to stress (Halter, 2014). For example, increased anxiety makes it difficult to process information. If a healthcare professional is having a stressful day, he or she may find it difficult to listen respectfully to a patient's or team member's minor complaints. Developmental level is another personal factor to consider. Consider the age and developmental levels of the patients with whom you communicate; for example, if your patient is a child you will communicate very differently from how you would with an adult.

Environmental Factors

The effect of environmental factors on communication may be overlooked by healthcare professionals because they are used to working in an environment that may be noisy and probably have developed the ability to "tune out" extraneous sounds such as the beeping of an empty intravenous (IV) pump or the sound of a dental drill. On the other hand, patients may find these sounds distressing and distracting and may not be able to fully focus on hearing information given by professionals. Other environmental factors that negatively affect communication may include a lack of privacy, the presence of others (Halter, 2014), unfamiliar or uncomfortable surroundings, and unfamiliar smells. There may also be other environmental factors depending on the specific situation.

Types of Communication

Verbal Communication

Verbal communication is communication using written or spoken words. There are several factors that can affect the interpretation of spoken verbal communication. Vocabulary and language can affect the receiver's understanding of the message. An example is a healthcare professional using words or technical language that are unfamiliar to patients or a patient with limited understanding of English. Pacing of speech is an important factor. Pacing is the speed, flow, pauses, rate, and rhythm of speech. Speech that is too fast may be difficult to understand, and speech that is too slow may cause the listener's attention to wander. Intonation includes tone of voice and placing emphasis on certain words. Think of the tone of voice you use when you are angry, sad, or happy. This affects the way your words are interpreted. Volume is important. Speaking too loudly or too softly can hamper communication. Clarity and brevity are also important factors. The shorter and clearer the message, the more likely it is to be accurately understood. Avoid long drawn-out explanations; instead keep your communication simple. Another important factor in communication is the credibility or believability of the speaker. As a healthcare professional, you need to speak with confidence and authority when communicating with patients and colleagues. Timing and relevance are considerations when communicating with patients and other professionals. The best time to discuss a topic is when the person expresses interest or when it pertains to the current situation. The person should be in optimal condition to receive the message. For example, educating patients or obtaining informed consent should wait until they are comfortable and not in pain or extremely anxious. In urgent or emergent situations, this may not be possible. However, every attempt should be made to plan communications for when patients are best able to receive them.

Nonverbal Communication

Nonverbal communication includes such things as body language, eye contact, and gestures. Other aspects of nonverbal communication include personal appearance, body posture, movement, gait and stance, facial expression, and sounds such as sighs or groans. Nonverbal communication is heavily influenced by culture and is usually less controlled or planned than verbal communication (Halter, 2014) and may even occur outside of your awareness. However, nonverbal elements have a powerful effect on communication, often greater than the effect of the content or words that are spoken. It is important that your nonverbal communication is congruent with your verbal communication (Halter, 2014). This takes effort and requires self-awareness and monitoring.

Achieving congruence between verbal and nonverbal communication may be learned through self-reflection (see Chapter 7).

Personal appearance can affect credibility. For example, an obese healthcare professional giving advice about diet and exercise may not be as believable as someone who appears fit. A professional appearance can facilitate the development of trust and a therapeutic relationship. On the other hand, inappropriate dress, heavy makeup, facial piercings and/or tattoos, unpleasant body odor, or lack of personal hygiene can detract from professional credibility. Although the importance of personal appearance may seem unfair, it is important to remember that the patient is the center of care, and every effort must be taken to establish a trusting relationship. This is true when working with other professionals. Therefore, presenting a professional appearance at work is helpful.

Body Language

Body language, also known as *kinesics,* is defined as a type of nonverbal communication in which physical behavior, gestures, movements, and mannerisms, as opposed to words, are used to express or convey information. Often, the emotional components of the message can be inferred by observing body language. Examples are slumped body posture and bowing the head in response to sad news. Posture and rhythm of movement are both forms of body language (Arnold & Boggs, 2016). A closed body posture, with arms or legs folded, can be interpreted as unwillingness to accept the message or not being "open" to what the other person is saying. On the other hand, leaning slightly forward with an open body posture can indicate interest in what the other person must say (Halter, 2014); this is the recommended posture for healthcare professionals to assume when speaking with patients, families, or colleagues.

Facial Expressions

Facial expressions are important in signaling feelings or emotions (Arnold & Boggs, 2016). They are almost universal in meaning across cultures, with a smile indicating happiness and a frown indicating displeasure. Facial expressions can reinforce spoken communications by connecting the message with the internal dialogue of the speaker (Arnold & Boggs, 2016). It is important that your facial expression matches the message you intend to convey. Otherwise, confusion can occur. For example, if a healthcare professional smiles while delivering bad news, it may appear that he or she does not care or may even be pleased. When the facial expression and message are inconsistent, the facial expression outweighs the content of the words (Arnold & Boggs, 2016). Lack of facial expression can be misconstrued as an indication of not caring. As a healthcare professional, do not be afraid to use facial expressions to reinforce your meaning, and make sure that you are aware of your expression when speaking with others.

Gestures

Gestures are often used to accentuate or reinforce verbal communication, or they may be used alone to communicate a message. An example is people who "talk with their hands." Overuse of gestures can be distracting and can cause the listener to lose focus. Gestures have different meanings in different cultures and should be used carefully to avoid unintentionally confusing or insulting people from cultures other than your own. For example, it is important to "understand the correct greetings (e.g., if a form of touch such as a handshake is permissible), what gestures mean, and the interpretation of eye contact" (Spector, 2017, p. 30). It is best to use gestures minimally and only when you are sure they will enhance your communication, such as pointing to a body area or demonstrating a movement.

