

HEALTHCARE COMMUNICATION FOR VIRGINIA COMMUNITY COLLEGE
SYSTEM NURSE AND ALLIED HEALTH PROGRAMS: AN INTERDISCIPLINARY
APPROACH TO RELATIONAL COMMUNICATION

by

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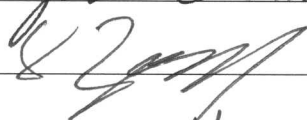
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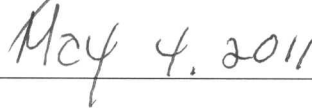


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Healthcare Communication for Virginia Community College System Nurse and Allied
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A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Arts at George Mason University

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DEDICATION

This is dedicated to the memory of my beautiful mother, Mary E. Piar. Thank you to my dear husband, Erle, who has encouraged me from the very beginning. Thanks to my sister, Margaret, and my brother, Richard, my two best friends in the entire world.

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The long journey to the finish line is dappled with unexpected events of average, ordinary, and extraordinary happenings. The happiest events involve my family and their support, and teaching; the saddest events involved the death of my parents. My goal for this study never changed. It was and is to provide community college students in the nurse and allied health programs the skills they need to effectively communicate with patients and others in their lives.

Dr. Victoria Salmon, my dissertation chair, is an extraordinary teacher, guide, and friend. It was her encouragement that pushed me to complete this dissertation “oeuvre.” While it may not be the sum of my life, it is a large portion of the past decade as my parents slowly succumbed to the illnesses of old age. I cannot thank her enough. My committee member, Dr. Don M. Boileau, was the first to introduce me to the sheer joy of communication study. His incredible knowledge of the discipline along with his exceptional teaching skills inspired me to pursue a doctorate with a communication specialty. I also give grateful thanks to my other committee member, Dr. Jeanne Sorrell, for so graciously accepting a place on the committee even with the limited time in her schedule. I knew there was a connection when I learned she planned to move to Cleveland for retirement—my hometown and the location of my family. I hope there will be many conversations on healthcare communication in the future.

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Finally, I would like to thank all the participants in the focus groups. Their warm reception and enthusiasm was a joyful experience.

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ABSTRACT

HEALTHCARE COMMUNICATION FOR VIRGINIA COMMUNITY COLLEGE SYSTEM NURSE AND ALLIED HEALTH PROGRAMS: AN INTERDISCIPLINARY APPROACH TO RELATIONAL COMMUNICATION

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George Mason University, 2011

Dissertation Director: Dr. Victoria N. Salmon

This study examines communication skills in the nurse–patient communication process through interdisciplinary data from the nurse and communication fields. The call for improved communication competency over the last 20 years, and the low rate of skill retention from remedial on-the-job communication workshops, confirm the need for improved communication training at the educational level. Research substantiates improved patient outcomes and patient satisfaction when relational communication is utilized in the nurse–patient relationship. Problems in creating an effective healthcare communication course are the absence of a theoretical framework and a multitude of definitions describing communication concepts and skills.

Community colleges educate over 60% of the nation’s nurse and allied health professionals, yet few Virginia community college nurse or allied programs require a communication course. Communication training is provided within clinical courses and

frequently utilizes a task-oriented approach. Findings show an interrelationship between conceptualized behaviors, such as therapeutic behaviors and interpersonal skill behaviors, within relational communication that is not apparent in task-oriented communication training. A model healthcare relational communication course was designed to fill the gap between education and practice for communication competence for nurse and allied health students. The model's framework is communication relational theory, which includes both conceptual behaviors and multidimensional interpersonal skill behaviors.

I. INTRODUCTION

In the film *Wit* (Nichols, 2001), actress Emma Thompson plays Dr. Vivian Berry, a respected English professor at a large university who is diagnosed with cervical cancer. After years of esteem as a professor, researcher, and colleague, she faces 8 long months confined to university hospital rooms while slowly losing ground to her disease. Vivian suffers further humiliation at the hands of one of her former male students, now the hospital gynecologist, who abruptly flies off the handle at his own acute embarrassment when he examines her. No thought is given to his patient's own mortification. She stoically suffers prodding and poking, as well as horrific pain, while her "colleagues" communicate to her in professional tones. No one talks to her as the patient she is—a scared, lonely, older woman who is dying. In the name of science and research, her identity as a person is lost; she is a "disease." Of all the doctors, nurses, and technicians, only one person makes a relational connection, a nurse named Evelyn. She covers Vivian when she is exposed, puts cream on her hands when they are dry, and sits beside her when Vivian is at her lowest. In one scene, Evelyn touches Vivian's thin arm and shares a Popsicle while discussing the "Do Not Resuscitate" document.

Nurses are the most frequent point of contact for patients, and other than medical outcomes, the most common denominator that determines patient satisfaction (Abdellah & Levine, 1957; Fleischer, Berg, Zimmermann, Wuste, & Behrens, 2009); Salimbene,

2004). Nurses are those Florence Nightingales who devote their lives to the care of others. They are perceived as concerned and caring professionals, but are they all adept at reading nonverbal cues? In the movie *Wit*, cancer patient Vivian Berry exhibits all the nonverbal signs of depression, pain, and sadness, but seldom is her nonverbal communication interpreted by the healthcare professionals surrounding her.

While medical knowledge and expertise are at the forefront of good healthcare, communication skills are *crucial* to the patient's well-being. Communication skills are rarely innate; they are learned behaviors taught in the classroom and applied through experience. Nonetheless, in this age of shortened stays in the hospital, outpatient surgery, and overworked nurses, communication skill acquisition becomes secondary in healthcare programs, usually incorporated in task-oriented clinical courses. One of the first course requirements to go, in the rush to fill the growing shortage of nurses, is the communication course (see, for example, Appendix A and Smith & Pressman, 2010). Yet, the last 20 years of literature consistently emphasize the essential need for communication skills in treating patients.

Communication in the healthcare environment encompasses interpersonal communication skills and relational communication. Interpersonal skills cover two equally important, self-directed behaviors: the ability to communicate effectively with others and the skill to interpret the expressions of others (Duggan, 2006; West & Turner, 2006). Interpersonal skills incorporate a multitude of behaviors while transmitting a message, for example, facial expressions and tone of voice. These skills are associated with relationship and express how both the message and the individual are understood.

Relational communication goes hand-in-hand with interpersonal communication skills, for any relationship is enhanced by competent and well-meaning communication that expresses intrinsic or symbiotic concern. Relational skills, also categorized as behaviors, are abstract concepts that reveal caring or non-caring attitude toward an individual or group. These particular behaviors exhibit the level of empathy, defined as the ability to put oneself in someone else's shoes, and determine the degree of trust and confidence an individual elicits from others (Finch, 2006; Wood, 2000). Finch (2006) states, "Even with the enlightened framework offered by Peplau [1952], nurses still do not precisely know the specific behaviors that promote the development of a nurse-patient relationship or exactly what type of communication processes enhance that relationship" (p. 15).

Both relational communication and interpersonal skills are essential in the interaction process, not only with the patient, but also with the patient's family (Abramowitz, Cote & Berry, 1987; Clukey, Hayes, Merrill, & Curtis, 2009; Rubin, 1990). "Taking time to be present with the family, getting to know them, and showing a personal interest in the family as a whole unit are critical to the demonstration of caring by the nurse" (Clukey et al., 2009, p. 73).

Communication competence facilitates relationships and plays a vital role in the patient's health. Both nurse research (e.g., Latham, 1996; Razavi & Delvaux, 1997; Sherwood, 1997) and health communication research demonstrate that disease prevention, the recovery process, patient compliance with treatment, and basic quality of life rely, to a significant extent, on communication skills (e.g., Fleischer et al., 2009; Kreps, O'Hair & Clowers, 1994). As cited in Fleischer et al., (2009), "The patient's

perception of the quality of the communicative relationship with a health-care provider is associated with both patient satisfaction and compliance, in this way influencing the process of care and eventually its outcome (Vivian & Wilcox, 2000)” (p. 345). A not-so-subtle underlying theme in the movie *Wit* raises the question of whether the final outcome could have been changed or, at least, could have lessened the distress of Berry’s final days. Had she been treated as an individual rather than a “disease,” she may have chosen a less aggressive and less painful treatment regime. While terminal outcomes generally do not change, research validates a strong association between more positive physical outcomes and the use of skilled relational communication.

The current research literature review confirms a need to improve communication skills at the educational level for all healthcare professionals. Few of the short-term remedial communication seminars provided through on-the-job communication training interventions have been successful (see, for example, Bowles, Mackintosh & Torn, 2001; Chant, Jenkinson, Randle, Russell, & Webb, 2002).

A specific aim of this research is to provide a framework and operationalized skill set to be used in a healthcare communication course for nurse and allied health students in the Virginia community college degree and certificate programs. Virginia community colleges do not offer a specific—or even a general—applicable communication course in healthcare programs. An interdisciplinary conceptualization of relational communication concepts based on the literature review provides a theoretical framework and an operationalized skill set that can be incorporated into a specific—and generalizable—healthcare communication course. Students could significantly benefit from a

communication course designed for relational and interpersonal skill acquisition. A course model, initially designated with the 195 trial indicator, Communication Studies and Theatre course CST 195 Healthcare Relational Communication, could eventually be given permanent status in the master course listing of the Virginia Community College System (VCCS). A model syllabus with activities for the 3-credit course is provided. Workforce modules, tailored to community healthcare organizations such as assisted living, can be extracted from this model.

II. THE PROBLEM

The basic problem, as supported by the literature, is the recurring need for improved communication skills in the interaction and relationship process between healthcare professionals and patients. Research findings in patient satisfaction studies over a 30-year span consistently and repeatedly corroborate that effective communication by nurses in their interactions with patients calls for major improvement (i.e., Burroughs, Davies, Cira, & Dunagan, 1999; Chant et al. 2002; Clukey et al., 2009; Duggan, 2006; Fisher, 1981; Fleischer et al., 2009; Peplau, 1987; Rubin, 1990).

Three specific areas emerge from the research that effectively identify the reasons for this continuing communication problem: a lack of communication training opportunities at the educational level, a deficiency in coherent definitions of healthcare communication terms, and an absence of a single theoretical framework from which these skills are taught.

Statement of the Problem

While most baccalaureate degrees in nursing require or suggest an interpersonal communication course in the junior year, no such requirement exists for the 2-year associate's degree in nursing (ADN), the associate degree in dental hygiene, the certificate for practical nurse (PN), or other allied health certificate programs offered in

the Virginia Community College System (VCCS). Six community colleges require a communication course in their nursing program. Of these six, only two recommend Interpersonal Communication (CST 126) as one of the choices. Depending on the VCCS college, the standard recommended communication course choice or the optional electives in nursing programs are either Public Speaking (CST 100) or Introduction to Speech Communication (CST 110). Three offer Introduction to Theatre or Introduction to Film as an alternative (Figure 1). A listing of communication course requirements by college is in Appendix A.

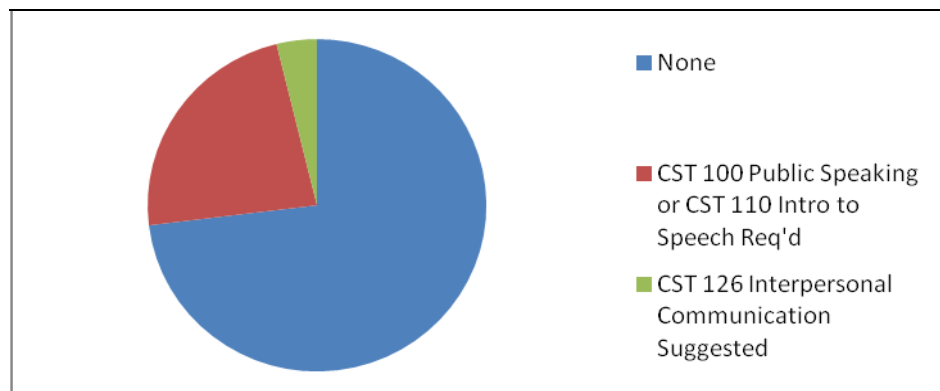


Figure 1. Communication course required in Virginia Community College System nurse and allied health programs. Note: CST = Communication Studies and Theatre.

Communication skills training, such as interviewing, cultural awareness, and conflict management are integrated in some nurse clinical courses; however, each course emphasizes *clinical* content rather than *communication* content. The communication behavior taught is frequently associated with a task, or is task-oriented, rather than with a relational behavior. In the communication discipline, both the general introduction

communication course (CST 110) and the public speaking course (CST 100) contain some elements of relational, interpersonal, and small group communication; however, neither course emphasizes both the relational and interpersonal aspects so important in healthcare contexts (Virginia Community College System [VCCS] Master Course File, n.d.). The existing VCCS interpersonal communication course, CST 126 Interpersonal Communication, addresses some of the relational areas needed in healthcare, but most often the course centers on individual, sustained, interpersonal relationships, such as marriage and family (VCCS Master Course File, n.d.). A healthcare communication course, while generalizable to all relationships, could provide the learning outcomes specific to communicating with patients in an effective and relational manner. The course also can supply multiple communication skills to be used in various healthcare contexts, including the nurse–physician relationship and coworker relationship.

Theoretical Framework

Parks' (1977) relational communication theory is the overarching structure in which this current research created the course and learning objectives. Relational theory fits well with a healthcare communication course as the theory approaches any interpersonal communication as a two-part process: the actual message content and the relational content. For example, when the nurse asks a patient, "From 1-10, what is your pain level today?" the message content is asking for an evaluation of pain. The relational content of this message is in the nurse's tone of voice, eye contact, and patient's perception of the question (for example, whether the patient trusts the nurse or fears a reproach for complaining).

A framework for the elements and assessment criteria to teach the healthcare communication course that fits well into the overarching relational theory is the Duran and Spitzberg (1995) Cognitive Communication Competence Scale (CCCS) derived from their previous research (Duran, 1992; Spitzberg, 1983; Spitzberg & Hecht, 1984). The model addresses three components of communication competency: knowledge of the appropriate communication behavior, skill to perform that behavior, and motivation to be effective (Spitzberg & Cupach, 1984).

The CCCS conceptualizes the overarching relational communication theory, providing a solid theoretical and applicable framework upon which this current research constructed and designed a course in healthcare communication. This application resolves one of the main problems addressed in the literature review: the lack of a cohesive framework to teach relational communication and interpersonal communication skills.

Research Questions Investigated

Communication is an essential component in healthcare. Interpersonal communication skills provide the basis for relational interaction between the nurse–patient and the healthcare professional–patient. Patient satisfaction and well-being are determined by skillful communication, in particular in the nurse–patient relationship. Currently, educational trends do not address teaching relational communication or interpersonal skills to the degree required for applicable proficiency. Without an overall framework and conceptualization of relational communication, and caring and behavior terminology, communication skills are taught in a fragmented way, often linked to task-

specific clinical skills rather than occurring in interactional processes. Therefore, the following questions were addressed in this study:

1. Is there a need for improved communication skills within the nurse and healthcare professions?
2. Does a communication discipline, relational theoretical framework offer a comprehensive structure that would include both the communication and nurse disciplines' conceptualized definitions of healthcare communication skills?
3. Would a healthcare communication course at the community college level improve communication skills for nurse and healthcare graduates of Virginia community colleges?

Delimitations and Limitations

Limitations of this current study occur in the variety of terminology used to define relational communication and interpersonal skills within the nurse research. Much of the nursing literature includes skills terminology as an element within more complex relational phrases, such as *patient satisfaction* and *caring behavior*. A delimitation in the communication research is the timeframe before 2003, when the majority of communication research in the medical field concentrated on the doctor–patient relationship. These pre-2003 studies mainly deal with clinical interviews between doctor and patient rather than with the nurse–patient or other healthcare relationships, such as the technician–patient interaction.

A limitation in both disciplines is the lack of research on a specific theoretical framework from which to teach relational and interpersonal communication skills. Finally, because of privacy rules regarding patient interviews as proscribed by the Health Insurance Portability and Accountability Action of 1996 (HIPAA), no patients were interviewed in this study. Focus groups were limited to a representational group of nurse and allied health faculty in three VCCS community colleges and one regional hospital. For the definitions of terms see Appendix B.

III. REVIEW OF THE LITERATURE

Background

A brief background on the nursing shortage, and the importance of the community college's role in educating nurse and allied health professionals, provide the context for this study's emphasis on healthcare communication training in VCCS nurse and allied health programs.

A critical nursing shortage is a major problem in our nation. By 2020, the U.S. will require more than a million nurses (Center for Health Workforce Studies, 2007; Cleary, McBride, McLure, & Reinhard, 2009; U.S. Bureau of Labor Statistics, 2008-2009). Community colleges play a paramount role in educating nurses and other allied health professionals. According to the American Association of Community Colleges (AACC) (2008), "More than 60 percent of the nation's newly registered nurses and the overwhelming majority of allied health professionals are educated by associate degree (two-year) programs" (para. 1). Roxanne Fulcher (2002, 2008), Director of Health Professions Policy at the AACC, states that 75.1% of community college nurses remain in the same state where they obtained their license, as compared to 5.6% of 4-year degree nurses. Additionally, 73% of rural area nurses receive their education from community colleges. Community colleges educate 63% of the nation's allied health professionals

including, but not limited to, dental hygiene, emergency medical services, occupational and physical therapy, radiology, and speech pathology (Fulcher, 2008).

The Virginia Community College System (VCCS) has a strategic role in providing qualified nurses and healthcare professionals to the citizens of the Commonwealth. Between 2010 and 2020, Virginia faces a 43% increase in the demand for nurses (U.S. Department of Health and Human Services, 2002). In addition, the number of Virginia nurses leaving the workforce by 2015 will exceed the number of new nurse graduates (Virginia Initiative for Nursing Education, 2006).

In 2003, the Virginia General Assembly tasked the State Council of Higher Education for Virginia (SCHEV), in cooperation with higher education institutions, the Board of Nursing, and the Advisory Council on the Future of Nursing in Virginia, to ensure a sufficient amount of nurses for Virginia (House Bill 2818, 2003; House Bill 2818 Amended, 2003). The problem in producing an adequate supply to meet the demand is twofold: a shortage of qualified faculty to teach in nursing programs, and a lack of capacity to accommodate student applicants (State Council of Higher Education for Virginia [SCHEV], “Condition,” 2004). In response to this legislation, SCHEV published its own strategic plan of action (SCHEV, “Strategic Plan,” 2004). In response to the plan, the VCCS initiated an expansion of their nursing programs throughout the Virginia college system (VCCS, 2009; Virginia Community College System & Virginia Hospital and Healthcare Association, 2005). Of the 23 VCCS community colleges, 22 currently offer the associate degree of applied science in nursing (ADN), and 14 offer practical nursing (PN) programs (Virginia Community College System, 2009) (See

Appendix A). In 2007, graduates from nursing programs in the VCCS reached 1,265, a number substantially higher than the 816 graduates in 2003 (Virginia Community College System, 2009).

Not only do community colleges provide more than half of the registered nurses (RNs) in Virginia, but community colleges also deliver high-quality education. According to a 2007 report, 87.2% of Virginia associate degree RNs pass the licensure exam on the first attempt (Virginia Board of Nursing Education Programs, 2008). Nationally, the first-time passing rate for associate degree RN students is 84.8%, comparable to 86.4% of baccalaureate degree holders (National Council of State Boards of Nursing, 2007).

Community colleges, just as baccalaureate institutions, adhere to standards of quality in educating their students. In the nursing field, the National League for Nursing (2000) identified communication skills as a core component and competency required for graduates of the associate degree in nursing.

Literature Search on Nurse–Patient Communication

Scholars from the communication and nursing disciplines emphasize relational and interpersonal skills acquisition in both data-based and descriptive studies; both disciplines make the plea for a comprehensive theoretical basis to define the teaching of these skills. Using an interdisciplinary approach in this review, core terms and concepts were extracted in order to create a cohesive conceptualization of terminology in both disciplines. The pertinent literature represents the viewpoint of both communication and nursing scholars on common fundamental concepts of relational communication and

interpersonal skills. This review examined (a) communication needs of healthcare professionals as reported in patient satisfaction research, (b) conceptualizations of the fundamental elements involved in relational and interpersonal communication, (c) the necessary theoretical communication framework in teaching communication skills, and (d) the success and failure of nurse communication training over the past 20 years.

The following databases were used for the review: CINAHL, MEDLINE, Communication Abstracts, Dissertation Abstracts, Communication and Mass Media Complete, and Social Sciences Citation Index. Search terms included *nurse–patient*, *nurse–patient relationship*, *nurse–patient communication*, *patient satisfaction*, *patient satisfaction–nurse*, *interpersonal–patient*, *interpersonal–nurse*, *interpersonal communication–nurse*, *relational–nurse*, and *relational communication*. Both data-based and descriptive studies were included. English language publications from the United States, Canada, the United Kingdom, Europe, Australia, and Taiwan were included. The time period covered relevant information from 1940 to 2009. Key terms included were *nurse*, *nurse aide*, *Emergency Medical Technician*, *x-ray technician*, and *dental hygienist*. The review did not include literature specific to doctor–patient communication.

The following categories were identified from this body of literature and are used to organize the review: conceptualization of patient satisfaction, patient satisfaction and nursing, nurse–patient relationship, and role of the communication discipline in healthcare.

Evolving Conceptualization of Patient Satisfaction

The concept of patient satisfaction is comprised of both the needs of the patient and the goals of the healthcare provider. Research on patient satisfaction dates back to the 1940s (Di Palo, 1997). In the 1950s, Peplau's (1952) seminal and revolutionary work, *Interpersonal Relations in Nursing*, emphasized the nurse–client relationship. Little follow-up on the patient satisfaction concept was done in the 1960s and 1970s. A renewed interest in the concept of patient satisfaction in the 1980s resulted from three factors in these two decades: societal demand for more consumer satisfaction (Pellegrino, 1999), the change to a managed healthcare system (Thiedke, 2007), and organizational desire for feedback on “the quality of nursing and medical care” (Avis, Bond, & Arthur, 1995, p. 317).

In the 1960s, hospitals initially began using surveys to assess quality of care from a continuous quality improvement (CQI) perspective rather than from a personal perspective (Ware, Davies-Avery & Stewart, 1978). Questions reflected a consumer's point of view on medical and technical competence. The purpose of the surveys was to improve hospital effectiveness in order to meet CQI goals, which frequently translated into additional federal or state funding. This type of survey, however, left out the interpersonal aspect, the person-to-person relationship between doctor–patient and nurse–patient (van Campen, Sixma, Friele, Kerssens, & Peters, 1995). In 1976, Ben-Sira revisited the importance of regarding the patient as a *person* rather than an illness. The development of validated instruments to measure a more complex patient satisfaction

survey to include the interpersonal relationship was finally initiated in the 1970s (e.g., Linder-Pelz, 1982; Ware & Snyder, 1975).

