... provided in this activity is for continuing education ... d is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

... All Rights Reserved. Materials may not be reproduced without the expressed written permission or consent of Elite Professional Educat... LLC. The materials presented in this course are meant to provide the consumer with general information on the topics covered. The information provided was prepared by professionals with practical knowledge of the areas covered. It is not meant to provide medical, legal, or professional advice. Elite Professional Education, LLC recommends that you consult a medical, legal, or professional services expert licensed in your state. Elite Professional Education, LLC has made all reasonable efforts to ensure that all content provided in this course is accurate and up-to-date at the time of printing but does not represent or warrant that it will apply to your situation nor circumstances and assumes no liability from reliance on these materials. Quotes are collected from customer feedback surveys. The models are intended to be representative and not actual customers.

Course verification

All individuals involved have disclosed that they have no significant financial or other conflicts of interest pertaining to this course. Likewise, and in compliance with California Assembly Bill No. 241, every reasonable effort has been made to ensure that the content in this course is balanced and unbiased.

Reflection + answer these 2 question

Learning objectives

After completing this course, the learner will be able to do the following:

- Examine the historical and theoretical basis of communication concepts.
- Demonstrate understanding of the fundamentals of human communication and their application to communication in healthcare.
- Describe barriers to healthcare professional-patient communication that impede therapeutic communication and positive patient outcomes. Compare ways to improve the effectiveness of communication with patients.

INTRODUCTION

Few things bind us as humans as tightly as communication. We all do it – communicate, that is – in a variety of forms and with varying degrees of efficacy. On its most fundamental level, communication among humans amounts to the transfer of information or ideas from one person to another. This point-A-to-point-B transmission process seems a simple enough concept, and it is so universally understood and accepted that it tends to be taken for granted. Yet communication between people is not necessarily a straightforward endeavor, nor even an easy one. Rather, communication represents a complex, dynamic social activity that pervades every aspect of our interaction with others. It is the "on" switch that powers all of human connection. It is the means by which we form and manage relationships, however simple or complicated those relationships may be.

In healthcare settings, few things promote the development of successful patient-provider relationships – and the positive impact of those relationships on patient outcomes and satisfaction – as indispensably as effective communication. Put simply, good relationships, built with good communication skills, make for good outcomes. Evidence supports this formula: The quality of patient-provider relationships has been shown to improve patient satisfaction and health outcomes (2016; Haverfield et al., 2020; Kornhaber et al.). The effective communication between healthcare clinicians and their patients demonstrates such wide-ranging benefits as improved adherence to treatment regimens, better utilization of healthcare resources, and lower costs (Drossman & Ruddy, 2020; Okunrintemi et al., 2017). On the other hand, lack of effective communication among healthcare providers can jeopardize patient safety. Miscommunication among clinicians, particularly during patient handoffs, has been found to be a leading cause of preventable adverse clinical events (Mardis et al., 2017; Muller et al., 2018). Inadequate or ineffective communication also can impact clinicians' job satisfaction, a key marker of patient safety and quality care. For example, nurses who perceive communication positively in their work settings are less likely to experience burnout or leave the profession (Sullivan Havens et al., 2018; Vermeir et al., 2017).

Healthcare professional consideration: Successful communication in clinical practice requires skill, sensitivity, and intuition. To optimize health outcomes, the practitioner-patient relationship relies as much on the development of trust and respect; the understanding of, and sensitivity to, patients' values, perspectives, perceptions, and culture; and the display of empathy as it does on clinical observ... and assessment.

Despite advances in communication theory and methods, historical barriers to effective communication in healthcare – constraints on time and staffing, environmental distractions, and shifting patient perceptions among them – steadfastly remain. Clinician education has traditionally favored clinical skills relative to a focus on so-called soft skills, such as communication, leaving many healthcare professionals feeling ill- equipped to successfully address the wide array of patient and collegial interactions they encounter, often for the first time, on the job. In addition, research is exploring the ways that rapid evolution of the healthcare industry and emerging technologies affect healthcare professionals' current and future ability to respond to their patients' and colleagues' communication needs, particularly among professionals who lag behind adoption of new technologies (De Leeu... et al., 2020). In the short term, as healthcare organizations endeavor t... fulfill The Joint Commission (TJC, 2010) standards regarding patient-centered care, healthcare professionals are called upon to successfully incorporate patient-oriented communication techniques into practice.

FUNDAMENTALS OF COMMUNICATION

Commonality lies at the root of communication. The very term derives from the Latin noun *communis*, which means "common," and is related to the Latin verb communicare, meaning "to make common" or "to share." Humans have participated in that sharing since long before ancient Rome attached a word to it, however. The phenomenon of communication has been fundamental to human life – and human survival – since the beginning of humanness itself.

Along the continuum of human existence, from prehistoric people's use of pictographs to the 21st century's manipulations of complicated computer code, we humans gained an evolutionary edge through our capacity to attach common meaning, both proximate and conceptualized, to our reality in ways that other species cannot. Researchers have long theorized that, from the start, our ability to mutually understand and exchange information – not only about our immediate surroundings but also, importantly, about abstractions beyond our direct experience – set us apart (Dance & Larson, 1976). Our values, beliefs, and emotions, alongside our perception of such wide-ranging concepts as freedom, fairness, art, or healthcare, rely o... our human aptitude for ascribing common meaning to both the tangi... and the abstract. Our cognitive powers, along with our collective capacity to think symbolically and to share that thinking with others of our species, are a uniquely human characteristic (Miyagawa et al., 2018). Evidence suggests that it is enabled by a distinctive area of ... brains, namely, the human ventrolateral frontal cortex, associate... language and other cognitive processes (Snow, 2016).

In other words, communication is part of our nature; it is a significa... portion of what makes us human.

Definition of communication

As central as communication is to human nature, it was not until the 20th century that scholars began to industriously theorize about the nature of communication. In little more than the past 100 years, communication science, as a distinct academic discipline, has explored the characteristics of language and other facets of communication, as well as developed models explaining the process by which it occurs. Yet definitions of communication remain as diverse as the theories that describe it, and theorists wrangle over factors, such as culture and intent, that may influence the meaning of the term (Trenholm, 2017).

Even as the science evolves, long-standing research has identified observable characteristics of communication (Dance, 1970). Communication, for example, is an inevitable behavior among people. Influential work in communication theory asserts that "no matter how one may try, one cannot not communicate" (Watzlawick et al., 1967, p. 30). We communicate even when we do not realize we are doing so.

Language, of course, often comes to mind when one considers the what of communication, but language is not unique to humans. Animals and certain plant species have their own means of communication. Human language distinguishes itself by its use of symbols. Our capacity to conceptualize, to think beyond our temporal being, allows us to assign meaning, not only to objects but also to actions and emotions, about all of which we conventionally share understanding (Onjefu & Olalekan, 2016). Across geography and culture, we use language to signify our collective knowledge of physical things (form) – book, chair, or stethoscope, for instance. We also use symbolic language to commonly recognize the manner in which we interact with those things (such as read, sit, or listen) and how we feel about them (for example, bored, comfortable, or grateful). No matter how you feel about it (emotion), you are able to read and understand (action) this course (object) because you share with your fellow humans a long-established, mutual understanding of the symbols – in this case, the words – it contains.

Language, then, conveys meaning, but words, spoken or written do not make up the whole of human language. Images and nonverbal actions carry meaning as well. Facial expressions; posture; affect; eye contact (or lack of it); tone, inflection, and pitch of voice; touch; physical gestures; social distance; and personal appearance, all have import. They each transmit a symbol or set of symbols – in other words, a message – that "says" something without need of speech. By way of example, a smile or grimace, a nod of the head, a direct or muted gaze of the eyes, and a subdued or high-pitched tone of voice all send a message from one person for interpretation by another, as do the manner that one sits and the way in which one dresses. Even silence can transmit meaning (Bonvillain, 2020).

Language does not always connect us. We may speak different dialects, for example, or our perceptions of body language can differ by culture. Human communication universally allows us to form and sustain relationships. Communication prompts interaction between people or groups of people by transmitting meaning in context, including dialect and culture. The words language and communication are often used interchangeably, but the terms differ in the same way the concepts of what and how diverge. Language is the means behind the meaning; in other words, verbal and nonverbal language are modes of capturing meaning (the what). Communication is the process by which that meaning is shared among people (the how).

Moreover, the communication process is neither stagnant nor one-way. For transmission of meaning to occur between humans, whether that meaning is expressed dynamically as information, thoughts, ideas, or feelings, it takes (at least) two – that is, two or more people. Human communication exists when messages are sent and subsequently received by people.

Of course, communication is not always an effective transmission of meaning. It may be misinterpreted or misunderstood, and its quality varies as much as the volume of messages sent and received in the course of human life. Multiple factors influence communication, from the channel or medium used to transmit information or other messages to the context – environmental, social, and cultural, to name a few – in which communication occurs. Scholars have extensively explored the impact of channel and context on communication, including within the dynamics of the healthcare climate and settings, but for purposes of this writing, a working definition of communication harnesses its principal characteristics.

On the basis of its component parts, human communication, as summarized in Table 1, is a dynamic, bidirectional process in which people form relationships by interacting through symbols to create, interpret, and exchange the meaning of thoughts, ideas, information, and emotions (Sillars & Vangelisti, 2018; Wood, 2018).

Table 1: Characteristics of Communication

Communication is ...	Meaning that ...
Ongoing	Communication is an enduring human behavior with no fixed beginning or end.
Two-way	Communication occurs when messages are sent and received.
Social	Communication allows people to create and sustain relationships.
Symbolic	Communication relies on the uniquely human capacity to generate meaning from symbols, including verbal and nonverbal language.

Note. Adapted from "Communication in Our Lives" by J. T. Wood, 2018, 6th ed., Wadsworth. Reprinted with permission. "Communication: Basic Properties and Their Relevance to Relationship Research" by A. L. Sillars and A. L. Vangelisti, 2018, *The Cambridge handbook of personal relationships*, p. 243-255. Cambridge University Press. Reprinted with permission.

Forms of communication

Communication, as a process, takes several forms. Here, too, scholars differ in the specificity of communication's forms, but a general discussion of the five principal types of communication clarifies the ways that people participate in the process.

Intrapersonal communication

Intrapersonal communication is self-talk. It is the two-way process of sending and receiving thoughts, ideas, information, and emotions within one person – a persistent personal dialogue that occurs primarily within our minds. In a social context, its influence on our self-identity and communication behaviors has been characterized for decades as communication in its most important form (Farley, 1992). Research indicates that self-talk serves important behavioral and self-regulating functions that either contribute to (positive self-talk) or detract from (negative self- talk) life satisfaction, which is regarded as a measurement of mental health (Kyeong et al., 2020).

We participate in internal conversation when we react to internal stimuli and external phenomena. When we are tired, for example, we communicate to ourselves that we should rest or sleep. When we observe an event that is external to us – anything from the pinging of our alarm clock to the blare of an emergency code, for instance – we respond with inner, instantaneous discourse about how we feel about it and what we will do in response.

We converse with ourselves about the things we experience as well as the people with whom we come in contact. We assess experiences or people and express feelings about them through an inner monologue. Who among us has not "silently" thought that an experience was, for

example, worthwhile or worthless, or that another person was, say, delightful or unpleasant?

Much of self-talk occurs at low levels of consciousness (Riccillo, 1994, as cited in Wrench et al., 2020). You communicate to yourself the need to turn off the alarm clock, typically with little awareness of doing so. On the other hand, you are likely to be more cognizant of your feelings – happiness or frustration, for instance – about having to wake. Internal vocalization allows us to process thoughts and sentiments that rise to high levels of awareness, not only in response to immediate stimuli but also to think through and plan future actions or reflect on past interactions. It helps us rehearse, for example, what we will say to others and the manner in which we will say it.

As with any other form of communication, intrapersonal communication can be expressed verbally or nonverbally. We might talk to ourselves "out loud" with vocal expressions of happiness or frustration. We might use a gesture, such as a thumbs-up motion, to reinforce our satisfaction with ourselves, or we might admonish ourselves with a slap on the forehead. We might also distill what is on our minds in writing by way of keeping a journal or diary.

At its core, our intrapersonal communication enables us to define our idea of ourselves. Our self-concept, and consequently our self-esteem, draws on our ability to tell ourselves we are good or bad, satisfied or dissatisfied, competent or inept. Oles and colleagues (2020) suggest that intrapersonal communication in the form of self-talk regulates self-control and direction ("You didn't do that well. Try again."), but it also offers opportunities to engage in inner monologues ("Why didn't I do that well the first time?") as well as inner dialogues that may involve another person ("If my supervisor saw that I didn't do that well the first time, she'd say I was lazy.").

