PART 1

Theories of communication

PART 1

This section introduces essential knowledge and key models of communication before exploring fundamental aspects of nursing practice such as the nurse–patient relationship and therapeutic communication. It then goes on to outline and demonstrate essential skills such as active listening, attending, and working with groups of people. These skills form the foundation upon which other communication skills can be developed.

Chapter 1 introduces some key models for looking at communication and breaking it down into its component parts. Chapter 2 examines the nurse–patient relationship itself and the skills needed to ensure the safety of the patient, enhance the therapeutic process, the management of the relationship from engagement to disengagement. Chapter 3 explains two key models of communication that underpin any person-to-person interaction and demonstrates how application of the theories enables the nurse–patient relationship to be therapeutic. Chapter 4 covers the basic skills and knowledge of communication and interpersonal skills in healthcare which the aim is to engender healing and well-being. Chapter 5 extends the theory of communication to groups and examines what happens when we communicate in teams or with families, relatives, or cohorts of patients.

1

Introduction to Communication Skills

Lucy Webb

The aims of this chapter are:

- To outline the importance of communication skills in healthcare and nursing
- Explore the underpinning theories and definitions of communication
- Demonstrate theories of communication in the practice setting
- Provide a context for the rest of the book

Introduction

Communication and interpersonal skills are essential components in delivering good-quality nursing care. Communication is identified as one of the essential skills students must acquire in order to make progress through their education and training to become qualified nurses (NMC, 2010). This book has been designed and developed to help students understand the underlying reasons why communication skills have become so important in nursing as well as the underpinning theories that attempt to define what communication is. In this chapter, as in all the chapters in this book, you will find examples and explanations of how different aspects of communication are applied in the nursing context. In this way, this book will assist you to develop your knowledge and skills so that you feel prepared for practice.

Why is communication important for nursing?

Important skills for the Nursing and Midwifery Council

The NMC standards for pre-registration nursing education (NMC, 2010) stipulate that, within the domain for communication and interpersonal skills, all nurses must do the following.

- Communicate safely and effectively.
- Build therapeutic relationships and take individual differences, capabilities, and needs into account.
- Be able to engage in, maintain, and disengage from therapeutic relationships.
- Use a range of communication skills and technologies.
- Use verbal, non-verbal, and written communication.
- Recognize the need for an interpreter.
- Address communication in diversity.
- Promote well-being and personal safety.
- Identify ways to communicate and promote healthy behaviour.
- Maintain accurate, clear, and complete written or electronic records.
- Respect and protect confidential information.

You will find all these competencies addressed throughout this book.

Communication as an aspect of care

In attempting to answer the question, why is communication important in nursing, it becomes apparent that communication and 'nursing' are indivisible. But first, what do we mean by nursing? According to McMahon (2002), Florence Nightingale once complained that her concept of nursing had been turned into nothing more than the administration of medicines. McMahon expresses concern that nurses themselves perceive nursing as some form of comfort-giving, or providing assistance towards the patient's self-care, claiming that nurses themselves find it difficult to define what the nature of nursing is. Nursing proves as difficult to define as 'care', which means that the role of the nurse and how it is differentiated from other health professionals is often misunderstood. Perhaps nurses provide care and doctors provide treatment, but McMahon (2002) argues that this does not address the skills and knowledge needed in modern nursing to provide good quality 'care', nor explains why students take three years to train before they become qualified nurses.

Since Florence Nightingale's time, nursing could be seen as having moved from a task-oriented practice towards a therapeutic process that encompasses a wide range of nursing roles, focused on the individual patient and his or her health and well-being. McMahon (2002: 7) attempts to define therapeutic nursing abilities as being characterised by six skills:

- developing the nurse–patient relationship;
- caring and comforting;
- using evidence-based physical interventions;
- teaching;
- manipulating the environment;
- adopting complementary health practices.

These are all skills developed by nurses during their pre-registration education; however, all of them demand good communication skills for effectiveness. It appears that this argument supports the notion that 'nursing', in addition to the applied knowledge and attitude, is underpinned essentially by communication skills.