In the 1980s, studies and surveys began treating patient satisfaction as a multidimensional construct. Brown, Stewart, and Ryan (2003) note that patient assessment should have included both the provider's technical competence, "as well as the quality of the provider-patient interaction" (p. 142). In a review on patient satisfaction surveys, Cleary and McNeil (1988) identified the characteristics needed by healthcare providers for patient satisfaction: communication skills, caring, and empathy. Pascoe (1983) characterized patient satisfaction as "a health care recipient's reaction to salient aspects of the context, process, and result of their service experience" (p. 189). Roter et al. (1995) found that at the highest level of patient satisfaction, communication skills that were equally balanced between the psychosocial and the biomedical were used. In a study of older American patients, the most common reasons for dissatisfaction with a health provider included "attitude" or "personality" (Weiss & Blustein, 1996).

Patient Satisfaction and Nursing

The nurse-patient relationship is a key component in patient satisfaction. The majority of studies found that the nurse-patient relationship was more influential than the physician-patient relationship. As early as the 1950s, Abdellah and Levine (1957) stated that nursing care was the major portion of service to patients in hospital care, and encompassed the greatest role in patient satisfaction. Leiter, Harvie, and Frizzell (1998), in a follow-up study, illustrated the significance of the nurse-patient relationship. Their findings showed that patient satisfaction with nursing care also "affects patient

satisfaction with the care provided by doctors” (p. 1615). Additionally, in research on hospital inpatient satisfaction, overall satisfaction consistently related more strongly to nursing care than any other patient–provider relationship (Abramowitz et al., 1987; Fleischer et al., 2009; Greeneich, 1993; Rubin, 1990; Yellen, 2003). Paulsel, Richmond, McCroskey, and Cayanus (2005) explored patients’ perceptions of the competence and caring dimension of source credibility as it related to physician, nurse, and support staff. The study discovered a strong correlation to the nurse–patient caring perception, but only a moderate correlation to the doctor–patient perception and the staff–patient perception. Sitzia and Wood (1997) state that “the patient’s judgments of the manner of professionals and the way that care was delivered exerted a high influence on levels of perceived satisfaction” (p. 1833).

In a 1984 to 1998 review of the literature on nursing–patient relationships (Suikkala & Leino-Kilpi, 2001), findings illustrated that most patients perceived and evaluated affective behaviors. The affective domain involves internal qualities of an individual, for example, attitudes, beliefs, behaviors, and emotions. In healthcare situations, these affective behaviors reflect the health provider’s attitude (whether physician or nurse) toward the patient as a person. Several studies confirmed that the affective response by patients was as important as the cognitive response to treatment: “Rather than being related to technical competence, satisfaction with care was related to communication, responsiveness, and reliability (Bowers et al., 1994) as well as having expectations met” (Leiter et al., 1998, p. 1611). Most patients desired and needed to communicate with nurses, doctors, and staff to gain as much information as possible

(Moret, Rochedreux, Chevalier, Lombrail, & Gasquet, 2008; Taylor, Kennedy, Virtue, & McDonald, 2006).

Roter and Hall (1993) conceptualized two functions of communication: communication as task-oriented (for example, communicating while administering medication), and communication as affective behavior. The nurse–patient relationship requires both functions for patient satisfaction; however, too often, the task-oriented function solely was used without the affective function. Both nurse and communication literature discussed the significance of the affective-relational aspect of communication in healthcare, particularly as it was researched in elder care communication in Caris-Verhallen, Kerkstra, and Bensing (1999) and other studies (Burgio et al., 2002; Caris-Verhallen, Timmermans, & van Dulmen, 2004; Carpiac-Claver & Levy-Storms, 2007; Chant et al., 2002; Kettunen, Poskiparta, & Liimatainen, 2001; McGilton et al., 2003; Roberts & Bucksey, 2007).

The Nurse–Patient Relationship

Peplau (1987, 1997) presented her theory of interpersonal relations as a “conceptual framework derived in large part from empirical study of human interactions, which aids nurses in enlarging their understanding of what transpires during nurse–patient relationships” (p. 162). Early on, Peplau (1952) solidly established the nurse–patient relationship as the core of nursing. The basic structure and phases of the nurse–patient relationship, as described by Peplau, include the introduction phase, the working phase, and the termination phase. These three phases act “as the progressive framework within which such conditions as trust, empathy, and genuineness form the essential bases

for therapeutic relationships” (Hagerty & Patusky, 2003, p. 146). Hagerty and Patusky argued that both the length of time and the linearity of the three-phase model should be questioned. Given the current healthcare environment of shorter hospital stays and briefer encounters between healthcare providers and patients, they suggested that a new paradigm be established for determining a therapeutic nurse-patient relationship.

Fleischer et al. (2009) reviewed nursing literature for concepts on nurse-patient communication and interaction. After reviewing 97 studies, they concluded that “communication and interaction skills are almost always seen as crucial for nurses . . . it [communication] is a core element of nursing care” (Fleischer et al., 2009, p. 350, 353). Conclusions drawn from empirical findings show that the “concepts of interaction, communication, and relationships are intertwined” (p. 344). Interaction, typified as a relationship, cannot occur without effective communication. Definitions of communication in nursing literature were most often labeled as instrumental (or task-related) or affective, or both. In nursing education, instrumental communication is more frequently taught. Fleischer et al. found the majority of cited communication models or theories for communication in nursing were “symbolic interactionism and classic sender-receiver models” (p. 345). No overarching theory exists in the nursing literature for interaction/communication; the most frequently used theories were either Peplau’s (1952) theory of interpersonal relations, which emphasized the nurse-patient relationship as the foundation of nursing practice, or King’s (1981) interacting systems framework, a conceptual model for nursing which maintains that each individual develops his or her own self-perception that will influence interaction and behavior. Other findings noted

that nursing communication frequently used commands, which are often associated with a “form of overt power” (Fleischer et al., 2009, p. 345).

The power dimension is extremely important when viewing the roles of the patient and the nurse in relational communication and behavior expectation. Depending on the context (hospital, nursing home, psychiatric ward), the balance of the power/control role by nurses either supports relational communication and patient satisfaction, or contributes to dehumanizing the patient. The “power” issue in the nurse–patient relationship was raised earlier by Hewison (1995), who noted that most nurse–patient interactions correlated with task completion and that, frequently, the power dimension of the nurse interaction can be a hindrance to any meaningful communication and interaction. When Shattell (2004) investigated the patient views and the paradox of the “nice” nurse and the powerful (not-so-nice) nurse, this dimension appeared to relate to the amount of time spent with the patient. Even though patients acknowledged the time constraints, and that nurses were “viewed as overworked and overwhelmed,” these same patients still desired “more and deeper connections with nurses” (p. 714).

Two observations worthy of note during the review of nursing literature on the nurse–patient relationship were the finding that most of these studies are grounded in psychological and sociological theories, as noted by Fleischer et al. (2009). Only one study reviewed included an interpersonal communication theory in the analysis of nurse–patient relationships. The second observation, and more important to this study, was a common agreement among the studies that these interactional communication skills can be learned, at least to a certain extent.

Centrality of Communication Discipline for Healthcare Communication

Communication education in higher education programs is vital to the success of graduates in our contemporary society. “Understanding how people use messages to generate meaning within and across various contexts, cultures, channels, and media (Korn, Morreale, & Boileau, 2000) is an issue of vital importance in contemporary society” (Morreale & Pearson, 2008, p. 224). Research evidence covering the years from 1955 to 1999 (Morreale, Osborn, & Pearson, 2000) documented the importance of communication education. In Morreale et al.’s (2000) annotated bibliography of 99 studies, five major themes emerged regarding communication education: (a) the key role of self-development of the “whole person” (as cited in Morreale & Pearson, 2008, p. 225), (b) improvement in quality of education instruction, (c) development of social and cultural skills, (d) professional success in the workforce, and (d) communication education should be taught by communication discipline instructors. A repetition of the study (Morreale & Pearson, 2008) with an updated review to reflect the current world environment confirmed through 93 additional studies that the same four themes were valid. Moreover, two new themes surfaced, “enhancing organizational process and organizational life” and “emerging concerns in the 21st century” (Morreale & Pearson, 2008, p. 228). These latter two themes were an expansion of the professional success themes, with several references “focused on health communication” (p. 228).

According to the Association of American Colleges and Universities (AACU), key skills required for the future workforce include problem solving, collaboration, and communication skills (2007). From media articles and journal studies, both nationally

and internationally, written and oral communication skills remain primary as competencies required of future employees (Booher, 2005; Clement, 2001; Friedman, 2006; Morrele & Pearson, 2008). In an international workforce survey on high school, 2-year, and 4-year college graduate readiness skills for the 21st century, skill deficiencies included oral and written communication skills (Casner-Lotto & Barrington, 2006). Thus, the centrality of communication skills for nurses needs to be addressed by the Virginia Community College System.

Identifying Core Communication Competencies in Nursing

The following sections investigate the communication core competency in nursing, define the construct, and review successes and failures in past training. A major problem is the lack of consistency in defining exactly “what is considered a communication skill” (Thompson, 2003, p. 96). Most of the problem lies in the definition and conceptualization of a given term. A widespread problem exists across the healthcare field, and is frequently investigated in physician–patient training research (Cegala & Broz, 2003; DiPalo, 1997; Street, 2003a). At the nurse–patient level, a multitude of terms were included to define relational and interpersonal communication skills. Terms such as *caring behavior*, *empathy*, and *therapeutic* were the most commonly used. Frequently, in nurse studies, these terms were grouped under one of three categories: interpersonal, relational, and/or caring skills (Crute, Hargie, & Ellis, 1989; Gijbels, 1994; Heaven & Maguire, 1996).

Nurse Discipline Perspective

The National League for Nursing (2000), in *Educational Competencies for Graduates of Associate Degree Nursing Programs*, identified the following communication core components and competency necessary for the associate degree nursing graduate:

Communication in nursing is an interactive process through which there is an exchange of information that may occur verbally, non-verbally, in writing, or through information technology. Those who may be included in this process are the nurse, client, significant support person(s), other members of the healthcare team, and community agencies. Effective communication demonstrates caring, compassion, and cultural awareness, and is directed toward promoting positive outcomes and establishing a trusting relationship.

Therapeutic communication is an interactive verbal and non-verbal process between the nurse and client that assists the client to cope with change, develop more satisfying interpersonal relationships, and integrate new knowledge and skills. (pp. 7-8)

The greater part of scholarly research in the 1980s concentrated on descriptive studies in order to define specific skills for inclusion in communication training programs. This earlier research remains valid from an historic perspective to reveal how and why certain communication traits were selected. Fosbinder, nurse educator and program administrator at Brigham Young University, published a frequently cited journal article on patient perceptions of nursing care. Her report (Fosbinder, 1994) reviewed the

1980s literature on interpersonal skills in nursing and concluded that patient satisfaction directly related to the interpersonal relationship between the patient and caregiver, and significantly influenced the patient's perception of satisfactory care.

Patients, as shown in other studies, more frequently associated nursing care (rather than physician care) with satisfaction. However, patients' perceptions commonly were in direct opposition to nurses' perceptions. Results of Fosbinder's (1994) review showed that of 14 satisfaction predictor variables, patients associated 10 variables of affective behavior with satisfaction, while only 4 were associated with technical competence (Bader, 1988). A review of 245 audiotaped observations of patients utilized open-ended questions. The outcome demonstrated that the primary focus of the patient was not on task performance, but on the nurse's interpersonal competence. Additionally, four areas, or themes, of patient-nurse interaction emerged from the Fosbinder review: translating (informing, explaining, instructing, teaching); getting to know you (personal sharing, humor/kidding, being friendly, "clicking"); establishing trust (being in charge, anticipating needs, being prompt, following through, enjoying the job); and going the extra mile (being a friend, doing the extra). In moving toward a theory of interpersonal competence, Fosbinder compared these themes with terminology in previous studies and was able to identify comparable skills: informing, explaining, instructing, self-disclosure, nonverbal (such as smiling or making eye contact), intercultural awareness, and the relational dimension, such as establishing trust and treating the person as a friend. Fosbinder noted that previous theorists also named specific aspects for inclusion, such as empathy and self-disclosure, which mirrored her own findings.

The implication of Fosbinder's (1994) report was an early call for an overarching framework in teaching communication skills that encompassed specific relational and interpersonal skill behaviors, not only in the nurse–patient relationship, but also in any healthcare provider's interaction with patients.

DeFrino (2009) presented a relational work theory of nurses which moves beyond the caring relationship to emphasize the importance of the relationship between nurse–patient and job satisfaction. Using the 2000 Fletcher, Jordan, and Miller theory of relational work of women, DeFrino ventured to categorize nurses' relational skills as separate from task-related skills, explaining that relational skills should not be trivialized as caring behavior solely associated with the female gender. Her emphasis was on the benefit of relational interaction between patient and nurse to the point where her goal was to put a monetary value on relational skills. Twenty years earlier, May (1990) had published a series of studies dealing with the interaction of nurses with patients as separate from task-oriented communication, several of which DeFrino referenced. May (1990), however, also raised the issue of practicality: Did nurses have time to spend developing a relationship with the patient?

Current studies such as Betcher (2010) and Warelow, Edwards, and Vinek (2008) answered the time question and reinforced that organizations must change in order to make the relational process take place, despite time constraints, for the benefit of the patient. Clukey et al. (2009) added to this growing list of researchers investigating the time element. Through their findings on nurse interaction with families, they stated, “Family members noted [nurse] noncaring behavior as being related to the nurse acting

bothered when a request was made. This suggests that technical competence may be meaningless in portraying caring unless a positive interpersonal relationship is established” (p. 81).

Communication Discipline Perspective

Turning the focus to the communication perspective, the majority of earlier communication literature (1980 to 1990s) on interpersonal communication in healthcare concentrated on the doctor–patient relationship. In more recent years, the studies included and even centered on the nurse–patient dyad. These more recent studies also tended to use the all-inclusive word *provider* to cover doctor or nurse or healthcare professional, and expanded the meaning of *patient* to include immediate and extended family members.

Before proceeding to the communication literature dealing specifically with nurse interpersonal communication, an updated insight into the basic skills associated with interpersonal communication in everyday life is warranted. The following studies emphasize core skills in relational and interpersonal communication that need to be learned prior to application in the healthcare context. This core competency of skills becomes the basis from which situational and professional achievements in relational communication result.

Spitzberg and Cupach (2003) supplied both the rationale for, and definition of, *interpersonal skills*. Finding a single term to cover interpersonal communication, as the authors noted, was not an easy task. Scholars used the terms *skill* and *competence* interchangeably, frequently combining social skills and interpersonal skills. Drawing

from their previous research, the authors derived their own definitions and model (Spitzberg, 2000; Spitzberg & Cupach, 1984) that list six criteria: “fidelity [clarity], satisfaction, efficiency, effectiveness, appropriateness, and ethics” (Spitzberg & Cupach, 2003, p. 575). The fidelity, or clarity term, “is generally used to describe message characteristics, somewhat independent of receiver perceptions. A message is clear to the extent that it represents the information it is intended to represent” (p. 576). The satisfaction criterion referred to both the sender and receiver feeling positive psychological valence at the end of an encounter (whether the interaction outcome was good or bad). The efficiency criterion referred to “the extent to which skills are used to achieve some outcome with a minimum of effort, time, complexity, and investment of resources” (p. 579). The effectiveness criterion dealt with “the extent to which an interactant accomplishes preferred outcomes through communication. . . . Effectiveness is one of the oldest and most firmly established criteria of competence” (p. 581). Appropriateness stood for acceptable behaviors as defined by the context of the exchange and the receiver’s perception in the given context. For example, did the patient feel the exchange truly was in his or her best interest, or was it simply a one-size-fits-all type of exchange? The ethics criterion can be equated with moral code. Rather than concentrating on the exchange’s accomplishment, ethics looked at the actual exchange with regard to society-defined and morally acceptable communication behavior.

According to the authors,

previous functions focused on functional, or ends-oriented, approaches to identifying skilled communication [Ethics] envisions a world in which ideal

speech situations could empower all and provide respect and voice to each person regardless of situation or stereotype. (pp. 582-583)

In summary, “skills are generally viewed as performances that are put to given socially valued purposes” (Spitzberg & Cupach, 2003, p. 583). The skills are used within a context which defines their appropriateness and selection from an interpersonal skill set.

Thompson, communication scholar and coeditor of *Handbook of Health Communication* (Thompson, 2003) and the journal *Health Communication*, noted that while the focus of health communication expanded in the last several years to include health campaigns, the key area of study remained the provider–patient interaction. Thompson and Parrott (2002), in their extensive review of communication research literature, classified the studies into two categories: those which were descriptive, and those which used communication as an independent variable. While their review was of empirical investigations of communication issues in healthcare, most of their references drew from social science and nurse research. According to the authors, the communication skills in the nursing and allied health professions usually targeted: (a) behaviors such as responding and initiating skills (questioning, explaining, listening, nonverbal, self-disclosure); and (b) interactional skills (interviewing, counseling, influencing). Other behavior skills were divided into four groups labeled as information giving, information seeking, information verifying, and socio-emotional communication (Cegala, Coleman & Turn, 1998). Patients categorized the desired behavior from nurses as listening, asking straightforward questions, maintaining eye contact, and verbal

responses that are clear, articulate, and loud enough to be heard (Bailey & Wilkinson, 1998).

Nonverbal Communication

Nonverbal research, as Thompson and Parrott (2002) pointed out, was interdependent on verbal communication, but some specific nonverbal research gave valuable insight relevant to interpersonal skills in the healthcare context. For example, establishing rapport between the provider and patient emphasized the nonverbal role, specifically in mirroring the patient's nonverbal patterns in terms of language pauses and body orientation (Harrigan, Oxman, & Rosenthal, 1985). Achieving a less domineering manner with patients over the age of 30 also was part of the nonverbal language (Street & Buller, 1988). Other nonverbal behaviors by healthcare professionals, such as head nods, eye contact, and fewer negative facial expressions, elicited more patient disclosure (Duggan & Parrott, 2001). Nonverbals also came into play when dealing with intercultural communication, specifically through gestures and body orientation.

Nonverbal communication training was noted as one area lacking in most training modules (Kruijever, Kerkstra, Francke, Bensing, & van de Wiel, 2000). As part of relational communication, nonverbal indications add to the definition of interpersonal relational goals and patient satisfaction (DiMatteo, Taranta, Friedman & Prince, 1980; Kruijever, Kerkstra, Bensing & van de Wiel, 2001). Elderly patients who received a comforting touch from nurses experienced more immediacy and affection (Moore & Gilbert, 1995). Nonverbal behaviors such as gaze, body orientation, facial expressiveness, smiling, conscientious listening, and the appropriate use of touch need to

be part of the training (DiMatteo, Hays, & Prince, 1986; Street, 2003b; Street & Buller, 1988).

Verbal Communication

Verbal communication research frequently concentrated on the use of medical terms, jargon, and acronyms. Research supported a discrepancy between care providers' self-evaluation of using less jargon and patients' perception of this practice. Yet, decreased patient satisfaction frequently was associated with the use of technical language by healthcare providers.

Street (2003a) explored essential skills of effective communication in healthcare environments, and provided a conceptual framework on factors affecting the communication function in provider–patient encounters. Although most of Street's report discussed physician–patient interaction, his overview on interpersonal communication applied to all types of providers (such as nurses and nurse practitioners in medical encounters). He advocated a patient-centered approach with traits such as caring, sensitivity, and an absence of clinician-dominated conversation. These traits included information giving, interpersonal sensitivity, and a partnership approach (i.e., a relational approach). Information giving required clarification of jargon, asking open-ended questions, and allowing for feedback from the patient, such as a reiteration of what the patient understood. Traits that displayed insensitivity were an uncaring attitude in verbal and nonverbal behaviors. Another trait of patient-centered dialogue was the ability to recognize nonverbal signs; for example, what emotion the patient's facial

expression communicated. These traits reflected a process that frequently determined future outcomes in the patients' health and compliance in treatment.

Training Evaluation

A broad study of academic communication skills training for nurses and other health professionals in England was initiated on the basis of the reported history of patient dissatisfaction with communications and information giving, and a concern about lack of interpersonal skills in graduates of recent educational programs (Chant et al., 2002). The results of the study uncovered a lack of proper research to evaluate communication skills training in pre- and post-nursing education and other healthcare disciplines. Hospital attempts to remedy poor communication skills at the aide or nurse level frequently involved on-the-job training seminars by commercial, rather than educational, professionals. The seminars typically were short in duration, concentrated on a specific skill set, and rarely provided follow up to determine the sustainability of the skills taught. Both the quality (remedial) and timing (post-education) of communication education in healthcare settings remained, for the most part, without consistent major success. More current research often cited the need for communication training during the education period to resolve this situation (for example, see Bowles et al., 2001; Cegala & Broz, 2003; Fallowfield, Saul, & Gilligan, 2001; Kreps, Arora, & Nelson, 2003; Kruijver et al., 2000).

However, it needs to be noted that not all intervention skill training failed. Based on the data from nurses that they received inadequate teaching about communication skills during their nursing education, Fallowfield et al. (2001) reviewed a learner-

centered residential 2-day course for senior cancer nurses. The course had a positive post-course success rate. The course model combined elements of the adult learning theories of Rogers (1983) and Knowles (1978) (as cited in Fallowfield et al., 2001) with experiential group methods such as video demonstrations, group discussion, and role-playing with simulated patients. A pre-/post-questionnaire and an interview were used to assess the effectiveness of the intervention training. The participants found the course highly relevant to their own nursing practice.

Other Fallowfield et al. (2001) findings revealed the nurses' acknowledgment of serious problems in their communication with patients, patients' families, and with professional colleagues, as well as problems in dealing with intercultural patient care (also see Ramirez, 2003). While this course targeted a specialized area of cancer treatment, the course was grounded in education and communication theories and can be generalized to most nurse-patient training. The results recommended providing effective communication training initiatives for nurses to assure improved patient care as well as enhanced personal well-being of nurses themselves.

The most successful communication skills programs were those that used diverse pedagogical techniques including experiential type activities such as role-playing, group discussion, and self-assessment from videotaping (Thompson & Parrott, 2002).

Dingman, Williams, Fosbinder and Warnick (1999) discussed the results of implementing a study on patient satisfaction with nurses' interpersonal behaviors using a caring model. They chose eight patient satisfaction characteristics based on Watson's Theory of Human Caring (1981) and Leininger's Transcultural Care Theory (1997). Dingman et al.'s

results indicated a higher rate of patient satisfaction by both nurses and patients after nurses received communication training.

More recently, Betcher (2010) conducted an educational research study to increase relational communication between palliative nurses and patients, and nurses and patient families on end-of-life issues. Citing the American Association of Colleges of Nursing (AACN) competency requirement for these issues, the study noted that textbooks lacked adequate information and training for palliative care. Initial communication training was included in a program on palliative care followed by intensive role-playing, video recording, and follow-on discussion. Outcomes were measured by a pre-/post-training Caring Efficacy Scale (Coates, 1996). Betcher's results showed nurse participants improved in their relational communication skills as well as achieved a higher level of confidence to communicate on these issues.

