

Second Edition

Communication Skills *for the* Health Care Professional

Concepts, Practice, and Evidence

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Dedication

John Robert Dower

The first to suggest to me that communication comes and goes in many different forms but is always there to be expressed.

To our patients, families, and ourselves:

As miraculous as our ability to communicate is, not all patients and families can speak to be heard, listen to know, understand to respond appropriately and in a timely manner, or even remember what we write or say. In fact, the patient might tell us the same about the healthcare professional. The reasons are many, but it is always important to assume little and consistently assess the communication that has passed among patients, providers, and families. Let it be our goal to not miss one or more critical components that will result in compromised care.

What's New in the Second Edition?

This text is an excellent addition to a course on interviewing and therapeutic management of health provider and patient alliances. The revision of the text builds on previous strengths and adds considerable discussion to the evidence that healthcare communications are vital to quality care and patient well-being. The second edition maintains the same general structure but adds *four* new chapters to enhance the student's ability to understand the importance of communication skills and the link between healthcare communications and quality care outcomes. A *fifth* new chapter addresses the considerable needs and challenges of communication with patients with low health literacy in phases of prevention and treatment. As previously presented, each chapter provides a thought-provoking quote about the issues to be discussed in the chapter. Also, there are objectives for each chapter, key chapter terms in the updated glossary, and new references in the updated reference list.

- One new chapter is added to the new section on communications under challenging circumstances. This is Chapter 13, *Communicating with Patients with Low Literacy*.
- There are four additional new chapters making up a new section on expectations for healthcare communications, evidence for quality, and behavioral change:
 - *Health Communications and Quality Care* (Chapter 1)
 - *Health Communications to Enhance Behavioral Change* (Chapter 22)
 - *Internet Use and Communications of Patients and Providers* (Chapter 23)
 - *Altering Systems of Care to Enhance for Healthcare Communications* (Chapter 24)
- All other chapters have been revised and updated.
- Updated resources, including Web sites, provide additional references, background knowledge, statistics, and recommendations for evidence-based practice.
- New tables describe therapeutic communication approaches to managing such typical clinical challenges as nonadherence, low literacy, fears, and conflicts.
- Up-to-date evidence to support the impact of healthcare communications is detailed in a description of studies in the literature.

KEY FEATURES

In-depth discussion of the principles, practices, and evidence for effective communication approaches are provided and organized into logically presented sections: the importance and value of effective patient–provider communications and basic principles of communications (Part I); a discussion of therapeutic communication skills, one technique at a time (e.g., empathy, trust, questioning, use of silence, reflection, interpretation; Part II); skills needed to

ensure therapeutic communications under challenging patient circumstances (e.g., patients in crisis, coping with chronic illness, and with limited literacy skills; Part III); communication patterns within and across providers and families (Part IV); ethics and healthcare communications (Part V); and finally, advanced issues (e.g., communications to enhance behavioral change, the use of the Internet in patient–provider communications, and systems of care that enhance or deter from effective communications; Part VI).

Key features of the text include learning objectives for each chapter, questions to address with respect to communication as a science, examples of dialogue from interactions between provider and patient, illustrations of the actual use of specific skills, explanations of the principles underlying the use of various skill sets, easy-to-read and -understand summaries in table format, notations about regulatory issues and standards of practice as appropriate, lists of resources pertinent to the subject of the chapter, and a complete glossary to assist students with definitions of terms.

Acknowledgments

As is the case for most extensive writing efforts, many people are to be thanked for their assistance along the way. Their names are not acknowledged on the cover, but their input was essential. Special thanks to faculty and students who offered their helpful advice and enthusiasm about what needs to be covered and how. Clearly, it was these individuals and the keen insight of Mike Brown, Publisher, who persistently asked about and saw the continued value of this material in educating health professionals. Those who granted permission to reprint excerpts of their work are appreciated. In some cases, the classic early work of those cited is invaluable to our in-depth understanding of communication processes. I would like to extend my appreciation to Katey Birtcher, Associate Editor of Public Health, Health Administration, and Clinical Nutrition, and those in the editing department of Jones and Bartlett for their extensive efforts in reviewing and recommending changes, including a tweaking here and a tweaking there.

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Preface

While healthcare communication skills and knowledge are the subject of many health professional educational programs, they might not receive the attention they deserve. These skills and knowledge are frequently taught—but only in the context of diagnostic interviewing. Until recently, there was little attention paid to ensuring that providers could not only conduct an assessment interview but could communicate well with a variety of patients. Even if providers have acquired the necessary skills, they might be concerned that within the current healthcare system, there is no time to use these skills, without recognizing that they cannot afford *not* to. Maguire and Pitceathy (2002) and others point out that providers (physicians in this case) do not communicate as well as they should. They summarize the case for better communication skill competency. Essentially, and this can be applied to all professional healthcare providers, good communication skills can help identify patients' problems more accurately, help patients adjust to the psychological stress of their illness, result in patient satisfaction with their care, and result in patients who are more likely to adhere to their advice and follow their treatment regimen; they conclude that even providers (doctors) have greater job satisfaction, and less work stress. Still, the majority of practitioners do not feel confident in their communication skills or perhaps had no formal training at all. If their skills were improved, the quality of care would improve, and the costs of this care could be reduced.

Effective communications are at the core of quality patient care. Patients require the help and support of other people. Every contact with a patient or potential patient requires courteous, considerate, respectful, and helpful communication. When patients get the responses they want, they feel good about their encounter with healthcare providers, and their need for positive interaction is satisfied. When patients feel good about their experience, they are more willing to cooperate and are more likely to repeat their contacts with us. If their experience is negative, however, they are likely to avoid and limit further contact. Depending on what is required to complete their care, patients' avoidance may have very serious consequences. It may cause them to avoid getting needed help, or it may cause them to ignore the healthcare instructions they have been given.

Negative communication experiences can cause anger and resentment toward providers and the healthcare system itself. If patients come to a healthcare facility, for example, and get routed to several providers without getting any real help, they will feel resentful about their encounter. One negative experience like this can require many additional positive interactions before its effects are completely erased.

