Advanced Patient Communication Skills for Doctors

A comprehensive resource to support improvements

- What needs to be communicated and why
- Creating dialogue
- Factors affecting communication and behaviour
- Communication approaches in healthcare

Oxford Medical

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Advanced
Patient Communication Skills
for Doctors

Written by
Stephen McGuire, Dr Tony Woolfson and Andy Cole

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About the authors

Stephen McGuire

Stephen is Oxford Medical's Training Manager and a practising optometrist. Before concentrating upon career development for doctors, he worked as Clinical Development Manager at Dollond & Aitchison, being responsible for the recruitment, development, standards of compliance and performance of optometrists. Further experience includes programme management, overseeing the implementation of change, establishing new ways of working, and healthcare in the retail sector with specific focus upon specialised technical training and patient communication.

Dr Tony Woolfson

Tony is a Consultant in General Medicine and Cardiology in Peterborough. Apart from practising clinical medicine, he has many years of experience as a medical writer, researcher, educator, trainer, communications and marketing consultant, executive coach and web designer.

His special interests are currently in promoting a more holistic approach to medical practice and in developing innovative training methods, courses and workshops for people who work in healthcare, communication, education, training and commerce.

Andy Cole

Andy has led training, development and talent management strategies for leading names in the private and healthcare sector. His practice covers business psychology consulting, executive coaching, corporate education, communications training and experiential leadership development.

An Honours graduate with postgraduate qualifications in HR Management, Business Psychology and Executive Coaching & Mentoring, Andy is a Fellow of The Chartered Institute of Personnel & Development, a member of the Association of Business Psychologists and the European Mentoring & Coaching Council.

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Chapter 1: Introduction

- "The single biggest problem in communication is the illusion that it has taken place." *George Bernard Shaw*
- "The two words 'information' and 'communication' are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through." *Sydney J Harris*

As a doctor, your ability to interact effectively with others – to ensure that all concerned hear what needs to be heard whilst you demonstrate respect, compassion and commitment to care - has a powerful impact upon your patients, carers and colleagues. This is explicitly recognised within the third and fourth domains of *Good Medical Practice*.

Good Medical Practice

1: Knowledge, Skills and Attitude

1. Maintain your professional performance
2. Apply knowledge and experience to practice
3. Keep clear, accurate and legible records

2: Safety and Quality

1. Put into effect systems to protect patients and improve care
2. Respond to risks to safety
3. Protect patients from any risk posed by your health

3: Communication, Partnership & Teamwork

1. Communicate effectively
2. Work constructively with colleagues and delegate effectively
3. Establish and maintain partnerships with patients

4: Maintaining Trust

1. Show respect for patients
2. Treat patients and colleagues fairly and without discrimination
3. Act with honesty and integrity

A proactive approach to reviewing and enhancing your patient communication skills must therefore be treated as equally important as any other clinical skill.

This book has been written to support you in your efforts to achieve and sustain improvements. The fact that you are reading this page suggests that this is an area of interest for you. We will introduce theories which we will bring to life through examples and short exercises, heling you to crystallise your personal thoughts and experiences, before outlining methods which you can employ to communicate more effectively.

Feel free to choose whether you prefer to read the book from cover to cover in the order it is written, or alternatively to dip into each chapter either now, or as a resource for the future.

1.01 What is communication?

Communication is often regarded as the transfer of conscious level information between one person and another. It may be helpful however to think more broadly about this if we are to become expert communicators.

Living systems can be thought of as networks of information exchange, conveying information at levels from the molecular to the linguistic. Humberto Maturana, a South American philosopher and scientist and one of the major systems thinkers of the 20th century studied and wrote extensively about this and he concluded that:

"The basis of communication is not primarily a transmission of information, but rather a coordination of behaviour between living organisms. Such mutual coordination of behaviour is the key characteristic of communication for all living organisms, with or without nervous systems, and it becomes more and more subtle and elaborate with nervous systems of increasing complexity."

Humberto Maturana

This ties in very well with our modern concepts of communication at all levels, from the words, through to body language and even possible non-sensory pathways. These concepts can be very helpful in broadening our approach when dealing with patients.

1.02 Your personal patient communication challenges

Take a few moments to write down what you believe to be your biggest personal patient communication challenges.
This may be particular patient types, personalities or demographics. Alternatively it could be particular situations which arise in the course of your practice, or it could be something else entirely.

1.03 What needs to be communicated and why?

One way to start trying to answer this question is to look at the aspects of communication which patients say they want to be improved. *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture*, is a report from October 2013 by Rt.Hon. Ann Clwyd MP and Professor Tricia Hart. They stated the top five reasons for complaints in NHS hospitals to be as follows:

Key reasons for hospital complaints	
Lack of information	Patients said they felt uninformed about their care and treatment.
Compassion	Patients said they had not been treated with the compassion they deserve.
Dignity and care	Patients said they felt neglected and not listened to.
Staff attitudes	Patients said they felt no one was in charge on the ward and the staff were too busy to care for them.
Resources	Patients said that there was a lack of basic supplies like extra blankets and pillows.

Whether you work in a hospital environment or not, these points give us the clearest clues regarding what a good doctor needs to communicate to their patient. This includes the effective transfer of information. The patient is a human being with thoughts, feelings and emotions who may be curious/frightened/frustrated. Doctors, nurses and the wider team must be seen to be both caring about the outcome and to be taking proper responsibility. There are numerous elements which contribute toward this.

In his book, *The New Consultation – Developing Doctor-Patient Communication* (2008), David Pendleton describes and explains an overwhelming amount of research that associates great communication with improved patient outcomes – from history taking through to ongoing management of health.

He describes how the cycle of care works best for the patient and encourages health improvement if there is an effective consultation. Studies by Kaplan et al (1989) and Stewart (1995) have shown how the quality of history taken and management communication directly impact upon health outcomes including pain control, physiological measures, symptom resolution, function and emotional health.

It is clear to Pendleton that everyone can improve their consultation skills. He believes (perhaps somewhat optimistically) that nearly all doctors have a range of sophisticated communication skills, though these are sometimes not used in the consultation.

Quoting the philosopher Kierkegaard, he asserts that:

> **If I want to succeed to bring a man towards a certain goal I have to start finding out where he is and start just there.**

To achieve this we must strive to hear the facts and the implications with an open mind.

And, taking further advice from the words of wise men, we must also be humble.
Socrates said:

> **If a man does not understand what you have said, prostrate yourself before him, for you have not explained yourself well.**

Before we explore how to improve communication, the two exercises set out in the tables over the following pages should help you to consider where you are at present.

Exercise 1: Consider an example of a recent communication scenario with one of your patients. You can choose one which either went very well or went badly. Use the table to make notes under each of the headings.			
What was said?	**Why it needed to be said?**	**How it was received?**	**What if…….it had been said differently?**
			You may wish to add notes to this column as you work through the different sections of this book.

Exercise 2:

Make some note of your own thoughts under each heading. (You may want to add notes to this table as you work through the different sections of this book)

What do patients need to communicate to their doctor?	What do doctors need from their patients?

What do patients need from their doctor?	What do doctors need to communicate to their patients?

Chapter 2: Creating dialogue

Dialogue by definition is a 'conversation between two people'. By implication the two parties involved should be of equal importance: both share information; both need to be heard. This is fundamental in being able to '*Establish and maintain partnerships with patients'* as required by *Good Medical Practice*.

There are many elements to creating genuine dialogue with a connection to each patient including: active listening; having and demonstrating empathy; authenticity and congruence; verbal language and body language as well as rapport.

2.01 Neuroscience

When we are looking to improve our communications skills it is very helpful to have some understanding of how our brains work.

There have been great advances in neuroscience in the last few years, helped greatly by the availability of various advanced forms of MRI brain scanning in showing which parts of the brain are working while we are paying attention to different things and doing different tasks.

Out of this has come the general understanding that *Homo sapiens* are really no different in many ways from any other animal! We are basically hardwired for survival, which makes total sense in evolutionary terms. Escaping death by being able to react immediately and avoid a charging wild animal is more important than being able to entertain thoughts about why and how the animal moves the way it does.

The rapid response systems lie in the lower areas of the brain and the limbic system, and our more complex thought processes reside more in the prefrontal cortex. Apart from experimental evidence from brain scanning, several people have put these concepts into practical formats which help us understand why we do what we do.

Probably the most eloquent exposition comes in Nobel Prize winning Daniel Kahneman's book, *Thinking, Fast and Slow,* in which he describes two different thinking systems:

- **System 1 (Fast)** is all about our immediate responses to things.
- **System 2 (Slow)** involves the higher cerebral functions of reflection and analysis.

Similar divisions have been described by:
- **Daniel Goleman** who refers explicitly to the limbic and prefrontal thinking processes
- **Robert Cialdini,** a psychologist who has studied marketing extensively, who refers to the lazy and the hard-working parts of our brain

- **Walter Mischel**, an experimental psychologist who studied children and found that the ability to defer gratification, a function of what he called the Cool Thinking System, was a major factor in determining how successful people would be in life compared to those whose activities were controlled more by the Hot Thinking System, (equivalent to Kahneman's System 1).

It is shockingly clear from all these studies that the major system that controls what we do is Kahneman's System 1. This may not be surprising from an evolutionary point of view, but it comes as a nasty surprise to us because we live under the illusion that our actions and behaviours are rational, while in fact they are largely based on rationalisations of impulses from our limbic systems. It is vital to understand this with humility if we are to communicate effectively.

2.02 Empathy

It appears obvious that good empathy is essential to effective communication. However it is important to understand what empathy actually means so that we can use it effectively.

Empathy can usefully be divided into three parts:
- cognitive empathy
- emotional empathy
- empathic concern

Cognitive empathy allows us to take in other people's perspectives, understand their mental state and at the same time manage our own emotions while we evaluate theirs. This involves mainly the top-down, pre-frontal brain systems also called Cool or Slow.

Emotional empathy takes us into different areas where we join the other person in feeling. Our bodies resonate or synchronise in whatever joy or sorrow the person may be going through. This facet of empathy operates through the bottom up (limbic) Hot, Lazy or Fast systems mentioned earlier.

While cognitive or emotional empathy means that we recognise clearly what another person thinks, and that we resonate with their feelings, it does not necessarily lead to sympathy or concern for their welfare.

Empathic concern goes further, leading us to care about them and mobilising us to help if that is necessary. This is, if you like, a mixture in which we use our primal systems for caring and attachment, where we moderate and focus these with our reflective top-down circuits through which we can make a conscious decision to help.

Cognitive empathy gives us the ability to understand another person's ways of seeing

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and thinking. This is obviously important in helping us choose the language that fits with their particular way of understanding things.

Emotional empathy builds on those ancient circuits in the brain that enable, for example, mothers to care properly for their young. These circuits are in the primitive parts of the brain and link to the more modern parts which form circuits known as mirror neurons. Studies using EEG have shown that when we are in tune with another person then our functional neural patterns become co-ordinated. So much so, in fact, that it has been shown repeatedly that the mirror neuronal circuits in the listener can sometimes actually anticipate by more than a second what the speaker is going to say.

Some people are naturally more compassionate than others. They are able to move more easily from cognitive through emotional empathy to empathic concern. But the very act of bringing these aspects of empathy into consciousness can help us all improve the effectiveness of what we do.

Worryingly, a number of studies have shown that doctors during the course of their training steadily decrease in day-to-day empathy. However, having become aware of this, various organisations have begun empathy training programmes which can provide useful practical training in improving skills in this area.

> **There is evidence that engaging with patients in an empathic way increases the efficiency of medical care provided by a doctor.**

2.03 Rapport

- Rapport is the feeling of harmony, recognition and mutual acceptance you get when both you and the other person develop a sense of mutual understanding

- It happens when you develop a genuine interest in the other person and in their view of the world

- In rapport, similarity (common ground) is emphasised; difference is minimised

- Having rapport with someone is like 'being on the same wavelength'

The conclusion to research by Dr. Wendy Levinson that doctors are less likely to be sued if they have rapport with their patient is one benefit of achieving this state. Although doctors obviously want to avoid being sued at all costs, a more positive driver is that information is more likely to be shared and understood by both doctor and patient when genuine rapport exists.

This state does not happen automatically and the diagram below describes the exchanges between two people as they progress up the different levels of interaction towards rapport.
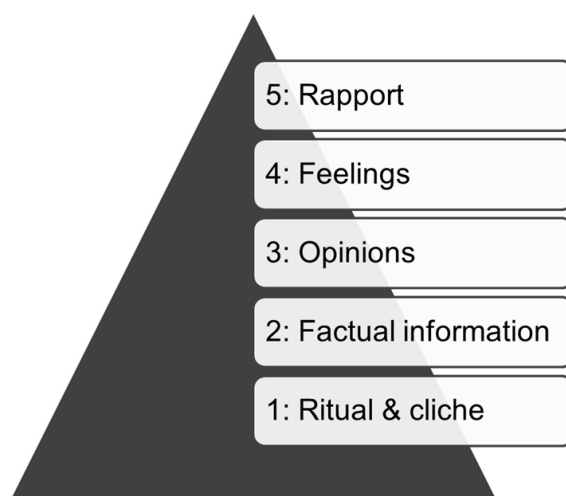
In general, we spend a great deal of our time in the lower levels, only progressing to the higher levels when the others involved and the circumstances mean that we are comfortable and that this feels appropriate, as illustrated in the everyday conversation below.

1: **Ritual and cliché**	"Hello, how are you?", "*I'm fine thank you.*" even when you are not!
2: **Factual information**	"It's very cold today.", "*Yes it is. I had to put my gloves on this morning*"
3: **Opinions**	"This would be a great day to go out for a really good walk.", "*Oh no. I think it's a day for sitting in with the tv on.*"
4: **Feelings**	"I just feel so caged in with the daily travel and working indoors.", "*No, I'm happier when I'm warm and comfortable.*"
5: **Rapport**	A free flowing exchange between the two parties when they share with trust and respect, even with opposing viewpoints.

It would be unusual to start off or even progress to the higher levels with strangers or in circumstances where we feel vulnerable, yet the doctor-patient interaction should ideally function at the rapport level – even when the two parties have never met before.

Although some patients will be willing, or might even expect to share very personal information during a consultation there are numerous reasons why others may hold back – feelings of embarrassment, vulnerability, or fear are just a few. When such feelings are present the patient may only be prepared to disclose information when they feel safe and this takes time.

Lack of time can be a barrier to the development of rapport. Busy schedules can result in the doctor's determination to 'just get on with it' and uncover information as fast as possible. In this mind-set what might appear to be idle chit-chat can seem like an irrelevant distraction or luxury which cannot be afforded. This has to be balanced with the reality that it will take much longer to encourage someone to share details of a

personal nature when they are uncomfortable, so the opening of any patient interaction is critical. The challenge therefore is to reach the rapport level quickly. To achieve this it is worth looking at rapport from a different perspective.

> Psychologist Will Schutz stated that the chances of creating rapport are increased when both parties feel:
> - **Significant**
> - **Competent**
> - **Likeable**

When our intention is to make the patient feel significant, competent and likeable, we may reach the stage of rapport more quickly and more naturally than following a process.

2.04 Introductions and the use of names

In all walks of life, a key part to feeling significant is that people know and use our name. Many oppressive regimes, including prisons or armed forces, intentionally depersonalise people by avoiding names. This includes giving numbers, labels and even different names.