In summary, the most successful post-educational, communication training sessions were those associated with experiential learning. Additionally, the majority of recommendations for interpersonal skills and relational communication concurred that training should begin in the education phase. Short workshops were suggested as on-the-job refreshers, rather than as remedial in nature. Workshops should include formative assessment as well as follow-up assessment at a later date to determine if the application and retention of skills learned were still valid.

Communication Theoretical Framework

Relational theory correlates to the nurse–patient dyad and thus became the central unifying theory from which to teach healthcare communication in this current study. By

using relational communication theory as the overarching theoretical basis, key communication concepts for nurse–patient interaction from nurse and communication literature could be cross-referenced. A relational theory implies personal judgment in choosing applicable communication avenues in any given situation, including the right choice of interpersonal communication skills to use between two individuals or in group communication (i.e., family and coworkers). Relational theory was then applied to such concepts as patient satisfaction, therapeutic caring, conflict management, and verbal and nonverbal communication.

As the central theoretical construct in this current study, relational communication acts to divide messages into two distinct components: the content component and the relational component. Three seminal works on relational theory are Parks' (1977) relational theory which emphasized the relational component of messages, Millar and Rogers (1987) who defined relational communication as direct interaction, and Burgoon and Hale (1984, 1987) who presented a relational schema of interrelated dimensions. According to Parks (1977), "Content or relational components of messages refer to the manner in which ongoing relational definitions are developed and maintained over time" (p. 373). To understand human interaction, Rogers and Millar (1987) believed the focus should be on human interaction researched through a relational approach, since message exchange between people includes both the content and the building of relationships. Burgoon and Hale (1984, 1987) defined "relational communication as the verbal and nonverbal themes present in people's communication that define an interpersonal relationship" (Rubin, Palmgreen, & Sypher, 1994, p. 308).

Spitzberg and Cupach (1984) and Duran and Spitzberg (1995) provided more of a model of communication competency than a theory. The model consisted of three components: knowledge, skill, and motivation. In the knowledge component, the speaker was able to recognize which communication behavior was appropriate in a given situation. The skill component was the ability to carry out the appropriate response or skill. The motivation component was the desire to communicate effectively. The Spitzberg and Cupach (1984) model can be applied to the specific criteria of effectiveness that make up a competent healthcare communicator and can be used to assess competency.

In summary, by employing relational theory as the overall framework, and combining the theory with a model of communication competency, the basic structure for implementing an effective healthcare communication course was created in this current study. Concepts of relational communication, along with identified interpersonal skills from the literature and learner-centered activities, formed the construct for the basis of a model healthcare communication course in nurse and allied health programs in this current study.

Summary of What is Known and Unknown About the Topic

For decades, research studies have called for improved relational communication and interpersonal skills for nurses and other allied health professionals. Part of what has hindered progress in teaching these skills is the lack of a clearly defined theoretical framework. Since 2005, a more comprehensive delineation of task-based skills versus interaction-based skills emerged. However, confusion remains in the conceptualization

and operational use of interpersonal and relational terminology. Relational communication is conceptual by nature, while interpersonal skills are defined communication actions. The approach to a creating model in this current study required both a theoretical framework and a coherent definition of needed interpersonal skills. The interdisciplinary research of nurse and communication literature provided a database to conceptualize relational communication in the nurse–patient interaction. Within the conceptualization both conceptual behaviors and specific skill behaviors were brought together. While a pilot course based on relational communication skills for healthcare professionals was tested in 2005 and 2006 by the researcher at a Virginia community college, and this pilot course provided the initial model course in this study, follow-up assessment to ascertain improvement and retention of these skills was not conducted. What remains unknown, then, is if the new conceptualization and operationalized structure for use in a healthcare communication course will improve communication skills for nurse and allied health professionals in the future.

Contribution This Study Makes to the Literature

This current study's contribution to the nurse and communication literature is an historical interdisciplinary data matrix of terms and concepts used to define the interaction process between nurses and patients over the past 20 years. In addition, the study provides a conceptualization of relational communication as a three-pronged approach (concepts, verbal, and nonverbal interpersonal skills) to teaching communication in healthcare programs at community colleges. Finally, the study provides an operationalization of the behavior concepts and interpersonal descriptors

used to achieve communication competency in healthcare settings. The model course syllabus and activities in this study may provide administrators and educators a replicative course for relational healthcare communication. Nurse and allied health students enrolled in such a course should find the learning outcomes beneficial to their future careers, and gain confidence in their interactive communication abilities. This study will help fill the gap between research findings and concrete application.

The following chapter details this study's methodology including the evaluation method and focus group research to collect and analyze relevant data from researchers, current healthcare faculty, and providers on the subject of nurse and allied health relational communication.

IV. RESEARCH PROCEDURES

Research Methodology

This study was about the discovery of communication proficiency for nurses and allied health professionals in their interactions with patients. If the discovery showed that communication competency needed to be improved, then a review of past problems, successes, and types of training was required in order to determine what could be done to remedy the gap in communication training. The discovery also aimed to determine if a single communication theory could act as the overall framework for conceptualizing and operationalizing key concepts and interpersonal skills required for improved communication in the healthcare context. A final aim of the study was to design a model healthcare communication course syllabus based on the findings of this study to be used in the Virginia Community College System nurse and allied health programs.

The research methodology for this study was a triangulated qualitative approach utilizing the evaluation method and focus groups. “Qualitative modes of data analysis provide ways of discerning, examining, comparing and contrasting, and interpreting meaningful patterns or themes” (Berkowitz, 1997, p. 1). While quantitative studies use more standardized procedures such as statistical analysis, qualitative analysis conducts research with words. However,

qualitative analysis is both systematic and intensely disciplined . . . qualitative analysis is arguably replicable insofar as others can be “walked through” the analyst’s thought processes and assumptions Part of what distinguishes qualitative analysis is a loop-like pattern. (Berkowitz, 1997, p. 1)

Chesebro and Borsoff (2007) define what qualitative research is, and they list “pragmatic” as one of the characteristics of all forms of qualitative research: “*Pragmatic*: The specific results obtained have immediate utility and/or produce direct and instant insight into ongoing social processes and outcomes; the research analysis resolves an existing social problem. It may or may not contribute to theory development.” Frey, Botan, Friedman, and Kreps (1992) stated applied research is “conducted for the purpose of solving a particular ‘real-world,’ socially relevant problem” (pp. 4-5).

Triangulation was used to validate data from the two distinct methodologies. According to Mays and Pope (2000), “Triangulation compares the results from either two or more different methods of data collection The researcher looks for patterns of convergence to develop or corroborate an overall interpretation” (p. 51). Frey et al. (1992) stated that,

In the context of communication research, triangulation means that different research techniques producing consistent results provide a more effective base for describing, explaining, understanding, interpreting, predicting, controlling, and critiquing a communication process or event than a single research technique producing a signal result. (p. 14)

Approval was granted by George Mason University's Human Subjects Review Board to conduct the research study at three Virginia community colleges and one regional Virginia hospital. Basic protocols for such research methods were followed.

Specific Procedures for the Evaluation Process

This study's main purpose was to conduct an inquiry to produce findings that could be applied in nurse and allied health care programs. The steps of the evaluation inquiry included data collection, reduction of the volume of information through analysis and evaluation, identification of significant patterns, and construction of a framework to present findings (Berkowitz, 1997). Data analysis, as defined by Miles and Huberman (1994) consists of "three concurrent flows of activity: (1) Data reduction, (2) Data display, and (3) Conclusion drawing/verification" (p. 10). By evaluating meta-analysis research over a 20-year span, this study reduced the data to a manageable set of key studies. In this step, relative effectiveness of communication training for nurses and relative frequency of terminology was reduced. For data display, an historical data matrix was created to analyze patterns. In the last step, conclusion drawing/verification, conclusion drawing was done through terminology categorization to form a conceptualized diagram and operationalized matrix of terminology. In this third element, "validity encompasses a much broader concern for whether the conclusions being drawn from the data are credible, defensible, warranted, and able to withstand alternative explanations" (Berkowitz, 1997, p. 6). The data verification process in this study was done through the focus group method for triangulation. "The meanings emerging from

the data have to be tested for their plausibility, their sturdiness, their ‘confirmability’—that is their validity” (Miles & Huberman, 1994, p. 11).

Inclusion criteria for studies was based on the following: (a) the study or chapter focused on elements of relational communication and interpersonal communication skills in the nurse–patient interaction, or a specific aspect of the relationship such as empathy; and (b) studies were limited to meta-reviews, literary reviews, or reviews of a single element of the nurse–patient interaction. Only studies involving nurse or healthcare staff–patient relationship were included; studies specific to the doctor–patient relationship were eliminated. The time period covered the last 20 years, from 1990 through 2010. Databases included CINAHL, MEDLINE, Cochrane Database of Systematic Reviews, Communication Abstracts, and Social Sciences Citation Index. Key search terms included: *nurse–relational*, *nurse–interpersonal*, *nurse–patient*, and *nurse and communication*. These terms were combined with *meta and literary review, reviews*. In addition, bibliographies of selected articles identified other relevant studies for inclusion. All studies that met the criteria were included, resulting in 26 subject studies.

Specific Procedures for the Focus Group Process and Research

The focus group research followed Morgan’s (1997) focus group qualitative research practices. Morgan stated that,

focus groups most often (a) use homogenous strangers as participants, (b) rely on a relatively structured interview with high moderator involvement, (c) have 6 to 10 participants per group, and (d) have a total of three to five groups per project. (1997, p. 34)

Volunteer participants represented nurse and allied health faculty, and nurse supervisors, from four divergent geographic locations. Identical research questions were posed by the researcher at each focus group. The researcher acted as the facilitator. Each group had a minimum of 6 and a maximum of 10 volunteer participants. Focus group data was collected on site at three Virginia community college campuses. Additional data was collected from one Virginia regional hospital focus group consisting of nurse and allied health supervisors and hospital administrators. The five common questions used for the research instrument are found in Appendix C.

Participants

Segmentation was used to select homogeneous groups for the research. According to Morgan (1997), segmented groups allow the researcher “to match carefully chosen categories of participants. . . . It is this homogeneity that not only allows for more free-flowing conversations among participants within groups but also facilitates analysis that examine difference in perspective between groups” (p. 35). Participants in the community college focus group research were volunteers from the full- and part-time nursing and allied health faculty from three community colleges in the Virginia Community College System. Faculty volunteers were considered eligible if they currently taught in the nursing or allied health degree or certificate programs at their respective college. Participants in the regional hospital focus group were volunteers from nurse and allied health departments within the hospital. Volunteers were considered eligible if they were directly involved in supervising nurses, nurse aides, or allied health personnel. Using focus groups in this research project provided the researcher “the

ability to produce concentrated amounts of data on precisely the topic of interest”
(Morgan, 1997, p. 13).

Focus Group Procedures

Of the 23 potential community colleges, 3 of 56 were selected for participation based on geographic representation and size of the nurse and allied health programs. Potential participants qualified if they had direct teaching contact with nursing or allied health students.

All three colleges initially were contacted by phone, email, or in person in order to determine which individual or department could grant approval. In two instances, the institutional board reviewed the protocol and granted approval; in the third instance, the college president reviewed the protocol and granted approval. All administrators were provided with an information sheet, a consent form, and the research instrument questions. In order to recruit voluntary participants, the information sheet was circulated to all allied health faculty by either the dean or coordinator of the allied health program at each college. The information sheet explained the focus group purpose, time factor, guarantee of anonymity, and assurance that final data information collected from all three colleges would be distributed to them. Colleges’ and participants’ identities were guaranteed confidentiality. The confidentiality factor was an important element of the focus group research in order to ensure that participants would speak freely about the pros and cons of current communication needs and training within their college’s programs.

Letters of approval were obtained from all three community colleges prior to the focus group meetings. A date and time were arranged by email or phone for each focus group. Focus groups took place at the participating college campus. The majority of faculty participants were involved in both clinical and classroom experience. These faculty participants' expertise included observation of students in actual clinical situations with patients, and ongoing evaluation of role-playing activities in the classroom.

Obtaining access and permission for the focus group research at regional hospitals proved more difficult. Morgan (1997) noted that with recruitment issues there are often impediments: "When working with highly specialized categories of participants, recruitment procedures have to be equally specialized" (p. 39). The direct observation method, often an alternative to the focus group method, was neither feasible in healthcare settings nor conducive to this study. The advantage and strength of conducting a focus group with nurse and allied health professional personnel at hospitals produced, as Morgan (1997) stated, "an opportunity to collect data from groups discussing topics of interest to the researcher" (p. 16).

Of the three regional hospitals approached, only one ultimately granted permission to conduct the research with hospital employees. Although no direct patient contact was involved in the research, one regional hospital required indemnification from the researcher's university by means of an insurance policy. This requirement was neither possible nor feasible through the researcher's university's Human Subjects Research Board and legal department. The second regional hospital did not respond to

queries from the researcher made by email and telephone. The third regional hospital required that the researcher present the project and all background material to their Internal Research Board (IRB). The presentation was conducted and permission was granted from the IRB at this regional hospital.

The same research procedure enacted with the community college administrations was followed for the research conducted at the one regional hospital. The IRB was presented with the information sheet, the consent form, and the research instrument. The information sheet was circulated by specific board members to individuals who were in a supervisory position for nurses and allied health employees at the hospital. Volunteer participants were recruited by the administration. Participants included oncology floor nurses, nurse supervisors, emergency (EMT) services, and nurse administrators responsible for nurse evaluations.

Method of Data Collection for Focus Groups

The method of data collection from the qualitative focus groups was face-to-face discussion with participating faculty members at the community colleges, and with participating hospital nurse supervisors and supervising administrators at the regional hospital. A short review of the information sheet was first presented by the researcher prior to the start of each focus group. Confidentiality of place and participants was guaranteed.

The focus groups were structured around a set of five directed questions with the researcher acting as facilitator. The directed questions allowed the researcher to follow up with specific questions for clarification and elaboration, although follow-up questions

were rarely used. Each participant was eager to express his or her observations and recommendations for improved communication skills for nurses and allied healthcare professionals. Participants used communication examples originating from their direct observation of students during clinical activities, their own clinical experience, and/or direct observation of nurses and allied health professionals in a hospital setting. Each focus group lasted precisely 1 hour. Each participant signed a waiver to allow the researcher to audiorecord the 1-hour focus group. The purpose of the recording was to allow the researcher to concentrate on the directed discussion during the actual focus group encounter, and to allow the researcher to transcribe the data after the actual session.

The focus groups were conversational with attempts made to include all participants. All four focus groups were treated equally; the same questions were asked at each session in the same order. The topic was introduced first with the purpose clearly stated. The advantage of using the same questions was to use a “group-to-group validation” (Morgan, 1997, p. 63) in the content analysis of the collected data. Using the same questions also avoided bias of any kind. Adherence to procedure included keeping to the 1-hour time limit for each focus group.

Treatment of the Data

To maintain confidentiality, Virginia community colleges were coded CC1 ($n = 7$), CC2 ($n = 10$), and CC3 ($n = 5$) to represent the three geographically diverse colleges. The Virginia regional hospital was identified as H1 ($n = 9$) without a geographic identifier. A total of 31 volunteers participated. No names of participants were identified in the collated data.

Data was transcribed by the researcher following each session as verbatim as possible. In a few cases, more than one person was talking at the same time. However, it was not felt that data was lost by these few instances. Data then was coded, categorized, and analyzed using an inductive analysis method, which moved from specific observations to broader generalizations and theories. In this case, after coding, the information provided by the participants was categorized by each focus group question. Answers were analyzed according to the number of times each answer was repeated both within each focus group, and subsequently, across all four focus groups.

The audiotapes are stored in a secure, locked filing cabinet at the researcher's residence. Transcripts of the focus group sessions are stored on one CD, which is locked in the filing cabinet along with the tapes. All tapes and transcripts will be shredded and destroyed after the project is approved and published. All participants will be given a copy of the final dissertation including the data derived from the focus groups as a whole.

Participants at each community college location and at the hospital focus group were enthusiastic about contributing to the research on communication and participating in planning a generalizable course model. The three colleges represented urban and rural institutions. The majority of participants noted the need for improved communication skills for nurse and allied health professionals in interactions with patients and with each other. As will be discussed in the findings, most of the answers for the final focus group question, #5, were already answered in the first question. In addition to nurse-patient communication, participants expanded on the need for communication skills between nurse and doctor by using examples of both positive and negative communication

situations. The hospital research group requested follow-up meetings with the researcher to discuss future communication skill training among the nurse and allied health staff.

V. FINDINGS

Poor communication skills in nurses and healthcare professionals “can lead to misunderstandings, frustration, errors and poor patient outcomes” (Pope, Rodzen, & Spross, 2008, p. 42). Nurse and allied health professionals require clinical skills and relational communication competence to ensure the best outcomes for patients. Proficient interpersonal communication skills are not one-dimensional, but are incorporated into the larger concepts of relational communication behaviors in the nurse–patient dyad and in healthcare communication as a whole. Relational communication can be taught, and it is best introduced at the educational level.

The plan of this study was to first collect data from the literature review studies on core communication skills associated with interpersonal and relational communication in the nurse–patient communication process. Data was collated from nurse and communication discipline research for an interdisciplinary approach. Next, core skills agreed upon by both disciplines as described in meta-reviews in both disciplines were then identified in an historical data matrix covering the last 20 years of research. The historical matrix data acted as the basis to identify a theoretical framework. Through the historical data matrix, theoretical frameworks in the nurse and communication literature were identified and evaluated to discover the most comprehensive theoretical framework. An analysis of the historical data in the data matrix also was used to conceptualize

behaviors of relational communication, and was subsequently used to create an operationalized matrix of the terminology. Data from the three focus groups at VCCS community colleges and one focus group from a regional hospital was obtained, transcribed, and categorized. The data collected from the evaluation and focus group methods then was analyzed and compared across focus groups and with the created conceptual matrix and the operationalized matrix of terminology for a triangulated approach to answer the research questions. Finally, the conceptual matrix and the operationalized behaviors matrix were used to create a replicable and generalizable model course for CST 195 Healthcare Communication.

The research questions in this study addressed the current need for improved communication skills for nurses and allied health professionals, whether an overarching theory and framework existed in the communication discipline from which to teach conceptualized skills, and to determine if a 100-level VCCS course model could improve the learning process of relational communication skills for students in the nurse and allied health programs in the VCCS. Findings are presented in this chapter.

Research Questions

1. Is there a need for improved communication skills within the nurse and healthcare professions?
2. Does a communication discipline, relational theoretical framework offer a comprehensive structure that would include both the communication and nurse disciplines' conceptualized definitions of healthcare communication skills?

3. Would a healthcare communication course at the community college level improve communication skills for nurse and healthcare graduates of Virginia community colleges?

Findings for Research Question 1

Research Question 1: Is there a need for improved communication skills within the nurse and healthcare professions?

The results of the literature review revealed the need for improved communication and relational skills for nurses and healthcare professionals is no less called for today than during the last 20 years. Studies as recent as 2009 indicate “that the quality of communication with patients is insufficient” (Utterhoeve, Bensing, Grol, Demulder & Van Achterberg, 2009, p. 442). A 2009 Cochrane Review on communication skills training in cancer, which covered the years 1980 to 2003, concluded that patients continue to complain about lack of communication and a sense of “caring behavior” from healthcare professionals at all levels (Moore, Wilkinson & Rivera Mercado, 2009). The sheer amount of literature on the failure of communication *training* for nurse and healthcare professionals additionally substantiated the need to improve current and future nurse/healthcare professionals’ communication skills.

Findings on Training Courses

The findings on communication training for nurse and healthcare professionals over the past 20 years, as noted in the literature review, ranged from having little effect, to recent reports of positive outcomes. However, the preponderance of studies did not

show a positive or long-term success rate. Other studies noted that skills were gained but due to lack of follow-up, rarely sustained.

In the 1980s, the majority of the training programs were on-the-job, short-term workshops with little follow-up to assess sustainability. From the late 1990s through 2009, follow-up assessments to in-service workshops did prove to have a more positive, if not lasting, effect on communication skill improvement.

An extensive and systematic review of training literature covering the years 1979 to 1998 was carried out by Kruijver et al. (2000). The research concluded that the training had either limited or no effect on skill acquisition or implementation in practice. In 2002, a Cochrane Review began a second review of the literature on communication training, starting where Kruijver et al. ended. This review consisted of the years 1998 to 2000 but also covered findings from as early as 1984. The findings yielded similar conclusions, and the results noted a limited number of successful training courses (Fallowfield, 2002; see also Razavi et al., 2002).

In 2005, Butler, Degner, Baile, and Landry (2005) reviewed all past literature, including Kruijver et al. (2000), and the Cochrane Review (Fallowfield, 2002). Their findings showed that, “Twenty years of research support the claim that communication provided by healthcare professionals often remains ineffective, with poor patient outcomes, negative experiences and dissatisfaction with care” (p. 863). Butler et al.’s recommendations called for research to be “refocused” to identify the skills needed for effective communication training using communication scholar research as the basis. In addition, recommendations were made to integrate communication skills training in the

curriculum of education healthcare programs as well as to implement workshops in healthcare settings. Finally, more attention needs to be done in post-training assessment to determine if newly acquired skills and behavior transferred to the workplace. A follow-up on nurse retention and application of communication skills learned in training (Duff, Firth, Barr, & Fox, 2009) used a validated confidence measurement instrument by Bandura from 1977 to validate retained skills.

Since 2005, conclusions on communication training remain somewhat discouraging and difficult to measure. Utterhoeve et al. (2009) conducted a review that took into account all healthcare professionals. The results of their review on communication training and patient outcomes were inconclusive. They noted that these results may come from measuring too many outcomes; for example, training outcomes on healthcare professionals' behavior should be tied to a specific patient satisfaction outcome rather than from a generalized patient satisfaction report. Hendriks, Vrielink, van Es, DeHaes, and Smets (2004) had earlier limited the patient's satisfaction with a specific communication behavior performed by specific healthcare professional, such as nurses, with improved results. Fellowes, Wilkinson, and Moore's (2004) evaluation of nurse communication training found nurses did use more emotional speech with patients after training, but follow-up patient satisfaction reports were too general to reflect an outcome either positive or negative.

Training Length and Teaching Techniques

Training time in healthcare communication skills ranged from less than 1-day workshops to 3-month academic courses. Several training courses were specific to the

context, for example, Williams' (2006) 3-day workshop to improve staff–resident communication in nursing homes to reduce elder speak. Other studies covered brief interventions, for example, one for improved communication in nursing staff in chronic care (Boscart, 2009), and one on improving nursing home communication (Williams, Kemper & Hummer, 2003).

