Chapter 2

Person-Centred Communication

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Learning Points

By the end of this chapter, you will:

- Understand what person-centred communication is
- Have learnt about some barriers to person-centred communication
- Be able to recognise unconscious bias and stereotypes
- Have the tools to move towards more person-centred communication.

Please note the focus of this chapter is communication with the older person, therefore the case study will be framed differently from those in the other chapters. The clinical elements will have less of a focus and instead the chapter will look at specific areas of communication that we must consider in our treatment of older people.

Case Study

You are responding on a double crewed ambulance to reports of a 74-year-old man called John who has fallen in the garden and has badly hurt his knee; he is in a lot of pain and is unable to move. The call was made around three hours prior to your arrival time.

The patient fell while jumping over a section of the garden where he had just planted some bulbs and did not want to stand on them. He landed awkwardly and thinks he twisted his leg which caused the fall to the ground. John thinks he heard a crack as he fell and is stating that the pain is the worst pain he has ever felt. He took some paracetamol around an hour before you arrived on scene, but it has not had any effect. In the garden with the patient is a woman and a man around the same age as John.

Introduction

Healthcare communication is an interdependent process: each involved party is reliant on the other for information (Pagano, 2015). The clinician needs information from the patient or a family member on a variety of often complex subjects such as presenting complaint, family history, medical history and social history to start to develop a working diagnosis and treatment plan with the patient (Pagano, 2015). Patients in turn need information from healthcare providers to understand what is happening and make their own decisions around their care (Pagano, 2015). It seems obvious to say that good communication is essential for good patient care. However, it is clear from an abundance of evidence and serious incidents that in the NHS and other patient and clinical settings it regularly goes wrong with significant consequences (Campbell et al., 2018; GMC, 2019).

What is Person-Centred Communication?

Person-centred care is the approach that is advocated for in all UK healthcare systems. It is a shared decision-making process between clinician and patient which is based on best medical evidence and the person's individual preferences, beliefs and values (NICE, 2021). There has been a shift away from paternalistic practices of physician led and directed care. Instead there is now a focus on working in partnership with our patients to ensure they are included and also empowered to determine and influence their treatment choices. Evidence suggests that when the patient is actively involved in their own care they better understand what is being proposed and are more likely to better manage their illness or symptoms, and to engage with further support (Naughton, 2018). Involvement in their own care can also significantly reduce patient stress and anxiety, and lead to a safer and more satisfying care experience (Naughton, 2018). To enable this method of care we need to move to a person-centred communication strategy. It is not a simple case of outlining a list of questions under specific headings that we see commonly in some of the communication literature. If it were as simplistic as a unifocal 'how to list' then we could assume that more people would be communicating this way with their patients, but the evidence suggests that this is not the case.

Communication Breakdowns

Storlie (2015) found in their research around communication with older people that there are five main causal factors commonly seen when looking at communication breakdowns, poor practice and clinical errors which were directly attributed to poor communication. These are:

- Ageist attitudes and language
- A lack of provider commitment to person-centred service delivery and patient care
- Inappropriate use of professional jargon by the provider
- Underdeveloped communication skills of the provider
- Impediments to effective communication stemming from cultural differences and from age-related physical, social and psychological changes in the older adult.

The list provides five areas of focus that will be explored individually throughout the rest of this chapter, using the case study to examine potential pitfalls, and importantly solutions and strategies to utilise when communicating with our older patients.

Ageism

We all have a variety of unconscious or implicit biases, which are beliefs we have about groups of people in relation to, for example, their race, gender, sexual orientation, disability, age or socioeconomic group (Wilson et al., 2021). These biases are created through factors such as our education, upbringing, influence of our family and friends, experiences and exposures which form the lens through which we see the world and the people in it (Wilson et al., 2021).

Ageist attitudes and tropes are present in everyday language, in the media and press, social media, marketing, film and television. Older adults are commonly shown through a lens of decline and diminishing value in society, often emphasising the 'burden' that older people place on society and families (Milner et al., 2012). These daily images reinforce stereotypes, enforce prejudice and misconceptions, and underpin discriminatory behaviour (Centre for Ageing Better, 2021). The pervasive societal stereotype around older adults is that they are less competent than younger people (Wilson et al., 2021). Older people are commonly portrayed as frail, vulnerable and dependent (Centre for Ageing Better, 2021). It has been difficult to shift this attitude and it has significant effects on care and treatment received in all facets of life for older people.