The value of a positive provider–patient relationship, where good communication skills are practiced, cannot be underestimated. In addition to being the doorway to quality care, the patient–provider relationship built on sound communications is regarded as the most crucial component of the healthcare delivery system. Del Mar (1994), in an assessment of related literature over a 35-year period, showed that providers' good communication skills are associated with better care and even better health. This original study has been supported repeatedly in the literature.

Communications are best taught using a variety of teaching modalities. This text presents concepts, practice examples, and the evidence behind the importance of communication in patient–provider encounters. Practice experience, where students demonstrate and evaluate their skills, is enormously helpful in aiding learners to examine their expertise and where they need improvement. Student evaluations of courses aimed at teaching communication skills are usually positive, indicating that they do feel that their interviewing and communication skills are improved with course work. Undergraduate and graduate healthcare professional training programs that deny students formalized instruction in communication skills and principles produce an incompletely trained provider. A variety of skills are needed and should be in place if students are to effectively practice in today’s complex healthcare environment.

The purpose of this textbook is to inform the reader about basic communication knowledge and skills, including concepts, practice, and evidence. Becoming proficient in communicating with a variety of patients and their families in varying healthcare settings and circumstances is a requirement of all healthcare professionals. Practicing effective communicative behavior with other health professionals is also mandated in this era of increased interprofessional collaboration. The literature—whether research reports, a review of the literature, consensus recommendations, affirmed experience, or any case studies and patient self-reports—is replete with examples of how communication can or did make a difference in the care that patients and their families received and the quality of care that was delivered.

Just reading about communication is not sufficient, however. Despite the abundant literature on communication and therapeutic response modes, communication knowledge and skills cannot be learned from textbooks alone. The critical test of providers’ competency is how they put these principles and skills into practice with patients. Because of this, laboratory experiences in which students test out and practice therapeutic responsiveness is critical in their professional role development. Practice, patience, and feedback can significantly affect providers’ attitudes about their abilities and feelings of self-efficacy.

Teaching staff who use this text will find the material detailed and informative. The text is intended to be applicable to upper-division undergraduate students as well as first-level graduate students and practicing health professionals. Most universities with health professional schools have an undergraduate core curriculum in which communication content and experiential learning is a requirement; therefore, the text is extremely useful to students who are entering the health professions but who have not yet encountered many patient–provider contacts. The text is designed to be useful cross-disciplinarily, and examples using these providers are used generously in the discussion. The importance of effective communication skills in all healthcare professions is undeniably important.

This text is dedicated to basic communication skills and concepts that are foundational to the healthcare professions. The chapter on human communications was enhanced by the analysis and synthesis of Gazda, Childers, and Walters (1982). I thank Dr. Rose Vasta for her contributions in elucidating the nature of selected therapeutic response modes.

Managing Care and the Implications for Healthcare Communication

The healthcare system's new tools will permit it to transfer both power and moral responsibility to families and individuals to manage their own health more effectively.
—Jeff C. Goldsmith

CHAPTER OBJECTIVES

- Identify factors affecting the current delivery of health care in the United States.
- Discuss health-promotion models that may establish and maintain health for the largest numbers of individuals in need.
- Identify how self-care, community-based programs, and interprofessional coordination are needed in today's healthcare climate.
- Discuss models of patient–provider communications and how these may reflect the current healthcare crisis.
- Identify typical stressors in patient–provider relationships.
- Identify potential patient responses to these stressors.

Powerful new tools emerging from the biotechnological revolution may soon render health care unrecognizable as we know it today. These changes will be felt in our methods of communicating with patients. The use of Internet sites, including provider–patient e-mail and the availability of health-related websites, is an example of how technology might affect the circumstances under which patient–provider encounters will take place. Healthcare communications are expected to be, on the one hand, more focused and, on the other hand, less direct as episodes of care are managed on the outskirts of the provider–patient relationship. Still, care may be more comprehensive than ever before. The compelling push in the opposite direction for managing patients' wellness over time and the need to actively engage patients in health-promoting behaviors emphasize a holistic approach. Providers' needs for skills in engaging, persuading, and facilitating change will remain critical.

Emerging in this biotechnological revolution are two primary issues: how will care be delivered, and what will be required of providers in these new delivery systems? How will communication between providers, clients, and families take shape? The first issue deals with healthcare delivery systems; the second, with the prevailing mode of interaction between provider and client.

Just what shapes health care and healthcare delivery systems and how these factors play a role in the evolution of health care in the United States

is addressed in this text. A paradigm for viewing health care from a health-promotion model is presented. Implications for provider–patient and provider–provider relationships and communications are discussed. The role of communications in the provision of care is examined, and needs for commitment, caring, and partnership are highlighted. This text is addressed with multiple healthcare disciplines in mind.

The rigid boundaries that previously existed between professionals and professional training programs are no longer appropriate, and this text attempts to transcend assumptions of dissimilarity on such basic issues as patient–provider communications and therapeutic communications. In this section of the text, the history of the American system of health care is briefly summarized. The current crisis in healthcare delivery is discussed in detail, enumerating the basis for needed healthcare reform. It is important to understand potential threats to patient–provider communications as system barriers to adequate health care. The prerequisites for therapeutic alliances today include reassurances that problems at the system level will not govern the character of interaction between patient and provider. Encounter conflicts surrounding the availability and sensitivity of providers reflect generic problems with healthcare delivery.

HEALTHCARE DELIVERY IN THE UNITED STATES—1600s TO 2000s

If we were to trace the evolution of health care in the United States from its inception in the early 1600s to today’s system of healthcare delivery, we might first conclude that because of so many differences—then and now—any comparison of these periods is impossible. Nonetheless, with closer examination, we can perceive certain common threads along with many differences. The evolution of healthcare delivery over the last 300 years is indeed significant. The healthcare system in the early colonial days (1620) was very different from the system we have today (2000s).