A major study was implemented by The Joint Commission (TJC), a non-profit organization that certifies healthcare organizations in the United States, to improve communication in healthcare student nurses (Krautscheid, 2008). The TJC study covered a 3-year period, from the spring 2005 to fall 2007 semesters, for communication competence outcomes of student nurses. Changes were incorporated in the teaching-learning strategies based on cognitive learning and previous application outcomes. Results did show an overall improvement in communication skills for nursing students. According to the study, “A common assumption among nursing programs that provide lecture content on communication strategies is that nursing students learned how to effectively communicate and that this knowledge will be effectively applied in clinical practice” (Krautschedi, 2008, p. 1). However, the study continues, lectures provide “the theoretical knowledge about the mechanics of communication, but lack practical knowledge and application regarding when, what and how to communication information” (p. 1). The TJC study (Krautscheid, 2008) coalesced the problem raised by the majority of studies in this review: Communication skills teaching is task-centered; what is needed is communication skills training that provides a relational communication framework, which then can be effectively applied to overall nurse communication.

A summary of salient points on teaching techniques of communication learned from the TJC study included “structured leveled learner-focused activities” in all areas of teaching with “multiple [learning] opportunities” geared toward both cognitive and affective learning (Krautscheid, 2008, p. 10). Other suggestions included education-level communication courses, continuing education courses and workshops, and follow-up summative assessments of skills retained over time. The literature also focused on the relational aspect of communication between nurse–patient, nurse–nurse, and nurse–doctor. Improvement results appeared greater when experiential learning and case studies were the base teaching technique. More recent studies called for incorporating technical equipment, such as video recordings for self-assessment, as useful tools for teaching and learning.

Summary on Findings for Research Question 1

The results of the literature review on meta-studies revealed that the need for improved communication and relational skills for nurses and healthcare professionals is no less called for today than in the last 20 years. Studies in the 1990s and 2000s indicate “that the quality of communication with patients is insufficient” (Utterhoeve et al., 2009, p. 442). A 2009 Cochrane Review on communication skills training in cancer, which covered the years 1980 to 2003, concluded that patients continue to complain about lack of communication and sense of “caring behavior” from healthcare professionals at all levels (Moore et al., 2009). Since 2005, most studies recommended communication training courses in the educational phase along with continuing workshops in the healthcare setting. Changes also occurred in the focus of training, moving from a specific

skill such as touch, to a relational emphasis of communication between nurse–patient and allied health professional–patient interactions. As technology advanced, the use of videotaping for self-assessment and analysis of filmed case studies appeared more frequently in the literature as training aids for improved communication skills.

Findings for Research Question 2

Research Question 2: Does a communication discipline, relational theoretical framework offer a comprehensive structure that would include both the communication and nurse disciplines’ conceptualized definitions of healthcare communication skills?

In order to determine whether communication relational theory (Parks, 1977) or a nursing theory would best act as the overall theoretical framework for healthcare communication, it first was necessary to review the nurse and communication literature on specific concepts, descriptors, and skills named. Descriptors of healthcare communication were extracted from nurse and communication studies covering the timeframe from the 1990s to 2010. The criteria for inclusion were *meta-analyses*, *meta-reviews*, and/or large studies and surveys concentrating on a specific communication descriptor, for example, *empathy*, in the nurse–patient relationship. Of the 52 studies reviewed, 26 studies met the criteria for selection. Table 1’s Historical Data Matrix is the descriptive matrix of concepts, skills, and descriptor data found in nurse and communication meta-analysis literature.

Table 1

Historical Data Matrix: Meta-Reviews of Nurse–Patient Relational Communication and Interpersonal Skills, 2010 Back to 1990

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[1] Stajduhar, Thorne, McGuinness, & Kim-Sing (2010)	Patient satisfaction in communication	Secondary analysis of large study	<ul style="list-style-type: none"> • Relational approach • Time: no minimum but active listening, eye contact, sitting down, not appear hurried • Demonstrate care: empathy, physical contact • Open to alternatives in care • Acknowledge fear • Balance honesty and hope • Information 	<ul style="list-style-type: none"> • Task approach • Time: none, overt appearance of too busy • “Nothing more we can do” • Lack of acknowledgement of fear • False hope • Lack of information 	Cancer study
[2] Berry (2009)	Nurse–patient communication	Study content analysis	<ul style="list-style-type: none"> • Information giving, counseling, open-ended questions, assure comprehension, requesting opinions, reassurance, statements of concern, agreement, approval 	<ul style="list-style-type: none"> • Provider has agenda questions, gathers medical information only, limits patient’s comments, gives directions, closed-ended questions 	Verbal communication only

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[3] Fleischer, Berg, Zimmermann, Wuste, & Behrens (2009)	Nurse–patient communication and interaction	Literature review	<ul style="list-style-type: none"> • Patient-centered: influence health and mental well-being of patient • Trust, knowledge, caring, respect, courtesy, empathy • Verbal: Ability to personalize approach—rate of speech, connecting, tone of voice • Conscious use of nonverbal techniques (contact/touch, proximity/personal space, physical orientation, body posture, head nods, facial movements, gestures, looking/eye contact, and paralinguistic aspects of speech silence) 	<ul style="list-style-type: none"> • Stereotyping, custodialism, rule enforcement, lack of intimacy, lack of friendliness, empathy and caring 	Most studies lack theoretical overview identification
[4] Carpiac-Claver & Levy-Storms (2007)	Nurse aides: older adults communication; affective communication	Study	<ul style="list-style-type: none"> • Relationship development: personal conversation, addressing resident (by name, terms of endearment), checking-in questions (Are you cold, hungry, thirsty), emotional support/praise (well-being, emotional support [empathy]) 	<ul style="list-style-type: none"> • Patronizing speech style: baby-talk, elder speak • Task-oriented communication 	Long-term care setting
[5] Finfgeld-Connett (2007)	Conceptualization of caring	Meta-analysis	<ul style="list-style-type: none"> • Consistent with previous studies. • Caring: context-specific interpersonal process characterized by expert nursing practice, interpersonal sensitivity, and intimate relationships 	<ul style="list-style-type: none"> • none 	Applies to all healthcare professionals

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[6] Timmins (2007)	Nurse communication skills: key communication requirements	Literature review	<ul style="list-style-type: none"> • Patient-centered • Developing nurse–patient relationship (termed therapeutic relationship): Information giving, listening, empathy, support in context regardless of time, openness, touch 	<ul style="list-style-type: none"> • Anti-engaged: guarding, too busy, dehumanizing, withdrawing, distancing, labeling 	
[7] Finch (2005)	Relational communication theory	Define relational preferences	Relational preferences behavior descriptors: <ul style="list-style-type: none"> • Caring: concern, compassion, considerate, genuine, kind • Warm/friendly: cordial, courteous, nice, personable, pleasant, rapport • Professional: businesslike, respectful, straightforward • Competent: efficient, knowledgeable, thorough • Empathy: understanding • Listens: attentive, interested • Honest/Sincere: truthful, authentic, real 		Nurse–patient communication assessment tool

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[8] Feldman-Steward, Brundage, & Tishelman (2005)	Conceptual framework of communication between healthcare professional/patient; design for course/evaluation	Meta-analysis	4 key areas: <ul style="list-style-type: none"> • focus of interaction • participant attributes • communication process (conveying, receiving, verbal, nonverbal, silence) • environment (external factors, physical setting, and context) 	<ul style="list-style-type: none"> • Blocking, non-immediacy 	Cancer context but can be generalized; applies to all healthcare professionals
[9] Stockman (2005)	Nurse–patient relationship (Peplau’s 1952 Interpersonal Relations Theory)	Literature review	<ul style="list-style-type: none"> • Positive attitude • Availability, trustworthy actions • Listening • Comfort • Consistent care • Empower clients 	<ul style="list-style-type: none"> • Unavailable • Inequality • Withdrawal • Negative feelings 	Psychiatric nurse–patient relationship

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[10] Williams & Irurita (2004)	Therapeutic and non-therapeutic interpersonal interactions	Study grounded theory	<ul style="list-style-type: none"> • Feeling secure: displaying competence, developing relationships; as a person, frequent contact • Indicating availability • Feeling informed: providing information; honesty, openness • Feeling valued: non-verbal interactions: eye contact, close spatial positioning (especially sitting), sensitive tone of voice, gentleness through touch, active listening, smiling • Verbal interactions: engaging patient in chitchat, commending, continuous and frequent contact, attending to little things (exceeding expectations) 	<ul style="list-style-type: none"> • Feeling insecure: displaying incompetence, insufficient or inappropriate interactions—verbal and nonverbal • Not being available • Feeling uncertain: inadequate information • Feeling devalued: non-verbal: lack of eye contact, spatial distance, absence of touch or rough touch, blank or serious expression; verbal: not engaging in chitchat, not remembering personal details, infrequent and limited contact 	
[11] Wanzer, Booth-Butterfield, & Gruber (2004)	Patient-centered communication (PCC)	Study	<ul style="list-style-type: none"> • Nurse/hospital staff: PCC training: empathy (nurse), immediacy, clarity (nurse/hospital staff) 		Pediatrics

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[12] Shattell (2004)	Nurse–patient interaction and review of theoretical model on face work from 1955's Goffman	Literature review	Face work theory: <ul style="list-style-type: none"> • Genuine, not in a hurry, available, willing to talk • Be valued and respected • Social interaction important 	<ul style="list-style-type: none"> • Loss of face: treated like object, loss of autonomy, self-esteem • Social labeling of patients, use of threats 	
[13] Yeakel, Maljanian, Bohannon, & Coulombe (2003)	Patient satisfaction (Wolf's Caring Behaviors Inventory)	Study training: multifaceted intervention	<ul style="list-style-type: none"> • Patient satisfaction items: nurses were caring, staff treated patients with respect and courtesy, staff introduced and explained role 	<ul style="list-style-type: none"> • Use of content-based communication 	
[14] Hagerty & Patusky (2003)	Review nurse–patient relationship, propose new model	Literature review	<ul style="list-style-type: none"> • Dynamic, iterative interactions • Mutually set goals • Time not a factor • Involved patient role 	<ul style="list-style-type: none"> • Relationship is linear • Task-oriented • Role expectation 	
[15] Aspinall, Addington-Hall, Hughes, & Higginson (2002)	Patient satisfaction measurement, 1970 to 2000	Literature review	<ul style="list-style-type: none"> • Patient need fulfillment • Demographic variables • Communication and information • Family involvement 	<ul style="list-style-type: none"> • Lack of theoretical underpinning • Differing methodology • No agreement on tools • Poor communication and information most frequently cited 	Palliative care

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[16] Johansson, Oleni, & Fridlund (2002)	Patient satisfaction	Literature review	<ul style="list-style-type: none"> • Clear information • Patient involvement • Time spent: listen • Respect, trust, honesty, cooperation, humor • Physical environment 		Age factor
[17] Kunyk & Olson (2001)	Conceptualization of empathy, 1992 to 2000	Literature review	<ul style="list-style-type: none"> • Concepts: communication process, caring, a special relationship • Three-stage process: empathy potential, empathy expressed, empathy received 		
[18] Suikkala & Leino-Kilpi (2001)	Nursing student–patient relationship. 1984 to 1998	Literature review	<ul style="list-style-type: none"> • Awareness of self and feelings • Caring with attitude of compassion/respect • Not hurried • Seeing patients as individuals • Empathy • Touching • Use of humor • Listening skills 	<ul style="list-style-type: none"> • Limited, descriptive and atheoretical in nature 	

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[19] Kruijver, Kerkstra, Bensing, van de Wiel (2001)	Nurse communication behaviors, 1979 to 1998	Literature review	<ul style="list-style-type: none"> • Empathy: affirmation as a person • Friendship • Information giving • Affective touch • Listening • Comforting strategies: humor, comfort • Emotional support • Respect, encouragement, information • Clinical know-how 	<ul style="list-style-type: none"> • Task-oriented touch • Insufficient information/vagueness • Avoidance: blocking behavior • Ignoring needs of family • Perceived lack of time 	Limited to nurse and cancer patients
[20] Caris-Verhallen (1997)	Communication for elderly nurse–patient relationship	Literature review	<ul style="list-style-type: none"> • Attitude • Showing respect • Giving comfort • Trust • Style of speech • Reassurance • Jokes and humor • Affective and instrumental touch • “Doing with” focus on patient and task (asking questions of patient) • “doing more”: establishing a relation • “doing for”: focused on patient, communication about care and social talk 	<ul style="list-style-type: none"> • “doing tasks” with no communication • Patronizing • Language to assert power • Blocking behaviors • Elder speak 	Elderly nurse–patient relationship

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[21] Hatrick (1997)	Relational foundations/theoretical review/new model	Literature review	<ul style="list-style-type: none"> • Value approach: intent, knowledge, commitment and actions • Relational caring: initiative, authenticity, responsiveness, mutuality, complexity, intentionality, reimagining 	<ul style="list-style-type: none"> • Behavioral approach: emphasis on behavioral communication skills: clarification, open-ended, empathy, listening, attending, self-disclosure, confrontation, immediacy 	Behavior approach not negative but mechanistic if value approach is not implemented
[22] White (1997)	Empathy	Literature review—concept analysis	<ul style="list-style-type: none"> • Critical attributes take place at moment of need • Active attending and listening • Verbal and nonverbal response to patient • Recognize and respond in same tone • Reassurance through verbal and nonverbal 		

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[23] Mahon (1996)	Analysis of concept for patient satisfaction/nurse relationship	Literature review—concept analysis	<ul style="list-style-type: none"> • Art of care/interpersonal manner/humaneness • Inherent personality of nurse • Nursing care characteristics • Communication ability • Information gathering • Information giving/explanation • Demonstrated concern • Mutual goal setting • Ability of patient to express feelings • Technical competence • Access • Availability 		Organizational and finance aspects not included
[24] Fosbinder (1994)	Interpersonal competence: patient satisfaction	Ethnographic and literature review	<ul style="list-style-type: none"> • Translating: informing, explaining, instructing, teaching • Getting to know you: personal sharing, humor, friendly, clicking • Establishing trust: being in charge, anticipate needs, prompt, follow through, like job • Going the extra mile: being a friend, doing the extra 		

(continued)

Table 1 (continued)

Authors (year)	Study focus	Type of study	Findings: Relationship building concepts/descriptors	Findings: Negative relationship and skills	Caveats
[25] Wilkinson (1991)	Analytical: relational behaviors	Study	<ul style="list-style-type: none"> Facilitating behaviors: introduction of self, purpose, acknowledge patient, open questions, encouragement, pick-up of cue, reflection, clarification, empathy, confrontation challenge, information giving, summarizing problems, patient questions, consultation of plan of action 	<ul style="list-style-type: none"> Blocking behaviors: stereotyping, false reassurance closed questions, “passing the buck”, disapproving, approving defending, change topic, change of focus too jolly 	Cancer study, 89% female patients
[26] May (1990)	Nurse–patient relationship	Literature review	<ul style="list-style-type: none"> Contextual interactions: nursing as a collective accomplishment, verbal interaction, establishing relationships Barriers presented in work environment/culture Talking only valid after “work” is done 	<ul style="list-style-type: none"> Technocratic approach controls nurse–patient interactions: little time in talk, tends to be superficial and task–oriented, avoids communication, controls all interaction Stereotyping patients 	Disparity between demands made on nurses versus establishing nurse–patient relationship

Discussion of Historical Data Matrix on Relational and Interpersonal Communication

Table 1 summarizes the meta-analysis of relational and interpersonal communication terminology either through literary reviews or major studies on a single concept (for example, empathy). Since 2005, more studies incorporate the terminology and concept of relational approaches and patient-centered care. Feldman-Steward et al. (2005) (see bracketed number 8 on Table 1) presented a conceptual framework for healthcare provider–patient communication interactions in cancer care with four key components. Two components focused on interaction and goal setting. Both interaction and goal setting must address the patient’s attributes (needs, beliefs, values, skills, and emotions). The third component was the communication process itself as seen in verbal and nonverbal messages (and appropriate use of silence) over the time frame of association with the patient. The fourth component was the physical environment in which communication occurs. Three of the four components were relational in nature, with the other defining interpersonal communication skills.

In more recent literature reviews, Stajduhar, Thorne, McGuinness, and Kim-Sing . (2010); Carpiac-Claver and Levy-Storms (2007); and Finch (2006) discussed the relational development and descriptors for relational communication. Stajduhar et al. (2010) (see bracketed number 1 on Table 1) provided descriptors of relational communication which go beyond “therapeutic reaction.” Primary among their descriptors was seeing patients as individuals rather than illnesses. Carpiac-Claver and Levy-Storms (2007) (see bracketed number 4 on Table 1) listed descriptors for relationship development in long-term care facilities, and relied on the relational communication theory approach with the message

having a content and relational component. Finch (2006) (see bracketed number 7 on Table 1) used a nurse–patient relational communication theory to identify behavior preferred by patients, such as caring, warm/friendly, professional, competent, displays empathy, listens, and is honest and sincere. The Finfgeld-Connett (2007) (see bracketed number 5 on Table 1) study fell in between a relational and patient-centered approach in their conceptualization of caring. Agreement was found in their review of studies that caring was a context-specific interpersonal process characterized by expert nursing practice (i.e., clinical expertise), interpersonal sensitivity, and intimate relationships.

More recent studies that used the patient-centered concept as the main focus of their meta-reviews were Fleischer et al. (2009), Berry (2009), Timmins (2007), and Wanzer, Booth-Butterfield, and Gruber (2004). Fleischer et al. (2009) (see bracketed number 3 on Table 1) discovered that interaction terminology was inconsistent. They identified patient-centered communication terminology as trust, knowledge, caring, respect, courtesy, and empathy. Descriptors of interpersonal behaviors covered both verbal and nonverbal skills. The study also revealed that communication can be learned, and that patient involvement in the communication process was often lacking in many studies. Berry (2009) (see bracketed number 2 on Table 1) covered the most common verbal communication style used in the nurse practitioner–patient dyad. Most nurse practitioners believed they used patient-centered communication but the study proved just the opposite: only 30% of the participants did. Descriptors of patient-centered verbal communication were information giving, information seeking, partnership building, social conversation, positive and negative talk. Timmons (2007) (see bracketed number 6 on Table 1) referred to patient-centered communication but

also the nurse–patient relationship as a therapeutic relationship. The study provided concepts such as empathy, support, openness, and specific interpersonal skills such as listening and touch. In the review of the literature by Stockman (2005) (see bracketed number 9 on Table 1), the focus was on current use of Peplau’s (1952, 1997) interpersonal relations theory as the theoretical framework for relational nursing in the psychiatric nurse–patient relationship. Her conclusions called for an update with newer theories. Stockman listed a modern catalog of concepts in interpersonal relationships: availability and trustworthy actions, comfort, consistent care, empowerment of clients, and listening. Wanzer et al. (2004) (see bracketed number 11 on Table 1) focused on the parents’ perception of patient-centered communication with their children in pediatric care. This large study found that immediacy behaviors (such as humor or laughter) and active listening were the most frequently associated behaviors with positive patient satisfaction in the nurse–child interaction.

Literature reviews prior to 2005 were categorized according to relational, interpersonal, or patient satisfaction. Two studies on the concept of empathy were Kunyk and Olson (2001) (see bracketed number 17 on Table 1) and White (1997) (see bracketed number 22 on Table 1). The earlier study, White (1997), provided descriptors on the concept: empathy needs to take place at the moment of need, active attending and listening should be present, both verbal and nonverbal responses must be used, and the need to recognize and address the patient in the same tone of voice. An additional behavior descriptor described in the study was reassurance, given to the patient through verbal and nonverbal communication. Kunyk and Olson (2001) (see bracketed number 17 on Table 1) defined the empathy concept as “caring,” created a special relationship, and provided a three-

stage process. The first was empathy potential, followed by empathy expressed, and finally, empathy received in the nurse–patient relationship. While this appeared to be a linear progression over time, the study reported that empathy was a much more complex and intertwined process. As a communication process, empathy was described as a central focus and feeling with another.

Earlier studies on the relational aspect of the nurse–patient communication process include Hagerty and Patusky (2003), Suikkala and Leino-Kilpi (2001), Caris-Verhallen (1997), Hatrick (1997), Wilkinson (1991), and May (1990). These studies share the terminology of *relationship* building, interaction in communication between the nurse–patient, showing respect, acknowledgement of the patient as a person, and empathy. Hagerty and Patusky (2003) (see bracketed number 14 on Table 1) raised the issue that communication was taught as task-oriented, and had a linear progression. They suggested an approach that incorporated mutual goals setting, and noted that the amount of time spent with the patient should not affect the relational dynamics. Suikkala and Leino-Kilpi (2001) (see bracketed number 18 on Table 1) raised the issue of self-awareness by the nurse as part of the communication process. In addition to a caring attitude, respect for the patient, and treating the patient as an individual, they included the interpersonal skill descriptors of empathy, listening, touch, and a sense of humor. Establishing a relationship between the nurse–patient and nurse aide–patient with the elderly was Caris-Verhallen’s (1997) (see bracketed number 20 on Table 1) major focus. The use of blocking behaviors (frequently raised in the literature review) was demonstrated by performing a task without either verbal or nonverbal communication, ignoring nonverbal signs of distress, or pretending not to hear the patient. A

good attitude, showing respect, giving comfort, as well as joking were part of “doing more” in establishing a relationship. The focus on the patient included communicating about care and the use of social talk. With elderly patients and residents, the style of speech was an important factor in the relationship, particularly by avoiding “elderspeak.” Hatrick (1997) (see bracketed number 21 on Table 1) divided the relational behavior into two categories: value approach and behavioral approach. The value approach listed relational caring concepts of commitment and authenticity. The behavior approach was an emphasis on interpersonal skills behavior such as listening, attending, clarification, and open-ended questions. While the listed interpersonal communication skills behaviors were not negative, the study was approaching relational communication from a different perspective. Basically, Hatrick’s perspective was that without the commitment and intent of the value approach, the models of interpersonal skills become less valuable and more mechanistic.

The two older studies on relational communication, Wilkinson (1991) (see bracketed number 25 on Table 1) and May (1990) (see bracketed number 26 on Table 1) both highlighted the negative interaction factors, such as blocking behavior and stereotyping. The element of “control” was named in May’s (1990) study where the nurse controls the patient through disapproving words or actions, communication avoidance, or controlling the communication exchange. The negative factors of displaying verbal and nonverbal “too busy” attitudes contributed to a negative perception by the patient. The issue of environmental factors as barriers in allowing the nurse time to establish a relationship also was raised in both studies. Positive interpersonal skills mentioned by both studies included

introducing oneself, acknowledging patient, encouragement, clarification, summarizing problems, and contextual interactions.

Studies that focused specifically on interpersonal communication skills were Williams and Irurita (2004) (see bracketed number 10 on Table 1), Shattell (2004) (bracketed number 12), Kruijver et al. (2000) (bracketed number 19 on Table 1), and Fosbinder (1994) (bracketed number 24 on Table 1). These studies crossed over in defining many of the same interpersonal skills. They also emphasized interpersonal skill acquisition, competence, and training. Verbal skills listed included information giving (and clinical know-how), explaining, tone of voice, and social interaction. Nonverbal skills were not being in hurry (available and/or frequent contact), listening, use of affective touch, spatial positioning (sitting), smiling, and “going the extra mile.”