Healthcare professional consideration: Internal dialogue involves contemplation, or reflective thought. Reflective thinking is an intentional thought process widely lauded in education and practice as a standard for improving, not only self-awareness, but also critical-thinking skills (Barbagallo, 2021; Mikes-Lui et al., 2016). Reflecting on an interaction allows the person to improve their communications by evaluating how the interaction may have been more effective and what role they played in the outcome.

Interpersonal communication

Interpersonal communication is the exchange of thoughts, ideas, information, and feelings between two or more people. It is the behavior we use to create, maintain, and end relationships. It is how we connect with one another, and the more we interact with another person or people, the more interconnected and interpersonal our relationships become.

We communicate interpersonally using all modes of verbal and nonverbal interaction. A spoken conversation between two people is interpersonal communication, but so is writing an email or a birthday card. A smile, wink, or scowl; a pat on the back; and a squeeze of another's hand count as interpersonal communication, too. Researchers have devoted copious amounts of study to the complexity of interpersonal communication – and with good reason: Interpersonal communication makes up the majority of human interaction (Trenholm, 2017). Noted theorist Julie T. Wood (2016), for example, describes several fundamental, widely accepted characteristics of the phenomena:

- *Omnipresent.* Interpersonal communication is ever present. Where relationships exist, communication also exists. Consciously or subconsciously, verbally or nonverbally, we cannot escape the sending and receiving of messages when we interact with other people. Anyone we personally encounter – a family member, friend, colleague, employer, or the person at the grocery store checkout counter – receives messages we transmit, whether in a conversation, an email, a smile, or myriad other ways.
- *Ongoing.* Interpersonal communication also is ever changing. As a process, it transforms over time. Our interpersonal communication with others has no clear beginning or end point; it is connected to the past, the present, and the future. One communication event precedes another, which precedes yet another, and so on. Similarly, a single communication event can lead to other events in the near and long term. Consider, for example, a colleague who approaches you for advice. Suppose you have worked with this colleague for months or even years. Your communication, and consequently your relationship, with this colleague did not begin with the advice they have just sought. Rather, your previous interactions led to this communication moment, likely because earlier communication established trust or authority between the two of you. It is possible in this scenario that the whole of your communication (and again, your relationship) could end once you have offered your colleague guidance (they may leave your place of employment, for instance). Yet it is equally possible you will interact with them again – within a few moments, the next day, or at some other future point. Your communication with your colleague might change over time and be influenced by a variety of environmental, social, or other factors, but its start and finish cannot be definitively determined.
- *Selective.* Of course, not all of interpersonal communication is as familiar as, say, your interaction with a colleague, or, more to the point, a close friend or family member. Interpersonal communication is selective in that it spans a continuum from impersonal to intimate contact. Sometimes we encounter strangers, as in the case of a grocery store clerk, with whom we have little communication, let alone communication of a personal or private nature. Other times when we engage in small talk with others, our relationships are casual, involving equally casual, but not personal, communication. Most interpersonal communication involves these two modes. We acknowledge people impersonally as though they were objects (such as a homeless person), or we communicate superficially with them, acknowledging them within the context of social roles (as with a classmate, co-worker, or patient) but refraining from engagement on a personal level. We select the relatively few people whom we consider unique individuals and with whom we choose to communicate in deep and complex ways.
- *Transactional.* People participating in interpersonal communication each gain meaning from the interaction. Interpersonal communication is by nature transactional and reciprocal. Each person in an interaction simultaneously and recurrently sends and receives messages. Recall that those messages can be transmitted verbally or nonverbally. When you instruct a patient and the patient nods to signify their understanding, each of you has given and taken in messages in a circular manner: You present information, your patient acknowledges receiving the information, and the exchange comes back to you as you take in the meaning of your patient's understanding. A variety of environmental, psychosocial, cultural, or other factors might influence that loop, however, which makes interpersonal communication fertile ground for misunderstanding. Some patients may nod acceptance of information when in actuality they do not understand what is being said, and some patients are frequently anxious or in pain and therefore distracted from an effective information exchange. Internal or external distractions, for example, can interfere with interpretation of the content of communication. The patient's comprehension of instructions might be sidelined by their self-talk revolving around health-related worries, or the arrival of another healthcare professional might interrupt, even momentarily, the patient's ability to focus on the information being provided. Culture likewise can contribute to misunderstanding. The up-and-down motion of a nod of the head might suggest affirmation in one culture but signify the opposite in another culture or be a signal to simply proceed in still another. Yet the duality of interpersonal communication, according to Wood (2016), extends beyond the fact of two-person exchange to the sharing of responsibility by people within exchanges. In interpersonal communication, each party shares meaning with the other, but each party also shares responsibility for whether communication is successful. Nurses bear the responsibility to ensure the patient's or caregiver's understanding of critical instructions or consent.
- *Irreversible and unrepeatable.* After you have said or written something, or perhaps used a form of body language to communicate (rolling your eyes, for example), have you ever thought to yourself that you wished you could take it back? Interpersonal communication does not work that way. Inherently, all communication has an impact, and those effects cannot be erased.

As much as one cannot not communicate, as previously noted, one also cannot "unhear" or "unsee" messages and, consequently, cannot undo them. Explanations, apologies, or denials are consequential in their own right, but they do not purge the existence of what was communicated in the first place. Also, interpersonal communication cannot be repeated. Moment by moment, we exert influence through interpersonal communication and become influenced by it. The act of communicating changes us in some way or another. We can no more capture at any moment in time the precise effect on our thoughts and emotions of something we have communicated than we can time travel. Each act of communication in which we participate is unique.

Evidence-based practice! Empathy and authenticity are key components of effective communication. The content of communication needs to acknowledge individual experiences, but also the plethora of experiences that signify why effective communication counts, including good clinical outcomes, improved patient satisfaction, better clinical well-being, decreased litigation, and time savings (Lim & Dunn, 2017).

Group communication

Group communication involves interaction among three or more individuals, but not just any people. The five individuals with whom you stand in a cafeteria line, for example, indeed represent a group, but in this case, the group is little more than a collection of people standing in a cafeteria line. You and the other members of such a group share some common characteristics and goals: We might infer each of you is hungry or thirsty, for instance. You all stand in line for the purpose of paying for your food or beverage. While waiting, you might send messages on an interpersonal level, knowingly or otherwise, to others in the group – by tapping your foot, perhaps, or in some other nonverbal way demonstrating impatience, or by engaging in inconsequential small talk with the person immediately alongside you. If someone with whom you are well acquainted waits in line with you, such as a colleague, friend, or family member, your level of interpersonal communication with that person during your wait will be more intimate than that with a stranger in the group. However, in this scenario, you would not participate in group communication because (absent concerted effort by the group to work as one to, say, hurry the process) you have not communicated as a group.

Rather, group communication occurs when three or more people exchange thoughts, ideas, information, or emotions with the express purpose of achieving an identified objective or outcome. As a goal-oriented exercise, members who participate in group communication exchange ideas and information about a common problem or interdependent aim. Group communication differs from intra- and interpersonal communication in that it tends to be more formal and task-focused, and it is not necessarily voluntary; often one is assigned to participation and/or roles within group settings.

In addition to its emphasis on the achievement of goals, scholars have long defined group communication in light of the manner in which participants' interactions affect group members (Jensen & Chilberg, 1991; Wilson & Hanna, 1990, as cited in Lumen Learning, n.d.). Group communication exists when assembled participants exert mutual influence over one another. In other words, group communication is a collaborative affair. People who communicate within groups do not do so independently; instead, they contribute to a communal exchange of information and ideas that affects each member of the group. Whether by motivation, inspiration, compromise, or manipulation, group members both influence others and are influenced by others in this information exchange (Lumen Learning, n.d.). Communication among interdisciplinary team members in clinical case conference discussions illustrates the concept of mutual influence in group communication. Research demonstrates the coexistence of competitiveness and collaboration in such discussions when, for example, physicians display a (historical) tendency toward dominating group exchanges at the same time nurses and allied health professionals alter the dynamic by questioning medical decision making (Liu et al., 2016).

Evidence-based practice! Use of Balint groups – involving facilitated groups of clinicians who regularly meet to present clinical cases to improve their understanding of clinician-patient relationships (American Balint Society, n.d.) – has been found to enhance both clinician-patient communication and clinicians' confidence in their ability to understand their patients, particularly among triage practitioners during the SARS- CoV-2 pandemic (Yang et al., 2021). Participation in Balient group activities has been shown to improve clinicians' self-efficacy and reduce burnout (Otten, 2017).

A third component of group communication involves group size. The number of participants in a group can affect the cohesiveness and quality of communication within the group. Too few members might result in gaps in perspectives or expertise, for example. Too many members, on the other hand, might disrupt the equal participation of group members. A group's size also determines how many social ties – links, relationships, connections, edges – are needed to join members to each other and to the group (Forsyth, 2018). The mode of communication among group members – face-to-face or through assisted means, such as telephone or two-dimensional video conferencing – likewise can shape the effectiveness of exchange between participants. Communication via conference call, for example, lacks access by participants to body language and other nonverbal cues that might color the discussion, whereas participants' acceptance of video conferencing technology may influence their satisfaction with the modality (Dobosh et al., 2019). The precise number of group members that constitutes an optimal collection of people for effective communication remains a matter of debate. Research focus groups, for instance, are typically limited to 8 to 10 members, whereas group meetings may still allow for each person to participate if the group size is 12 to 15 members. Techniques such as "round robin" or weighted voting can be used to elicit interaction.

However, a consensus view among communication scientists uses size to categorize group communication as either small-group or organizationally based. Small-group communication is typically associated with interpersonal communication behaviors; members of small groups tend to interact with one another as unique individuals. Organizational communication, on the other hand, relies more on the structure, hierarchy, and culture of an enterprise, which govern relationships and the exchange of information within groups (Krcmar et al., 2016). That is not to say that organizations are devoid of interpersonal communication. To the contrary, organizations are made up of individuals who, for the most part, participate in groups of varying sizes, and those individuals influence group dynamics, positively or negatively, through interpersonal communication. In an institutional context, small-group communication operates as a subset of organizational communication (Krcmár et al., 2016).

Regardless of group size, function, or aspiration, communication within groups shares common characteristics, as outlined in Appendix A.

Public and mass communication

The terms *public communication* and *mass communication* are often used interchangeably. The concepts do share similarities, but their differences are sufficiently significant to warrant unique definitions. Public communication is identified as sender-focused, meaning that the bulk of the messages involved in this form of communication originate with one person or group. Receivers consume these messages, but their side of the sender-receiver equation remains somewhat restrained. Public speaking, a familiar form of public communication, illustrates these limits to two-way interaction. By and large, a public speaker (sender) conveys thoughts, ideas, information, and emotion to a collection of people in an audience (receivers) on topics in which an interest is shared. The speaker is typically physically distanced from the audience. Because the receivers tend to be a heterogeneous group, the speaker may be equally detached from the onlookers in background, culture, expertise, or viewpoint. Even so, speakers endeavor to connect with their audiences. They characteristically evaluate the demographic makeup of participants (i.e., age, gender, ethnicity, etc.) as well as the audience's attitudes, values, and beliefs beforehand. They work to

make their material understandable and relatable to a diverse group and attempt to bond with participants by establishing their credibility and gaining the audience's trust. For their part, audiences interact with speakers principally through nonverbal feedback, such as applause and attention or inattention reflected in body language.

In some instances, audience feedback takes the form of question-and-answer sessions or written commentary, but unlike interpersonal and group communication in which senders and receivers participate in feedback loops, the focus of the ideas and information imparted in public speaking remains on the speaker. Much of public speaking includes face-to-face contact, which allows speakers to "read" their audiences for clues to the manner in which their messages are received. Other forms of public communication stay faceless. Virtually any message freely conveyed in public spaces, from published opinions to government positions and safety announcements, counts as public communication. Such messages are shared with, and become part of, the community at large. As such, public communication fulfills an indispensable role in civil societies. It promotes discourse and debate on issues of general interest or import to citizens within the so-called public sphere, connecting the public at large to civil and other societal institutions (Fuchs, 2020). It can also inform the public about health, safety, or emergency issues.

Where public communication takes the form of one-to-many exchange, mass communication relies on many-to-many (versus one-to-one or one-to-many) properties. Mass communication also is sender-focused, but it lacks the measure of personal connection that public communication (or interpersonal or group communication, for that matter) affords. Mass communication differs from other forms of communication not only in the width of its reach, with audiences potentially numbering millions of people around the globe, but also in its reliance on print, audio, or digital technology to distribute messages. Radio; broadcast, cable, and streaming television; books, newspapers, and magazines; and websites, email, webinars, podcasts, blogs, and social media all fall under the category of mass communication. Each serves as a media channel, or as the means of information transmission; each would not exist without technology-driven distribution. (Incidentally, public communication transforms into mass communication when it is transmitted via media channels.)