The therapeutic effect of good communication delivered through good care is supported by evidence. Social support appears to have a role in providing reassurance and can even lower blood pressure (Kamarck *et al*., 1998). Health professionals who can communicate at an emotional level are seen as warm, caring, and empathetic and engender trust in their patients, and this encourages disclosure of worries and concerns that patients might otherwise not reveal (Letvak, 1995; Bensing, 1991). Additionally, informative and useful communication between the practitioner and the patient is shown to encourage patients to take more interest in their condition, ask questions, and develop greater understanding and self-care (Crow *et al.*, 1999). This is particularly so when the patient is given time and encouragement to ask questions and be involved in treatment decisions. It is also shown that patients can experience measurable health benefits when nurses provide a good environment, use therapeutic communication, give accurate information, and encourage positive motivation in patients (Kwekkeboom, 1997).

So, good communication in the nurse–patient encounter is itself a beneficial and therapeutic intervention as well as the vehicle for good care, and can be regarded as important as other care or treatment. In brief, evidence suggests that health communication helps patients to:

- express their physical and emotional needs;
- ask questions and be more involved in their care;
- gain a sense of control over their condition and treatment;
- develop trust and confidence in the process and so comply with treatment;
- gain physical health benefits such as reduced pain and lowered blood pressure.

The changing nature of healthcare

Another key element that underlines the importance of good communication is the changing nature of healthcare itself. Improved medicine and treatment over the last century has moved healthcare away from a focus on acute illness to the management of chronic disease. More people are living with survivable chronic illness and need to be encouraged to be self-caring, for example, those with diabetes need to manage their blood sugar levels. Quality of life has become as important as survival now that people are living longer with chronic conditions such as cancer, bi-polar disorder and severe physical or learning disability.

Therefore treatment choice has become much more dependent on the individual patient's preference and what suits the patient's values and expectations. In many circumstances, the patient has become the expert in their own treatment and care management (DoH, 2001*a*).

A raft of government initiatives has driven health provision towards patient-centred care in the UK. The Patient's Charter (DoH, 1992) and the NHS Plan (DoH, 2000) initiated a shift of services to revolve around the patient rather than the patient needing to fit in with the services, for example, broader appointment times and access hours and waiting list reduction. Patients started to be acknowledged as the experts in their care, especially in managing chronic ill-health (DoH, 2001*a*). Patients are viewed as active participants in their care and the provision of care services, with a focus on service users' rights and contributions to policy and service planning (DoH, 2001*b*, 2006*a*, 2006*b*). We have also entered an age of consumerism whereby patients expect more from their healthcare providers and in which patients have access to information and are much better informed about health issues. This can be referred to as a shift from a medical model of healthcare to a bio-psychosocial model of healthcare whereby the biological, psychological, and social aspects of the patient's well-being are taken equally into consideration in an holistic manner to address the patient's quality of life (Ogden, 2004).

Overall, there has been a major shift in the relationship between patient and practitioner which has turned the old paternal system of 'doctor knows best' to one of patient-centred care and the 'expert patient'. Bensing (2000) sums this up in a simple diagram of two dimensions that dictate the relationship between the patient and the practitioner, see Figure 1.1.

This model maps out the patient–practitioner encounter by who has control on one dimension and how medicalized the communication is on the other dimension. For instance, a visit to the GP may involve the doctor informing the patient that he or she must take the medication in order to get better (a doctor-controlled, medical encounter), or the patient informing the doctor that the side-effects are interfering with his or her work and social life and that another type needs to be tried (a patient-centred, bio-psychosocial encounter).

We can encapsulate the modern approach to the patient–practitioner encounter by outlining the three key factors seen in Table 1.1.

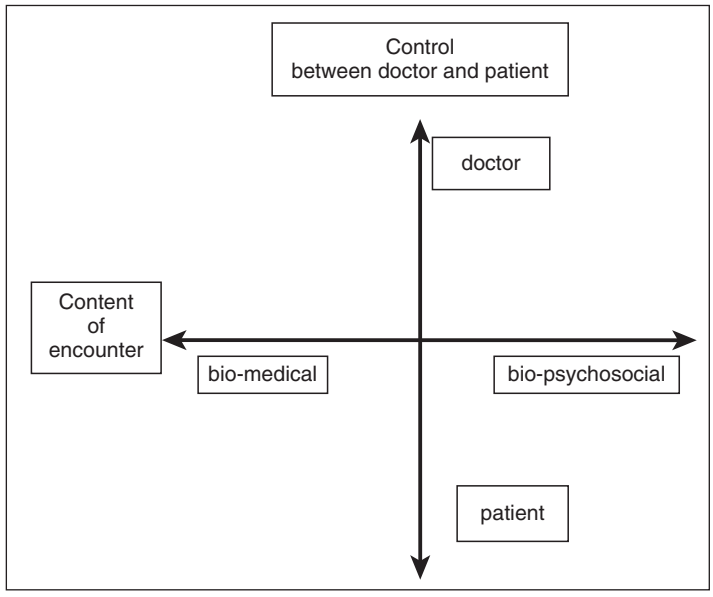

Figure 1.1 Bensing's dimensions of patient-centredness. Repr. from Bensing, 'Bridging the Gap: The Separate Worlds of Evidence-Based Medicine', *Patient Education and Counselling,* 39(1): 17–25; with permission from Elsevier