One of the most important aspects of effective and compassionate communication with patients is to demonstrate that you know who they are. How often do you hear people referred to as "the patient", "your next appointment", "the 11:20" representing the time they are due to see you or by some other category that they fall into? The depersonalising act of giving numbers, labels and even different names is more common than we often care to think.

> Dale Carnegie said in his famous book "How To Win Friends and Influence People":
>
> **"Remember that a person's name is to that person the sweetest and most important sound in any language."**

The patient's name is on every piece of documentation related to them so it is readily at hand in the vast majority of circumstances.

There is some debate about how best to address patients. Nurses in particular and many doctors have taken to calling almost all patients by their first names because they feel that the informality of this makes for easy communication. Others are not

comfortable with this and continue to address most patients by their surnames.

To an extent, these differences are explainable by the cultural norms of clinicians in different age groups and also their ethnic and geographical origins. There is no right or wrong answer to this and what is of primary importance is that patients are addressed with kindness and respect, and in ways that they themselves are maximally comfortable with.

Equally as important as demonstrating that you know the patient and regard them as significant is that they know who you are and what you do. In the pressured environment of modern medicine, it is all too easy when you have a lot of things to do focus just on getting on with the job, ticking the next task off your list.

This was particularly brought to light recently by Dr Kate Granger who while receiving cancer treatment was appalled at how few of the staff who were looking after her took the trouble to introduce themselves to her and explain what their role was in her care. She started a campaign called 'Hello My Name Is' (http://hellomynameis.org.uk/), and this has now been taken up and promoted not only by the British Medical Journal and more widely in the National Health Service, but by doctors and health services all over the world.

2.05 Words, tone and body language

Communication goes beyond the words which we use. Think of the impact that the addition of each simple emoticon has on the text message below:

You will often find in the communications literature assertions to the effect that in communication 7% of the impact is in the words, 38% is in the para-linguistics (tone, pitch, speed), and 55% in the body language.

This comes from a study done by the American psychologist Albert Mehrabian. The only problem is that this is not at all what he said! He actually did two studies, one involving just single words and voice tonalities and the second involving single words, tonalities and pictures of faces. What he and his colleagues found was that the photographs of faces allowed more accurate interpretation of meaning of the single words than the way that the words were spoken.

He did give the figures quoted above but he was also very clear that the experiments involved single words and facial photographs only and that these studies were about words with emotional content only.

His basic message really was that we get a lot of our clues about the emotional intent behind people's words from non-verbal sources, and when the two are in conflict we tend to believe the non-verbal. This is in accord with our daily experience and makes complete sense.

However, it does not imply in any way that the words we use to communicate are unimportant. It has been shown in many other studies that the actual words we use in any given situation are critical to getting our message understood.

One aspect of the impact of our choice of words is explored in *Section 3.02 Framing.* We should also judge our choice of words to ensure the individual we are talking to hears what is meant to be heard with the least difficulty. Age, occupation, culture and previous experience with any health issues will play a part in whether a patient will find some words familiar, ambiguous or unfathomable. Words and phrases which are efficient communication for one person will be complete jargon to another.

It is also worth noting that there may well be other channels of communication that are not yet fully defined. For example, there is clear scientific evidence that living things may communicate in ways that do not directly involve the five "normal" senses, possibly through energy fields which we have so far been unable to detect with current scientific methods. This is a contentious and much debated subject within the scientific community. For further information, it is worth reading the contributions of Cambridge biologist Rupert Sheldrake.

2.06 Physical Contact

In all cultures physical contact is a vital component of communication. In general it can probably be said that women are more comfortable with physical contact between them than are men, but there is a tremendous variation both within and between cultures.

It is very important to keep in mind that physical contact is an act of intimacy and it requires permission, either implied or explicit. Forms of physical contact are often formalised, for instance shaking hands, which goes across many different cultures.

In emotionally charged circumstances it may be very tempting to hold a patient's hand, touch their arm or put your arm around their shoulders. However it is vital to be aware that the need to do this may be yours rather than the patient's, and that they may be upset by what they may perceive as an invasion of their own personal space. Having said that, a gentle touch handled in the right way may well be really valued and helpful to the patient in the right circumstances.

2.07 Presence and Focus

We can learn a lot by stepping out of the world of healthcare and looking at work in apparently unrelated fields. Acting coach Patsy Rodenburg has described a three circle model of Presence, illustrated below, which describes where energy is channelled during interactions with others.

Energy flows in
- *"I'll think about me whilst you talk about you "*
- *"I'd rather listen than talk"*

1st Circle

Energy flows between
- *"I can think and talk about you"*
- *"I connect in to you"*
- *"My positive intention is evident from my non-verbal behaviour"*

2nd Circle

Energy flows out
- *"I'll talk about me whilst you talk about you"*
- *"I'd rather talk than listen"*

3rd Circle
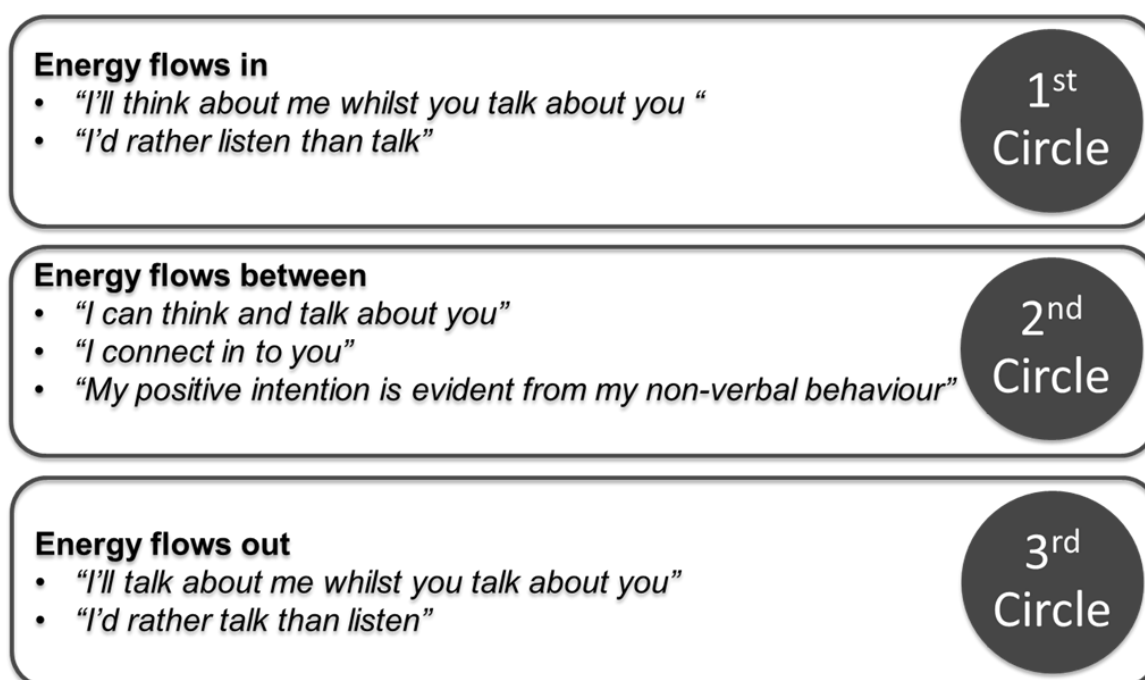
Daniel Goleman, initially well known for his writings about Emotional Intelligence expanded his ideas in a more recent book called *Focus – The Hidden Driver of Excellence* which contains similar principles to Rodenburg's Presence model.

In it he argues that 'paying attention' is an art form which has become lost in our busy, noisy, fast-moving world and he describes three sates of focus:
- **Inner focus** – when we direct our attention to ourselves
- **Outer focus** – when we direct our attention to those people we are communicating with
- **Other focus** – when we direct our attention to the situation and information from the outside world

Using examples from the business environment, he describes various situations in which there are mismatches between the different levels of focus that people are able to engage with. An example of this is the extremely driven executive who puts all his or her attention into what's going on in the outside world (other) in order to get things done but not taking time to either reflect internally (inner focus) on the implications of what they're

doing, or pay attention to the effect they are having (outer focus) on the people around them. This can be disastrous for any company. In many ways the lack of inner and outer focus was at the root of the problems which led to the Mid Staffordshire and Vale of Leven Enquiries where there were serious lapses in the standards of patient care.

What we require, Goleman proposes, is to direct our attention through a triple focus 'zoom lens' in order to function with maximal effectiveness, both in our personal and professional lives. This enables us to adjust our focus appropriately and flexibly to what is going on within us and to what people around us are communicating to us, while keeping ourselves well informed about the wider world around us. Just like a muscle, this zoom lens will weaken if under or poorly used, but it will grow and develop if it is effectively exercised.

This ties in well with what we know about how our brains function and the importance of expanding and tuning our awareness, which is the first step to the conscious adjustment of behaviour.

2.08 The Johari Window

Devised by American psychologists Joseph Luft and Harry Ingham in 1955, The Johari Window is a simple grid model which illustrates levels of awareness of individuals and groups and has strong links to the ideas we have been exploring in creating dialogue.

It is based on two axes:
- X-axis: What is known and unknown by 'self'
- Y-axis: What is known and unknown by 'others'

This creates four quadrants or 'panes' as illustrated in the diagram

1: Open Area *Known by both self and others*	**2: Blind Area** *Known by others but not by self*
3: Hidden Area *Known by self but not by others*	**4: Unknown Area** *Not known to anyone*

The Open Area is increased in size by two key activities:
- Disclosure of personal information by 'self'
  - This reduces the size of the Hidden Area
- Feedback and input by 'others'
  - This reduces the size of the Blind Area

We can apply this to the patient doctor relationship where the patient is represented by 'self'

1: Open Area *Known by both patient and doctor*	**2: Blind Area** *Known by doctor but not by patient*
3: Hidden Area *Known by patient but not by doctor*	**4: Unknown Area** *Not known by either*

Though many factors come into play in healthcare, as a general rule:
- The more the patient is prepared to share and disclose, the more informed the doctor becomes
- The more the doctor explains facts and shares observations, the more informed the patient becomes

When considering the development of your personal patient communication skills it is also beneficial to apply The Johari Window from the aspect where you put yourself in the role of 'self'. For example, there will be elements of your patient interactions of which you are unaware, that are apparent and can be observed by others. Equally you may have feelings or reasons for your behaviour and style which you have not shared with others.

There is much to be gained by involving others to support you to expand your Open Area and have a greater awareness of your patient interactions. Clarity on current strengths and development areas are significant steps toward making improvements. This can be achieved by taking feedback directly from patients, for example during the Appraisal process. Another method of both increasing your awareness and gaining new ideas on how to improve is by proactively involving your colleagues.

2.09 Shadowing to improve patient care

In their *Patient and Family-Centred Care Toolkit* (2014) the King's Fund advocates the practice of shadowing as a means to improving patient care. In this activity one person closely follows and observes the patient's experience, using this as a catalyst for change.

The key points of a constructive shadowing process would be:
- Gain agreement from a suitable person to be the shadow
- Set aside the time for the exercise to take place, including the time for review and feedback
- Agree any specific areas on which you would like feedback
- Introduce the shadow to the patient(s) as you greet them and gain their permission
- The shadow is indeed a shadow during the consultation from start to finish, advising the patient they will not be involved in the conversation, examination or decisions
- The shadow makes thorough factual notes about the interactions and observations
- Thank the patient(s) at the end of the consultation
- Have a review session with the shadow (ideally directly after the consultation)
- Set time to repeat the process at some point in future to focus on change

There are undoubtedly challenges with applying this model including gaining the time and commitment from the shadow and making the space for a suitable review session - the benefits of improving patient care is the driving force to resolving these issues.

Who is a 'suitable person' for the shadow role?

This could be anyone who can be trusted with confidentiality and you believe will give you constructive feedback, for example your peers, clinical and administrative staff, students or senior management. Although the automatic inclination may well be to look to direct peers and to seniority for support, junior, less experience and 'less qualified' individuals can often add great value on the grounds that they can give offer a different point of view, based on their own experience. With this in mind, there are benefits in seeking the input of a variety of individuals over time. Alternatively you may prefer to work with one shadow, such as a mentor. As taking on the shadow role can prove to be a worthwhile learning experience in itself, it is worthwhile pairing up with a colleague and agreeing to shadow each other.

What should the shadow focus upon?

Shadowing can be effectively applied to the improvement of many aspects of clinical care. When conducted in the endeavour of improving patient communication an experienced shadow may be capable of observing without a brief and giving excellent feedback during the review. In some cases, the shadow is given a pro-forma with points

and topics to be checked or commented upon – creating rapport; demonstrating empathy; full collection of all relevant symptoms and so on. As a positive, this can serve to prompt the attention to these points, however the 'ticking the box' can be a risk. If you have asked for the exercise in the first place, it would be entirely reasonable to discuss what you want to achieve and this should help to give the shadow direction.

What if it is not a typical consultation?

When participating in shadowing exercises our natural instincts are that we want to be observed conducting a 'routine' or typical consultation. Many clinicians will argue, probably correctly, that the very fact that they are being observed will change their behaviour.   To conclude that there is therefore little to be gained however misses the point. A positive mind-set to adopt is to recognise that shadowing will indeed heighten our awareness of our actions and that this is in itself a driver for learning and improvement. There are benefits to the shadow observing more than one consultation if possible. This gives the shadow the opportunity to witness different interactions, and often the doctor being observed will relax and be more natural as the exercise progresses.

What if the patient is uncomfortable with the shadow?

The patient's experience has of course to be respected and if the shadow detects that their presence in the background is having a detrimental impact in any way then they should be prepared to make an exit, thanking the patient as they leave.

What would be a good review format?

You may be familiar with Pendleton's rules for feedback and feel that they can work well for such a review. If you have been shadowed, you can still take charge of and lead the review process, especially if you have instigated the exercise in the first place.

1. You state what was done well
2. Shadow states what was done well
3. You state what could be improved
4. Shadow states what could be improved
5. Agree the steps and actions for improvement

Gibb's Model of Reflection is another useful approach to structured debriefing. Often used for personal reflection, this can be a very useful framework to use for a review, particularly when you have a good relationship and rapport with the shadow, specifically encouraging the consideration of feelings. Gibb's model is described on the next page.

Although these frameworks are sometimes criticised for being too rigid and formulaic, they do provide a helpful guide to work with for any review. It is important to strike a good balance to ensure that conversation flows during the review rather than being stifled by processes.

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Gibb's Model of Reflection		
1: Description	• *"What happened?"*	Don't make judgements yet or try to draw conclusions; simply describe.
2: Feelings	• *"What were your reactions and feelings at each stage?"*	Concentrate upon gathering what the feelings were and are. Analysis comes later in the process.
3: Evaluation	• *"What was good or bad about the experience?"* • *"What went well?"* • *"What went less well?"*	Your value judgements and opinions.
4: Analysis	• *"What sense can you make of the situation?"* • *"What was really going on?"* • *"Were different people's experiences similar or different in important ways?"*	Bring in ideas from outside the experience to help you.
5: Conclusions – general	• *"What can be concluded, in a general sense, from these experiences and the analyses you have undertaken?"*	Clarify the learning points and implications of what has happened for the organisation, team or speciality.
6: Conclusions – specific	• *"What can be concluded about your own specific, unique, personal situation or way of working?"*	Clarify your personal learning points and the implications for yourself.
7: Personal actions plan	• *"What are you going to do differently in this type of situation next time?"* • *"What steps are you going to take on the basis of what you have learnt?"*	Make commitments to change.