A goal of any one of these channels might be to personalize an audience's experience with it – a television advertisement intended to "speak" to one's values or beliefs, for example, or a bulk email individualized with one's name – but such tactics amount to artifice. Mass communication has historically excluded a means for personal interaction among the people who use it. One might react to mass communication by calling a television station or book publisher to express a viewpoint, writing a letter or email to a newspaper, or posting a comment on a website, but direct, immediate, person-to-person contact has not been part of the mass communication matrix.

Digital, or online, modes of communication, notably social media channels, are changing communication dynamics, however. Interaction-oriented social media channels, such as Facebook, Twitter, Snapchat, TikTok, and others, allow more immediate exchange of information and ideas, and technologies such as video conferencing encourage face-to-face interaction. The extent to which these and other Internet-enabled technologies affect interpersonal relations, public discourse, and mass dissemination of messages has warranted and will continue to warrant further exploration (Cappella, 2017; Rauchfleisch & Kovic, 2016).

Mass communication can help or hinder public awareness, education, and acceptance of best-practice healthcare information. Although the public generally trusts healthcare providers, patients receive health-related information from a variety of sources beyond the patient-provider relationship. Mass communication channels, in particular social media, serve as fertile sources of healthcare inaccuracies and misinformation that may carry crucial health consequences for patients (Love et al., 2020). Rumors, myth, and false information that emerged during the SARS- CoV-2 pandemic offer an example of the power of social media and other mass communication channels to disseminate information that impedes positive patient outcomes (Ali, 2020). Potentially less dire but nevertheless low-quality or harmful misinformation, such as false claims about the efficacy of "natural" or other remedies, that lack the accuracy and reliability of peer-reviewed evidence-based treatments, are also readily found across the Internet.

Healthcare professional consideration: A growing body of research will continue to explore the impact of healthcare misinformation. In the meantime, healthcare professionals will be increasingly called upon to gain understanding of the impact of healthcare misinformation on their patients' lives, raise their awareness of digital and other mass communication environments where misinformation foments, and steer patients toward credible sources (Southwell et al., 2020).

Self-Assessment Quiz Question #1

Communication is best defined as:

a. A one-way method of transmitting information from one p[erson] to another.
b. An encounter between people that has a distinct beginning and end.
c. An ongoing process that allows people to form and sustain relationships.
d. A process unique to humans.

Self-Assessment Quiz Question #2

The majority of interaction between and among people occurs throu[gh]:

a. Interpersonal communication.
b. Intrapersonal communication.
c. Group communication.
d. Mass communication.

Communication models

Different forms of communication affect our lives in different ways. Communication scientists developed models that organize our varied experiences with the phenomenon and explain how the communication process essentially works, helping us better understand and control – and perhaps improve – our communication behaviors (Trenholm, 2017). A fundamental understanding of the complex process of human communication begins with a look at three main communication models: linear, interactive, and transactional. Each of these models employs the following key terms:

- *Sender* – The sender, also referred to as the encoder, is the person who conceptualizes a message and initiates delivery of the message. Channel – A channel is the medium used to transmit a message from a sender to a receiver. Channels can be physical in nature, including speech and nonverbal communication, or mechanical, such as print and electronic media.
- *Receiver* – Also known as the decoder, the receiver is the person who extracts meaning from a transmitted message.
- *Encoding and decoding* – Encoding is the process by which the symbols that form the basis of verbal and nonverbal communica[tion] are produced. Decoding is the process by which those symbols a[re] translated into meaning.
- *Feedback* – In two-way communication, feedback is the respons[e] or reaction to a message. It occurs in a loop between senders and receivers.
- *Context* – Context in communication means the environment, atmosphere, or circumstances surrounding the communication. [It] includes elements such as time and place but also such factors a[s] values, attitudes, beliefs, and cultures of both senders and receiv[ers].
- *Noise* – Anything that interferes with the delivery, receipt, or interpretation of a message or feedback relating to the message [is] considered noise. The source of noise can be internal (as in the [case] of intrapersonal communication) or external. External nois[e] physical barriers that interrupt the sending and receiving of [messages], such as the blare of an alarm or the clamor of a crowded room; physiological obstacles, such as deafness or blindness; and sem[antic] barriers, as in words that mean different things to different pe[ople].

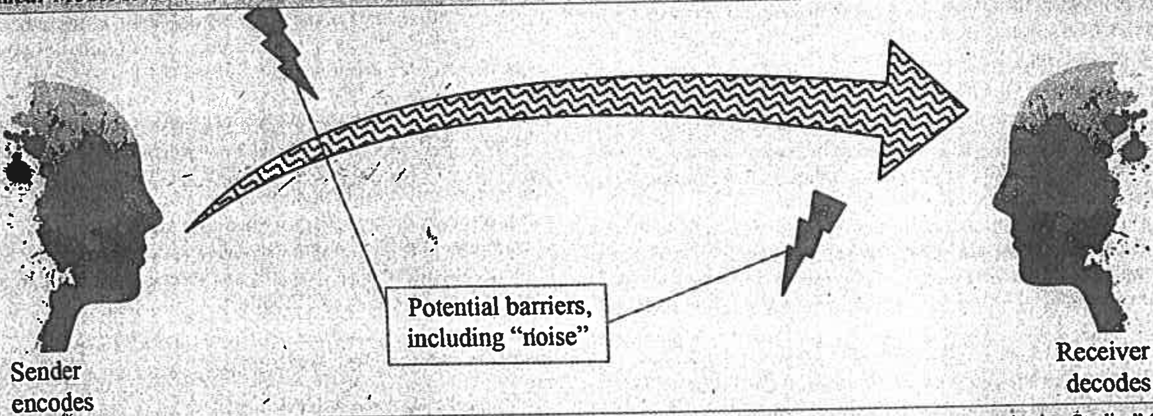
Linear model

The ancient philosopher Aristotle is credited with perhaps the earliest communication model, which conceived communication as messages that travel along a straight line between a speaker and a hearer, but mathematics heralded the modern linear model of communication (Hilbert, 2021). This model is often called the Shannon-Weaver or transmission model. The linear model was developed in 1949 for Bell Telephone Laboratories as a means to map the communication process through telephone and radio channels. The linear model describes a direct, one- way, intentional transmission of a message from a sender to a receiver.

The linear model, depicted in Figure 1, demonstrates the point-A-to-point-B transmission process that we tend to think of when we casually consider communication encounters in our everyday lives. It factors in potential interruptions to the process by way of so-called noise. As we have seen, however, communication is a complex process that takes varied forms. Critics of the linear model point to its assumption that communication encounters have a beginning and an end; in other words, in this model, no two messages can be sent or received simultaneously. As a sender-focused representation of communication, it neither allows for feedback nor addresses how receivers extrapolate meaning from messages.

Although the linear model does not suitably explain the back and forth associated with face-to-face communication in interpersonal and group forms of communication, it does describe mechanical communication, such as computers that "talk" to one another. It likewise illustrates the mechanisms of mass communication in the human realm, in which one-way, sender-driven messaging does not expect to elicit direct response by receivers or, for that matter, the means to immediately know how sent messages are interpreted by audiences. Technology-enabled communication among people, however, can exhibit properties of the linear model, such as voicemails, texts, emails, or social media posts that senders cannot be certain are received or understood.

Figure 1: Linear Model of Communication

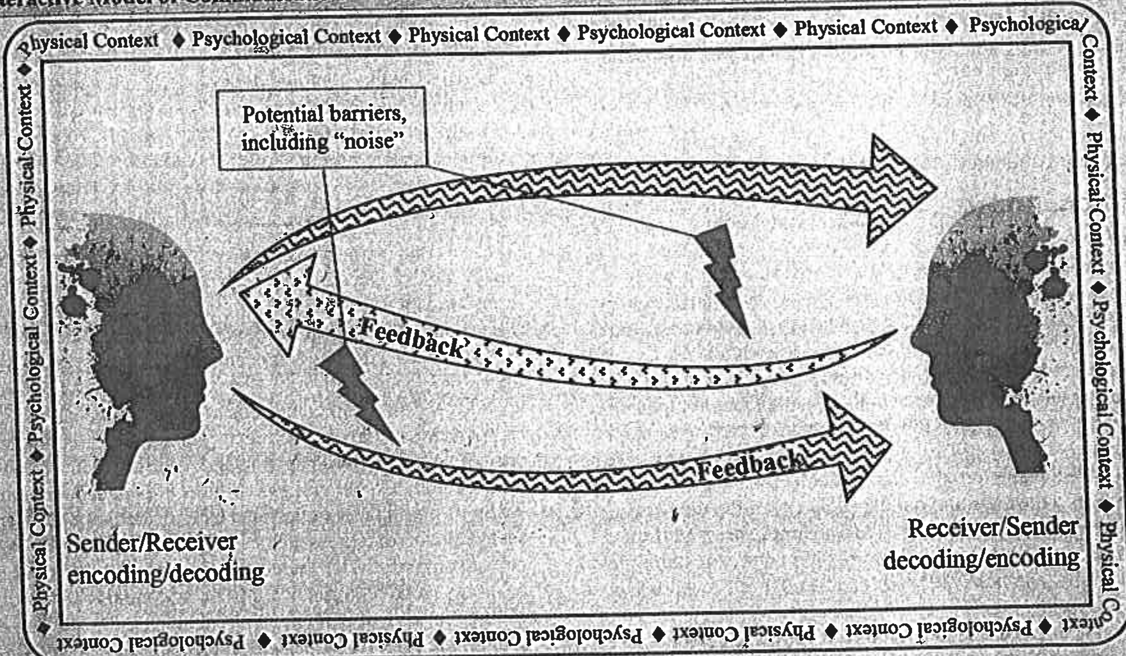


Note. Based on University of Minnesota Libraries Publishing, 2016, "Communication in the Real World: An Introduction to Communication Studies" (http://open.lib.umn.edu/communication/chapter/1-2-the-communication-process/). Reprinted with permission.

Interactive model

Figure 2 illustrates the interactive model of communication, which takes into account a two-way process of creating messages and generating feedback between senders and receivers. Developed in 1955, the interactive model recognizes that people actively participate in the exchange of messages; that is, receivers respond to the messages of senders and senders, in turn, react to those responses. In other words, communication involves senders and receivers by way of feedback, and this feedback, both verbal and nonverbal, need not be intentional (Wood, 2018).

Figure 2: Interactive Model of Communication



Note. Based on University of Minnesota Libraries Publishing, 2016, "Communication in the Real World: An Introduction to Communication Studies" (http://open.lib.umn.edu/communication/chapter/1-2-the-communication-process/). Reprinted with permission.

As with the linear model, the interactive model of communication recognizes the concepts of channels through which messages are transmitted and noise as a potential barrier to communication, but it also incorporates the notion of context in communication encounters. People generate, or encode, messages and decipher, or decode, them within the context of their personal experiences. Those experiences include the physical environment in which communication occurs (e.g., a quiet room versus a raucous one) that could enhance or interfere with the encoding and/or decoding process, as well as psychological factors (e.g., self-esteem, stress, happiness, fear, or anxiety), which similarly influence the quality of encoded and decoded messages (Wood, 2018).

The interactive model expands the linear model by emphasizing not just how messages are received but rather how, through context and feedback, they are understood. The cause-and-effect nature of the interactive model, however – receivers respond to senders, who respond to receivers, and so on – does not account for simultaneous feedback, nor does it acknowledge that communication in relationships changes over time. It does not reflect the concept of feedback that is based on what is decoded by the receiver. For example, the receiver is responding to the message as they perceived or decoded it, and this may not have been the intended message.

In the interactive model, communication between people alternates from one to the other. Consider, for example, an encounter in which you ask a colleague for instructions on completing a task. You, as the sender in this unique encounter, ask for information. Your desire for information is decoded by your colleague, who then becomes a sender, encoding a response and passing the instructions back to you. You might offer feedback by way of thanks or a follow-up question, but you must wait for the instructions before you can react. Technology-aided communication provides another illustration of this alternating pattern of sending and receiving information and ideas. When you send an email or text message, for instance, you necessarily wait for a response before you are able to react.