What is communication?

There is a large number of models and definitions of communication which in itself signifies that communication is a vast topic and difficult to pin down to simple explanation. Communication occurs whenever one person, in some way or another, transmits a message of some sort and someone else picks it up and interprets it. DeVito defines communication as: 'the act, by one or more persons, of sending and receiving messages that are distorted by noise, occur within a context, have some effect, and provide some

Table 1.1 Paradigm of patient-centred care: the three elements

	Consequence	Impact on nursing
Changes in morbidity	People surviving and needing chronic illness management	Shifts focus from biological need to quality of life and self-care
Availability of and access to medical information	Less trust in the 'paternal' system, rise in consumerism and higher patient expectations	Patients become 'experts' in their own care and treatment
Power balance toward the patient	Better educated patient has access to medical information	Patients become active participants in their care; need information and control over their own care

Figure 1.2 Linear model of communication

opportunity for feedback' (1988: 4). This definition implies an interaction of some kind between at least two people. It also suggests that the interaction is two-way—that the person sending the message receives some sort of feedback, even if it is non-verbal, or even silence.

Basic models of communication have key factors in common. They usually represent a sender and a receiver of a message and some form of distortion of the message between the sender and receiver. These see communication as linear, which can be depicted in a simple flow chart (see Figure 1.2).

The sender needs to adapt the message in a way that can be received accurately and the receiver needs to share many aspects of the sender's context (cognitions, culture, language, and symbolism) in order to decode it correctly. For example, if a nurse tells a patient that the doctor is concerned about the patient's 'discharge' (meaning in this case their discharge home from hospital) the patient needs to understand the context of 'discharge' to know whether the nurse means a physical bodily discharge is worrying the doctor or if the doctor is reluctant to send the patient home.

Linear models represent the single exchange of information quite well but often struggle to represent the complexity of communication context and the interference, or 'noise' that is inherent in the communicating process. Circular models attempt this by representing the feedback to the sender and the adjustments the sender can then make. An example is seen in Figure 1.3.

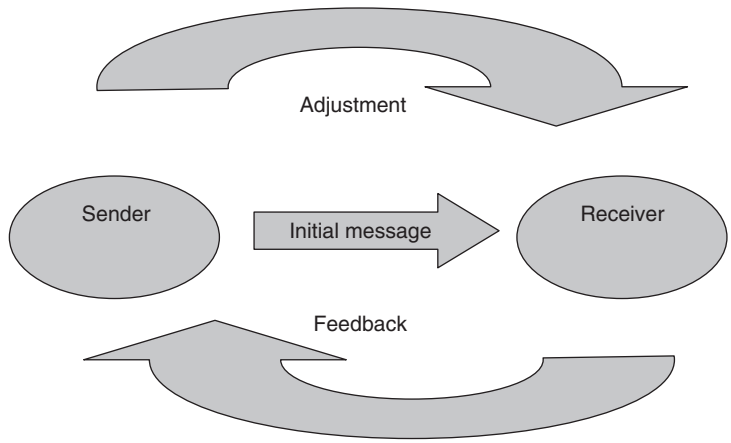

Figure 1.3 Circular model of communication

This type of model shows more than a two-way interaction. In this model the sender is getting feedback on how the message has been received. In our example above, the patient hearing the doctor's concern about discharge asks the nurse where the discharge is coming from. The nurse then adjusts her message and explains that the doctor is worried that the patient might not cope well at home.

Still, the model does not include any explanation about what has caused the misunderstanding. This is often represented in models as 'noise' or interference. A systemic model would attempt to include this important element, see Figure 1.4.

