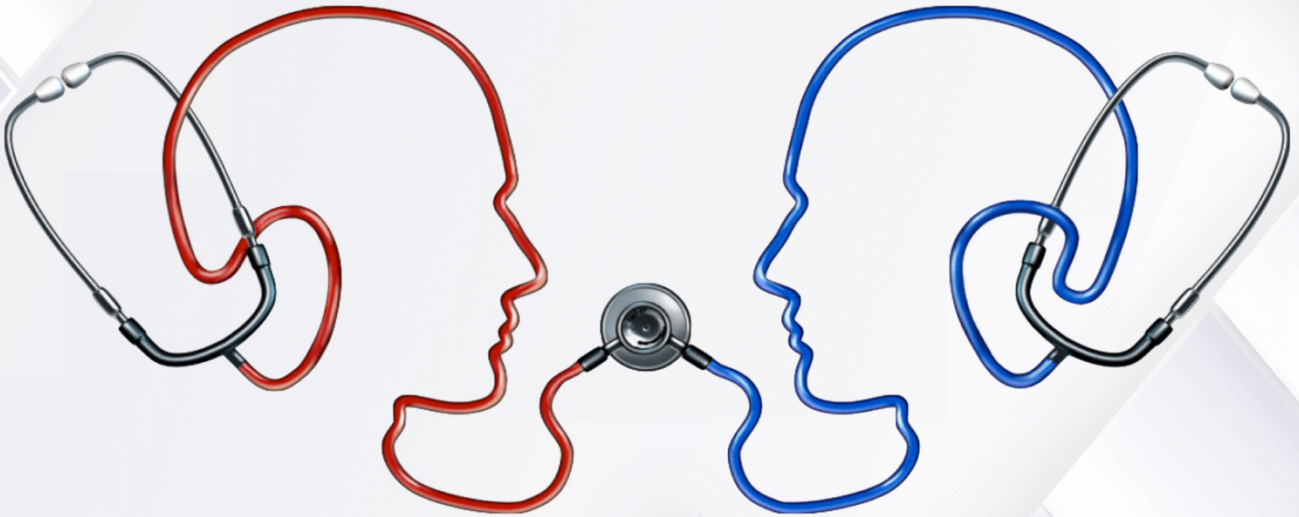


Bad News Communication Protocols
in the Medical Field

COMMUNICATION GUIDE

Erasmus+
This project (2019-1-RO01-KA202-064021) has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein

Bad News Communication Protocols in the Medical Field
Erasmus+ Strategic Partnership

Project # 2019-1-RO01-KA202-064021

Communication Guide

Abstract

Communication is one of the elements that is fundamental to the existence and survival of human beings in any kind of environment and context. Communication can be summarily defined as a process of sharing information, ideas, views, feelings, etc. between individuals or groups, in order to reach a common understanding. Communication is more than a simple transmission of information as it requires an attuned rapport - mutual understanding as an element of success in conveying or imparting information, emotions, ideas or opinions.
Whether it is presenting information to a large group of people, sharing a thought with a friend, giving written instructions to an employee or slightly nodding your head to express approval, communication is absolutely necessary on a daily basis in almost every circumstance as it is one of the most important skills for building relationships of any kind.

When it comes to the healthcare industry, communication skills are paramount for healthcare professionals in order to develop effective rapports and partnerships with colleagues, patients and their next of kin, with the ultimate purpose of improving the quality and the outcome of the medical act. Moreover, communication doesn`t only influence and affect patients and their families but it also has a significant impact on the healthcare professionals.

Over the course of a career, healthcare professionals are faced with the task of delivering bad news to their patients and families. This particular aspect of communication can be particularly difficult for the healthcare provider, especially if they do not possess the right set of skills not only for delivering bad news but also for handling the impact of communicating that news on the receiver and themselves.

The purpose of the current guide is to provide healthcare professionals with information that enables them to develop their communication skills, particularly when it comes to delivering bad news.

Table of contents

Communication

Definitions and Overview

Communication is one of the elements that is fundamental to the existence and survival of human beings in any kind of environment and context. Communication can be summarily defined as a process of sharing information, ideas, views, feelings, etc. between individuals or groups, in order to reach a common understanding. Communication is more than a simple transmission of information as it requires an attuned rapport - mutual understanding as an element of success in conveying or imparting information, emotions, ideas or opinions.

Whether it is presenting information to a large group of people, sharing a thought with a friend, giving written instructions to an employee or slightly nodding your head to express approval, communication is absolutely necessary on a daily basis in almost every circumstance as it is one of the most important skills for building relationships of any kind.

Communication is as old as the dawn of human civilization. Humans used to communicate by means of signals, sounds or gestures when there was no language developed. Without communicating, society could not have been as it is in present times, as it is communication that has transformed mankind into the most prosperous group on the earth.

Communication used to be thought of as unidirectional, where the receiver`s role was purely passive. This is referred to as the linear model. Nowadays, this model has been revised and communication is now seen as a dynamic, ongoing and plurilateral process where speakers and receivers are simultaneously sending and receiving messages. This model is being referred to as the transactional model.

The word communication has its roots in the Latin word "communis" which means "to share". Effective communication takes an important amount of work as, broadly speaking, it stems from an overall understanding of the fact that humans are simultaneously similar and different.

Throughout the years, Communication has been defined in a variety of ways and it is very difficult to point out one single authoritative definition of it. In 1976, scholars Carl Larson and Frank Dance undertook the task of compiling a list of definitions and they came up with as many as 126 definitions appearing in research and communication scholarships. It is without doubt that the number of definitions has increased since.

Here is how a few different authors define communication:

Keith Davis:

"Communication is the process of passing information and understanding from one person to another."

Ordway Tead:

"Communication is a composite of (a) information given and received, (b) of a learning experience in which certain attitudes, knowledge and skills change, carrying with them alternations of behaviour, (c) of a listening effort by all involved, (d) of a sympathetic fresh examination of

issues by communicator himself, (e) of a sensitive interaction of points of view leading to a higher level of shared understanding and common intention."

Louis A. Allen:

"Communication is the sum of all the things one person does when he wants to create understanding in the mind of another. It is a bridge of meaning. It involves a systematic and continuous process of telling, listening and understanding."

Fred G. Meyer:

"Communication is the intercourse by words, letters or messages".

G.G. Brown.:

"Communication is transfer of information from one person to another, whether or not it elicits confidence. But the information transferred must be understandable to the receiver."

Regardless of how many scholars define communication, the common denominator is present in all of them and that is the fact that through communication people and society bind together in a world that moves on human interactions and the exchanges and relationships built up through communication. Social cohesion and cohabitation depend on communication and progress and prosperity rely on the effectiveness of it.

Communication is more complex and layered than it looks at a fist glance. In their book *The Basics of Communication*, Steve Duck and David McMahan state that there are seven key characteristics of communication:

- Communication involves symbols
- Communication requires meaning
- Communication is cultural
- Communication is relational
- Communication involves frames
- Communication is both presentational and representational
- Communication is a transaction

Exploring these characteristics can provide a wider understanding of what communication involves and how each element influences the final outcome. One example of this complexity is cultural assumptions - " <Menu> rather than <a list of all the food that we prepare, cook, and serve in this restaurant for you to choose for your meal> is said because it is assumed the customer will know the code word menu and its meaning in a restaurant as opposed to its meaning on a computer screen " (The Basics of Communication; Duck, McMahan). The result of a message exchange is not just the transmission of that message but a creation of further worlds of meaning where personal perspectives play a defining role.

Communication and symbols

According to the Oxford Dictionary, a symbol is "a mark or character used as a conventional representation of an object, function or process", etc. All communication is characterized by the use of symbols that can be either verbal or nonverbal such as words, logos, pictures, gestures, sounds or anything else that is a representation of something else. The interpretation of the symbols is also extremely complex and can range from a direct (and almost universal) meaning such as a red octagon in traffic perceived as "STOP" or the stick figures used to indicate men`s and women`s restrooms to a more contextual meaning such as the shape of a heart as a symbol of love, stars on a shoulder pad as a representation of rank, a high end brand logo as a symbol of wealth and status or a touch on the arm as a symbol of sympathy. The symbols that look like what they represent (the bathroom stick figures) are called iconic while the rest are the ones that have no pictorial connection to what they represent.

It is important at this point to make a delimitation between a symbol and a sign. While the terms can be generally used with the same meaning, interchangeably, when it comes to communication, they do not represent the same things. Symbols are arbitrarily selected to represent something while a sign is an indicator of something specific or a consequence that cannot be changed by arbitrary actions or labels, i.e. smoke as a sign of fire, a weather vane as a sign of the direction of the wind, etc.

Communication and meaning

For the communication process to take place effectively, symbols and signs need to have a meaning. Meanings are not tied to only one symbol, but they can be expressed using a variety of symbols. Moreover, the same symbol may have a very different meaning depending on

circumstances such as geolocation, culture, etc. In example, a person can say "it works" to convey that something is functioning or use a thumbs-up gesture to indicate the same meaning.

Meaning is influenced by a series of variables such as social construction, context and the accompanying verbal and nonverbal cues as well as the medium through which a message is transmitted.

The way in which a symbol develops meaning depending on how it used in a society, a group or a context is referred to as social construction. Hopper, Knapp and Scott (1981) exemplified this concept with romantic couples or very close friends who develop code words and phrases also known as personal idioms. In example there is no problem saying to your partner "my hands are cold" as a code for "I don`t like this party, we should go as soon as possible" but the second phrase would be offensive and impolite if said out loud.

When it comes to context, there is an array of specifics. One example of a context is location (physical context). If a person says "there is a fire" while you are next to the barbeque it would have a different meaning than if the person would say the same phrase in a crowded office building. Another example is the relational context that can impact the meaning. In example, the phrase "I love you" has a different meaning coming from a parent than coming from a person you are dating. The meaning of a message is also influenced by the medium chosen to deliver that message. A delicate message (such as " I want to break up", "I am quitting", "John Doe passed away") can be of course delivered by a variety of means - talking face to face, text messages, written notes, posts on social networks, etc., and the medium influences the way the receiver perceives (in particular at an emotional level) not only the main message but also the additional messages such as how you viewed the relationship, the amount of respect you think they deserve, etc.

Last but not least, verbal and non-verbal cues have an impact on meaning. Imagine a doctor inviting you in his office to discuss the results of your medical tests by saying "please come in" with a smile on his/her face or the same instance where the doctor is serious and a bit frowned.

Communication and culture

Another aspect of communication is the fact that it is cultural. People have a high (and natural to some extent) tendency to take cultural knowledge for granted and make assumptions. Each individual manifests its culture through communication. As Duck and McMahan state in their book *The Basics of Communication*, " Each time you talk to someone, from your culture or another, you are taking knowledge for granted, doing what your culture expects, and treating people in ways the culture acknowledges". The cultural influence may manifest in a variety of ways from the greeting - one, two or three kisses on the cheek vs a handshake to distance between the interlocutors, eye contact, attire, the way the conversation is closed, etc.

Communication and relations

It is almost an understatement that relations influence communication as in fact, they are intertwined, and one impacts the other as much as vice versa. In any instance of communication, we can identify two levels: the content and the relation. "Relationships create worlds of meaning for people through communication, and communication produces the same result for people through relation- ships." (*The Basics of*

Communication; Duck, McMahan). It is thus obvious that the relationship between sender and receiver, whether it is obvious or not, has a substantial impact on the meaning, the way the information is perceived and digested.

Communication and frames

Frames represent basic forms of shared knowledge that create a setting for the communication. Frames can be seen as an element of support that enables people to figure out things faster and adapt the communication accordingly. In example, in the situation of a job interview, understanding the interview frame provides you with the scenario where you know you will be expected to answer questions. Same situation for a doctor appointment where the frame prepares you for answering personal health and lifestyle related questions without being offended or considering that the interlocutor is being invasive or overstepping.

Communication, presentation and representation

When we think of communicating, the first thought is a description of information, facts, etc. and this is the one element that deems communication as representational. Nevertheless, the information we convey is naturally passed through our personal filters thus also conveying the perspective and view of the sender and becoming presentational. Hauser (1986) stated that communication is not a neutral descriptive representation but rather presentational and potentially persuasive. The presentation characteristic is manifested through your choice of words, the way you arrange them, your tone, non-verbal cues and often, also what you choose not to say plays a role as important as what you say. A

good example of these two characteristics is during a court trial. Both the defense and the accusation attorneys present the same facts but in two different ways they see the event. This can also be exemplified by TV channels that present different aspects of the same event in order for the receiver to perceive reality the way they want them to.

Communication and transactions

As it was discussed at the beginning of this chapter, communication has a myriad of facets and ways of being analyzed and defined. It can be seen as a simple action when a sender "leaves" a message for the receiver (voice message, post-it note on your desk, etc.) This approach of communication as action should rather be named attempt of communication as it doesn`t take into account whether the message has been received or not. Another concept approaches communication as interaction where an actual exchange of information between two or more people is needed in order for communication to take place. A different and more complex way to regard communication is as a transaction or "the construction of shared meanings or understandings between two or more individuals." (The Basics of Communication; Duck, McMahan) Whenever people communicate, something more than the exchange of literal information happens, there are meanings that are born beyond the content of the message. When two people argue - power is exerted or in other words, transacted. When two friends share intimate thoughts, trust is transacted, when a gentleman opens the door for a lady, politeness is transacted, etc.

It is without doubt that communication is way more complex and multidimensional than one would tend to believe. Relationships, culture, ethnicity, heritage and even reality are created, maintained, challenged and altered through communication.

Communication Components

There are a number of elements that revolve around communication and the following are the eight essential components of communication:

- Source
- Message
- Channel
- Recipient
- Feedback
- Environment
- Context
- Interference

Source

The source conceives the message and sends it to the audience aka recipient. The source aka sender is the one who encodes the message by choosing the symbols in order to convey the intended meaning. By analyzing the recipient`s feedback and verbal and non-verbal cues, the source can respond with supporting information or clarifications if the audience has not properly received the message.

Message

The message is composed by symbols put together in order to convey meaning. The full extent of the message also involves nonverbal cues, grammar, style, organization, lexical semantics, etc. "The message is the stimulus or meaning produced by the source for the receiver or audience" (McLean, 2005).

Channel

The channel represents the means or way in which the message travels between the source and the receiver and oftentimes more than one channel is used at the same time. Communication channels divide in three main categories:

1. Verbal

Verbal/ spoken channels involve some of the largest aspects of communication - speaking and listening. Examples of verbal communication are face to face conversations, phone conversations, voice messages, speeches, radio announcements, online voice/ video conversations (Skype, Hangouts, etc.). An important aspect involved in spoken communication is the ***Tone***. Using a different tone can change the perceived meaning of a message and either incite or defuse misunderstandings and ambiguous perceptions.

2. Written

Written channels are the means for communicating textual messages. This category can include text messages, emails, letters, instructions, memos, tweets, etc. They can either be printed/ handwritten on paper or appear on a screen. One of the contrasting aspects between verbal and written communication is that the latter is often asynchronous - meaning that the sending/ receiving/replying happen at different times.

3. Non-verbal

Non-verbal channels are the way in which we communicate what we don`t say. Research shows that over 55% of face-to-face communication happens or comes from non-verbal cues. To be more specific, according to a study (Mehrabian, 1981) a receiver`s comprehension of a message is based on the source`s words only 7% while 38% is based on paralanguage elements such as tone, pace and volume and 55% is based on non-verbal cues such as body language.

Recipient/ audience/ decoder

The recipient is the person for whom the message is intended/ directed. The recipient listens/ sees/ touches/ smells/ etc. to receive and interpret a message from the source. The recipient`s understanding of the message is impacted by a variety of factors such as knowledge, responsiveness, reliance of encoder, etc. “The receiver receives the message from the source, analyzing and interpreting the message in ways both intended and unintended by the source” (McLean, 2005).

Feedback

Feedback means responding to the source, whether it is intentional or unintentional. Feedback is composed of a variety of verbal and non- verbal signals that allow the source to comprehend how well and accurate the message was decoded. It is also the means through which the receiver can ask for clarification, can express agreement/ disagreement, can indicate a need for a more engaging communication, etc.

Environment

The environment is the space where the sending and receiving of messages takes place. The environment may influence or indicate if a discussion is formal/ professional or more open and less formal and it is composed of many elements such as surroundings, people, technology, etc. “The environment is the atmosphere, physical and psychological, where you send and receive messages” (McLean, 2005).

Context

Context is a cumulus of elements that directly or indirectly influences the use and expectations of language and behavior among participants to communication. The elements can be physical, social, chronological, cultural, situational, etc.

Interference

Interference, also referred to as noise may come from any source that can alter or block the intended meaning of a message. Interference can be external such as car horns, loud music, bad reception, eye-catching billboards, an environment that is too hot/cold and it impedes your attention, etc. or internal/psychological. This happens when your thoughts/ feelings occupy your attention while communicating such as the nervousness and doubt you might feel while communicating bad news, etc.

As expressed in the previous pages, communication is an extremely complex process that involves sharing, understanding and meaning and it encompasses eight essential elements that have the power to make or break efficient communication.

The process of communication

Communication is a two or more ways process where an exchange of information takes place, and it includes at least the eight main elements treated in the previous chapter. The communication process can be very simply illustrated with the following sequence:

1. There is a sender

2. There is a recipient

3. The sender has an idea/ holds information/ etc. - This step is the beginning of the process when the source intentionally decides to send a message to a recipient

4. The sender encodes the idea into a message - When encoding the idea, the source needs to select the proper code that is relevant and fits the message in a way that will allow the recipient to decode and understand it

5. The message travels through the chosen channel - the source selects an appropriate channel to send information verbally or non-verbally. When possible, it is the most recommended to choose a channel that can convey a message using more than one type of clue, that facilitates feedback and allows establishing personal focus.

6. Noise interferes in the transmission process

7. The recipient receives the message

8. The recipient decodes the message - The recipient will always decode the message using their personal knowledge of the code used as well as by applying its own cultural/ psychological/contextual filters.

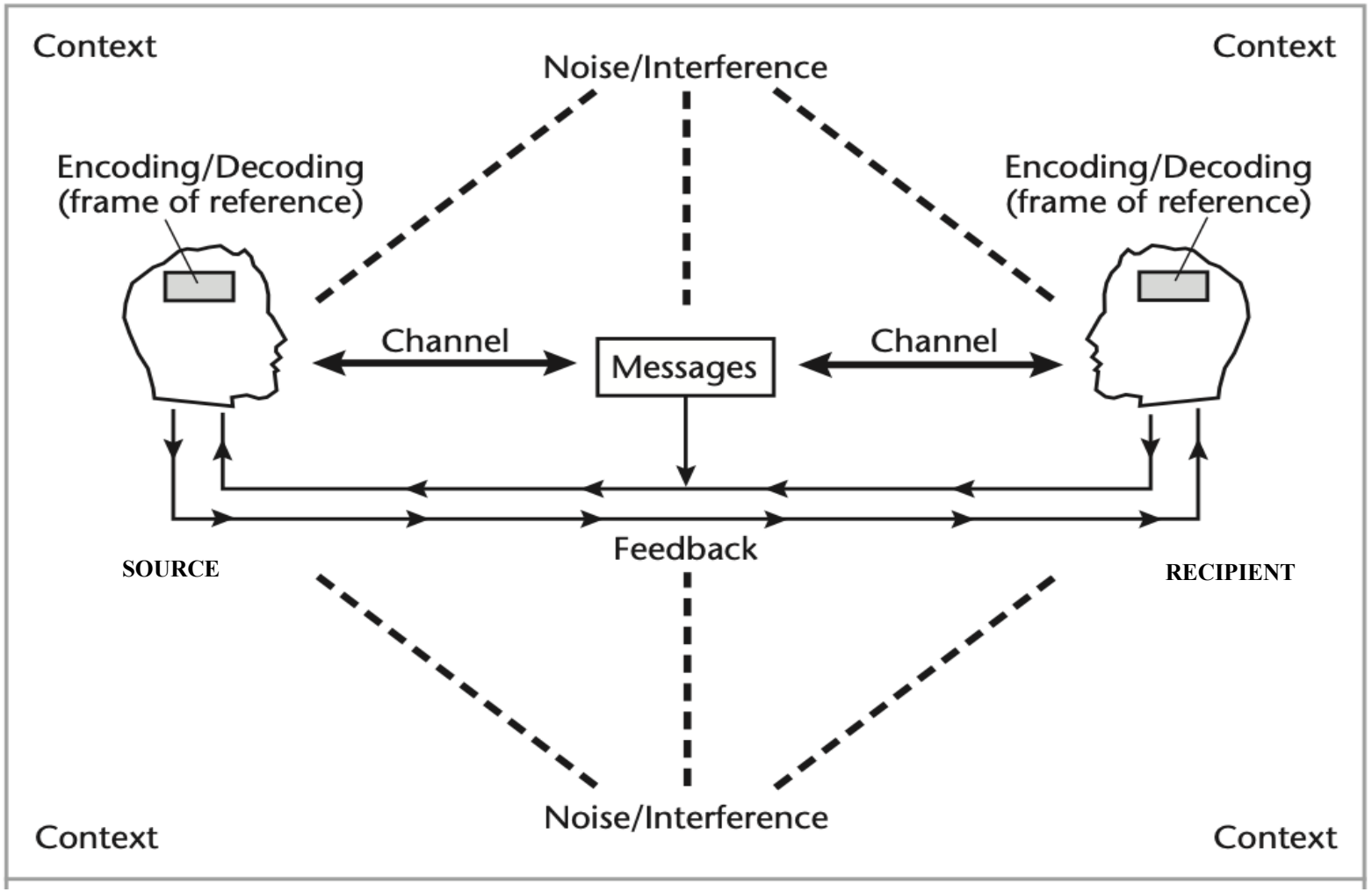
9. The recipient gives feedback - The recipient sends a message back to the initial source (thus exchanging roles) in order not only to respond to the actual conveyed message but also to indicate their level of comprehension of the meaning of the message.

The cycle repeats as long as communication takes place.

