

PART 1

FUNDAMENTALS OF COMMUNICATION FOR COMPASSIONATE PRACTICE

Part 1 is designed to help students develop a better understanding of themselves within the context of healthcare. It aims to allow them to explore their communicative and collaborative abilities in order to more effectively apply these to their patients. Whilst there is some discussion of 'how to do communication', the emphasis is on examining the factors influencing underlying attitudes towards ourselves and others. This section will refer to patients and clinical scenarios but the focus is on the individual practitioner. It illustrates how theory and contemporary psychological applications can enhance coping mechanisms, communication and collaborative skills for student nurses and midwives.

Chapter 1 looks at understanding the context of communicative and compassionate care. It examines the centrality of communication to collaborative relationships and the values underpinning care. Chapter 2 explores the components of professional communication in nursing and midwifery and begins to introduce the student to an understanding of reflective practice. Chapter 3 looks at the developmental psychological theory of Piaget and Bowlby. These important psychological building blocks help develop an appreciation of the processes that affect our own and others' behaviour and communication patterns. Chapter 4 highlights contemporary health issues and the need to develop more effective forms of health behaviour change methods. Part 1 then concludes with emotional intelligence/competence and mindfulness; acknowledging that it is essential that nurses and midwives look after their own psychological wellbeing, in order to effectively communicate and collaboratively care for patients and service users.





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Essential Values for Communication, Compassion and Collaborative Care

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By the end of this chapter, you will have developed an understanding of:

- the importance of communication and the context of failures in compassionate communication and care
- the ethical values underpinning compassionate communication: respect and preservation of dignity
- the complexity and centrality of the therapeutic relationship.

Don't forget to visit the Values Exchange website at <http://sagecomms.vxcommunity.com> for extra practice and revision activities.



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Introduction

Nationally and internationally the requirement for nurses to communicate effectively and ethically is highlighted and documented in essential standards and codes of behaviour. In the United Kingdom, the Nursing and Midwifery Council's standards for pre-registration nursing state:

All nurses must build partnerships and therapeutic relationships through safe, effective and non-discriminatory communication. They must take account of individual differences, capabilities and needs

and

They must ensure people receive all the information they need in a language and manner that allows them to make informed choices and share decision making. (Nursing and Midwifery Council England, 2010, p. 15)

In this chapter, we argue that in order to achieve the standards expected in the effective delivery of healthcare, it is crucial to fully understand the importance of compassion, apparent failures in compassion, the ethical values underpinning positive communication and the centrality and complexity of communication in therapeutic relationships. It is also necessary to appreciate that a seemingly simple task such as communicating with a patient is actually a complex and skilled process. This chapter unpicks the intricacies of communication and encourages the student to maintain an inquiring approach to practice that might look undemanding at first glance.

The importance of communication and remaining compassionate

Will you remain compassionate and caring in your communication?

Student story 1.1: Janet

Janet is a first-year student nurse. She is one of the more mature students at 35 but is full of enthusiasm for her career change and considers herself to be a 'people person'. She used to work in a high-powered job in finance and, had she stayed, would certainly have earned more money than she ever will in nursing. However, she became disillusioned with finance, feeling that a lifestyle associated with simply earning money was not for her. Consequently, she has given up a lot to be a student nurse and hopes it will all work out. She is married and has two children who are now half way through secondary school, so this seems a good time to make the change. Her husband and children are supportive of her doing a nursing course. She feels a bit anxious about learning the technical aspects of the job but thinks she is making progress. Janet has just started her first placement on a busy medical ward. She's enjoying the work but notices that because she looks older than the other first years (they are both 19), the patients seem to expect her to be able to provide reassurance in a way that they don't expect from the younger students. In addition, when the practice educator comes round and sees all of the students in a group, the younger students always seem to expect her to answer first when they are asked a question. It's all a bit more difficult than she expected.

She's also very aware that just as she has entered nursing, there is a lot of publicity about poor standards of care. Janet is very determined that she will maintain her own high standards but she recognises that the ward is very busy (it is winter and lots of older people are being admitted) and she can also see that some of the healthcare assistants are cutting corners.