Factors Influencing Healthcare Delivery Systems

Those who study trends in healthcare delivery usually identify at least four elements that account for the character of delivery systems through time: (1) societal influences, (2) public health programs, (3) existing health problems, and (4) levels of technology. Forces affecting the evolution of systems of care in hospitals are depicted more specifically as (1) advances in medical science, (2) the development of specialized technology, (3) the development of professional training, (4) the growth of health insurance, and (5) the role of government.

For example, if we took a trip back in time to the colonial period (roughly 1620–1781), we would observe several factors that would account for the direction of health care. Society in the colonial period reflected small agricultural communities. Trade was important, and several port towns (Boston, New York, Charleston) were the chief points of entry for intercontinental trade. There were distinct health problems that reflected this social structure; epidemics were of concern and the port towns were seen as avenues for significant communicable diseases (e.g., yellow fever). Physicians and nurses were few but participated in initiating quarantine standards. The clergy played a signifi-

cant role in caring for the ill, visiting patients and their families at home. Voluntary boards of concerned citizens were involved in public health concerns, but governmental involvement was negligible. Medical technology was insufficient to control health problems. However, ordinances were passed to control problems of sanitation, waste disposal, and public markets in the port towns.

In the 300 years that have ensued, vast changes in society and in health care make the problems and issues just articulated vastly outdated. Important social events such as the Civil War, and later, World War I and World War II influenced greatly what our healthcare delivery system became.

From the close of World War II through 1965, the delivery of care shifted dramatically to become the care of the infirm in hospitals. Urban areas became more prominent fixtures, and rural areas shifted to large farms. Housing improved and immunizations continued to improve our ability to fend off disease—this time, polio. With acute problems and infectious diseases more under control, chronic diseases came to the forefront. Diseases such as arthritis, heart failure, asthma, and diabetes drew our attention. In 1950 the government made its first significant contribution to health care, investing \$73 million in medical research. While hospitals tended to dominate the delivery system, community programs were staffed to help patients and their families cope with chronic illness; these agencies included public health department programs and visiting nurses' associations.

The Vietnam War, extending from 1964 through 1973, influenced not only our social-political structure but also the structure of our healthcare system. Prevention of chronic diseases was still important, but the realization that these diseases would not be eradicated without significant changes in the health habits of the population prevailed. Health promotion programs to control smoking, diet, and substance abuse were stressed. By 1985 there were a total of 6,872 hospitals; the majority (5,784) of them were designated short-term acute-care hospitals. The federal government administered a mere 343 hospitals, while state and local governments administered only about 1,600 of the hospitals. While acute-care hospitals predominated, long-term care and nursing-home facilities also existed but in much smaller numbers. Home health agencies continued to deliver care to the chronically and terminally ill patient in the home.

Changes occurring from 1984 to date reflect tremendous shifts in health care. Public health problems continue to include environmental threats (e.g., pollution), but health problems once defined as disease and injury have shifted to include societal problems. What were once considered society's problems—teen pregnancy, drug abuse, domestic violence—are now being classified as significant threats to our nation. Along with the continual focus on the maintenance of the quality of life of those with chronic illnesses and disabilities, an environment for healthy living has become increasingly critical to the effective management of healthcare problems.

Current Healthcare Crisis

Traditionally, the American healthcare system has been organized around acute illnesses; the role of the healthcare system was to rescue us from these illnesses and take custody of us until we were well (Goldsmith, 1992a, p. 19). In

the past two decades, this focus has been significantly shaken by our ability to manage health care on an ambulatory basis. The travesty is that we have built a vast and costly apparatus around this acute-care focus. Thus, the fit between healthcare needs and healthcare services has worsened significantly.

While Americans may disagree about issues related to the social problems that face our nation—including violence, homelessness, drug abuse, and teen pregnancy—there is general consensus that these social problems both affect and reflect the state of our nation's health and will have a significant impact on the future ability of Americans to stay healthy.

Most Americans agree that the healthcare system that exists in the United States today needs to be reformed. Public opinion polls have shown that only a quarter of the American public has faith in the current delivery system to meet our nation's healthcare needs. Healthcare reform was one of the major issues of the 1990 Conference of Governors (Kaplan, 1991). Healthcare reform was a major focal point in the 1992 presidential campaign and is retaining priority in recent presidential campaigns. Legislators continue to study and search for solutions to needed reform and acknowledge three basic deficiencies in our healthcare system: (1) affordability, (2) accessibility, and (3) accountability (IOM, 2004).

Affordability

To understand the problem we face in affordability of health care in the United States, it is important to examine how the costs of health care have escalated and how they are predicted to soar continually. In 1940 the nation spent \$4 billion on health care. By 1950 these costs had tripled. The current situation is that healthcare costs keep rising and inequities in accessibility becomes clearer. In short, even with the advent of managed care, the nation's healthcare expenditures are high and headed higher.

What seems to be at the heart of the problem is the ability of insurance programs to deliver on the basis of need and recommended level of service. Those who pay for health care (frequently, employers) can no longer afford the same level of service formerly provided. The cost of care is exceedingly high in the United States. A recent report by the Institute of Medicine (IOM, 2004) called for the United States to implement universal health care by 2010. It is estimated that if some form of healthcare reform to reduce the costs of care does not occur in the United States, the economic viability of the United States will be significantly threatened some time in the 21st century. In this same report, it was stated that 43 million Americans are uninsured, and lack of health insurance causes 18,000 unnecessary deaths each year in the United States.

Accessibility

The enormous costs of health care are only part of the problem, albeit, a very serious part. A second significant challenge is healthcare accessibility. A 2001 report of the Institute of Medicine, *Crossing the Quality Chasm: A New Health Care System for the 21st Century*, called for a reform that centered on the needs of patients and assured they get the care they need in a timely manner. Despite the enormous costs of care, our current system of healthcare delivery does not equally provide for everyone.