Here are a few practical tips to improve the communication process:

- Simplify the message, adjust the language to your audience and keep the information to the point
- Consider your audience, know them, their knowledge level, their needs and interests
- Actively listen to what the people around you communicate. This will improve your communication skills
- Keep the communication flowing by asking questions that are insightful and engage the interlocutor
- Be mindful of your body language and the one of the interlocutors
- Make and maintain eye contact, it is a cue that you are actively listening and giving appropriate attention to your interlocutor

- Patiently clarify the meaning of your message. It might happen that the recipient doesn`t always perceive the intended meaning of your message. Make sure you take your time to clarify the message and help them better understand what you intended to convey.



THE COMMUNICATION PROCESS

Types of communication

When it comes to communication, there are several ways people share information with one another. Throughout the years, many researchers and scholars have categorized communication in a multitude of types, genres and sub-types. While each one of them has particular or specific characteristics, most of them sprout from four main categories:

1. Verbal
2. Nonverbal
3. Written
4. Visual

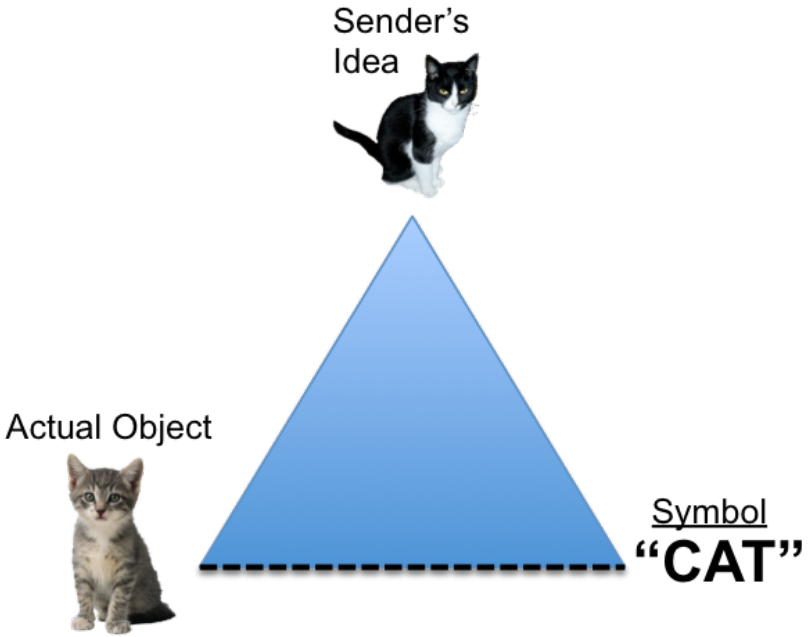
Verbal Communication

Verbal communication can be defined as a process that is agreed upon and that utilizes a rule-governed system of symbols that are employed in order to share meaning. It involves the use of language with the purpose of transferring information and is one of the most utilized types of communication. It is a frequent confusion that verbal communication refers only to spoken communication but in fact, it is about language, both spoken and written. When verbal communication manifests through spoken language, it is referred to as Oral and written or sign language is referred to as Non-Oral. Therefore, communication can fall in to various categories as exemplified in the following table.

	Verbal Communication	**Nonverbal Communication**
ORAL	Spoken language	Laughing, crying, coughing, humming, etc.
NON-ORAL	Written/ sign language	Gestures, Body language, etc.

As mentioned in the **"Communication and symbols"** section, communication relies on symbols that represent something else. Nelson & Kessler Shaw state that symbols are "*arbitrary representations of thoughts, ideas, emotions, objects, or actions used to encode and decode meaning"*

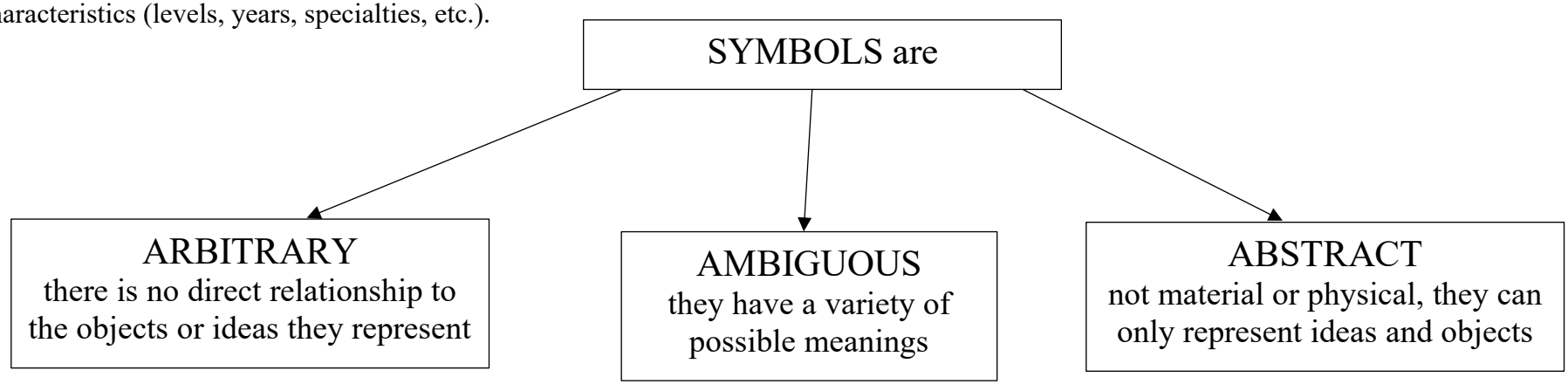
It is agreed upon that words (symbols) are comprised of letters (components) that when used in a particular order, stand for both the actual object as well as for our interpretation of that object. C. K. Ogden and I. A. Richards have illustrated this idea in a triangle of meaning. The word "cat" does not have any direct connection to the actual cat, nor it is the actual cat. Instead, it is a symbolic representation of our idea of "cat".



When it comes to symbols, there are three distinct traits that manifest. Symbols are arbitrary, ambiguous and abstract. As exemplified in the above illustration, the cat on the left side represents a real cat that looks in a particular way. On the top side of the pyramid, we can see what the sender`s idea of a cat looks like. This example illustrates the agreement that the symbol "cat" represents both a real cat and the sender`s idea of a cat. Communication is generally considered successful when an agreement is reached in regards to the symbols being used (Duck).

Another trait refers to ambiguity, meaning that a symbol can have several possible meanings. In example, a person says they have an apple at the office. Is the person referring to a fruit or their computer?

The third mentioned trait is that symbols are abstract - they are not material or physical. This characteristic allows us to communicate complex concepts in a simplified way. In example, this trait allows us to use a phrase such as "the public" in a broad way, in order to mean all the people attending a show without having to distinguish among the diverse groups that make up the audience. Another example is using the phrase "the students" in order to refer to all the people that are currently studying in a formal environment without having to define all the separate characteristics (levels, years, specialties, etc.).



Spaynton, https://commons.wikimedia.org/wiki/File:Vcsymbols.png

It is very important to mention that effective verbal communication relies not only on obvious skills such as the ability to speak clearly or listen, to write correctly, etc. or subtle skills such as the ability to clarify and reflect, but also on elements of non-verbal communication such as body language, tone of voice, etc.

Placement of Emphasis	Meaning
I did not tell John you were late.	Someone else told John you were late.
I ***did not*** tell John you were late.	This did not happen.
I did not ***tell*** John you were late.	I may have implied it.
I did not tell ***John*** you were late.	But maybe I told Sharon and Jose.
I did not tell John ***you*** were late.	I was talking about someone else.
I did not tell John you ***were*** late.	I told him you still are late.
I did not tell John you were ***late***.	I told him you were attending another meeting.

One of the most common elements of verbal communication is the tone, which has a great impact on the perceived meaning of a message. A great exemplification of the power of the tone is the following table based on Kiely, M. (1993) called "Don`t use that tone with me!" The emphasis shows how the tone can change the meaning of a message.

Even if verbal communication amounts for a rather small part of the overall message (20-30%), it is extremely significant and it is important to improve specific skills as much as possible.

Here are a few important aspects of verbal communication and a few tips to improve your specific skills:

Opening Communication

Very often, the impression we make in the first minutes of encounter is very important and has the potential to impact the way future communication will happen. In example, if you meet someone and hear them speak with a foreign accent, you form an opinion on their background and their ability of understanding, and this might change what you say and how you say it. In this particular example, you might consider that it is better to speak slower, without cultural jargon but rather a simpler language in order to facilitate understanding and that you also need to listen carefully to ensure you understand all the information the person is trying to convey.

It is therefore important to understand the importance of first impressions and behave accordingly.

- **PRACTICAL TIP:** Use a strong and confident speaking voice to make sure that it is easy for your audience to hear you clearly and easily understand the message you are trying to convey.

Speak effectively

The transmission of a message is highly influenced on the choice of words, the way they are said and the way they are reinforced with other elements of non-verbal communication. Therefore, it is important to choose your words considerately and adjust them to the context and the audience. It is also important to pay attention to your tone of voice and pace as these elements send important messages to your audience.

- **PRACTICAL TIP:** Steer away from filler words such as "like", "so", "um", "myeah" etc. Whenever you feel tempted to use them in order to pause and collect your thoughts, try replacing them with a breath.

Practice Active Listening

It is rather common that people have a tendency of spending more energy focusing on what they are planning to say rather than listening to their interlocutor. Active listening is vital for effective communication and improving this skill will help you grow as a communicator.

- **PRACTICAL TIP:** Try not to think of your next question or line when the other person is sharing information. Concentrate on your interlocutor instead on how you are going to reply.
- **PRACTICAL TIP:** Avoid distractions as much as possible. For example, if you find yourself in a very noisy environment you can suggest finding a quieter place to continue the conversation.
- **PRACTICAL TIP:** Be objective and try to steer away from stereotyping the speaker. Often, prejudices interfere heavily with the perceived meaning of a message.

There are a variety of more subtle techniques and practices that can help you improve the effectiveness of your verbal communication. Among these, reflection, clarification, questioning and reinforcement are extremely useful and extremely impactful when it comes to building rapport and reinforcing openness in your audience.

Reinforcement

It is highly recommended to use positive reinforcement and encouragement when communicating. The tools that facilitate this range from positive words to maintaining eye contact, nodding in approval or displaying a friendly facial expression and body position.

- **PRACTICAL TIP:** Using such techniques can lead to an increased participation to the discussion (particularly in group environments, diminish fears and reduce shyness in the others as well as yourself thus paving the way for the development of meaningful, valuable and long lasting relationships.

Reflection and clarification

Reflection is a technique that is often used within counselling but it`s benefits apply to a wide range of communication contexts. This technique involves feeding back to your interlocutor your understanding of what they communicated and thus allowing for proper clarification of the essence of what was expressed. This can be done through paraphrasing or relating what the speaker said in your words.

- **PRACTICAL TIP:** By employing this technique, you can make sure that you properly understood the message and allow your interlocutor to clarify or expand if there is a need. Moreover, this behavior demonstrates that you are interested and respectful of what the other person has to say and that you are considering their point of view.

Questioning

Questioning often goes hand in hand with reflection and clarification and it is used to obtain information and test your understanding while enabling you to explicitly seek support from your interlocutor. Questioning is also a good conversation starter as it allows you to draw someone

into a conversation or show interest.

There are two main types of questions that are used when communicating: closed and open.

- Closed questions allow the speaker to be in control of the communication and to focus the conversation in order to obtain very clear, straight forward and concise answers when necessary. These types of questions tend to seek a very short answer, often one or two words and most of the times these are yes/no types of questions.

Some examples of closed questions are:

- Did you take your medicine this morning?
- Did you feel dizzy after the fall?
- Have you been measuring your blood pressure regularly?
- etc.

- Open questions allow the interlocutor more scope for self-expression and facilitate involvement in the conversation by demanding elaboration and further discussion.

A few examples of open questions are:

- What did you feel after taking the medicine?

- What do you think is the cause of this blood pressure spike?

- What kind of behavior did your grandfather display before fainting?

- etc.

Open questions can also be divided in a variety of categories such as:

- **Leading questions** -to point the interlocutor`s answer in a certain direction.

In example, asking "Did you have a good physical therapy session?" will point the interlocutor towards thinking of the positive aspects of the it and relating those, while simply asking " How was therapy today?" is not asking for a verdict on how good or bad the session was but rather a more balanced accurate depiction of events, good or bad.

- **Recall questions** - to prompt the interlocutor to remember something

In example, " When was the last time you measured your blood pressure?", "What was your temperature last time you checked?"

- **Process questions** - to point the interlocutor towards putting more thought in the answer and sharing of an opinion

In example, "What kind of habits do you think have led to the development of this disease?", "Which of these lifestyle changes seem doable for you?

- **Rhetorical questions** - these questions do not require an answer and are most often employed in order to prompt the audience to reflect on something or to keep attention.

In example, "Who would not hope to become fit overnight?", "Who wouldn`t want their family members to stay healthy into old age?"

- **Funneling questions** - these are a series of questions that vary from less to more restrictive or vice versa. This can be a very useful tactic to obtain the maximum amount of information.

In example, when dealing with a patient that is reluctant on honestly disclosing information that is important for the diagnosis or treatment, a healthcare professional can employ a series of funneling questions such as:

1." Can you tell me about your last seizure?"

2. "Who else was there with you?"

3. "Did you feel like any of the food you had at dinner tasted weird?"

4. "What kind of alcohol did you serve, wine or spirits?"

5. "And approximatively how many drinks did you have?"

As seen in this example, at each step the questions become more focused and the answers more restrictive.

The variety is not only present when it comes to questions but there is also a vast array of possible responses. While the myriad of possibilities is almost infinite, theorists have identified several main types of responses among which:

- **Direct and honest** - the type any questioner would want to achieve

- **Deceiving** - a lie as a less desirable answer that can be picked up on based on both the plausibility of the content as well as the non-verbal cues
- **Partial** - a response that contains selective information
- **Out of context** - an irrelevant or unconnected response given in attempt to change the subject
- **Avoidance** - this is used mostly when the person was asked a difficult question and they employ avoidance by answering with another question or giving an answer that is trying to draw attention to a positive aspect of the topic
- **Distorted** - different from deceiving answers, distorted answers may be the result of the person`s perceptions and biases and most often, respondents do not realize that their answers are influenced by bias. There is also the intentional employ of this technique when people tend to exaggerate certain aspects.
- **Stalling** - in the same category as avoidance, stalling is employed when the respondent needs more time to formulate an answer that is plausible and acceptable
- **Refusal** - refusal answers can either be expressed by saying " I do not want to answer" or by remaining silent.

Closing Communication

Generally, when closing a conversation, people employ both verbal and non-verbal elements. Non-verbal cues can vary from starting to avoid eye-contact to turning away, standing up or checking the time and closing the laptop or the notepad, etc. In terms of verbal signals, two different

ways of closing can be " Ok, I got to go now" or " Thank you very much for taking the time to explain, that was very helpful for me". Closing communication is also very important as it influences (to a certain extent) the way a conversation is remembered, and it provides the context to make future arrangements.

Non-Verbal Communication

The way we behave while we communicate often has more meaning than the actual words we say. Non-verbal communication can be briefly described as any information or meaning shared through anything other than words such as sounds, behaviors, smell, facial expressions, gestures, body language - kinesics, the physical placement of the communicators - proxemics, etc. This kind of communication can manifest both intentionally and unintentionally. As opposed to verbal communication that normally uses one channel, non-verbal communication employs multiple channels simultaneously thus making it continuous while verbal communication is distinct.

Non-verbal communication is comprised of a wide array of types such as appearance, kinesics, artifacts, haptics, proxemics, chronemics, vocalics and environment, that become invaluable tools for sharing meaning in our interactions as these signals can give clues and additional information on top of what is verbally expressed.

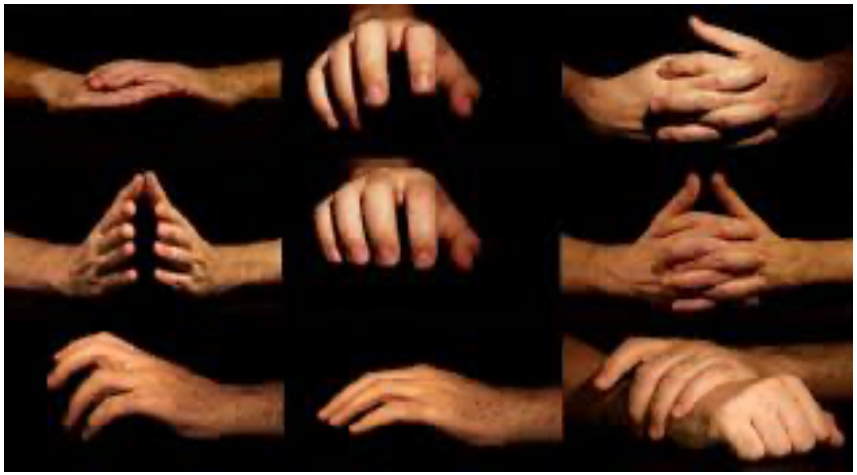
Appearance

The way we choose to look- clothing, colors, hairstyles and any other factor affecting appearance is considered a type of non-verbal communication. There are numerous studies that have demonstrated that different colors can evoke different moods thus appearance can influence both physiological and psychological reactions and interpretations.

Kinesics

Kinesics refers to the analysis of body and face movements, the use of gestures, posture, etc. The word is rooted in the word "kinesis" which means "movement". Kinesics include a series of elements that are very complex themselves such as facial expressions, eye contact, head movements and gestures.

- ***Gestures*** are deliberate movements and signals employed to communicate meaning without words. While the array of gestures is infinite some of them can be divided into three categories as follows:

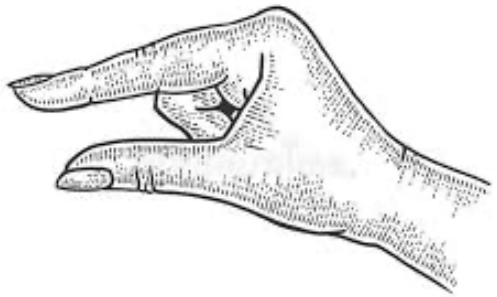


- *Adaptors* - touching gestures and movements that are generally connected to a state of anxiety or arousal. These gestures can be pointed towards oneself, other people or objects/ artifacts. In example, shaking our legs, clicking a pen, tapping with the fingers, etc. are some adaptors that we subconsciously manifest in order to consume excess energy when we are nervous or while waiting. Other examples

of adaptors can be self-touching gestures like caressing, twirling hair or touching our collar bone that can indicate both a state of discomfort or a state of arousal.

- *Emblems* - gestures that have an agreed-on meaning and that are distinct from the sign language used by hearing/speaking impaired people. The specific meaning can vary based on cultural backgrounds or context. In example, a raised thumb stands for "OK", a raised middle finger is an insult and a circular movement of the index finger next to the side of your head is commonly understood as "crazy".

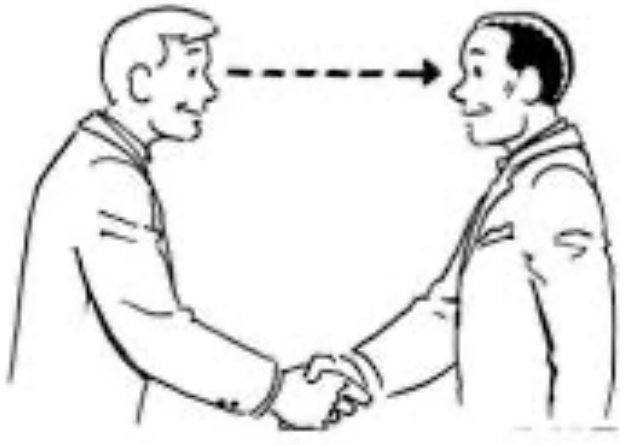
- *Illustrators* - gestures that are used to complete or illustrate a verbal message. They are mostly employed involuntary, and they flow as natural gestures. One example of an illustrator is a hand gesture that shows the size of an object.