Ageist stereotypes and biases permeate across society. Judi Dench famously brought up these stereotypes and biases which are present within the paramedic profession. In the film *Nothing Like a Dame* she describes an encounter with a paramedic following a sting on her bottom from a hornet. The paramedic opened the interaction with 'And what is our name?' with the second question being 'And do we have a carer?' Judi openly expresses her anger about the biases and stereotypical attitudes and assumptions surrounding older people.

There is also a need to consider the intersectionality issues of bias and stereotyping. Pedersen and Nielsen (2019) when considering gender bias identified that women and men (or those who identify as such) are often stereotyped according to the traits that they are assumed to possess, which leads in many instances to unequal treatment based solely on gender. Social identity theory states that demographic characteristics such as race or gender shape socialisation experiences which influence and affect identity formation, attitude, belief and perceptions (Pedersen and Nielsen, 2019). When considering these intersects, an older woman will face both gender stereotyping and discrimination as well as stereotyping and bias surrounding her age. An older black woman may face biases and discrimination based on her race in addition to her gender and age. We all need to be aware of this as clinicians, and think about the stereotypes and biases that we take into patient encounters often without thinking. It will have very real consequences and significantly influence how we communicate with our patients if we do not acknowledge these factors and start to try and address them.

Now let us revisit John, our patient in the case study. What assumptions did you make about him when you read about the incident in the garden?

Your brain would have automatically started filling in the gaps and painting the picture of that encounter; it would have started placing the various people in the scenario into categories, to make sense of the situation. The brain does not like an incomplete story. The snippets of information that you get on your way to a patient if responding for the ambulance service, or before a consultation, allow space for assumptions. What might you have assumed about John? Did you consider that John still worked? He was a lawyer before semi-retirement and now acts as a consultant for several law firms throughout the country. He is well renowned and respected in his field.

Would this have been the first thing that came into your mind do you think when you read that you were responding to an older male patient who had fallen in his garden?

Honest reflection and consideration of this helps to understand our stereotypes and biases. It is only when we start acknowledging these, reflecting on the factors that contribute to these stereotypes, that we can start to address them. We also need to consider the other people in the patient encounter. It is often as important in patient-centred communication that you build a relationship with those who are closest to the patient and work with them, as well as the patient, to arrive at a co-constructed treatment plan.

How may you have greeted the woman in the case study? Women are often called 'love' or 'dear' or 'flower' (insert your own local term for an older woman); we will explore some of the reasons for this later in the chapter. Men often command more respect: they will commonly be greeted as 'sir' or 'boss' (again, insert your own standard local greeting) initially. What assumptions would you have made about her? Who is she to John? Many of us would assume she is his wife, based on age and the fact that she is in the garden with him. She is in fact his sister Wendy who has lived with him for several years. The other man in the scenario – who is he? He is John's husband, Steve; he came home from work when John and Wendy called to say that John had fallen and was unable to get up. Granted you were not given much information to be able to determine this from the initial description, but this is the reality of frontline healthcare, these are the snippets, the quick pictures, the hasty views that you will have initially. What assumptions would you have made? How would you have asked who everyone was? It is unrealistic to expect you to know exactly who everyone is at the scene in relation to the patient, and indeed who the patient is or anything about them, and that is exactly the point: do not guess, do not assume – ask and learn.

Lack of Provider Commitment

It should go without saying that all people matter, irrespective of their age, race, sexual orientation, gender, religion or any other category they may be put into. Unfortunately for many people this is not their experience of healthcare. People want to be seen for who they are, they want to feel that they are valued, that their opinions and ideas about their care and their life matter to the healthcare clinician involved in their care and to have their undivided attention even if only for a few minutes (Storlie, 2015). Safe and trustful communication between healthcare providers and patients is essential for reducing healthcare injuries and negative experiences (Johnsson et al., 2018). At the heart of communication must be the patient: their

values, their preferences, their expressed needs and their direct involvment in their own care (Johnsson et al., 2018). It must be considerate of the person's individuality, humanity, dignity, right to be recognised and their ability to bring their whole self to the situation (Hewitt-Taylor, 2015), irrespective of any protected characteristics or their socioeconomic status (which is not recognised in the equality act currently).