Student story 1.2: Jack

Jack is a first-year learning disability student nurse. He had worked as a support worker in learning disabilities prior to commencing his nursing course. Jack is 33; he took quite a while to work out what he wanted to do in life. He started a sociology degree in his 20s but felt it wasn't for him and did not complete the course. He has had a number of jobs in sales but, again, felt that it wasn't for him. A friend worked as a residential social worker in a community facility for people with physical and learning disabilities. Jack started by doing some agency shifts and found that he really enjoyed the work and felt it was more socially meaningful than anything he had done previously.

Along the way, he has acquired a partner and a small child so his decision to enter nurse training is a bit of a short-term sacrifice, but he and his partner have talked it through. He hopes it will lead to a fulfilling long-term career and a good means of supporting his family.

Jack is enjoying the teaching and mixing with other like-minded students on his course. He has been on a couple of placements. These have gone well but have also served to reinforce the idea that there is much to be done to achieve more equality and respect for people with learning disabilities. He is very aware of the tendency for people to ignore the person with a disability and instead address the carer.

Visit the Values Exchange website at <http://sagecomms.vxcommunity.com> for a broader discussion on this Student story.



Communication may be commonly assumed to be a simple two-way exchange of information. However, it is much more than that and in nursing and midwifery, for much of the time, it is necessary to have communication that demonstrates compassion where one 'must be receptive to another's communication' and 'put him/herself in the other's place' (Reynolds, 2005). Patients and service users can be extremely anxious as to what might lie ahead. The impact of a kind and compassionate approach should never be underestimated, as Patient story 1.1, taken from Patientopinion.org/, demonstrates. The Patient Opinion website has been operational in the UK for over 10 years and provides real-time feedback to healthcare services (patientopinion.org.uk).

Patient story 1.1: Gratitude

I honestly can't thank the nurses and doctors at ***** unit enough for their care and compassion during my visit. I have luckily never had a stay in hospital before this visit so I had been initially apprehensive but the nurses soon eased my worries when I entered the ward. The staff were very attentive, efficient and friendly. Even though I quite suddenly required more treatment than I had initially expected, I felt very reassured by the nurses and doctors throughout the whole experience. If it hadn't been for their professionalism and compassion, I would have felt frightened by the change in the situation. They kept me informed about everything that was going to happen and treated me with exceptional kindness. There was one nurse in particular (I am sorry I can't remember her name) who was with me throughout and was absolutely fantastic, thank you! (www.patientopinion.org.uk/, 2016)

This is the type of patient feedback that everyone wants to hear. Traditionally, the nursing profession has been commonly assumed to contain people who can communicate and possess ‘caring’ and ‘compassionate’ characteristics. Indeed, it is deemed mandatory by the national governing bodies that candidates for entry to the profession exhibit these characteristics at the recruitment stage (Bryson and Jones, 2013). Despite these gatekeeping efforts, however, recent scandals such as The Francis Report (Francis, 2010, 2013) and the inquiry into Winterbourne View (Bubb, 2014) have revealed a troubling paradox wherein those within an ostensibly ‘caring’ profession have failed to exhibit such fundamental characteristics of care and benevolence to devastating effect for patients and their carers. Investigations into these scandals repeatedly identified compassionate, collaborative and effective communication as severely lacking.

The following extracts are taken from two reports produced by Sir Robert Francis at the request of health ministers following complaints by relatives of service users at the Mid Staffordshire NHS Foundation Trust.

Patient story 1.2: The Mid Staffordshire care scandal

Following a fall the patient was admitted to Stafford Hospital. When the patient requested a bedpan he was told by the nurse to soil himself as she was too busy to help. (Francis, 2010, p. 6)

The first inquiry heard harrowing personal stories from patients and patients’ families about the appalling care received at the Trust. On many occasions, the accounts received related to basic elements of care and the quality of the patient experience. These included cases where: Patients were left in excrement in soiled bed clothes for lengthy periods; Assistance was not provided with feeding for patients who could not eat without help; Water was left out of reach; In spite of persistent requests for help, patients were not assisted in their toileting; Wards and toilet facilities were left in a filthy condition; Privacy and dignity, even in death, were denied; Triage in A&E was undertaken by untrained staff; Staff treated patients and those close to them with what appeared to be callous indifference. (Francis, 2013, p. 25)