The final category of the historical data matrix was patient satisfaction studies. Concepts under this category included both concept and skills behavior. Yeakel, Maljanian, Bohannon, and Coulombe (2003) (see bracketed 13 on Table 1), Aspinal, Addington-Hall, Hughes, and Higginson (2002) (see bracketed 15 on Table 1), Johansson, Oleni, and Fridlund (2002) (see bracketed 16 on Table 1), and Mahon (1996) approached relational communication and interpersonal skills from the patient-satisfaction perspective. Three of these studies shared a conceptual based point of view. Inherent in this view were the concepts of caring, respect, and fulfilling the patient needs (Yeakel et al., 2003; Aspinal et al., 2002; Johansson et al., 2002). Mahon (1996) (see bracketed number 23 on Table 1) approached patient satisfaction and the nurse–patient relationship as an analysis of the concept. The art of care, interpersonal manner, as well as humaneness were the descriptors.

Included in the delineation of concepts were the inherent personality of the nurse and the nurse's communication proficiency. Two additional traits included technical competence and family involvement.

Once the historical data matrix (Table 1) was created and analyzed, it was necessary to review nurse and communication theories in order to discover which theory best provided a framework to incorporate the data.

Findings on Theoretical Framework

Interpersonal and Relational Theories From the Nursing Discipline

Few, if any, theories exist on relational theory in the nurse literature (DeFrino, 2009). Peplau's (1952, 1997) interpersonal nursing theory was one of the first to stress the "therapeutic nurse-patient relationship as the crux of nursing" (as cited in DeFrino, 2009, p. 302). Nurses need to see "the patient more than as an object of clinical attention but to understand [the patient] . . . as a subject (not an object) with a social history" (DeFrino, 2009, p.302). In the current environment, where nurses have greater constraints on their time and are required to use more technical equipment, even less time is allotted to the nurse-patient relationship.

DeFrino (2009) stated that "the nurse-patient relationship is vital specifically because of the rushed, computer-dominated, non-human orientation that gives nurses less time to be with the patient and more time to monitor, record, program, and generally have distance from the patient" (p. 306). DeFrino (2009) proposed a new theory based on Fletcher, Jordan, and Miller's theory of relational work of women, stating that, "power and knowledge lie in relational work and that without the ability to engage in it, patient outcomes are poorer and

nurses are professionally dissatisfied” (p. 294). DeFrino’s theory’s purpose is to show that the relational work done by nurses is valuable and should be part of the job definition. Her derived theory incorporated relational practices in nurse–patient, nurse–patient’s family, nurse–physician, and nurse–coworkers dynamics in the healthcare environment. As proposed, DeFrino’s new theory is “relational” in terms of the inherent value of women’s caring as a dynamic function in nurse’s work. “The dynamic of relational practice needs to be put into context at the workplace in order to appreciate how all nurse’s hard work [has] disappeared” (p. 300). DeFrino’s theory emphasizes the on-the-job importance of relational communication; however, her theory does not cover the actual teaching or descriptors of interpersonal skills needed in training.

Nursing theories most frequently cited in nurse literature such as Peplau (1952, 1997), King (1981), Leininger (1978), Orlando (1961), and Watson (1979, 1985) discussed the nurse as “helper” and the patient as recipient, or focused on specific aspects of communication skills such as “caring, empathy, and trust” (Finch, 2005, p. 14).

Peplau (1952) constructed her initial nurse–patient theory of interpersonal relations to show the developing nature of the therapeutic relationship. She described four phases of the nurse–patient interaction: (a) orientation (establishing a working relationship), (b) identification (nurse helps patient identify his or her needs), (c) exploitation (nurse and patient communicate to identify and discuss patient’s health goals), and (d) resolution (old health goals completed or adjusted and new goals established). In this fourth phase the patient concludes the relationship with the nurse. The linear progress of these goals stressed the

interaction between the nurse and the patient. The nurse used both instrumental (clinical) tasks and affective behaviors associated with relationships.

King's (1981) theory of goal attainment was a conceptual framework that stated individuals were an "open system interacting with the environment," and each individual was "a dynamic human being whose perceptions of objects, persons, and events influence his behavior, social interaction, and health" (as cited in Williams, 2001, p. 25). The conceptual framework included three interacting systems: personal (the individual), interpersonal, and social. The interaction between the nurse–patient must include the ideas that each individual develops a perception of self over time, that interactions (or interpersonal communication) must occur between the nurse and patient, and that the patient has his or her own set of social values and rules of behavior.

Leininger's (1978) culture of care theory put "care" as the central focus of nursing. This construct, called transcultural nursing, identified "a lack of cultural and care knowledge as the missing link to nursing's understanding of the many variations required in patient care to support compliance, healing, and wellness" (George as cited in Sitzman & Eichelberger, 2004, p. 94). Culture, in Leininger's theory, "referred to the differences in meanings, values, or acceptable modes of care within or between different groups of people" (Sitzman, & Eichelberger, 2004, p. 95).

Orlando's (1961) interaction theory expanded on Peplau (1952) by focusing on meeting the patient's needs through instrumental and affective behaviors. The needs are met "through a process of deliberative interaction in which the nurse recognizes the verbal and

nonverbal behavior indicative of unmet needs, validates those needs with the patient, and acts to meet the patient's needs" (as cited in Caris-Verhallen, 1997, p. 917).

Watson's (1979, 1985) theory of human caring provided an "ethical" and "philosophical foundation for the human dimensions of caring" (Watson, 2006, p. 193). The theory included 10 "carative" factors, the transpersonal aspects of a "caring moment," and the holistic relational aspects of the nurse-patient dyad. The original factors included concepts and actions of sensitivity, development of a helping-trusting relationship, promotion of transpersonal teaching and learning, and assistance with the gratification of human needs. Watson saw caring as a moral obligation within nursing. Idealistically, in the future, care will become as important as the actual curing process.

One unexpected finding in the nursing literature in the 1970s and 1980s was that more studies began referring to the "theory-practice gap" in nursing. Part of the "gap" referred to nursing and clinical theories, but the other part referred to communication skill theory and practice, particularly once students became nurses in the field. Studies indicated that students and professionals found that what was taught and what was needed on the job differed considerably, leaving them dissatisfied with their lack of communication skills. For example, Brereton's (1995) review of the literature illustrated the problems of confusion in definitions where some definitions used communication theory and others used interpersonal theories. He also found that many studies assumed that prior life-experience socialization skills were more relevant than they actually were. He stated that "interpersonal skills develop only after long-term learning," and that it is finally time to affirm that communication skills are not based on "common sense" (p. 321). Another idea raised was

that teaching interpersonal skills may be limited to the knowledge base of the instructors, that is, communication skills were taught by nursing faculty, rather than by communication faculty. A specific recommendation of this study asserted, “The importance of developing communication/interpersonal skills (using theory as a basis for practice rather than relying on experience alone) needs to be recognized by teachers, mentors, and students” (p. 323).

To summarize the nursing theoretical literature, the studies of DeFrino (2009) and Brereton (1995) covered over 40 years of research on nurse–patient relational theories. The findings indicated that a specific theory to address what is involved in a nurse–patient relationship and “what type of communication processes enhances that relationship” remains undefined (Finch, 2006, p. 15). A theory-to-practice gap exists in teaching communication skills, particularly when communication skills are taught in clinical courses by nurses. While the nursing researchers borrow most of their theories from psychological and sociological theorists, communication theorists, who to an extent do the same, provide more encompassing interpersonal and relational theories to assimilate the broader relational concept of communication.

Theories From the Communication Discipline

In the communication discipline, interpersonal communication relies heavily on transactional models and relational communication theory. Interpersonal skills, as defined in the communication field, cover two, equally important, self-directed behaviors: the ability to communicate effectively with others, and the ability to interpret the expressions of others (Duggan, 2006; West & Turner, 2006). Both the sender and receiver are equally involved in a reciprocal and bidirectional process. The communication discipline, by its nature, provides

more encompassing theories related directly to the sender and receiver of messages whether between two people (a dyad) or among a group. What the communication discipline can offer from a theoretical perspective is a framework of communication, as well as a skill set that can be used in any relational context.

Parks' (1977) explication of dimensions of relational communication theory explained that "[Relational theory] is one of the few perspectives to deal with the relational or transactional aspects of communication. It is capable of making predictions of, and providing explanations for, a wide range of behavioral phenomena in interpersonal relationships" (p. 379). His basic premise of the dimensions of relational communication took into account a relational and a content component. This concept also included a power dimension of control in any relationship at any given point in time. "The unit of analysis is no longer the individual; it is the relationship or transaction The exchange as a whole, rather than single messages, constitutes the basic unit of analysis for relational communication" (Parks, 1977, p. 374). A one up/one down power dimension exists in most relational situations (for example, supervisor–employee, parent–child, nurse–patient). During the 1960s and 1970s, most relational theory focused on family. However, even at that time, Parks (1977) and those theorists who followed, advocated that other contexts must be investigated and included (i.e., health communication as in Burgoon & Hale, 1984). Relational communication can make predictions and provide explanations for an extensive range of behavior phenomena in the interpersonal relationship.

Millar and Rogers (1987) defined relational communication as direct interaction since message exchange between people includes both the content and the building of

relationships. Specifically, their model provided a method to examine the relational dimension of control, which is defined as “establishing the right to define, direct, and delimit the actions of the dyad at the current moment” (p. 120). They defined a three-dimensional model based on control, trust, and intimacy that explicated behaviors intrinsic to relationships (Rogers, 2004; Rubin, Perse, & Barbato, 1988).

Communication scholars Burgoon and Hale (1984, 1987) provided fundamental topoi of relational communication. Their purpose was to define specific descriptors involved in relational communication. They developed a schema of 12 distinctive relational communication themes and included nonverbal communication as part of relationship: dominance–submission, intimacy, affection–hostility, intensity of involvement, inclusion–exclusion, trust, depth–superficiality, emotional arousal, composure, similarity, formality, and task–social orientation. From previous research on relational communication theory, they posited that relational communication was more of a “multifaceted prism” and “may lead to an underestimate of how much relational meaning is present in a typical exchange” (1984, p. 194).

Summary of Theoretical Findings

While the relational theories and models of Millar and Rogers (1987) and Burgoon and Hale (1984, 1987) add further dimensions and scope to relational communication, Parks’ (1977) relational theory provided a very basic and conceptual framework from which other theories evolved. As a basic conceptual frame, it is the best possible theoretical construct in which to place learning and teaching communication behaviors in the nurse–patient and healthcare professional–patient interaction. The main premise for relational communication

in nursing is to provide the framework for a therapeutic, caring, patient-centered relationship between the nurse (and other healthcare providers) and the patient. Nursing relational and interpersonal theories, as well as communication relational and interpersonal theories, add to the basic theory, but do not encompass the whole spectrum of relationship and skills. Parks' (1977) relational theory can do that by acting as an overall umbrella for the core components of a message in any relationship—the message content and the relational content. The most important interpersonal skills brought up in the theories and interpersonal skills literature in the nurse–patient relationship can be specifically delineated and placed within this overall framework.

In summary, Parks' (1977) relational theory is the most encompassing of the theories evaluated to act as the theoretical framework for relational communication behaviors and specific interpersonal skill behaviors for to develop the relational, interactional process in healthcare.

By collating and categorizing the data on behavior and interpersonal skills from the Historical Data Matrix (Table 1), it became possible to substantiate Parks' (1977) relational theory as the framework by using a grounded theory approach to validate the concepts extracted from the data.

Conceptualization of Data

Concepts, by definition, are abstract. According to Martin and Turner (1986), “Concept discovery refers to the strategic process of moving from data to abstract categories (Glaser, 1978; Glaser & Strauss, 1967), labels (Turner, 1981), or concepts” (p. 147). Berkowitz notes in her section on analyzing qualitative data that

Much of qualitative analysis . . . is structured by what Glaser and Strauss (1967) called the “method of constant comparison,” an intellectually disciplined process of comparing and contrasting across instances to establish significant patterns, then further questioning and refinement of these patterns as part of an ongoing analytic process. (p. 6)

While the “method of constant comparison” is part of grounded theory discovery, this study borrowed the process to compare data from both methodologies to find patterns. The goal was to see if the data comparisons could be categorized by conceptualized patterns of behavior. Concept discovery’s aim

is to find a level of abstraction high enough for one to avoid creating a separate concept . . . for every “fact” observed but low enough to ensure that the discovered concept relates explicitly to the substantive phenomenon under study. (Martin & Turner, 1986, p. 149)

In this study, data discovered about descriptors from the Historical Data Matrix to describe communication in the nurse–patient interaction over a 20-year period were categorized into patterns and formed into larger concepts. What emerged from the analysis were three specific concepts of communication behaviors bound together through relational communication theory: conceptual behaviors, verbal interpersonal skills, and nonverbal interpersonal skills.

In the review of the literature and meta-analysis studies, concepts frequently were listed either with descriptors (i.e., immediacy and use of touch), or listed without descriptors and definitions (i.e., therapeutic behavior). Skills often were listed as descriptors with

inherent definitions (i.e., nonverbal touch and listening), or simply as a group of interactional or interpersonal skills, (i.e., open-ended questions). However, once all descriptors—whether concepts or skills—were compiled, categorical relationships among them emerged resulting in behavior concepts (intangible) and behavior skills (physical). The results of this analysis revealed three core areas: communication *concept behaviors* for empathy and/or relationship building, *verbal interpersonal skills behaviors* for relational communication, and *nonverbal interpersonal skills behaviors* for relational communication (see Figure 2).

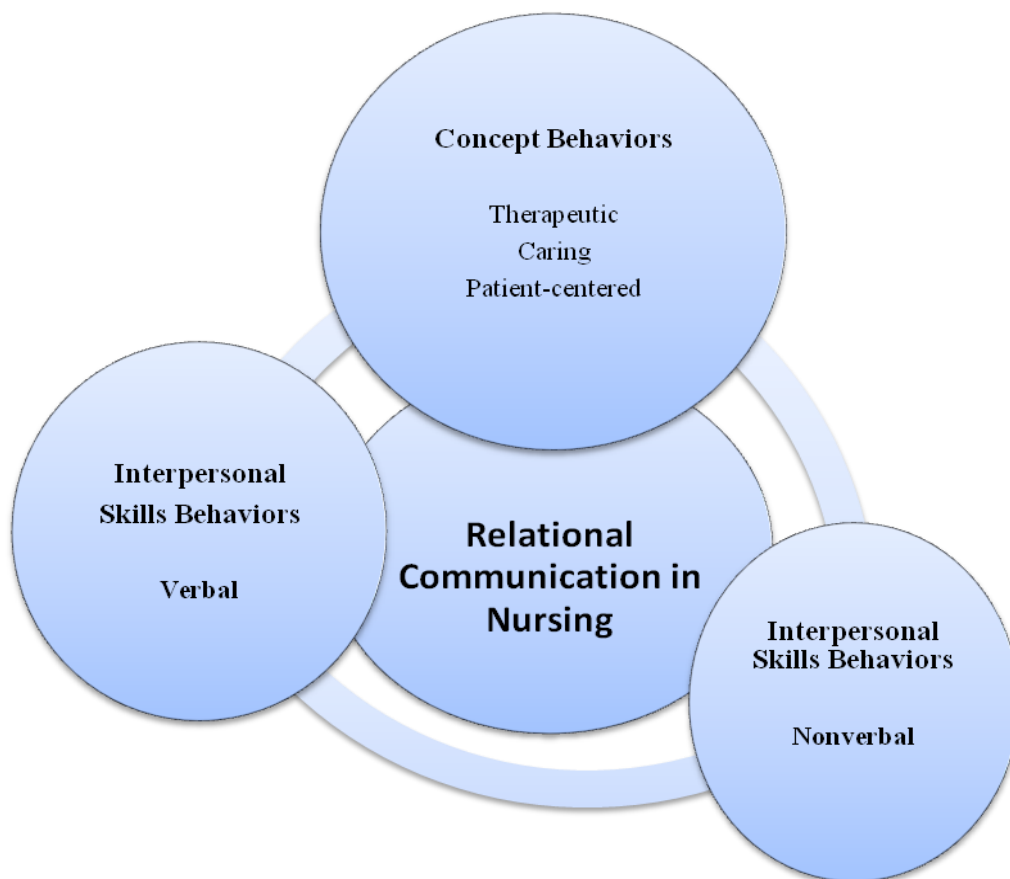


Figure 2. Conceptualization matrix of relational communication in nursing.

Figure 2 displays the components of relational communication in nursing and allied health professions. Intangible concepts such as “therapeutic,” “caring,” and “patient-centered” describe the overall intangible ideas of what nursing care embraces in the relationship between nurse–patient and healthcare provider–patient. Both the “interpersonal skills behaviors” of verbal and nonverbal comprise the physical action skills needed to implement the intangible concepts.

Theoretical Findings Summary

In order to validate the use of Parks’ (1977) relational theory as the overarching theoretical framework in which to teach relational communication to nurse and allied professionals, the grounded theory method (Glaser & Strauss, 1967) was applied to the data accumulated in the Historical Data Matrix as a reverse validation. Relational theory is a bottom-up approach, in which the message itself is broken into two distinct areas: the actual content (whether verbal or nonverbal) and the relational content (i.e., marriage, friendship, nurse–patient). The grounded theory method moves from investigation of all data toward a theoretical construct. “The researcher will want to develop a theoretical account that facilitates discussion of the general features of the topic under study and is firmly based or grounded in the data collected” (Martin & Turner, 1986).

Florence Nightingale’s warning that, “Experience teaches me that nursing and medicine must never be mixed up. It spoils both...” is relevant to the discussion on teaching communication skills through a relational communication theory and approach. The relational approach *does include clinical competence* in the nurse–patient dyad, as well as the relational concepts and skill sets of verbal and nonverbal interpersonal skills. Medical or

clinical competency can go hand in hand when the framework of the nurse–patient relationship is under the umbrella of a relational communication approach. The grounded theory method evaluation on the historical literature data, listed in Figure 2 as the operationalized descriptors of the nurse–patient relationship, subsequently validated the use of relational theory as the framework based on the descriptors in the literature.

The conceptualization of the Historical Data Matrix data into three specific areas corroborated the underlying theory of Parks’ (1977) relational theory as the central and theoretical framework for the nurse–patient communication process.

Operationalization of Concepts in the Nurse–Patient Relationship

Once the three core concepts were discovered, it was necessary to operationalize these descriptors to use in a grounded theory approach. By listing all behaviors and skills included in the conceptualization, an operationalized matrix of the terms was created (Figure 3). The operationalized matrix acted as the foundation for this current study’s theoretical approach and the creation of a healthcare communication course model for nurse and allied health students in the VCCS.

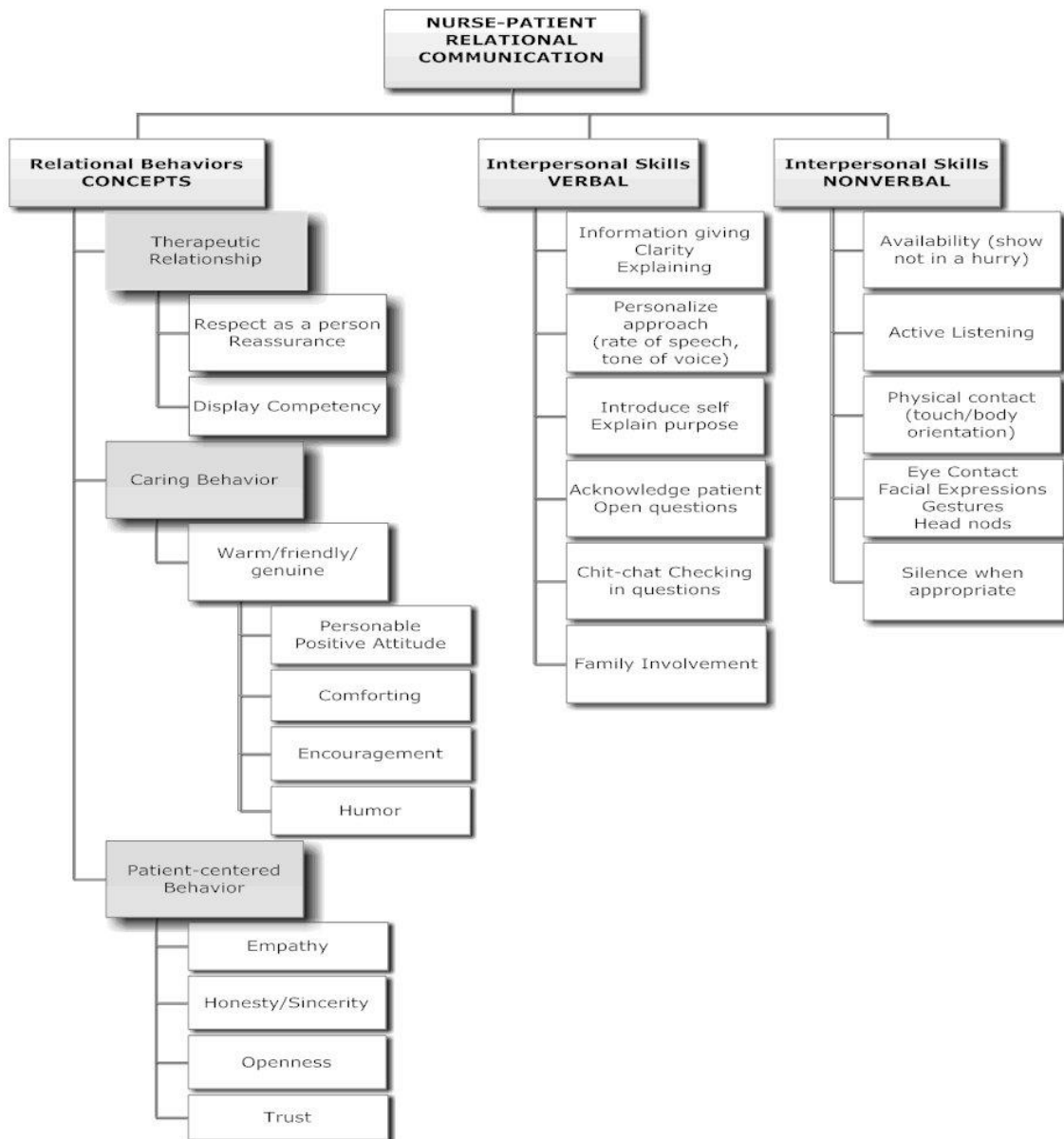


Figure 3. Operationalized matrix of nurse–patient relational communication.

Hierarchy of Concept Behaviors and Interpersonal Skills Behaviors in Figure 3

As listed in Figure 3, the three abstract concepts under *Relational Behaviors Concepts* include Therapeutic Relationship Behavior, Caring Behavior, and Patient-Centered Behavior. These general behavior concepts are more abstract than defined

interpersonal skills, yet they form unified clusters. Each is distinct in its descriptors. The Therapeutic Relationship includes “respect as a person” and “display of competency” (corresponds to Table 1 Historical Data Matrix Table study numbers 2, 3, 8, 10, 12, 16, 18, 19, 20, 21). Caring Behavior includes the general descriptors of “warm, friendly, and genuine.” These can be broken down to include “personable,” “positive attitude,” “comforting,” “encouragement,” and “humor” (corresponds to Table 1 Historical Data Matrix study numbers 2, 3, 7, 9, 10, 12, 13, 19, 20, 21, 22, 23). Patient-Centered Behavior includes “empathy,” “honesty/sincerity,” “openness,” and “trust” (corresponds to Table 1 Historical Data Matrix study numbers 1, 3, 4, 5, 7, 10, 11, 16, 17, 18, 19, 20, 22, 24, 26).