- **Head movements** are gestures commonly used to convey a variety of emotions and meanings. In example, nodding your head is a sign of acknowledgement, a headshake left and right signals "no" and tilting your head indicates interest as well as submission and trust. (Pease & Pease, 2004)

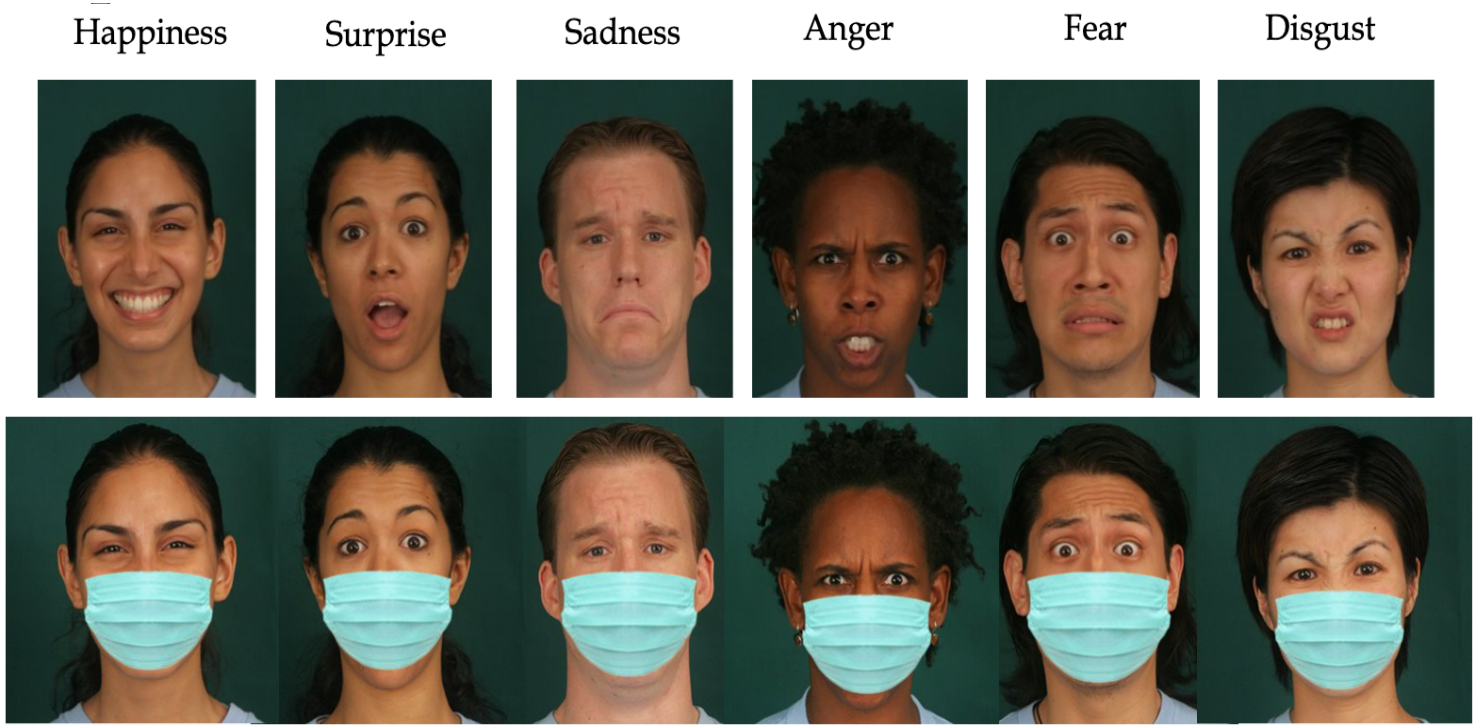
- Eye contact is an important tool used to communicate as the face and the eyes are generally the points of focus while communicating. The study of eye behaviors in communication is called oculesics. Eye movements can regulate or monitor interaction and can also help establishing connections and they are an important component of active listening skills. Eye contact can serve a few specific objectives such as:

- Receiving nonverbal communication from interlocutors
- Providing turn taking cues
- Signal cognitive activity (looking away when processing information or remembering)
- Intimidate
- Flirt



- **Facial expressions** are extremely relevant as the face is the most expressive part of the human body. Numerous researchers have provided studies that support the fact that there is universality in facial expressions that convey states such as anger, disgust, happiness, sadness, surprise and fear. In 1971 researchers Paul Ekman and Wallace Friesen have conducted research in the Fore tribe of Papua New Guinea that solidified this concept and that later on became the basis for F.A.C.S. - facial action coding system, a science dedicated to encoding and decoding facial expressions.

In contexts where finding out the truth is vital (such as justice and medical), the use of F.A.C.S. techniques can prove extremely valuable and even provide life-saving information.



Haptics

Haptics refers to the analysis of communication by touch. When it comes to haptics as means of non-verbal communication, several categories can be identified among which social-polite, functional- professional, friendship-warmth, love-intimacy and sexual-arousal. (Heslin & Apler, 1983)

Proxemics

Proxemics refers to the analysis of how distance and space impact communication. Proxemics can be a good indicator for the level of relationship between communicators and can also offer clues necessary for adjusting communication overall.

The concepts of personal space and territoriality are part of proxemics.

Territoriality is shared across many species and stands for the innate drive to take up and protect spaces. There are three main categories of territory:

- ***primary*** - a space that is exclusively ours and we fully control such as our house, our closet, our room, our car, etc.
- ***secondary*** - a space that doesn`t belong to us but it is available for our use without needing further actions to reserve it, such as a shared classroom
- ***public*** - a space that is open to everybody

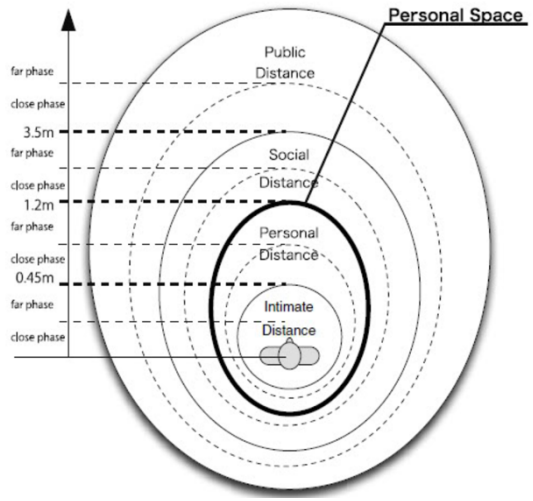
The definition of *personal space* may vary from individual to individual, based on a variety of factors such as context and relationship, etc. In 1963, Edward Hall, a cultural anthropologist categorized the interpersonal distances of people in four distinct spaces: intimate, personal, social and public.

- *The intimate* space is the closest to the subject and it ranges from 1 to 46 cm. This zone is generally dedicated to loved ones, family members and close friends and it stretches from direct physical contact such as hugging, touching, kissing, etc.

- *The personal* space ranges from 46 cm to 1.2 m and is generally dedicated to interaction between family members, friends and acquaintances.

- *The social* space ranges from 1.2 to 3.7 meters and is mostly dedicated to formal settings, new acquaintances, work colleagues, etc.

- *The public* space ranges from 3.7 to 7.6 and over and is generally dedicated for speaking in front of larger audiences such as in a classroom, in an auditorium, etc.

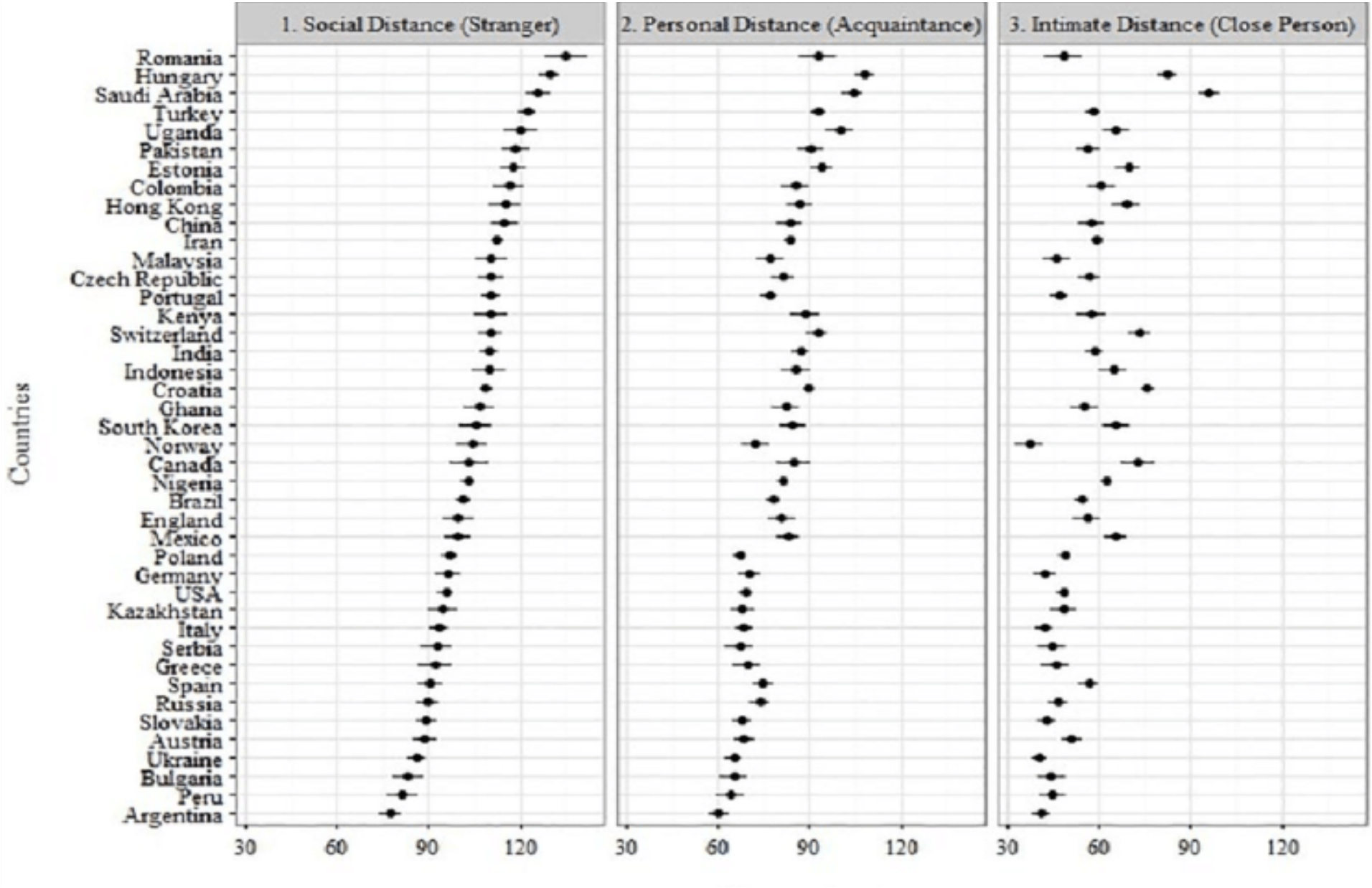


Proxemics zones as defined by Hall by Hamid Laga et al., Tokyo Institute of Technology

The understanding of proxemics varies among groups and cultures as there are a variety of habits and norms that influence it. Sociologists have put forth a few theories regarding the social norms that influence how people define personal space. A study conducted by an international team of researchers looked at almost 9000 people in 42 countries with the intention of measuring the "space bubble" of individuals around the world and to try to understand why differences exist.

The results varied quite a lot between countries. For example, in Romania people preferer strangers to keep a considerable distance but are very comfortable with having friends get very close.

The following table shows the preferred distance by country expressed in cm.


1. Social Distance (Stranger)
2. Personal Distance (Acquaintance)
3. Intimate Distance (Close Person)
Countries
Romania
Hungary
Saudi Arabia
Turkey
Uganda
Pakistan
Estonia
Colombia
Hong Kong
China
Iran
Malaysia
Czech Republic
Portugal
Kenya
Switzerland
India
Indonesia
Croatia
Ghana
South Korea
Norway
Canada
Nigeria
Brazil
England
Mexico
Poland
Germany
USA
Kazakhstan
Italy
Serbia
Greece
Spain
Russia
Slovakia
Austria
Ukraine
Bulgaria
Peru
Argentina
30
60
90
120

Chronemics

Chronemics refers to the analysis of time and its impact on communication. According to Andersen (1999), time can be classified as biological, personal, physical and cultural.

- ***Biological time*** is the rhythm of living beings, a circadian rhythm that impacts when we wake, sleep and eat. It is important to take this category into consideration as interfering with it (late night call, lunch-time meetings) can negatively impact not only communication competencies but also physical and mental health (repetitive disturbances) and personal relationships.

- ***Personal time*** refers to the way in which we experience time individually. This can be influenced by several factors such as mood, stress level, interest level, etc. When we enjoy something, we feel like time passes very quickly while when we are involved in something that doesn`t interest us at all time seems to drag on forever.

- ***Physical time*** refers to the standard cycles such as days, years, months and seasons. This category can impact communication as the elements can influence the psychological and physical states of individuals as they can experience discomfort illness that is impacted by cold temperatures such as rheumatoid affections or they can experience emotional distress due to atmosphere (dark and cold in winter as opposed to warm and bright in spring & summer).

- ***Cultural time*** refers to the way large groups of people see time. There are two main orientations: the monochronic cultures that like and prefer to do things with a certain orderliness, one thing at the time and believe there is an appropriate time and place for everything and the

polychronic cultures that tend to do multiple things simultaneously. For example, the French and Americans are polychronic while the Germans tend to be monochronic.

Environment

The environment of interaction influences both verbal and non-verbal communication. Individuals can manipulate the non-verbal environment in the same manner they would control their tone of voice. The placement of objects in a space can help shape the climate of the interaction, from formal or distant to friendly and intimate. Also, the objects that are on display can nuance an interaction as well as smell which is many times overlooked. In example, think of the smell of home-made food that most often create a positive emotional response as it is associated with childhood and care.

Vocalics/ Paralinguistics

Paralinguistics refers to factors such as loudness, tone of voice, pitch, inflection, accent pattern or any other vocal elements that are distinct from actual language. In example, saying "Your test results are ok" in a strong and joyful tone of voice, the meaning is most likely to be interpreted with enthusiasm while saying the same phrase in a hesitant tone might be perceived with negativity and as lack of interest.

Artifacts

Artifacts refer to physical objects that can offer clues about an individual's beliefs and habits. Artifacts can refer to clothing items, jewelry, tattoos, body piercings, decorations, homes, cars, etc. Artifacts are often part of the environment and appearance categories. In example, observing that a person is wearing a necklace with The Star of David or a Cross will inform us of their religious beliefs.

Here are a few practical tips to improve your non-verbal communication skills:

- In order to improve your skills and competence for encoding non-verbal messages you must make all the efforts to increase your awareness of the context in which the communication happens as well as the messages you are sending and receiving.
- Be aware that nonverbal cues can complement, enhance or contradict each other. Make sure your message is consistent across all channels.
- Keep in mind that the norms for sending and receiving non-verbal messages particularly touch and personal space vary widely based on contexts (relation, culture, etc.)
- To improve your skills for decoding non-verbal messages try to avoid dedicating too much attention to any one cue (only eye contact) but look for multiple non-verbal cues and try to understand if they are consistent with each other and the spoken message.
- Try to employ non-verbal cues when communicating sensitive subjects as this type of communication aids in emotional expressions that need and give emotional support.

Visual Communication

Visual communication entails graphical representations of information created with the purpose of efficiently creating meanings or differently put, it is communicating ideas and information through the use of symbols and imagery. The realm of visual communication is extremely broad and encompasses elements such as signs, infographics, maps, illustrations, diagrams, photos, motion graphics/filmography, interactive content, and may other examples.

Visual communication is one of the main types of communication and there are theories and evidence that suggest that is the oldest type of communication. Specifically, cave paintings that date as far back as 40000 years represent a primitive form of communication, a kind of prehistoric documentation with representations of animals, sacred spaces, landscapes and other elements. Around the 4th millennium BC, societies became more advanced and traveling brought close people who spoke different languages and dialects. In order to communicate, they developed pictograms (images that represent a physical object) that helped them.

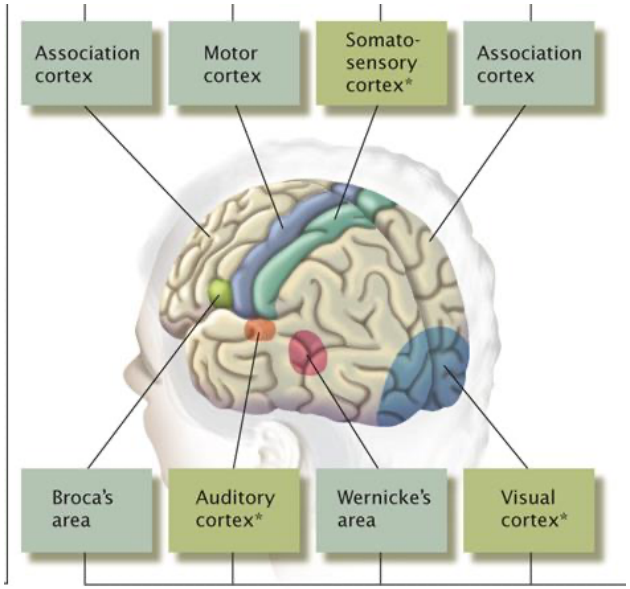
We refer to the study of visual communication and symbols as semiotics, a science that studies "how people make meaning out of symbols, and how those symbols are interpreted." (What Is Visual Communication? - Definition, History, Theory & Examples, 2016).

The relationship between meaning (social or cultural) and symbol is referred to as semantics. These two elements are extremely important as they can shape the context and prompt the receiver to make particular associations.

For example, racial or social stereotypes depend (to a rather large extent) on semiotics and semantics. Think about an image showing a person with a darker complexion, a headdress with feathers, war paint and a particular outfit - you will most likely associate this with a Native American because that is the learned relationship between the symbol and it`s cultural meaning.

As observed in the following pictogram, there are several functional areas of the brain.

- Wernike`s Area - language interpretation
- Motor cortex - controls movement
- Sensory cortex (somatosensory + auditory + visual) - receives sensory information
- Broca`s area - language organization & speech production
- Association cortex - integrates information

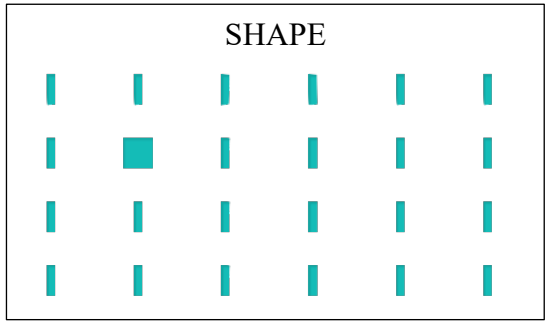


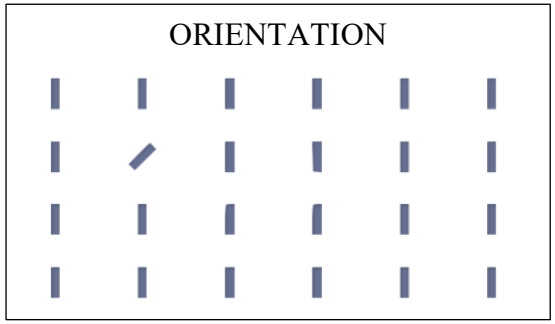
*Somatosensory cortex, auditory cortex, and visual cortex make up the sensory cortex.

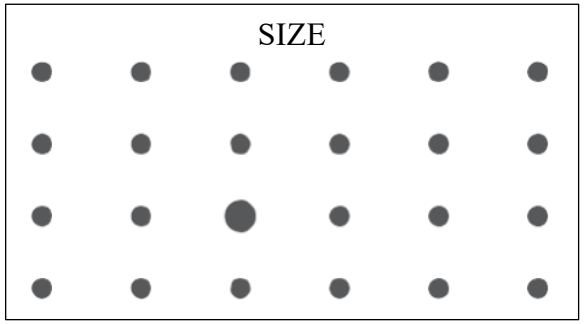
Humans are biologically built to process the world visually which is why visual communication is impactful and efficient:

- It takes the brain 1/4 of a second to process visual cues
- The human brain is pre-wired to interpret relationships between objects automatically allowing almost instant comprehension with minimal effort

PRACTICAL EXAMPLE: Notice how fast your eyes find the differences of attributes.







- The brain interprets visuals quicker than processing language associated with them

PRACTICAL EXAMPLE: Which sign is easier/faster to process?

- A popular statistic says that people remember 80% of what they see, 20% of what they read and 10% of what they hear therefore visuals have a decisive role in information retention.

In a healthcare context, employing visual communication tools can help make a complicated message accessible and tangible. In example, using a poster of a human body to point out the organ that is causing an issue to a patient with limited biology knowledge, drawing a time-line of the treatment plan for a patient who has a hard time remembering at what point of the day to take medication, use a facial pain-scale to aid children in identifying what they feel, etc.

Effective communication is a multisensory experience and visuals can influence or even define context, provide supporting examples for messages, evoke emotions, clarify messages, catch attention, etc.

IMPORTANT INFORMATION: Visual communication can be an important tool for:

- Creating a link between raw data and usable knowledge
- Providing quick, concrete and vivid representations
- Saving space
- Communicating in a universal language
- Being persuasive

Written Communication

Written communication entails writing, typing or printing symbols to send messages. As opposed to most categories of verbal communication, written communication provides a record of information and is essential in environments where record maintenance is required such as a healthcare setting.

When it comes to the healthcare industry, written communication represents one of the most prevalent forms of communication between primary and specialized care or healthcare providers from different disciplines. Insufficient communication skills can lead to a series of unwanted outcomes such as discontinuity of care, compromise of patient care, inefficient us of resources, burned-out and overworked medical personnel and of course patient/provider dissatisfaction and negative economic consequences.

Effective written communication relies on grammar, punctuation, choice of symbols, correct organization of order as well as cohesive composition. Written communication is most often asynchronous and can be constructed over a long period of time.

Here are a few valuable skills for written communication:

Clarity - help the receiver understand what you are saying.

PRACTICAL TIP: Use coherent language and stick to concrete, specific information.

Conciseness - help maintain clarity by avoiding complicated structures or unnecessary information.

PRACTICAL TIP: Include only details that are necessary to communicate the information

Active voice - make the content accessible and easy to follow

PRACTICAL TIP: Use active voice whenever possible in order to make your sentences flow better and allow the reader to move through the message at a faster pace.

Example:

Active Voice - Mrs. Doe took her medicine every day.

Passive Voice - The medicine was taken every day by Mrs. Doe.

Active Voice - Nurse Jane will administer Mrs. Doe a dose of B12 daily.

Passive voice - A dose of B12 will be administered daily to Mrs. Doe by Nurse Jane.

Grammar and punctuation - make your sentences easy to understand

PRACTICAL TIP: Make sure you make correct use of punctuation, articles, prepositions, tenses, genders and other basic grammas elements.

Organize - get the reader to take action

PRACTICAL TIP: Know your goal before writing, it will keep your message focused and clear. Lead with the key point and add the necessary supporting details.

Formal Communication

Formal communication represents an interchange of information that is controlled and deliberated. It normally happens through proper, predefined channels and it follows a hierarchical structure. The flow of communication is timely and systematic, and this helps with efficiency. Formal communication is generally adopted in circumstances where formal relationships are necessary or have been previously established. Some of the main characteristics of formal communication are the following:

- It is of an official nature - making it binding and effective
- It is mostly in writing, but it can also be verbal - due to the fact that it is generally written, the risk of ambiguity and confused meaning is reduced. Also, being written, it can be kept and revisited at any given time when referencing is necessary
- It flows through a structured layout - encourages bureaucracy and authoritarianism
- It requires maintenance of specific standards - such as official procedures, formalities, etc.
- It is generally rigid - stereotype language is often used thus making the delivery of the real meaning more difficult

Formal communication can happen vertically (both downward and upward) as well as horizontally:

-Vertical downward - from the top/upper level of the hierarchy. Example: orders, information, policies, rules, instructions, etc.