A systemic model acknowledges that the messages to and from the sender are subject to interference, from the very way the message in encoded, through the environmental distortions, to the way the message in decoded. A simple example might be our nurse–patient scenario of misunderstanding the word 'discharge'. The nurse assumes the patient is more aware of her condition than she is and will understand there is no physical discharge present. The patient however has not taken much notice of explanations about her condition but has been concerned about possible physical discharge after her operation; it has been on her mind, unspoken. Therefore, the patient immediately interprets the word 'discharge' to mean a physical process rather than her return home.

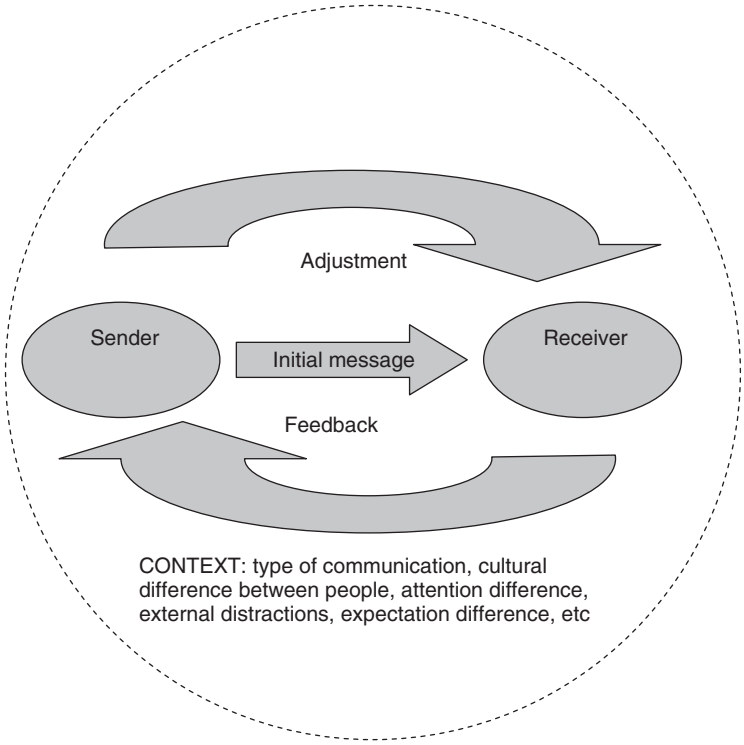

Figure 1.4 Systemic model of communication (simplified)

A more complex scenario might be where a nurse is giving information to worried relatives about the condition of a loved one. The relatives may be too worried to attend to the information objectively and feel more anxious after hearing words which were meant to reassure, such as 'resuscitated successfully' and 'is in intensive care now'. This communication also relies on a quiet and undisturbed environment with no distractions for the family or the nurse. Also, the nurse needs interpersonal skills to understand that the family are likely to be distracted and worried and require simplified language and information in order to understand accurately what the nurse says. See the Practice example box 1.

Practice example box 1: Complex communication

A gentleman with moderate dementia was taken out on a trip to a steam railway. He got confused by the historical nature of the environment and refused to board the train without his wife (who had been dead some years). Rather than tell him bluntly that his wife was dead, the nurse chatted to him about events in his past, including attending a funeral with his daughter, an event he could often recall. The nurse asked him whose funeral it was and he said 'my wife's funeral'. The nurse had used a conversational approach to remind him that he was in the present and that his wife had died some time ago. To do this, the nurse needed time and space with the gentleman to construct a conversation and distract him from anxiously searching for his wife and reorient him to the present.

The gentleman boarded the train and was appropriately sad at remembering his wife's funeral rather than distressed that she was being left behind.

Interpersonal skills

As we can see in the models and example, effective communication relies a great deal on the skills of the message sender and the ability of the receiver to interpret what is being communicated. These aspects of communication epitomize the interpersonal skills of a good communicator. The skilled communicator has information-presenting abilities and good listening skills. In addition, a skilled communicator is aware of and makes allowances for barriers to communication such as cultural differences, the emotional and cognitive states of others and external distractions. Michael Argyle (1983) suggests that the skilful interpersonal behaviour includes:

- *Perception of others' reactions*: The communicator is attuned to the other's behaviour and signs of understanding or misunderstanding.
- *Attention to feedback and corrective action*: The communicator has learnt what kind of response is needed according to the feedback from the other.

For instance, reticence from the other may prompt encouraging remarks or open questioning.