Interpersonal Verbal Skills Behaviors

The most frequent skills referenced in the Historical Data Matrix (Table 1) were either verbal or nonverbal interpersonal skills. Verbal skills are face-to-face communication consisting of sounds, words, speaking, and language. “Information giving/clarity/explaining” ranked highest of all verbal interpersonal skills. Information giving covers the amount of information given to a patient, how clearly it was explained (without medical jargon), and whether the information can be easily understood (corresponds to Table 1 Historical Data Matrix study numbers 1, 2, 6, 7, 8, 11, 13, 15, 16, 19, 26).

Other verbal interpersonal skills were “personalize approach” and include addressing a person by name, using the necessary rate of speech, and tone of voice (corresponds to Table 1 Historical Data Matrix study numbers 2, 3, 4, 6, 7, 10, 18, 20,

22). “Acknowledge patient” and ask “open questions” when interacting (corresponds to Table 1 Historical Data Matrix study numbers 2, 3, 4, 8, 10, 11, 14, 16, 19, 25, 26) involve the patient in conversation. “Introducing self and explaining purpose” for seeing patient, while frequently mentioned under the information giving category, was separate from the function of purely providing information. While not listed in meta-review studies as frequently as others, this skill often played an important role in the interaction process (corresponds to Table 1 Historical Data Matrix study numbers 5, 11, 13). “Chitchat and checking-in questions” meant a more patient-centered approach, but defined this verbal skill more specifically (corresponds to Table 1 Historical Data Matrix study numbers 4, 7, 10, 17, 20, 23, 25). “Family involvement” includes speaking to family members who are present, acknowledging their presence, and asking questions of family (if appropriate) (corresponds to Table 1 Historical Data Matrix study numbers 9, 15).

Interpersonal Nonverbal Skills

Nonverbal skills are acts that impart thoughts, opinions, or information without the use of spoken words. Nonverbal descriptors most frequently noted, in order of importance, were “availability” first (i.e., did not appear to be rushed) (corresponds to Table 1 Historical Data Matrix study numbers 1, 6, 10, 11, 12, 14, 16, 19, 22, 26). In most studies using this descriptor of “not in a hurry,” blame for appearing rushed was placed squarely on the current healthcare environment where fewer nurses are available for a larger number of patients.

The next most frequently listed descriptor was “listening” (corresponds to Table 1 Historical Data Matrix study numbers 1, 6, 7, 8, 9, 10, 16, 18, 19, 21, 22). Most described “listening” as “active,” meaning the nurse was engaged in what the patient was saying, rather than multitasking. Other descriptors were more evenly distributed throughout the studies. The descriptor of “touch” (corresponds to Table 1 Historical Data Matrix study numbers 3, 6, 10, 18, 19, 20) often was referred to as a therapeutic or comforting touch. “Eye contact” (corresponds to Table 1 Historical Data Matrix study numbers 1, 3, 10), “spatial positioning” (i.e., sitting) (corresponds to Table 1 Historical Data Matrix study numbers 1, 3, 10, 11), “tone of voice” (corresponds to Table 1 Historical Data Matrix study numbers 3, 10, 20), and “smiling/humor” (corresponds to Table 1 Historical Data Matrix study numbers 8, 16, 18, 20, 25) were descriptors of nonverbal paralanguage that contributed to either the concept of caring behavior or patient-centered behavior.

Triangulation Through Focus Group Data

The purpose of the focus group research was to triangulate the findings from the data collated from the nurse and communication disciplines research, as presented in Table 1 and Figure 2.

Approval was granted by George Mason University’s Human Subjects Review Board to conduct the focus group research. A total of four focus groups were held between April and October 2010 with a total of 31 participants. Three focus groups were held at geographically diverse VCCS community colleges with the nurse and allied health faculty. One focus group was conducted at a Virginia regional hospital with nurse and

allied health supervisors and administrators. Each focus group was conducted in the same manner: a 1-hour time limit, location at the college or hospital, and voluntary participation. Participation criteria for the college focus groups was that faculty be either in nurse or allied health programs. For the regional hospital focus group, volunteers were supervisors of nurses and/or allied health professionals. Participants in all focus groups were provided with a pre-approved Information Sheet prior to the session that listed the purpose of the research, outlined the format of the session, and explained why the session was audiotaped.

All volunteers signed a consent form which permitted the researcher to audiorecord the session for transcription purposes only. Tapes and transcripts are securely stored and will be destroyed upon publication of this study. In order to gain nonrestrictive cooperation, all colleges and the hospital, as well as the voluntary participants, were guaranteed confidentiality. Participants are coded in the findings. The session had five preapproved directed questions (Appendix C). Each focus group was asked the identical questions in the same sequence. Virginia community college nurse and allied health faculty focus groups are coded as CC1, CC2, and CC3. The one Virginia regional hospital focus group is coded as H1.

Findings From Focus Groups: Nurse–Patient Relationship

The Research Instrument consisted of five questions (Appendix C). The first two questions were:

1. What communication behaviors by a nurse do you consider most effective in establishing a relationship with a patient?

2. What complaints from patients do you hear most frequently regarding ineffective or non-existent communication skills with nurses?

Questions 1 and 2 results were combined to show the positive and negative communication behaviors in the nurse–patient relationship (see Table 2). Question 1 asks for communication behaviors that promote a relationship while Question 2 asks for known patient complaints regarding communication. Table 2 was modeled according to the Operationalized Matrix (Figure 3).

Table 2

Focus Group Findings on Nurse–Patient Communication

Concepts and interpersonal skills	Negative behaviors included in discussing concept or skills	Focus group
<u>Relational Behaviors</u>		
Therapeutic	Insensitive to nakedness	CC3, H1
Caring		No mention
Patient-Centered		H1
<u>Interpersonal Skills</u>		
<u>Verbal</u>		
Information giving	Not providing information on medicine and effects	CC1, 2, 3, H1
Personalize approach	Not asking questions, not waiting for response	No mention
Acknowledge patient		CC1, 2, 3
Introduce yourself/ explain why here		CC1, 2, 3, H1
Chitchat	Does not talk at all. just do task, using medical jargon	No mention
Family Involvement		H1
<u>Interpersonal Skills</u>		
<u>Nonverbal</u>		
Availability	Appears rushed or “too busy”	CC1, 2, 3, H1
Listening	Not listening	CC1, 2, 3, H1
	Avoidance behavior	
Touch		H1
Eye contact		CC1, 2, 3, H1
Voice tone		Not mentioned
Sitting		Not mentioned
Smile/humor		Not mentioned
<u>Other Descriptors</u>		
	Environment factors: noisy, constant in and out	H1
	Exams were “hurry up and wait”	H1

Note. CC = Community College 1, 2, 3 and H1 = Regional Hospital.

Collating the focus group data and comparing the results with the results in the Operationalized Matrix (Figure 3) created from the evaluation methodology produced similar findings in the three conceptualized areas: Conceptual Behaviors (see Figure 4), Interpersonal Skills Verbal (see Figure 5), and Interpersonal Skills Nonverbal (see Figure 6). While the researched Operationalized Matrix (Figure 3) lists a larger variety of behavior and skills required for relational communication between the nurse-patient, the general concepts are validated by the focus group findings.

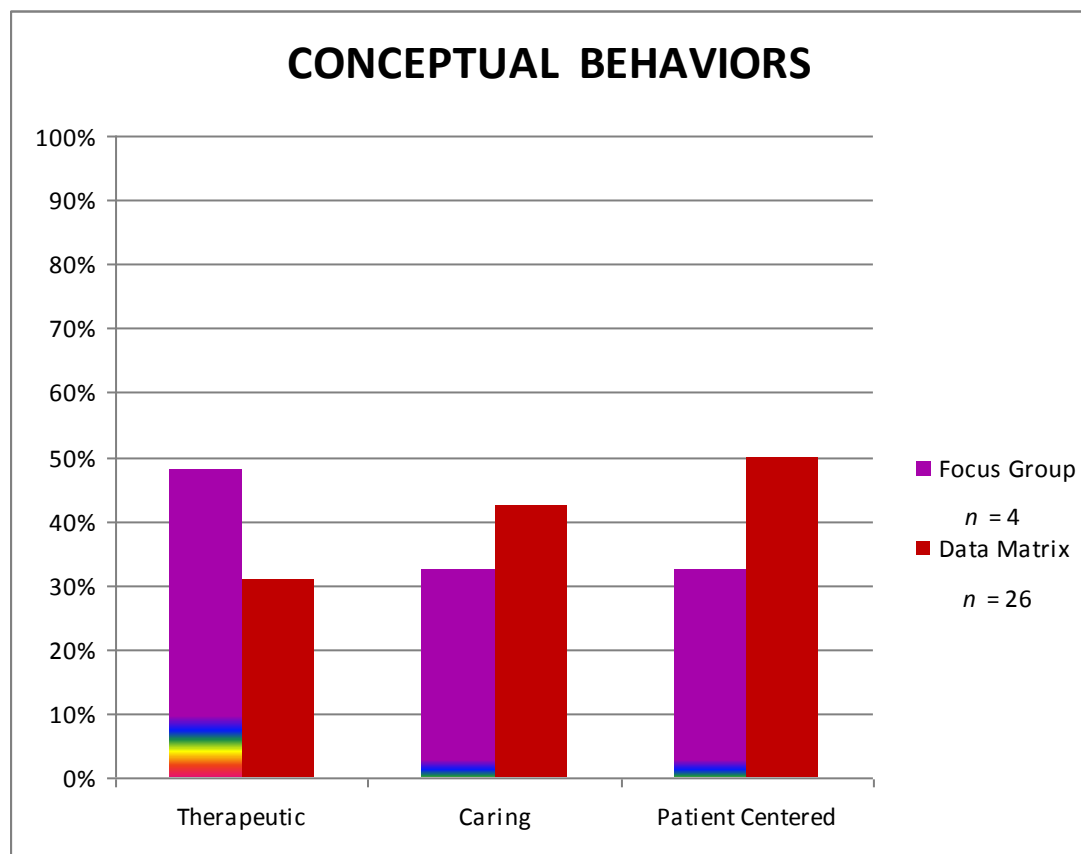


Figure 4. Focus group and data matrix conceptual behaviors.

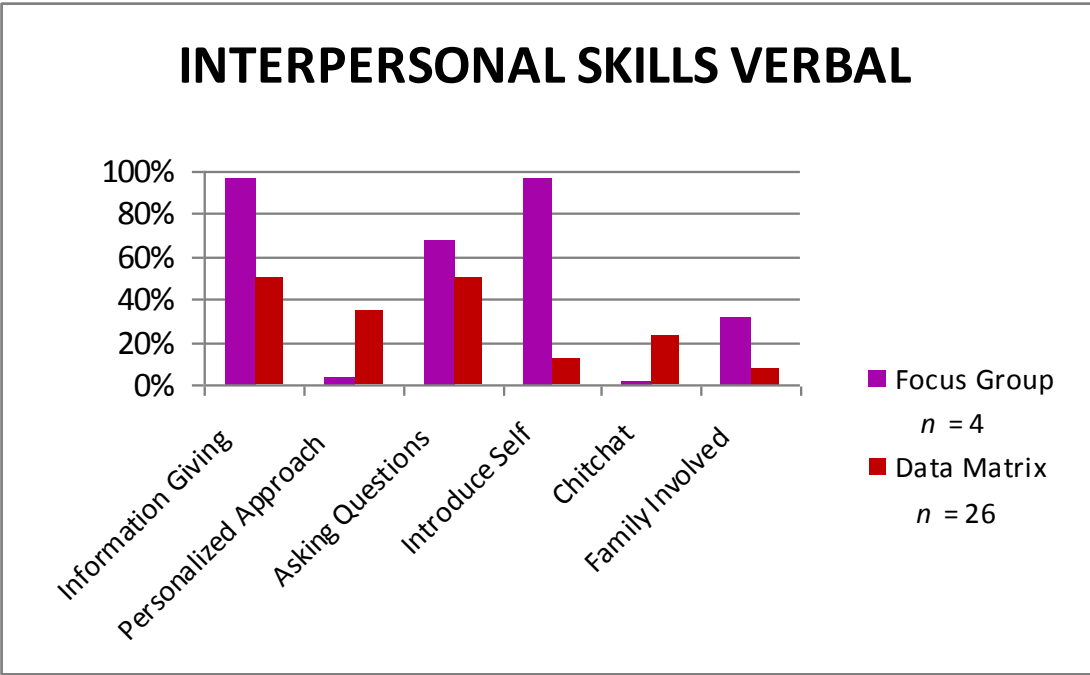


Figure 5. Focus group and data matrix: interpersonal skills: verbal.

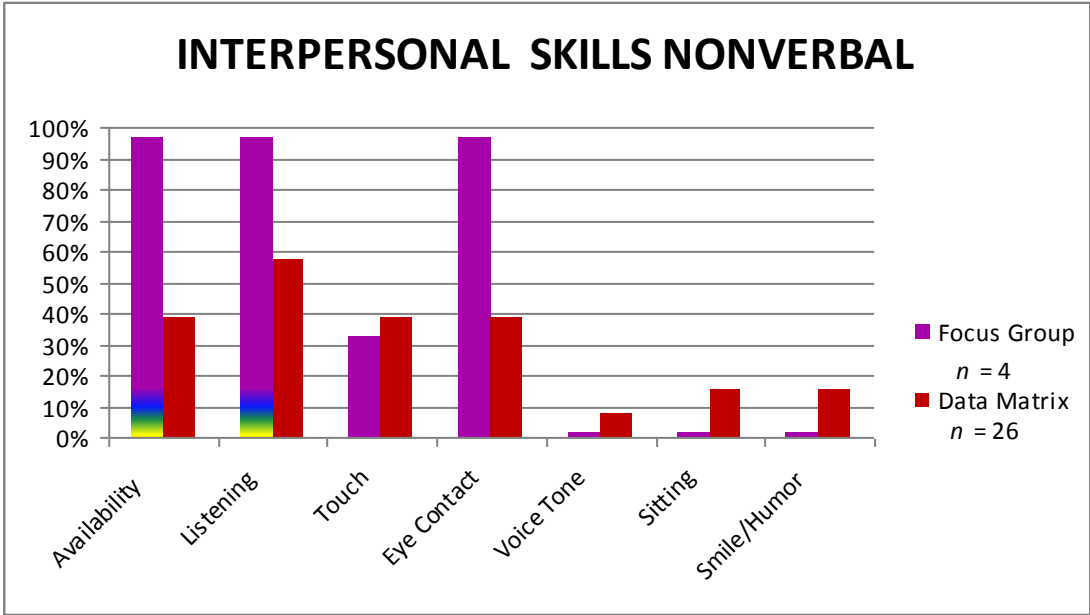


Figure 6. Focus group and data matrix: interpersonal skills: nonverbal.

Focus Group Findings for Communication With Each Other and Physicians

Question 3 of the Research Instrument in the focus group research asked, “Do you feel nurses require communication skills training in dealing with each other and/or with physicians?” Table 3 lists the specific problem areas noted by the focus groups.

Table 3

Nurse–Nurse and Nurse–Physician Communication

Problem areas in communication	Focus groups
Cross-discipline respect	CC1, 2, 3, H1
Class system, pecking order	
Afraid of doctors	CC1, 2, H1
Need to know boundaries	H1
Gender	CC2
Intercultural	H1

Note. CC = Community College 1, 2, 3 and H1 = Regional Hospital.

While the research question implied a yes/no answer, and was acknowledged as such, a follow-up question by the researcher was: Could you give examples of problems between healthcare professionals? In response, all focus group participants reported communication problems between nurse–physicians, nurse–nurse, and nurse–technicians. They named the lack of respect accorded to nurses by physicians, lack of respect by nurses to allied health professionals (i.e., radiologists, X-ray technicians), and nurse–nurse hierarchy in the system. Several participants dubbed it “the pecking order.” Nurse and nurse supervisor participants noted that frequently nurses are afraid of physicians, or afraid that the physician will humiliate them in some way. The regional hospital focus group reported that while interdisciplinary respect was good communication, healthcare

professionals need to know their boundaries: nurses are trained to a higher level than X-ray technicians, doctors are trained to a higher level than nurses, and so forth.

Gender communication problems were brought up by one group (CC2) as a communication hindrance, but others noted that the nursing field, while still predominantly female, is changing to include more male nurses. The focus group that brought up the gender communication problem talked at some length on the subject. Male nurses are often perceived by patients to be doctors, or, if not doctors, superior to female nurses. Almost all of the female nurse participants agreed that this perspective is a predominant patient view. The regional hospital group raised the issue of intercultural communication as a problem in healthcare. The participants explained that this communication barrier was not just with patients, but among coworkers, from physicians to nurses to allied health professionals and other non-medical staff. As the medical team becomes more culturally diverse, a need to understand the differences in culture becomes more important for communication.

Focus Group Findings on Communication Training for Nurses, Allied Health, and Staff

Questions 4 and 5 of the Research Instrument for the focus groups dealt with the current communication training provided by colleges and hospitals. Question 4 asked “What specific communication training do you most frequently provide (or wish to provide) for your current healthcare professionals (nurses, technicians, receptionists)?” As Table 4 demonstrates, VCCS colleges rely on the required Developmental Psychology course—a theory rather than skill course—in their nursing and allied health programs as

an all-inclusive training in dealing with individuals. Components of communication, such as a therapeutic relationship and conflict resolution, are incorporated in the clinical teaching courses. College 1 suggested CST 100 Public Speaking or CST 110 Introduction to Communication as electives in their programs. However, comments from Colleges 1, 2, and 3 were that public speaking does not teach what is needed in nurse communication training. One participant stated that, “Public speaking is not what nurses generally do. They need to know how to communicate with people of all ages and cultures, in varying stages of ill health.” Others echoed these sentiments. The regional hospital focus group uses a commercially partnered overall quality improvement program for all employees that includes communication as a component.

Table 4

Communication Training for Nurse and Allied Health Professionals

Colleges current training	Hospital current training	Suggested
PSY 230 Developmental Psychology	Commercially developed patient-centered training program	Specific communication skill(s) training seminar
Therapeutic communication component		
Conflict resolution component	Short communication seminars	
CST 100 Public Speaking or CST 110 Introduction to Communication (suggested)		Specific communication course for nurse/allied health

Note. CST = Communication Studies and Theatre.

Focus Group Findings on Best Practices for Development of Healthcare Course

Question 5 of the Research Instrument for focus groups asked, “What examples of communication practices and how they should be taught can you provide for use in the course development (i.e., generalizations of what is to be done and specific examples for teaching the application)?

In this final question the focus groups felt they already covered the best and worst skills. Regarding additional areas for training, the community colleges and the hospital focus groups believed conflict management was an area that required more attention prior to the job and while on the job. Another generalized area was the need for more intercultural training. The community colleges referred to role-playing, interviews, simulation lab, and self-assessment videos as the best teaching practices (Table 5).

Table 5

Best Teaching Practices and Needed Components for Communication Training

Teaching practice	Needs more attention in communication training	Focus group
Role-play	Conflict management	CC1, 2, 3, H1
Interviews	Generational communication	CC1, 2, 3, H1
Simulation lab		CC1, 2, 3
	Intercultural communication	CC1, H1
Self-assessment through videos		CC1, H1

Note. CC = Community College 1, 2, 3 and H1 = Regional Hospital.

Findings Summary Research Question 2

The second research question in this study, “Does a communication discipline, relational theoretical framework offer a comprehensive structure that would include both the communication and nurse disciplines’ conceptualized definitions of healthcare communication skills?” was answered by the creation of an Historical Data Matrix (Table 1), an evaluation of historical data, the conceptualization of behaviors (Figure 2), and the operationalized matrix (Figure 3) of the most frequently referenced descriptor concepts and interpersonal skills in healthcare. The data was triangulated by the findings in the five focus groups.

Differences in Findings Between Literature Data and Focus Group Data

It was interesting to note where the data from the literature and the focus group data differed. In the conceptual behaviors, the focus groups used the term “respect” more frequently than “therapeutic behavior” as cited in the literature. The terms “genuine,” “comforting,” and “humor” were frequent descriptors of caring behaviors by the focus group participants, whereas the literature frequently used caring behavior as a more general overall concept. Most descriptors under patient-centered behavior matched the literature almost exactly, but the literature showed a greater number of descriptors. “Personalized approach” and “chitchat” were left out of verbal interpersonal skill descriptors by the focus groups. This result may reflect the differing contextual situations. The clinical practice in college nursing programs is where the student is in a learning environment and under stress, while the focus groups represented experienced nurses. Still, the hospital focus group did not mention these verbal-specific traits. In

nonverbal interpersonal skills, tone of voice, sitting, and smiling/humor also did not come up in the focus groups. These interpersonal skills reflect patient feedback in patient satisfaction studies and may need future emphasis in communication training.

Research Question 3 Findings

Research Question 3 was: Would a healthcare communication course at the community college level improve communication skills for nurse and healthcare graduates of Virginia community colleges?

An interpersonal communication course for healthcare professionals was piloted in 2005 and 2006 by the researcher of this study at a Virginia community college. Pilot courses within the VCCS area only are permitted for two full semesters before a request for permanent status within the VCCS Master Course listing must be made. The pilot course, with modification, acted as a model for this current study's proposed CST 195 Healthcare Relational Communication course. The pilot course initially was created using relational communication theory (Parks, 1977) and social cognitive theory (Bandura, 2001). No formal data was collected; only student anecdotal feedback validated the course's value in teaching relational communication and interpersonal skills.

The model course presented in this study is designed solely on relational theory as the framework (Appendix D). The model's foundations are the conceptualization of relational theory (Figure 1) and the operationalized matrix as course content (Table 3).

Textbooks and Relevant Course Material

Few, if any, communication textbooks address both relational communication and interpersonal skills acquisition; most do one or the other. However, *Looking Out, Looking In* did emphasize the “transactional nature of interpersonal relationships” (Adler, Proctor & Towne, 2005, p. xi) with chapters on the relational aspect and chapters on specific interpersonal skills. In addition, the text covers conflict resolution, a topic raised by all focus group participants that needs to be incorporated into communication training. In the first running of the pilot healthcare course in 2005 and 2006 an interpersonal skills text was used. West and Turner’s (2006) *Understanding Interpersonal Communication* did not provide the relational elements required, which meant downloading articles found through the CINAHL and other databases. Both texts provided access to companion website. The film *Wit*, referred to at the beginning of this current study, added a healthcare dimension to the course and provided a good quantity of contextual situations for discussion and learning. The nurse and allied faculty at the college were another source for providing case studies. Most of the 22 students taking the pilot healthcare communication course were either in the nursing program or an allied health program or were about to enter the program.