-Vertical upward - flows from the lower level of the hierarchy to the superiors. Example: reports, complaints, suggestions

-Horizontal - an exchange of information between parties of the same level. Example: coordination related info., requests, suggestions, etc.

Formal language

Formal language used in professional or academic circumstances. It does not include colloquialisms, contractions, slang or 1st person pronouns. Formal language constructions tend to be more complex as longer sentences are likely to be more prevalent and the standard approach for any topic involves introduction, elaboration and conclusion. Formal language is generally objective as it shows a limited range of emotions and emotive punctuation such as ellipsis and exclamation marks are avoided.

Informal Communication

Informal communication represents a multidimensional, relational type of communication that is not bound by specific exigencies and does not require pre-determined channels. It is particularly quick and most frequently it does not involve any paper trail. Informal communication occurs as a natural form of communication as people interact freely and approach a very diverse range of subjects.

Informal Language

Informal language takes a personal tone and may include figures of speech, slang, broken syntax, contractions, etc. It is characterized by simplicity as short or even incomplete sentences are accepted alongside abbreviations or contractions. Informal language allows the expression of empathy and emotion and a personal emotional tone can be detected

. **IMPORTANT! Language Style Differences**

	Formal Language	**Informal language**
Definition	Used for professional, academic, legal, purposes	Used for casual communication and personal purposes
Sentence characteristic	Long and complex	Short and simple
Voice	Passive	Active
Tone	Official, Serious, Somber	Light, Friendly
Language	Formulaic	Direct
Interjections	No	Yes
Pronoun	Third person	First, second and third person
Contractions	No	Yes
Slang	No	Yes
Emotional tone	None/ extremely limited	Wide
Connecting words	furthermore, consequently, therefore, etc.	so, and, but, etc.
Verbs	single word	phrasal/ idioms
Preferred Vocabulary	Latin/ French origin words	Anglo-Saxon origin words
	Impersonal constructions (It is said that.....)	Active constructions (They say that.....)

Communication Barriers

As expressed in the previous chapters, communication is not only an instrument used scarcely when needed but it is an integral part of any living being, from a cellular level to a large scale. One of the aspects involved in the complexity of communication relates to barriers that occur, hindering or even preventing the effectiveness of our communication.

There are a myriad of communication barriers and these can happen throughout the communication process, at any stage. Barriers can be categorized in three main types with an almost infinite array of sub-types and specifics:

-Physical Barriers - such as distance, closed doors, physical impairments, material obstacles, etc

- Psychological/Emotional Barriers - the psychological state of the communicators always impacts the way the message is sent, received and interpreted.

- Language Barriers - refer to the way a person communicates both verbally and non- verbally

Some of the most common communication barriers that we can encounter:

- The use of specific language, over-complicated terms, jargon and unfamiliar symbols

- Distractions, irrelevance, lack of attention

-Emotional barriers, taboos, different perceptions

-Physical disabilities such as speech impairment and hearing problems

- Differences in viewpoint, stereotyping and false assumptions

-Physical barriers such as personal protective equipment (face masks, face covers, etc), distance and obstacles such as an interaction of two people sitting across the room, etc.

-Different norms of social interaction such as the perception of personal space, etc.

Regardless of the volume of effort dedicated, communication barriers cannot be eliminated completely. Nevertheless, there are several approaches that can be employed in order to limit the negative consequences of barriers. Understanding the causes and the preferences of the interlocutors are essential for efficient communication.

Overcoming communication barriers is a skill that can be learned and developed. Here are a few tips and tricks that can be utilized in order to bridge barriers in communication:

PRACTICAL TIP:

Practice Active Listening. Try to devote attention to what is being said and listen with all your senses and make sure your interlocutors see that you are listening. This can prevent them from concluding that you are not interested in their message thus making them more comfortable and allowing them to communicate more efficiently, openly and honestly.

PRACTICAL TIP:

Offer verbal and non-verbal signs. Smile (if appropriate), nod, make eye contact and don`t hesitate to ask clarifying questions and to paraphrase the ideas of the speaker. Don`t hesitate to use small verbal comments such as "aham" to assure the interlocutor that you are listening and encourage them to continue.

PRACTICAL TIP:

Use the appropriate language. Always consider who you are talking to and avoid using medical terminology or specific terms and jargon when communicating. Not being familiar with the terms used can make your interlocutors intimidated and ashamed of admitting their lack of understanding.

PRACTICAL TIP:

Pause, breathe, ask. Ask questions to make sure the understood meaning of the information you are conveying is the one intended and make pauses. This will give your interlocutor a window to ask questions without feeling like they are interrupting.

PRACTICAL TIP:

Be constructive. Regardless if you must give negative or positive feedback, make sure it is always constructive. This can improve the

relationship and the efficiency of any further communications.

PRACTICAL TIP:

Practice empathy. Try to understand and consider the emotional state of your interlocutor so you can better acknowledge their needs and address their concerns.

PRACTICAL TIP:

Be considerate. Always make sure that you choose an environment that facilitates distraction free communication. (private space)

PRACTICAL TIP:

Review and edit. When using written communication take the time to revise and make necessary corrections. This will allow you to ensure that your message has a high degree of accuracy and professionalism.

PRACTICAL TIP:

Proofread. In written communication, make sure you are using proper spelling and grammar and avoid forms of language that might be difficult to understand such as abbreviations, jargon, slang, etc.

Generational gaps and communication

In our day to day lives and particularly in a healthcare environment, the characteristics of interlocutors can vary broadly as health concerns and issues apply to everybody. Given the fact that communication styles and preferences may differ from generation to generation, a good understanding of the main characteristics of each generation can help us adjust our communication styles and reduce specific barriers.

Let`s take a look at the generational intervals:

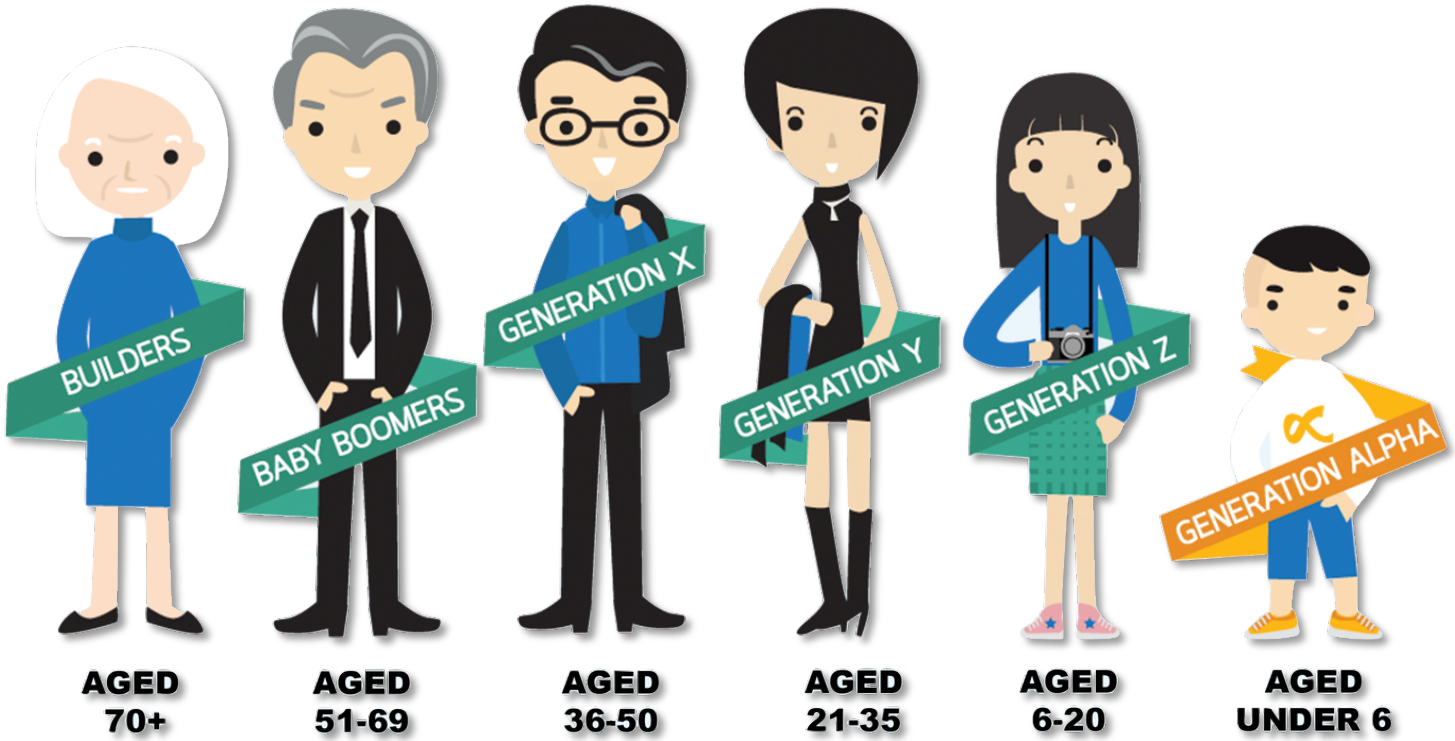


Image source: https://stepone-tz.com/news-notes/getting-tourism-ready-for-generation-alpha,Getting Tourism Ready For Generation Alpha ,March 3, 2020

According to an ABS, McCrindle infographic released in 2019, here are some milestone characteristics of each generation:

CATEGORY	BUILDERS	BABY BOOMERS	GENERATION X	GENERATION Y	GENERATION Z	GEN ALPHA
Slang terms	We prefer proper English if you please Born: < 1946 Age: 74+	Be cool Peace Groovy Way out Born: 1946-1964 Age: 55-73	Dude Ace Rad As if Wicked Born: 1965-1979 Age: 40-54	Bling Funky Doh Foshizz Whassup? Born: 1980-1994 Age: 25-39	Fam GOAT Slay Yass queen Born: 1995-2009 Age: 10-24	lit yeet hundo oof rn idnc Born: 2010-2024 Age: under 10
Social markers	World War II 1939-1945	Moon landing 1969	Stock market crash 1987	September 11 2001	GFC 2008	Trump / Brexit 2016
Iconic cars	Model T Ford Final, 1927	Ford Mustang 1964	Holden Commodore 1978	Toyota Prius 1997	Tesla Model S 2012	Autonomous vehicles 2020s
Iconic toys	Roller skates	Frisbee	Rubix cube	BMX bike	Folding scooter	Fidget spinner
Music devices	Record player LP, 1948	Audio cassette 1962	Walkman 1979	iPod 2001	Spotify 2008	Smart speakers Now
Leadership style L - Leader L - New leaders	Controlling	Directing	Coordinating	Guiding	Empowering	Inspiring
Ideal leader	Commander	Thinker	Doer	Supporter	Collaborator	Co-creator
Learning style	Formal	Structured	Participative	Interactive	Multi-modal	Virtual
Influence/advice	Officials	Experts	Practitioners	Peers	Forums	Chatbots
Marketing	Print (traditional)	Broadcast (mass)	Direct (targeted)	Online (linked)	Digital (social)	In situ (real-time)

Image source: https://generationz.com.au/wp-content/uploads/2018/09/GenZGenAlpha.pdf, ABS, McCrindle | 2019

As presented in the previous illustration, each generation has been defined and has experienced different things thus it is normal and expectable that their communication styles and preferences differ and being familiar with the key characteristics of their communication styles can be extremely useful for limiting the consequences of barriers.

PRACTICAL TIPS:

The Builders Generation - Age: 70+

- The best way to communicate to this generation is face-to-face and telephone
- They expect information to be presented in a logical manner and a clear speech
- Correct use of grammar is very important
- They pay attention to manner and prefer formal titles (Mr., Mrs., Dr., etc.)
- Respect is critical whether it is for their age and experience or for a chain of command or history/legacy
- They like to ask questions
- They appreciate handwritten notes
- They enjoy answering questions and being used as a resource of knowledge

The Baby Boomers - Age: 51-69

- They are the 1st generation to explore electronic communication
- They prefer face-to-face communication, open and direct
- High availability mentality and attitude
- Less formal than the Builders
- They like recognition
- They don`t mind being called by their first name

The Generation X - Age: 36-50

- They tend to be skeptical and cautiously conservative
- They are blunt and direct
- They prefer talking in short and concise sound bites
- They don`t like to be micromanaged - dislike too inquisitive approaches
- They care about work- life balance and prefer to have their private time respected
- They are not interested in recognition
- They like online and digital forms

The Millennials (Gen Y) - Age: 21 - 35

- They like to be asked what their preferred communication method is.
- They prefer texting and immediate responses
- They prefer scheduled communication
- They prefer brief and to the point communication

The Generation Z - Age: 6 - 20

- They are well versed in technology
- They listen and value advice but like to express their own opinions
- They like constant communication
- They are less likely to be patient and they ask many questions

Regardless of the generation, effective communication is a key element of a functional and prolific society and understanding the specifics of each generation can be of great help in overcoming the challenges of communication between groups.

Here are a few tips and tricks for efficient communication with individuals from different generational tiers:

PRACTICAL TIP:

Always consider the forms of communication that they are most comfortable with. For senior generations, face to face communication is preferred and a lack of it might make them feel unappreciated and even offended. For younger generations, technology is a more acceptable means of communication and is considered equally respectable.

PRACTICAL TIP:

Always consider the importance and relevance of formality. Nowadays, colloquialisms, slang, emojis and GIFs are frequently employed during communication by the younger generations. While this is regarded as normal for them, the senior generations might have a more difficult time to understand and adapt the progressively informal styles manifesting in today`s society and they might perceive them as a lack of effort, a lack of respect and even as an indication of flawed education.

PRACTICAL TIP:

Always consider sensitive topics. The way younger generations approach sensitive subjects such as sexuality, religion or politics is very different than how it used to be in the age of the seniors. Make sure that you understand that something that feels comfortable to talk about for you might be too difficult for an elder person thus determining them to create a barrier and avoid communicating all together as a defense mechanism.

PRACTICAL TIP:

Have a wide-open conversational aperture. Try to adopt a mindset where there always something to learn from the others. Advice from older generations can be very valuable as they have earned it through experience while advice from the younger generations can help hinder rigidity and discover the benefits of more flexible approaches.

Efficient communication across generations relies heavily on the willingness and ability to listen, process and learn. The specific traits presented are not necessarily absolutes but rather clues to help you be more aware of how different generations approach communication and to indicate what are the best strategies for efficient communication.

The importance of effective communication in healthcare

When it comes healthcare, effective communication should not be regarded as an optional capacity but rather as an essential, integrated part of the medical act. The delivery of care is dependent on how the exchange of information happens between the main care provider, other medical staff and specialists that are involved in the case, the patient, and frequently, the next of kin. In the big picture, the importance of each of these

players cannot be undermined thus making health related communication extremely complex. This multidirectional aspect requires healthcare providers to be properly equipped not only to be effective sources but also to lead the interlocutors and help them communicate efficiently.

Patients or next of kin need to be able to communicate information about their health issues and concerns and the healthcare provider must be adequately equipped to comprehend and correctly interpret the information in order to provide the appropriate care. Moreover, the healthcare provider`s ability to convey information to the patient is also essential as they need to efficiently communicate and help patients understand the after-care protocols (administration of medicine, the signs they need to pay attention to, self-evaluation techniques, etc.) in order to ensure that the care recommendations are properly met but also to help patients take preventative measures and maintain their health and lower the incidence of recurring health complaints. Besides the patient-system interaction, healthcare providers of all levels must be able to communicate efficiently with each other in order to best coordinate and deliver proper healthcare. If any of the communication chains is compromised (patient-system or system-system) the quality of healthcare becomes impaired.

Effective communication in healthcare depends on a multitude of components and is strongly impacted by elements such as health literacy (for patient or next of kin), cultural competency and language barriers. The Agency for Healthcare Research and Quality suggests that all healthcare settings should consider the premise of "universal precautions" meaning that all patients should be approached with the assumption that they are at risk of not understanding their health status, their conditions and how to deal with them therefore healthcare providers need to confirm the patient`s accurate understanding through use of assessments and to intervene where necessary.

Healthcare and bad news - the importance of diagnosis and prognosis

Bad news represent a difficult yet unavoidable part of healthcare for physicians and patients alike. While there are a variety of techniques that can and must be employed when communicating such news, it is difficult to say that there is a perfect recipe for performing this task as each interlocutor is different. These individual characteristics and traits preclude a "standard/ one size fits all" approach, thus the communicator can explore a series of tools and techniques in order to discover the optimal approach.

The main goal of employing bad news communication protocols and techniques is to convey the bad news in a manner that cradles understanding while minimizing distress for the patient or next of kin.

According to Ptacek & Eberhardt (1996, p. 496), in a healthcare context, bad news represent any information that "results in a cognitive, behavioral or emotional deficit in the person receiving the news that persists for some time after the news is received". Another definition is provided by Buckman (1984, p. 1597) who describes it as "any news that drastically and negatively alters the patient's view of his or her future".

Generally, bad news is associated with somber diagnosis such as cancer or Alzheimer`s disease or death but the range of bad news is broader than that and it can range from telling a patient that they need to take medication for the rest of their life, telling a female patient that she has a low egg count or telling family members to prepare for a degradation of the patient`s cognitive or motor functions.

Patients need to clearly understand both the diagnosis and prognosis in order to be involved in the medical decision making and make sure their preferences and values are present in the treatment and care plans.

A *diagnosis* is an identification of a patient`s condition via medical examination and exploratory tests. Once a diagnosis is set, the *prognosis* follows which is the predicted course and outcome of the diagnosed condition. Often, prognosis is associated with life expectancy but in fact it considers both disease and treatment related information such as the spread of the disease, the chance of a cure, 5- or 10-year survival rates, qualitative expectations of disease progression, and differences in morbidity and mortality with and without treatment (Rodriguez et al., 2008).

IMPORTANT:

There is a tendency of considering that the delivery of bad news ends after the diagnosis has been communicated but in fact, the communication of the prognosis is extremely important as it has a great impact on the way the patient (and the next of kin) manage the disease, the treatments that they choose to pursue and the way they adjust to the diagnosis and all the life changes that come with it.

From the first encounter with a patient, the exchange of information serves not only for obtaining medical history and conveying treatment plans but also to build a relationship that can be a valuable instrument for those patients that search for a psychosocial healing connection or therapeutic relationship. When it comes to unfavorable diagnosis and prognosis or bad news in general, especially in contexts where biomedical approaches are limited or nonexistent, the value of a therapeutic relationship is tremendous as it has a major impact on symptom resolution, function, pain control, emotional health and even physiologic aspects such as BP, pulse or blood sugar levels.

It is without doubt that effective communication is critical for achieving good medical outcomes whether these are related to successful treatment, health maintenance, disease prevention or improvement of quality-of-life for chronic or palliative patients.

Bad News - the healthcare professional`s perspective

A survey applied to over 300 healthcare providers in Romania, Italy and Cyprus revealed that many physicians find delivering bad news difficult and stressful, regardless of the frequency of the experience. Among the most common feelings they experience when delivering bad news, a majority of physicians identified sadness as well as the fact that they are not indifferent regarding the situation. The majority of respondents agreed that the way they deliver bad news has an impact on the receiver`s reactions. Several similar studies conducted across the world reveal that physicians who deliver bad news frequently tend to have high levels of burnout and those of them who perceived their training in communication skills to be weak were more likely to have increased stress and burnout levels. (Ramirez et al., 1995; Sharma, Sharp, Walker, & Monson, 2007).

When it comes to the physician`s perspective regarding conveying information about prognosis, a majority reports experiencing a greater difficulty than in disclosing diagnosis. One survey revealed that many healthcare providers tend to delay or even completely avoid communicating prognostic information unless the patient specifically requests it. Another study revealed that physicians are more likely to discuss treatment-focused information such as chances of treatment to work rather than disease related prognosis such as chances of survival. Rodriguez et al. (2008) reveals that in terms of framing practices, 27% of prognostic statements were framed negatively (chance of death), 50% were framed positively (chance of survival) and 23% used mixed framing.

When it comes to the most frequent emotional response that they experience when delivering bad news, the majority of healthcare providers from all three countries - Romania, Italy and Cyprus placed sadness on the first place followed by fear and they have all placed indifference as a very rare response thus revealing that their involvement with the patient is important.

When asked what the biggest challenge is when delivering bad news, physicians identified negative emotions, the balance between being clear but also empathic, lack of social support, timing, selection of right vocabulary, the understanding of the patient`s personality and personalization of the communication, etc.

It is obvious and natural that healthcare providers have to overcome their own difficulties when it comes to delivering bad news. Regardless of the years of experience, it is always an unpleasant and undesirable task and physicians do not want to feel like they are taking hope away from the patient or their next of kin. Moreover, the hectic pace of a clinical setting may push the physician to communicate bad news in contexts that are not necessarily convenient for such important and intimate conversations. Moreover, generally, medical training places more emphasis on the biomedical model while communication skills tend to be given less attention that they deserve. Due to this, often times healthcare providers feel unprepared for the implications and intensity of communicating bad news to their patients and next of kin.

IMPORTANT:

“The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty

to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits."
(American Medical Association's First Code of Medical Ethics, 1847)

Impact of communication on performance and satisfaction

There is strong evidence that indicates that a patient`s capacity and willingness to follow through with treatment and medical recommendations, to self-manage a condition or adopt a healthy, preventive lifestyle is strongly impacted by the healthcare provider`s communication style and skills. A series of studies conducted over the past three decades show that a healthcare provider`s skills and abilities to efficiently communicate, to explain, to actively listen and to empathize can have profound influence on the mental health of the patient as well as on the biomedical aspects and of course on patient satisfaction and overall perception over the quality of medical care.
Therefore, communication in healthcare contexts has a variety of outcomes that influence the overall performance:

- Diagnostic accuracy - diagnostic decisions rely heavily on history taking and yet studies reveal that this process is often hindered as patients are not given the opportunity or the time to tell their story.