2.10 Further methods for increasing awareness and deepening understanding

There are further ways in which you can increase your awareness and both broaden and deepen understanding of yourself and the world around you. Although it is relevant to bring these possibilities to your attention, the teaching of these methods is beyond the scope of this book.

Firstly, if you consciously wish to do so, you will find yourself naturally paying more attention to what goes on around you rather than being occupied predominantly with your own thoughts.

If you want to do something more active, any elementary meditative practice will serve the purpose. Most simple meditation is much easier to do than people think and you only need to start with very short meditation exercises to have a significant effect. A very useful technique is mindfulness meditation, originated by the American scholar and philosopher Jon Kabat–Zinn.

Beyond this there are many possibilities which generally require more time and effort. Such possibilities include studying and participating in silent or focused retreats, entering personal therapy or using mind altering techniques such as Shamanic practices or Grof Holotropic Breathwork. These latter techniques require particularly skilled handling and considerable care is required in choosing properly trained, appropriately motivated facilitators.

Just as with increasing your awareness, there are many ways in which you can seek to deepen and broaden your understanding of yourself and the world around you.

There is a myriad of fascinating written material in any particular areas that interest you and this can be done at little expense, either financial or in terms of time requirement.

If you want to go deeper, there are many groups where people explore their own feelings and experiences in relation to both their lives and their professions. For doctors there is an extensive network of Balint groups, started by the psychoanalyst Michael Balint many years ago, where doctors meet to discuss cases and ethical situations, looking at them together from the point of view of very personal and often quite deep perspectives. Not everybody finds the psychoanalytic basis of this type of group to their taste, but there is no question about the good intentions of everybody concerned and the environment can be considered very safe.

There is also a wide range of psychoanalytic, psychodynamic and more eclectic forms of therapy. What is likely to be helpful for any given individual is very variable, as is the quality of the therapists. Again, as with increasing your awareness, some care is required in choosing and finding someone who you will trust to explore with you your inner life.

Chapter 3: Factors affecting communication and behaviour

The ways in which we communicate and behave vary greatly from person to person. The ways in which any single person communicates and behaves is also very variable from one day to another, from one situation to another. Our interactions also vary from one person to another. This is influenced by a wide variety of factors which we will explore in this section.

The impact of these variations range from a lack of connection, through to misunderstanding and potentially to conflict.

3.01 Listening

Following on from Rodenburg's model on Presence, it is worth acknowledging that when two individuals, e.g. doctor and patient, are in active conversation, there are in reality three conversations in play:

- The internal conversation going on inside the doctor's head
- The external conversation which others can hear and observe
- The internal conversation going on inside the patient's head

The "simple" act of listening is more complex than is often thought, requiring giving full attention to people and interpreting what is being said.

There is a lengthy list of factors which can prevent us from actually paying attention and prevent us from listening.

Listening Barriers include:

- Environmental distractions - phones, talking, background noise
- Physical surroundings - poor acoustics, lack of privacy
- Personal distractions - hunger, headache, feelings of stress or sleepiness
- General inattentiveness – daydreaming, boredom
- Pressing problems - immediate lack of time, too busy to focus
- The other person's communication style - inarticulate, strong accents
- Over-concentrating on detail at the expense of getting the gist/sense
- Lack of interest in the topic
- Rebuttal tendency – developing counter argument while they're still speaking
- Detouring because of something the speaker said earlier

In addition, there is another lengthy list which affects the way in which we interpret what we hear. As an example, what will be taken as a complement from one person may be perceived as an insult from another, even when the exact same words are used due to the reputation and relationship of the messenger to the listener.

Listening filters include:
- Our thoughts/feelings about the topic or its relevance   - Personal interests (i.e. "I*f I'm interested, I listen; if I'm not, I don't"*)   - Our assumptions, preconceived notions, expectations   - Our experience, associations, biases and prejudices   - Our mood/attention span at the time   - Our feelings about/attitudes toward the speaker   - Perceived style differences with speaker - conflict of values, beliefs   - Speaker's voice tone, vocabulary, jargon   - Speaker's appearance, body language, gestures   - Speaker's position of authority or lack thereof

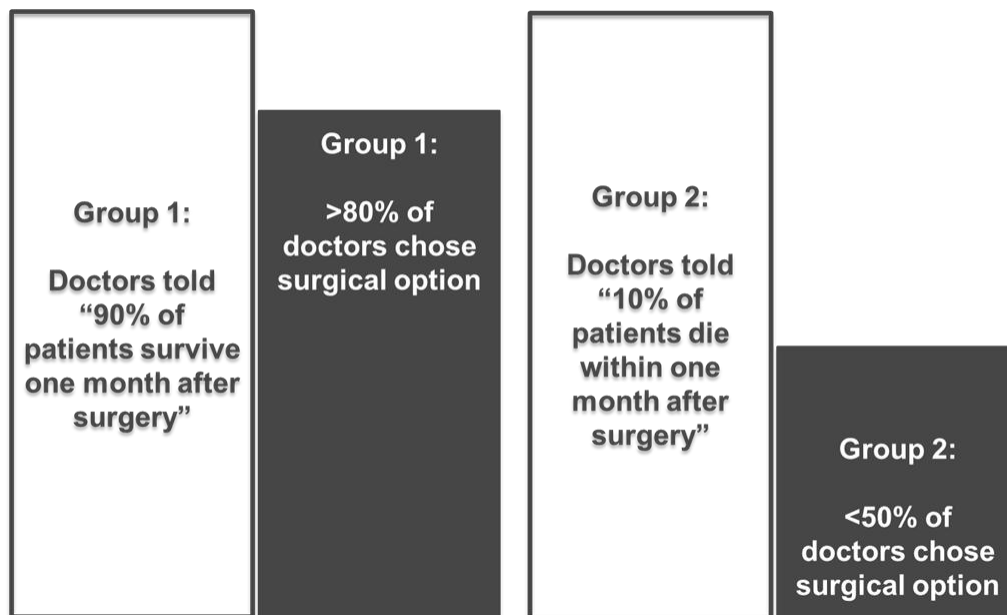These barriers and filters apply equally to both doctor and patient.

3.02 Framing

Framing describes the context in which information is provided. This is far more important than most people realise.

In experiments described by Daniel Kahneman, doctors were told that the five-year survival rates in lung cancer are much better when surgery rather than radiotherapy is used initially but that the short-term mortality is higher with surgery. The doctors were split into two separate groups and the information was presented to each group in a different manner with the impact on their decisions recorded afterwards.

Group 1 was told that the one month survival following surgery was 90%; Group 2 that the one month mortality was 10%. Logically of course, the odds are exactly the same. When asked how they would advise a patient given the figures that they had, more than 80% of the group given the survival figures chose surgery and less than 50% given the mortality figures chose surgery.

Survival sounds much more attractive than mortality!

| Group 1: Doctors told "90% of patients survive one month after surgery" | Group 1: >80% of doctors chose surgical option | Group 2: Doctors told "10% of patients die within one month after surgery" | Group 2: <50% of doctors chose surgical option |

If even doctors are affected to this degree by framing effects, then we can only imagine how much more susceptible patients are to the same effects.

This study and others are the subject of a 2014 article by Gerd Gigerenzer in the *British Medical Journal*. He acknowledges the magnitude of framing effects, but quotes other studies which have shown that if people are provided with both the survival and the mortality figures at the same time, framing effects seem to become less important.

Even this is not the whole story. There is also a very powerful effect of the order in which information is presented. It has been shown in many other studies that whichever piece of information is shown first affects the reaction to the second.

The framing of questions can also have a significant impact upon the response. You will probably have practised the use of open questions beginning with 'who', 'where', 'what', 'when', 'how' and 'why' to encourage patients to talk. "How often do you have a headache?" is likely to elicit a different response from, "Do you have any headaches?" Careless framing can also result in leading questions, for example, "You don't have any headaches, do you?" In this case the patient may feel they have been told they should not have headaches and be more likely to 'agree' that they do not.

Don't think about a big red balloon.

Contrary to the Mehrabian myth, discussed in *section 2.05, Words, tone and body language,* the words which we use are very important and influential. It is surprisingly easy to place thoughts in the minds of others and to make people think and feel very differently. Had you thought about a big red balloon before it was mentioned? Are you managing not to think about it?

You may be wondering if this is relevant to your patient communication. Look at the following statements and consider them in the light of the 'red balloon' effect.

- I don't want you to be upset but…..
- Try not to flinch when I do this
- This is quite complicated and difficult to understand
- It's not something which should keep you awake at night
- A lot of people feel embarrassed at this sort of thing

The patient may not have felt upset, embarrassed, worried or expected to be confused until these phrases were mentioned – but they are now, even though the intentions of the clinician were positive. Accidentally steering thoughts through careless use of words is of course very different from empathically acknowledging that someone is upset, worried or confused. In such a case it is entirely appropriate to talk about the actual emotions and state of mind.

Just as it is easy to inadvertently cause negative feelings or actions through our words, the skilled communicator can utilise the same effect in a constructive manner:

- I'd like you to remain very still
- I'd like you to listen very carefully;
- I will explain this in everyday language;

The point here is that you must be conscious of the way that you present information in consultations, that it is remarkably easy to enter thoughts into your patients mind and to be aware that both you and your patients are subject to different types of bias that you may not be conscious of.

3.03 Cultural differences

The belief that 'all people are basically the same' is at odds with the extensive evidence that collected groups of people are very typically very different from each other, holding widely disparate values and beliefs which impact directly upon their communication and behaviour. When we are unaware of these differences we increase the chances for misunderstanding, misinterpretation and even unintentional offence to arise. Awareness and respect for the differences can dramatically improve the effect of our interactions.

The concept of 'culture' only exists by comparison. Dutch Social Psychologist Geert Hofstede has conducted extensive research into the subject over the years. He defines culture as "the collective programming of the mind distinguishing the member of one group or category of people from others."

Hofstede has developed a model to describe cultures by grading the prevailing attitudes in six dimensions:

Hofstede dimensions of national culture	High score	Low score
Power Distance Index	Acceptance and expectation of hierarchy where everyone has their place with no justification required.	The people strive to equalise the distribution of power and demand justification for inequality.
Individualism versus Collectivism	Preference for a loose knit social framework where individuals take care only of themselves and their immediate families.	Preference for a tight framework with the expectation of support from others in exchange for unquestioned loyalty.
Masculinity versus Femininity	Preference for competitiveness, achievement, heroism, assertiveness and material reward.	Preference for consensus, co-operation, modesty, caring for the weak, quality of life.
Uncertainty Avoidance Index	Uncomfortable with uncertainty and ambiguity. Rigid codes and control with intolerance of the unorthodox.	Relaxed attitude to uncertainty and ambiguity, less likely to try to control the future.
Pragmatic versus Normative	Less focus on holding on to the past encouraging efforts to change and prepare for the future.	Prefer to maintain time honoured traditions and view societal change with suspicion.
Indulgence versus Restraint	Allows free gratification of desires and impulses related to enjoying life and having fun.	Suppresses gratification of desires and impulses, regulating this by means of social norms.

Nationality is an obvious place to start with culture, being a common approach to defining the differences between ourselves and others. You can compare the cultural dimension scores for 100 countries at the The Hofstede Centre's website, which can be found at *www.http://geert-hofstede.com/countries.html*. Here are the results for a selection of countries:

	UK	Australia	Egypt	India	Israel	Japan	Pakistan	Poland	USA	Sweden
Power Distance	35	36	70	77	13	54	55	68	40	31
Individualism vs Collectivism	89	90	25	48	54	46	14	60	91	71
Masculinity vs Femininity	66	61	45	56	47	95	50	64	62	5
Uncertainty Avoidance	35	51	80	40	81	92	70	93	46	29
Pragmatic vs Normative	51	21	7	51	38	88	50	38	26	53
Indulgence vs Restraint	69	71	4	26	No data	42	0	29	68	78

You may well have expected some of the similarities and differences between certain countries which this data suggests and be surprised by others. Israeli is less tolerant of hierarchy than India; the USA is far more individualistic than Pakistan; Sweden much less interested in heroism and more relaxed about uncertainty than Japan; Japan is more pragmatic in its approach to change than Egypt; self-control is prevalent in Pakistan than the Swedes who are more likely to act on their impulses.

Although this information gives some clues it is essential to realise that there are considerable variations in attitudes and behaviours within each of these societies. The highly populated and vast sub-continent of India is the home of numerous discernible cultures. Even in the UK we recognise differences between north and south and between different cities.

Culture also shifts with time. We only need to watch a selection of television programmes from each decade to illustrate this. The language, attitudes and activities constantly morph, adapt and progress - or otherwise. What was 'hilarious' in the 1970's is 'unacceptable' now. Activities popular with young people in the 1980's are laughed at by their current equivalents. Such changes lead to differences in culture which are easily observed across different age groups. The elderly can be horrified or baffled by the attitudes of the young and vice versa.

Organisations, governments and marketeers study these cultural changes and indeed try to influence them to their own ends. The key drivers of change have been identified as:

- **Political** – history, who is in control and relationships with other bodies
- **Environmental** – including natural events
- **Societal** – demographics including age, migration, religion
- **Technological** – consider the impact of television, the internet, smart phones
- **Legislative** – rules, whether imposed or created
- **Economic** – distribution, availability and changes to resources

We are all typically participating in numerous cultures throughout our daily lives, adjusting our communication and behaviour as we move from one situation to another. We interact differently with our friends than we do with our families; with the people we commute with on a daily basis compared with the staff in a shop we visit regularly; with our working group than with colleagues from a different department and so on.

In our efforts to understand the influence of culture has upon patient behaviour, there is a world of difference between the mind-set of:
1. Swedish people are modest, non-competitive and caring; versus
2. The prevailing attitude in Sweden is modest, non-competitive and caring

The first leads to stereotyping, assumptions and potentially even bias; the second leading to awareness of potential differences to be considered and explored. Anyone who watched the Swedish ice-hockey team winning the silver medal at the 2014 Winter Olympics in Sochi will testify that aggressive, competitive behaviour is a reality from some members of the population.

Communication can be improved through knowledge, recognising and respecting differences and finding common ground. To this end, a great deal can be gained from exploring cultures, history and traditions. At the same time, it is essential to bear in mind that we are all individuals who may well be who we are <u>in spite of</u>, rather than because of our background or demographic tags.

3.04 Personality type and preference

In modern psychology there are numerous models and frameworks to categorise different aspects of personality, preferences and approaches to interaction. A leading influence on how we talk about 'personality types' comes from the work of Carl Jung and is popularised by the *Myers Briggs Type Indicator (MBTI)* ®. Jung generalised concepts about use of energy, information gathering and decision making to find ways in which the similarities and differences between the way people think or act can be assessed.