Economists describing the problem of accessibility estimate that up to millions of people go uninsured despite the fact that the United States spends more of the gross domestic product (GDP) on health care than any other country in the world. The Institute of Medicine's report, *The Uninsured Are Sicker and Die Sooner*, explains that uninsured people are more likely to receive too little medical care and receive it too late, resulting in their getting sicker and dying sooner.

Essential guidelines that are continually considered include the following:

1. Healthcare coverage should be universal.
2. Healthcare coverage should be continuous.
3. Healthcare coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable to society.
5. Healthcare coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

How can this be? Despite the fact that the American healthcare system is one of the most technically advanced in the world and that so much is spent on health care, a substantial proportion of the population is locked out of the system. This problem is described as one of both the uninsured and underinsured. This, however, is not the only basis for the problem of access. Surely the lack of healthcare services in rural areas, and even in some urban areas, contributes to the problem of accessibility and therefore healthcare disparities.

The first and extremely invalid assumption that the public makes is that these people are largely the unemployed. This assumption is incorrect. Those people who are locked out of health care are employed, often at very low wages, but the employers cannot afford the high costs of health insurance.

The problem is also not distributed evenly over all groups. The elderly, for example, do not fall into this group. Since 1965, they have been covered under Medicare. The indigent are not part of the group either. Medicaid provides for them if they are poor, blind, and disabled. Although Medicaid helps the indigent, the services provided under Medicaid are being curtailed, and fewer poor people are assisted.

The criticism around Medicaid has included arguments that some groups are favored over others, and the favoritism that exists may further enhance the nation's social problems. Consider, for example, teenage pregnancy. In 1980 the only way to obtain health insurance (through Medicaid) if you were poor was to become pregnant. Most states allow low-income families eligibility if those families support small children. The issue of inequities in the provision of services has become a political football more than once.

What appears to be the case, at least people fear it is the case, is that health care is a luxury. This luxury is provided only to certain groups. And the luxury that does exist makes the absence of care appear even more unfair.

The recent IOM report on healthcare disparities indicates that research has extensively documented the pervasiveness of racial and ethnic disparities in health care. In 1999, as part of a national effort to eliminate healthcare disparities, Congress required the Agency for Healthcare Research and

Quality (AHRQ) to produce an annual report to be called the National Healthcare Disparities Report (NHDR). The report includes tracking disparities in access to quality care. The American Medical Association (AMA) summarized the problem: although there have been improvements in the health of U.S. residents, racial and ethnic minorities remain disadvantaged and experience a lower quality of health services and are less likely to receive routine care and have higher rates of morbidity and mortality than nonminorities. These disparities in health care were said to be present even when controlling for gender, condition, age, and socioeconomic status.

Accountability

The third and less frequently discussed issue surrounding healthcare delivery today is the problem of accountability. It is shocking to realize that despite the extremely large amounts of money expended for health care, we know relatively little about its outcomes. Is it effective? Is it even safe? Is it efficient? (We already know that it is too costly!) Well, this is changing; there is an emerging effort to identify outcomes and to examine where problems exist. An example of this is the emphasis on assessing medication errors in health care, their source, their costs, and how they may have been prevented.

Can you imagine the Chrysler Corporation not knowing the quality of its product or IBM not improving on its products and services? Not very likely, you would say. Well, why does the healthcare industry not know what a successful product is or how much it should cost to deliver the best product to the greatest number of people?

The most difficult piece of evidence to explain is the great variability in healthcare provisions with the resultant outcomes being the same, or at least much the same. We observe variation in practices. For example, some patients are provided more tests, but they do not necessarily survive any longer than less-tested individuals with the same healthcare problem. For example, at a Veterans' Administration hospital in California, 40% of the patients received an angiogram following myocardial infarction (MI). Those MI patients in the same geographical region, but privately insured, were reported to receive angiograms 80% of the time. It was reported that there was no evidence to suggest that those who were treated more aggressively (with angiograms) were any better off, given the survival rates of these patients (Kaplan, 1991). Other examples have shown that more frequent hospitalizations, or hospitalizations that cost more, are not more effective in prolonging life. We have even been shown the contrary—that certain medical intervention was not only unnecessary but could have put the patient at significant risk for other problems. As surprising as it seems, especially in light of the high costs of care and the advancement in technology that has occurred, we cannot establish with more exactness what treatment yields what outcome.

Those who predict or try to influence the shape of healthcare reform usually recognize that any change that does occur will have to address all three elements—affordability, accessibility, and accountability—simultaneously. Most important, we are now not only faced with healthcare problems as we have known them for years, we are faced with a “sick” system as well. Altering the sick system will be as important as treating illness and promoting health.

A PARADIGM FOR ENSURING BETTER HEALTH TO LARGER NUMBERS AND EMERGENT DELIVERY SYSTEMS

The challenge of ensuring better health to larger numbers of people and delivering that care equitably raises several complex issues: What is health? How is it established and maintained? How is this objective met with the largest numbers of Americans?

Needs for Reform and Health-Promotion Models

Older notions of public health and individual entitlement tend to deemphasize the dynamics of several factors that affect the health status of most persons. A social ecological orientation to health considers the interaction of numerous social, political, and environmental as well as physical and emotional conditions that affect individuals' quality of life. At the risk of being too abstract, a paradigm that ensures better health to larger numbers includes all of these factors and affects and is affected by public policy.

A basic assumption behind such a paradigm is that health is a multifaceted phenomena encompassing emotional well-being, physical health, and social integration. It is a model that recognizes the interplay among individuals, families, and groups that are set within particular socio-culturally defined fields. It is a model that views health and illness on a continuum and estimates years of health based on projections of life span. When years of health are the aim, the effect of medical treatment on everyday functioning and a person's quality of life must be evaluated. We should then be able to assess the particular impact of a drug or surgical procedure on the quality of life of the patients we see.