- Patient perception - interruptions and limited time allowance not only compromise diagnostic accuracy but may also determine the patient to perceive that their story, what they are communicating, is not important. This may lead to reticence to communicating further and providing more information and eventually destabilizes the care-giver - patient relationship.

- Adherence - the extent to which the patient`s behavior follows the recommendations from their healthcare provider is extremely important and efficient communication has a great impact on the level of adherence. A Health Care Quality Survey conducted by the World Health Organization revealed that over a quarter of patients do not fully adhere to their physician`s indications and advice. Most of the reasons they invoked have the potential to be solved through better and more efficient communication:

  - 25% found the indications too difficult to follow
  - 7% said that they did not understand what they had to do
  - 39% disagreed with their healthcare provider in terms of advice and recommended treatment
  - 20% felt the recommendations were against their personal beliefs
  - 27% were concerned about the cost of following the recommendations

- Patient safety - it is estimated that about one third of adverse events in healthcare are attributed to human and system errors. Research has revealed that nearly 66% of all medical errors sprout from ineffective team / patient communication. The vulnerability for medical error is higher when the healthcare providers are stressed, are handling high task situations and they are not communicating effectively (Team strategies and tools to enhance performance and patient safety (TeamSTEPPS), Department of Defense and Agency for Healthcare Research and Quality)

- Team satisfaction - some of the core elements that are essential for the healthcare team satisfaction include administrative and interpersonal support, respect, value, understanding, being listened to, clarity of roles and duties, work equity and of course fair compensation. When communication among team members is done effectively, it facilitates a culture of mutual support thus leading to increased job satisfaction and lower burnout rates.

- Malpractice exposure - a study looking at plaintiff depositions in malpractice cases (Beckman, H. B., Markakis, K. M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Archives of Internal Medicine) revealed that 71% of the claims were initiated as a consequence of a healthcare provider - patient relationship issue and most patients perceived their healthcare provider as uncaring. Moreover, one out of four patients claimed that the delivery of medical information was not properly done and 13% specifically identified poor listening as an issue.

Here are a few practical tips that address some of the important elements that influence performance and the level of patient satisfaction:

PRACTICAL TIP:

Communication - Always take your time and do our best to explain the information clearly. Try to understand your patient`s experience, their values and views and provide viable options. Always take your patient`s problems seriously and avoid making them feel like they don`t matter.

PRACTICAL TIP:

Expectation - Always do your best to provide the patient with the opportunity and the necessary time and context to tell their story.

PRACTICAL TIP:

Control - Try to encourage your patients to always express their concerns, ideas and expectations.

PRACTICAL TIP:

Decision- making - Always acknowledge the fact that the social and mental wellbeing of your patient matters as much as their physical functioning.

PRACTICAL TIP:

Time - Do your best to allow sufficient time for each of your patients. Often patients feel like they are against the clock when talking to their healthcare provider and this can compromise both the relationship and the exchange of essential information.

PRACTICAL TIP:

Dignity - Try to invite your patients to partner in the healthcare decisions and show them that their opinions and feelings are being respected.

Psychological and physiological impact of bad news

Communicating bad news is unfortunately a part of a healthcare provider`s routine and this predicament has without doubt psychological and physiological repercussions on the medical care provider and the patient alike.

A research of publications and relevant studies revealed that for a healthcare provider, communicating bad news may trigger a series of physiological responses such as:

- increased heart rate
- fluctuations in mean arterial pressure and cardiac output
- increased level of cortisol levels
- enhanced immune responses
- etc.

These findings indicate the fact that communicating bad news is not only psychologically straining on a healthcare provider but can also cause physiological stress reactions that can become hazardous for the healthcare provider`s own health and wellbeing.

When it comes to the patients, the measurements of physiological responses have not been investigated enough to generate a statistic but observation has revealed that they often display responses such as:

- shaking / body tremors

- sensation of cold

- sensation of a "hole in the stomach"

- loss of concentration and ability to respond

- skin redness

-etc.

A thorough monitoring of physiological reactions of patients is quite difficult in such contexts but based on the average reactions to stress we can assume that they experience the myriad of known stress reactions such as *increases in blood pressure, heart rate, sympathetic nerve activity and circulating catecholamines, and activation of the hypothalamic–pituitary–adrenal axis leading to increases in glucocorticoids (cortisol and corticosterone).* (Pacak K, Palkovits M, Kopin IJ, Goldstein DS. Stress- induced norepinephrine release in the hypothalamic paraventricular nucleus and pituitary-adrenocortical and sympathoadrenal activity: in vivo microdialysis studies. Front Neuroendocrinol. 1995).

When it comes to psychological responses, healthcare providers identified a feeling of losing control, concerning emotions and decrease in confidence and patient trust. Moreover, some physicians stated that communicating bad news makes them feel as if they have to exchange the role of a healer to that of an executioner and for some, it reminded them of their own death and of the fact that they cannot control this aspect of life thus making them feel powerless and frustrated. Several surveys revealed that the stress that a physician feels in regard to communicating bad news can last from several hours up to over three days.

Healthcare is probably one of the domains with the highest risk of stress related issues and consequences. Physicians are highly susceptible to burnout, an affection that is triggered and enhanced by emotional exhaustion, low productivity accompanied by feelings of underachievement and depersonalization. These feelings become heightened in those healthcare providers who have insufficient preparation and training for such instances.

When it comes to the patient`s psychological response, there are a lot of circumstances that influence how they feel and what they experience. One curious information that has been revealed by several studies conducted around the world is that not all patients want to find out their diagnosis and prognosis. Patients who receive bad news often perceive the information as too threatening and may go in denial or minimize the significance of the information. Morse et al. identified the fact that most patients used metaphors to describe how they felt when receiving bad news. These were interpreted as " feelings of unreality (unable to comprehend the news), danger and harm, physical forces (“being hit by...”), sinking in (time is often needed for the news to be understood), feelings of vulnerability (risk for self and the body), words are not only “heard” but also “felt”, incongruity between body/ mind, struggling to understand the news." (Prado AJF, Silva EA, Almeida VA, Fráguas Júnior R. Ambiente médico: o impacto da má notícia em pacientes e médicos – em direção a um modelo de comunicação mais efetivo. 2013).
Among the things they desire, many patients point out the fact that having clear and accurate information about diagnosis, prognosis and treatment plans help them feel better prepared for making decisions. Patients want their physicians to be empathic, sensitive and understand them and how they perceive the potential life changes that the diagnostic might mandate.

PRACTICAL TIP:

As mentioned, not all patients want to receive all the information about the state of their health, so it is important to assess exactly how comfortable and willing the patient is when it comes to truth disclosure. When patients receive too much information that they cannot process or when they feel like there are gaps in the information received, they might try to look for it outside the doctor`s office by researching on the internet or asking around. Many studies revealed that such practices can provide misleading, incorrect and inappropriate information that can have important negative consequences for the patient and the relationship with the doctor and the recommended therapy.

IMPORTANT:

It has been identified that the three main elements that make a difference for the patient when receiving bad news are:

- Content: the clarity and quality of information, understandability, completability and completeness
- Facilitation
- Support: caring, empathy, attention

In terms of negative aspects, the most frequent issues that patients have identified in regard to the moment they receive bad news are:

- Not enough time devoted to the conversation -
- Inappropriate physical context (on the hallway, by the door, etc.)

- Uncaring behavior displayed by the physician when delivering bad news (depersonalized approach)
- Lack of physician`s attention
- Usage of specific medical terminology
- Lack of emotional and cognitive support from the healthcare provider
- Lack of direction or facilitation in terms of what comes next
- Dismissive attitude

The fact is that truth disclosure is a strenuous task for healthcare providers and performing it with compassion and effectiveness is difficult, but it can make things less uncomfortable for themselves but also for the patient and their next of kin. For patients, the way this kind of news is delivered has an immense impact on the way they perceive the disease and the choices they make regarding future therapy thus directly impacting their quality of life.

Effective communication of bad news

From the first encounter with a patient to interventions and developing a treatment plan, the physician-patient relationship and the outcome of

the care is built on communication. In the context of bad news, effective communication is not only important for helping the patient cope, but also strengthens the relationship between them and the healthcare provider and this has long lasting positive ripples in the overall healing process or where healing is not possible, on the quality of life of the patient. It is rather difficult to specifically define efficient BN communication, but it is without doubt that essential elements can be identified and discussed alongside the desirable outcomes of such conversations. Overall, effective communication of bad news should satisfy the purpose of forming a solid basis for a constructive partnership between the patient, their next of kin and the medical team providing healthcare, thus significantly increasing the chance of proper treatment and/or recommendations adherence.

Based on several studies, a few elements have been identified as being definitory for an effective communication of bad news. Among these:

- Communication should be emotionally attuned to serve the cognitive goal of understanding the emotion of the patient (clinical empathy)
- Sensitive delivery in a manner that fits the circumstances and fosters trust
- Active listening and ability to check the patient`s understanding
- Effective questioning skills in order to elicit the patient`s main concerns, the perception of the problems and very importantly the emotional, social and physical impact on them and their next of kin
- Providing information using effective explanatory skills tailored to the patient`s needs and capabilities
- Counseling and educating the patient
- Making informed and personalized decisions based on the patient and their preferences, views, opinions and values

- Discussing the treatment options in a manner that helps the patient to fully comprehend the implications

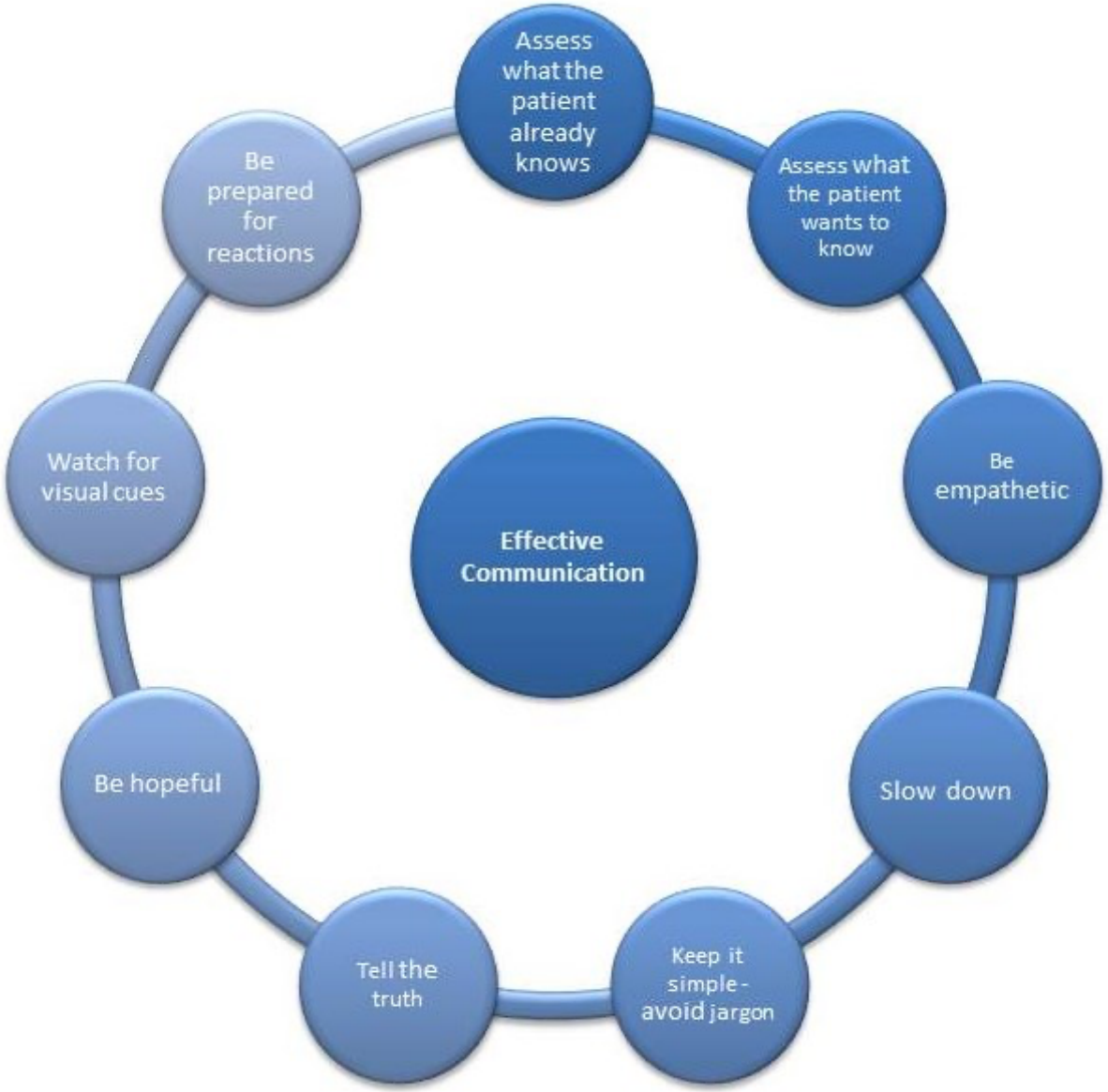


Image source : Physiopedia contributors, https://www.physiopedia.com/index.php?title=File:Effective_Communication_Cycle.jpg&oldid=102189

PRACTICAL TIP:

In order to improve your overall abilities and attain effective bad news communication skills, pay close attention to the following elements:

- Active listening

- Nonverbal communication

- Stress management

- Assertive - respectful communication

PRACTICAL TIP:

-Always try to listen in a way that allows you to understand the emotion of the patient and the intentions behind the message, the full meaning of what is being said both verbally and non-verbally.

PRACTICAL TIP:

- Always make the interlocutor feel heard and understood and show that their personal views matter and acknowledge their emotional state.

PRACTICAL TIP:

- Empower your patient and allow them to be proactive and in charge when it comes to their health and quality of life.

Effective communication in healthcare can lead to outcomes such as:

- Enhanced patient and healthcare provider satisfaction
- Lower risk of burnout for physicians
- Lower risk of malpraxis claims
- Increased information disclosure from patients
- Strong rapports built between patient and professional
- Increased patient participation in the decision making process
- Increased accuracy of diagnosis
- Better adherence to treatment
- Realistic patient expectations
- Etc.

Barriers to effective bad news communication

Besides the fact that communicating bad news is a challenge in itself, this particular type of communication can be hindered by a plethora of barriers that may arise. A great difficulty results from the fact that the nature of this communication can actually accentuate the barriers and the

barriers can also negatively affect the way the information is perceived and digested by the receiver. Besides the typical communication barriers that apply, communicating bad news in a clinical setting comes with a variety of specific obstacles that can be personal, institutional, socio-cultural, training/education level, language issues, etc.

Personal barriers

Different perceptions - Generally, delivering bad news involves a triad formed by the healthcare provider, the patient and their next of kin. Each member of this triad can have different perceptions regarding bad news. Studies showed that physicians tend to express their professional viewpoints without or before trying to assess how severe the diagnostic/prognostic is from the patient`s perspective.

Personal psychological barriers may happen in scenarios where one of the interlocutors needs to "adjust" their own style and this might cause them to feel unauthentic.

A variety of psychological experiments conducted by Tesser and others revealed that the person who has to communicate bad news often deals with high intensity emotions such as anxiety, fear of negative evaluation and feel a burden of responsibility that often leads to a reluctance for delivering bad news. This has been named the "MUM" effect.

PRACTICAL TIP: It is important to assess and understand how the patient feels about the received news. You need to allow them to process and react in order to properly manage the duration and intensity of their emotions such as fear, anxiety, denial or resignation.

The comfort zone - Delivering bad news may sometimes make the physician feel powerless or even frustrated. The natural tendency of staying in a comfort zone might determine the physician to delay or even limit the delivery of bad news.

PRACTICAL TIP:

It is important to give your patients the chance to find out all the information from you, as this can prevent them from looking and finding misleading information in other places. It is also important for yourself to not carry the burden of omission. Even though avoiding such conversations might relive you of some stress for the moment, postponing the encounter will trigger an accumulation of stress and anxiety on the long term.

Healthcare provider`s fears - Physicians reveal that they often fear being perceived as cold or uncaring by patients and their next of kin. Moreover, they experience discomfort when talking about death and often feel anxious in anticipation of the patient`s or the family`s reactions to bad news.

PRACTICAL TIP:

Try to see yourself as more than a passive messenger of medical information for your patient, think and behave as an interpreter and shaper of your patient`s health and wellbeing. Putting yourself in a "big picture" mindset will allow you conquer the fear of the immediate reactions and

better manage them.

Institutional barriers

When it comes to communicating bad news, institutional limitations mostly refer to the overall organization and the support that the physician benefits from. If the scheduling is difficult, physicians might experience time constraints that can harm not only the preparation process for delivering bad news but also the necessary emotional processing after the encounter.

Another example of institutional barrier is represented by the fact that it is very rare that the physician receives emotional support from his colleagues and superiors before and after such encounter and this can hinder the physician`s ability to cope with the process.

Institutional barriers can manifest strongly not only in the aspect of patient-healthcare provider communication but also when it comes to interprofessional communication and collaboration. Research has shown that some of the most common occurring barriers to interprofessional communications that are enhanced by institutional aspects relate to:

- Hierarchy
- Disruptive behavior
- Generational differences
- Gender
- Historical interprofessional and intraprofessional rivalries

- Differences in schedules and professional routines
- Varying levels of preparation, qualifications, and status
- Differences in accountability, payment, and rewards
- Concerns regarding clinical responsibility

PRACTICAL TIP:

In order to limit the occurrence of such barriers, it is important to have ongoing initiatives and attitudes that nurture a cooperative agenda rather than a competitive one. Standardized communication tools or procedures can help create an environment where healthcare providers can freely communicate and express opinions and concerns regardless of their position, specialty, status, etc.

Language Issues

When it comes to healthcare, language barriers may lead to miscommunication between the healthcare provider and patient as well as between the members of the healthcare team. Such instances can lead to reduced patient satisfaction, higher risks and a decreased quality of the healthcare delivery and patient safety.

Most commonly, language barriers happen when the healthcare provider and the patient do not share a native language, when there is high use of jargon or too much information is conveyed without necessary clarifications thus creating an information overload. Understanding the meaning of what is said can be challenging if people speak too fast or use specific vocabulary.

PRACTICAL TIP:

When we refer to interprofessional communication, jargon can be a significant aid, but it is important to make a conscious effort to avoid clinical acronyms and jargon when communicating with a patient or next of kin who doesn`t have the knowledge of the specific terms. Always try to us appropriate vocabulary and age-appropriate terms.

Socio-cultural Issues

There is no doubt that a healthcare provider has to interact with people that come from extremely diverse socio-cultural contexts. The socially transmitted behavior of an individual strongly influences the way they communicate, not only from the point of view of symbols and signs but also due to different mindsets.

Some of the most common socio-cultural issues gravitate around the following:

- Stereotyping: people have a tendency to rely on oversimplified clichés about individuals from different cultures, ethnicities, social levels, etc.

- Ethnocentrism: people have a tendency to look at other cultures through their own lens. When this happens, we tend to believe implicitly that our creeds and the way we do things is the right way and we judge behaviors that are not in conformity with our way of seeing things.

- Conflicting values: sometimes we might feel like other people`s behaviors compromise our values, or we just disagree or don`t understand their behavior and this is when cultural clashes occur. Some of the common conflicting mindsets/ behaviors are:

- preference of direct communication VS indirect communication

- preference for task-oriented interactions VS relationship oriented

- preference for open strong disagreement VS subtle disagreement

- preference for informal VS formal

- preference for structure VS flexibility

- preference for egalitarianism VS hierarchy

- etc.