He defined two mental functions to describe where we focus our attention and how we take on information:
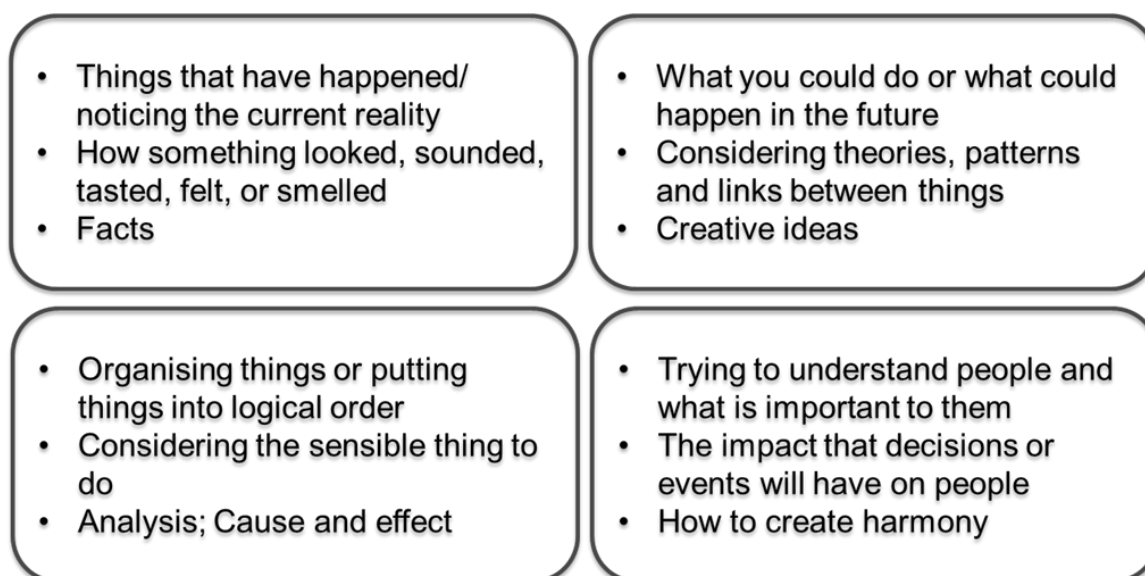
- **Sensing** – including concentrating upon facts, details, the past and the present
- **Intuition** – including concentrating on possibilities, connection and the future

He defined two mental functions to describe how we come to conclusions and make decisions:
- **Thinking** – including linking ideas together through logical connections, being objective and impersonal
- **Feeling** – including weighing relative values and merits of issues, being subjective and personal

We all need to call on each of these four functions in order to operate successfully in our everyday lives. That said we all have personal preferences regarding the priority which we give to each of these functions.

Consider what is going on in your mind whenever you are alone, relaxed, relatively unoccupied and happy. You may well be able to match this to one of the four boxes below.

- Things that have happened/ noticing the current reality
- How something looked, sounded, tasted, felt, or smelled
- Facts

- What you could do or what could happen in the future
- Considering theories, patterns and links between things
- Creative ideas

- Organising things or putting things into logical order
- Considering the sensible thing to do
- Analysis; Cause and effect

- Trying to understand people and what is important to them
- The impact that decisions or events will have on people
- How to create harmony

Just as we will all have a preference regarding what we concentrate upon internally we will all have a preferences in terms of what we share externally with the outside world and in what we want to hear from others.

Any difference between our own preferences and those of others is a further reason why we often find some people easier to talk to than others, why others seem to "speak a different language" and this can be at the root of some communication challenges.

You can explore more about personality types and differences through profiling methods including Myers-Briggs Type Indicator, Interaction Styles, Social Styles and many others.

We will return to these themes during Chapter 4: Communication Approaches in Healthcare.

3.05 Logical Levels

Robert Dilts is a famous exponent of Neurolinguistic Programming (NLP). Drawing upon perspectives developed by Gregory Bateson, Dilts determined that people operate on different logical levels when making decisions in everyday life.

Dilts presents 6 levels that describe Purpose, Identity, Beliefs, Capability, Behaviour and Environment. (In some writings, "Purpose" is referred to as "Spiritual"). Although this principle is often presented as a hierarchical pyramid, the levels may take on more relevance when illustrated as a series of concentric circles.

Purpose
Identity
Belief
Capability
Behaviour
Environment
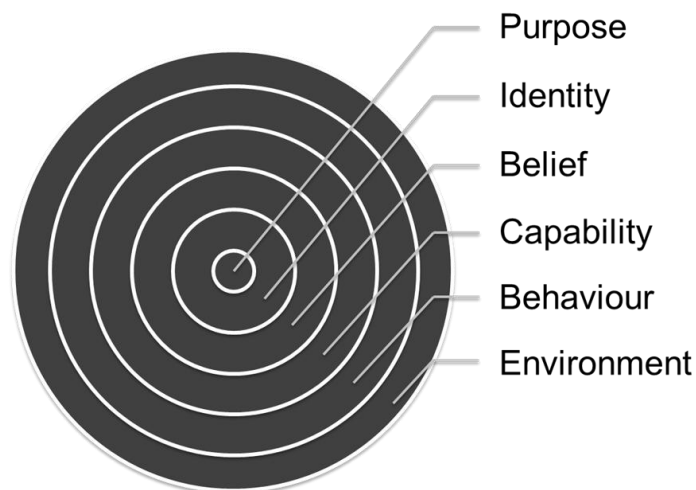
The implication is that we face different challenges when seeking to influence different people to change the way they think and act.

The deeper the logical level, the more embedded that logic is. For example, a patient who is reluctant to cut down or to stop smoking may be thinking at any one of the following levels:

- Most of my friends smoke (*environment*)
- It's a habit (*behaviour*)
- It would take a lot of determined effort (*capability*)
- Nobody I know has become ill (*belief*)
- Smoking makes me feel "cool" (*identity*)
- I'm a free agent who lives life to the full (*purpose*)

You will no doubt recognise some of these levels when you listen to your patient's

responses to recommendations that you have made for their health management. Careful questioning and listening to identify the level which is the key driver of behaviour will give vital clues to the appropriate approach to adopt in the circumstances. For example, the effective approach with an adolescent who has adopted worrying dietary habits because "all my friends are trying to lose weight" is significantly different from another demonstrating the same behaviour because "I am fat and this is why people don't like me."

Communicating with others who are expressing themselves or being driven by different logical levels can lead to confusion, frustration and potentially conflict. Misalignment between doctor and patient at the deeper levels can also lead to difficulties.

A doctor's behaviour and communication will be driven by their own purpose, identity, beliefs and so on. Taking three separate doctors where the first is "on a mission to save lives at all costs", the second who "must avoid the risk of litigation" and the third "wants to make the world a better place" are each likely to take a very different approach to a single patient who is declining a recommended procedure on religious grounds. There can be great benefit in explicitly defining your personal 'purpose' as a doctor and considering this in the light of what you believe your patients want from you. Recognising and respecting the differences can be both challenging and, at the same time, the key to reaching agreement on actions.

Make a note of some situations where you have found yourself communicating on a different logical level to your patient:

Are there any common themes?

What do you believe that your patients want from you in general?

How would you define your 'purpose' as a doctor?

What difficulties has this created for you or could create in future?

What approaches could you take to address these difficulties?

3.06 Health Belief Model

Dilts makes reference in his work to the Health Belief Model, first developed in the 1950s by social psychologists Hochbaum, Rosentock and Kegels, and this can be used to help further explain attitudes and behaviours. The table below describes the six elements of the model after further work by Rosenstock and others in 1988.

Concept	Description
1: Perceived Susceptibility	One's opinion of the chances of getting a condition
2: Perceived Severity	One's opinion of how serious a condition is and what its consequences are
3: Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact
4: Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action
5: Cues to Action	What one believes is acting or will act as a reminder of the need to undertake the advised action
6: Self-Efficacy	The level of confidence in one's ability to take the advised action

It is important to bear in mind that these elements influence the communication and behaviours of both patient and doctor alike and that once again there is the potential for mismatch.

There is space in the following table for you to reflect and to make notes of your own experiences regarding this. It is particularly worth considering the times when there has been a mismatch between your own beliefs and that of your patients.

Concept	How could this have affected your patients' communication and behaviour?	How could this affected your own communication and behaviour?
Perceived Susceptibility (Consider both high and low levels of belief)		
Perceived Severity (Consider both high and low levels of belief)		
Perceived Benefits (Consider both high and low levels of belief)		
Perceived Barriers (Consider both high and low levels of belief)		
Cues to Action (Consider both being able and not being able to think of cues for the patient)		
Self-Efficacy (Consider both having high and low levels of confidence in the patient's ability)		

3.07 Drivers of 'non-compliance'

There will inevitably be times when a patient is not 'compliant' with the advice which they have been given. Patients may fail to correctly follow their recommended treatment regime, to return for appointments at the appropriate interval or to make changes to their lifestyle.

At a detailed level, there can be numerous reasons for this with the Health Belief Model having significant implications. The patient's beliefs however are only one of the factors which could be at play here. Broadly speaking, the drivers of these patient behaviours can be categorised into the following three key reasons:

- The patient does not understand what they are supposed to do
- The patient knows what to do but has chosen not to take the advice
- The patient knows what to do but is unable to act upon the advice

Category of "non-compliance"	Potential drivers
1: The patient does not understand what they are supposed to do	- The advice was not 'heard' by the patient *"I don't remember being told that"* *"It's too much information"* *"It's all too complicated"* *"It doesn't make sense to me"* *"I'm too upset to take this in"* - The advice has changed from before without this being made clear
2: The patient knows what to do but has chosen not to take the advice	- Numerous points from the Health Belief Model and denial: *"It won't happen to me"* *"It's not that bad"* *"It's too much trouble"* *"I don't want to"* *"I don't like taking medicine"*
3: The patient knows what to do but is unable to act upon the advice	*"I can't break the old habit"* *"I can't get into the new habit"* *"I keep forgetting"* *"I can't fit that in to my life"*

Clearly, avoiding any of these situations has to be the preferred option. They will, however, inevitably arise, both with patients you have met before and those who have consulted other doctors. It is essential that the true driver of the behaviour is clarified and the appropriate approach adopted in order to make progress. Solutions to these issues including the concept of concordance are explored in *Chapter 4: Communication Approaches in Healthcare.*

3.08 Associations

It is human nature to make associations based upon our experiences, attitudes and beliefs. Some of these are deeply rooted in our psychology and can be both surprising and uncomfortable when they are brought to the fore.

This can be demonstrated by way of computerised Implicit Association Tests. You can find a range of these at the Project Implicit website (*www.implicit.harvard.edu)* focused on a variety of topics including alcohol, weight, gender, sexuality, age and race among others.

Four patient scenarios are described over the next couple of pages. Although these cases are based on events in a GP surgery or in an A&E department, you will meet similar characters and situations regardless of your specialty.

Step1: In each case:
- **Write down your honest, immediate reactions and thoughts about the patient**
  - o **Both medical and non-medical**
- **Who does the patient remind you of?**
- **What will they say or do next?**

Patient 1: Nigel

- Nigel is a 45 year old English male who presents to A&E at 23:30. He came in very drunk and complained of a severe headache. He got angry when asked to wait but wasn't violent or verbally aggressive and has since calmed down.
- He told triage that he has been to A&E before. There are no records of any recent visit although Nigel says he *was* here as he remembers the posters and has "nostalgia".
- It is now 01:00 and when you call him through you hear Nigel loudly discussing local pubs with another patient who seems to be a friend.
- Nigel is clean and tidy, dressed for a night out in the city and calls you Doctor. He smells strongly of alcohol and complains about his splitting headache.

Write your honest, immediate reactions and thoughts about Nigel:

Who does Nigel remind you of?

What will Nigel say or do next?

Patient 2: Rebecca

- Rebecca is a 19 year old female who has asked for an emergency walk-in appointment at the GP surgery.
- She tells reception that she needs to know how long she will have to wait. She is a Type-1 diabetic who lost her insulin last night when out on the town. She states that she is staying with friends and not feeling good.
- The reception team have told you Rebecca is here and could she be fitted in. She is not a patient at your practice and has completed all the paperwork to be seen as an emergency.
- When you first call Rebecca through she is nowhere to be seen.
- After your next patient you call her again. This time she is sitting with a friend and both are quietly giggling.
- Rebecca is wearing casual clothes with a lot of make-up and very brightly coloured hair.
- She says, "Thank you doctor," in a mock serious voice, then bursts out laughing as she gets up to join you.

Write your honest, immediate reactions and thoughts about Rebecca:

Who does Rebecca remind you of?

What will Rebecca say or do next?

Patient 3: Antonio

- Antonio is a 58 year old Portuguese male who has booked an appointment at the GP surgery.
- He tells reception that he doesn't want to cause a fuss but wants to know how long he will have to wait. He remarks that this is the first time he has got up since yesterday as he'd had an "exhausting, big weekend".
- The reception team have told you Antonio is here and you call him into your consulting room.
- He is clean and tidy wearing a Millwall Football Club tracksuit and walks with an exaggerated limp.
- As Antonio sits down, he places a high caffeine energy drink on the floor by his chair. He smiles warmly and calls you Sir/Miss.

Write your honest, immediate reactions and thoughts about Antonio:

Who does Antonio remind you of?

What will Antonio say or do next?

Patient 4: Orla

- Orla is a 45 year old Irish female who has booked an appointment at the walk-in surgery.
- She remarks that this is the first time she has managed to get here as it is such a long walk and that she hopes she will have time to sit and relax before her appointment is called.
- The reception team have told you Orla is here. When you look over you see she is clean and tidy, wearing a large coat and looks quite hot. She is finishing off a chilli dog and reading a cheap magazine.
- As you call her over, Orla says "Hello Pet", rolls her eyes and takes your arm.

Write your honest, immediate reactions and thoughts about Orla:

Who does Orla remind you of?

What will Orla say or do next?

Remember the instruction was to write down your honest, immediate reactions and thoughts about the patient, so if there is anything which did spring to mind and has not been noted down, then go back and add these comments.

	Facts – there is evidence that this is true	**Opinion –** you think this is true but have no proof	**Beliefs** – your personal thoughts, feelings and associations
Nigel Has neuralgia caused by a scalp infection			
Rebecca Blood glucose level is dangerously high			
Antonio Has plantar fasciitis			
Orla Has uncontrolled asthma			

Step 2: Copy the statements from each patient into the relevant box below.
For completion, the actual medical condition for each patient is stated here.

Step 3: What does each list tell you? Make a few notes regarding your thoughts.

Step 4: Consider a couple of your patients from your last day in practice and list the assumptions which you made about them.

The associations which we all make help us to 'fill in the blanks' and reach quick and intuitive assumptions – a positive example of our Hot/Fast/System1 thinking. However it is inevitable that not all of our associations will be helpful and that not all of our assumptions will be correct. Remember that Cialdini referred to the Hot/Fast/System1 as the lazy part of our brain.

Step 6: Review your list from Step 5 and tick off the assumptions which may not have been true. Now note down the potential impact below.
Consider impact on your own communication and behaviour as well as the direction of the interactions and outcomes.

When we know people, the strongest associations we have are based on our relationship, the context and our perception of their reputation. These associations impact upon our thinking, leading in turn to us adjusting our communication style and behaviour. It is important to recognise that we constantly make similar adjustments based on our subconscious associations with people we meet for the first time.

Once again, in our efforts to both understand and improve our communication it is important to recognise that the patient will be making simultaneous associations about their doctor and the circumstances – associations and assumptions which will directly impact upon their communication and behaviour. The White Coat Syndrome where blood pressure increases simply through awareness of the measurement being taken is an example of circumstance affecting feelings with a direct physical effect.

3.09 Perception of time

You will notice that this sub-heading is *Perception* of time, rather than the finite, measurable unit of time. Dr David Eagleman has described how time is not like a river which flows evenly and is ever advancing. Rather it is, just like vision, a construction of the brain and easily influenced. At the simplest level we all experience occasions where we are fully absorbed in something we are interested in, where 'time flies'. Conversely when we are kept waiting for something important, 'time stands still'. Time can also appear to 'slow down' during brief, intense moments where we experience great fear.