Learning Activities

The learning techniques included in the pilot course and in the model course presented in this current study are a communication journal, three experiential projects, small group speeches, and class presentations. Students in the pilot course were required to keep a communication journal that served both as a reflective journal and an

experiential journal. For example, students were frequently required to use their own family and friends for discussions on relational aspects and specific communication skill acquisition. Short interviews with family on perspectives of stereotyping, gender, and generational differences served as practice prior to a project or presentation. As one student in the pilot course wrote in her final reflective exam:

I notice the difference in the way our family communicates with each other. As we went over new material in class I would make a conscious effort to use what I learned in communicating not only with my family member[s] but also in my everyday life . . . I would discuss a chapter with my husband and a week or two later he would tell me he used these at his work place to either communicate something or resolve a situation with positive results.

Experiential Learning

Learning by doing was a fundamental concept of Dewey (1934). The learning process must be grounded in experience. Lewin (1951) proposed that the individual must be active in the learning process in order to achieve success. Piaget (1972) defined intelligence as the interaction between the individual and environment. What is now called experiential learning flows from these theoretical foundations (Figure 7).

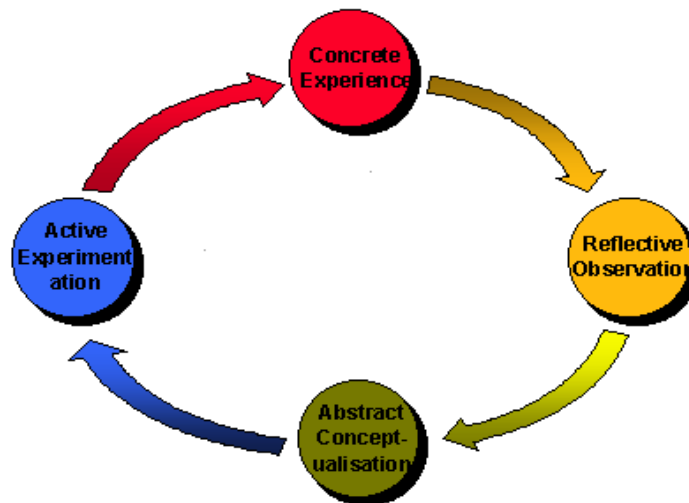


Figure 7. Experiential learning.

Concrete experience is developed through activities such as role-playing, interviews, reflective papers, surveys, case studies, and service learning (Kolb & Kolb, 2005; Kolb, 1984). An example of a reflective and experiential activity for journal writing in healthcare communication has the student record the various roles and personas each student enacted on a daily basis in home and in society. For example, a student may be a mother, sister, church member, decorator, event planner, and so forth (see Journal Activity, Appendix E). After keeping a list of the various roles the student has in life, he or she reflects on their communication styles in each situation. This reflection prepares students to reflect on the diversity of patients each will encounter in the healthcare field and how different communication skills are needed in these diverse situations. The learning outcome prepares students to look for patterns and understand concepts such as therapeutic or caring behaviors. A class discussion after this activity builds relational communication in the classroom and shows how this activity can be

applied in future healthcare contexts. Reflection also allows students to think critically about what each of them would do differently in future, similar circumstances. It helps students become more aware of the “individual” on the other end of the communication.

Learning Through Experiential Projects

Another area of experiential learning includes getting the students out of the classroom and learning on their own. One project on the concept of empathy asks the students to interview an administrator or volunteer at a homeless shelter or battered woman’s shelter (pregnancy centers and soup kitchens are other good places) (see Appendix F). Students prepare, and review with the instructor, questions ahead of time and gain necessary permissions. Afterward, students give an oral presentation in small groups. The project itself involves critical thinking, problem solving, and communication preparation. The oral reports in groups provide small group presentation practice, as students will do when a patient’s family is involved and in other group functions in healthcare.

Another project example involves nonverbal skill acquisition (Appendix G). Students observe patients and families in waiting rooms at large hospital outpatients centers. (Note: This activity does require the instructor to gain prior permission from the hospital. Help for this can usually be done through the Nurse and Allied Health department who performs clinicals at certain hospitals.) Students are required to sit for 30 minutes and observe the faces of patients as they approach the receptionist desk. In particular, they needed to note the patient’s facial expression after checking in to observe how staff members of a hospital communicate with patients (nice, do not even look).

They also observe the tone of voice, sound level, and manner in which the nurse calls the patient into a treatment room. Without staring at the patient or family, if possible, the student is to observe facial expressions. Observations include kinesics, facial expression, proxemics (distances), and haptics (touch) whenever possible. Results are reported orally but informally to the entire class. This effective project for teaching nonverbal observation in the pilot courses became one of the students' favorite activities. However, even with permission, students should not go together in groups larger than two. Students were given two weeks to fulfill this project in order to avoid any possible perceived intrusion on patients.

A third experiential activity has students interview an elderly person in their family, a disabled person whom they know, or a friend they know who previously had drug problems. Other ideas were brainstormed in the classroom. The procedure in this project was similar to the interview with volunteers or administrators in homeless/pregnancy centers. Permissions were required from the person they were to interview; questions need to be prepared and pre-approved by the instructor. This activity is again on the concept of empathy but students also have to write a reflection on how they would feel if they were in this person's place. In the pilot course this was a formal speech presentation to the class with an outline submitted prior to the speech. One student wrote specifically about her encounter with a person she knew from church who shared her story on physical abuse by her husband. The student wrote:

This was something that stayed with me and got deep inside. When I made an effort to reconnect and she was willing to talk to me I had such a feeling of [peace]. . . . This project is one that will remain with me for the rest of my life. Such student feedback indicates how the subject matter will have a lasting impact.

Other Learning-Centered Activity Ideas

Role-playing in the classroom with a dyad or a group situation (Appendix H) provides a relational development activity through interviewing classmates who take on a patient role. Several options are provided and feedback within the group gives each situation a less stressful environment. An outside activity on e-mailing an irate patient is a way to reinforce relational communication in technology (Appendix I).

Course Assessment

Assessment tools found in the literature need to be revalidated to include both relational and interpersonal skills. A number of validated assessment measurements on interactions focus on the physician–patient relationship (e. g., Duggan & Parrott, 2001; Mercer & Howie, 2006; Roter & Larson, 2001) or assessment of conflict in interpersonal relationships (e.g. Canary & Cupach, 1988), or general relationships behavior (Burgoon & Hale, 1987), but none fit the healthcare relational communication competence needed for this study. A new measure of communication between clinician–patient interaction in healthcare settings provides a possible measurement instrument than can be adapted to assess relational communication in the nurse–patient relationship. Siminoff and Step (2011) developed the Siminoff Communication Content and Affect Program (SCCAP), a

computerized program that uses relational communication theory and includes behaviors and affective dimensions. The SCCAP is currently in the process of testing.

Findings on Research Question 3

Predictability of the success of a 100-level healthcare course cannot be verified. What can be verified is that approaching teaching relational communication and interpersonal skills through a relational theoretical approach can offer the optimum solution to teaching relational and interpersonal skills required in nurse and allied health programs.

These activities are not task-oriented communication training but focus on the student developing relational communication skills. Experiential activities contribute to retention of learning and skills. Other examples of teaching techniques that focus on the learner, as listed in the findings for Research Questions 2 including videotaping interviews, are activities designed so that the student may self-assess and reflect, or perform critical analysis of case study video clips. Courses in healthcare communication need to be “structured leveled learner-focused activities” in all areas of teaching with “multiple [learning] opportunities” geared toward both cognitive and affective learning (Krautscheid, 2008, p. 10). The need to fill the gap between theory and practice raised in the late 1990s and again in 2008 is still present as well (Brereton, 1995; Krautscheid, 2008).

VI. CONCLUSIONS AND IMPLICATIONS

Conclusions

This study examined the communication skills in the nurse–patient communication process from a relational perspective. Empirical research justified the research question in regard to validating the need for improved communications skills for nurse and healthcare professions. Studies over the last 20 years provide confirmation that the need for improved communication skills still exists and that “the quality of communication with patients is insufficient” (Utterhoeve et al., 2009, p. 442). Nurses are the most frequent point of contact for patients, and other than medical outcomes, the most common denominator that determines patient satisfaction. Few remedial and on-the-job communication training efforts have succeeded in providing sustainable communication behavior change. Recommendations call for educational level communication training for healthcare professionals.

Problems in providing successful communication training are threefold: an absence of a single overarching theoretical framework to structure training, a deficiency in coherent and consistent definitions of healthcare communication terms, and a lack of opportunities for communication training in the educational phase. Community colleges provide “more than 60 percent of the nation’s newly registered nurses and 63% of the

nation's allied health professionals" (Fulcher, 2008). More than 75% of community college nurses remain in the same state where they obtained their license, comparable to 5.6% of 4-year degree nurses. The Virginia Community College System (VCCS) has made a concerted effort to expand its nursing programs; currently 22 of the 23 community colleges in the VCCS system offer an associate's degrees in nursing. While most nursing baccalaureate degrees require, or suggest, an interpersonal communication course in the junior year, no such requirement exists in the VCCS 2-year nursing associate degree (ADN), the associate degree in dental hygiene, practical nurse (PN) certificates, or other allied health certificate programs offered. Only a few ADN nursing students have a communication requirement in their programs. Communication skills in these programs are taught within clinical courses, and skills are most frequently taught through a task-oriented approach rather than a relational approach.

Through the literature from nurse and communication discipline research, communication relational theory (Parks, 1977) was found to be the most comprehensive theory to provide a structured framework to address nurse-patient communication behaviors. Its approach to communication exchanges covers both the content of the message and the relational component of the exchange. The earliest patient satisfaction surveys used a continuous quality improvement measurement on medical technical competence, but soon evolved to include both clinical and interpersonal satisfaction. Communication skills and the concepts of caring and empathy place the emphasis on the patient as a person: "Communication and interaction skills are almost always are seen as crucial for nurses . . . and [communication] is a core element of nursing care" (Fleischer

et al., 2009, p. 350, 353). This change resulted in the need for interpersonal communication competency at all levels of healthcare, first at the physician–patient level but particularly at the nurse–patient level where interaction with patients is most frequent.

At its onset, relational communication theory research was most frequently applied to family situations and long-term relationships; however, the concept of a relational perspective in any interpersonal context, short- or long-term, soon became apparent. In the nurse–patient relationship, interpersonal skill proficiency does not include “caring” or “therapeutic” behaviors. In order to achieve a greater understanding of the dynamics of a relationship, a larger framework was needed. To this end, relational theory enfolds both the caring relationship and competence in verbal and nonverbal interpersonal skills.

Once a theoretical framework was established, the array of communication skill concepts and definitions found in nurse and communication literature to define the nurse–patient relationship presented a problem in categorizing. A 20-year historical data table of major reviews of the literature categorizes descriptors and concepts from interdisciplinary research (Table 1). By evaluating the terms as described in the literature, it soon became apparent that more than one concept was required under the relational communication framework. Figure 1 describes three distinct behaviors to achieve a relationship: conceptual behaviors (therapeutic, caring, and patient-centered along with clinical competency), and verbal and nonverbal interpersonal skill behaviors. All three are part of a relational approach to facilitate and define what is required in the nurse–patient relationship. This threefold approach solved the problem frequently

addressed in the literature on finding a theoretical base and framework that can take into account the complex nature of the nurse–patient interaction process.

Operationalizing the range of descriptors and definitions of particular skill sets and overall concepts found in the literature was fundamental to understanding what these terms actually meant. By culling the array of descriptors named in the historical data matrix of 26 meta studies (Table 1), each term with all its complexity was explained using the researcher’s terminology. Collating the data terminology under each term produced a robust conceptualization and definition of key concepts and overlapping terminology. This collation provided a more complex and complete picture of concepts and skills.

Verbal skills, repeatedly specified as central for interaction that includes the patient in the process, formed a natural hierarchy through repetition in the literature. “Information giving” ranked highest in the verbal domain. However, expansion of the term shows its multi-dimensional nature. Not only is the information itself important, but how it is given, how clearly it is explained, and whether reiteration is required become part of the definition. Nonverbal skills become part of relational construct. Within the “information giving” skill, tone of voice, proxemics when providing the information, and interpreting the patient’s nonverbal reception of the information all play a major role in this formally defined, single verbal communication skill.

To state it another way, an interrelationship exists between the skill behaviors and overall concept behaviors within relational communication is not apparent in task-oriented communication training. This view of communication in nursing validates the

approach to teaching interpersonal skills and conceptual behaviors through a relational perspective. Without this perspective, communication skills are taught in a disconnected and fragmented way, or as being task-centered, allowing for little sustainability or critical thinking assimilation by students, practicing nurses, and healthcare professionals to understand the larger concept.

Conceptualizing the nurse–patient relationship as well as operationalizing behavior requirements addressed the problem of a deficiency in coherent and consistent definitions of healthcare communication terms.

As for a model for a healthcare communication course, no guarantee can be provided that a course designed using relational theory as a framework together with the conceptualization of behavior concepts and a hierarchy of interpersonal skills will provide communication competency in the nurse–patient and healthcare professional–patient interaction process. What can be validated through the literature is the use of an overall relational theoretical perspective to resolve the problem of using one theory as the basic framework. Key behavior concepts of a therapeutic, caring, and a patient-centered approach are validated; consistent verification of required verbal and nonverbal skills is shown not only through the literature and grounded theory, but also from this current study’s focus group data. The focus groups provided individual perspectives from instructors and practitioners in healthcare today. They raised an issue found only rarely in the literature: conflict management within the healthcare organization. Conflict management is usually addressed in interpersonal communication, nursing clinical training, and in the usual program course requirement of a developmental psychology

course. However, inter-staff conflict appears to be a larger problem that also needs to be addressed in a healthcare communication course.

The fact that the literature addressed more descriptors of behaviors than did the focus group does not invalidate the findings from either method. The literature covers over 20 years of research, a vast amount of time to gather the most comprehensive list of behaviors and skills. The focus group data cross-verified the most important concepts and behaviors. However, none of the focus groups mentioned “chitchat” or social conversation as part of relationship building behavior. Triangulating the two methods does confirm that the emphasis is now on relational communication, and is shifting away from a focus on learning one or several interpersonal verbal and nonverbal skills. Correspondingly, the approach in training needs to progress from the task-oriented method to a relational perspective that will advance what is truly needed in communication training for healthcare professionals at all levels.

Finally, the design of a model course syllabus for a CST 195 Healthcare Relational Communication course based on the findings of this study, along with successful experiential learning teaching techniques substantiated by the literature (Kolb, 1984; Krautscheid, 2008), can be replicated at any Virginia community college and modified for workforce modules.

Implications

A pilot healthcare communication course within the VCCS would provide summative assessment and, through the use of alumni reporting and surveys, could act as the longer-term assessment validation. Recommendations are for VCCS colleges to use

the model course in their nurse and allied health programs. Assessment techniques would be needed in the summative assessment of the course and follow-up assessments on the job to determine if the skills were learned, applied, and retained. The same procedures would be necessary in any modules extracted for the 3-credit course model. Assessment tools found in the literature will need to be revalidated to include both relational and interpersonal skills. While measurements exist for interpersonal skills and relational factors, until recently, none matched the relational and skill set variables in the nurse–patient interaction. A number of validated assessment measurements on interactions focus on the physician–patient relationship or conflict management communication. A newly created computerized assessment tool for clinician–patient and family relational communication, the Siminoff Communication Content and Affect Program (SCCAP) (Siminoff & Step, 2011), offers a hopeful assessment tool that can be adapted to measure nurse–patient communication competence.

The weight of evidence substantiates improved communication skills and communication training for nurses and allied health professionals in the healthcare field. The purpose of this study was to use an interdisciplinary approach to identify an overarching theoretical framework to incorporate nurse and communication literature on essential communication behaviors required for patient-centered relational communication to provide optimal patient outcomes. A secondary goal was to conceptualize and operationalize specific communication behaviors and skills to incorporate into relational communication training. The final goal was to design a model

healthcare relational communication 3-credit course to be used in Virginia community college nurse and allied programs (Appendix D).

It is imperative to produce skilled communicators from nurse and allied health professional programs who can establish a relationship despite time constraints on the job, fewer nurses in healthcare organizations, and shortened stays by patients. If these students understand the concept of relational communication, and the multifaceted approach required to create effective relationships with patients and coworkers, they can achieve self-fulfillment as well as patient satisfaction. A pilot relational healthcare communication course within the VCCS would provide summative assessment and, through the use of alumni reporting and surveys, could act as the longer-term assessment validation.

Recommendations for Future Study

Based on the research done in this study on the last 20 years of communication specific to the nurse–patient and allied health professional–patient relationships, future studies on the relational approach to teach healthcare communication, as presented in the conceptualization and model course syllabus, could either verify this approach or find areas for improvement. What is first required is to verify the conceptualization and model as presented, which could be accomplished through pilot courses within community college nursing and allied health programs. Specifically, a starting point is to adopt the model syllabus for use either within a program, or as a recommended Communication elective prior to acceptance into a nurse or allied health program.

Pre-/post-assessment instruments need to be developed, or existing instruments need to be modified, to specifically target the nurse–patient and allied health–patient relational communication competencies. Post-education follow-up assessments are needed to measure the success and retention of skills and behaviors learned from the course in the educational phase.

Another area for future study is to create modules from the 3-credit model course. These modules could be used for non-credit workforce training tailored to specific healthcare organizations, or could be incorporated into a 1- or 2-credit course within a certificate program. Other studies could be generated on using these modules as “refresher” training seminars for nurses and allied health professionals in hospitals.

A possible key utilization for modules and future study would be in assisted living communities. Nurses, nurse-aides, and food and activity managers are frequently employed in the assisted living environment, yet few, if any, of these personnel have had any communication training. Based on personal observation and interaction with these key personnel when the researcher’s parents resided in an assisted living facility, the need for relational and competent communication is immense. Healthcare personnel and employees of such facilities require the same relational communication approach and communication competency in their everyday interaction with elderly residents that nurse and allied health professionals do in the hospital environment (Carpiac-Claver & Levy-Storms, 2007).

Finally, patient satisfaction surveys in assisted living facilities and nursing homes, dental clinics, outpatient facilities, and any other area of relational interaction between a

healthcare professional or employee and the patients/residents could further the research in healthcare communication and the relational communication field. While a greater number of studies since 2003 have specifically focused on the nurse–patient relationship, other allied health professional–patient interactions require more research.

**APPENDIX A. COMMUNICATION REQUIREMENTS IN VIRGINIA
COMMUNITY COLLEGE SYSTEM (VCCS) ASSOCIATE DEGREE IN
APPLIED SCIENCE IN NURSING (ADN) PROGRAMS**

Table A1

Communication Requirements in Virginia Community College System (VCCS) Associate Degree in Applied Science in Nursing (ADN) Programs

Community college	Communication CST required*	CST options for requirement	Humanity/Fine Arts elective: 3 credits	Suggested CST Humanity elective
Blue Ridge	No		No	
Dabney	No		No	
Lancaster				
Danville	No		1	
Germanna	No		1*	
J. Sargeant Reynolds	No		1	And may substitute Humanity for English 112
John Tyler	No		1	
Lord Fairfax	Yes	100, 110		
Mountain Empire**	No		1	130, 151, 152
New River	No		1	
Northern Virginia	Yes	110, 115 126, 229	1	
Paul D. Camp	Yes	100	1	
Patrick Henry	Yes	110		
Piedmont	No		1	
Rappahannock	No		1	
Southside	No		No	
Southwest	No		1***	130, 151, 152
Thomas Nelson	Yes	100, 126	No	
Tidewater	No		No	

(continued)

Table A1 (continued)

Community College	Communication CST required*	CST options for requirement	Humanity/Fine Arts elective: 3 credits	Suggested CST Humanity elective
VCCS Commonwealth Nursing Program Online	No		1	
Virginia Highlands**	No		1	151, 152
Virginia Western****	No		1	
Wytheville	Yes	100	1	

Note. CST = Communication Studies and Theatre. * Plus an additional 3-credit Humanity or Social Science elective. ** Part of Virginia Appalachian Tricollege Nursing Program. *** Plus an additional 3-credit Humanity or Social Science elective. **** Virginia Western only offers VCCS Commonwealth Nursing Program (CNP) online. Course Codes: CST 100 Principles of Public Speaking, CST 110 Introduction to Speech Communication, CST 115 Small Group Communication, CST 126 Interpersonal Communication, CST 130 Theatre Workshop, and CST 229 Intercultural Communication.

APPENDIX B. DEFINITION OF TERMS

Allied health professional. A person with specialized training, licensed when necessary, who has responsibilities bearing on patient care.

Attribution error. Overestimating the internal causes of another's behavior or underestimating the causes.

Chronemics. A type of nonverbal communication dealing with the perception of time and the use of time to define identities and interaction.

Cognitive complexity. The number of constructs used to create perceptions.

Constructivism. A leading theory stating how individuals organize and interpret experience through cognitive perceptions to construct knowledge.

Culture. Beliefs and practices to interpret experience that are shared by a number of people.

Empathy. Ability to feel with another person or to feel what another person feels in a particular situation.

Haptics. A type of nonverbal behavior dealing with touch.

Interpersonal communication. A selective, systemic, and ongoing process in which individuals interact to reflect and build personal knowledge and meaning.

Kinesics. A type of nonverbal behavior dealing with body position or body language.

Listening. A complex process that consists of being mindful, hearing, selecting, organizing information, interpreting, responding, and remembering.

Metacommunication. Communication about communication.

Models. Representations of ideas or acts and how these ideas and actions work.

Nonverbal communication. All forms of communication other than the written or spoken words themselves.

Paralanguage. A form of nonverbal communication dealing with sounds but not the use of words; often associated with the connotative aspect of meaning.

Poxemics. A type of nonverbal communication dealing with physical or psychological space.

Relational communication. Refers to what communication expresses about the relationship between communicators.

Relational dialectics. Opposing forces or tensions that are normal parts of all relationships. The three relational dialectics are autonomy and intimacy, novelty and routine, and open and closed.

Transactional model. Communication model that presents communication as a dynamic process that changes over time.

Valance. The emotional result of an interaction, whether positive or negative.

APPENDIX C. RESEARCH INSTRUMENT

Focus Group Questions

Procedures: Questions will be given verbally. Focus groups will be recorded and transcribed.

1. What communication behaviors by a nurse do you consider most effective in establishing a relationship with a patient?
2. What complaints from patients do you hear most frequently regarding ineffective or nonexistent communication skills with nurses?
3. Do you feel nurses require communication skills training in dealing with each other and/or with physicians?
4. What specific communication training do you most frequently provide (or wish to provide) for your current healthcare professionals (nurses, technicians, receptionists)?
5. What examples of communication practices and how they should be taught can you provide for use in the course development (i.e., generalizations of what is to be done and specific examples for teaching the application)?