A critical departure in the adaptation of a health-promotion model is the adherence to concepts that are foreign to more traditional medical approaches. For example, the traditional medical model stresses patho-physiology. Specific disease processes, characteristic of both illness and injury, are judged in relation to body systems and specific clinical evidence, such as lab tests and blood pressure. Opinions about intervention based on these clinical measures may produce different, even contradictory, conclusions. Medical interventions (e.g., medications to lower blood cholesterol) aim to reduce death due to coronary heart disease. Biological models are used to justify this choice of treatment, and the model argues that there is a benefit to this treatment because it reduces deaths from coronary heart disease. Interestingly enough, in controlled experimental studies, the overall outcome—morbidity—for this group of patients (from all causes) is not affected. A clearer example of the problem of the traditional medical model becomes apparent when the issue is surgical intervention. The benefits of surgery are usually stressed without equal attention being given to the complications that can occur. In contrast, a quality-of-life health-promotion model will give significantly more weight to a variety of factors, including treatment benefits, estimates of the relative value of treatment versus no treatment, and side-effects that occur in relation to the treatment chosen. Decisions about treatment become quite specific with clarification of what intervention is essential, very important, or only valuable to certain groups of individuals.

The Promotion of Self-Care and Community-Based Programs

The demand for inpatient care is predicted to decrease, not disappear. Acute care will not remain the model for the American health system; the ultimate focus will be outside the hospital. Goldsmith (1992b) points out that planners and public health policy makers have come to realize that community-based systems, whether founded on a public health model or medical group practice (or some combination of the two), are the foundation for an effective new system of care. This model will stress health promotion and active participation on the part of patients who are no longer the passive recipients of health care.

An outcome associated with newer health-promotion models is the achievement of high levels of self-care potential. Self-care refers to the actions performed by patients (or their significant others) directed at alleviating the effects of illness and its treatment. These actions, taken with the interest of protecting and promoting health and well-being, reflect many sociocultural interpretations that the patient places on his or her current illness and future goals. One of the variables repeatedly cited in providing quality of care through health promotion is the character of the patient–provider relationship, particularly that between physician and patient. Features of this relationship that were associated with positive patient behaviors were (1) the friendly and accepting attitude of the provider, (2) patients' perceptions that the physician had spent time with them, (3) patients' feelings that they had control in the interaction and input in their treatment programs, (4) patients' satisfaction with the care they received, (5) a treatment program that was actually tailored to them as individuals, (6) situations in which patients felt that information was willingly shared with them, (7) absence of formal disagreement with patients, and (8) continuity of the specific provider–patient relationship. Although the largest proportion of these data focused specifically on patient–physician encounters, the conclusions have validity for encounters between other health providers and patients.

It is clear from current projections of trends in healthcare source delivery that not only the patient will be instrumental in deciding the impact of healthcare reform, whole communities will shape the manner in which this care will be rendered. Less care will occur in acute-care hospitals; more care will occur in brief urgent-care centers. An increasingly significant proportion of the care of the very ill will occur in the home. Providers will be asked to assist in this transition.

In truth, the American system has few alternatives; inpatient hospitalization is too costly and the advent of diagnostic-related groups (DRGs) no longer permits the extended hospital stays enjoyed a little more than a decade ago. The de-institutionalization of healthcare delivery will characterize the major shifts in delivery systems. Rather than just inpatient or outpatient service, there is likely to be a flexible flow in the use of a variety of services extending through the course of disease and illness to include end-of-life care.

Managed Care and Interprofessional Collaboration

Adapting a health-promotion model of care has direct implications for the collaborative relationships of health providers.

If we endorse a broad concept of health and recognize the value of the quality of our patients' lives, we depart from tendencies to view patients through the narrow channel of disease or illness. Once open to health in the broader context, not just the absence of disease, we automatically recognize the importance of multiple health and human service providers. The overall goal—maintaining the patient's optimal level of health and increasing the patient's years of freedom from disease and absence from disability—frees us to think out of the box, not only of formal approaches to cure and care administered by physicians, nurses, dentists, pharmacists, and many other providers, but we are also encouraged to consider the multitude of alternative health care approaches and strategies that lie outside scientific medicine.

This health-promotion perspective emphasizes both the advantages and the appropriateness of multilevel interventions. Many of these interventions are complementary. Reducing stress, for example, can occur through meditation; it can also be attained through relaxation and massage programs. Others are synergistic, building on one another to produce the desired results.

What concept of interprofessional teamwork is appropriate? Under the old disease-oriented approach, providers were relegated to positions of importance with respect to their role in ridding individuals of disease. Physicians, under this model, are at the top of the hierarchy for several reasons. They had the authority to cure disease. Under this model, because disease is paramount in directing healthcare providers, physicians automatically assumed the primary leadership role.

Managed care has been considered as a potential solution to containing healthcare costs, and at the same time, ensuring equitable care to all Americans. The managed care model is expected to be the prevailing form of healthcare delivery now and in the future. According to many providers, managed care of the ill will require, at the very minimum, multidisciplinary teams consisting of physicians, nurses, home-care providers, and ambulatory-care practitioners. Under managed care, the aim is to provide a range of services in such a way that these services and their costs will be scrutinized and controlled. Three basic managed care programs exist at present: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and fee-for-service plans.

HMOs and PPOs have been criticized for their drawbacks. Despite the fact that they were designed to provide preventive healthcare services and to improve the continuity of quality of care, the results reveal problems. Healthier individuals are favored by managed care systems over those who are at high risk, those who require high-cost procedures, and those who are chronically ill and need long-term care. Managed care has also been criticized for overlooking quality of care in order to meet the basic aim of cost containment. Also, low-income populations are often not served by these plans.

Managed care systems and case management are being hailed as the primary solution to needed healthcare reform. Skills and knowledge that are necessary to function in these systems of care are being defined. The real and potential importance of effective communication skills is clear, particularly as they relate to healthcare assessments, disease management, and multidisciplinary collaboration. The outcomes of health care are clearly a reflection of the provider's command of effective communication skills and knowledge as they are executed in new roles.