- *Timing of social responses*: This requires the communicator to know when to speak, when to listen, when to interrupt or prompt, or when to take the lead or be led.
- *Self-presentation*: A good communicator has self-awareness and is able to use this self-knowledge to present themselves to the other. This gives the other feedback about who the communicator is and therefore how to interpret and respond to them, for instance, sitting in a forward-leaning position assures the other that they are being listened to.
- *Rewardingness*: This is the ability to engage the other in the communication and know how to reward communication behaviour. For instance, using nods, smiles, and eye contact encourages someone to talk about themselves.
- *Taking the role of the other*: Here the communicator can put themselves in the shoes of the other in order to understand how they are seen. For instance, if they realize that being dressed formally is offputting to a young teenager they can respond by removing a tie or rolling up their sleeves.

Argyle breaks communication skills down into behavioural skills rather than skills of insight, understanding, and cognition. Another definition of good communication comes from Becker *et al.* (1987: 9) who suggest that a skilful communicator: 'must be able to identify the emotions or intent expressed by the other person and make sophisticated judgements about the form and timing of the appropriate response'. In this definition, the skilled communicator uses accurate perception and good judgement to understand the interactions and know how to make appropriate adjustments. It may be that all these factors are part of the skills of a good communicator; that skills are made up of a good sense of reality, awareness of self and others, accurate reading of situations, good timing and ability to use the self to facilitate meaningful and positive communication. Many of these skills can be learnt and developed through practice and through personal development by improving self-awareness and awareness and understanding of other people and their cognitive and emotional states.

Power

Phillips (1978) describes interpersonal skills as:

> The extent to which [a person] can communicate with others, in a manner that fulfils one's rights, requirements, satisfactions, or obligations to a reasonable degree without damaging the other person's similar rights, [. . .] in a free and open exchange.
>
> (Phillips 1978: 13)

By this, Phillips means that a good communicator is equitable; he or she does not need to sacrifice anything of themselves to be understood, or manipulate or expect the other to make sacrifices to understand. This suggests that a good communication results in both parties being satisfied with the communication and neither is left feeling ignored, forgotten, or otherwise ill-used. Therefore, Phillips's version of good communication may exclude communication with a goal to manipulate such as used by a salesman or perhaps a politician!

This brings us on to an important aspect of communication in healthcare: the power differential between a practitioner and a patient. Earlier, we looked at the changing nature of healthcare and used Bensing's dimensions of patient-centredness to identify the type of relationship between a practitioner and a patient. The history of medicine and medical practice shows how the practitioner–patient relationship was one of unequal power; the doctor was the expert and the patient was merely a recipient of his authority and learning. This describes a type of 'paternalistic' relationship of father and child. The culture of medicine and healthcare practitioner–patient relations has, arguably, retained much of this paternal structure in that the power imbalance is often still very much in favour of the practitioner, be they a doctor, nurse, or other health professional. Ellis *et al.* (2003) suggest that power-distorted communication is common in healthcare and is embedded in the language, procedures, and organizational practice that ensures domination by care professionals. Thompson (1986) suggests that health professionals feel better able to obtain compliance and cooperation from patients if they are in control and, when the focus of treatment is to fight the illness, the patient becomes less important in a formalized medical encounter. In such a culture, people who become patients often adopt an inferior position to the healthcare professionals and become passive recipients of care and treatment. Szasz and Hollender (1987) looked at doctor–patient relationship patterns of relating and identified three styles, outlined in Table 1.2. These can apply as much to nurses in modern healthcare, especially where nurses take a clinical lead in many aspects of care.

The changing nature of healthcare demands more patient empowerment in self-care and acknowledgement that the patient is often the best person to understand the context of their own healthcare management. This suggests that many nurse–patient

Table 1.2 Styles of doctor–patient relationship

Relationship style	Description	Characteristics
Activity/passivity	Full exploitation of medical power and authority	Cross-examination: doctor asks questions, patient gives answers
Guidance/cooperation	Doctor allows patient some autonomy and participation	Doctor's agenda dominates. Patient allowed some involvement within doctor's remit
Mutual participation	Both parties accept responsibility to problem-solve	Patient encouraged to use doctor's expertise to solve his or her health problems

Source: Szasz and Hollender, 1987.

interactions are best served by a mutual participation style of relating, if effective long-term health and well-being is the objective of the healthcare professional.