A demonstration of the distortion of time perception which occurs when something out of the ordinary or unfamiliar occurs and seems to last longer can be observed in *The Oddball Effect* video on the National Geographic Channel website:
http://natgeotv.com.au/videos/brain-games/the-oddball-effect-CCA36520.aspx

Considering time as a resource, Sendhil Mullainathan and Edar Shafir, among others, have reported the phenomena of "tunnelling" when this resource becomes scarce. In these circumstances we ignore everything but the apparent immediate need, with a sharp rise in impulsive decision making and assumptions. As a consequence, the impact upon IQ test scores has been shown to drop a subject experiencing the phenomena from one intelligence category to another.

> *"Because we are busy, patients wait to see us – and they use waiting time to pad their problem list."*
>
> *"Under the tick of the merciless clock, we work less efficiently, less creatively, less comprehensively."*
>
> *"Our mind slows and narrows. We ultimately forfeit what our patients need most: patience, compassion, deep understanding, wider scope, and the gift of human relationship."*
>
> David Loxterkamp

According to the work of Beckman and Frankel (1984), the average patient takes 90 seconds to explain why they are visiting, yet the average clinician interrupts after just 18 seconds.

Too little or too much time will influence the communication and behaviour of patients, including their ability to absorb information. Only some of this will be within the control of the doctor and the support team as, for example, the patient may have been thinking about their visit for a long time before the consultation.

With this in mind, effective time management on the doctor's part has an impact on patient interactions. By implication, planning, processes and team support all have to be considering in the efforts to enhance patient communication.

3.10 Stress

Taking the Cambridge Dictionary's definition of stress: *great worry caused by a difficult situation*, it can be of little surprise that it is a common issue for patients, families, friends and doctors. We often react to stress by acting 'against type' and clumsily using our less preferred, lesser developed mental functions. There are many difficult situations which arise in the world of healthcare, so it makes sense that those involved will be communicating less effectively and more clumsily in these circumstances.

One common psychological view of stress management which you may hear expressed is how reactions to stress lead to behaviours that associate with anxiety in a recognisable pattern.

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According to psychoanalyst Karen Horney, (*Self Analysis*, 1942, 1945) the ways in which we express stress create needs that can be classed into three broad categories:

Impact of needs	Expression of stress
Needs cause individuals to seek affirmation and acceptance from others.	Moves you *towards* others
Needs create hostility and antisocial behaviour	Moves you *away* from others
Needs result in hostility and a need to control other people	Moves you *against* others

Whilst we all use each of these strategies when dealing with stress, if we overuse one or more of them then we may experience anxiety and potentially develop neuroses. We do gain advantage when we "get rid of a problem" by not thinking about it or dealing with it, certainly in the short term; this is basic problem solving – if there is something we don't want (bad news, advice we don't want to hear) then we will ignore it, or even avoid it. If, however, we start dealing with all stresses and problems using these strategies, then we may only become more and more anxious.

Later studies from the 1980s of coping with stress, e.g. *The Acceptance & Commitment Theory*, show how through *experiential avoidance,* we simply create extra suffering for ourselves. This is where we *move away* from something in order to cope, to avoid or get rid of unwanted private experiences. However, sole or high incidences of the use of experiential avoidance is associated with anxiety disorders, depression, poorer work performance, substance abuse, lower wellbeing, high risk behaviour and some personality disorders.

Neurological research published in 2015 illustrated that stress hormones reduce our ability to empathise with strangers and that we have a natural stress response when we are in a room with a person that we don't know. This response is quickly resolved however through simple interactions which encourage us to get to know each other. The power of general conversation to put the other person at ease may well have mutual benefit for both doctor and patient.

3.11 Five stages of grief

You may well be familiar with the work of Elizabeth Kübler-Ross, an American psychiatrist and an expert in near death studies who wrote the seminal work *On Death and Dying*. In this book she defined the five stages of grief that have shaped the thinking surrounding how people deal with unpleasant and unwanted developments in their lives for many years. The five stages of denial, anger, bargaining, depression and acceptance are illustrated on the graph below.

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5 stages of grief
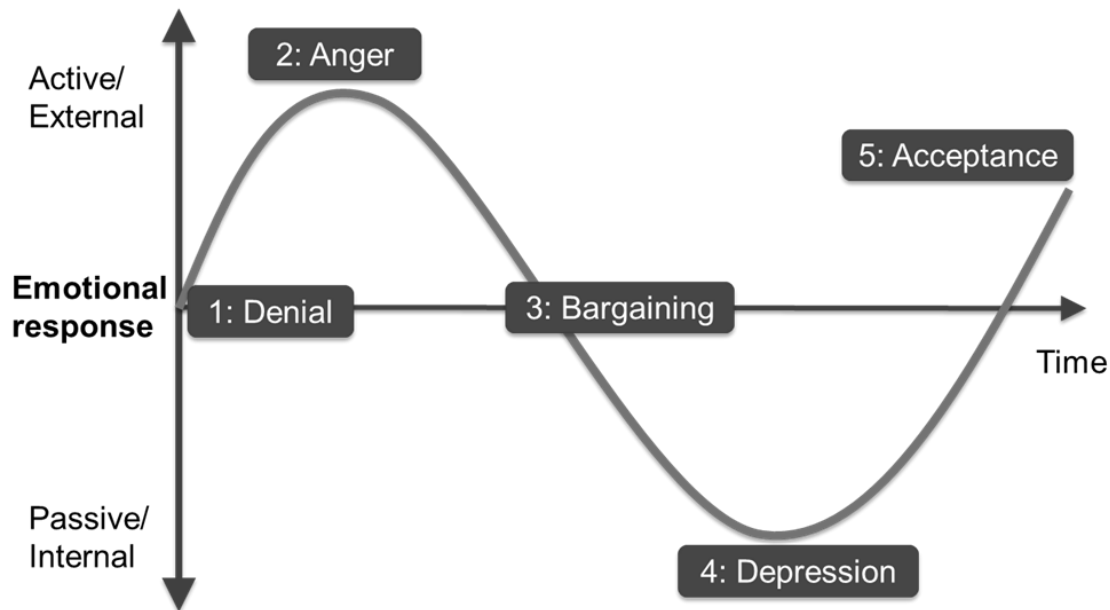
The basic principle of this cycle has been widely adopted in many fields to describe the human reaction to imposed change. Many writers have interpreted the five stages with different labels into numerous versions of the 'change curve'. The basic principle is that it is necessary to progress through each stage in order to reach a genuine state of acceptance. With this in mind, we can be better prepared and less surprised by the communication and behaviours which a patient will display when faced with change and be better placed to react accordingly.

3.12 Family members, third parties and the internet

Family members, third parties and the Internet are regarded by many doctors as potentially extremely disruptive factors in a consultation, who therefore tend to exclude them as much as possible.

Family members and third parties can indeed sometimes appear to be interfering inappropriately in the patient's life and in the consultation, but for the most part this comes only from worry and anxiety about their relative or friend. The individual relationships and circumstances can colour the interactions during the consultation in many different ways.

Though sometimes challenging, it is vital not to disregard the great supportive effect that they can have if you make the effort to engage with them in an open way rather than

regarding them as a nuisance. They can be particularly helpful for instance in addressing the drivers of 'non-compliance' described earlier as well as being essential for emotional support. It is however obviously essential that this is with the patient's consent, and sometimes it is necessary to make this explicit.

There are of course circumstances in which the involvement of others can be for less than honourable reasons and then it is the doctor's duty to protect the patient. These circumstances are very rare, and only open awareness and full attention to the situation in front of you will enable you to define accurately when this is likely to be the case.

As doctors, your immediate response when a patient comes into a consultation clutching printouts from the Internet may well be one of frustration and despair. While it is true that a certain amount of information obtained from the Internet may be wrong, the vast majority of it will not be! The information revolution is certainly having an effect on the role of the doctor in society. The days are gone where the clinician has exclusive access to medical and scientific information. As the average person becomes increasingly aware of their health and related issues, it is beneficial for the doctor to concentrate on the role as healer, accepting the wealth of information available, travelling with and assisting the patient in understanding and dealing with their disease processes. This is a true and constructive equal partnership between doctor and patient.

Chapter 4: Communication approaches in healthcare

So far, we have explored what communication is, the key elements of creating dialogue and some of the numerous factors which influence and change the communication and behaviour of both doctor and patient. In this section we will describe approaches and models which can provide solutions to the challenges faced in improving patient communication skills.

4.01 Continuity of care

In the list of key reasons why hospital patients complain introduced early in this book, the issue of staff attitudes was raised, including the point that "patients said they felt no one was in charge…." To quote further from the report, "as a result, there was no-one to talk to, or raise concerns with, and problems were left to fester."

Multi-professional teams, shift patterns, referral from one department or specialist to another can all act as contributing factors towards this. It is very easy for these circumstances to result in the patient or family members meeting a new doctor where the impression is that they are starting from scratch and they are required to tell their story from the beginning to a new stranger who knows nothing about them.

In some ways, the solutions here fall into the categories of management and organisation. In the effort to improve patient communication these factors need to be addressed and should be resolved by working with relevant colleagues, including service managers.

At the same time, this new doctor meeting the patient for the first time has the opportunity to create an entirely different perception, i.e. that of one team of people working together in providing continuity of care. Here, we do overlap into the topic of team communication skills and good record keeping, where each person involved in the process of care is provided with the relevant information in a manner that they can quickly digest.

In terms of direct patient communication, explicitly outlining the continuity of care can make a major difference to the patient realising that this continuity is in place. This can be simply outlined through the approach of **Last time; this time; next time** where there is reference made to each stage.

In cases where you are the only doctor actively involved in the patient's care, this can be simply expressed along the lines of:
- This is what has happened so far
- This is what is happening right now
- This is what will happen next

The table below gives some example statements to illustrate how this approach can be applied during consultation with a patient who has been referred to you by another doctor:

	Example statements
Last time	• *Last time you were here you met my colleague Dr. Khan* • *I have the full notes of your discussions, your measurements and your scan* • *Dr. Khan's letter to me is that he wants me to investigate………..*
This time	• *What I will do today is to ……… and will either return you to Dr. Khan or to another colleague depending on results* • *I am adding my notes of my findings to your record*
Next time	• *Because of these findings I would like you to see one of my colleagues who specialises in this area* • *At that appointment they will have your full notes along with the reason I want you to meet them.* • *I am also letting Dr Khan know about this*

When interwoven with the opportunity for the patient to tell their own story, this acts to strengthen the perception that, rather than being passed from pillar to post, continuity of care is in place.
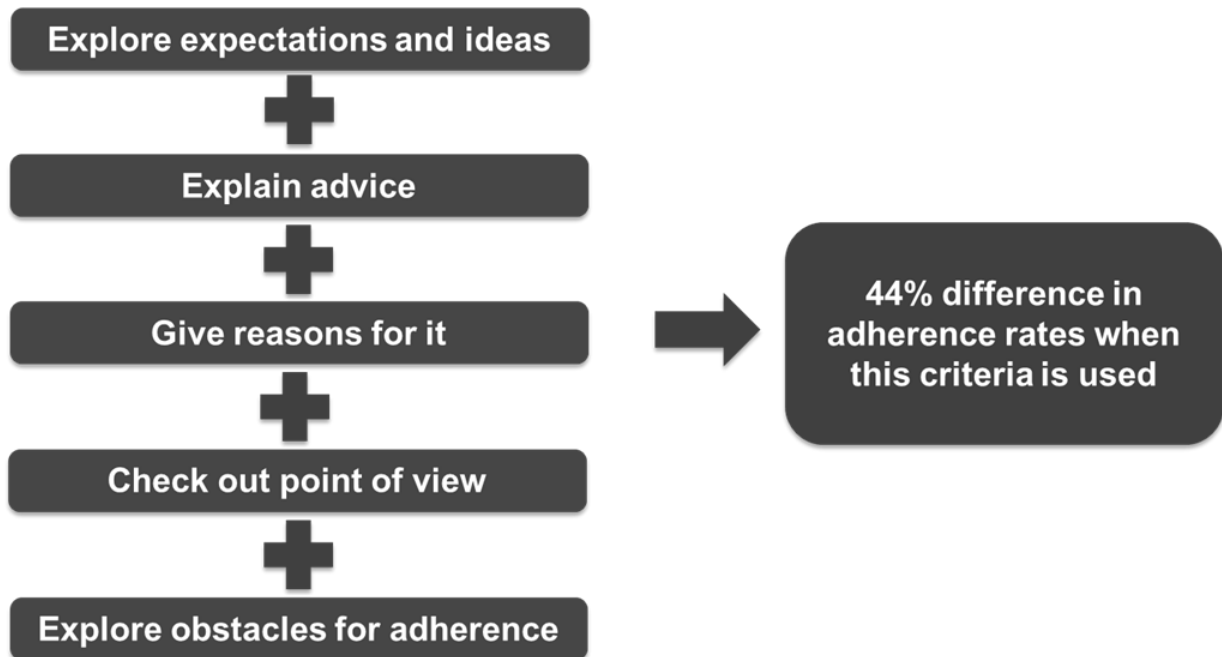

4.02 Concordance versus compliance and adherence

The three terms concordance, compliance and adherence may be used interchangeably but incorrectly when discussing whether patients take their medicines as they should. It is important to understand the difference in philosophy between the three if doctors are to ensure the best clinical results.

Compliance and adherence describe the degree to which the patient does what he or she is instructed to. A patient therefore may be described as compliant or adherent to a treatment schedule.

The costs of non-compliance and non-adherence are numerous and significant. There are human costs with direct health impacts, financial costs in terms of wasted medications, appointment slots and the time taken to recover and address the arising issues. There are obvious knock on effects to the care of other patients.

In 1991, Lessen outlined the impact of the doctor's approach on adherence, identifying 5 key elements which, when placed in the correct order, lead to significant improvements.

| Explore expectations and ideas |
| + |
| Explain advice |
| + |
| Give reasons for it |
| + |
| Check out point of view |
| + |
| Explore obstacles for adherence |

→ 44% difference in adherence rates when this criteria is used

Historically the stereotype of the doctor-patient relationship was one where the doctor made all decisions with the patient's thoughts and feelings peripheral to the process. To this day there are some persistent poor examples of care where this situation continues.

The 2010 White Paper, *Liberation of the NHS* submitted by Andrew Lansley, Secretary of State for Health at the time, was a response to unacceptable situations which had arisen within the NHS and paved the way for the *Health and Social Care Act* which restructured the NHS in England in 2013. One of the key paragraphs in this paper stated:

> "…..patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to information that they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care."

Since publication, the latter two sentences of this statement have been questioned by many, the most recent being Andrew Lansley's successor, Jeremy Hunt, who stated during an interview with HSJ magazine in November 2014 that "patient choice is not the key to improving performance."

One of the attributes defined in Domain 3 of *Good Medical Practice: Communication, Partnership & Teamwork*, is "establish and maintain partnerships with patients". Where compliance and adherence refer to the way that a patient behaves, concordance on the other hand is more about the consultation process itself.

> **Concordance between a doctor and a patient is achieved when both consider that their interaction is an active and equal dialogue.**

It is a patient centred concept and is closely connected with informed patient choice, patient partnership and full patient involvement in decisions about their health care.

It has to be said that although many doctors have heard the terms and even pay lip service to the concepts, many patients and their families continue to think that there is a lot of progress still to be made in this area!