Jensen et al. (2021) in their work on person-centred care in the emergency department (ED), noted that the high-intensity workflow is characterised by a constant level of uncertainty and unpredictability around which patient will present next. This is the same for frontline clinicians in the paramedic profession and advanced clinical practitioners (ACPs) within the community and leads to a challenging environment in which it is difficult to conduct unhurried person-centred care conversations. It is, however, essential that we do include our patients in the decisions we help them to make, either with them as individuals or with the help of their family members. Involving our patients in their care and allowing them to inform and direct their treatment choices leads to a patient who has been supported and empowered by the healthcare system to subsequently become more engaged in their care plan thus improving outcomes in the long term (Jensen et al., 2021).

John is married to Steve and identifies as queer or gay. Studies looking at LGBTQIA+ experiences of healthcare have demonstrated that providers' biases can range from subtle covert behaviours, known as microaggressions, to blatant homophobia, biphobia and transphobic discrimination (Smith and Turell, 2019). John and Steve would have seen the portrayal of gay men during the AIDS epidemic; they will have been aware and out in society when Section 28 was in situ which prohibited the 'promotion' or discussion of homosexuality. This is all a part of their story and history. Much of healthcare policy and education centres around heteronormativity. As a result, LGBTQIA+ individuals are missed out from the outset. They frequently report discomfort in healthcare situations, and often feel the need to withhold information, change providers to avoid a provider knowing too much or following a negative experience, or they do not seek healthcare at all (Smith and Turell, 2019). A lack of inclusion and involvement in their own care has had lasting damaging effects on many members of the LGBTQIA+ community, as it will do for other marginalised groups and those who have felt excluded from their care, or have experienced poor communication during healthcare encounters. Healthcare practitioners must understand how important communication is and want to fully engage with it to avoid experiences such as these. Individuals must value its importance and see it as a priority in order to deliver person-centred care consistently and successfully.

Jargon

Research indicates that there is a mismatch between what the healthcare providers think they have communicated and what the patients hear and understand following healthcare contact (Miller et al., 2021). Providers generally think that they consistently speak in plain language to their patients, but clinicians routinely overestimate the patients' understanding of medical terminology or jargon (Miller et al., 2021). Jargon is one of the core barriers to effective communication. It is routinely used in patient interactions by clinicians and is overly complex, confusing and often in complete opposition to respectful

person-centred communication (Stone et al., 2021). Jargon and complicated medical terminology should always be avoided. Where there is any doubt that your patient may not understand what is being said, active listening, clarifying questions and asking the patients to relay their understanding back are all tools that can aid understanding and foster a respectful professional relationship between you and your patient.

Underdeveloped Communication Skills

Good communication, with a clear and consistent focus on a person-centred approach, is not easy. It is something, irrespective of your length of service, grade or age, that needs to be practised, routinely reflected on and, as with other elements of care, implemented with a consistent view to best evidence and a commitment to maintaining and honing the skills required. An inability to build rapport, a lack of active listening strategies, a lack of openness and a lack of questions due to assumptions already being made and relied upon as fact will cause significant communication problems.

Storlie (2015) encourages clinicians, when reflecting on their communication with older adults, to consider the following contemplative questions:

- Is your communication with older adults mostly person-centred, is it generally effective, always respectful and do you think it is mutually satisfying? If so, why? What are you doing and/or not doing that is creating this experience for you and your older patient? List some of the areas where you feel that you have strengths, and identify any areas where you feel you need to make improvements.
- Identify someone who you believe communicates effectively and respectfully with older adults. What is it that the person does that enables them to have these effective person-centred conversations? List the major factors and imagine how you can start to build these techniques into your own communication.