The press, politicians and organisations representing service users have rightly expressed outrage at this state of affairs and demanded change (www.patients-association.com). Such scandals of poor health and social care, however, are not unique to this decade. Vulnerable service users have been the recipients of neglect and even abuse over many years. Timmins (2012) points out that the traditional method of funding healthcare used to rely on a little more funding than the previous year, plus extra to cover an inevitable scandal. Although exemplary care is delivered by many professionals, at the same time, others lose the capacity to maintain and sustain a compassionate approach. Behaviours demonstrating poor communication, uncompassionate care and disinterest in collaborative relationships with patients and service users have not only been an endemic feature of health and social care, they are also almost considered par for the course.

Lack of compassion is a recurring theme in many reports of poor healthcare. For the recipient, compassion goes hand in hand with good communication. There are various definitions of compassion, including sympathy, pity, and a desire to help or alleviate suffering

(Baughan and Smith, 2013). However, we would suggest that the quality of empathy – a recognition of others’ emotions, the ability to see the situation from their perspective – is more useful for the professional demonstration of compassion in contemporary times (Dinkins, 2011). Empathy, like communication, may be assumed to be intrinsic to human nature, however the effective demonstration and maintenance of empathy are not so simple.

The concept of ‘burnout’ for professionals in caring work is well known and documented in the literature. Burnout and desensitisation are real risks which can lead to a high level of breakdown in communication (Personal communication with year 3 nursing students, 2014). Burnout is associated with emotional blunting and uncaring attitudes towards service users (Zhang et al., 2014). It is widely acknowledged that professionals in health and social care need to be open to and attend to their own emotions to prevent ‘compassion fatigue’ and burnout (Baughan and Smith, 2013, p. 77). (This concept will be revisited in some depth in future chapters, alongside techniques to enable you to avoid burnout and preserve an empathic and compassionate approach.)

Communication problems have remained one of the most common sources of complaint in health services in the UK and in other countries. Reader et al. (2014, p. 685) found that complaints about problematic communication and poor staff–patient relationships ‘were almost equal’ in number to those about the quality of clinical care. The quotations in Patient story 1.3 have been taken from recent postings on the UK Patientopinion.org/ website. These statements illustrate the heightened emotions and anxieties of health service users and carers and how this experience is either ameliorated or worsened by communication with health professionals.

Patient story 1.3: Positive and negative communication

A desperately worrying and devastating time for us, as my father was very poorly and vulnerable. The doctor showed exceptional medical care and compassion to helping my father get the best possible care he could.

I was treated with respect from the time I arrived. It made such a difference to have someone take the time to undertake an examination and explain the findings and treatment plan without trying to rush you through.

In this instance I am disgusted by the lack of compassion, empathy and help shown primarily towards my mother but also to me ... To sum up: the care of my 95-year-old father who has dementia lacked dignity or any sense of urgency that any person of any age should expect.

A hospital was supposed to be a place to feel safe and cared for but not in this case. Summary – lack of compassion and care, low numbers of qualified staff, light left on in wards at night and very noisy talking laughing staff at nursing stations at night.

(www.patientopinion.org.uk/, 2014)

These quotations describe people from the same professions but with very differing presentations to patients. In order to safeguard against such examples of poor communication

in the delivery of healthcare, it is crucial to consider how healthcare professionals who seemingly start out with positive intentions may intentionally or unintentionally end up exhibiting negative attitudes and behaviours towards those for whom they are supposed to care. Communicative behaviour is the outward expression of health professionals' internal attitudes and values (Gault et al., 2013). Consequently, it is necessary to examine the ethical values underpinning and enabling positive attitudes and behaviours in caring for others.

Respect and dignity

How will you ensure that your practice demonstrates respect and preserves dignity?

The Nursing and Midwifery code of conduct in the UK explicitly states that 'you must treat people as individuals and respect their dignity' (NMC, 2015, p. 4). Service user comments emphasise the importance of being respected and not treated in an undignified manner. Many healthcare procedures have the capacity for great indignity. Again, Patientopinion.org/ (2015) illustrates how healthcare staff can minimise the potential indignity by communicating respect and empathy or, alternatively, worsen the experience.