Smith et al (1994) described the minimum standard for attention and concordance from the patient's point of view to be as follows:

> **Minimum standard for attention and concordance**
>
> My doctor knows me and explains with this in mind.
>
> *Smith et al (1994)*

4.03 The Z-model

Section 3.04: Personality Type and Preference introduced the concept that different people think and communicate in different ways, dependent on their individual preferences. When these differences are brought to the fore, there are a number of potential traps that we can fall into. Two extreme and problematic attitudes which people sometimes adopt are:

- **Be like me syndrome**
  - The way I prefer to think and talk is right and others should change to fall in line
- **Be like them syndrome**
  - The way I prefer to think and talk is wrong and I have to change to fall in line

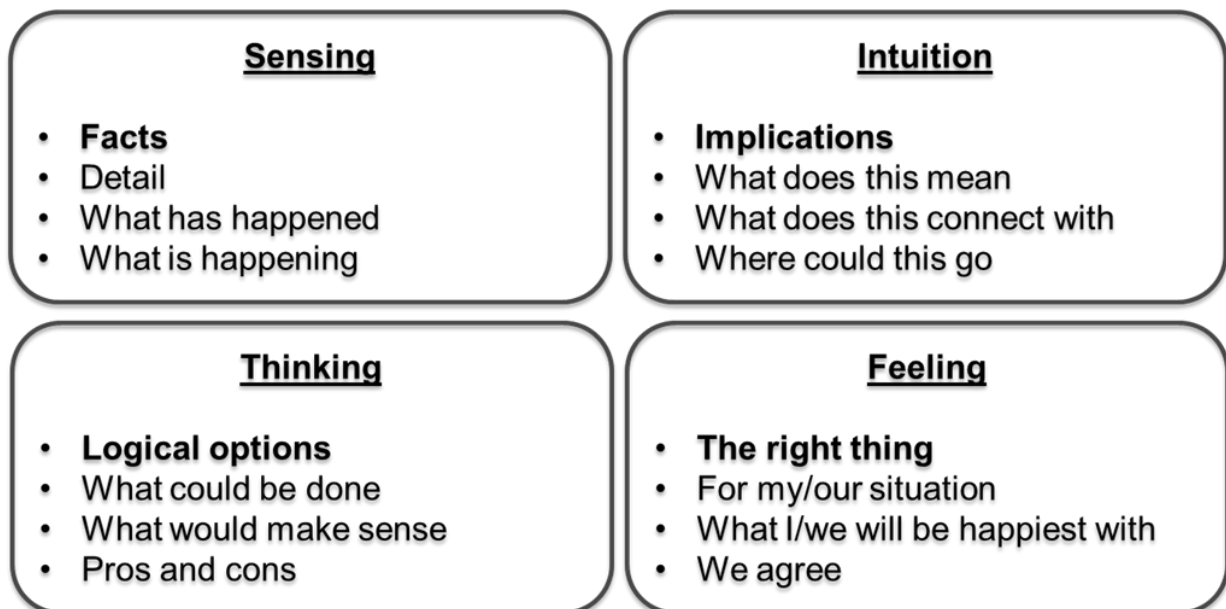A far more positive and constructive alternative approach is:

- **Be the best me that I can be**
  - I recognise the differences that exist and use this to become a better communicator

One approach which the doctor can undertake is to identify the style of communication that the patient is demonstrating and adapt accordingly. One structured model to

achieve this is *FLEXCare®*, defined by Susan Brock and based upon the Myers-Briggs Type Indicator. Though we will naturally adapt our communication without a second thought with people who we know very well, applying this method to daily consultations requires a depth of knowledge and a great deal of practice. It can indeed be challenging enough to work out our own personality type and preferences and even more so for others. Social Styles and Interaction Styles are simpler concepts which can form a more digestible introduction to this approach.

The Z-model is a framework which can be easily applied to communication across the consultation, improving concordance, compliance and adherence with relevance to the delivery of a recommendation and summary.

To start explaining this framework we will return the thoughts of Carl Jung, whose four mental functions are illustrated in a basic form below:

Sensing	**Intuition**
• **Facts** • Detail • What has happened • What is happening	• **Implications** • What does this mean • What does this connect with • Where could this go
Thinking	**Feeling**
• **Logical options** • What could be done • What would make sense • Pros and cons	• **The right thing** • For my/our situation • What I/we will be happiest with • We agree

As illustrated earlier, we all have our individual preferences regarding which of these functions we use. This governs what people want to hear and how people express themselves. One person for example may like to hear a lot of facts, express how they feel and give their opinions. Another may prefer to hear about the options which make sense, expressing what these might mean for them. There are numerous combinations with obvious potential for clashes, "not speaking the same language" and confusion.

- A doctor may for example, describe lots of facts and give their patient a range of options – the patient left wondering what the implications are and what the right thing is for them.
- Another may mention what the patients symptoms are connected with then state what will be done next – the patient feeling boxed into a situation where there is no choice.

The key is to consider what both parties to the interaction <u>need</u> to hear, rather than what they want, or prefer to hear. The reality is that both patient and doctor need to explicitly explore each of these four areas for concordance to be a reality, in the following order:
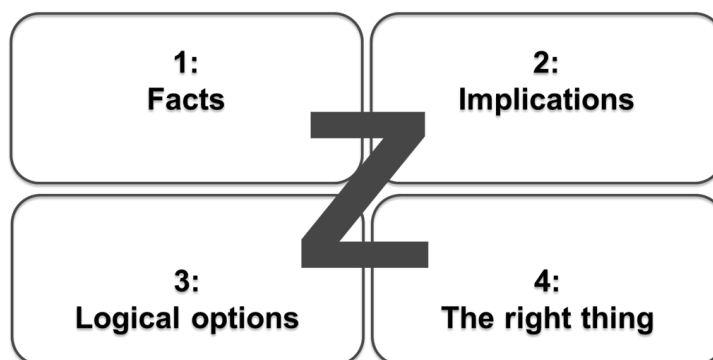
This Z-model is widely utilised to improve communication and decision making in many walks of life including education, management, sales and marriage counselling to name a few. It also fits very well with the generic flow of healthcare consultations:

- Facts are shared during initial discussion of history and symptoms (and communicated as the examination/treatment progresses)
- The implications and reasons for symptoms/condition/behaviour are shared
- The choices for different approaches for treatment are discussed
- A recommendation is given/ agreement is reached on the right thing to do in this specific patients circumstances

This also provides an excellent framework to deliver a recommendation, where the facts, implications and options are outlined before stating what you believe to be the best course of action and why. If can also be used to clarify any message as a summary at the end of the consultation and provide an excellent opening summary at the beginning of the next appointment with the patient.

4.04 Theories of adult learning

Patients and their families typically want to know what is wrong, needing to be capable of following guidance and benefit from recognising progress. There can be a lot of information for the doctor to impart in a short time frame which is both unfamiliar and complex to the receiver. Effectively, we are talking here about the learning process.

In *Section 3.04, Personality type and preference*, we described Jung's concept of the different mental functions which people prefer to focus their attention, take on information, come to conclusions and make decisions. We looked in *Section 4.03* at how applying this theory using the Z-model approach can help both patient and doctor make decisions together.

There are numerous theories about and frameworks to support the process of adult learning which can be applied to enhance patient communication.

Howard Gardner first proposed his model of Multiple Intelligences in 1983 and this has been widely adopted in many training situations. He defined seven distinct cognitive processes and explained that we all function and learn in different ways. The intelligences are:

| Learning preference	Application to patient communication
Linguistic	Verbal explanations, spoken or written; what words mean
Logical-Mathematical	Cause and effect; sequences; patterns; logic and numbers
Visual-Spatial	Seeing; pictures; diagrams; models; visual descriptions
Musical-Rhythmic	Repetition; rhyming mnemonics; rhythmic phrases
Bodily-Kinaesthetic	Doing; feeling; touching; holding; practicing.
Interpersonal	Discussion with others; asking questions; different people
Intrapersonal	Time to reflect; diaries and logs; setting personal goals

Rather than labelling learners as having one specific form of intelligence, Gardner explained that each individual has their own unique blend. It is important to bear in mind that we do still learn from our lesser preferences. It is easy to again fall into the habit of communicating using our personal preferences whereas, in general, the most effective approach is to use as many methods from all styles with everyone. A caveat is to be aware that some patients, even those with a strong visual preference, could be upset by images of diseases or anomalies, so it is advisable to give the option before presenting such material.

Consider how you currently connect with these learning preferences in your daily practise? What do you do well and what could you do more? The table on the following page provides space for you to make some notes.

	What do you do well?	What could you do more?
Linguistic		
Logical-Mathematical		
Visual-Spatial		
Musical-Rhythmic		
Bodily-Kinaesthetic		
Interpersonal		
Intrapersonal		

An alternative approach to the theory of learning has developed from the work of David Kolb which can be illustrated as a four stage learning cycle

The learning cycle
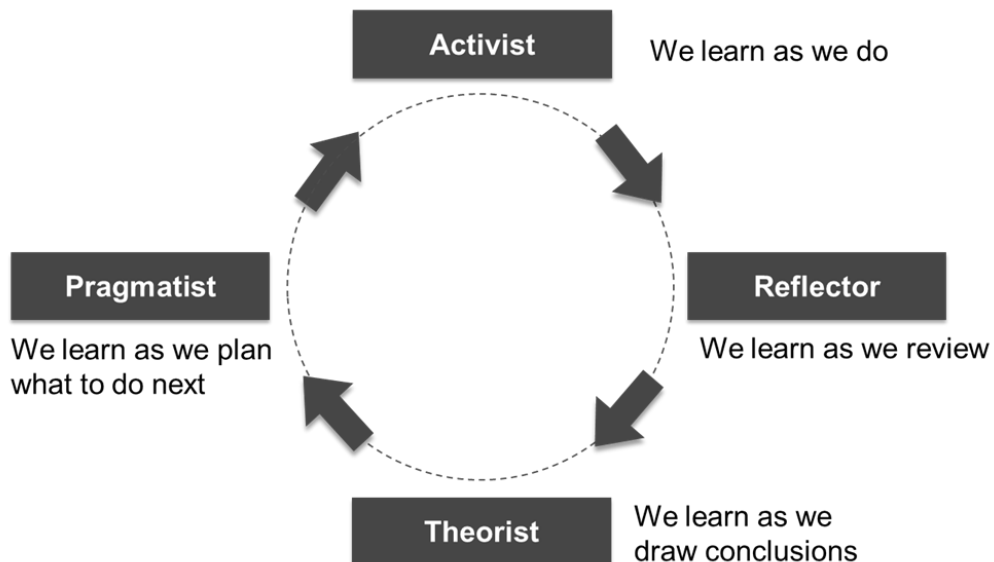
Once again, we all have our individual preferences for the type of learning described at each stage and benefit from using all four methods.

It is worth paying particular attention to the Reflector stage of this process. Just like the Intrapersonal preference from Gardner's Multiple Intelligences, this is likely to be an internal process. Many people require time with their own thoughts in order to absorb information and this may well require time, space and even silence.

Excellent communication is about what we say, what we do and how we do it, to ensure that what needs to be heard is heard and understood. Having patience, using silence and giving physical space have a significant part to play here.

4.05 Influence and persuasion

Influencing is something that we all do on a daily basis both professionally and socially. How well we do it is the difference between the impact we want to make and the one we're having. Influencing improves by planning to use certain approaches in situations or with people we find difficult.

According to global leadership consultancy, Development Dimensions International,

there are 5 things that enhance influence within interpersonal relationships:

- Maintain or enhance self esteem
- Listen & respond with empathy
- Ask for help & encourage involvement
- Share thoughts, feelings & rationale in order to build trust
- Provide support without removing responsibility

In his book, *Influence – The Science of Persuasion*, Robert Cialdini proposes 6 different types of influence:

Type of influence	
Reciprocity	People generally try to return favours, pay back debts, and treat others as they want to be treated. Sometimes we are happy to do this and other times we might feel a bit indebted to someone else, so try and make amends by being as helpful as we can in return. For example, seeing a patient at short notice and going the 'extra mile' could increase the chances that a patient will work harder to follow your advice.
Commitment (& consistency)	Once we're committed to something, we're more inclined to go through with it. Caldini says that we have a deep desire to be consistent. This means that establishing a real personal commitment to a health goal is more likely to gain acceptance and follow-through than if the patient is simply told what to do.
Social Proof	This relies on our likelihood to adopt behaviour that we see in others. For example, we're more likely to work late if others in our team are doing the same, put a tip in a jar if it already contains money, or download an app that many others seem to be using. This includes relaying, statistics, the experiences of patients and enabling participation with self-help groups.
Likeability	We're more likely to be influenced by people we like– people might be similar or familiar to us, they might be more polite or act in ways we prefer, or we may just simply trust them
Authority	Doctors may employ this influence technique more than they realise! We feel a sense of duty or obligation to people in positions of authority. This is why advertisers of pharmaceutical products employ doctors to front their campaigns, and why most of us will do most things that we think someone in authority requires of us.
Scarcity	Things are more attractive when their availability is limited, or when we stand to lose the opportunity to acquire them on favourable terms. This is often recognised as a sales tactic but could also be present in situations where there is limited time to make a decision, for example to undertake a particular treatment option.

Here is short illustration of how all six of these may be used to play a part during a patient interaction:

Authority	"I am your doctor", (this will be evident, but may be unsaid)
Reciprocity	"If you can do X, then I will be able to do Y"
Commitment	"Let's agree to do three things in the next week"
Social Proof	"All my patients are doing this now and its making a real difference"
Likeability	"You've made a real effort here, I'm really impressed"
Scarcity	"We only have this time available for you at present or it may be another month two before we can go ahead."
Authority	"I am your doctor" (again this may be evident, but go unsaid)

It has been shown that likeability has the greatest impact on influence. But it is also worth bearing in mind that if any one of these tactics is applied without authenticity people do spot this and influence can actually diminish.

The questions on the table overleaf have been designed to help you consider and make notes regarding your current approach to influencing patients and how you could make improvements.

Which of these 6 methods of influence do you rely on most in your practise?

Which of these could you use more than you do at present?

What would be the benefits of this?

What would be the risks involved, i.e. what could go wrong?

What will you need to bear in mind to use these additional influencing methods well?

4.06 Breaking bad news – the doctor's mind-set

A great deal has been written and taught about how to break bad news to patients. The first thing to consider is what actually constitutes bad news.

For most doctors, bad news would be the finding of a malignant tumour on a CT scan or having to tell a relative that a patient would be unlikely to survive their stroke. From the patient's point of view however, many situations that doctors encounter every day would be almost equally as bad. What is routine for the doctor may well be a once in a lifetime message for the patient and/or their relatives and there is a risk of being desensitized through regular exposure to situations.

The diagnosis of diabetes is a very good example. Not only does it commit the patient to lifetime treatment with often a considerable number of medications and possibly injections several times a day, but it also means that the patient's life will be shortened and they may very well develop serious and unpleasant complications.

'Bad news' is both highly contextual and personal. An amateur sportsman being told that a knee injury will mean sitting on the side-lines for a year or a young dancer that a back injury means having to miss a big performance can be a major blow both socially and to their self-image, accompanied by a host of other emotions. One forty-five year old may be shocked to find out that they have very high blood pressure, bringing back memories of losing both a parent and close uncle at a young age due to strokes and heart attacks. Another patient of exactly the same age may shrug their shoulders thinking "well, I'm not getting any younger, am I".

Though there are clearly vast differences between the situations of the aforementioned sportsman and dancer compared to patients who require end of life conversations, the concepts of loss and 'life-changing' are highly circumstantial and a matter for the individual. It is widely accepted that the five stages of grief described in *Section 3.11* are our typical responses when we experience change which is imposed upon us. Keeping this in mind, recognising where the receiver of the unwanted message is on this change curve and responding accordingly has great benefit in supporting progression toward acceptance.