Regular reflection on patient contacts with a focus on communication, as with other areas of practice, is an effective way of making improvements. It will help you develop your person-centred communication skills and enable you to help your older patients make the decision that is right for them.

Cultural Differences and Age-Related Changes

Barriers to true person-centred communication and care can include resources, policies and the structure of the organisation involved, workplace culture and values, individual clinician beliefs, values and priorities (Hewitt-Taylor, 2015). In addition to these barriers there are the physical and cognitive barriers that are often assumed to be present in the older adult based purely on the age of the patient and the biases surrounding them. You need to ascertain when you have met the patient whether there are any physical barriers or impediments that you need to be aware of. Do not assume there is a deficit in hearing and automatically talk very loudly to the patient.

It can be seen as patronising and disrespectful. If there is a deficit in hearing, sight or any other barrier to them communicating with you, then find out where possible how they like to communicate. What do they need? Would it be useful for instance to write things down for them? Or, if wearing personal protective equipment, would it help to remove your mask to enable lipreading?

Culture, or difference in culture, needs to be considered when trying to build a rapport with the patient and/or family. Culturally competent communication needs to be at the heart of person-centred communication. If we fail to acknowledge the patient's culture, celebrate their differences, and allow the unique elements of individuals to inform their care and the decisions that they make, then we are failing them. Brooks et al. (2018) state that culturally competent communication is the effective verbal and nonverbal interactions between a patient and healthcare provider where a mutual understanding and respect of each other's values, beliefs, preferences and culture is present, and the objective is to achieve a culturally sensitive care and treatment plan for the individual. It is unrealistic to expect you to know all there is about every culture and even if this were the case, there would still be a level of assumption present. It is not the case that everyone from a certain culture will wish to be treated the same. What instead needs to be a core focus is the absolute desire to learn with the patient and family, where appropriate and applicable, about each individual patient and the care they wish to receive.

Moving Towards Person-Centred Care

Throughout the literature there are many communication models proposed for use in healthcare. It is an often-overwhelming task searching through them all. Much of the literature on communication with older persons still maintains an increased focus on the 'deficits' of ageing, concentrating on frailty, loss of sight, hearing and so on, and overcoming these deficits (Eliassen, 2015). This not only replicates stereotypical tropes of ageing but firmly establishes a power dynamic between healthcare provider and patient, framing all patients as vulnerable and in need of extra care (Eliassen, 2015). However, the older population is increasingly diverse. There is a growing majority of adults moving into their 60s still physically and mentally able, active and socially engaged, with many choosing or having to work beyond standard retirement age (Eliassen, 2015). It is important that you move away from assumptions and stereotypes, starting your dialogue with the patient respectfully and openly, in order to get to their truth and their needs. Simple strategies include making sure you get down to the patient's level if they are sitting or lying down as it is intimidating to be towered over. Shake hands (if this is appropriate) and use a kind approach. Ensure you ask how they would like to be addressed, as the wrong greeting can cause an instant barrier. Use open body language, active and attentive listening, minimise distractions around the patient and if you are working with a colleague, involve the patient in your discussions with them. Try and arrange additional support for those who may have difficulties with partaking in shared decision making, particularly if there is not a family member, friend or carer available to help or, importantly, if the patient does not want them involved (NICE, 2021).

Person-centred care must focus on getting to know the person, including their history, values, beliefs, priorities, understanding of the current situation, responsibilities,

preferences, future aspirations and how they are making sense of – or how they understand – what is happening and what the potential plans are (Hewitt-Taylor, 2015). You effectively need to enter your patient's world, to try and understand how they see things. It does not mean that you must agree with their perceptions or ideas or adopt them as your own while with them, but instead you should be able to view matters through the eyes of the person you are treating, understanding and appreciating how these factors and their individuality shapes and influences their reality and choices (Hewitt-Taylor, 2015). This respect for self-determination of the patient does not mean that you should withdraw totally from the decision-making process. The patient needs your help; they need your guidance and expertise as well as your understanding of the evidence and the likely consequences of the choices they are considering. However, what this conversation cannot be is coercive or intentionally leading (Hewitt-Taylor, 2015). NICE (2021) stipulate clearly that when you are giving information to the patient then you must use high-quality evidence and not lead the patient incorrectly. These conversations, preferences, fears, values and cultural influences need to be documented so that the shared decision can be evidenced and used by ongoing clinicians.