Patient story 1.4: Dignity and respect

Due to the nature of the tests and procedures it could have been embarrassing and unpleasant but everyone was so nice and accommodating I almost forgot where I was! ... Treated with dignity and care for a potentially embarrassing investigation.

I'm embarrassed talking about my condition, at the best of times. But to be in the hands of someone whom I thought would have been a professional; I have been left feeling degraded, and a little violated at the lack of respect and dignity I was shown.

(www.patientopinion.org.uk/, 2015)

Clearly, as illustrated by the quotations in Patient story 1.4, it is possible to be careless in communication and to leave the service user feeling humiliated. Wainwright and Gallagher (2008) discuss how easily (and unthinkingly) professionals may reinforce the experience of disrespect, through simple and repeated acts of carelessness. Becoming a patient or health service user almost always involves dependence on the healthcare practitioner, with considerable scope for violation of privacy. Codes of conduct now emphasise the need for nurses and midwives to understand the 'trust and privilege inherent in the relationship between nurses and people receiving care' (Nursing and Midwifery Board of Australia, 2008, p. 1), and their obligation to minimise the power imbalance between patient and professional.

These complex understandings and interactions can appear a challenging task. However, nurses and midwives can develop both intellectual interpretations and

practical behaviours relating to respect and dignity with the aid of relevant theory. Respect is defined as ‘to hold in high regard; to show consideration for others’ (Mosby, 2012). Fraser and Honneth’s (2003) theory of recognition focuses on respect and helps in understanding how feeling disrespected (as in the patientopinion.org/ statement above) is deeply wounding. He argues that a lack of respect or disrespect is damaging, interfering with our existing sense of identity acquired through years of interaction with others. To find oneself denied respect in any situation is an assault on identity and self-esteem. The use of inappropriate verbal and non-verbal responses to someone attempting to talk about their ‘embarrassing’ condition communicates disrespect to that person.

Nordenfelt discusses ‘dignity of identity’ (2009, p. xiii). This type of dignity underpins respect for human rights and relates to the value or worth people have purely on the basis of their being human and regardless of ethnicity, social class, gender or sexual orientation. The Royal College of Nursing (2008) also affirms that dignity is associated with identity and feelings of self-worth or how ‘people feel, think and behave in relation to the worth or value of themselves’. Gallagher (2004) provides an example of an elderly person presented with a cup of tea minus a saucer. Although the young nurse seemed oblivious to the fact, the older woman, due to her age, class and value system, felt that she had been insulted. She believed that being given tea without a saucer indicated a lack of respect for her identity and thus was an affront to her dignity.

One of the ways in which we demonstrate respect is in our willingness (or lack of it) to work co-operatively with others. The NMC code of conduct also states that ‘you must work in partnership with people to make sure you deliver care effectively’ (Nursing and Midwifery Council, 2015, p. 5). It might be assumed that as healthcare practitioners we automatically include the service user in decision making and communication about their care. Conversely, collaborative communication is a complex skill but one that is essential not only in healthcare but also in modern life generally. As Sennett (2012) notes, in his book *Together*, most of us exist as social animals within societies, with many interdependencies. Few, if any, can manage to get through life without interaction with others. Co-operation and communication between humans are necessary to both avoid conflict and make progress. However, as demonstrated by history, the ability to communicate and co-operate with one another has often been in short supply. Humans, throughout history, have tended towards tribalism or the tendency to feel solidarity only with those perceived as similar to themselves. Tribalism is dangerous in contemporary life and, as Sennett notes (2012, p. 3), ‘in the form of nationalism, destroyed Europe during the first half of the twentieth century’. Whereas tribalism might have been helpful historically in very simple societies, it becomes a problem in current, complex societies where the ability to communicate collaboratively with those who differ from ourselves is essential (Sennett, 2012).