APPENDIX D. COMMUNICATION STUDIES AND THEATRE CST 195 HEALTHCARE RELATIONAL COMMUNICATION SYLLABUS

MODEL Syllabus

CST 195 Healthcare Relational Communication Syllabus

VCCS Course CST 195 Healthcare Relational Communication

Day/Time/Room

Instructor:

Contact the
Instructor:

E-mail:

Office: Room xx

Office Hours: Office Phone:

Course

Description:

Examines effective relational communication interaction and develops appropriate and effective interpersonal skills and strategies for one-on-one skills. Emphasis on analyzing and acquiring relational communication skills for all relationships between healthcare professionals and patients/groups/coworkers to include oral, nonverbal, listening, intercultural, and conflict management to create and sustain effective communication in the healthcare field. Oral and written presentations.

Lecture: Hybrid

[Note: This class can be taught as a standard 3-hour course]

The course is an approved alternative curriculum choice to CST 100 Principles of Public Speaking and CST 110 Introduction to Speech Communication.

Credits:

3 credits

Textbooks:

Suggested:

Adler, R. B., Proctor, R. F., & Town, N. (2005). *Looking Out; Looking In*. Belmont, CA: Thomson Wadsworth. Text includes an interactive CD.

[Note: The new 11th edition will be available in 2011 under CENGAGE Learning publications]

[Note: This textbook was used in the pilot course.]

	<p>West, R. & Turner, L. (2006). <i>Understanding Interpersonal Communication</i>. Belmont, CA: Wadsworth. Text includes access to companion website</p>
Required Software/Plug-ins:	<p>VCCS E-mail: We will use the VCCS e-mail system for all our correspondence in the course.</p> <p>BlackBoard Orientation: We will review this together in class.</p>
Student Learning Outcomes	<ol style="list-style-type: none"> 1. This course seeks to increase student “relational communication.” As students become more socially sensitive they recognize the various conditions that help or hinder the process of establishing relationships and using interpersonal communication skills. 2. The course seeks to increase student “behavioral flexibility.” As students become more flexible in their behaviors they select the appropriate behavioral responses to specific communication situations in their life and the healthcare environment. 3. The course seeks to motivate students to demonstrate behaviors that facilitate competent communication to improve healthcare provider–patient interaction and professional communication. <p>By the end of the course, you will be able to:</p> <ul style="list-style-type: none"> • Identify the fundamental elements of the communication process. • Comprehend how a healthy self-concept improves communication. • Apply language effectively to reflect the intended message in healthcare situations and environments. • Analyze and construct nonverbal cues to optimize patient–client and professional communication. • Evaluate and manage relational conflict in healthcare situations. • Analyze and evaluate effective and noneffective communication skills. • Apply effective listening habits and skills. • Synthesize and apply effective relational communication and interpersonal skills in the healthcare environment. <p>COURSE REQUIREMENTS/ASSESSMENTS</p> <p>Since this is an oral communication skills course, I want to provide you with many opportunities to develop these skills. Aside from general class participation, other activities may include preparing for and performing and evaluating role-playing activities and in-class oral presentations.</p> <ol style="list-style-type: none"> 1. Complete all readings and exercises 2. Class participation/BlackBoard discussion participation 2. Journal 3. Projects

4. Oral presentations to small group and to class
5. Quizzes and exams

Assigned readings and exercises will be graded according to hand-ins and participation in class discussion. (It is best to be prepared for each class! Do your reading and assignments before you come to class!)

Your journals will be reviewed twice a semester for a grade on completeness in assignments.

We have 3 projects: An observation/individual and oral presentation, an individual empathy project and oral presentation, and a role-playing interview and oral presentation.

We have 4 quizzes, one for each 2 chapters of our textbook, and reading handouts, and a comprehensive final exam.

PROJECTS

Project 1 – Observation (nonverbal) of healthcare waiting room setting (group presentations)

Project 2 – Empathy one-on-one research (listening/empathy)(individual presentations to class)

Project 3 – Interviewing (role-playing) of difficult patient

ORAL PRESENTATIONS

Group presentation of Project 1

Formal speech presentation on Project 2

Informal oral presentations to group for class work

JOURNAL

Your journal will be on specific readings and activities and will include observations and surveys of family and friends. Reflection time and writing is required for each of these activities in order for you to expand your understanding of the relationships in interpersonal communication.

LEARNING METHODS IN COURSE

We will use class discussions, films, group work, role-playing, informal and formal speeches, projects, quizzes and exams. Lecture will be at a minimum! The learning activities will be interactive with practical application of the concepts and skills of good communication in healthcare roles. You will be able to use the skills in your everyday

life, your relationships, and in your future job as nurses and healthcare providers.

I invite all of you to help in making this course relevant to your lives. Your input on how you perceive the course, what changes and improvements you feel will make the course better, and your ideas on relevant activities (and those that stink) are important to the success of this course. **Your ideas and opinions are welcome in this class!**

Grading:

GRADING AND EVALUATION

Class participation /attendance 10%

Journals 25%

Projects 30%

Oral Presentations (part of projects)

Quizzes 25%

Exam 10%

Grade Scale

A = 93-100

B = 83-92

C = 73-82

D = 63-72

F = 62 or below

You grades will be posted on BlackBoard under Tools/My grades

Policies

COURSE POLICIES

ATTENDANCE POLICY: Each class is important. We meet only once a week and cover new concepts and skills each time we meet. You will all have **one free absence** (will not count against your grade) for the time when an event in your life must be taken care of right away. In this case, let me know via e-mail or phone. You will need to contact another student to get notes and information on what we did in the class and what you need to complete. **Your second absence will reduce your grade by 5%.**

The classes are so important, however, that missing more than 3 classes automatically constitutes a failure in the course. You do not come to the campus for our web classes. You will post on BlackBoard anytime up to the due date.

LATE WORK POLICY: All readings and assignments must be completed prior to class. Projects are due on time. A 10% reduction will be made on late work (up to 6 days). No work will be accepted after one week past the assignment due date.

Quizzes can be made up at the Testing Center within 1 week of the date. Contact me to arrange a date/time.
NO MAKE-UP WORK IS AVAILABLE FOR IN-CLASS EXERCISES OR EXAMS.

Academic Honesty/Plagiarism Policy

All students are expected to complete the work on their own. Any material (term papers, essays, assignments) obtained elsewhere and presented as your own will constitute an immediate failure grade in this course with a recommendation for additional disciplinary action according to [college name] policy listed in the Student Handbook. (see Academic Honesty and Plagiarism Policy [online address])

Code of Student Rights, Responsibilities, and Conduct
[college name's] website:

Disability Policy

Counseling, advising, and academic support, including “reasonable accommodations,” are arranged for students who bring appropriate documentation of a disability and are prepared to self-advocate. Special needs served under the 504/ADA Program range from specific learning disabilities to severe mobility impairments and emotional disorders.

Information

[Name of school] Information

The Student Web page links you directly to Computer Lab hours, the Library, Financial Aid, transfer information, and other valuable resources, including the weekly [college name] newsletter.

Free tutoring help is available. Please contact me for more information.

Important [college] Dates

Class Calendar
& Assignments

Class calendar and assignments

Class Date	Wk	Assignments (Due on class date)
Introduction, Overview	#1	Introduction, Syllabus Review, Course Review

		<p>Getting to Know You Activity</p> <p>BlackBoard Orientation – Signing on and forums</p> <p>CD & Book website</p> <p>Learning Style Inventory</p> <p>Communication Skills Inventory</p> <p>Assignments: Interactive activities, journal, class discussions.</p>
Understanding Relational Communication	#2	<p>Read Chapter 1 [relational communication]</p> <p>Use your CD, go to the website, and click on Chapter 1. Go to Interactive Activities and do <u>1.1 Interactive Models of Communication</u> and <u>1.3 Technical versus Interpersonal Skills</u></p> <p>Be prepared to answer the questions verbally in class. No need to print out or write.</p> <p>Please fill in the forum on your own personal information.</p> <p>Journal Activity:</p> <p>1. P. 31 Application Focus/Case in Point #2 & #4.</p> <p>2. Learning Style Inventory -- Is it true? Agree with results or not? Reflect on what you think is your own learning style.</p> <p>Class Discussion Questions: Case in Point #3 & #5.</p>
Understanding Perception	#3	<p>Read Chapter 2 Communication, Perception, and the Self</p> <p>Do the Interactive Activities (you can click on the blue below and get right there)</p> <p><u>2.1 Cultural Stereotypes About Americans.</u> Answer the questions and put them in your Journal.</p> <p><u>2.2 Social Perceptions of Hair & Baldness</u> Answer the questions and put them in your Journal.</p> <p><u>2.3 Illusions and Paradoxes, Seeing is Believing?</u> Very cool! We'll talk about it in class.</p>

		<p><i>Journal Activities:</i> 1. Take the "Self Monitoring Scale" on p. 52 and record your score in your Journal. Write a few paragraphs on what you found out about yourself (and whether you agree or disagree with the results).</p> <p>2. P. 60 Application Focus/Case in Point #2</p> <p>Class Discussion Questions: P. 60 Case in Point/Application Focus #1 & #5.</p>
Nonverbal Communication Online	#4	<p><i>Online discussion day (no class)</i></p> <p>Read Chapter 7 Nonverbal</p> <p>Take the Touch Avoidance Inventory (p. 204) so we can take it in class and compare how we use it in healthcare settings.</p> <p>Post on the FORUM under Touch Avoidance – reply to 2 others</p> <p>Do the <u>Interactive Activities</u> (you can click on the blue below and get right there)</p> <p>7.1 Mixed Messages in Negotiations</p> <p>Nonverbal Communication in Negotiations and check out "Is it lying?: A cross-cultural perspective" at the bottom of the page.</p> <p>7.3 Eyes, Mouth, and Tilt of Head (this one is fun!) Facial Expressions Game</p> <p>7.4 Test Your Paralanguage Skills (this one too!) Paralanguage</p> <p>7.5 Nonverbal Behavior in Japan</p> <p>Traveltst.ca</p> <p>Post on the FORUM under NONVERBAL Articles – reply to 2</p> <p>Observation assignment: A 5-minute observation of strangers in a public place. Make it 2 males or 2 females in a public place.</p> <p>Remember, the point of this is to observe yourself observing!</p> <p>4 stages of the perception process:</p> <ul style="list-style-type: none"> • Stage 1 - sorting out stimuli (what do you notice first.- clothes, hair.)

		<ul style="list-style-type: none"> • Stage 2 - categorizing stimuli (making sense of what you saw) • Stage 3 - assignment meaning (based on your own experiences) • Stage 4 - recalling memories (what do you associate what you see with your own experiences) <p>Post on the FORUM under 5-Minute Observation – reply to 2</p> <p><i>Journal Activities:</i> Application Focus; Case in point #1 OR #2 depending on which applies to your life more -- an elder parent or a dating situation. (p. 208).</p>
Intercultural	#5	<p>Chapter 3 – pages to be assigned</p> <p>Class Discussion of nonverbal</p> <p><u>Article Reading:</u> I've posted 2 professional journal articles (Warfield, Eckman) of interest to Nonverbal, one of which is interesting for the medical profession. I will also start loading these articles under the new t button on the left - ARTICLES of interest. Ekman_Article_Nonverbal.doc (45568 Bytes) Warfield_Article_Nonverbal.doc (57344 Bytes)</p> <p>Class Discussion: Be able to give a brief summary of each article in your journal. Comment on what you thought about the articles.</p> <p>Project 1 Overview</p>
	#6	<p>Quiz 2 due online</p> <p>Project 1 Presentations</p>
Empathy	#7	<p>Film: <i>Wit</i></p> <p>Class Discussion on movie.</p> <p>Quiz 3 Take Home (Chapter 7 & 3)</p> <p>Discussion Project 2</p>
7 Listening Online	#8	<p><i>Online discussion day (no class)</i></p> <p>Read Chapter 5 Effective Listening</p> <p>Do the <u>Interactive Activities</u> (click right on them below)</p>

		<p>5.1 Listening in the Workplace Visit URL: <u>A case study of listening benefits</u> What are the most important listening skills? Post on the FORUM Listening Benefits – reply to 2 Of the 10 bad habits listed, how many are you guilty of? Make a chart of your 8 people; choose the top 3 and save it for the next exercise.</p> <p>5.2 The Importance of Listening Visit <u>Be an Effective Listener!</u> Using your list from the above activity, write down the name of at least 2 people you feel are a good listeners. 2. Now describe one of those person’s behaviors as he or she listens. What skills does her or she use? Post on the FORUM under Great Listening –reply to 2</p> <p><i>Journal</i> 1. During the next 3 days, try emulating the listening skills of the person you named. Do you find that you’re better able to hear messages? Do you find that people respond to you as though you were a better listener? 2. Do 5.4 Identify Your Listening Problems Visit URL: <u>Listening Problems Check List</u> How many problems did you check? Do you notice any similarities in the problems you checked? What can you do to improve your listening in some of the situations you checked? Set some listening goals to help you move toward becoming a more effective listener</p>
Verbal	#9	<p>Read Chapter 6 Complete Interactive Assignments: Title: 6.3 The Power of Words</p>

		<p><u>The Definition of Terror</u> <i>Journal Activity #1 & for class discussion:</i> What other words could be defined as “powerful” in the healthcare context? Write down some of these words. Are they context-appropriate? That is, in what instances would you use them for effect, and in what instances would you avoid using them? Title: 6.4 Gender-Free Language Visit URL: <u>Gender-Free Language</u> <i>Journal Activity 2 & Class Discussion question:</i> What are your thoughts on the controversial issue of political correctness? Are we too sensitive about correctness? Explain your answer. See the box Ethics & Choice on pg. 165 re the mascot. Ask 4 other people (2 men/2 women) about their views on politically correct language. Put down their age and answer. <u>Class discussion question:</u> Is it ethical to be equivocal or to use strategic ambiguity to patients? If so, in what circumstances; if never, why not? Project 2 discussion Quiz 3 online (Chapters 5 & 6)</p>
	#10	<p>Quiz 3 Due Project 2 Presentations</p>
	#11	<p><i>Online discussion day (no class)</i> Quiz 4 Study day Post on the FORUM under Project 2 reflections – reply to 2</p>
Conflict Management and Workplace Relationships	#12	<p>Quiz 4 Due <u>Read Chapter 9 Communicating Power & Conflict.</u> We will review this with Chapter 6 in class. They go well together. The outline is under Chapter Outlines Button. I'll hand out and go over the questions for Project 2 as well as the</p>

		<p>grading and presentation format.</p> <p><u>Interactive Activities</u></p> <p>9.1 Conflict in Context <u>News About Types of Conflict</u></p> <ol style="list-style-type: none"> 1. For class, select one area of conflict you are interested in exploring and locate a relevant article. 2. Bring the article to class or summarize it to inform your classmates of a current issue about conflict 3. See if you can integrate some of the terms and concepts from Chapter 9 of your textbook into your presentation. What type of conflict can you identify? What, if anything, is being done to help resolve the conflict? <p><i>Journal Activities</i></p> <p>In your journal, note the times you engage in interpersonal conflict during the week. Record the following information about your conflicts:</p> <ul style="list-style-type: none"> • The persons involved • The relationships between/among the persons involved • The topic of conflict • A rating of how important that conflict was to you (not very important =1 to very important =7) • A brief description of what was said during the conflict • A rating of how satisfied you were with the conflict (not at all satisfied = 1 to very satisfied =7) <p>Write a brief explanation of how this conflict relates to the material in this chapter. You should have at least 3 examples! AND Class discussion</p> <p><u>Conflict - An Essential Ingredient For Growth</u></p> <ol style="list-style-type: none"> 1. Although this site focuses on organizational communication, read the five styles and identify one person you
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		<p>know whose communication about conflict is best described by each style.</p> <p>2. Choose one of the people you've thought about. Provide an example of a situation or characteristic that leads you to believe the person follows the communication style you chose for him or her.</p> <p>3. Name one conflict you anticipate in the healthcare environment. Explain what it is and how it can be resolved in a win-win scenario</p>
Interviewing	#13	Project 3 Presentations.
Healthcare Teaching	#14	<p><i>Online discussion day (no class)</i></p> <p>Read Handouts</p> <p>Relational communication with children and the Elderly</p> <p>Course Evaluations</p> <p>Post on the FORUM under Project 3 reflections – reply to 2</p> <p>Final Exam Study Day</p>
	#15	Final Exam due

APPENDIX E. JOURNAL ACTIVITY EXAMPLE

CST 195 Healthcare Relational Communication

Purpose: A better sense of your many identities and how you communicate in each identity

“Will the real me please stand up!”

Keep a record of the situations in which you communicate over a 2-day period.

Make 2 columns.

In the first column, for each situation, identify a dramatic title to represent the image you try to create. A few examples might be “helpful housekeeper” or “super cook” or “party animal.”

In the next column, identify whether or not you felt this identity was your own making or a reflection of someone else.

You should have at least 20 different identities.

Write 2 paragraphs (about 6 sentences each) reflecting on your many identities. Reflect on whether the identity was on your own or because that is how someone else made you feel (from a relational message).

Analysis: What did you learn about yourself?

APPENDIX F. EXPERIENTIAL PROJECT EXAMPLE

Project 1 CST 195 Healthcare Relational Communication

Learning Outcome: Concept of empathy. Walk in someone else's shoes!

Activity: Choices

1. Meet and talk with a resident of a nursing home.
2. Meet and talk with the administrator or volunteers at a homeless shelter or battered woman's shelter. Other ideas, check with me first.

Nature of interview:

Use your skills so far developed in

Good communicators: Know how to react to different communication situations

Self-monitor your verbal and nonverbal presentation to others

Review your own self-concept and recognize your strengths and weaknesses
when communicating (remember you can do it!)

Identity management: Remember it depends on the situation. Be respectful.

Intercultural: Remember older people react differently to the world than you,
just like people of other cultures react differently

Language: Use good grammar. Try not to be abstract. Prepare in advance.

Try not to use powerless language or hesitations (Ex: I'm kinda looking
for or Uh, well, I'm not sure.)

Try not to use disruptive language (Let the person finish his/her thoughts)

Nonverbal: Be aware if the person is uncomfortable by identifying kinesics,
territoriality, proxemics. Use touch (haptics) to relax the person. A
simple touch on the arm or hand can do wonders!

Listening: Understand and respond! (Okay to take notes.) Use prompting,
questioning, paraphrasing (if you need more time or don't understand).

Be aware of gender, situation, think about your own style of questioning.

How long to interview: About ½ hour - 45 minutes.

Approvals: Be sure you called ahead, stated who you were, and why you are doing this.
Is there anyone you need to check with before talking to a patient/resident?

Take notes: Explain to the person that you need to take notes. Do not record them
without permission.

Oral Report to Class: 5-7 minutes (practice!)

Complete a 1-page outline for your speech. Outline should include your main points:

Introduction (why you chose this situation; give some background)

Purpose: How did you accomplish “putting yourself in their shoes”?

-Who you interviewed

-What they said

Conclusion: What conclusions did you come to about this interview? How did you empathize with the people you talked to (or talked about). Would you recommend others do this? Why? Or why not.

Adapted from Sheldon, L. K. (2004). *Communication for Nurses*. Thorofare, NJ: Slack. p. 7.

APPENDIX G. PROJECT 2 EXAMPLE

Observation – Nonverbal Skills Project

1. Go to a hospital outpatient waiting room
(Other suggestions if you know someone in clinicals and you can tag along OR another clinical setting with a receptionist.
Note: All observations dates, times, and partners for this project must be pre-approved by the instructor. Please see me for sign-up sheet.
2. Discreetly observe faces of incoming patient when they turn around from the initial check in.
What do you see? Fear, anger, sadness?
Is the person male or female?
What is approximately their age?
Are they alone or with others?
3. Spend some time observing the receptionist(s).
Does the receptionist look at the patient when not writing?
Is the receptionist carrying on a conversation with someone else while the patient is in front of them?
Does the receptionist smile?
How much space is between the receptionist and the patient? Is there a barrier?
4. If you choose to do this with a partner, share the workload responsibility. (For example, one can make the chart, another can give the oral report.)

Oral Report to class: (1-2 minutes)

1. Give us the background:
State where/when/day/time/number of persons observed (patients, receptionists, individuals)
2. What did you observe? See page 188 chart on Visual-Auditory Codes
Kinesics
Facial expression
Proxemics
Haptics
3. What did you learn? What can you share with us to make what you learned valuable to all of us?

GRADING: 70% on completeness of report/presentation. You may use a visual if you like but it is NOT required. 30% on your peer evaluations

APPENDIX H. EXAMPLE ACTIVITY ROLE-PLAY

Concept: Relationship development and use of interpersonal verbal and nonverbal skills

Exercise

Break into groups of three. Each person in the group has a role: a nurse, a patient, and an observer. Each person in the group will role-play in one role for 5 minutes. Pick one of the scenarios. As the "nurse," begin the encounter with the appropriate introductions and assess the reason the "patient" has sought healthcare.

- A 17-year-old boy with a seizure disorder who is not taking medicines regularly.
- A 49-year-old man with a two-pack-a-day smoking habit for 35 years who has bronchitis.
- A 20-year-old woman with a Chlamydia infection and a new sexual partner.
- A 77-year-old woman with a recent transient ischemic attack and dizziness who does not like using a cane.
- A 7-year-old boy who broke his wrist skateboarding and was not wearing protective gear.

As the "nurse," try to assess the "patient's" problem and arrive at mutually set goals. As the "observer," assess the "nurse's" actions using the following guidelines.

- Did the nurse begin the relationship with a warm, respectful manner?
- Did the nurse solicit the patient's perception of the situation?
- Did the nurse make judgments about the patient's behavior?
- Was the nurse empathetic to the patient's feelings about the situation? (How?)
- Did the nurse ask the patient's opinion?
- Did the nurse observe and understand the nonverbal communication of the patient?
Did the nurse listen attentively? (Or was the nurse multi-tasking?)
What other behaviors and interpersonal skills did you observe?

After each role-play, discuss your observations within your group. Specifically discuss if a relationship was established. What verbal and nonverbal interpersonal skills were used?

APPENDIX I. LEARNING ACTIVITY

CST 195 Healthcare Relational Communication

Learning Outcome: Using relational communication in technology

Concept: Using computer-mediated communication (CMC) (transactional model, content/relational messages).

Activity

The head of nursing hands you this e-mail that came to her directly. Before she passes it to the hospital administrator, she wants to know what happened and asks how you would reply to it.

You find out the facts. Mrs. Townsen, a 25-year-old woman, brought her 7-year-old son in last week with a broken leg. Mrs. Townsen was swearing at Tess, one of the nurses and your good friend, because they had to wait 2 hours for the doctor to come in. Tess tells you the boy broke his leg skateboarding and was comfortable. However, the hospital was very busy that day and Mrs. Townsen made a huge scene, cursing and swearing and blaming Tess for the wait. The boy was well-behaved and sweet.

Her e-mail:

“You people just sit around and drink coffee. I was so mad cause I was late for work that day and the boss fired me. Billy and me had to sit their for 4hours waiting for you lazy nurses to git to us. You need to find me a new job its your fault. That black nurse don’t know what she is doing.”

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REFERENCES

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CURRICULUM VITAE

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