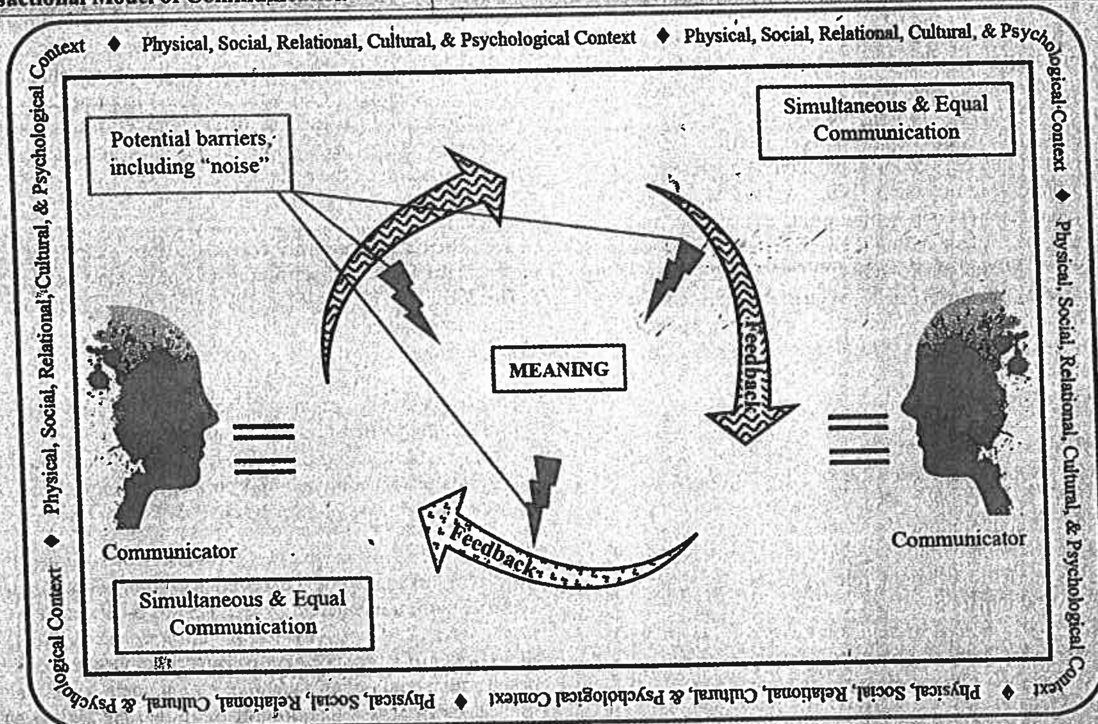
As described by the interactive model, the communication between you and your colleague also does not contemplate forms of communication other than questions and answers, such as nonverbal communication, that could be present at the same time. Your colleague might smile in response to your request, indicating their pleasure in helping you, or they might imply annoyance by rolling their eyes at your request. Then, too, the model fails to weigh the impact of your previous encounters with your colleague. Through your previously established relationship, you might have come to understand your colleague's eye roll as an expression of playfulness rather than exasperation.

Transactional model

The transactional model views communication as an ever-changing process in which senders and receivers assume multiple roles that vary over time (Wood, 2018). The model demonstrates equality in communication, meaning that people participate equally and instantaneously, in verbal and nonverbal exchanges. People act as both senders and receivers of messages at any point in a communication encounter, and they can accomplish each action at the same time (e.g., you can furrow your brow to indicate confusion at the same time you voice the feeling). Consequently, the model replaces the notion of senders and receivers with the all-encompassing label communicators, as shown in Figure 3.

Healthcare professional consideration: According to the transactional model, we do not communicate solely to exchange information. Rather, we use communication to shape how we perceive ourselves and the ways in which we relate to others. The model describes the mechanism by which we form and nurture relationships through interpersonal communication. Nurses also use interactions with patients to assess neurological status, orientation, anxiety, and to simply casually invite the patient to express concerns or questions.

Figure 3: Transactional Model of Communication



Note. Based on University of Minnesota Libraries Publishing, 2016, "Communication in the Real World: An Introduction to Communication Studies" (http://open.lib.umn.edu/communication /chapter/1-2-the-communication-process/). Reprinted with permission.

As with other models of communication, noise is an ever-present factor in the transactional paradigm. Context, too, is taken into account in this model, although to a more detailed degree. In addition to the physical and psychological fields of experience or context supported by the interactive model, the transactional model involves factors that naturally occur beyond a unique communication encounter. Specifically, thre[e] contextual dynamics influence communication:

- Social context – Social norms shape communication. People lear[n] common rules that guide their exchanges with others – saying thank you, for example, or refraining from interrupting when another person is talking – through observation and trial-and-error

experience. Social conventions facilitate shared meaning and understanding in communication. Intentionally or unintentionally avoiding them leads to misunderstanding and, often, feelings of awkwardness.

- Relational context – The type of relationships we have with others and the length of time in which we have participated in those relationships also influence how we communicate. People are more apt to forgo social norms when they have developed tight bonds with other people, as in, say, a family relationship, as opposed to the manner in which they conduct themselves with strangers or in casual meetings with others.
- Cultural context – Miscommunication can occur as a result of, or be compounded by, cultural differences. Nationality and ethnicity, for example, contribute to our identity; mold our values, attitudes, and beliefs; and affect how we interchange and understand messages. Norms governing communication vary by and within cultures. Individuals encode and decode the meaning of messages according to their personal backgrounds, values, beliefs, and self-perception.

Self-Assessment Quiz Question #3

The three primary models of communication are:

a. Sender, channel, and receiver.
b. Message, medium, and feedback.
c. Intrapersonal, interpersonal, and group.
d. Linear, interactive, and transactional.

Self-Assessment Quiz Question #4

In communication science, anything that interferes with the delivery, receipt, or interpretation of a message is referred to as:

a. Feedback.
b. Transmission error.
c. Noise.
d. Decoding error.

Implications for practice

All manner of communication is present in clinical practice. As a healthcare professional, you participate in intrapersonal communication when you reflect on the manner in which you responded to a patient or colleague and in group communication when you join a learning activity, engage a patient's family in discussion, or serve on a clinical standards committee. Lectures you attend involve public communication and mass communication offers you information about the latest clinical study in your specialty. Your text to a colleague instructing him to perform a task followed the linear model of communication; it became interactive when he responded he had already done so and you, in turn, expressed your thanks. Had you worked with your colleague for some time, the interaction was likely informed by the relationship you had established. The smile his response elicited in you would have fallen under the transactional model of communication.

The bulk of communication in healthcare settings, however, is interpersonal in form. Among the family of communication classifications, distinct types, such as intrapersonal and group communication, frequently include, or progress to, their interpersonal cousin. Communication science has long understood that self-talk informs and influences interpersonal behavior (Farley, 1992), and evidence supports a link between intrapersonal adaptability and interpersonal relationship outcomes (Wilde & Dozois, 2019). Interpersonal communication occurs within group interaction, and internal dialogue that takes place within the backdrop of small-group communication affects interpersonal connection or the lack thereof. For example, Moreland and colleagues (2015, as cited in Maginnis, 2018) found that clinicians' sense of self is predictive of their interpersonal relationships within nurse groups (such as unit or professional role), accounting for feelings of either powerlessness or the willingness to address conflict with their peers.

Healthcare professional consideration: By definition, exchanges between healthcare professionals and patients are interpersonal. Conceptualized in the transactional communication model, provider-patient interactions are active, immediate, and characterized by shifting roles within communication encounters. Practitioners, for instance, assume a symmetric, or equal, role when they exchange information and ideas with patients about achieving mutually agreed-upon health goals, such as strategies for overcoming obesity or lowering hypertension. Those same practitioners take on an authoritative role when their clinical expertise is sought (Arnold & Underman Boggs, 2016).

Communication scholars have recognized the complexity of interpersonal communication within healthcare settings, where provider-patient exchanges form lasting impressions that influence patients' health-related behaviors and quality outcomes. Challenges to engaging in effective interpersonal communication exist in all human relationships, but those challenges take on vital importance when communication between healthcare professionals and patients can affect patient outcomes or have life-or-death consequences (Chan et al., 2018; Ruben, 2016). The nursing profession, for example, has recognized the intricacy of message sending and receiving in nursing practice with its adoption of therapeutic communication, a subset of interpersonal communication specific to the promotion of patients' health and well-being, and the associated patient-centered care paradigm. Other clinicians likewise apply principles of therapeutic communication. Nurses are often seen in a paternalistic role by patients when, for example, nurses dictate care, such as when a patient will bathe, sleep, and participate in care regimens. In response, patients often comply and accept information provided by the nurse without completely understanding the message.

Tenets of therapeutic communication

Therapeutic interactions between healthcare professionals and patients are purpose driven (Nokuthula Sibiya, 2018). Arnold and Underman Boggs (2016) define therapeutic communication as an ongoing, purposeful, cooperative process undertaken by healthcare professionals and patients to identify and achieve patients' health-related objectives. Translated into daily practice, therapeutic communication involves not only the exchange of information about health-related goals between practitioner and patient, but also the practitioner's purposeful effort to encourage the patient's expression of thoughts, ideas, and emotions as a means to advance the patient's well-being. Components of therapeutic communication are summarized in Appendix B.

Healthcare professional consideration: Therapeutic communication forms the basis of practitioner-patient interpersonal relationships (Kornhaber et al., 2016) and is rooted in time-honored frameworks for interpersonal relations in clinical practice. Maslow's (1943) basic needs model helps practitioners prioritize interventions, but it is fundamentally an interpersonal communication theory. Put simply, people need to communicate their various levels of needs. Healthcare professionals often turn to Erikson's psychosocial development theory to aid in recognizing, fashioning, and communicating developmentally and age-appropriate interventions (Arnold & Underman Boggs, 2016; Orenstein & Lewis, 2020).

The literature most often cites Peplau's theory of interpersonal relations (1997) in the context of therapeutic communication in nursing. Peplau's seminal work, considered a precursor to contemporary patient-centered care models (Ortiz, 2018), saw the clinician-patient relationship as the product of a professional, planned interpersonal process in which practitioners and patients share common goals and equal responsibility for self-awareness. Effective interventions, she maintained, culminate from the practitioner's recognition of their own behaviors and the behavior of patients throughout evolving phases of the clinician-patient relationship. Accordingly, practitioners assume a variety of roles in patient encounters, from stranger to resource person, teacher, leader, surrogate, and counselor, each of which serves to not only create relationships with patients, but to build, strengthen, and enrich them. Through these progressive therapeutic exchanges, practitioners identify, understand, and meet patients' needs so that, ultimately, their assistance with patients' health concerns is no longer required (Adams, 2017).

As with any form of interpersonal communication, therapeutic communication occurs in verbal and nonverbal forms and within intrapersonal, psychosocial, cultural, and environmental contexts. Nursing licensure requires proficiency in therapeutic communication (National Council of State Boards of Nursing [NCSBN], 2019), including the need for healthcare professionals to recognize nonverbal cues in assessing patients' health status, in addition to the manner in which practitioners' own voiceless behaviors – for example, eye contact, mirroring patients' facial expressions to reflect understanding and empathy, and touch – influence patients' comprehension and acceptance of their health-related needs. Likewise, healthcare professionals participating in effective therapeutic communication take into account factors that influence or interfere with the communication process and the accomplishment of patients' health goals. Noise is prevalent in encounters with patients who, for example, may be distracted by pain or worry or who feel apprehension or loss of privacy in healthcare settings (Arnold & Underman Boggs, 2016). Healthcare professionals also face a range of distractions, from the diversion of their own intrapersonal communication (a preoccupation with a personal concern, for instance) to alarms emitted by medical equipment or interruptions by cell phones, other patients, and colleagues.

Nursing consideration: Therapeutic communication requires self-reflection among healthcare professionals. Awareness of such factors as one's values, beliefs, biases, and cultural differences helps clinicians avoid inadvertent speech or behaviors that negatively influence patients' perception of the therapeutic relationship. Professional mindfulness promotes the empathy and objectivity that encourages healthcare professionals to value patients as individuals with unique needs and preferences, a hallmark of patient-centered care (Arnold & Underman Boggs, 2016; Nokuthula Sibiya, 2018).

Therapeutic communication in small groups is most often associated with inpatient and outpatient counseling in psychotherapy, although group communication is used for therapeutic purposes in other healthcare environments, such as long-term care settings (Arnold & Underman Boggs, 2016).

Communication as core competency

Effective communication is a requisite skill in clinical practice, particularly in a contemporary healthcare climate that has made patient-centered care the new paradigm for improvements in the healthcare system as a whole. The New England Journal of Medicine (2017) describes patient- centered care as a healthcare delivery model in which patients are treated as partners with their healthcare providers and those providers interact with patients in ways that take into account not just the patients' clinical perspective, but their emotional, mental, spiritual, social, and other unique viewpoints as well. Because communication forms the basis of interpersonal relationships, this partnership exists only when healthcare professionals and patients mutually engage in therapeutic interaction. Patient-centered care encourages the active participation of patients in their own healthcare and it relies on the creation of understood meaning between providers and patients to optimally achieve patients' unique health goals.