Healthcare professionals exist like everyone else within society, have been socialised within that society and are likely to enter healthcare education holding the values with which they have grown up. Here, again, communicative collaboration is an example of a task that may look simple on the outside but is actually an intricate endeavour. Therefore, an understanding and examination of our capacity to truly collaborate versus our tendency towards tribal behaviour are required. Are healthcare workers likely to hold judgemental attitudes towards those dissimilar to themselves? Does the health professional really want to work collaboratively with the service user or do they actually wish to tell the service user how to behave?

CRITICAL THINKING EXERCISE 1.1

CONSIDER THE FOLLOWING SCENARIOS AND EXPLORE YOUR RESPONSE

You are on placement in a surgical ward in a large general hospital. A fellow student seems to make remarks that you feel are judgemental when referring to patients. He says things like 'Asian people do this' or 'gay people are known to do that'. Should we accept this behaviour from another student? Should you act on this and, if so, how?

You are on placement in a community mental health team. One of the service users tells you and your mentor that she is not taking her medication as prescribed. She has a history of relapse when she fails to take medication. She says it makes her drowsy and interferes with her ability to look after her children. What would be your response?

The centrality and complexity of communication in the therapeutic relationship

Do you think that communication comes naturally and that you will easily build therapeutic relationships?

Building therapeutic relationships and demonstrating effective healthcare communication are complex skills, based on positive professional values and ethical practice (Seago, 2008). It is recognised that students in nursing and midwifery need to develop highly sophisticated communication skills to provide compassionate care to the people they look after (NMC, 2010). Student contributors to this book reported that they often start their learning programme feeling that they already know how to communicate and questioned the value of this part of the course. Seago (2008) and Happell (2009) also support this perspective, emphasising that people generally underestimate the complexity of healthcare communication. On commencing modules in communication skills, students report an increasing awareness of the importance, and difficulty, of this area of skill development. This includes how to break bad news, how to communicate with relatives, how to ensure someone has understood important information, how to work with the person to develop collaborative plans to improve health (rather than just 'telling' someone what to do), how to deal with colleagues who do not communicate in the best way with their patients, how to communicate new ideas about good practice and influence change – all these and more are communication challenges for students.

The therapeutic relationship will be discussed at length throughout the book but it requires some brief exploration at this point. 'Therapeutic' is considered to be an essential element in healthcare relationships but also a term much used and possibly abused in healthcare. The dictionary defines 'therapeutic' as 'the art of healing' or 'concerned with the remedial treatment of disease' (OED, OUP, 2003, p. 455). It can take many forms such as curative, preventative, supportive or palliative. Chambers (2005, p. 302) notes that 'therapeutic relationships ... can be taken for granted', yet they are rarely explored or challenged in any meaningful manner. Garwood-Gowers et al. (2005) argue that the term itself is problematic as there is little consensus on what therapeutic means. There has been a tendency to be content with the term 'therapeutic' meaning whatever the particular practitioner wishes it to mean. Therefore, if the practitioner has convinced themselves that what they do is 'therapeutic', the service user is simply expected to agree.

It is, therefore, necessary to explore the therapeutic relationship rather than assume we must be therapeutic simply because we wear the uniform. Dzopia and Ahern (2009) explore the factors that make a relationship therapeutic in character. Qualities of warmth, genuineness, not being judgemental and conveying understanding are cited but, as they acknowledge, these can be difficult to define. Displaying the communicative behaviours of relating to the patient as a person, being available and signalling a desire to help are perceived as therapeutic by patients (Williams and Irurita, 2004). Yet, too often, it is assumed that these values and skills are easily acquired or even intrinsic to human nature.

CRITICAL THINKING EXERCISE 1.2
CONSIDER THE STATEMENTS BELOW
AND RESPOND TO EACH

The audience does not play a role in communication.

People who speak the same language do not have a problem with communication.

Speaking directly is universally acceptable.

The more words used in communicating, the better.

It is the speaker's job to make me understand.

Communication is an inborn talent – either you have it or you don't.

Non-verbal signals are universally understood.

Silence is not feedback.

Communication means giving information.

Visit the Values Exchange website at <http://sagecomms.vxcommunity.com> to develop your critical thinking skills and debate your thoughts and decisions.