PRACTICAL TIP:

In order to limit the occurrence of socio-cultural barriers try to:

- avoid stereotyped notions and frames of reference

- use mutual language, signs and symbols and make a conscious effort to understand the context of communication

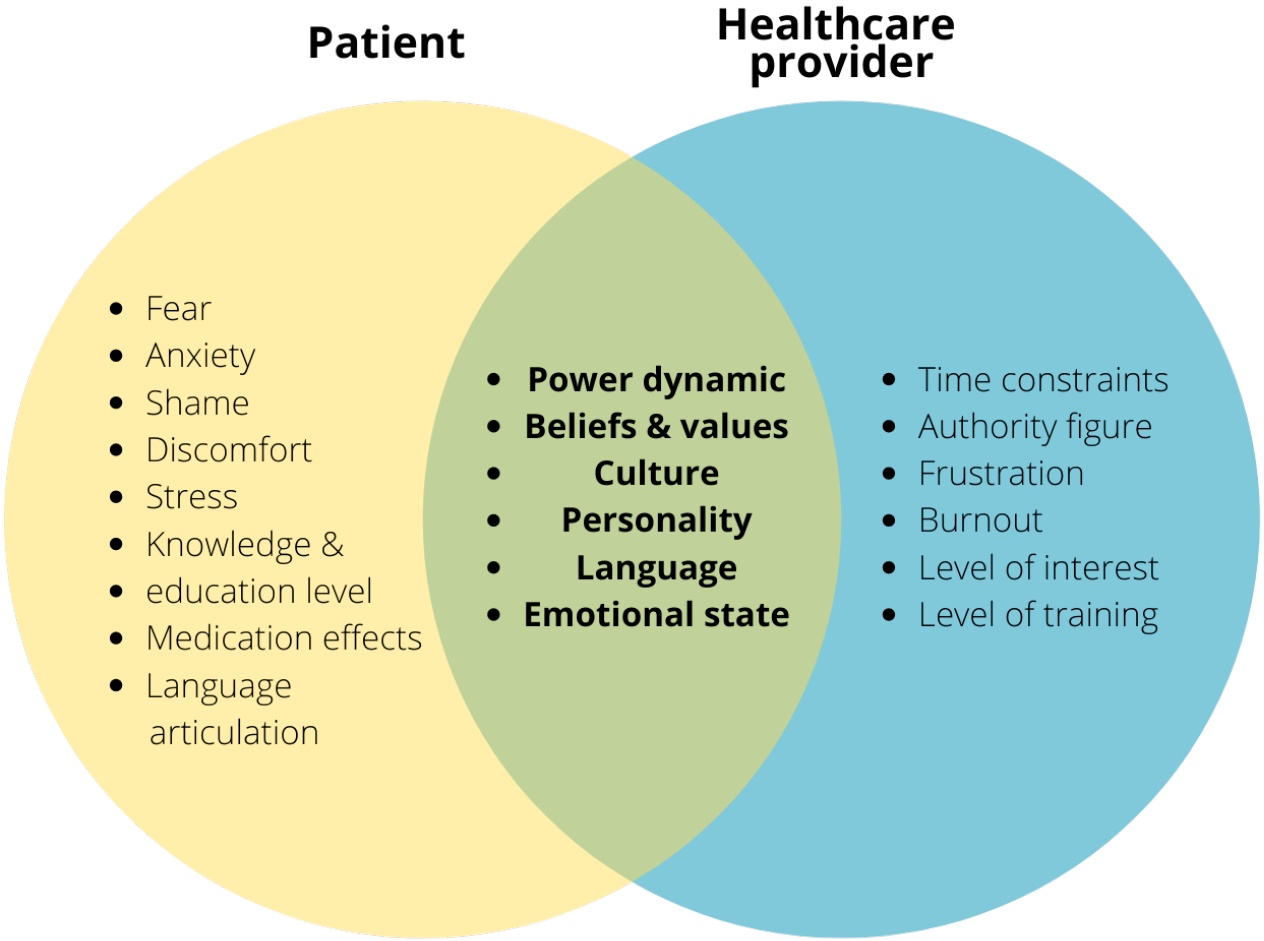
- be open to new ideas and provide space for mutual respect and understanding

- ask questions when there is doubt and be willing to give clarifications yourself if needed

Training issues

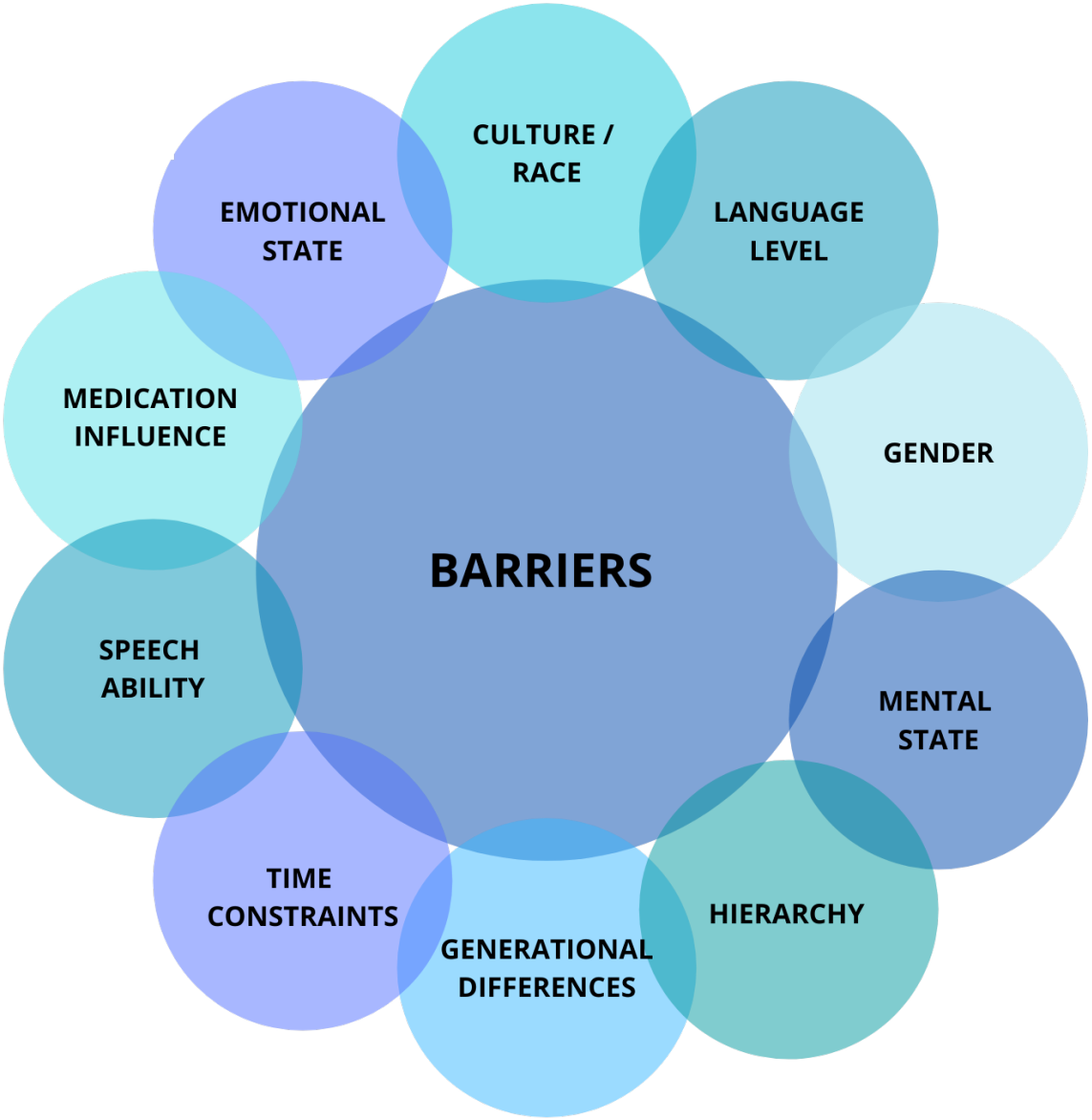
While some people can be natively gifted with better communication skills, there is a great difference between inspiration and actual training. Several surveys conducted by the authors or by other researchers have revealed that a majority of the interviewed healthcare providers feel like there is room for improving their communication skills. A statement from the Institute for Healthcare Communication reads " “Communication training for clinicians and other health care professionals historically has received far less attention throughout the training process than have other clinical tasks.”

It is thus extremely important to understand that a lack of adequate training can have a damaging impact that extends far beyond the quality of the medical act itself, but also on the mental wellbeing of the healthcare providers, the patients and their families and last but not least, communication inefficiencies can cause a rise in financial damage.



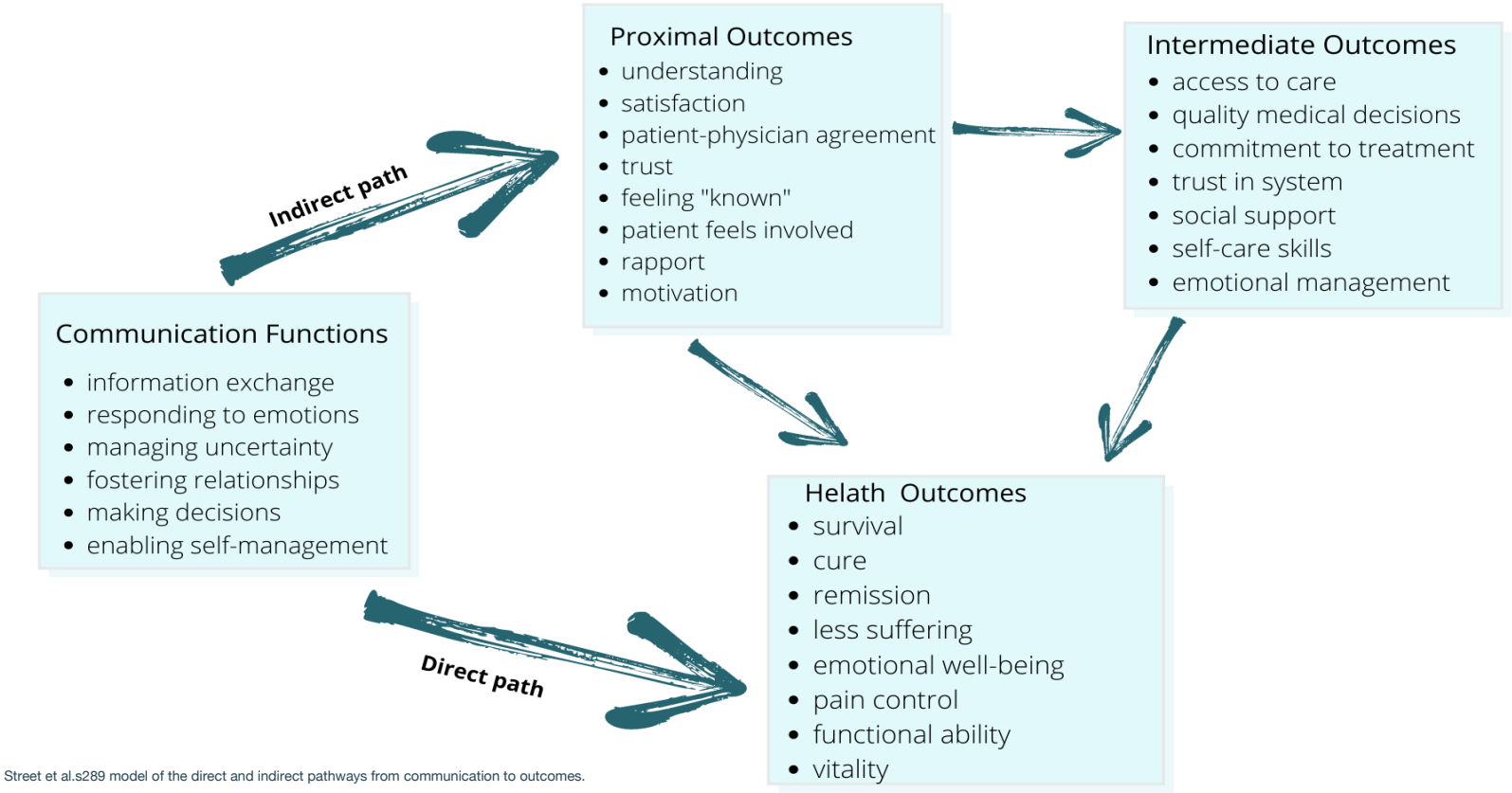
Environments with high and competing demands, time constraints, difficulties in finding privacy, background noise alongside the potential of communication abilities hindered by disease, medication or emotional states and last but not least different cultural views can lead to ineffective communication and misinterpretation of key information that is essential for the healthcare act.

Possible Communication Barriers



Strategies for improving communication skills

As established in the previous sections, communication is a vital part of healthcare and the interactions between patients and their healthcare providers have an important impact on the outcome of the medical act. Proper communication can be therapeutic and research has identified three categories of outcomes that can be attributed to it through direct or indirect pathways: Proximal, Intermediate and Health outcomes.



Street et al.s289 model of the direct and indirect pathways from communication to outcomes.

The communication of bad news is a complex process that requires a high level of professionalism and preparedness. The bearer of the news must be able to convey the message with the appropriate tone and understandable terminology all while assessing the reactions of the patient and next of kin. In order to help individuals improve their communication skills, a series of strategies and models have been developed by researchers to provide inputs for a standardized communication meant to ensure effectiveness.

The SPIKES model

The SPIKES protocol is a common model for communicating bad news designed by Walter Baile and his colleagues at the University of Texas MD Anderson Cancer Center in Houston TX. The acronym stands for Setting & listening, Patient perception, Invitation to give information, Knowledge, Explore emotions and Empathize and Strategy and summarize.

The purpose of this protocols is to help healthcare providers to:

1. Establish an appropriate setting
2. Check the patient`s perception of the situation that prompted the bad news
3. Determine the amount of information that is known by the patient/ next of kin and how much information is desired
4. Know the full medical facts and their implications before initiating communication
5. Explore the emotions raised during the conversation

6. Respond with empathy

7. Establish a strategy for support (SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer.

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP Oncologist. 2000; 5(4):302-11.)

The steps:

- **Setting up** - this involves preparing the stage for optimal communication by being well organized in terms of information, appropriate vocabulary, consistent message among all the members of the healthcare team. This step also includes preparation in terms of physical space and privacy should be always sought.

- **Perception** - this involves assessing the patient`s and their family`s perception and the amount of information they have and very importantly how much they want to know. Often this proves to be challenging for the healthcare provider as they must respect the patient`s desire in terms of level of information but they must also ensure that the patient and family know enough and are able to make informed decisions. This stage is extremely important as it also allows the physician to observe "if the patient is engaging in any variation of illness denial such as wishful thinking, omission of the essential but unfavorable medical details of the illness, or unrealistic expectations of treatment."(SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer.Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP Oncologist. 2000; 5(4):302-11.)

- **Invitation** - it is the patient or the family who should be granting the permission to have information shared. The physician should inquire about the extent of understanding and the context in which the information fits, and then, using the information shared by the patient in regard to their understanding of the illness, the healthcare provider should ask permission to share information.

- **Knowledge** - the delivery of bad news should start with a statement of warning that allows the patient and their next of kin to brace for emotional impact. The content is extremely important and "the sharing of bad news must be presented based on the assessed level of patient's understanding, compliance, and wishes for disclosure. Instead of using technical language, showing patients concrete examples of trends in lab work or radiology can make an abstract concept clearer. The actual sharing of the bad news should be done slowly so that the patient and family understand." (Rosenzweig M. Q. (2012). Breaking bad news: a guide for effective and empathetic communication. *The Nurse practitioner*, *37*(2), 1–4. https://doi.org/10.1097/01.NPR.0000408626.24599.9e)

- **Empathy** - receiving bad news can trigger a wide range of emotions for the patient and the healthcare provider should make a conscious effort to respond appropriately and with kindness. Empathetic communication should be used throughout the entire interaction with the patients or their families.

- **Strategy** - the last component of the SPIKES model is to clearly establish that patients have a clear plan for the future. It is important to always ensure that the patient understands the information that has been provided in order to prepare them for active participation in the treatment decisions. Frequently clarifying the details of the plan can increase the likelihood of the patient adhering and following through with the plan.

The ABCDE model

The ABCDE protocol puts an accent on five aspects of the bad news communication process. The mnemonic stands for Advanced preparation, Build a therapeutic environment and relationship, Communicate well, Deal with patient and family reactions and Evaluate the effects of the news.

The steps:

- **Advanced preparation** - thoroughly review the patient`s history and a mentally rehearse and prepare emotionally. This stage involves making arrangements for the presence of a support person if a patient desires so, as well as determining what the patient knows about their condition.

- **Build a therapeutic environment and relationship** - make sure that you provide adequate time and privacy, provide seating space for everyone present, maintain eye contact and position yourself close enough to touch the patient if it is appropriate.

- **Communicate well** - avoid technical terms, medical jargon and abbreviations and try to use plain language. Allow for silence pauses and don`t rush the patient but rather move at their pace.

- **Deal with patient and family reactions** - practice active listening, explore feelings and express empathy. Address emotions as they manifest.

- **Evaluate the effects of the news** - Clarify and correct misinformation if needed. Explore what all the provided information means for the patient and their close ones while being cognizant of your and your team`s emotions.

The REDE model

The REDE model stems from a conceptual framework that puts the healthcare provider- patient relationship at the center. It is designed as an organization of empirically validated communication skills that are categorized in three main components of a **R**elationship:

- **E**stablishment

- **D**evelopment

- **E**ngagement

The steps:

Relationship:

- **Establishment** - this phase refers to the creation of a supportive atmosphere that is essential for personal connection and for fostering trust. It represents an emotional investment that both parties make that allows the relationship to rely on solid grounds and nurture collaboration.

PRACTICAL TIPS:

- First impression matters. Try to always convey respect and value with your welcome because the way the stage is set for the conversation matters even if at a first glance it is irrelevant to the clinical picture. Make a conscious effort of showing that you are receptive and that you see them as a person first and patient second.

- Try to always share the agenda as the patient`s reactions can be great indicators to help minimize your biases in terms of patient concerns and priorities and it also facilitates partnership.

- Introduce technology as a partner. Often times, the patients fail to understand that the computer and electronic health records and documents are an integrated part of the healthcare act and tend to see it as a detractor. It is important to point out that the utilization of technology is a means of enhancing and facilitating the healthcare act.

- **Development** - this phase revolves around growing and evolving the relationship once a supportive environment has been established. This involves getting to know the person better and understanding their clinical tableau in a complex biopsychosocial context.

PRACTICAL TIPS:

Practice reflective listening in a way that allows you to understand and acknowledge the intended meaning of your patient`s message. This technique has shown to increase openness, disclosure as well as an improved information recall.

Elicit the narrative and the perspective. It is common to have a tendency of having a data gathering centered approach during a history of present illness interview, but it is very important to try to understand the patient`s perspective on the symptoms as well. Try to be curious and explore the psychosocial response to symptoms and the idea of disease as well as the clinical facts.

- **Engagement** - this phase relates mostly to the educational and treatment aspects of a patient interaction. Engaging the patient improve the overall health outcomes by increasing the level of information comprehension and recall, self-sufficiency and efficacy as well as recommendation adherence.

PRACTICAL TIPS:

Don`t make it a monologue. There is generally a high quantity of information that the patient receives during a visit to their healthcare provider and often times they don`t comprehend or accurately recall an important amount of it. Try to engage in dialogue and emphasize the importance of the patient`s role in their own treatment or health management plan.

Share effectively. Simply stating medical facts might not always be sufficient. Make an effort to frame the information in a context that the patient understands and allow them to ask for clarification.

Provide closure. Try to review the time spent and demonstrate respect and importance and try to put the patient at ease in regards to the fact that your relationship is a continued partnership.

The PEWTER Model

The PEWTER protocol was initially developed as a tool for school counselors, but it has been adopted in clinical settings as a framework that helps with the effective communication of bad news. The mnemonic stands for Prepare, Evaluate, Warning, Telling, Emotional Response and Regrouping.

The steps:

- **Preparation -** this stage is very complex at it can be viewed as both internal and external. It involves competency in applying communication skills as well as being aware of personal thoughts, values and beliefs. The healthcare provider needs to consciously understand the role they are portraying in the communication and try to switch the paradigm from "bearer of doom" to "guide helping a patient on a journey to a new stage in life". The view over this role will determine the characteristics of the communication, will influence the verbal and non verbal approach, etc. In terms of external aspects, the physical setting is very important and it should be thoughtfully chosen and prepared in order to insure privacy and limit interruptions, distractions and other potential barriers. This phase also involves reviewing all the patient records and available information prior to the encounter and preparing the meeting in a manner that is considerate regarding the background and personal circumstances of the patient, the timing of the meeting, etc.

- **Evaluation -** this step involves assessing what the patient knows, suspects or understands about the situation. This allows for any misinformation to be corrected prior to delivering the bad news.

- **Warning** - this is a significant stage of the process as it allows the patient to start processing the fact that bad news is coming. This is normally done by using a verbal structure such as " I`m afraid I have some difficult news to share with you" followed by a pause that allows the patient to have the cognitive and emotional shift and process the idea that something is wrong and open their mind to what the news might be.

- **Telling** - this is the stage where the healthcare provider shares the news with the patient. This is generally the stage where the healthcare provider experiences the highest level of stress. It is important in this stage to present the information in a compassionate manner, to use a vocabulary that is easy to understand, to avoid technical terms and jargon and very importantly to present the information in a manner that allows you check in with the patient after every piece of information and make sure that they clearly understand the information that is being shared.

- **Emotional Response** - at this stage the stress is at a peak for the patient and they start emotionally responding to the news they have received. It is very important for the healthcare provider to be attuned to this response and assess if breaks are needed or even another

meeting at a different time as some people may be overwhelmed. It is in this stage that the healthcare provider can assess if it might be necessary to involve family members or friends.

- **Regrouping -** this is the final stage of the PEWTER protocol and it involves helping the patient determine what are the steps that they need to take next. Beside the therapeutical indications, the healthcare provider should direct the patient to appropriate resources, support groups or additional services that might be of help in managing the situation. It is important to present the information in a manner that offers hope without being unrealistic. In the less negative scenarios, this can be hope for treatment, hope that the quality of life will not be altered or that the prognosis is not life limiting. Nevertheless, in some contexts hope might not be obvious and great attention should be paid to how things are discussed. In these situations, hope should be offered in terms of hope for support, hope for continuous relation with the healthcare providing team, etc.

PRACTICAL TIPS:

Always prepare for difficult conversations by thoroughly understanding the extent of the implications of the diagnosis and choosing an appropriate physical setting for discussing it.

Set the discussion agenda and objectives prior to the encounter to ensure that all information is communicated properly.

Kaye`s 10 step model

This 10-step model has been developed by Peter Kaye and it represents a set of suggestions for communicating bad news. The central idea of this model is the importance of interlacing facts with questions about feelings. As opposed to the models presented previously, this model is not a mnemonic but rather a task centered approach to some stages that should be present in any bad news communication encounters. The ten steps are: 1- Preparation, 2- What does the patient know, 3- Is more information wanted, 4- The warning shot, 5- Allow denial, 6- Explain if requested, 7- Listen to concerns, 8- Encourage venting, 9- Summary and plan, 10 - Provide availability. While the succession of some of this steps is natural, there is no exact order for using this stages.

The steps:

- Preparation - this stage involves knowing and understanding all the facts about the patient and who he wants present for the discussion. This step also involves preparing an appropriate physical setting that is private and where there are enough comfortable chairs for everybody present. It is also in this step that the healthcare provider introduces himself (if it is the first time they meet someone present)

- What does the patient know? - this stage involves finding out how the patient perceives the situation and the facts. It is the moment to ask for a narrative of events from the patient or family. Try to use as many open ended questions such as "How did it all start?"

- Is more information wanted? - this stage is where the healthcare provider can assess how much information the patient wants at that moment. This can be done by following the nonverbal cues as well as by asking calibrating questions such as "Would you like me to explain more about this?"

- Give a warning shot - this is the stage that allows you to prepare the patient for the news they are about to receive. This is done by expressing a warning statement such as "I`m afraid this looks serious" or " I`m afraid I have some difficult news to discuss". It is important to always allow a pause for the patient to react.