Research has identified an inextricable link between care quality and communication aptitude that substantiates communication as a critical competency for healthcare professionals. Associating poor communication with 70% of errors in healthcare settings, the NAM (2000; formerly the IOM), a driving force behind widespread changes to healthcare delivery in the United States, declared effective exchanges between clinicians and patients to be a prerequisite for patient-centered care. In a subsequent report (NAM, 2001), the organization included among its recommendations for redesigning a patient-centric healthcare system such rules as basing patient care on continuous healing relationships, customizing care to patients' needs and values, recognizing patients as the source of control in therapeutic relationships, and freely and openly sharing knowledge and information. Additional analysis by the organization (NAM, 2003) specified requirements for communication competency in health professions education.

TJC (2017), the accrediting body for healthcare organizations, likewise has implicated poor communication or miscommunication in sentinel healthcare events, particularly during handoff communication. Accordingly, it mandates effective patient- and family-centered communication practices in hospitals, including the provision of quality and safety information, respect for patients' personal and cultural values and preferences, identification of patients' verbal and written information needs, and adherence to guidelines for managing patie[nt-]provider communication (TJC, 2010).

Patient-focused exchanges between practitioners and patients are so relevant to the work of clinicians that for some practitioners, such as nurses, professional organizations have firmly embedded communication in their education and performance standards. Again, the NCSBN (2019) requires mastery of therapeutic communication concepts as a condition for registered nurse licensure, and the American Association of Colleges of Nursing (2008, 2011) emphasizes proficiency in interpersonal and interprofessional communication as essential elements of nursing curricula. In expanding the NAM's recommendations to better prepare nurses to participate in system-wide improvements to healthcare quality and patient safety, the Quality and Safety Education for Nurses (QSEN) Institute guides nursing education by establishing core competencies in patient-centered care and interprofessional collaboration (QSEN, n.d.), both of which rely on the development of effective communication skills. Time pressures, heavy workloads, and extensive technology demands have created work stres[s] that can constrain effective communication with patients, particularly during pandemic crises. Exceptional effort is often needed to effectivel[y] communicate with patients.

Ineffective communication: correlations and consequences

Research grounds the premise that providing optimal care to patients requires healthcare professionals to sharpen their communication competency. The consequences of miscommunication and other failur[e] in message transmission within interpersonal exchanges involving clinicians are well documented. Pervasive across healthcare settings, inadequate communication can lead to substandard care or missed opportunities and, ultimately, negative clinical outcomes. For example

- *Patient recall and adherence* – In any given clinical encounter, patients decode an assortment of messages transmitted by their healthcare providers. Sometimes the messages they receive contain an extensive, even overwhelming, amount of information; sometimes those messages bear unwelcome news. A variety of issues can influence the manner in which patients process information during and after exchanges with healthcare professionals. Patients' language, education level, literacy, age, and degree of anxiety offer examples of factors that can interfere with patients' understanding and recall of their health status and treatment options.

Evidence-based practice! Research demonstrates that patients recall as little as one-fifth of the medical information they have discussed with a clinician; those with chronic disease, for example, forget as much as 40% to 80% of the content of their discussions in healthcare encounters (Richard et al., 2016).

Furthermore, patients' impression of the competence of their healthcare providers forms the basis of their trust in the provider-patient relationship and, consequently, their confidence in the health information they receive (Howe et al., 2019). Patients bring expectations for both information and empathy to clinical encounters (Howick et al., 2017). As much as any reassurance healthcare practitioners express verbally, their displays of empathy, signaled by such nonverbal communication as eye contact, leaning forward to address patients directly, or therapeutic touch, can impact patients' trust, recall, and adherence to treatment plans. Healthcare profession[als'] lack of eye contact with patients or reassuring smiles, for example, ca[n] adversely affect patients' recall of the information discussed in care settings (Hillen et al., 2016).

- *Patient satisfaction* – A growing body of evidence ties patien[t] experience to positive clinical outcomes (Agency for Health[care] Research and Quality [AHRQ], 2020a). Patient experience is generally gauged by patient satisfaction, commonly known as patients' impressions of the care they experience. Driven by qual[ity] improvement standards and reimbursement requirements, health[care] organizations have employed patient satisfaction surveys, such a[s]

the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (Centers for Medicare and Medicaid Services [CMS], 2020) and the Consumer Assessment of Healthcare Providers and Systems (AHRQ, 2020a), as leading measures of service quality. Likewise, many healthcare organizations rely on patient-experience data collected by independent consulting firms through targeted surveys that provide performance benchmarks and real-time feedback.

Although such tools have proven successful in quantifying patient satisfaction, they do not entirely capture the complexity of patients' experience in healthcare settings (Street & Mazor, 2017). Patient satisfaction is indivisibly linked to the interpersonal relationships created and maintained between patients and their healthcare practitioners. Influenced as these relationships are by environmental, demographic, socioeconomic, cultural, and other factors, the degree of satisfaction expressed by patients significantly varies (Berkowitz, 2016; Pelletier et al., 2019). Even so, patients' impressions of their relationships with their healthcare providers have been shown to be strong predictors of patient satisfaction (Bible et al., 2018). Patient-centered communication likewise correlates with patient satisfaction (Bossou et al., 2021). Evaluation of patient satisfaction levels should include a time-related analysis of workload and staffing issues.

> *Evidence-based practice!* Quality of care is often regarded as a high-ranking predictor of patients' assessment of a healthcare organization's overall quality (Karaca, 2019) because a clinician's skill in explaining, listening to, and empathizing with patients directly affects patients' experiences in the healthcare environment (Burgener, 2017).

- *Patient safety* – In the years since the NAM's (formerly IOM) landmark report revealed the extent of the connection between inadequate communication and medical errors, healthcare organizations have sought to minimize communication failures. Particular attention has been paid to gaps in practitioners' knowledge of communication breakdowns and the implementation of structured training programs and standardized tools. Yet ineffective communication continues to impact patient safety across healthcare settings. TJC has identified poor communication or miscommunication as a leading cause of sentinel events (Burgener, 2017); in particular, the organization has pointed to inadequate communication during patient care handoff between clinicians as a contributing factor to adverse events (TJC, 2017). Other research suggests medical errors are underreported, owing in part to nonreporting of near misses (Scott & Henneman, 2017).

Self-Assessment Quiz Question #5

Healthcare professionals and patients engage in therapeutic communication to:

a. Identify and achieve patients' health-related objectives.
b. Conclude clinician-patient interaction.
c. Allow the clinician to make all healthcare decisions.
d. Allow clinicians to exceed professional boundaries.

Self-Assessment Quiz Question #6

Patients' impressions of their relationships with healthcare providers have been shown to be a strong predictor of:

a. Miscommunication.
b. Patient satisfaction.
c. Professional standards.
d. Contextual dynamics.

Self-Assessment Quiz Question #7

Patients' feelings of lack of privacy and control in healthcare settings are examples of which type of communication barrier?

a. Environmental.
b. Socioeconomic.
c. Global.
d. Administrative.

PRACTITIONER-PATIENT COMMUNICATION

Unquestionably, the dynamics of patient-clinician communication influence patient satisfaction, safety, and outcomes. That influence can be positive or negative, overt or subtle. Effective communication holds the power to secure patients' health and well-being.

Communication is a complex process: however, effective communication is even more so. The two-way makeup of communication dictates that a definition of quality exchanges between patients and healthcare professionals cannot rest with those professionals alone. Rather, deciphering the meaning of effective communication relies equally on practitioners' and patients' interpretation of what it is and is not. To arrive at a consensus meaning of effective communication, it is helpful for healthcare professionals to recognize and understand instances in which it does not exist – in other words, to explore occurrences that impede quality communication from both practitioners' and patients' perspectives.

Impediments to effective practitioner-patient communication

Barriers to quality communication in clinical practice come in a variety of forms – some are obvious, whereas others are more enigmatic. Either way, obstacles to effective communication exist at all levels of healthcare and in its varied settings, and they influence how information, ideas, and emotions are perceived by both parties in communication encounters. Communication scientists call the sum of all factors that affect the perception of meaning between people metacommunication. A full assessment of obstacles to quality practitioner-patient communication takes metacommunication into account, including nonverbal cues that supplement or contradict verbal messages.

Environmental distractions

Noise, in its literal sense, can interfere with patients' abilities to successfully decode the messages they receive in clinical encounters. The din common to certain healthcare settings, such as the emergency department and intensive care units, and the sounds emitted from customary medical machinery – electrocardiograph (ECG) bleeps, chirping alarms, or the swish of suctioning equipment, for example – can divert patients' attention or inhibit their ability to hear. Sounds emitted by other people can likewise interfere with patients' ability to receive and comprehend information. A patient may be distracted by sounds of pain or distress in fellow patients or by exchanges in close proximity between practitioners and patients or family members, practitioners and practitioners, or patients and their family members. Machine- and human-generated noise also can elicit fear and anxiety in patients. For instance, a patient may be less likely to acknowledge or accept the reassurances of a healthcare professional about their health status while preoccupied with the flat-line tone of another patient's ECG. Although healthcare personnel are accustomed to tuning out sounds of floor cleaners, overhead pages, and food and supply carts, patients are more aware of these distractions. Patients have often had interrupted sleep and may be irritated by environmental noise.

Physical noise is less of an obstacle to communication from the viewpoint of clinicians, who are well acclimated to the frequency and intensity of sounds in healthcare settings. In the context of communication theory, however, the concept of noise moves beyond tangible sounds to encompass any internal or external barrier that impedes the encoding and decoding of messages and feedback. Fear and anxiety in patients, for example, can be present in clinical encounters in the absence of physical noise. Patients' worry over their health status and concern about being embarrassed or judged by healthcare professionals fall under the category of intrapersonal noise that can hinder their ability to receive and comprehend the intended messages of their healthcare providers. Feelings of powerlessness similarly

stem from intrapersonal communication and extend to interpersonal exchanges. Patients' receptiveness to messages can be influenced by their feelings of lack of privacy and control in healthcare settings, as when they cannot command who is or is not present in their clinical encounters or control when a clinician disrupts communication to respond to a page or cell-phone alert or attend to another patient with pressing needs. Moreover, patients may perceive an imbalance in power in their relationships with clinicians when they lack understanding of their condition and feel practitioners speak in ways or of topics that are beyond their comprehension (Ringdal et al., 2017). Patients may be embarrassed to question the meaning of medical terms used by healthcare professionals.

Patients increasingly desire to fully participate in their care and the support of healthcare professionals contributes to the development of meaningful patient-provider partnerships. However, communication barriers persist when patients – particularly among those who possess low health literacy or who are members of vulnerable populations – are uncertain or uncomfortable with their role in encounters with providers. Patients' self-efficacy affects the quality of their relationships with providers; but adopting an active role in the relationship by, for example, asking questions, is challenging for some patients. Other factors, ranging from patients' feeling overloaded by information or having insufficient time to process information during a clinical encounter, to the disruption of conversation caused by clinician use of electronic health record systems, to a hectic healthcare environment that causes some patients to refrain from open and timely communication out of concern that their needs will interrupt busy healthcare professionals, can likewise present obstacles to effective communication and the formation of the partnership touted by patient-centered care models (Gordon et al., 2020).

Healthcare professional consideration: For their part, some nurses cite organization-related factors – for example, the complexity and fragmentation of healthcare systems – as impediments to effective communication with patients (Arnold & Underman Boggs, 2016). Nurses report that environmental factors peculiar to healthcare settings, including heavy workloads that reduce time spent with patients, cause fatigue and contribute to stress and impede nurse-patient communication (Arnold & Underman Boggs, 2016; Norouzinia et al., 2016). The scheduling of 12-hour shifts and overtime demands contribute to the work stress that can create limited communication time with patients.

The SARS-CoV-2 pandemic highlighted another environmental barrier to healthcare communication: the use of personal protective equipment (PPE) and its impact on patient-provider interaction. Masks, respirators, face shields, goggles, and protective clothing — mandated for all healthcare workers to prevent the spread of the highly contagious virus — were found to adversely affect some, though not all, clinicians in their efforts to communicate with patients and colleagues. Such communication breaks carried the potential to jeopardize the effectiveness of interventions and patient safety (Hines et al., 2020; Marler & Ditton, 2020). At the time of this writing, researchers speculated that mask wearing by providers and patients during the pandemic impeded not only verbal communication by reducing the volume or changing the tone of voice in a mask-wearer, but also nonverbal communication cues by compromising the ability to view mouth and lip movement and facial expressions (White et al., 2021). Marler and Ditton (2020) theorized that patients with cognitive, hearing, and other communication impairments, including elderly patients, may have been particularly susceptible to physiologic and psychological stress resulting from their inability to rely on auditory stimuli or inferences from facial expressions in mask- or respirator-wearing clinicians. Additionally, PPE use during the pandemic made clinicians indistinguishable from one another from the patient perspective, negating patients' perception of consistency in their healthcare providers and disrupting the development of patient-provider rapport central to therapeutic communication (Marler and Ditton, 2020). Patients who have impaired hearing are often reluctant to admit that they did not hear all of the conversation or believe that they heard something other than what was said.