Symbols

Symbols are representations of an event, action, object, person, or place that can be used to communicate about it. Examples of symbols used to communicate in healthcare settings include line drawings, graphic representations, and photographs. The variety of symbols used in health care range from concrete to abstract. The more a symbol resembles what it represents, the more concrete the symbol is. Fig. 10.2 depicts some familiar concrete symbols used to indicate "No Smoking" areas, parking areas for individuals with disabilities, and the universal symbol for female and male restrooms.



FIG. 10.2 Concrete communication symbols.

Less-concrete symbols include manual signs made with one or two hands and include a specific hand shape, position in space, and movement. Manual signs can be a visual or tactile way to communicate, borrowing vocabulary from ASL. Most of these signs do not clearly resemble their referent and are considered less concrete, or abstract. For examples, see Fig. 10.3.



FIG. 10.3 Less concrete communication symbols, borrowed from American Sign Language. (From National Institute on Deafness and Other Communication Disorders. [2017, May 19]. *American Sign Language*. Retrieved from https://www.nidcd.nih.gov/health/american-sign-language.)

Touch

Many professionals believe that the use of touch, as in holding a patient's hand, can convey caring. However, this type of touch may be unwelcomed or misinterpreted by some patients or families. If you feel the desire to touch or even hug a patient, first reflect on whether the touch has therapeutic value. It is always best to ask your patient for permission before touching to convey caring. Although some people may find it calming to be touched, others may consider it an invasion of privacy (Halter, 2014). It may be taboo in certain cultures. Some facilities, especially mental health facilities or those caring for children, have "no touch" policies (Halter, 2014). Make sure you know your facility's policy regarding the use of touch in non–direct care situations.

Much of what we do as healthcare professionals involves touching patients. In all situations, it is best to tell the patient you will need to touch him or her, where, and for what purpose before doing so. It is also good technique to tell patients what they can expect to feel, if this is known. For example, some IV medications may sting or burn while being injected, so warning patients that they may experience a burning sensation, and that this is normal, can help prevent anxiety.

Eye Contact

The level of comfort one has with direct eye contact and its social meaning and appropriateness is often culturally determined (Halter, 2014). Using direct eye contact while communicating with another can create a sense of confidence and credibility, whereas downcast or averted eyes can indicate shame, weakness, or submission. If the eyes wander during a conversation, it may be interpreted as a sign of dishonesty (Arnold & Boggs, 2016). On the other hand, in some cultures, direct eye contact may be considered a sign of disrespect. It is generally recommended to use direct eye contact (without staring) during professional discussions. Before making a clinical judgment of a patient's attentiveness or honesty based on eye contact, determine whether there is a cultural aspect operating.

It is always best to verify any interpretation you make of a patient's eye contact directly with the patient or the family. For example, a 24-year-old outpatient mental health patient who was Hispanic would not look directly at the nurse practitioner (NP) during the assessment interview. The NP attempted to determine the reason for the lack of eye contact, stating, "I notice you seem to be avoiding looking directly at me. Tell me about that." The patient leaned over and whispered something to his mother, who then said to the NP, "Juan said he can't look at you because he sees skeletons when he looks at people's faces." If the NP had assumed that the patient was avoiding eye contact out of a cultural norm of respect, and not asked about it, she may have missed the fact that the patient was experiencing visual hallucinations.

Improving Nonverbal Communication

The first step in improving nonverbal communication is to relax, then take a few deep breaths and clear your mind. Focus on the issue at hand and pay attention to your body. Lean slightly forward with an open body posture, arms and legs uncrossed. Use facial, hand, and body gestures judiciously and with thought. Watch the people with whom you are communicating to detect their nonverbal communication, which may be in response to yours. One method to use in improving your nonverbal communication is to observe effective professionals interacting with others. Another strategy is to ask a trusted colleague for feedback on your nonverbal communication. Videotaping interactions (with permission) can also be helpful in analyzing your nonverbal communication. You should consciously practice improving your identified areas of weakness and practice active listening, which is detailed later in this chapter.

Active Learning

Communication Self-Assessment

Answer the following true-or-false questions as honestly as possible;

then review your answers and draw at least two conclusions about your habitual communication patterns that you need to work on to improve. Check your conclusions for accuracy with a friend who knows your style of communicating well. Then score yourself using the following key.

1. 1. I find it easier to start conversations by talking about myself.
2. 2. I usually listen about as much as I talk.
3. 3. I tend to be long-winded.
4. 4. I rarely interrupt others.
5. 5. When people hesitate or speak slowly, I try to complete their sentences for them.
6. 6. I pay close attention to what others say, as well as to bodily cues.
7. 7. I find it difficult to make eye contact with the person I am talking with.
8. 8. I can usually tell if someone is angry or upset.
9. 9. I find it difficult to express myself assertively.
10. 10. I expect others to read my mind.
11. 11. I hesitate to interrupt someone to ask for clarification.
12. 12. People often tell me personal things about themselves.
13. 13. I find it is best to change the subject if someone gets too emotional.
14. 14. If I cannot "make things better" for a friend with a problem, I feel uncomfortable.
15. 15. I am comfortable talking with people much older or much younger than I am.
16. 16. I have difficulty saying no.
17. 17. I speak to others the way I like to be spoken to.
18. 18. I get irritated easily.
19. 19. I tend to withdraw from conflict or remain silent.
20. 20. I try to evaluate when someone will be most receptive to my message.