Managed Care versus Case Management

Managed care is a system of managing and financing healthcare delivery to ensure that services are needed, are efficiently provided, and are appropriately priced. Through a variety of means, including preadmission certification, concurrent review of necessity of services, and financial incentives, managed care attempts to contain costs, ensure optimal patient outcomes, and maximize the efficient use of service utilization.

As previously indicated, managed care is one system of delivery that is proposed to correct the problems in healthcare delivery that were, and continue to be, out of control. Managed care is rapidly changing traditional approaches to health care. The managed care industry can be understood by segmenting the industry into three distinct options. Current and future developments in managed care suggest that it has fulfilled its promise in supporting quality care and cost containment concerns remain. Still, problems remain and have led to erosion of the system with cost increasing significantly after the turn of the century (Lagoe, Aspling, and Westert, 2005).

Frequently associated with the concept of managed care is the term **case management**. Although managed care and case management are sometimes used interchangeably, they refer to distinctly different phenomena (see Figure I-1). Managed care generally denotes the way care is structured for reimbursement. Case management, however, is a technique used to monitor and coordinate treatment, usually for specific diagnoses. Traditionally a utilization review process, case management means that care is closely monitored and coordinated, particularly with regard to high-cost service-intensive diagnoses. Case management includes activities of assessment, treatment planning, referral, and follow-up to ensure that comprehensive and continuous services are provided. Case management oversees reimbursement for care in that it ensures that the coordinated payment and reimbursement of services is properly executed.

The emergence of managed care is congruent with case management because both aim to ensure quality and control costs. Managed care systems have been widely endorsed as necessary options in health care reform. The goals of these organizations—to ensure maximum value from resources—is congruent with the

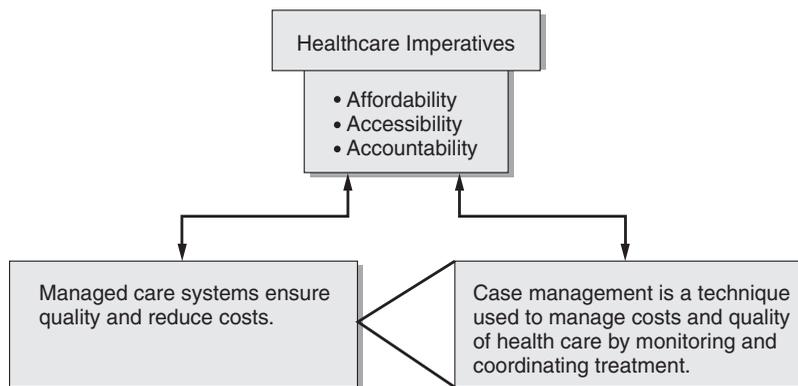


Figure I-1 Needs for Healthcare Reform and Managed Care Systems.

basic philosophy of health care professionals (Hicks, Stallmeyer, and Coleman, 1992). This philosophy holds in high esteem a focus on the total needs of an individual, not just on the disease process and on maintaining health to minimize the need of future expensive healthcare intervention.

Underlying Problems and Issues with Managed Care and Case Management

Healthcare reform is not new and different; reform can be traced back in time to the health initiatives of President John F. Kennedy's New Frontier and President Lyndon B. Johnson's Great Society. Because healthcare reform spans several decades, we can safely conclude that reform in the United States is a continuous process.

Managed care, though, has come under severe criticism. Primarily, this criticism is leveled at the premise that accessibility, affordability, and accountability in health care are realistic. Some providers claim that addressing any one of those three elements will inevitably compromise another (Kissick, 1994). Choices need to be made, and these choices may preclude the possibility of simultaneous significant improvement in all areas.

Managed care is not altogether new, but neither is case management. Case management is not new to our concept of professional practice because disease management has been a familiar approach of providers in their caregiver roles. Controlling costs is also not a unique idea, because providers have been historically motivated toward this aim. Case management, though, has undergone widespread criticism. The case manager is sometimes viewed as an extension of an already extensive bureaucratic system, adding yet another layer to the healthcare delivery system. It is felt that quality of health should be provided and managed by healthcare professionals. The reliance on those other than healthcare professionals—particularly clerks in insurance offices who, in some cases, decide treatment options—defies our ability to ensure quality.

These issues have generated a great deal of debate: (1) What professional is best suited to be a case manager? (2) What added expertise is needed to function in this role? (3) What approach is best suited to execute the role with arguments for and against direct contact versus telephone triaging of patients?

In part, concerns about case management have surfaced because of the rapid proliferation of case management systems. The current managed care industry is criticized because it is felt that case managers were needed before adequate planning for their preparation could occur. Essentially, the professionals managing care may not have the expertise to execute their roles. No real data, however, are available to judge the quality of care under case management. While data about patients' responses to case management are limited, patients are said to value the system because it eases their burden in managing their own care.

Shifts in Care Delivery

In keeping with the need for healthcare reform and the methods used to secure accessibility, affordability, and accountability, certain predictable trends are shaping health care. These trends have particular implications for provider encounters with patients and their families.

Community Ambulatory Care

Diminishing hospital use and vast expansion of ambulatory care are occurring. Health promotion and disease prevention—high-priority aims in health-care reform—are achieved largely in community ambulatory care settings.

Disease Management

These predicted shifts in the focus of care clearly indicate that the majority of services will occur in the community ambulatory care setting. This does not, however, mean that disease is no longer a concern. A new term, *disease management*, describes a community approach to treating chronic conditions. Diseases such as HIV and other chronic, severely debilitating conditions are examples. The care processes of disease management include prevention and health promotion. Early identification of disease; assessment of problems secondary to disease; and development, implementation, and evaluation of a plan of care are encompassed in this approach to disease management.