It is important that nurses acknowledge power differentials inherent in patient–practitioner relationships and make those contextual and personal adjustments outlined in Figure 1.4 to facilitate communication. Burnard (1997) recognizes other important power differentials between people that are also relevant to healthcare encounters and may be superimposed on the already existing differentials of healthcare provision itself, such as between people of different sexes and gender, ethnicity, culture, ability and disability, and social class. Also, for many cultures, age difference can be a source of power differential.

Nurses are expected to work in anti-oppressive and anti-discriminatory ways in accordance with NMC requirements to respect diversity and challenge inequality, discrimination, and exclusion from access to care (NMC, 2010). Colin Goble (2009) suggests that the nursing profession has been slower than professions such as social work to pick up on this professional requirement, perhaps because the shift from institutional to person-centred community-based care is relatively recent in nursing. However, for Goble, improved empowering care requires nurses to develop such practice through individual and collective reflection in order to ensure equal access to, and delivery of quality care.

Application of communication in nursing

Methods of communication

The model in Figure 1.2 suggests that the message from one person to another is encoded in some form and transmitted to the other. This encoding can form many types of format of transmission, or several types combined. For example, a person who does not want to engage in a conversation formats the information to the other by giving short answers or mumbling (vocal channels), reduced eye contact, and folds their arms (body language). They might also try to change the conversation, look at their watch (behaviour) or simply bluntly state they do not want to talk (verbal). Additionally, they could write this down or use other and more sophisticated tools for communication such as use sign language, flash cards, or even send a text message! DeVito (1988) states that communication is inevitable, no matter what we do, even silence or not responding says something to the other person. All behaviour, whether verbal or non-verbal, intentional or unintentional, is a form of communication, including how we move, dress, walk, or use touch. As communicators, nurses need to be aware of their own intentional and unintentional messages and also be skilled in reading the messages of others.

Practice example box 2: A reluctant patient

A shy teenage boy presenting with depression was proving to be difficult to engage in any conversation during a school visit. He had his arms and legs crossed, avoided eye contact and only gave me 'yes', 'no' and 'don't know' answers. I found I was virtually talking to the wall.

We sat in an office-cum-storage room for privacy and the room contained stacked stage and MC equipment. He frequently looked away from me at the equipment, and I read this as reluctance and discomfort in talking to me about his feelings. After some silence, I changed my focus and asked him conversationally 'what *is* all this stuff?'

He said something like 'It's MC stuff for school discos and so on.' He suddenly sounded confident and on surer ground so I asked him to explain what it all was. At this, he became quite animated and it appeared that he had an ambition to do MC-ing as a hobby or career but never got the chance with the equipment. The conversation turned back to him and his frustrations. A stroke of luck that we happened to sit in that room, but no accident that I read his communication and attempted a different tack. I call this *'going fishing'* when I'm with a reluctant interviewee—trying other avenues of conversation and topic to get the words flowing.

See the Practice example box 2 of a reluctant patient. This shows the unintentional communication of the boy and how it was picked up by the nurse. Notice that the nurse does not know the change of talk will work, but that attempting to 'go through the door' he was opening made a breakthrough.

DeVito also points out that communication is inevitable. When we send a message that is picked up by someone, its stays sent. We cannot unsay or negate the message, though we might need to modify its effect. Take a heated argument as an example. We've all been there and said something we later wish we hadn't. We might then try to reduce the damage by apologizing, or attempt to qualify and explain what we meant. What we are doing in fact is trying to change the message received. For nurses in a professional role, we need to maintain a professional standard of behaviour in our communications with patients, relatives, and colleagues in order to maintain effective working relationships.

Chapter 4 looks at channels of interpersonal communication in more detail.

The nurse–patient relationship

The relationship between the nurse and the patient is often seen as a therapeutic relationship in itself where it is based on partnership, intimacy, and reciprocity

(McMahon, 2002). Its purpose is different to a social relationship in that it has a focus on the patient's well-being as a priority and the nurse and patient do not need to have anything in common or even like each other (Arnold and Boggs, 2006). This relationship can last only five minutes in an Accident and Emergency Department or primary care practice, or continue and develop for months or years during chronic illness management. It can be intensely personal when breaking bad news, or quite superficial such as when directing a patient to the appropriate clinic room. However, all these scenarios are nurse–patient encounters that impart to the patient something of the support and meaningfulness of their engagement with healthcare. It tells the patient whether they are viewed as important, valued, whether they will be listened to or discriminated against.


Chapter 2 examines the nurse–patient relationship in depth.