Key: If you answered True to questions 2, 4, 6, 8, 12, 15, 17, and 20, you are on your way to becoming an effective communicator. If you answered True to other questions, select several to improve. Set a realistic goal and seek help from a trusted friend or faculty member.

From Black, B. (2012). *Professional nursing: Concepts & challenges* (8th ed.). St. Louis: Saunders.

Cultural Considerations in Communication

How people communicate and what constitutes "appropriate" communication vary among cultures. The United States is one of the most ethnically and culturally diverse countries in the world; therefore, many patients and clinicians come from a variety of cultural backgrounds. A person's culture includes membership in any number of subcultures, such as people with disabilities or certain sexual identification. Ideally, to promote culturally competent health care, settings should provide a culturally diverse staff that reflects the communities they serve. However, this is usually not the case.

When interacting with patients or colleagues, it is important to determine the degree to which their communication is affected by

culture-specific practices and beliefs. Ask your patient if there are any cultural considerations related to care, communication, or touch that you should be aware of (Hook, Davis, Owen, Worthington, & Utsey, 2013). If time permits, perform a cultural assessment (as discussed in Chapter 5). Do not assume you know your patient's preferences based on your ideas of his or her cultural background, or even worse, based on physical features. See Caselet 10.1 for an example.

Caselet 10.1

Antonia Di'Giovanni



(Photo © Ingram Publishing/Thinkstock.)

Antonia Di'Giovanni was a patient in the prenatal clinic. She was getting an ultrasound and has expressed her desire to know the gender of her unborn child if possible because she really wanted a boy. When the sonographer determined that it was a boy and announced it to Ms. Di'Giovanni she impulsively hugged Ms. Di'Giovanni, who became very upset, stiffened, and told the sonographer, "Get your hands off me!" This

confused the sonographer because she thought that Italian people liked to be touched. She asked Ms. Di'Giovanni if she wanted her cell phone to call her family, and made a gesture meant to convey talking on the phone. Ms. Di'Giovanni became even more upset and yelled at the sonographer, "Get out of here right now and get my mother!" The sonographer did so, and asked someone else to attend to Ms. Di'Giovanni but was very confused regarding the patient's behavior.

It was determined that Ms. Di'Giovanni was uncomfortable with being touched because of childhood trauma. When the sonographer hugged her, it brought uncomfortable feelings and caused anxiety for Ms. Di'Giovanni. The gesture meant to convey talking on the phone was interpreted by Ms. Di'Giovanni as a gesture that means "giving the evil eye," and she thought that the sonographer was placing a curse on the unborn child. This example demonstrates the danger of using touch and gestures without knowledge of the patient's preferences or cultural meanings.

Discussion Questions

1. 1. What should the sonographer have done to avoid upsetting the patient?
2. 2. Can you see evidence of stereotyping in this caselet? Explain.

Language Barriers

Language differences may be a significant obstacle to providing multicultural health care (Spector, 2017). It may be difficult to understand patients and colleagues who are nonnative English speakers or those with a different regional accent than yours. Healthcare professionals who want to improve their communication skills can learn to change their speech pronunciation with the help of a qualified speech–language pathologist (SLP). The process of changing an accent is known as "accent modification" or "accent reduction" (ASHA, n.d.).

When communicating with non-English speaking patients or family members, or those who do not speak English fluently, you should obtain the services of a trained medical interpreter. See Box 10.1 for guidelines concerning the use of interpreters.

Box 10.1

Guidelines for the Use of Interpreters

- • Use trained interpreters whenever possible.
- • Avoid using family members as interpreters, except in a life-threatening emergency.
- • Obtain the patient's permission to use an interpreter.
- • Explain that the interpreter is required to keep all information confidential.
- • Many healthcare facilities have a "language line" with which you can call a trained interpreter in one of many available languages to communicate with your patient.
- • Allow extra time for communication.
- • Speak directly to the patient, not to the interpreter.
- • Be sure the interpreter is interpreting verbatim, not summarizing or explaining.
- • Clarify with both the patient and interpreter if something is unclear.
- • Make sure you allow the patient opportunity to ask questions or add information.

Adapted from Arnold, E., & Boggs, K. (2016). *Interpersonal relationships: Professional communication skills for nurses.* St. Louis: Saunders Elsevier.

In addition to accents, language usage and colloquialisms also vary. For example, in some parts of the United States, sweet carbonated beverages are called "soda," and in others, "pop." It is always a good idea to clarify terms. Certain expressions, phrases, or "sayings" may be specific to one's culture and not understood by those from other cultures. For example, the phrase "a stitch in time saves nine" is meant to indicate the value of prevention or early intervention. However, to someone unfamiliar with this adage, it may be misinterpreted to mean that sutures are needed. Avoid using such phrases, unless you are sure the person with whom you are speaking will understand.

Active Listening

How well do you listen to patients, to other healthcare providers, or to others in general? In an iconic study by Beckman and Frankel (1984), it was found that physicians interrupted patients' initial statements 77% of the time and that the average time to interruption by the physician was only 18 seconds. In a more recent study, Rhoades, McFarland, Finch, and Johnson (2001) reported that patients spoke, uninterrupted, an average of only 12 seconds after a resident entered the room. See Research Highlight: Speaking and Interruptions During Primary Care Office Visits.