- Allow denial - in this stage you need to allow the patient to control the amount of information they receive. For some individuals denial is a coping mechanism, a defense.

- Explain if prompted - It is important to provide step by step explanations when they are requested. You need to diminish the information gap in a considerate and empathic way as often times after such conversations, the way the explanations have been given is remembered more accurately than the details themselves.

- Listen to concerns - at this stage you need to ask your patient about their feelings and thoughts and allow them space for answering while also making them comfortable to express how they feel. You can ask questions such as "What are your concerns now?", etc.

- Encourage ventilation and expression of feelings and acknowledge them - this stage is extremely important for the patient as you can convey consideration and appreciation towards the patient and the situation they are in. You can make them feel heard and understood without judgement.

- Summary and plan - this is the stage where all the concerns should be summarized and addressed, the treatment or disease management plan should be presented and explained and also the stage where hope can be fostered.

- Offer availability - this stage involves acknowledging that future needs and concerns might change and offering availability for any future communication and support for the patient and family.

There are a variety of proposed models and protocols and there is no consensus as to which protocol is the best one. The complexity and multitude of aspects involved in communicating bad news make it difficult to identify a "one size fits all" type of approach, therefore it is

recommended that healthcare professionals try to experience and adopt one of the models that they are most comfortable with and that provides them with the right tools, skills and the confidence required to effectively disclose and discuss difficult news with patients and their families.

Communicating bad news over the telephone

Delivering bad news is a difficult task regardless of how many attenuating circumstances there are, and when the conversations needs to take place over the phone, the challenges are even greater.

Particularly during this time where the world is impacted by the COVID 19 pandemic, hospital visits have been massively restricted and many healthcare providers have been put in the position of communicating sensitive news over the phone more than ever before. In addition to this, healthcare providers have been challenged with finding solutions and ways to keep the patients in touch with their loved ones even when their access in the medical facilities was prohibited.

While most bad news communication protocols emphasize elements such as physical setting and nonverbal communication, when it comes to delivering bad news over the phone most of these tools are not available thus fostering distress in both the bearer of the news and the receiver.

It is important for a healthcare provider to be prepared for such situations by following a series of steps in order to facilitate effective communication.

The steps:

- Prepare for the phone call the same way you would prepare if you were meeting face to face. Make sure you know all the facts and chose an environment where the phone conversation can take place in privacy and with as little distractions as possible (do it from your private practice rather than from the hospital reception or triage area). It is also important to verify that the receiver is in the right environment to discuss such news.

- Once they pick-up, confirm the identity of the interlocutor and their relationship with the patient and make sure to introduce yourself and your role regarding the patient.

- Give a warning shot and make sure you pause before telling the actual news. Use structures such as " I am afraid I am calling you with some unfortunate news" or "I wish I had better news to give you today" or "I`m sorry, I wish I didn`t have to give you this kind of news today". At this time, you might want to suggest that the person sits down for the conversation.

- If someone else is present with the interlocutor, offer to speak with them as well or offer to call a different person that might be concerned with the news as well. it is important that you repeat exactly the same information to all the interlocutors in order to confirm the message.

- Do not end the phone conversation before the other person indicates that they are ready to end it.

- Ensure that the receiver has direct contact details for you or a colleague that is involved in the situation.

- Once the phone call is terminated, make sure you inform the reception and security staff of the situation and the fact that the family should be arriving.
- If possible, try to make sure that the family is greeted by a staff member on arrival and that they are being offered support in navigating the situation both mentally and physically (formalities, documents, etc.)

PRACTICAL TIPS:

Pay particular attention to your tone of voice. It is extremely important as you are unable to employ other non-verbal communication elements. Convey the news with empathy and simplicity and use silence to allow the receiver to process and react to each part of your conversation.

Responding to patient emotion

It is important to acknowledge the fact that sensitive or difficult news will determine emotional responses from patients and their families. While the intensity and the type of response can vary a lot - from crying to aggressivity and beyond the ability to listen, recognize and adequately respond to the emotions of your patients and their next of kin is a valuable trait that is essential for a healthcare provider.

A patient or their relative can become challenging for a variety of reasons such as pain, being unwell, substance abuse, fear, anxiety, language difficulties, previous poor experiences, frustration, guilt, etc. These reasons may lead to them being angry, violent, demanding, threatening and unwilling to listen and cooperate. Dealing with these reactions requires care, judgement and control and any deviations can end up exacerbating the situation. It is important to always remain calm and composed, listen to their message and ask open ended questions while acknowledging them and their grievances. Showing willingness to discuss can provide the recalcitrant patient with the opportunity to state what is the cause of their anger and, understanding this can be of great help in finding a solution.

Patient emotion assessment tools

Even though patient or next of kin violence doesn`t happen every day, it is a rather common occurrence in healthcare settings. In order to assist healthcare providers in reducing the risk of such occurrences and being prepared to react effectively, a series of instruments are available to assess the risk of violence. There are two main types of factors that can influence the degree of potential violent behavior: static - relatively

fixed such as gender, age, history of first violence, pathologies, etc. and dynamic - fluid and changeable such as access to weapons, intoxication, social support, etc..

Some of the most common static factors that increase the risk of violent behavior are:

- low socio-economic status
- housing issues/ instability
- employment instability
- history of previous violence or destruction of property
- diagnosis of mental or personality disorder
- substance use disorder

The most common dynamic factors that increase the risk of violent behavior are:

- intoxication
- alcohol, opioid or benzodiazepines withdrawal
- psychosis
- paranoid delusions
- physical agitation

- verbal aggression

- ineffective pain management

- anger

The STAMP assessment

Research has identified a series of behavioral cues that may be associated with imminent violence risk in a clinical setting. The mnemonic STAMP stands for the main cues that are to be observed in this sense:

Component	Assessment cue
Staring	Prolonged glaring or absence of eye contact
Tone and volume	Sharp, caustic Sarcasm Demeaning inflections Raised volume
Anxiety	Rapid speech Dilated pupils Hyperventilation

	Flushed appearance Physical indicators of pain such as grimaces, writhing, clutching body Tremor
Mumbling	Talking under the breath Criticizing/ making accusations just loudly enough to be heard Repetition of ideas/ questions/ requests Slurring Incoherence
Pacing	Walking around in limited/ confined areas (in a circle, around a bed, in a waiting room Walking back and forth to staff office/ desk/ area Flailing around in bed Resisting or opposing healthcare

The DASA assessment

The DASA tool has been developed for psychiatric setting assessments and it identifies a series of behaviors that are correlated with an increased risk of violent behaviors. The DASA acronym stands for Dynamic Appraisal of Situational Aggression and the tool has been developed in 2006 by Ogloff & Daffern. The tool is based on the Broset Violence Checklist (BVC).

Component	Assessment cue
Irritability	the patient is considered easily annoyed or angered and unable to tolerate the presence of others.
Impulsivity	the patient has been sudden, impulsive and unpredictable in their affect or behaviour during the previous 24 hours.
Unwillingness to follow directions	the patient has become angry and/or aggressive with the previous 24 hours when they were asked to adhere to some aspect of their treatment or to the ward's routine
Sensitive to perceived provocation	the patient has tended to see others' actions as deliberate and harmful. They may misinterpret other people's behaviour or respond with anger in a disproportionate manner to the extent of provocation. They are prickly, overly sensitive and quick to anger

Easily angered when requests are denied	the patient has tended to become angry when their requests have not been granted immediately. They do not accept the delay in gratification of their requests, may become angry, surly or aggressive
Negative attitudes	definite serious negative attitudes exhibited
Verbal threats	the patient was verbally aggressive or displayed a verbal outburst, which is more than just a raised voice, and where there is a definite attempt to intimidate or threaten another person. The person may shout angrily, insult others or curse

Modified from The DASA manual - Proffessor James Ogloff & Michael Daffern - Monash University & Forensicare

The MOAS assessment

The modified Overt Aggression Scale is a behavior rating instrument used to evaluate the frequency and intensity of violent and aggressive episodes. The MOAS is a great tool that allows to track behavior patterns in time. It is comprised of four categories and each cue has a different score.

Component	Assessment cue
Verbal aggression	0 No verbal Aggression

	1 Shouts angrily, curses mildly, or makes personal insults 2 Curses viciously, is severely insulting, has temper outbursts 3 Impulsively threatens violence toward others or self 4 Threatens violence toward others or self repeatedly or deliberately
Aggression against objects	0 No aggression against property 1 Slams door, rips clothing, urinates on floor 2 Throws objects down, kicks furniture, defaces walls 3 Breaks objects, smashes windows 4 Sets fires, throws objects dangerously
Aggression against self	0 No autoaggression 1 Picks or scratches skin, pulls hair out, hits self (without injury) 2 Bangs head, hits fists into walls, throws self onto floor 3 Inflicts minor cuts, bruises, burns, or welts on self 4 Inflicts major injury on self or makes a suicide attempt
Aggression against others	0 No physical aggression

	1 Makes menacing gestures, swings at people, grabs at clothing 2 Strikes, pushes, scratches, pulls hair of others (without injury) 3 Attacks others, causing mild injury (bruises, sprain, welts, etc.) 4 Attacks others, causing serious injury

Modified from Kay SR, Wolkenfelf F, Murrill LM (1988), Profiles of aggression among psychiatric patients: I. nature and prevalence. Journal of Nervous and Mental Disease 176:539-546

The BROSET assessment

The Broset Violence checklist is a six-item checklist designed to assist in the prediction of possible violent behaviors. The absence of a behavior represents a score of 0 while the presence of a behavior represents a score of 1. A total score of 0 signifies that the risk is small, 1-2 represents a moderate risk and preventive measures should be considered and a score above 2 represents a high risk and preventive measures should be taken alongside a violence management plan.

Component	Assessment cue
Confused	Appears obviously confused and disorientated. May be unaware of time, place or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.

Verbal threats	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Physical threats	Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another persons clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Attacking objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.

Increasing the odds for safety

It is of utmost importance for a healthcare provider to be properly equipped to make decisions that lower the risk of aggressive and dangerous incidents thus increasing the chance for safety. There are a variety of techniques that a healthcare provider can employ in order to diffuse a tensed situation and de-escalate a potential dangerous situation.

The LEAP framework

One of the basic techniques that are useful in high conflict situations is the LEAP protocol. The mnemonic stands for Listen, Empathize, Agree and Partner. This protocol is useful when dealing with patients that are experiencing emotional crisis by guiding the verbal exchange and intervention.

This framework allows you to set limits and identify consequences without threatening the patient. Example phrase: " Your behavior makes it difficult for me to help you. I would like you to work on calming down so we can work on making you feel better/ on making the pain stop/etc.)"

PRACTICAL TIPS:

- Verbal intervention and limit setting - if a patient has angry comments you can point out the behavior and how it hinders your ability to provide proper care. Make sure that you allow a break for the patient to calm down.

- Try to always maintain a calm stance and communicate in a neutral voice, using simple language. Try to avoid arguing and contradicting.

- Avoid intense eye contact as this can be perceived as threatening and confrontational.

- Try to keep sufficient and appropriate space between you and the patient. This decreases the perceived threat while also increasing your ability to maintain physical safety or leave the area.

- Always validate the patient`s concerns and acknowledge their point of view as this can be extremely helpful when it comes to calming down and regaining behavioral control. This includes maintaining your attention on what they are saying and reflecting their concerns with interventions such as "I can see you are angry", " I can see you are frustrated because you feel like nobody is helping you".
- Validating the patient`s concerns and feelings increases their ability to trust, to build rapport and even form an alliance that eventually significantly impacts the ability to solve the situation and increase safety for all parties concerned. Validation and normalization of feelings and concerns can be done by saying things like " I can see how what you are going through is overwhelming", "It is very frightening to be in here with so many people you don`t know", "Experiencing this is very difficult and I understand that", etc.

De-escalation techniques

As discussed in the previous sections, patients and their next of kin might experience and display difficult behaviors triggered by chronic and emotional pain, loss, fear, substance withdrawal or dependency, etc. Such situations can become not only extremely unpleasant for the healthcare providers and patients themselves but can also become dangerous. It is important to be aware of the fact that even though these kinds of behaviors can escalate very quickly, de-escalation is not possible at the same velocity but rather a step-by-step approach for making the situation better.

In dedicated literature, de-escalation is defined in a variety of ways and also referred to as crisis resolution, conflict management, defusing, etc., but generally, de-escalation can be described as a mix of methods, techniques and strategies to reduce agitation and aggression.

While each of these situations are unique, there are several cyclical de-escalation models that have proven to be efficient in clinical settings.

The Dix and Page Model

The Dix and Page is a cyclical model that is comprised of three elements that are interdependent: Assessment, Communication and Tactics. (ACT). The cyclical aspect refers to the fact that each element must be continuously revisited during the application of the method.

Assessment

Dix and Page based this element on Frude`s (1989) model of progression of five factors as the reference by which to assess a patient`s or relative`s behavior:

Situation- refers to the elements that the patient or relative is focused on right before displaying aggressive behavior

Appraisal - refers to the patient`s or relative`s understanding of the situation

Anger - refers to the emotional response to the appraisal

Inhibitions - refers to the patient`s or relative`s attitude and general ability to manage aggression

Aggression - refers to the actual behavioral result

Communication

Dix and Page recommend that communication must appear sincere and customized and therefore state that it should not be taken verbatim from a fact sheet. The principles their model advocates for refer to both verbal and non-verbal communication and they include:

- Maintaining a non-aggressive posture
- Avoiding physical contact with the patient (even if it is intended as a reassuring or gentle touch)
- Avoiding using jargon
- Self disclosing
- Bringing attention to the impact of the patient`s or relative`s behavior

Tactics

Dix and Page suggest abstract models designed to reimagine the relationship between the healthcare provider and the patient or relative rather than a specific technique approach. Their models include:

- attitude and behavior cycle
- win-lose equation

- debunking
- aligning goals
- transactional analysis

These tactics of Dix and Paige are purposefully vague so as to emphasize the importance of not using standard scripts that are inflexible and present as insincere and even cold. The guidance they offer suggests that the de-escalators should invalidate the patient`s need for aggression by fully empathizing with their grievances and frame their own goals to align with the patient`s.

The Turnbull et al. model

The Turnbull et al. framework is characterized by the idea that there is not one particular order of utilization as it emphasizes flexibility. The framework incorporates 10 learning objectives:

- legal aspects (such as restraining rights)
- theories of aggression
- triggers of aggression

- de-escalation skills
- disengagement breakaways (such as bear hugs, strangle holds, disarming, etc)
- basic control and restraint (such as wrist locks, bear hugs, etc)
- advanced control and restraint (such as the three-arm team, removal, relocation, etc)
- integration of de-escalation and control and restraint
- guidelines for practice
- reporting incidents

It is important to mention the fact that physical restraint techniques as part of de-escalation frameworks and training are useful and necessary in the sense that such knowledge can limit the incorrect use of potentially fatal techniques. Nevertheless, such techniques should only be employed to prevent immediate physical injury to the medical staff or the patient itself. The implications of such techniques underline why de-escalation skills are extremely important in order to prevent the requirement for physical restraint in the first place.

The Turnbull et al. model refers to seven important skills for verbal and non-verbal response to aggression:

- enlist colleagues for help
- ask questions about the patient`s/ relative`s feelings
- give clear instructions
- maintain friendly eye contact and non-threatening body posture

- be personable and able to separate yourself from "the system"

- show concern

- demonstrate empathy to match the patient`s/ relative`s mood

The Safewards Model

The Len Bowers Safewards framework is built around the principle that conflict and containment exist in symbiosis and that patients or relatives who are contained through restraint, seclusion or special treatment are more likely to escalate aggressiveness and violence as a response to being contained. As opposed to other de-escalation frameworks, the Safewards framework does not begin at the first sign of aggression but rather involves understanding the sources of the patient`s or relative`s discomfort throughout the process of de-escalation. This structure gives the framework a wide and general view and as opposed to other models that are centered on the interaction between the healthcare provider and the patient or relative, the Safewards model regards the full healthcare ecosystem.

The elements of the model are:

- **Originating Domains** – elements of the ward that can lead to flashpoints. These elements are unalterable elements of hospital life and can be further broken down into six general categories:

- patient community (patient-patient interaction)
- patient characteristics (symptoms and demography)
- regulatory framework (legal framework and hospital policy)
- staff team (how staff manage feelings and interact with each other)
- physical environment (hospital layout and comfort)
- outside hospital environment (what the patient's family and community is like outside the hospital).

- **Flashpoints** – situations in which aggression could arise as a result of one of the originating domains.
- **Patient Modifiers** – the ways in which patients respond toward originating domains and toward each other.
- **Staff Modifiers** – the way that staff manage patients or the environment to reduce conflict and containment.
- **Conflict** – any patient behavior that threatens their safety or the safety of others.
- **Containment** – ways in which staff manage conflict, e.g. medication, seclusion, restraint, etc.

(Shulman, 2020)

This framework introduces the idea that staff modifiers play a central role and have the possibility to impact the other domains in order to limit conflict and the containment actions that it causes. The main idea is that the conflict-containment cycle can be avoided through thorough consideration of all the elements of the patient`s experience that allow mitigation of the flashpoints.

SAFETY TIP:

While conflict management and de-escalation are the desired outcomes in such situations, if at any point aggressive behavior escalates it is important to take steps quickly to minimize the risk of harm. This includes calling for assistance, leaving the area, or using physical restraint or seclusion depending on the setting and context.

If you find yourself in contexts with a risk of violence, keep an eye on sharp objects or any other items that can be used as a weapon, and be sure that items on your body can't be used aggressively. This concern applies most specifically to items around your neck, such as stethoscopes, jewelry, scarves, ties, etc.

Practical tips for de-escalation

Don`t judge - Do not judge or dismiss the feelings and thoughts of the patient or relative in distress. Always keep in mind that regardless if they are justified or not, what they are feeling is real. Have respect and understanding for them and consider that what they are going through might be the most important thing in their life at that moment.

Be aware of personal space - Pay attention to your posture, position and proximity when you communicate with a patient or relative in distress. Allowing the appropriate personal space not only keeps you safer but also shows respect and tends to decrease an individual`s anxiety. If there are reasons that prompt you to enter someone`s personal space, explain why you are doing so to avoid confusion and fear.

Be aware of nonverbals - Generally, when an individual is in distress, they tend to hear less of what you say and react more to nonverbal communication. Keep your tone and body language neutral and pay attention to your gestures, facial expressions and movements

Be aware of your own emotions - It is important to understand that we cannot control somebody else`s behavior but the way we respond to it determines if the situation defuses or escalates. Keep your calm, remain rational and professional. Think positive thoughts such as " I know what to do in this situation", " I am equipped to handle this situation", etc.

Feelings are important - While facts are extremely important, in situations of distress, feelings are at the core of the matter. It is very common that people have difficulties in identifying how they feel about what they are going through, it is important that you actively listen in order to comprehend the interlocutor`s real meaning. Acknowledge and be supportive of what they feel. Saying things like "I understand, that must be scarry " or " I imagine that is very difficult for you", etc. will show your distressed patient or relative that you understand what is happening and care.

Deflect challenging questions - When a distressed interlocutor challenges you or your authority, ignore the challenge but not the person. Redirect their attention to the issues that matter and bring the conversation to what can be done to solve the problem.

Allow silence - Silence can give a distressed person a chance to reflect and understand the things that are happening and what they need to do next. It can also allow proper reflections for decisions. Not allowing time might cause a rise in stress level as the patient or relative might feel rushed.

**It`s not personal** - . Always keep in mind that many times the root cause of someone`s aggressiveness and rudeness may be stress, fear, fatigue, illness, ignorance, or a past experience of trauma or abuse. Acknowledging their hurt does not justify or excuse their bad behavior, but it can help reset your perspective on the situation so you can handle it objectively and professionally. (Sánchez Wohlever 2019)

Delivering Bad News - Flashcards

Breaking Bad News Flowchart (adapted from Riddleston 2018)

Do I have the facts?
Ensure privacy and set the scene
Find out whom the patient wants present

↓

What does the patient know?
'What do you understand so far?'

↓

Is more information wanted?
'Would you like me to tell you the full details of the diagnosis?'

↓

Give a warning shot
'I'm afraid the results are not good'

↓

Allowing denial
'It must be very hard to accept this'

↓

Explanation/Information giving
Give information in small chunks
Check out understanding

↓

Listen to concerns
Allow time for expression of worries and acknowledge their importance.

↓

Encourage ventilation of feelings
'How are you feeling now?'
Be aware of common reactions

↓

Summarise and plan
Outline the plan of care and explain it
Offer permanent record of important points discussed

↓

Offer further discussion
Follow-up appointment, contact from specialist /nurse

↓

Communicate with the 'Team'
Inform patient's GP or care team
Document in notes

SAVE Flashcard

Support - "Let`s work together"

Acknowledge - "This has been hard on you"

Validate - "Most people would feel the way you do"

Emotion naming - "You seem sad"

Patient`s perspective exploration - VIEW Flashcard

Vital activities - " How does this impact your daily life?"
- " How does this disrupt your daily activity?"

Ideas - "What do you think is wrong?"

Expectations - "What are you hoping I can do for you today?"

Worries - "What worries you most about it?"

Dialogue - ARIA Flashcard

Assess using open ended questions
- What the patient knows about diagnosis and treatment
- How much and what type of education the patient desires and/or needs
- Patient treatment preferences
- Health literacy

Reflect patient meaning and emotion

Inform
- Tailor information to patient
- Speak slowly and provide small chunks of information at a time
- Use understandable language and visual aids

Assess patient understanding and emotional reaction to the information provided

The ABCDE Flashcard

Advanced preparation
Review the patient's history, mentally rehearse, and emotionally prepare.
Arrange for a support person if the patient desires.
Determine what the patient knows about his or her illness

B uild a therapeutic environment/relationship
Ensure adequate time and privacy.
Provide seating for everyone.
Maintain eye contact and sit close enough to touch the patient, if appropriate

Communicate well
Avoid medical jargon, and use plain language.
Allow for silence, and move at the patient's pace

Deal with patient and family reactions
Address emotions as they arise.
Actively listen, explore feelings, and express empathy

Encourage and validate emotions
Correct misinformation.
Explore what the bad news means to the patient.
Be cognizant of your emotions and those of your staff

The BREAKS Flashcard

Background
Know the patient`s background, clinical history and family or support person.