The nurse as a member of the multidisciplinary team

Nurses do not work with their patients in isolation. Nurses are members of multidisciplinary teams that should be co-ordinating their roles and expertise to provide the best care for patients. The NMC stipulates a level of competence in working effectively across professional and agency boundaries in its standards for pre-registration education (NMC, 2010). To qualify as a nurse, therefore, students should be able to contribute to teamworking by understanding their own role in the team, respecting the role of others, and managing the resources available within the team for the benefit of their patients. Working with others from different professional backgrounds, and often with different priorities, can be challenging but it is often the nurse who takes the lead in coordinating health- based care by using good communication and management skills to provide a holistic care package for the patient. Nurses working with children will need to understand their specific role in safeguarding children, and nurses working with patients and families with social and psychological needs will also need good skills to work collaboratively with other care professionals to deliver integrated patient care.

Health and social care teams offer particular challenges for a range of historical organizational reasons. Thompson (1986) suggested that, traditionally, healthcare teams have often been little more than a series of individuals with responsibilities for different 'parts' of the patient's care and treatment and each individual in the team is inclined to act in their own sphere of expertise, with little consultation or information-sharing with others. The transformation of healthcare delivery from institutions to community-based care, the ethos of holistic care for the whole patient and improved technology, for McCray (2009) has changed the focus toward multi-professional practice.

Goble (2009) suggests several existing challenges to multi-professional working:

- power relationships between different professions;
- competing roles between organizations;
- differences in traditions and cultures between service agencies and professions;
- defending professional identity.

Goble suggests that different professions have different priorities for care to fulfil their roles and different traditional ways of exercising power. For instance psychiatrists may focus on a patient's symptom control while mental health nurses may focus on the patient's quality of life; social services may prioritize an unwell schizophrenic person's rights to liberty while the medical profession will be mindful of the need to protect the public. Additionally, Goble suggests that different professions can feel threatened by a loss of clear role and adopting a 'siege' mentality.

Thompson (1986) suggested barriers of traditional professional practices and identities over twenty years ago that may still stand in the way of integrated and coordinated multidisciplinary teamworking. Outlined below, they appear scarily similar to Goble in 2009.

Traditional professional practices

Different professions have different traditions and cultures of communication. Doctors, for instance, may prioritize and record physical information in medical notes, often using formalized language, symbols, and abbreviations that have highly medical meaning, not understood by other professions. Nurses too can exclude other professions from information through the nurse-only tradition of handovers between shifts.

Professional identities

Different professions may feel threatened by other professions bringing new methods or expertise in promoting patient care. Protective practices of professional identity may include information withholding, disengagement from the care role, or even a 'battle' for supremacy to be the key care coordinator. None of which will benefit the patient.

The dynamics of teams can often be complex and can take on a destructive and obstructive identity. The structure and processes of groups will be examined in Chapter 5 of this book, which will also illustrate how the communication and interpersonal skills of the individuals involved are essential in identifying and avoiding the types of destructive behaviour that limits the effectiveness of a team approach to patient-centred care.

Conclusion

This chapter presents an argument that communication between the nurse and the patient is therapeutic in itself. Additionally, good communication aids the process of healing and care, while poor communication can be a barrier to good care. The relationship between any health practitioner and the patient has changed over the years as our understanding of health and the factors that impact on health have changed. No longer

is health delivered in a patriarchal 'doctor knows best' approach, but the patient is considered to be an expert in their own health needs. This has led to an approach to care and treatment that is a partnership between practitioner and patient which changes the approach to communication and interpersonal relating greatly between the nurse and his or her patient.

A note on the structure of the book and terminology

This book is intended for nurses in education and training and newly qualified nurses. The chapters in this book are organized so that take the student through the process of understanding the theory of interpersonal communication in Part I, appreciating how this theory is applied to practice in Part II, and subsequently developing skills in practice in Part III. At the beginning of each part, you will find a short overview outlining the scope and breadth of content in that section.

Chapters are written to apply to all fields of care and strive to address the needs of all or any nurse in a range of settings. Some practice examples given in the chapters may appear to be specific to one particular field of care, for example, a case study in A&E, or working with children. However, each scenario can be applied across a range of practice areas and the communication skills being addressed are applicable to all fields of care. Therefore, each chapter has something to offer nurse students pursuing any particular care area.