Research Highlight

Speaking and Interruptions During Primary Care Office Visits

One study examined physician–patient communication patterns and interruptions in communication during patient visits with family practice and internal medicine. The results revealed that patients spoke, uninterrupted, an average of 12 seconds after the resident entered the room. One-fourth of the time, residents interrupted patients before they finished speaking. Residents averaged interrupting patients twice during a visit. The time spent with patients averaged only 11 minutes, with the patient speaking for about 4 minutes. Verbal interruptions, a knock on the door, pager interruptions, and computer use all interfered with communication. Computer use during the office visit accounted for more interruptions than pagers. The frequency of interruptions was associated with the patient's less-favorable perceptions of the office visit. Female residents interrupted their patients less often than did male residents. All residents interrupted female patients more often than male patients. Early and increased interruptions were associated with patients' perceptions that they should have talked more. Third-year residents interrupted patients less frequently than did first-year residents (Rhoades, McFarland, Finch, & Johnson, 2001).

Not listening is the most common problem in communication. Poor listening skills prevent the receiver from correctly understanding the content of the sender's message. Many people have developed what is known as *selective listening*. Because healthcare professionals are asked to absorb so much information in a given encounter, they often become selective listeners. Selective listening means filtering out sounds and details that are believed to be of no interest or concern to them. One physician explained it this way: "It is not that we don't hear our patients;

we are very good at practicing 'selective listening,' in which we pick out those patients' words that align best with our own clinical interpretation" (Buist, 2016, pp. 286–287). Unfortunately, selective listening often results in inadvertently filtering out valuable information.

Often, listening is passive. The use of standardized assessment questions often contributes to this problem. A healthcare professional, for example, may be focused on a standardized assessment format of questions and not listening attentively to the answers received; most often they are distracted, half listening, or half thinking about something else. In addition, the interviewer may be focused on the patient's words, or on the form or the computer screen, and not be at all aware of the patient's nonverbal communication as the exchange occurs. Sometimes, even before the patient provides the complete information needed, the healthcare provider is busy formulating a response to what he or she already decided the problem is. Although practitioners have limited time for patient interactions and this approach often seems the most efficient, it is commonly ineffective in gathering robust and pertinent assessment data. In contrast, posing open-ended questions to the patient such as "What can I do for you today?" has been shown to be far more effective to gather the necessary information. Asking open-ended question provides the opportunity for the practitioner to be quiet and listen. However, regardless of the types of questions that we ask our patients or our colleagues, *actively* listening (to their responses) is the key to clear communication and mutual understanding. Active listening encourages people to be more open and provide more complete information.

Active listening is a structured form of listening and responding in which the listener focuses on the speaker's message with all senses (Fig. 10.4). Active listening requires skill and practice; it requires that you focus and give your undivided attention to the speaker. You need to pay attention to both verbal and nonverbal communication while observing for congruence. Active listening requires that you relate what you hear to what you already know and to analyze the speaker's entire message for a deeper understanding (Davis & Brantley, 2005). You must convey sincere interest and caring as you listen. Do not interrupt the speaker, but instead give him or her the deliberate opportunity to complete his or her message. Be aware of your body language; make eye contact and assume an open, engaged posture. Use nonverbal cues to show that you are listening (changing head position, nodding, smiling, etc.). The speaker is the focus of your attention, so take notes and record information only as needed during the interaction. You should use open-ended questions and prompts such as, "Go on" or "Can you tell me more about that?" to encourage more information and further signal that you are actively listening. Seek clarification as needed. It is most important to be silent and listen intently. Withhold your comments and judgment until you have heard and processed the entire message.

To make sure that you correctly understand the sender's message, briefly summarize what the sender has told you and reflect it back to him or her for confirmation after the interaction. This provides the speaker with the opportunity to clarify unclear points and to be sure that you understood the intended message. If you did not, he or she can explain further. You should also take this opportunity to interpret the speaker's words in terms of feelings. Instead of simply interpreting the verbal communication, you might summarize your interpretation of his or her emotion or psychological response to the matter at hand (e.g., "You seem afraid," or "That was really hard for you, wasn't it?"). Active listening is key to avoiding misunderstandings because the process allows you to confirm that you actually do understand what the speaker has tried to communicate to you. Some of the most common active listening techniques are illustrated in Table 10.1.



FIG. 10.4 Active listening requires giving undivided attention to the speaker. (© JackF/iStock/Thinkstock.)

TABLE 10.1

Technique	Description	Example
Using silence	Refrain from speaking. Give the person time to think and organize and share their thoughts without interruption. A healthcare professional may express interest nonverbally through body language.	Healthcare professional is silent and waits for patient to respond.
Offering general leads	The use of short phrases to encourage the person to continue talking.	"Go on." "Anything else?" "And then what?"
Accepting	A nonjudgmental attitude and response that indicates understanding (but not necessarily agreement).	"I understand that you think this amputation is the worst thing that could happen to you." Eye contact; nodding.
Restating	Healthcare professionals use their own words to repeat the main idea expressed by the person. This gives the person the opportunity to correct inaccuracies.	Patient: "I don't believe in taking medication." Physician: "You don't want to take medication."
Reflecting	Questions are reflected back to the person so that he or she can process his or her own answers. The healthcare professional verbalizes the implied feelings in the person's comment.	Patient: "Do you think I should have the radiation?" Nurse: "What do you think you should do?" Patient: "I'm not ready to be discharged." Social Worker: "It sounds like you are afraid to go home tomorrow."
Focusing	Call attention to certain points, words, or events of importance; this is especially useful when the person moves rapidly from subject to subject.	"You are describing many problems with your illness. Let's focus on the sleep problem you mentioned."
Exploring	Examining certain ideas, experiences, or relationships further.	"Tell me more about that." "Can you describe that experience a bit more?"
Seeking clarification	An attempt to clearly understand the meaning of the person's statements by asking for further information.	"I'm not sure I understand exactly what upset you during your daughter's visit. Can you explain that to me again, please?"