Disease management consists of taking a single problem such as AIDS, cancer, diabetes, or cardiac and psychiatric conditions (conditions known to be chronic) and applying regular interventions for consistent outcomes. Early identification is critical to patients who can benefit from early detection. The individual's unique needs are understood to be the essential part of assessing the problem as well as developing care plans. Care is to be individualized and patient-centered. In plan development, the protocol for care is based on defined medical practices that promote health rather than those that simply treat disease. The plan is put into action using health-promotion strategies prior to such anticipated periods and routine illness treatment. Plan evaluation occurs regularly but is not confined to measures of treatment. Rather, evaluation also includes measures of the level of health maintained over time.

Interprofessional Collaboration and Consultation

Interprofessional collaboration and consultation are necessities of both managed care and case management. To develop and implement successful managed care approaches, support from key participants—administrators, physicians, nurses, and other healthcare providers—is required. The ability to work with other individuals on a continuous basis is essential to the success of case management. Case management within and outside hospitals requires consultation with finance personnel, administrators, and various providers (e.g., dietitians, physicians, social workers, physical therapists, and nurses) to obtain relevant information about potential problems.

The idea is to collaborate with many in order to design strategies for solving problems. Ideally, case managers are professionals—nurses or physicians. These professionals communicate with provider groups to identify problems, plan strategies, and evaluate progress within patient care critical pathways as well as to evaluate the overall impact of these actions. Within case management, therapeutic relationships with patients and families are important. Case managers rely on those relationships to derive mutually acceptable outcomes. Consultation with patients and families and the development of a collaborative relationship with these individuals are said to be as important as the collaboration and consultation that occur within colleague relationships.

THE SKILLS AND KNOWLEDGE OF PROVIDERS IN A MANAGED CARE ENVIRONMENT

Generic to All Providers

The skills and knowledge that are necessary for providers who work in managed care environments are defined, in part, by the expected outcomes of managed care and case management approaches.

Managed care includes a commitment to reduce cost, make services accessible, and control and monitor quality. Managed care should (1) positively affect the cost of service, (2) improve provider consultation and communication, (3) engage other key providers in participating in care planning, and (4) improve continuous quality improvement through the design of critical-care pathways. Additionally, patients should be positively affected in that their care is coordinated for them and that there is a reduction in unpredictable outcomes. Thus, they should be more knowledgeable and better prepared to understand and participate collaboratively in the planning and evaluation of their care.

Although there are a variety of case management models, common to all are the following service components:

- Client identification and outreach.
- Individual client assessment and diagnosis.
- Service planning and resource identification.
- Linking clients to needed services.
- Actual service implementation and coordination.
- Monitoring service delivery activities.
- Patient advocacy to reduce problems of access to care.
- Evaluation of these activities and their expected outcomes (Allred, Arford, Michel, Dring, and Carter, 1995).

To accomplish these goals, providers need to function as both multidisciplinary and multi-service integrators. Integrators operate at the hub of the wheel as they bring together and coordinate broad-based services.

Roles Specific to Case Manager

Case managers in managed care organizations steer, guide, and track patients through a variety of care activities, thus enhancing continuity of care. A major instrument in this tracking process is the critical-pathway analysis imbedded in the patient's plan of care. Critical pathways and critical-path tools were so coded based on the Critical Path Method (CPM), a part of the Program Evaluation Review Technique (PERT) developed by the U.S. Navy and Lockheed Aircraft Corporation.

The patient-care plans that are developed identify a "critical pathway" of key events (activities and interventions) that must occur as projected if the desired patient outcomes are to be achieved within a specified time period. The case manager oversees these pathways and facilitates interventions to ensure that patients progress appropriately and satisfactorily. The coordination and collaborative consultation that occurs requires skillful assessment and negotiation.

The specific facets of the case manager role have been detailed in the literature. A thorough account of this role for nurses is presented by Hicks, Stallmeyer, and Coleman (1992). Patient advocacy, patient education, resource and risk management, benefits interpretation, and provider liaison are all aspects of this role.

The Role of Communication in Delivery of Health Care

Exploring the issue of the importance of communication skills and knowledge to providers is somewhat like discussing the need for eyes in order to see. Most providers would not argue either the relevance or importance of these skills and knowledge. The issue is rather what communication skills and knowledge are needed and how will they be acquired. Additionally, in this era of evidence-based practice, providers can no longer be satisfied with knowing how to do it, they must understand why and what evidence there is to support benefits of these approaches.

In this text, dimensions of the phenomena of human communication and, more specifically, healthcare communication are explored in depth. Essentially, every provider needs a foundation in the basic anatomy and physiology of communication. Providers need to know the variables that affect reception, processing, and expression. They need to understand the relationship of communication to quality care outcomes. They also need to understand the multicultural context in which communication occurs. Providers deliver healthcare services, all of which—disease prevention, health promotion, health screening, and health education—require foundations in therapeutic communications. Therapeutic response modes are needed not just to successfully assess individuals and families, they are needed to manage care and to increase patient awareness and capacity for personal health management and self-care. Specialized knowledge and skill are needed to relate effectively in these capacities when crisis or prolonged chronic illness are the subjects of healthcare management.

To participate fully in interprofessional managed healthcare teams that are collaborating with other providers and patients and their families, knowledge of the dynamics of group and family communication patterns is required. Communicating effectively with all relevant constituencies—patients, providers, and regulatory agencies—calls for effective negotiation skills. The ethical precepts of communicating in managed care, particularly with regard to patients' rights to informed choice and informed consent, must serve to critically guide our practice in these emerging models that now dominate healthcare delivery. Finally, advanced issues (e.g., communication and models of behavior change, communication and the use of the Internet, and communications as a function of systems of care) further extend the coverage of the topic of how the provider will use and alter factors that enhance communications.

CONCLUSION

In summary, vast changes have occurred in the American healthcare system over the past 300 years. These changes have reflected many factors, including the advancement of medical technology, the American social structure, and

threats to health and equitable healthcare delivery that have plagued us over time. With a seemingly unwavering belief in the American system of health care, the American dream became one that included absence of disease and, if that was not possible, remarkable chances of recovery from extraordinary debilitating conditions. This American dream is quickly becoming a significant nightmare as we attempt to assure all Americans of the privilege of health and absence of disease. Recognizing our goals and concomitantly restructuring our delivery systems while containing costs is the challenge for healthcare reform.