In breaking bad news – at whatever level that may be - the fundamental requirement is that the elements and models of communication we have been exploring up until this point must be delivered at their very best. Genuine empathic concern is of the greatest importance.

Doctors are generally still taught that they should not get involved with their patients emotionally and that to survive they must make a distance between themselves and a patient's pain, emotional or physical. This is a relevant point to return to the information

described in *Section 3.10: Stress*, in particular the wide range of negative impacts which can result from sole or high reliance upon experiential avoidance as a coping mechanism - from poor work performance through to personality disorders.

Brené Brown's presentation *The Power of Vulnerability* is one of the most watched lectures on *www.TED.com,* the website of the non-profit organisation dedicated to spreading ideas in the form of short, powerful talks. From her research she describes four key factors common to people who have a strong sense of love and belonging:

Four factors common to people who have a strong sense of love and belonging	
They have courage	• Courage to "tell the story of who they are with their whole heart."
They have compassion	• They are kind to themselves first and then to others. • "We can't practice compassion if we can't treat ourselves kindly.
They have connection	• Connection as a result of authenticity. • They are "willing to let go of who they thought they should be in order to be with who they are."
They fully embrace vulnerability	• They are willing to do things where there are no guarantees.

"We live in a vulnerable world", she points out, "and one of the ways we deal with it is that we numb vulnerability." She goes on to explain that we cannot selectively numb emotion without consequence. By avoiding vulnerability, grief, fear, disappointment and numbing these hard emotions we numb joy, we numb gratitude and we numb kindness. This makes us miserable, so we look for purpose and meaning - and then we feel vulnerable, creating a dangerous, downward spiral.

So, rather than creating distance from the patient for personal protection, a more modern view is that personal empathic involvement is an essential part of the healing partnership that we are privileged to be able to guide. In this view, it is considered to be unhelpful to attempt to minimise the full implications of whatever is being discussed and more fully therapeutic to attempt to understand and feel what this means to the patient and their family. Doctors who use this approach, with appropriate support from their colleagues, mentors and families, very often report that their professional lives have become and continue to be much richer.

The approach of personal empathic involvement requires a significant degree of personal self-management and the concepts of Presence and Focus outlined in *Chapter 2.05* are a good place to start.

Another useful concept to call upon here is the model of Resilience proposed by Daryl Conner. In his work he describes resilient people as those who have the ability to absorb high levels of intensity, to take on a difficult situation and to bounce back quickly. He defined the five qualities required for resilience as being:

- Positive
- Focused
- Organised
- Flexible
- Proactive

The table below describes some examples of how these qualities may be applied to the self-management of a doctor breaking bad news to a patient.

Quality for resilience	Examples of the doctor's mind-set
Positive	• "I believe that this patient has the right to know the truth" • "We have progressed to a stage where we have a conclusion"
Focused	• "I am concentrated entirely on this situation and the people involved" • "I have removed all distractions"
Organised	• "I have all the information to hand and can explain the options" • "I have a proven strategy which I will use to break the news" (see *Section 4.07, Breaking bad news – a strategy*) • "I know who I can discuss this situation with and I will review it once it is over for personal support"
Flexible	• "I have to expect the unexpected – I cannot know how they will react" • "My framework is only a guide and I have to react"
Proactive	• "I have taken steps to improve my communication: shadowing colleagues, practicing, taking feedback" • "I will remember what I learned from the times that I have faced similar situations" • "I have prepared myself mentally"

Being proactive in this model of resilience also includes honestly reviewing, recognising situations which have had an emotional or stress inducing impact upon you and taking

appropriate steps. For some doctors the approach of the reflective diary, based upon Gibbs Model of Reflection described in *Section 2.09* will be an effective approach. For others the support gained either informally through discussion with trusted colleagues or through structured sessions, for example with a Balint Group, action learning set or personal therapist will be invaluable.

4.07 Breaking bad news – a strategy

There are a number of ways that the delivery of bad news can go wrong including:
- coldly, bluntly or awkwardly dropping a bombshell in a manner which increases the shock
- muddling around, not be clear enough, leaving the patient unsure of what they are being told
- conveying unwarranted optimism
- backing out and avoiding delivery of the news altogether

These issues are more likely to arise when the doctor responsible is lacking confidence or feeling particularly stressed and anxious with the task. In keeping with other aspects of communication confidence can be improved by having a framework to refer to for guidance.

The process of breaking bad news can be viewed as the intention to achieve four clear goals:
- To determine the patient's knowledge and readiness to hear the news
- To provide information in a manner which the patient understands and is in keeping with their needs and desires
- To support the patient through the immediate emotional impact and feelings
- To develop a strategy for the way forward with the input and co-operation of the patient

SPIKES is a six step strategy for breaking bad news which you may be familiar with which. Initially developed for the field of oncology by pulling together a number of respected communication techniques it is now widely used in many aspects of healthcare and beyond. The six steps of SPIKES are:

> **S** – **SET-UP** the interview
> **P** – Assessing the patient's **PERCEPTION**
> **I** – Obtaining the patient's **INVITATION**
> **K** – Giving **KNOWLEDGE** and information to the patient
> **E** – Addressing the patient's **EMOTIONS**
> **S** – **STRATEGY** and **SUMMARY**

Not every situation will require all six steps of SPIKES, however they are meant to flow sequentially. Effective completion of each step requires different skills and techniques. The table below describes each step further and illustrates how some of the topics and models discussed throughout this book relate to each stage.

Set up	Prepare yourself, the receiver and the environment	- Preparing yourself mentally (*section 4.06*) - States of presence and focus (*section 2.07*) - Eliminating listening barriers (*section 3.01*) - Last time, this time, next time (*section 4.01*)
Perception	What does the patient know, understand and believe?	- Develop rapport (*section 2.03*) - Encourage disclosure (*section 2.08*) - The Health Belief Model (*section 3.06*) - Drivers of 'non-compliance' (*section 3.07*)
Invitation	How much information does the patient want to know and how do they want to receive this?	- Logical levels (*section 3.05*) - Cultural differences (*section 3.03*) - Personality type and preference (*section 3.04*) - Theories of adult learning (*section 4.04*)
Knowledge	Delivering the facts, ensuring what needs to be heard is heard.	- The impact of framing (*section 3.02*) "My doctor knows me and explains with this in mind (*section 4.02*) - The Z-model (*section 4.03*) - Awareness of different learning preferences (*section 4.04*)
Emotions	Managing the emotions with empathic concern	- Empathic concern (*section 2.02*) - Awareness of the impact time pressure on empathy (*section 3.09*) - The impacts of stress on both yourself and the patient (*section 3.10*) - Awareness of the cycle of grief (*section 3.11*) - Potentially handling complaints and conflict (*section 4.08*)
Strategy and Summary	Agreement on how to proceed and recap.	- Continued awareness of the cycle of grief (*section 3.11*) and concordance (*section 4.02*) - Influence and persuasion (*section 4.05*) - Potentially having to say 'no' (*section 4.09*) - The Z-model (*section 4.04*) - Last time, this time, next time (*section 4.01*)

!t may be really appreciated by the patient or relatives if you hold their hand or gently touch their arm at some point in your communication, as discussed in *section 2.06 Physical Contact*. However, in the process of receiving bad news people may initially react with denial and numbness. Under these circumstances, or for people from some cultures, attempt at physical contact may be absolutely inappropriate and may even constitute an assault. It is vital to be sensitive both to your own feelings so that you can evaluate them properly and to the feelings of the people in front of you so that good contact and communication is achieved.

4.07 Handling complaints

News stories regarding complaints in relation to the NHS appear with disappointing regularity. A 2014 poll of 4,000 people in the UK by Populus for the consumer group Which? Reported the following results

:

- Only a quarter had been happy with the way that their complaint was handled
- This had risen from 16% just two years earlier
- More than half felt that their complaint had been ignored
    - More than in other parts of the public sector
- 43% were dissatisfied with the outcome
- Four out of ten who had a problem didn't actually complain

Without doubt, prevention is always better than cure. Improving the ways that we communicate with patients and their families, as we have been exploring in this book, should reduce complaints arising in the first place. That said, it is inevitable that there will be times when we shall fail to meet patients' expectations due either our own shortfalls, or those of our teams and colleagues.

In the efforts to improve the handling of complaints, we will start by looking at why they occur in the first place, and then what it feels like to complain before describing useful approaches.

Complaints are usually based on something and lead to someone suffering from some kind of loss. This loss could be:
- Emotional
- Physical
- Reputational
- Financial (and other resources, including time)

Complaints can arise from the following sources:
- Information – no information, the wrong information and/or at the wrong time
- Opinions – expressed without empathy
- Objectives – when not shared
- Emotions – over emotional or under emotional
- Values – mismatches to the logical levels (see *Chapter 3.04*)

Similar to the diagram in section 3.05 Logical Levels, these sources can be represented diagrammatically. It is likely that the depth of the persona making the complaint will increase if the issue is closer to the centre.
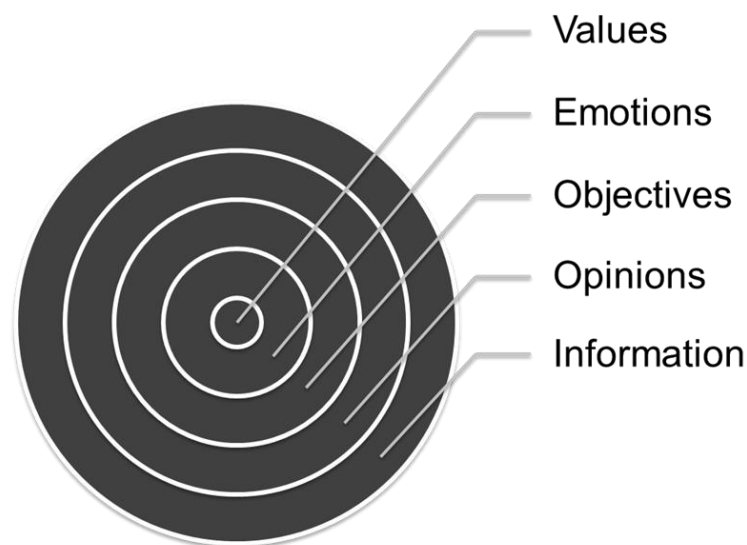
In March 2014, more than 70 organisations were identified as being involved in dealing with complaints about the NHS and social care in England alone by Healthwatch England.
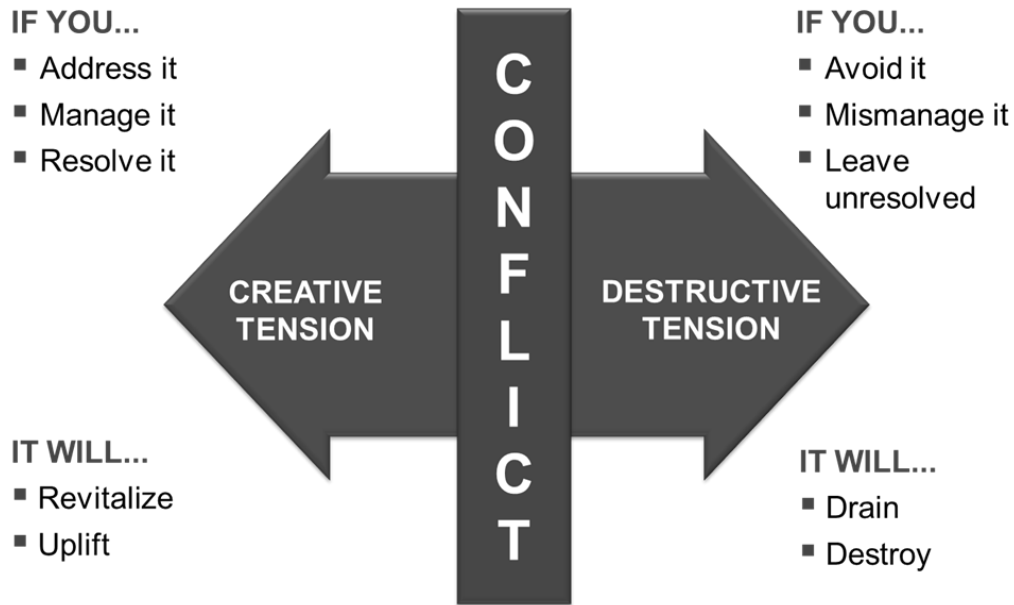
On the release of the *Care Quality Commissions Report: Complaints Matter* in December 2014, Prof.Sir Mike Richards, Chief Inspector at hospitals said that although most providers had complaints systems in place, people's experiences of them were not consistently good: "*We know from thousands of people who contact the CQC every year that many people do not even get as far as making a complaint, as they are put off by the confusing system or worried about the impact that complaining might have on their loved ones' care. More needs to be done to encourage an open culture where concerns are welcomed and learned from.*"

In Ann Clwyd and Prof. Tricia Hart's report: *A Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture*, (mentioned earlier in *Chapter 1.03*), there is a chapter titled *What it feels like to complain* which summarises what patients, relatives, friends and carers want to see improved. These are listed on the following page.
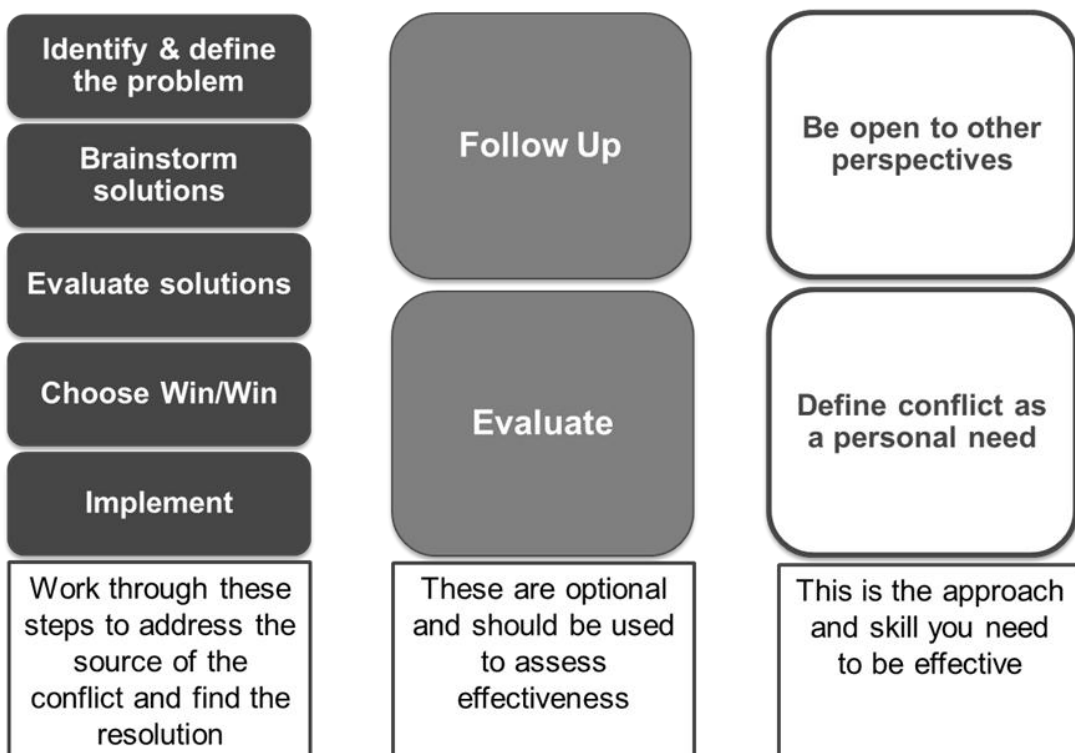
What patients, relatives and their friends want to see improved	
Information and accessibility	Patients want clear and simple information about how to complain and the process should be easy to navigate.
Freedom from fear	Patients do not want to feel that if they complain their care will be worse in future.
Sensitivity	Patients want their complaint dealt with sensitively.
Responsiveness	Patients want a response that is properly tailored to the issue they are complaining about.
Prompt and clear process	Patients want their complaint handled as quickly as possible.
Seamless service	Patients do not want to have to complain to multiple organisations in order to get answers.
Support	Patients want someone on their side to help them through the process of complaining.
Effectiveness	Patients want their complaints to make a difference to help prevent others suffering in the future.
Independence	Patients want to know the complaints process is independent, particularly when they are complaining about a serious failing in care.