Student contributors to this book described their 'worst fears' on commencing their first early practice placements. Although younger students felt anxious at the prospect of providing adequate communicative support to older patients, more mature students suggested they had even more to fear. One of these described experiences where staff and patients would assume that she had abilities well beyond her sphere of competence as a first-year student. Both groups of students agreed that they experienced feelings of fear and embarrassment when confronted with difficult communicative situations on placement (Student focus group, 2013).

Student story 1.3: 'Your worst fear'

You are a first-year student on a placement on a hospital ward. You have been working here for three weeks and have settled into the demands of the placement with commitment and enthusiasm. As a result of your dedication, you are popular amongst the clientele, and have built positive therapeutic relationships with all of them. Your mentor is pleased with your

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progress, and the staff team tell you that you are the kind of person that they would like to employ once you qualify.

'Ruth' was admitted during your second week. She is a 24-year-old woman with whom you feel you have a close professional relationship. She has a partner and two small children and they all clearly love each other very much. You cannot help but be touched by this, and by the deep affection Ruth shows to both her children (who are 2 and 3 years old), as well as her partner. They are also very fond of you, and often talk about you and their gratitude for your good care of Ruth.

There was some mystery surrounding Ruth's admission, and so she was admitted for tests, of which she has now undertaken many. Her results are now due.

You arrive for your shift today, and your mentor says that Ruth has asked to see you specifically, although she doesn't know why. Approaching Ruth, she asks you for a 'very large favour' and then bursts into tears. She explains that her results have revealed that she has a very rare form of an especially aggressive cancer, and it is now developed to such a stage that there is nothing that can be done except palliative care; the consultant has told her that she has about 10–20 days left.

Ruth is understandably devastated, particularly as she had no inkling that she was terminally ill. She now feels horribly guilty for making light and joking with the children about being ill, as she assumed she'd be home in no time. Her partner doesn't know as yet, and she thinks that he won't cope with the terrible news well at all, as he's 'super sensitive'.

Because of all this, Ruth doesn't believe that either she or her partner are the best people to explain the situation to their children, and the favour she is asking is for you to sit down and do this for them instead. She says she knows it's a huge thing to ask, but she has noticed how kind, clever and professional you are...

- What would you do?
- How would you feel?
- What would you say?
- What would you be telling yourself?

This is a frightening prospect and unlikely to happen on your early placements but it does describe the worst imaginings of student nurses who reflect on the initial stages of their course. The scenario above represents a situation that is potentially challenging to the novice practitioner. However, this is not designed to scare students off before they start but to illustrate the sensitive context of the world of healthcare communication. In order to be communicatively and ethically competent, the following chapters within this book will enable you to reflect and develop coping and communicative skills for scenarios such as this.

Critical debate 1.1: The good communicator

Can compassion and good communication be learned or are these qualities that one is born with?

If these can be learned, what is the best method?

If you think that compassion and good communicative skills are qualities we are born with, what should we do about colleagues who seem to lack them?

Conclusion

To conclude, communication within the therapeutic relationship is a complex task and there are too many instances where it has gone badly wrong. Nevertheless, the current cries of outrage at failures in compassionate care and communication are not new but a persistent feature in some areas of healthcare. In many cases, the inability of nurses and midwives to care for their own emotional wellbeing results in poor care for service users. There is a tendency to assume that good communication skills and a compassionate nature simply come with the job. We argue that this is a dangerous assumption. Effective and empathic communication can be enhanced by an appreciation of the ethical and theoretical understanding underpinning complex but essential communication skills. Practitioners need to learn how to look after their own emotions and to recognise emotion in others alongside skill acquisition. The following chapters will break these elements into their constituent parts and enable the learner to develop emotionally, theoretically and practically.

Further suggested activity

Explore patient websites/social media outlets. What are they saying about health services? What are their most persistent complaints? Try the following websites:

Hello my name is home page – www.hellomynameis.org.uk – or #hellomynameis campaign on Twitter
 Patient Opinion home page – www.patientopinion.org.uk/
 The Patients Association home page – www.patients-association.com

To access further resources related to this chapter, visit the Values Exchange website at <http://sagecomms.vxcommunity.com>

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