Verbalizing the implied	Put into words what the person has only said indirectly. This allows the person to agree or disagree.	Patient: "It's a waste of time for me to be here." Physical therapist: "Are you feeling like no one is helping you?"
Summarizing	The healthcare professional highlights the main idea expressed during the interaction.	"You had two main concerns tonight. The first one was..."

Active Learning

Listening Exercise

This exercise requires you to have a partner to complete it. It will provide you with an opportunity to practice and experience active listening. One person will be the "speaker," and one person will be the "listener." Roles may be switched after completion of the exercise, if desired, so that both participants will have a chance to practice and experience active listening.

Instructions for the Experience

1. 1. The speaker is instructed to describe a loss he or she has experienced in his or her own life. It can be loss of a significant person, loss of a pet, loss of some aspect of health, loss of an object, or any other significant loss in the person's life.
2. 2. The speaker is to talk about the loss for 5 minutes.
3. 3. The second person is the listener. The listener needs to listen silently for 5 minutes. The listener may not speak at all during the 5 minutes.

Discussion Questions

1. 1. For the speaker:
   - What did it feel like to describe your loss?
   - How did the listener respond to you?
   - Did you feel that they were being attentive?
   - Was there any particular thing that made you feel that they were in fact listening to you?
2. 2. For the listener:
   - How did it feel for you to listen in silence for 5 minutes?
   - Did the 5 minutes seem short or long?
   - What aspects of the telling of the story of loss were most significant to you?
   - What did you learn from this experience of attentive listening?

Hospice Education Network. (2013). *ELNEC Core Module 6: Communication—Listening Exercise*. Washington, DC: American Association of Colleges of Nursing.

Interprofessional Communication

The actual words that we choose to use are important. Healthcare professionals have a large vocabulary of medical terminology and technical terms. This "language of health care" is often foreign to those unfamiliar with medical terminology. In fact, sometimes the use of discipline-specific terminology is not understood by our professional colleagues. The use of this unfamiliar language, or jargon, may lead to misunderstanding and intimidation in our patients and our colleagues. Both patients and professionals sometimes fail to seek clarification and hesitate to ask questions for various reasons (being embarrassed at not knowing, feeling "less than," feeling "stupid"); therefore, it becomes imperative that we avoid jargon and choose words that can be clearly understood by most people. Lack of a common language can result in diagnostic errors and inappropriate treatment. Use terms that provide clear, objective, and specific information and that are not open for interpretation. When it is necessary to use unfamiliar words and terms, it is our responsibility to clearly explain them and make sure that our patient or colleague understands our message. For example, a statement like "You should take your Lisinopril once a day" is not clear; the healthcare professional giving this instruction should say clearly, "You will need to take Lisinopril, which is your blood pressure medication, once a day. It is best to take it in the morning when you first get up so it will work throughout the day."

Respectful Language

The way we use language affects others. Healthcare professionals are expected to demonstrate respectfulness in all communications by using words that respect the strengths, skills, talents, and individuality of others. The principles that follow will be useful in acknowledging all people on an equal basis through the language that you use (Law Society of British Columbia, n.d.). They are useful in helping to avoid unintended offence through increasing our awareness of many common assumptions and prejudices used in everyday language.

These principles are useful for ensuring respectful language usage; the first two principles are closely related. The first principle is *Avoid mentioning personal characteristics unless they are relevant*. Personal characteristics, such as race, sexuality, diagnosis, or disability should be used only when they are relevant to the specific communication. When a person's personal characteristics are relevant to the communication, follow the second principle of *inclusive language and person-first construction*. Inclusive language doesn't demean or stereotype people based on personal characteristics like gender, race, ethnicity, disability, religion, or sexual orientation. Inclusive language avoids the use of certain words that might be considered to exclude particular groups or people, especially gender-specific words, such as "man" or "mankind," and masculine pronouns, such as "his," the use of which might be considered to exclude women (Collins English Dictionary, n.d.). It is equally important to avoid terms that exclude, marginalize, diminish, or lower the status of any individual group (e.g., "us and them" constructions). Person-first construction places the person ahead of personal characteristics (e.g., "a person with schizophrenia" instead of "a schizophrenic"). *Person-first communication* focuses respectful attention on the individual's personhood rather than on characteristics such as their disease, disability, culture, or ethnicity (Law Society of British Columbia, n.d.).

The third principle relates to specific terms that you might use when

Vocabulary and

referring to groups or individuals. Do not make assumptions about how an individual may want to be addressed; it is most important to respect the preferences of the person being addressed (Law Society of British Columbia, n.d.). One example can be found in Chapter 1 in the discussion related to which term should be used when referring to the consumer of care (patient, client, consumer, or service-user). The solution to this dilemma is if in doubt, it is best to simply ask what the person wishes to be called. The same holds true for the dilemma of what "name" to call a person. So, when deciding whether to call a person (colleague or patient) by a formal title or simply by his or her first name, it is generally best to ask. This same principle applies to groups we may work with in our communities; for example, a group for teens overcoming issues related to an experienced sexual assault may prefer to be called a "survivors" group rather than a "victims" group. Another example is the use of gender-specific pronouns with transgender patients. Sometimes, especially at the beginning of the transition process, transgender individuals may adopt a gender identity different from their gender presentation. In these cases, it is best to ask for the gender-specific pronoun preference of the individual, instead of making an assumption about how the person would like to be addressed.