When faced with someone making a complaint, it helps to be mindful of the content in *sections 3.09, Perception of time; 3.10, Stress and 3.11 Five stages of grief*. Though this may be the first time the receiver is aware that there is an issue of any kind, the complainer may have been building up to this point for some time. They may well be communicating more clumsily than usual due to stress and be functioning at any one of the five stages of the grief process. In general, the earlier an issue is recognised and addressed, the better for all concerned. This makes the handling of complaints a 'front line' task for all healthcare staff rather than something to be passed on to others. It is important to recognise, however, when the resolution of a complaint is beyond your abilities or your remit and requires appropriate escalation.

Complaints create conflict and tension, with the approach taken by the receiver being a deciding factor in whether this tension becomes a creative force or a destructive one. Avoiding, mismanaging or leaving the issue unresolved with damage relationships and lead to further problems. Addressing, managing and resolving the complaint becomes a positive driving force, improving relationships.

IF YOU...
- Address it
- Manage it
- Resolve it

CONFLICT

IF YOU...
- Avoid it
- Mismanage it
- Leave unresolved

CREATIVE TENSION

DESTRUCTIVE TENSION

IT WILL...
- Revitalize
- Uplift

IT WILL...
- Drain
- Destroy

The '5 plus 2 approach to conflict', illustrated below, can be productively employed when faced with a complaint.

Identify & define the problem		
Brainstorm solutions	Follow Up	Be open to other perspectives
Evaluate solutions		
Choose Win/Win	Evaluate	Define conflict as a personal need
Implement		
Work through these steps to address the source of the conflict and find the resolution	These are optional and should be used to assess effectiveness	This is the approach and skill you need to be effective

You may be able to see how the Z-model, described in *Section 4.03*, can overlap with the first four stages of the left hand column

- **Facts -** What are the facts as the complainer sees them?
- **Implications -** What are the implications for them and/or relevant others?
  - It is essential that these two stages are used to clearly identify and define the problem from the complainer's point of view before judging whether the addition of facts from your own point of view will be helpful or otherwise
- **Logical options –** This aligns with the Evaluate Solutions stage
- **The right thing –** Choosing Win/Win where both parties are happy with the chosen action is the ideal position.

Of course agreements must then be put into action or the complaint is likely to escalate further.

4.08 When and how to say "No"

Sometimes you may be asked to do things that you may not consider appropriate. This may be a request for further investigations or treatment when you know that they are not indicated or sometimes for documentation to provide support for requests made to other agencies which you do not feel that the patient is entitled to. You may even be asked to do something that requires misrepresentation on the patient's behalf.

It is essential that you adhere to your personal and professional ethics for a number of reasons. Firstly and obviously, you may put yourself at risk if you cross legal or professional guidelines. Secondly, it is your duty to protect the patient in a similar way from putting themselves at risk. Thirdly and not so obviously, you will inevitably lose the patient's respect if you do cross any of these boundaries, even though this will often happen at a subconscious level on both your parts.

It is always helpful to clarify the driving forces of the other person's request, plea or demand as this will give clues to the correct factual approach to take. Any one of, or a combination of the factors affecting communication and behaviour described in Chapter 3 could be at the route of this.

The guiding principle here is to remain firm, explaining fully and sensitively why you are not prepared to do what you are being asked. This requires a degree of emotional intelligence on your part, concentrating on positive models of being in charge and being assertive.

Accepting and dealing with conflict and anger requires a certain amount of assertiveness to start with, the courage to stand your ground, to think things through and trying to seek a satisfactory resolution for all involved.

Assertive behaviour is based upon our own innate 'beliefs' that we all have certain 'rights', rather than upon reacting to the aggression of others. If we don't protect and exercise our rights, we may lose them. 'Asserting' our rights, by making others become aware of them, should ideally lead these others to accept our position naturally and without anger.

With challenging behaviour and 'tricky' patients, it can be difficult to strike the right balance between asserting our rights (behaving assertively) and appearing to be aggressive, confrontational or difficult ourselves.

Assertiveness includes:
- being clear in expressing our own views, feelings, opinions
- making ourselves understood by being direct and clear
- straight talking without hurting people's feelings
- concentrating on issues rather than personalities
- being self-assured
- expressing emotions/needs without violating others' rights
- demanding what you want in a confident way that harms no one
- being decisive and not afraid to stand up for yourself
- being responsible for yourself and taking charge of your own life
- channelling your self-esteem to express yourself without anger

When addressing challenging behaviours, one of the most effective ways to communicate assertively is to express yourself using 'I' statements. These suggest that 'I' am taking responsibility; or 'I' am in charge; or 'I' am within my rights to do this. 'You' messages, on the other hand, more often push responsibility away from us and sound as if we are blaming someone else. (We probably are!)

For example, "I am finding this difficult" indicates taking responsibility for your own feelings as opposed to "You are making this difficult for me" which implicates the other person.

Assertive behaviour might look like:
- Good eye contact (beware cultural aspects)
- Standing/sitting comfortably – not fidgeting
- Strong, steady voice – not shouting or mumbling
- Assertive language e.g. "I take responsibility"; "I'm not afraid to put my name to something"
- Co-operative words – "Let's…" or "We could…"
- Empathic statements of interest – "What do you think?" or "How do you feel about that?"

In some cases, it may even be a relief to the patient that you maintain your position. Even though to do this may be challenging in the moment, it may also be the key to a continuing and more productive relationship with the patient.

Chapter 5: Final thoughts

Returning to the message at the beginning of this book, good communication is at the heart of good medical practice. And at the heart of good communication is the ability to listen well, to empathise with and create rapport with our patients.

We have given you an overview of some of the philosophies, approaches and techniques designed to help doctors communicate well.

We do not believe that individual doctors are naturally good or bad communicators, although clearly some find clear communication easier than others. We are convinced that communication skills can be and should be learned in just the same way as all other clinical skills.

Fundamental to this principle is the concept that communication is not just, or even mainly, about giving information to patients and relatives, but rather it is the ability to create situations that allow honest and constructive dialogue, so that such information can be conveyed clearly and accurately, taking into account the backgrounds and personalities of all involved.

It has been said many times before and we repeat and emphasise here that it is not what you say that matters. What matters is what the person with whom you are attempting to communicate hears and understands.

We believe that the insights and tools in this book will be useful to readers and workshop participants, but they are only insights and tools, and what is really critical is your intention and commitment to communicate to the best of your ability. If the intention is genuine, and there is a willingness to learn and continue learning, most people can become excellent communicators.

References

Chapter 1 - Introduction

General Medical Council. *Good Medical Practice* (2013)
- http://www.gmc-uk.org/guidance/good_medical_practice.asp.

1.01   What is communication?

Maturana, H. *Biology of cognition*, in *Maturana and Varela, Autopoiesis and Cognition.* Dordrecht: D. Reidel. 1980

Beckman HB and Frankel RM, *The Effect of Physician Behavior on the Collection of Data.* Ann Intern Med. 1984;101(5):692-696

1.03   What needs to be communicated and why?

Clwyd A & Hart T; *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture;* (2013)
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

Pendleton, D. (2003). Introduction. in *The new consultation developing doctor-patient communication*, Oxford: Oxford University Press

Chapter 2: Creating Dialogue

2.01   Neuroscience

Mischel W and Ebbesen E B. *Attention in delay of gratification*. Journal of Personality and Social Psychology 16 (2) 1970: 329–337.

2.02   Empathy

Decety J et al. *Physicians Down-Regulate Their Pain-Empathy Response*: An ERP Study. NeuroImage 50, no. 4 (2010): 1676-82.

Levinson W et al. *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons.* Journal of the American Medical Association 277 (1997): 553-69.

Hojat M et al. *The Devil Is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School.* Academic Medicine 84, no. 9 (2009): 1182-91.

Riess H. *Empathy in Medicine: A Nurobiological perspective.* Journal of the American Medical Association 304, no. 14 (2010): 1604-1605.

Goleman D. *The Empathy Triad. (*Chapter 10) in: *Focus - The Hidden Driver of Excellence.* Bloomsbury Publishing Plc. London. 2013

Cleveland Clinic, Empathy: The Human Connection to Patient Care,
- http://www.youtube.com/watch?v=cDDWvj_q-o8

2.03   Rapport

Schutz W, *FIRO: A Three-Dimensional Theory of Interpersonal Behavior*. New York, NY: Rinehart (1958)

2.05   Words, tone and body language

Stephens GJ et al. *Speaker-Listener Neural Coupling Underlies Successful Communication.* Proceedings of the National Academy of Sciences 107, no. 32 (2010): 14425-30.

2.07   Presence and Focus

Rodenburg, P. (2007). *Positive presence: How to use your personal energy for success in every situation*. London: Michael Joseph.

Goleman D. *The Leader's Triple Focus*. Chapter 19 In: *Focus - The Hidden Driver of Excellence.* Bloomsbury Publishing Plc. London. 2013

Mischel W and Ebbesen E B. *Attention in delay of gratification.* Journal of Personality and Social Psychology 16 (2) 1970: 329–337.

Francis R, QC, *The Mid Staffordshire NHS Foundation Trust Public Enquiry*, (2013)
- http://www.midstaffspublicinquiry.com/report

The Rt Hon Lord MacLean: *The Vale of Leven Hospital Enquiry Report*, (2014)
- http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf

2.09   Shadowing to improve patient care

The King's Fund, *Patient and Family-Centred Care Toolkit,* (2014)
- http://www.kingsfund.org.uk/projects/pfcc

Gibbs, G. (1988) *Learning by doing: A guide to teaching and learning methods,* Oxford Centre for Staff and Learning Development, Oxford Polytechnic. London: Further Education Unit. Section 4.3.5

2.10   Further methods for increasing awareness and deepening understanding

Kabat-Zinn J. *Coming to Our Senses: Healing Ourselves and the World Through Mindfulness*. Hyperion, 2006

Williams M and Penman D. Mindfulness. *A practical Guide to finding peace in a frantic world.* Piatkus London 2011

Balint M. *The Doctor, His Patient and the Illness.* London: Churchill Livingstone, 1957

Chapter 3 – Factors affecting communication and behaviour

3.01   Listening

Rodenburg, P. (2007). *Positive presence: How to use your personal energy for success in every situation*. London: Michael Joseph.

3.02   Framing

Kahneman, D. *Thinking, Fast and Slow.* 2012. Penguin Books. London.

Gigerenzer, G. *Should patients listen to how doctors frame messages*. BMJ 2014;349:g7091.

3.03   Cultural differences

Hofstede G, Hofstede GJ, Minkov M, *Cultures and Organizations: Software of the Mind.* 3rd Edition; McGraw-Hill USA, 2010

Office of Government Commerce, *Managing Successful Programmes;* (2007). TSO. London

3.04   Personality type and preference

Briggs Myers I et al, (2003) A *Guide to the Development and Use of the Myers Briggs Type Indicator®*, CPP

3.05   Logical Levels

Bateson, G. (1989). *The Individual, communication, and society: Essays in memory of Gregory Bateson*. Cambridge [England: Cambridge University Press

Dilts, R., & Hallbom, T. (1990). *Beliefs: Pathways to health & well-being*. Portland, Or.: Metamorphous Press

3.06 Health Belief Model

Glanz, K., Marcus Lewis, F. & Rimer, B.K. (1997). *Theory at a Glance: A Guide for Health Promotion Practice*. National Institute of Health.

3.07 Drivers of 'non-compliance'

Sokol J et al. *A study of patient compliance in a contact lens wearing population.* CLAO J 1990 16:3 209-213

3.08 Associations
Banjani M & Greenwald A, *Blind Spot, Hidden Biases of Good People,* Delacorte Press 2013

Project Implicit website, 2014
- www.implicit.harv ard.edu

3.09   Perception of time

Eagleman D; *Brain Time; a*n essay in *WHAT'S NEXT? Dispatches on the Future of Science*, Edited By Max Brockman; Vantage Books 2009

Sendhil Mullainathan and Edar Shafir: *Scarcity: Why having too little means so much*; MacMillan 2013

David Loxterkamp; *Staying ahead of getting behind: reflections on "scarcity"*; BMJ 2014;348;g2634

3.10   Stress

Horney K; *Self-Analysis;* WW Norton & Co (1942)

Cherry K. *Horney's List of Neurotic Needs;*
- http://psychology.about.com/od/theoriesofpersonality/a/neuroticneeds.htm

Martin LJ et al, Reducing Social Stress Elicits Emotional Contagion of Pain in Mouse and Human Strangers, Current Biology, Volume 25, Issue 3, p326–332, 2 February 2015,

3.11   Five stages of grief

Kübler-Ross, E. *On death and dying.* New York Macmillan 1969

Chapter 4 – Communication approaches in healthcare

4.01   Continuity of Care

Clwyd A & Hart T; *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture*; (2013)
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

4.02   Concordance versus compliance and adherence

NICE Clinical Guideline 76. *Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence.* 2009.

Clyne W, Granby T & Picton C. *Competency framework for shared decision making with patients: Achieving concordance for taking medicines.* Medicines Partnership Programme, National Prescribing Centre, 2007.

Keele University website, 2014
- http://www.keele.ac.uk/schools/pharm/npcplus/medicinespartner/documents/Concordant_Competency_Framework_2007_000.pdf

4.03   The Z-model

Brock S and Allen J; *Health Care Communication Using Personality Type*, Routeledge, (2000)

4.04   Theories of adult learning

Gardner H, *Frames of Mind,* (1983), New York, Basic Books

Kolb D, *Experiential Learning: Experience as the Source of Learning and Development* (1984), New Jersey, Prentice Hall

4.05   Influence and persuasion

Cialdini, R. (2007). *Influence: The psychology of persuasion* (Rev. ed; 1st Collins business essentials ed.). New York: Collins.

4.06 Breaking bad news – the doctor's mind-set

Kübler-Ross, E. *On death and dying*. New York Macmillan 1969

Brown B, *The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and Embrace Who You Are* (2010); Hazelden

Conner D, *Managing at the Speed of Change*, (1992), New York: Random House

4.07   Breaking bad news – a strategy

Baille W. et al; *SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer,* The Oncologist, August 2000, vol. 5 no. 4 302-311

4.08   Handling complaints

Healthwatch England website, 2014
* http://www.healthwatch.co.uk/complaints/our-work

Care Quality Commission (2014), Complaints Matter,
* http://www.cqc.org.uk/content/publications

Clwyd A & Hart T; *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture;* (2013)
* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

4.09   When and how to say "no"

Back K & Back K; *Assertiveness at Work; A practical guide to handling awkward situations* (2005); McGraw-Hill Publishing; London