Worldwide, healthcare professionals used a variety of means to overcome PPE-induced barriers to communication with patients, including simple measures such as employing white boards/blackboards and sticky notes (Bagnasco et al., 2020). Patients hospitalized for treatment of SARS-CoV-2, as well as those confined in long-term care facilities or to their homes following isolation measures or community lock down, were at risk for complicated feelings of fragility, loneliness, and disempowerment that was exacerbated by lack of family contact. In the acute care setting, safety protocols deprived patients who were ill or dying of the support of family members at their bedsides (White et al., 2021). Clinicians embraced communication technologies, such as smart phones and touch-screen tablets, to virtually connect patients with their families and friends and to keep families and friends informed of their loved ones' conditions (Schwerdtle et al., 2020). Healthcare professionals likewise widely employed telehealth video conferencing technologies to communicate with patients for a variety of interventions ranging from outpatient care during stay-at-home orders and isolation or quarantine (Elkbuli, et al., 2020; Wosik et al., 2020) to screening to limit exposure to the virus in emergency departments (Chou et al., 2020).

Health literacy and medical jargon

Health literacy is an important driver of clinical outcomes. Research recognizes low levels of health literacy as a contributing factor in suboptimal or even poor outcomes. On the other hand, a higher level of health literacy, and the patient engagement it spurs, is thought to be indispensable to patients' successful navigation of an increasingly complex healthcare environment (McKenna et al., 2017). Asking patients if they would like a further explanation of instructions or checking for comprehension may offer patients an opportunity to clarify unknown terms.

In a fundamental sense, health literacy is a by-product of the communication process. Patients acquire and process the information they need to make healthcare decisions based on their ability to encode and decode information that is often complicated and scattered. Of course, health literacy involves speaking, reading, and writing about health-related topics, as in discussing one's health with a practitioner, reading care instructions or locating information on healthcare services, and completing forms. At its most basic level, however, it also requires numerical aptitude (to correctly measure medication, for example, or follow nutrition labels) and the grasp of such calculation-related concepts as probability and risk. The sheer volume and complexity of healthcare information can overwhelm even the most adept-appearing patient.

Wide-ranging factors, from socioeconomic status and culture to individual feelings of stigma or confidence, influence patients' health literacy and their communication with healthcare practitioners. Health literacy can act as a facilitator to effective patient-provider communication when patients feel empowered to contribute to their own healthcare; it serves as a barrier when patients feel they are not able to adequately describe their health status or feel insufficiently respected or listened to by clinicians. Patients who feel armed with information that they comprehend and can place in the context of their life circumstances gain the confidence to proactively engage in healthcare decision making and action, potentially impeding or preventing negative health outcomes (McKenna et al., 2017). Patients whose health literacy levels fail to inspire such feelings of control can succumb to wariness of healthcare settings and professionals to the extent that their uncertainty impedes the development of effective patient-partnership relationships. Underlying mistrust of practitioners has been found to be more pronounced in patients with lower levels of health literacy (White et al., 2016).

Healthcare professional consideration: To improve health literacy, best practices recommend healthcare professionals use plain language. Transmitted in both verbal and written form, plain language is considered a message(s) that is readily decoded by receivers. In other words, information conveyed in plain language is understood by people at the moment they hear or read it (U.S. Department of Health and Human Services [HHS], n.d.).

The benefits of the use of plain language are straightforward: In exchanges between patients and their practitioners, both parties immediately and simultaneously share common meaning of the terms used. On the other hand, use of medical terminology or jargon interferes with patients' comprehension of facets of their care. Barring any physiological impediments, patients generally understand an instruction spoken or written as "take this medication every morning," as opposed to "take this medication q.a.m.," the latter of which contains a term beyond the knowledge of the typical layperson. While healthcare professionals can unwittingly lapse into medical jargon for a variety of reasons, not the least of which is the fast pace and pressure associated with their jobs, the use of jargon has been shown to reduce patient participation in their care (DeCelie, 2020).

To improve patients' understanding of discharge instructions, many hospitals have created discharge lounges. In this setting, patients are brought from their rooms to a lounge area where family and patients sit in a relaxed environment and discuss discharge information on medications, home care, and follow-up plans. This system has been shown to minimize environmental noise and distractions to improve effective communication as well as free up patient rooms while follow-up appointments are made and the family prepares to pick up the patient.

Linguistics, social identity, and culture

Communication is impaired when practitioners and patients do not speak the same language, literally and figuratively. Multiple factors influence the manner in which messages are given and received in healthcare settings, not the least among them being the dialect, age, gender, race, sexual orientation, religious affiliation, and socioeconomic status of patients and their practitioners, and the cultural norms to which they both adhere.

The literature is rife with evidence of the need for healthcare professionals to develop therapeutic relationships with patients of diverse backgrounds. Safe, quality care relies on practitioners' respect for patients' values, experiences, and customs. For instance, the ethical standards of nursing (ANA, 2015b) demand that nurses recognize and value the individuality of each patient in every professional interaction, regardless of the patient's health issues, personal characteristics, beliefs, or social or economic status and, unobstructed by the nurse's own characteristics, status, or bias. An encyclopedic accounting of the diversity of patients' traits and the influence of those traits on practitioner- patient communication cannot be accomplished here, but the following themes describe factors that commonly impinge on the effectiveness of practitioner-patient communication:

- *Linguistics* – Healthcare professionals assume unacceptable risk to patient safety when they try to communicate with patients whose first language is not shared with their own, in other words, when English (in the United States) is not a patient's (or the practitioner's, for that matter) first language. All practitioner-patient communication can be vulnerable to miscommunication, but exchanges between clinicians and patients using different dialects are far more susceptible to misinterpretation and error; and use of family members, children, or other ad hoc interpreters can lead to miscommunication and heightened risk of adverse events (Showstack, 2019). In any country or setting, research has identified language barriers as significant obstacles to the provision of adequate, appropriate, effective, and timely care to patients with limited proficiency in the language of their healthcare providers (Ali & Watson, 2017). In the United States, patients with limited proficiency in English tend to have longer lengths of hospital stays and higher readmission rates than their English-speaking counterparts, regardless of their socioeconomic status (Squires, 2018).

US law, such as the Civil Rights Act of 1964 and the Americans With Disabilities Act, and federal regulations and executive orders compel healthcare organizations and professionals to overcome language barriers for non-English-speaking and physiologically challenged individuals by providing language services, such as qualified interpreters (Schwei et al., 2016; Squires, 2018). TJC (2020) standards also require the identification of patients' preferred language and the provision of language services for patients with different dialects and sensory impairment.

Nursing consideration: Practitioners report that their challenges with low health literacy in patients are primarily because of language differences and they recognize that patients who have limited proficiency in English may not receive the same quality of care as English- speaking patients. While use of translators can be beneficial to ensuring quality care among patient populations with language barriers, further research is required to develop best practices for working with translators to assess patients' health literacy (Wittenberg et al., 2018).

- *Social identity* – Adults encode and decode messages differently than children do. Men and women interact with others in discrete ways; men and women of diverse racial, ethnic, religious, or socioeconomic backgrounds communicate differently still. Gaps between generations can contribute to gaps in shared understanding of messages. Any one of a multitude of characteristics with which people socially identify can become a barrier to quality communication, even when senders and receivers share some of those characteristics.

Recall that most patient-provider interactions follow the transactional model of communication, by which we shape our perceptions of ourselves and the ways in which we relate to other people – all in the context of our personal experiences. We form attachments to people based on our respective fields of experience, including the social norms to which we have been exposed and the type and length of our relationships. Social norms and the level of familiarity in relationships can be powerful drivers of intrapersonal and interpersonal communication. Generally speaking, for example, we understand that conversing with a middle-aged adult as if they were a toddler would defy a social convention or that an exaggeratedly friendly exchange with a person whom we just met would be a social faux pas.

In addition to our deference to convention, communication accommodation theory (CAT) suggests people consciously or unconsciously adjust their mode of communication – the tone or pitch of their voice, the speed of their speech, the words they choose, or the gestures they use, for instance – to either promote understanding and build rapport with others or to highlight differences (Arnold & Underman Boggs, 2016). CAT explains our tendency to address children differently than adults, adopt the rhythm of another person's speech, or, to the contrary, verbally or nonverbally turn away from exchanges with others. Although additional research is warranted, convergence, a subset of CAT that explains the ways in which people adapt their communication to reduce social and other differences, may demonstrate efficacy in patient-provider encounters, particularly with communication with patients of advanced age (Momand & Dubrowski, 2020).

- *Culture* – As a body of knowledge, beliefs, values, and behaviors, culture shapes our identity and the ways in which we communicate intrapersonally, interpersonally, in groups, and through media. Ubiquitous in clinical encounters, culture guides both patients' and practitioners' attitudes toward every aspect of health and care, from concepts of wellness to viewpoints on death. An increasingly diverse population in the United States means healthcare professionals are progressively more likely to engage in intercultural exchanges with patients. Complicated and at times confounding, intercultural exchanges can be further muddled by multiple cultural identities. A patient or practitioner, for example, can be simultaneously guided by the norms of American culture; an ethnic culture; a generational culture; and lesbian, gay, bisexual, and transgender culture. The use of titles (Ms., Miss, Reverend, Dr., or rank) is generally culture-based and the use of first names is also a patient's preference in some cultures. Transgender patients should be asked how they would prefer to be addressed to promote sensitive communication.

The healthcare environment has its own culture. Clinicians are comfortable within this culture; they know how the healthcare system functions, the protocols it follows, and the tasks accomplished by its members. To lay patients, however, healthcare settings are foreign environments. Navigating the strange land of healthcare settings adds to the apprehension or stress patients so often feel as they try to unravel the mysteries of medical jargon, diagnoses, medications, treatments, and procedures – and all while illness renders them at their most vulnerable

(Ruben, 2016). Lack of congruence between the culturally steered viewpoints of patients and their practitioners, let alone differences in language, interferes with the encoding and decoding of messages in patient-provider encounters, which can hamper the development of therapeutic relationships and provider decision making. Lack of cultural competence and unconscious bias among healthcare providers have been implicated in disparities found in patient care activities across healthcare settings (Perez-Stable & El-Toukhy, 2018). TJC recognizes that bias in clinical decision leads to patient safety concerns (TJC, 2016). Table 2 provides further examples of culturally based factors that influence patient care.

Healthcare professional consideration: Culture acts as a barrier to effective communication and quality outcomes when practitioners fail to recognize, accept, appreciate, and examine differences in patients' values, beliefs, and preferences. The cultural competence required of healthcare professionals by such organizations as TJC (2010) and HHS (n.d.) arises from the recognition that cultural differences strongly influence patient-provider communication and decision making, which in turn affect patient satisfaction and clinical outcomes.

Clinician-family communication

Communication among family members, patients, and practitioners profoundly influences health-related decision making. Families can facilitate positive outcomes for their loved ones by acting as patients' counselors, advocates, and caretakers, but their involvement in healthcare events might also impede patients' understanding of their health concerns and ability to make informed decisions about their care. Sometimes families cause aggravation for patients and clinicians alike (Arnold & Underman Boggs, 2016).

Families add a layer of complexity to healthcare communication. All of the barriers to effective communication that pertain to patients apply to families as well. Communication between families and clinicians can be constrained by the influence of the healthcare environment and the diversity of members' health literacy, language, social identity, and culture. The diversity of families is likewise demonstrated by their varied composition. Families are made up of childless dyads, single-parent households, stepfamily or blended households, extended family members, and same-sex partners and their children, among others. Moreover, families are composed of individuals, each with their own values and preferences about health and healthcare. Reactions among family members to the patient experience, particularly during emergent situations or other crises, can widely vary (Arnold & Underman Boggs, 2016).

The same assorted values and viewpoints that clinicians bring to interactions with patients also occur – positively or negatively – in their exchanges with families. For example, critical care nurses report that their attitudes toward the involvement of family in patient care decisions and activities are formed by such factors as their own values and beliefs concerning family participation, their concerns about patient safety and trust in family members' capabilities as caregivers, their interpretation of family dynamics in the context of a patient's care, and the culture of their workplace or unit (Hetland et al., 2018). Physical space allowed for performing patient care may restrict the presence of family or the care may require privacy that will limit family presence. Restriction should be explained to the patient and family and the most liberal visitation policies should be adopted to promote patient satisfaction and safety.