The fourth principle focuses on the use of *gender-neutral language*. Avoid the use of biased or stereotyped terms that may be demeaning. Generics are nouns and pronouns that are intended to be used for both men and women. However, linguistically, some terms once considered generic are now seen as male-specific. For example, the word "man" was generically used to mean "human being" or "person," but over the years it has come to mean only "male persons," and the term "chairman," originally intended to be gender neutral, has been replaced by the term "chairperson" as a more appropriate generic term. Be careful that the generics you choose to use are indeed gender neutral. In addition, avoid using gendered adjectives where gender is not relevant (e.g., "male nurse," "lady doctor") (Law Society of British Columbia, n.d.).

The use of respectful language is incredibly powerful in healthcare communication. Consider the way that colleagues and patients speak to you; consider how the words that they use to describe you can create pride, identity, and purpose. On the other hand, consider how the use of negative, incorrect, or demeaning language can be detrimental to your sense of self-worth and well-being. It is important that we consistently incorporate all of the principles of respectful communication in creating and nurturing a sense of partnership with those we care for.

Interprofessional Communication Tools

Accurate and complex information needs to be communicated within the context of the interprofessional team, sometimes within a short period. As part of an effort to reduce errors in healthcare settings, The Joint Commission analyzed more than 4800 sentinel events and identified communication as the top contributing factor to medical error, with handoffs playing a "role in an estimated 80% of serious preventable adverse events" (The Joint Commission, 2010, as cited in Popovich, 2011, p. 55). Preventable adverse events, such as injuries related to medical errors, are a major cause of death in the United States. Failures of communication, including miscommunication during transfer of patient care from one clinician to another, are a leading cause of these errors.

The phrase *patient handoff* is used to indicate "a transfer of care involving a transfer of information, responsibility, and authority between clinicians" (Abraham, Kannampallil, & Patel, 2014, p. 154). The handoff process involves a "sender," the caregiver transmitting the patient information and care of the patient to the next clinician, and a "receiver," the caregiver who accepts patient information and the care of the patient. The intent of the handoff is to clearly and accurately communicate patient information in the provision of safe and continuous high-quality care. Handoffs happen when accountability and responsibility for a patient are transferred from one team member to another (e.g., shift-to-shift report), from one service program to another (e.g., from an inpatient unit to a diagnostic service area), or from one organization to another (e.g., from inpatient rehabilitation to a community rehabilitation program).

Standardized Communication Tools

The commercial aviation industry had significant success preventing flight accidents related to communication failures using standardized communication tools (Nemeth, 2012). These tools have been instrumental in the creation of strategies to enhance teamwork and reduce risk in healthcare settings (Leonard, Graham, & Bonacum, 2004). Because of the complexity of care, coupled with the inherent limitations of human performance, it is critically important that clinicians have standardized communication tools to ensure accuracy during patient handoffs (Leonard, Graham, & Bonacum, 2004). The adoption of standardized communication tools is proposed to be an effective strategy in enhancing teamwork and reducing risks; standardized communication techniques can serve the same purpose that clinical practice guidelines do in assisting practitioners to make decisions and take action (O'Daniel & Rosenstein, 2008). To meet this need, a wide variety of handoff strategies and tools were developed and implemented.

Simple guidelines are best for managing complex environments. One example is SBAR (situation, background, assessment, recommendation), an easy-to-remember situational briefing model for communication, which has been found to be very effective in briefing the entire care team. It quickly ensures that all team members are "on the same page" and that all relevant clinical issues are being addressed (Leonard, Graham, & Bonacum, 2004). More information about SBAR can be found in the Additional Resources box at the end of this chapter. The quality of a handoff process "is adversely affected by many factors, including the lack of standardized handoff tools; information omissions and inaccuracies; communication breakdowns related to language, social, and skill issues; lack of training; and contextual constraints" (Abraham, Kannampallil, & Patel, 2014, p. 154). Although many quality improvement projects on patient handoffs have been conducted, the search for the ideal standardized tool continues (Patterson & Wears, 2010). Each healthcare institution should identify standardized communication tools that are best suited to their own needs and environments. Information related to some of the most common handoff tools can be found in the Additional Resources box at the end of this chapter.

Difficult Conversations Within the Interprofessional Team

Difficult conversations in the workplace are challenging to everyone. These include conversations with patients or colleagues in which we have to deliver unpleasant news, discuss a safety concern, address a delicate personal subject, or talk about something that needs to change or has gone wrong. These conversations can be uncomfortable, and therefore

they are often avoided. The problem with avoidance is that it blocks interprofessional communication, it is an obstacle to achieving optimal care outcomes, and it may contribute to inadvertent patient harm. When considering whether to have a difficult conversation, it is important to consider that best practices dictate effective communication, even when difficult (Polito, 2013). There are published guidelines and recommendations available to assist healthcare professionals in this area (Kersun, Guy, & Morrison, 2009). The following section presents discussion and guidelines for having difficult conversations.