Affordability, accessibility, and accountability are major recurrent system barriers to the delivery of effective healthcare services. They are not isolated problems; they affect providers' one-to-one encounters with patients. Patients' reactions to providers reflect their fears and concerns that basic health care is costly, may not always prove adequate, and is frequently administered by a nonresponsive system. These fears and concerns are translated into communication difficulties where patients mistrust providers' intentions and the system as a whole.

Attitudes of mistrust and fear of neglect, if they do exist among patients, are not without basis in reality. Previously, they may have been described as an anticipated set of concerns felt by most patients but without much substance. Still, there is a new context for patient anxiety, and it can hardly be ignored. Thus, it becomes even more imperative that providers be guided by sound principles of interpersonal communication.

Healthcare reform will include new goals for health promotion where patients fulfill certain self-care behaviors never before expected of them. Reform will occur outside the hospital, in neighborhoods, and in community settings. It will require new concepts of interprofessional collaboration. Finally, it will require a growing sensitivity and awareness of patient-provider encounters that work and do not work. Certainly the trust, confidence, and security that providers evoke in their encounters—an element of professional practice always held in high esteem—will play a critical role in the reform that takes place at the system level. To this end, the parameters of good interpersonal communications are the “handbook” for all health professionals. Provider-client communications are both a determinant and a by-product of successful healthcare delivery. Exhibit I-1 describes some patient perceived difficulties critical to correcting communication deficits.

Exhibit I-1 Patients' Descriptions of Difficulties in Communicating with Providers in Inpatient Settings: Verbatim and Implied Reactions

“Having to tell my story over again.”
Please save me the energy and humiliation.

“Not having doctors get together on their opinions—each one telling me something different.”
If my doctors are not together, how can I trust what they do?

continues

Exhibit I-1 Continued

“The RNs, doctors, and physical therapists communicate poorly (to one another) . . . and they do not follow-up on the information they give.”
Do they think I don’t notice this and worry?

[What is difficult is] “wanting to speak to someone who really cares (and not having anyone).”
I’m lonely and isolated, somebody recognize me.

“I get frustrated, irritated when nurses are not able to respond because they are ‘overwhelmed.’ ”
What is their work if it isn’t to care for me?

“When nurses say, ‘I’ll be back in 5 minutes’ and don’t come back at all or it takes a long time.”
How can I trust what they say to me?

“Having nurses lie to me (e.g., about not having blankets).”
What can I really believe?

“The nurses didn’t involve my family (in discharge planning).”
My family needs support and counseling—I’m afraid they won’t get it.

“I rarely ask for a nurse unless I really need one—nurses don’t come when you call them—I ask the nurse for minor things and don’t get them.”
Will I always know when I need a nurse?

“I don’t know what is expected of me—I don’t want to be a bother.”
If I ask them what is expected, will I bother them?

“Night nurses don’t answer call lights.”
Sometimes I wonder if there really is someone out there behind the door.

“I’m beginning to feel like an inmate—not a patient . . . staff are more concerned about hospital procedures than patient needs.”
I feel locked up, punished by the way they treat me.

“People are nonentities—I feel like a prisoner, alone in my room.”
Nonentities are not entitled to anything.

“People come into your room without permission.”
“People come in and don’t identify themselves. I feel like a guinea pig.”
How can I tell if they should be here or not? What are they going to do to me?

“Some nurses are more professional than others—some bring their problems to work. Their attitudes are reflected in their work . . . causes you to wonder if they really care about you. You feel dependent and worry if they really care. You feel helpless.”

If they can be both professional and unprofessional, how can I make sure I get the professional one?

“When I ask one member of the medical team a question, he always answers, ‘You’ll have to ask Dr. D.’—don’t get information when I want it.”
Does he know the answer—why is he withholding it?

“(Staff) were not present to support my wife with the stress she is experiencing due to my illness.”
I don’t think they realize how she must feel.

“Medical students who don’t know what they are doing—come in at 2:00 a.m. to take my blood, drop equipment, say ‘my resident/teacher will probably tell me to go back and try it again.’”
Are medical students given experiences they can do right?

“(I worry about) morale and high turnover. I don’t want to worry about my care—but some nurses work two or three shifts in a row.”
How can they be up to speed? Will I suffer because of this?

“Lack of communication between doctors, hospital, and volunteers. More competition than cooperation.”
“Too many different doctors and nurses are involved in my care . . . I worry that they might not be communicating . . . that orders from one doctor might conflict with orders from another.”
“It is very bothersome when I have to fill a doctor in on the aspects of my care.”
What would happen if I wasn’t able to monitor my own care?

“Not always understanding doctor’s answers to my questions, I ask a question and get a nonanswer for an answer. I am supposed to be satisfied with that!”
Do they think they are really helping by treating me that way?

“When you push the call light and the nurse doesn’t come—a volunteer comes instead. This happened with my roommate: My roommate yelled all night for the nurse.”
What does it take to get a nurse?

“I’ve tried to get a vegetarian diet. I’m still getting a regular diet despite five days of asking for a change, talking to the dietitian, etc.”
I can’t get through to them no matter what.

“The nurses don’t think about how it must feel to be a patient.”
They are insensitive to my needs.

“I’m afraid my doctor is not telling me the truth (cancer diagnosis).”
I can’t trust what he says.

continues

Exhibit I-1 Continued

“The nurse got mad when I told her I couldn’t take my pill with water.”
Why is she mad at me? Doesn’t this ever happen with other patients?

“There is really only one nurse who takes the time to talk to me.”
I must make sure I get that nurse.

“Not having answers about why I’m sick.”
Do they know and are just not telling me?

“Too many different nurses; hard to form a relationship with a nurse—causes you to hesitate to open up and confide (in them).”

“Doctors not knowing what’s wrong with me—not taking my symptoms (diarrhea) seriously.”

My communications don’t count. I don’t count.