Table 2: Examples of Cultural Influences on Patient-Provider Interaction

Influence	Description
Health beliefs	In some cultures, people believe that talking about a possible poor health outcome will cause that outcome to occur.
Health customs	In some cultures, family members play a large role in healthcare decision making.
Ethnic customs	Differing roles of women and men in society may determine who makes decisions about accepting and following through with medical treatments.
Religious beliefs	Religious faith and spiritual beliefs may affect healthcare-seeking behavior and people's willingness to accept specific treatments or behavior changes.
Dietary customs	Disease-related dietary advice will be difficult to follow if it does not conform to the foods or cooking methods used by the patient.
Interpersonal customs	Eye contact or physical touch will be expected in some cultures and inappropriate or offensive in others. The presence of unaccompanied male nurses in female's rooms may be prohibited in some cultures/religions.

Note. From Agency for Healthcare Research and Quality, 2020b, "*Health Literacy Universal Precautions Toolkit 2nd Edition*" (https://www.ahrq.gov/health-literacy improve/precautions/tool10.html). Reprinted with permission

Improving the effectiveness of practitioner-patient communication

The healthcare industry's shift toward patient-centered care as a pathway to improved care quality has renewed interest in communication theory and its particular application in healthcare settings. Linear transmission of information between practitioners and patients, in which patients receive information without opportunity for feedback and clinicians assume a dominant role in patient-practitioner interaction, has given way to participatory, transactional modes of building and sustaining therapeutic relationships. Contemporary and emerging care models seek not only to better provide and explain healthcare information, but also to understand and incorporate how patients make sense of and apply that information to healthcare decisions in the context of their unique personal experiences (Ruben, 2016).

Shared decision making

Shared decision making is an outgrowth of the construct of patient-focused care. Its premise centers on transactional communication that develops a partnership between clinicians, patients, and families. In shared decision making, practitioners form collaborative relationships with patients in which healthcare decisions meld practitioner expertise and evidence-based care with patient values, preferences, and life context. It emphasizes conscious effort on the part of clinicians to understand and appreciate the breadth of patients' circumstances and involve patients in choosing care options based on their unique needs and perspectives of the importance of those options in their lives (Kunneman et al., 2016).

Research has demonstrated a positive relationship between shared decision making and patients' reports of satisfaction with healthcare encounters, but the state of the science lacks empirical evidence of a direct link between jointly achieved patient-provider decisions and clinical outcomes (Muller et al., 2018; Truglio-Londrigan & Slyer, 2018). Additionally, uncertainty exists among clinicians about the defining characteristics of shared decision making and its appropriate use (Kon et al., 2016). Despite this lack of clarity, the ethics of promoting patient autonomy and self-determination has justified inter[est] in and adoption of shared decision-making principles (Muller et al., 2018), and professional organizations have outlined approaches [that] both adhere to ethical standards and promote effective communica[tion] skills. An example of a basic conceptual framework for shared decision making involving a treatment decision and suggested ways to participate in the shared decision- making process are provided in Appendices C and D, respectively.

Communication and the building of relationships with patients form the foundation of shared decision making. Healthcare professionals promote shared decision making by actively seeking trusting and respectful partnerships with patients that engender collaboration and power-sharing. Patients who feel the trust and respect of clinicians are more apt to approach their relationships with clinicians openly and freely share information. Shared decision making can improve patient compliance that is critical to recovery.

Healthcare professional consideration: At times in shared decision-making relationships, healthcare professionals can be challenged to strike a balance between their patients' needs, desires, and preferences and evidence-based practice. When patients' values or beliefs conflict with clinical guidelines, practitioners should consider principles of ethical practice, which involve the concepts of patient autonomy and beneficence. In such situations, however, healthcare professionals should also look to their communication skills to encourage deliberation, negotiation, and consensus with patients on healthcare decisions (Truglio-Londrigan & Slyer, 2018).

Communication tools and techniques

Targeted communication tools have demonstrated efficacy in overcoming barriers to effective patient-practitioner communication, promoting patient satisfaction, and improving clinical outcomes.

Professional healthcare organizations recommend the use of health literacy universal precaution in clinical encounters and in the development of printed patient education materials. The precautions, described by the AHRQ (2020c), are intended to treat all patients, regardless of their education or level of proficiency in health-related matters, as if they are at risk of not understanding information about their health. Health literacy skills can vary not only between individuals but within individuals, and they can change over time (McKenna et al., 2017) or be influenced by illness, fatigue, and fear (Liang & Brach, 2017).

Guidelines for the precautions emphasize clear, concise, jargon-free communication (see Appendix E) and employ the use of the teach-back method of ensuring comprehension.

The teach-back method was developed for use chiefly in primary care, but its implementation is also supported in other clinical specialties (Almkuist, 2017). The method involves an iterative, sender-receiver feedback loop in which practitioners convey information in plain language and test patients' comprehension by asking them to repeat the information in their own words. If patients do not adequately transmit their understanding back to practitioners, the looped feedback process continues until the practitioner is assured the information is understood. AHRQ (2020b). The Institute for Healthcare Improvement recommends use of teach-back activity to meet the standards of health literacy universal precautions (Yen & Leasure, 2019). Despite low levels of health literacy in the American population and the efficacy of the teach-back method, however, more than two-thirds of surveyed adults reported they had not received teach-back instruction in healthcare encounters in a one-year period, a gap that potentially risks patient dissatisfaction and adverse outcomes (Liang & Brach, 2017).

Motivational interviewing is a technique that originated in primary care drug and alcohol addiction counseling as a means to guide behavior change. Its use has migrated to other healthcare specialties with positive results (Gesinde & Harry, 2018; Rehman et al., 2017). The counseling- style approach of motivational interviewing acknowledges that patient-centered care does not follow a one-size-fits-all pattern. The technique has been successfully applied to a range of instances, from improving medication adherence to reducing vaccine hesitancy, that call for facilitating changes in patient behavior in ways that lead to improved outcomes (Oh & Lee, 2016; Gagneur, 2020; Gisebde & Harry, 2018). It aims to support patients' decision making by fostering a culture of partnership between healthcare professionals and patients, encouraging engagement in the relationship, and reinforcing patients' motivation for change (Gagneur, 2020). The approach likewise seeks to adapt to patient preferences and culture (Gisebde & Harry, 2018; Oh & Lee, 2016). For example, determining care options that suit patients' preferences and boost patient adherence can involve tradeoffs between clinicians' preferred course of action and other clinically sound choices that yield or nearly yield the same result. A clinician might prefer that their patient, a single, working parent of young children who is overweight, reach a mutually established goal for body mass index (BMI) within 6 months. However, in consideration of limits on the patient's available time to prepare calorie-conscious meals, the clinician and patient may determine 9 months to be a realistic and acceptable goal – one that raises the prospect the patient will adhere to a structured weight-loss plan.

Motivational interviewing has been found beneficial in instances in which patients express ambivalence about a necessary behavior change (Oh & Lee, 2016) and it is frequently used in combination with shared decision-making tactics. The four overlapping stages of motivational interviewing are summarized in Table 3.

As healthcare organizations increasingly underscore the importance of effective patient-provider communication, researchers are exploring the effect of communication interventions in a variety of patient populations and their potential application across healthcare specialties. The BATHE (a mnemonic for Background, Affect, Trouble, Handling, and Empathy) technique in primary care settings, for example, facilitates rapport between patients and clinicians using a brief five-step question-and-answer tool, summarized in Appendix F (Cayley, 2018). Typically employed as a mental health screening tool, the BATHE technique has shown some efficacy in engendering feelings of empowerment in patients with chronic conditions, such as diabetes (Akturan et al., 2017), and has shown positive effects on patient satisfaction with inpatient experiences (Pace et al., 2017).

The CRASH Course in Cultural Competency Skills training program helps clinicians adjust their interpersonal communication skills to accommodate the values, preferences, and behaviors of an ever-more-diverse patient population. (The CRASH mnemonic stands for the following: consider Culture, show Respect, Assess/Affirm differences, demonstrate Sensitivity/Self-awareness, and show Humility.) CRASH seeks to build practitioners' confidence in providing holistic care by competently addressing the health concerns of racially and ethnically diverse patients. It integrates patients' culture into clinical decision making (McGregor et al., 2019). Principal elements of the protocol are outlined in Appendix G.

Communication interventions on a narrow scale also have demonstrated improvements in patient-clinician therapeutic exchanges. When employing nursing's Commit to Sit initiative, for example, nurses take time to briefly sit, rather than stand, at the bedside while exchanging information about care plans with patients. As a demonstration of nurses' empathy and skill in interpersonal relations, the Commit to Sit protocol has shown markedly improved patient satisfaction scores (George et al., 2018; Lidgett, 2016).

Table 3: Stages of Motivational Interviewing

Stage	Description
Engaging	Building and maintaining a trusting clinician-patient partnership.
Focusing	Supporting the patient in establishing a direction for change.
Evoking	Exploring and reinforcing the patient's motivation(s) for change
Planning	Designing a realistic and specific plan of action.

Note. Adapted from "*Practical Guidance on the Use of Motivational Interviewing to Support Behavior Change*" by L. Johnston, C. Hilton, and F. Dempsey, 2021, in S. Belo Ravara, E. Dagli, P. Katsaounou, K. E. Lewis, & Pisinger, Eds., "*Supporting Tobacco Cessation* [ERS Monograph]," European Respiratory Society, pp. 56-75 (https:/doi.org/10.1183/2312508X.10002320). Reprinted with permission.

Therapeutic communication skills

No matter the communication strategy you use in interchanges with patients, your ability to fulfill your professional responsibilities relies as much on your mastery of therapeutic communication skills as it does your clinical expertise. Competency in therapeutic communication skills underlies the achievement of a patient's health-related goals (Arnold & Underman Boggs, 2016).

Therapeutic communication skills can be taken for granted or blurred by environmental factors and other barriers. The hectic pace of your workplace, for example, might trigger lapses in your demonstration of empathy or prompt you to exhibit nonverbal cues (a heavy sigh, a deeply inhaled breath, or tightly crossed arms, for instance) that patients interpret as disapproval. Self-talk might overpower your objectivity and confidence to, for example, present bad news to a patient, impelling you to provide false reassurances instead. You may think a brisk demeanor shows your professional efficiency; your patient might interpret the meaning of your behavior as unsociable. Diligence in patient sensitivity and effective communication techniques will help to ensure the best patient outcomes.

Skilled therapeutic communication, however, is distinct from social communication (Arnold & Underman Boggs, 2016). Although practitioners might engage in social banter with patients as a means to alleviate anxiety, perhaps, or to diffuse conflict, therapeutic communication techniques are purposely directed toward advancing patients' health outcomes. Appendix H provides a refresher on patient-focused therapeutic communication skills.

Self-Assessment Quiz Question #8

Healthcare professionals assume unacceptable risk to patient safety when they:

a. Accommodate all patients' preferences in decision making.
b. Communicate with patients when there is a language barrier.
c. Ask open-ended questions in clinical encounters.
d. Reduce internal and external distractions.

Self-Assessment Quiz Question #9

Which type of barrier to effective communication potentially occurs when practitioners lack awareness of differences between their values and preferences and those of their patients?

a. Linguistic.
b. Relational.
c. Environmental.
d. Cultural.

Self-Assessment Quiz Question #10

Which tool is used in health literacy universal precautions to ensure patients' understanding of health-related information?

a. Language services.
b. BATHE interviewing.
c. Shared decision making.
d. Teach-back method.

Technology-assisted communication

Existing and emerging information and communication technologies (ICT) intend to facilitate communication between healthcare professionals and patients, as well as between other practitioners. ICT is used to simplify and expedite communication for purposes ranging from patient diagnoses and care management to patient education, counseling, and support. It takes various forms, from email and mobile texts to automated decision support, e-health portals, personal digital assistants, and telehealth systems. Next generation ICT applications aim to improve healthcare services and delivery through 5G network upgrades that reliably connect anyone, anywhere, at any time through any device or service; the so-called Internet of Things that seamlessly integrates smart devices; and artificial intelligence and machine learning, among others (Maria et al., 2020; Tuli et al., 2020).