Effective teams share a common purpose and intent, trust, respect, and collaboration; they value familiarity over formality and watch out for one another so that mistakes are not made (O'Daniel & Rosenstein, 2008). Creating a safe environment for such familiarity to occur is a prerequisite and requires flattening the hierarchy, or power distance, between team members to make it safe to speak up, express concerns, and alert team members to unsafe situations (Leonard, Graham, & Bonacum, 2004). Knowing how to speak up and communicate concerns is an important skill to acquire. Although we can sometimes take time to plan for a difficult conversation, that is not always possible, so it is crucial to be prepared.

General Guidelines for Having Difficult Conversations

Concerns, problems, and issues should be handled quickly and at the level at which they arise. The first step in the process is to approach the interaction with openness and an interest in problem solving, rather than a need to blame or to be right. Use direct statements (i.e., "I see a problem and I need to talk to you about that now"). Address the person involved calmly and directly in a "matter-of-fact" manner; state the problem clearly and objectively and with respect for the person you are addressing. Ask that you be allowed to share your concern fully, without interruption, with the promise that you will listen to what the other person must say afterward. Stay on point; be focused. Focus on the problem without value judgment; avoid value-laden terms (e.g., "good," "bad," "wrong"). Avoid words like "always" and "never," they overgeneralize and are generally inaccurate. Do not just focus on the problem; propose what you think is a safe and realistic solution. After you have shared your concern and proposed a solution, actively listen to the other person's response; do not interrupt. Make sure you understand what he or she said before you respond. Ask for clarification if needed. Continue the process illustrated by the assertion cycle (Fig. 10.5) until you agree on a solution.

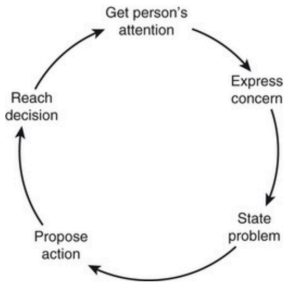

FIG. 10.5 The assertion cycle. (From Leonard, M., Graham, S., & Bonacum, D. [2004]. The human factor: The critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care, 13*[suppl 1], i85–i90.)

These guidelines can be adapted to talk about interpersonal issues between you and a peer or another team member. When discussing the issue, focus on how it specifically affects you, be clear and calm, be respectful, and use "I" statements (for information on "I" statements, see the section on "I" statements that follows). Ask how the situation affected the other person. Give the person the opportunity to share his or her perspective. Use active listening. Acknowledge your contribution to the situation, see your part, and invite the other person to work with you to make things better.

Tempering Emotion

The expression of strong feelings, or emotions, interferes with problem-solving communication. It is important to own your own feelings, rather than blaming other people. There will be differences in how you and others see things. One communication strategy that is effective in preventing blame and shame related to others is the use of "I" statements. "I" statements allow you to be assertive in telling another how you feel and state your case without arousing the defenses of the other person. Be clear and specific about what the other person may have done that contributed to your reaction, but frame it carefully. "I" statements allow you to say how the situation makes you feel or what you would do in that situation instead of telling the other person what he or she should or should not do. Consider, for example, that you are angry and becoming resentful because your peer frequently comes back from lunch late, causing you to miss having lunch with your friends at a prearranged time. Using an "I" statement you might say, "Tom, I feel pretty angry because I missed having lunch with my friends. This is the second time this week you came back late; can we talk about that?" Addressing the issue of your anger in this way, instead of avoiding it, represents clear, respectful communication that can lead to a problem-solving conversation instead of growing resentment. In another example, consider observing a team member preparing to remove a surgical dressing and inspect an incision on a patient, without first washing hands and donning gloves. Rather than saying, "Wash your hands. You can cause an infection by not washing your hands and wearing gloves!" you can focus calmly on the other person's actual behaviors. You can say something like, "I know you are really busy. I'll get you some gloves while you wash your hands." In this way, you focus on resolving your fear that the patient will get an infection as well as providing the solution to the identified problem.

Critical Language: Using the CUS Strategy

The use of critical language is a strategy that identifies agreed-upon communication signals (short phrases) within the culture of a specific interprofessional team to indicate the need to stop and communicate a significant care concern. To do this the team agrees on several short phrases that they will adopt. The adoption of critical language was derived from the CUS Program at United Airlines; CUS stands for the following short phrases: "I'm *concerned,* I'm *uncomfortable,* this is *unsafe,* or I'm *scared*" (Leonard, Graham, & Bonacum, 2004, p. i87). When any of these phrases are used, all team members know that "we have a serious problem here, stop and listen to me." The use of critical language creates the needed environment to get everyone to stop, listen, and problem solve. It creates the expectation that the issue at hand will be communicated clearly and directly.

Crisis Communication

Leadership and clear communication are critical in an emergency or crisis situation. Those present must work together smoothly as an effective team. Because most clinical and community emergencies don't allow for precise preplanning, a leader must quickly emerge at the scene who will provide clear direction. The leader in an emergency or crisis situation is usually the professional at the scene who has the education, training, and the team expectation of being in charge before the emergency occurred. The leader "must be able to rapidly analyze a complex environment, assess where and what sort of help is required, assemble an effective, multidisciplinary staff of care providers, and communicate effectively among staff and population in need" (Hershkovich, Gilad, Zimlichman, & Kreiss, 2016, p. 1). There can be only one leader. The leader is in charge during the emergency and responsible for navigating stressful and frequently changing, circumstances. The leader must be able to make informed decisions rapidly and be capable of ongoing self-assessment and adaptation to unfamiliar and rapidly changing conditions, thus ensuring the seamless provision of optimal care (Hershkovich, Gilad, Zimlichman, & Kreiss, 2016).