It is recognized that different fields of nursing care may use different terminology for patients, carers, service users, and so on. We have chosen to refer to recipients of direct care as 'patients' and family members or informal carers are referred to as 'carers'. We have also used the term 'young people' to differentiate younger children from adolescents, as the needs of these two age groups can often be very different according to their psychological and social developmental stages.

Also, we have attempted to make clear that references to patients, family members, and nurses in general that are not gender specific by referring to these groups as 'he or she', or 'they' singular. However, some authors may refer to a nurse as gendered because the author is identifying with the nurse.

To find more resources to aid your learning please now go online to www.oxfordtextbooks.co.uk/orc/webb

Further reading

Burnard, P., and Gill, P. (2008) *Culture, Communication and Nursing*. Harlow: Pearson Education.

McCray, J. (2009) *Nursing and Multi-Professional Practice*. London: Sage.

References

Arnold, E., and Boggs, K. (2006) *Interpersonal Relationships: Professional Communication Skills for Nurses.* London: Elsevier.

Bateson, G. (1979) *Mind and Nature*. New York: Dutton.

Becker, R., Heimberg, R., and Bellack, A. (1987) *Social Skills Training for Treatment of Depression*. New York: Pergamon Press.

Bensing, J. (1991) *Doctor–Patient Communication and the Quality of Care: An Observation Study into Affective and Instrumental Behaviour in General Practice*. Utrecht: Nivel/Utrecht University.

—— (2000) 'Bridging the Gap: The Separate Worlds of Evidence-Based Medicine and Patient-Centred Medicine', *Patient Education and Counseling,* 39: 17–25.

Burnard, P. (1997) *Effective Communication Skills for Health Professionals* (2nd edn). Cheltenham: Stanley Thornes.

Crow, R., Gage, H., Hampson, S., Hart, J., Kimber, A., and Thomas, H. (1999) 'The Role of Expectancies in the Placebo Effect and their Use in Delivery of Health Care: A Systematic Review', *Health Technology Assessment,* 3(3): 1–96.

DeVito, J. (1988) *Human Communication: The Basic Course*. New York: Harper & Row.

Department of Health (1992) *The Patients Charter*. London: DoH.

—— (2000) *The NHS Plan*. London: DoH.

—— (2001*a*) *The Expert Patient: A New Approach to Chronic Disease Management in the 21st Century*. London: DoH.

—— (2001*b*) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: DoH.

—— (2003) *Essence of Care: Patient Focused Benchmarks for Health Care Practitioners.* London: DoH.

—— (2006*a*) *Our Health, our Care, our Say.* London: DoH.

—— (2006*b*) *The Care Service Improvement Partnership: Integrated Care Network. Strengthening Service User and Carer Involvement: A Guide for Partnerships*. Discussion Paper, London: DoH.

Ellis, R., Gates, B., and Kenworthy, N. (2003) *Interpersonal Communication in Nursing: Theory and Practice*. Edinburgh: Churchill Livingstone.

Goble, C. (2009) 'Multi-professional Working in the Community', in J. McCray (ed.), *Nursing and Multi-professional Practice*. London: Sage.

Kamarck, T., Peterman, A., and Raynor, D. (1998) 'The Effects of Social Environment on Stress-Related Cardiovascular Activation: Current Findings, Prospects and Implications', *Annals of Behavioural Medicine,* 20: 247–56.

Kwekkeboom, K. (1997) 'The Placebo Effect in Symptom Management', *Oncological Nursing Forum,* 24(8): 1393–9.

Letvak, R. (1995) 'Putting the Placebo Effect into Practice', *Patient Care*, 29: 93–102.

McCray, J. (2009) 'Preparing for Multi-Professional Practice', in J. McCray (ed.), *Nursing and Multi-Professional Practice*. London: Sage.

McMahon, R. (2002) 'Therapeutic Nursing: Theory Issues and Practice', in R. McMahon and A. Pearson, *Nursing as Therapy.* Cheltenham: Nelson Thornes.

Ogden, J. (2004) *Health Psychology: A Textbook*. Buckingham: Open University Press.

Phillips, E. (1978) *The Social Skills Basis of Psychopathology*. New York: Grune and Stratton.

Szasz, T. and Hollender, M. (1987) 'A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor–Patient Relationship', in J. D. Stoeckle (ed.), *Encounters between Patients and Doctors: An Anthology*. Cambridge, Mass: MIT Press.

Thompson, T. (1986) *Communication for Health Professionals*. New York: Harper & Row.