To offer this care and build the required partnership, the healthcare clinician must continually develop their communication and observation skills, reflecting on both positive and negative experiences. It is not something that many people are going to be instantly good at. It is important that you not only focus on medical knowledge and technical clinical skills but also develop cognitive and emotional intelligence skills. Ongoing reflection and development of these skills is important.

The proposed communication model outlined in Table 2.1 merges and adapts the work of Naughton (2018) and Silverman (2016) and offers some guidance on the core components of the person-centred communication strategy.

Table 2.1 A person-centred communication strategy.

Objective	Healthcare Clinician	Communication Skills
Foster the relationship	Build a rapport with patient and family Appear open Demonstrate respect Demonstrate care and commitment Acknowledge the patient's feelings and emotions	Warm respectful greeting Unbiased approach Maintain eye contact Show interest, be attentive Listen actively Express empathy
Gather information	Determine the purpose of current patient encounter Discover primary complaint Explore patient expectations Get to know patient What matters to them	Open-ended questions Allow patient the time to complete their responses Do not rush Clarify and summarise regularly Explore the impact of illness on patient

Objective	Healthcare Clinician	Communication Skills
Provide the correct amount and type of information	Assessing where the patient is starting from – what do they know already? Regularly check understanding to ensure the patient is with you at each step Aid accurate recall	Check understanding at each stage Can the patient repeat what has been said? Teach back method (NICE, 2021): patient to 'teach back' what has been discussed, deeper than 'do you understand?'
Achieve a shared understanding	Relating explanations to patient's perspectives Providing opportunities to contribute Picking up cues Eliciting reactions and feelings	Check your own understanding of the patient's perspective Check understanding at each stage Explore any anxiety around treatment Validate patient's feelings Open and empathetic approach
Shared decision making	Sharing thinking Involving the patient Exploring options Ascertaining level of involvement patient wishes Negotiating mutually acceptable plan	Explore the patient's preferences Identify and explore any barriers to treatment Check understanding at each stage Identify any barriers to potential self-management Ensure these are relayed to next stage care clinicians

Communication with Other Healthcare Providers

As with our patient interactions, good communication is essential when we are relaying information to, or liaising with, other professionals to establish a care plan and care strategy for our patients. Both mechanisms involve a complex mix of formal and informal communication which is both verbal and written. Failures in communication during handover are a major cause of critical incidents (Eggins et al., 2016). Patient-centred communication and care, as discussed and rationalised in detail within this chapter, must be at the heart of all interactions with our patients, and this includes handover. Evidence suggests that patients should also be central and involved in the handover process. Having the patient central in the handover process emphasises shared patient and clinician decision making, it demands transparency and honesty around the patient's care and helps continue or further develop rapport with the patient (Eggins et al., 2016). Evidence suggests that this involvement results in fewer misunderstandings, greater compliance with treatment and therefore fewer

healthcare contacts (Eggins et al., 2016). Including the patient necessitates that you explain all elements appropriately and clearly. It dictates that you would not be able to use jargon and incorrectly assume that another healthcare provider knows and understands what you are saying. It ensures that both the patient and the receiving clinician is fully aware of what has been done and what is being proposed.

Conclusion

Person-centred communication is not simple or easy; however, it is the best way to care for our patients. Person-centred care encourages us to look beyond the illness or injury that the patient presents with, encouraging us to acknowledge that all people are different. We all have our own needs, values, personalities, likes and dislikes, we are all unique and this should run through the heart of the decisions and communication strategies that we use. Older people face a raft of complicated societal biases and stereotypes that we all need to acknowledge, but should not allow to influence or determine our attitudes and assumptions about the patient. We need to acknowledge the unique differences of older people and help and guide them to make the best decision for them.

Questions

1. Consider this chapter's content and apply what you have learnt to a recent patient or event. What would you change?
2. How will your approach to older people differ now, considering what you have read?
3. How does this knowledge help to challenge common stereotypes of older age?

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