ICT, including the use of electronic health systems for documentation, has dramatically transformed the work of healthcare professionals. In daily practice, the ability of health information technologies to improve communication and, ultimately, patient outcomes, is dependent on healthcare professionals' adoption of new technologies and development of technical competence. Healthcare professionals' attitudes toward technology can be influenced by such factors as age, education level, years of service, and prior use of computers or other digitally based technology (Maria et al., 2020). Practitioners who lag behind in the adoption of and demonstrated competence in ICT may not only be hindered in their ability to adhere to professional practice standards, but they may also experience feelings of stress, frustration, and incompetence that further impede or delay their acceptance of technological innovations (De Leeuw et al., 2020). Extensive technology can also result in nurses focusing more on the screens and monitors than the patient. Research continues to explore the effects of ICT on clinical practice and the efficacy of technology- assisted practitioner-patient interpersonal communication.

CASE STUDY

Mr. Miller is a physically active 67-year-old who, before his retirement 2 years ago, had achieved a master's degree and worked in an executive capacity in his profession. He arrived at his primary care practice with reports of mild chest discomfort, slight dyspnea, and fatigue. He has a previous history of smoking for more than 20 years, a current history of hyperlipidemia controlled by atorvastatin 10 mg daily for 10 years, and mild hypertension managed by diet and exercise. His BMI falls within the normal range.

A physical examination, chest x-ray, and baseline ECG were unremarkable, but his blood pressure was 148/90 mmHG. His physician ordered laboratory tests. During the blood draw, the nurse noted Mr. Miller seemed quiet and distracted. He directed his gaze toward the floor and did not ask questions other than when he could expect the results of the laboratory findings.

Four days later, in the midst of overbooked cases and as Mr. Miller is attending his grandson's soccer game, the nurse calls his cell phone. Reading from Mr. Miller's health record, she relays that his physician noted an elevated hs-CRP (high-sensitivity C-reactive protein) value necessitating an exercise stress test. The nurse also instructs Mr. Miller to increase his atorvastatin to 20 mg daily. Responding to Mr. Miller's question about the meaning of the laboratory results, the nurse perfunctorily states, "It is a possible signal of heart disease, so the doctor wants you to have a stress test. We will put in the order and you will receive a call with the date and time of the test and other instructions." Mr. Miller responds with a simple, "Okay." To the nurse, Mr. Miller sounds subdued, even downcast. At the conclusion of the call, she thinks about ways in which she could better approach conversation with Mr. Miller during his follow-up visit in a week's time. For his part, Mr. Miller becomes preoccupied with worry about his heart health and self-restricts his usual physical activity.

Questions

1. Which elements of metacommunication should the nurse consider in future interactions with Mr. Miller?
2. Which techniques should the nurse apply to improve the effectiveness of communication with Mr. Miller?

Responses

1. Upon reflection, the nurse senses Mr. Miller may have felt intimidated or in some way defeated by the prospect of a cardiovascular issue. In reviewing her interaction with Mr. Miller, she recognizes that several barriers may have influenced his feelings about his laboratory results and upcoming test, his ability to express his concerns, and her own behavior. For example, she challenges her assumption that, based on his education, work experience, and demeanor, Mr. Miller has a high level of health literacy. She contemplates environmental obstacles – a busy workday that left her feeling pressed for time and the distracting

noise of the outdoor event Mr. Miller was attending at the time of their telephone call – that potentially interfered with both the encoding of her message to Mr. Miller and his decoding of the information he received. She further considers whether Mr. Miller's social identity could be linked to his perception of success and control in his life, a viewpoint he may now feel is threatened by the possibility of poor heart health.

2. The nurse resolves to prepare for her conversation with Mr. Miller during his follow-up visit. She makes a mental note to relax and take time to review his medical record and the results of his stress test before their meeting. Additionally, to lessen any potential anxiety for Mr. Miller, she will ensure the practice's portable ECG is absent from the examination room to which he is assigned. She plans to be consciously present during the exchange and explore the degree to which Mr. Miller understands cardiovascular disease and his feelings about his current health. She will probe whether anything in his field of experience – the premature death of a family member, perhaps – might account for the fatalistic feelings she suspects he possesses. She also reminds herself to avoid the use of medical terminology and answer his questions in plain language, adjusting the length and tenor of her answers to match his during the course of their conversation.

   Drawing on her knowledge of therapeutic communication principles, the nurse warmly greets Mr. Miller at the scheduled appointment time with a smile, eye contact, and an upbeat attitude. She sits across from him, tilting away the computer screen displaying his health record. She initiates a series of questions, waiting until Mr. Miller has completed his answers, issuing verbal and nonverbal prompts, when necessary, to elicit further information, restating his responses to ensure mutual understanding, and displaying empathy for his concerns. F… example, the nurse may use the following questions to prob… thoughts:

   - *"I sense you have been concerned about the stress tes… the results. Can you tell me about that?" "It sounds li… has caused you a great deal of worry. How have you l… handling that?"*
   - *"Let me see if I understand. Your concerns come fron… that heart disease contributed to your father's death, … brother died prematurely, and you are worried about … wife becoming a widow? Those are all valid concern… can understand why this situation makes you feel ner… let's take a minute to talk about family risk factors an… to reduce your anxiety."*
   - *"What do you understand about heart disease, the ri… factors involved with it, and the available treatments…*

   Following the physician consult, the nurse returns to expl… next test Mr. Miller will undergo, a coronary angiogram. … alongside Mr. Miller and together they review a patient e… pamphlet about the procedure, including how he should p… for the test and what he can expect during and after the p… The nurse prompts Mr. Miller to demonstrate his understa… asking, "I want to be sure we both have this right. Can yo… what you should do before the angiogram?"

   At the close of the session, the nurse inquires how Mr. M… about the procedure and the information he has been give… She reiterates strategies Mr. Miller can use to reduce his … reinforcing the degree of control he holds over his own h… Miller responds that he feels much more confident and o… about his overall health and treatment plan.

Conclusion

Communication forms the bedrock of healthcare practice. It underlies the patient-centered, therapeutic relationships healthcare professionals use to promote and support patients' health and well-being. When interpersonal communication between healthcare professionals and patients is effective, improved patient satisfaction, adherence, safety, and clinical outcomes result.

Demonstrated competency in communication is not a nice-to-have skill for healthcare professionals; it is must-have know-how in clinical practice. Practitioners must be proficient in interpersonal communication to meet standards established by healthcare organizations, but also, crucially, to ensure every patient receives the quality care to which they are entitled in every clinical encounter.

As much as communication is ever present in clinical encounters, it is ever changing, which presents particular challenges in a healthcare environment in flux as well. It also is often fraught with obstacles to the shared meaning between practitioners and patients that is so i… the provision of safe, quality care.

Evidence-based techniques help to guide healthcare professio… toward effective communication with patients. No one comm… strategy will suit all practitioners or perform equally well wit… patients, however, nor will mastery of interpersonal skills ove… all barriers to effective communication all of the time. Rappo… established and broken, and even the most highly skilled com… will not communicate well in every situation. Even so, know… of communication theory, models, and techniques, along wit… application in healthcare practice, provides practitioners the … needed to meet the central challenge of effective communica… to build better relationships with patients and, ultimately, im… quality of their care.

References

- Adams, L. Y. (2017). Peplau's contributions to psychiatric and nursing knowledge. *Journal of Mental Health and Addiction Nursing, 1*(1),e10-e18.
- Agency for Healthcare Research and Quality. (2020a). Consumer assessment of healthcare providers and systems.https://www.ahrq.gov/cahps/about-cahps/index.html
- Agency for Healthcare Research and Quality. (2020b). Health literacy universal precautions toolkit (2nd ed.): Consider culture, customs,and beliefs: Tool #10. https://www.ahrq.gov/health-literacy/improve/precautions/tool10.html
- Akturan, S., Kaya, C., Unalan, P., & Akman, M. (2017). The effect of the BATHE interview technique on the empowerment of diabeticpatients in primary care: A cluster randomized controlled study. *Primary Care Diabetes, 11*(2), 154-161.
- Ali, P. A. & Watson, R. (2017). Language barriers and their impact on provision of care to patients with limited English proficiency: Nurses' perspectives. *Journal of Clinical Nursing, 27*(5-6), e1152-e1160.
- Ali, S. (2020). Combatting against Covid-19 & misinformation: A systematic review. *Human Arenas.* https://doi.org/10.1007/s42087-020-00139-1
- Almkuist, K. D. (2017). Using teach-back method to prevent 30-day readmissions in patients with heart failure: A systematic review.
- *MedSurg Nursing, 26*(5), 309-312, 351.
- American Association of Colleges of Nursing. (2008). The essentials of baccalaureate education for professional nursing practice.http://www.aacnnursing.org/Education-Resources/AACN-Essentials
- American Association of Colleges of Nursing. (2011). The essentials of master's education in nursing. http://www.aacnnursing.org/Education-Resources/AACNEssentials
- American Balint Society. (n.d.). https://www.americanbalintsociety.org/content.aspx?page_id=22&club_id=445043&module_id=406070American Nurses Association. (2015a). *Code of ethics for nurses with interpretive statements* (2nd ed.).
- American Nurses Association. (2015b). *Nursing: Scope and standards of practice* (3rd ed., p. 71).
- Arnold, E. C. & Underman Boggs, K. (2016). *Interpersonal relationships: Professional communication skills for nurses* (7th ed.). Elsevier.Bagnasco, A., Zanini, M., Hayter, M. Catania, G., & Sasso, L. (2020). COVID-19 – A message from Italy to the global nursing community.*Journal of Advanced Nursing, 76*(9), 2212-2214.
- Barbagallo, M. S. (2021). Nursing students' perceptions and experiences of reflective practice: A qualitative meta-analysis. *Teaching andLearning in Nursing, 16*(1), 24-31.
- Berkowitz, B. (2016). The patient experience and patient satisfaction: Measurement of a complex dynamic. *Online Journal of Issues inNursing, 21*(1), 1.
- Bible, J. E., Shau, D. N., Kay, H. F., Cheng, J. S., Aaronson, O. S., & Devin, C. J. (2018). Are low patient satisfaction scores always due tothe provider? *Spine, 43*(1), 58-64.
- Bonvillain, N. (2020). *Language, culture, and communication: The meaning of messages* (8th ed). Roman & Littlefield.
- Brega, A. G., Barnard, J., Mabachi, N. M., Weiss, B. D., DeWalt, D. A., Brach, C., C… Albright, K., West, D. R. (2015, January).AHRQ health literacy universal precaution… (AHRQ Publication No. 15-0023-EF, prepared by Colorado Health OutcomesProgr… Colorado Anschutz Medical Campus under Contract No. HHSA290200710008, TO… Healthcare Research and Quality.
- Burgener, A. M. (2017). Enhancing communication to improve patient safety and to … satisfaction. *Health Care Manager,36*(3), 283-243.
- Cappella, J. N. (2017). Vectors into the future of mass and interpersonal communica… Big data, social media, andcomputational social science. *Human Communication Re…* 545-558.
- Cayley, W. E., Jr. (2018). Four evidenced-based communication strategies to enhanc… *Family Practice Management, 25*(5),13-17.
- Centers for Medicare and Medicaid Services. (2020). HCAHPS: Patients' perspecti… survey. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instr… HospitalQualityInits/HospitalHCAHPS
- Chan, E. A., Wong, F., Cheung, M. Y., & Lam, W. (2018). Patients' perceptions of th… with nurse-patient communication inoncology settings: A focused ethnographic stu… *13*(6), e0199183.
- Chou, E., Hsieh, Y., Wolfshahl, J., Green, F., & Bhakta, T. (2020). Onsite telemedici… coronavirus (COVID-19) screening tolimit exposure in the ED. *Emergency Medici…* 335-337.
- Dance, F. E. X. (1970). The "concept" of communication. *Journal of Communicati…*
- Dance, F. E. X. & Larson, C. E. (1976). *The functions of human communications: A… approach.* Holt, Rinehart & Winston.DeCelie, I. (2020). Patient participation strate… bedside handover. *Patient Experience Journal, 7*(3), 119-127.
- De Leeuw, J. A., Woltjer, H., & Kool, R. B. (2020). Identification of factors influen… health information technology bynurses who are digitally lagging: In-depth intervi… *Medical Internet Research, 22*(8), e15630.
- Dobosh, M. A., Scott Poole, M., & Malik, R. (2019). Small group use of communi… A comparison of modality on groupoutcomes. *Communication Research Reports, …*
- Drossman, D. A. & Ruddy, J. (2020). Narrative review: Improving patient-provide… improve health care. *ClinicalGastroenterology and Hepatology,* 18, 1417-1426.
- Elkbuli, A., Ehrlich, H., & McKenney, M. (2020). The effective use of telemedicin… maintain a structure in a healthcaresystem: Current response to COVID-19. *Ameri… Emergency Medicine.* https://doi.org/10.1016/j_ajem.2020.04.003
- Fuchs, C. (2020). *Communication and capitalism: A critical theory.* University of …