Efficient communication is a crucial aspect of leadership during an emergency situation. Team discussions and consensus have no place during an emergency; to avoid confusion, errors, and omissions the leader is the only one who gives directions and/or delegates to the team. Effective leaders are decisive and able to communicate clearly (Fig. 10.6). There is no debate about directions given by the leader in an emergency. To provide both efficient and effective direct communication the leader should address team members by name to make it clear who they are speaking to; no one on the team is named *somebody,* so saying "Somebody call a Code!" may not get immediate results. A form of physical contact, such as placing a hand on a person's shoulder, can be used to get someone's needed attention, and in all cases, the leader should make eye contact with the person he or she is communicating with to further confirm who he or she is speaking to. When giving directions to the team it is important that the leader "tell, don't ask." Although it is considerate to say "please," saying "Will you…?" or "Could you…?" leaves some question about what is expected.



FIG. 10.6 In emergency situations, verbal communication is handled by a designated team member.

Throughout any crisis situation, the leader is constantly processing verbal and nonverbal communication from the team and from the emergency situation. If something is not working, the leader must demonstrate the confidence and flexibility to change direction and clearly communicate changes to the interprofessional team.

Giving and Receiving Performance

Feedback

Giving timely, sensitive, instructive feedback to someone related to workplace performance can be challenging. Responding to someone's response to your evaluation of their performance or responding to feedback on your own performance can be equally challenging. When faced with performance issues that have the potential for negative patient or population outcomes, it is best to deal with them promptly. Many healthcare professionals feel poorly equipped to handle such conversations, and resistance to confronting performance issues is common (Fig. 10.7). Effective team members must be able to tackle, rather than avoid, such conversations. Guidelines vary, but generally it is always best to provide performance feedback in an appropriate space, preferably one that is quiet and private. Maintaining confidentiality is important. It is important to set a positive tone and be empathetic, respectful, and open-minded. Always project willingness to understand the other person's point of view. People do not always understand how their behaviors affect others around them; they do not want to be told they are failing or making mistakes. Come to the discussion prepared for an open dialogue with facts and data to support your case, but allow the other person to offer a plan for improved performance and remediation of the situation.



FIG. 10.7 Resistance in confronting performance issues is common.

Stay positive. Focus on the issue, not the person. Do more active listening than talking. Explore the issue together. It is not uncommon for the person receiving the feedback to resist and deny that it (i.e., the situation) is his or her fault. If you hear denial or excuses ("I don't have time," "We've always done it that way"), a suggested practice is to "respond with fogging"; a partial agreement presented in a nondefensive

and caring way to handle the resistance statement ("That may be, yet you still need to follow protocol," or "Perhaps so, yet...") (Polito, 2013, p. 142). Do not dwell on the negative. Be respectful, calm, and clear. Research shows that these conversations are made less threatening and less difficult if the parties communicate in ways that "protect" and "give face to" each other (Bradley & Campbell, 2016). This involves downplaying or not drawing attention to the other person's failings; giving the other the chance to rationalize or justify his or her actions; and supporting and enhancing the other's status through complements, affirmations, and indications of group inclusion. These acts show respect for the other person and help him or her to feel competent, liked, and valued (Bradley & Campbell, 2016).

Work toward what is expected next. Ask for the individual's suggestions on how he or she might improve performance; consider alternatives. Be clear with what is expected. The goal is that the team member will leave the conversation knowing he or she can do better and what the expectation is. The person should know and acknowledge that he or she is accountable for self-improvement. Plan to follow up in a reasonable amount of time to see how things are improving.

Additional Resources

The following resources are provided to assist you in identifying effective communication tools and techniques to facilitate discussions and interactions enhancing interprofessional collaboration. These resources are especially useful during transition periods and emergencies, when mistakes due to miscommunication are more likely to happen.

Foundational Resource

The Transitions of Care Portal.
https://www.jointcommission.org/toc.aspx

This portal is a valuable source of information from The Joint Commission and other healthcare organizations related to the topic of transitions of care (the movement of patients between various healthcare settings).

Patient Handoff Resources

A *hand-off* is a real-time process of passing patient-specific information from one caregiver to another to ensure the continuity and safety of the patient's care (The Joint Commission, 2014). This process results in the transfer and acceptance of patient care responsibility and is achieved through effective communication. Some of the most common hand-off tools are presented here.

CLINIC SAFE Handoffs Pocket Card.
http://www.beckersasc.com/asc-quality-infection-control/patient-safety-tool-clinic-safe-handoffs-pocket-card.html

The Picker Institute offers a free pocket card that was developed by University of Chicago Medical Center researchers to guide safe end-of-year patient handoffs in an internal medicine residency clinic. The CLINIC SAFE pocket card is part of a University of Chicago project called Engineering Patient Oriented Clinic Handoffs, or EPOCH.

Hand-off Communications Targeted Solutions Tool™ (TST).
http://www.centerfortransforminghealthcare.org/tst_hoc.aspx

The Joint Commission's Center for Transforming Healthcare offers this tool to organizations working to improve their hand-off process. The TST® for Hand-off Communications:

- • Facilitates the examination of the current hand-off

BOOK REFERENCE:

Slusser, M, et. Al. (2019). Foundations of Interprofessional Collaborative Practice in Health Care. Elsevier Inc.