Rapport
Build a rapport, and allow time and space to understand the patient`s concerns

Explore
Determine the patient`s understanding, and start from what the patient knows about the illness.

Announce
Preface the bad news with a warning.
Use nonmedical language.
Avoid long explanations or stories of other patients.
Give no more than three pieces of information at a time.

Kindle
Address emotions as they arise.
Ask the patient to recount what you said.
Be aware of denial.

Summarize
Summarize the bad news and the patient`s concerns.
Provide a written summary for the patient.
Ensure patient safety - suicidality, ability to safely drive home, etc.
Provide follow-up options - on call specialist, help-line,etc

The SPIKES Flashcard

Setting	Arrange for a private room or area.Have tissues available.Limit interruptions and silence electronics.Allow the patient to dress (if after examination).Maintain eye contact (defer charting).Include family or friends as patient desires.	“Before we review the results, is there anyone else you would like to be here?”“Would it be okay if I sat on the edge of your bed?”
Perception	Use open-ended questions to determine the patient's understanding.Correct misinformation and misunderstandings.Identify wishful thinking, unrealistic expectations, and denial.	“When you felt the lump in your breast, what was your first thought?”“What is your understanding of your test results thus far?”
Invitation	Determine how much information and detail a patient desires.Ask permission to give results so that the patient can control the conversation.If the patient declines, offer to meet him or her again in the future when he or she is ready (or when family is available)	“Would it be okay if I give you those test results now?”“Are you someone who likes to know all of the details, or would you prefer that I focus on the most important result?”
Knowledge	Briefly summarize events leading up to this point.Provide a warning statement to help lessen the shock and facilitate understanding, although some studies suggest that not all patients prefer to receive a warning.Use nonmedical terms and avoid jargon.Stop often to confirm understanding.	“Before I get to the results, I'd like to summarize so that we are all on the same page.”“Unfortunately, the test results are worse than we initially hoped.”“I know this is a lot of information; what questions do you have so far?”
Emotions	Stop and address emotions as they arise.Use empathic statements to recognize the patient's emotion.Validate responses to help the patient realize his or her feelings are important.Ask exploratory questions to help understand when the emotions are not clear.	“I can see this is not the news you were expecting.”“Yes, I can understand why you felt that way.”“Could you tell me more about what concerns you?”
Strategy and summary	Summarize the news to facilitate understanding.Set a plan for follow-up (referrals, further tests, treatment options).Offer a means of contact if additional questions arise.Avoid saying, “There is nothing more we can do for you.” Even if the prognosis is poor, determine and support the patient's goals (e.g., symptom control, social support).	“I know this is all very frightening news, and I'm sure you will think of many more questions. When you do, write them down and we can review them when we meet again.”“Even though we cannot cure your cancer, we can provide medications to control your pain and lessen your discomfort.”

Handy Phrases - NURSE Flashcard

Naming
"It sounds like you are worried about…"
"I wonder if you are feeling angry."

Understanding
"If I understand what you are saying, you are worried how your treatments will affect your work."
"This has been extremely difficult for you."

Respecting
"This must be a tremendous amount to deal with."
"I am impressed with how well you have handled the treatments."

Supporting
"I will be with you during the treatments."
"Please let me know what I can do to help you."

Exploring
"Tell me more about your concern about the treatment side effects."
"You mentioned you are afraid about how your children will take the news. Can you tell me more about this?"

Bibliography

Turner Sharp PhD, MSN, PMHNP-BC, Michele. 2021. "Workplace Assessing Risk, Promoting Safety". Nursing made Incredibly Easy!. Nursingcenter.Com. https://www.nursingcenter.com/wkhlrp/Handlers/articleContent.pdf?key=pdf_00152258-201501000-00009.

Shulman, Abigail. Feb. 2020. "Mitigating Workplace Violence Via De-Escalation Training". Iahssf.Org. https://iahssf.org/assets/IAHSS-Foundation-De-Escalation-Training.pdf.

Palmer, John. 2019. "Joint Commission Issues De-Escalation Guidebook For Healthcare Facilities And Workers - Patient Safety & Quality Healthcare". Patient Safety & Quality Healthcare. https://www.psqh.com/analysis/joint-commission-issues-de-escalation-guidebook-for-healthcare-facilities-and-workers/.

Appold, Karen. 2015. "De-Escalation Training Prepares Hospitalists To Calm Agitated Patients". The-Hospitalist.Org. https://www.the-hospitalist.org/hospitalist/article/122540/de-escalation-training-prepares-hospitalists-calm-agitated-patients.

"Quick Safety". 2019. The Joint Commission, Division Of Healthcare Improvement 47. https://www.jointcommission.org/-/media/tjc/documents/resources/workplace-violence/qs_deescalation_1_28_18_final.pdf?db=web&hash=DD556FD4E3E4FA13B64E9A4BF4B5458A.

Eilers, Emily. 2021. "CPI's Top 10 De-Escalation Tips". Crisis Prevention Institue. https://www.crisisprevention.com/Blog/CPI-s-Top-10-De-Escalation-Tips-Revisited.

Koul P. A. (2017). Effective communication, the heart of the art of medicine. Lung India : official organ of Indian Chest Society, 34(1), 95–96. https://doi.org/10.4103/0970-2113.197122

Ranjan, P., Kumari, A., & Chakrawarty, A. (2015). How can Doctors Improve their Communication Skills?. Journal of clinical and diagnostic research : JCDR, 9(3), JE01–JE4. https://doi.org/10.7860/JCDR/2015/12072.5712

Payan, Enna, David Montoya, John Vargas, Maria Velez, Alfonso Castano, and Alicia Krikorian. 2009. "Barriers And Facilitating Communication Skills For Breaking Bad News: From The Specialists' Practice Perspective". Scielo.Org.Co. http://www.scielo.org.co/pdf/cm/v40n2/v40n2a3.pdf.

Sánchez Wohlever, Amaryllis. 2019. "How To De-Escalate Troubling Patient Encounters". Blog. FPM Journal. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/incivility_in_the_exam_room.html.

Dance, F. E. X., & Larson, C. E. (1976). The functions of human communication: A theoretical approach. New York: Holt, Rinehart & Winston.

Hauser, G. (1986). Introduction to rhetorical theory. New York: Harper & Row.

Hopper, R., Knapp, M. L., & Scott, L. (1981). Couples' personal idioms: Exploring intimate talk. Journal of Communication, 31, 23–33.

Watzlawick, P., Beavin, J., & Jackson, D. (1967). Pragmatics of human communication: A study of interactional patterns, pathologies and paradoxes. New York: Norton.

Wood, J. T., & Duck, S. W. (Eds.). (2006). Composing relationships: Communication in everyday life. Belmont, CA: Thomson Wadsworth.
Content Source: Boundless. Defining Communication (Links to an external site.).Boundless Management Boundless, 26 May. 2016.

Eight Essential Components of Communication https://sbctc.instructure.com/courses/1367224/pages/read-eight-essential-components-of-communication?module_item_id=21078647

Communication for Business Professionals by eCampusOntario. https://ecampusontario.pressbooks.pub/commbusprofcdn/

"Prachi Juneja" Components of Communication Process https://www.managementstudyguide.com/components-of-communication-process.htm

McLean, S. (2005). The basics of interpersonal communication. Boston, MA: Allyn & Bacon.

Survey of Communication Study. Authored by: Scott T Paynton and Linda K Hahn. Provided by: Humboldt State University. Located at: https://en.wikibooks.org/wiki/Survey_of_Communication_Study. License: CC BY-SA: Attribution-ShareAlike

https://www.skillsyouneed.com/ips/question-types.html - TYPES OF QUESTION
© SkillsYouNeed (2017) Barriers to Effective Communication

Survey of Communication Study. Authored by: Scott T Paynton and Linda K Hahn. Provided by: Humboldt State University. Located at: https://en.wikibooks.org/wiki/Survey_of_Communication_Study. License: CC BY-SA: Attribution-ShareAlike

Argyle, Michael F., Alkema, Florisse, & Gilmour, Robin. "The communication of friendly and hostile attitudes: Verbal and nonverbal signals." European Journal of Social Psychology, 1, 385-402: 1971.

Blumer, Herbert. Symbolic interaction: Perspective and method. Englewood Cliffs; NJ: Prentice Hall. 1969.
Buck, Ross., & VanLear, Arthur. "Verbal and nonverbal communication: Distinguishing symbolic, spontaneous, and pseudo-spontaneous nonverbal behavior." Journal of Communication, 52(3), 522-539: 2002.

Klein, Calvin. 10 Things You Can Tell About Your Date Through Body Language Web 2014 http://www.buzzfeed.com/calvinklein/things-you-can-tell-about-your-date-through-body-language

Burgoon, Judee, et al. "Patterns Of Nonverbal Behavior Associated With Truth And Deception: Illustrations From Three Experiments." Journal Of Nonverbal Behavior 38.3 (2014): 325-354. Communication & Mass Media Complete. Web. 28 Oct. 2014.

Burgoon, Judee K., Buller, David B., Hale, Jerold L., & deTurck, M.A. "Relational Messages Associated With Nonverbal Behaviors." Human Communication Research, 10, 351-378: 1984.

Burgoon, Judee K., Buller, David B., & Woodall, W. Gill. Nonverbal communication: The unspoken dialogue. New York: Harper & Row: 1996.
Dolin, Danielle J., & Booth-Butterfield, Melanie. "Reach out and touch someone: Analysis of nonverbal comforting responses." Communication Quarterly, 41(4), 383-393: 1993.

Edwards, Vanessa Van. "How to Read A Man's Body Language." The Huffington Post. TheHuffingtonPost.com, 30 Jan. 2014.

Ekman, Paul. "Communication through nonverbal behavior: A source of information about an interpersonal relationship." In S. S. Tompkins & C. E. Izard (Eds.), Affect, Cognition, and Personality. New York: Springer: 1965.

Ekman, Paul, & Friesen, Wallace V. “Head and body cues in the judgment of emotion: A reformulation.” Perceptual and Motor Skills, 24, 711-724: 1967.

Floyd, Kory, and Larry A. Erbert. “Relational Message Interpretations Of Nonverbal Matching Behavior: An Application Of The Social Meaning Model.” Journal Of Social Psychology143.5: 581-597: 2003.

Friedman, Howard. “The Interactive Effects of Facial Expressions of Emotion and Verbal Messages on Perceptions of Affective Meaning.” Journal of Experimental Social Psychology, 15.5 (1979): 453-469.

Givens, David B. Head-nod, [Webpage]. Center for Nonverbal Studies. 2000.
Available: http://web.archive.org/20011029115903/members.aol.com/nonverbal3/headnod.htm[2006, April 20th].

Givens, David B. (2000). Head-shake, [Webpage]. Center for Nonverbal Studies. 2000. [2006, April 20th].

Gore, Jonathan. “The Interaction Of Sex, Verbal, And Nonverbal Cues In Same-Sex First Encounters.” Journal Of Nonverbal Behavior 33.4 (2009): 279-299. Communication & Mass Media Complete.

Hall, Cathy W., Chia, Rosina, & Wang, Deng F. “Nonverbal communication among American and Chinese students.”Psychological Reports, 79, 419-428. 1996.

Hall, Edward T. Beyond culture. New York: Doubleday. 1959.

Hall, Edward T. The hidden dimension. New York: Doubleday. 1966.

Hall, Judith A. Nonverbal sex differences: Communication accuracy and expressive style. Baltimore: The Johns Hopkins University Press. 1984.

Harris, Jean A. “Learning To Listen Across Cultural Divides.” Listening Professional 2.14-21 Communication & Mass Media Complete. 2003.

Horchak Oleksandr V, Jean-Chrisophe Giger, and Grzegorz Pochwatko. “Simulation of Metaphorical Actions and Discourse Comprehension.” Metaphor and Symbol, 29.1 (2014): 1-22.

Kalbfleisch, Pamela. “Deceit, Distrust, and Social Milieu: Applications of deception research in a troubled world.” Journal of Applied Communication Research, 308-334. 1992.

Kirsh, Steven, Jeffrey Mounts, and Paul Olczak. “Violent Media Consumption and the Recognition of Dynamic Facial Expressions.” Journal Of Interpersonal Violence 21.5 (2006): 571-584. Available from: ERIC.

Knapp, Mark L. Essentials of nonverbal communication. New York: Holt, Rinehart & Winston. 1980. (2nd ed. With J. Hall 1992) Print.

Le Poire, Beth, Ashley Duggan, Carolyn Shepard, and Judee Burgoon. Relational Messages Associated with Nonverbal Involvement, Pleasantness, and Expressiveness in Romantic Couples. Taylor & Francis. Taylor & Francis Online, 06 June 2009.

Levine, Robert. A Geography of Time: The Temporal Misadventures of a Social Psychologist, or How Every Culture Keeps Time Just a Little Bit Differently. New York: BasicBooks, 1997. Print

Levine, Timothy, Thomas Feeley, and Steven McCornack. “Testing the Effects of Nonverbal Behavior Training on Accuracy in Deception Detection with the Inclusion of a Bogus Training Control Group.” Western Journal of Communication, 69.3 : 203-217: 2005.

Malandro, Loretta. A., & Barker, Larry. Nonverbal Communication. Reading, MA: Addison-Wesley. 1983. Print.

May, Sarah T. “Proxemics: The Hula Hoop And Use Of Personal Space.” Communication Teacher 14.2 (2000): 4-5. Communication & Mass Media Complete. Web. 28 Oct. 2014.

Mead, George. H. Mind, Self, and Society. Chicago: University of Chicago Press. (1934) Print.

Mehrabian, Alabert. Silent Messages: Implicit Communication of Emotion and Attitudes (2nd ed.). Belmont, CA: Wadsworth. (1981) Print.

Motley, Mark. T. “Facial Affect and Verbal Context in Conversation: Facial Expression as Interjection.” Human Communication Research, 20 (1), 3-40 (1993) Print.

Park, Hee Sun., Levine, Timothy. R., McCornack, Steven. A., Morrison, Kelly., & Ferrara, Merrissa. “How People Really Detect Lies.” Communication Monographs,69(2), 144-157. 2002: Print.

"Restaurants See Color As Key Ingredient." tribunedigital-chicagotribune. N.p., n.d. Web. 11 Aug. 2015.

Sallinen-Kuparinen, Aino. "Teacher Communicator Style." Communication Education, 41, 153-166. 1992. Print.
Schachner, Dory., Shaver, Philip., & Mikulincer, Mmario. "Patterns of Nonverbal Behavior and Sensitivity in the Context of Attachment Relationships." Journal of Nonverbal Behavior, 29(3), 141-169. 2005.

Scherer, Klaus, and Ursula Scherer. "Assessing The Ability To Recognize Facial And Vocal Expressions Of Emotion: Construction And Validation Of The Emotion Recognition Index." Journal Of Nonverbal Behavior 35.4 (2011): 305-326. Communication & Mass Media Complete. Web. 28 Oct. 2014.

Shutiva, Charmaine. "Native American culture and communication through humor." Our voices: Essays in culture, ethnicity, and communication, an intercultural anthology (1994): 117-121.

Sternglanz, R. Weylin., & Depaulo, Bella. M. "Reading Nonverbal Cues to Emotion: The Advantages and Reliabilities of Relationship Closeness." Journal of Nonverbal Behavior, 28(4), 245-266. 2004.

Tracy, Jessica L., and Richard W. Robins. "The Nonverbal Expression Of Pride: Evidence For Cross-Cultural Recognition."Journal Of Personality & Social Psychology 94.3 (2008): 516-530. Communication & Mass Media Complete. Web. 28 Oct. 2014.

Vrij, Aldert., Akehurst, Lucy., Soukara, Stavroula., & Bull, Ray. "Detecting Deceit via Analyses of Verbal and Nonverbal Behavior in Children and Adults." Human Communication Research, 30(1), 8-41. 2004.

Vrij, Aladert., Edward, Katherine., Roberts, Kim., & Bull, Ray. "Detecting Deceit via Analysis of Verbal and Nonverbal Behavior." Journal of Nonverbal Behavior, 24(4), 239-263. 2000.

Wilson, Steven R., et al. "Mothers' Trait Verbal Aggressiveness As A Predictor Of Maternal And Child Behavior During Playtime Interactions." Human Communication Research 34.3 (2008): 392-422. Communication & Mass Media Complete.

http://www.analytictech.com/mb021/cultural.htm. Image Proxemics zones as defined by Hall by Hamid Laga et al., Tokyo Institute of Technology

Hall, Edward T. (1966). The Hidden Dimension. Anchor Books. ISBN 978-0-385-08476-5.

^ Hall, Edward T. (October 1963). "A System for the Notation of Proxemic Behavior". American Anthropologist. 65 (5): 1003–1026.

How does your culture affect your attitude to personal space? Sep 25, 2020 https://www.loteagency.com.au/how-does-your-culture-affect-personal-space/

Engholm, C. 1991. When business East meets business West: A guide to practice and protocol in the Pacific Rim. NY: Wiley. – 136.

Graham, John. (1985). The Influence of Culture on the Process of Business Negotiations: An Exploratory Study. Journal of International Business Studies.

Hall, E. T. (1966). The hidden dimension. New York, NY: Doubleday.

Hall, E. T. (October 1963). “A System for the Notation of Proxemic Behavior”. American Anthropologist. 65 (5).

Nydell, M. K. (1987). Understanding Arabs: A guide for Westerners. – 44.

Verluyten, S. (2012). Intercultural Skills for International Business and International Relations. Leuven, Belgium: Acco.

Sorokowska, Agnieszka & Sorokowski, Piotr & Hilpert, Peter & Cantarero, Katarzyna & Frackowiak, Tomasz & Ahmadi, Khodabakhsh & Alghraibeh, Ahmad & Aryeetey, Richmond & Bertoni, Anna & Bettache, Karim & Blumen, Sheyla & Błażejewska, Marta & Soares Bortolini, Tiago & Butovskaya, Marina & Castro, Felipe & Cetinkaya, Hakan & Cunha, Diana & David, Daniel & David, Oana & D., Pierce,. (2017). Preferred Interpersonal Distances: A Global Comparison. Journal of Cross-Cultural Psychology. 48. 002202211769803. 10.1177/0022022117698039.

Researchers quantified how close is too close to get to another person in different countries around the world - https://qz.com/956391/the-global-guide-to-getting-all-up-in-someones-personal-space/

The Washington post, Amanda Erckson What ‘personal space’ looks like around the world. April 24, 2017 at 1:00 p.m. GMT+3 https://www.washingtonpost.com/news/worldviews/wp/2017/04/24/how-close-is-too-close-depends-on-where-you-live/

Allmendinger, K., "Social Presence in Synchronous Virtual Learning Situations: The Role of Nonverbal Signals Displayed by Avatars," Educational Psychology Review 22, no. 1 (2010): 42.

Andersen, P. A., Nonverbal Communication: Forms and Functions (Mountain View, CA: Mayfield, 1999), 36.

Baylor, A. L., "The Design of Motivational Agents and Avatars," Educational Technology Research and Development 59, no. 2 (2011): 291–300.

Buller, D. B. and Judee K. Burgoon, "The Effects of Vocalics and Nonverbal Sensitivity on Compliance," Human Communication Research 13, no. 1 (1986): 126–44.

Evans, D., Emotion: The Science of Sentiment (New York: Oxford University Press, 2001), 107.

Floyd, K., Communicating Affection: Interpersonal Behavior and Social Context(Cambridge: Cambridge University Press, 2006), 33–34.

Fox, J. and Jeremy M. Bailenson, "Virtual Self-Modeling: The Effects of Vicarious Reinforcement and Identification on Exercise Behaviors," Media Psychology 12, no. 1 (2009): 1–25.

Guerrero, L. K. and Kory Floyd, Nonverbal Communication in Close Relationships(Mahwah, NJ: Lawrence Erlbaum, 2006): 176.
Hall, E. T., "Proxemics," Current Anthropology 9, no. 2 (1968): 83–95.

Hargie, O., Skilled Interpersonal Interaction: Research, Theory, and Practice, 5th ed. (London: Routledge, 2011), 63.

Heslin, R. and Tari Apler, "Touch: A Bonding Gesture," in Nonverbal Interaction, eds. John M. Weimann and Randall Harrison (Longon: Sage, 1983), 47–76.

Jones, S. E., "Communicating with Touch," in The Nonverbal Communication Reader: Classic and Contemporary Readings, 2nd ed., eds. Laura K. Guerrero, Joseph A. Devito, and Michael L. Hecht (Prospect Heights, IL: Waveland Press, 1999).

Kim, C., Sang-Gun Lee, and Minchoel Kang, "I Became an Attractive Person in the Virtual World: Users' Identification with Virtual Communities and Avatars," Computers in Human Behavior, 28, no. 5 (2012): 1663–69

Kravitz, D., “Airport ‘Pat-Downs’ Cause Growing Passenger Backlash,” The Washington Post, November 13, 2010, accessed June 23, 2012, http://www.washingtonpost.com/wp-dyn/content/article/2010/11/12/AR2010111206580.html?sid=ST2010113005385.

Martin, J. N. and Thomas K. Nakayama, Intercultural Communication in Contexts, 5th ed. (Boston, MA: McGraw-Hill, 2010), 276.

McKay, M., Martha Davis, and Patrick Fanning, Messages: Communication Skills Book, 2nd ed. (Oakland, CA: New Harbinger Publications, 1995), 59.

Pease, A. and Barbara Pease, The Definitive Book of Body Language (New York, NY: Bantam, 2004), 121.

Strunksy, S., “New Airport Service Rep Is Stiff and Phony, but She’s Friendly,” NJ.COM, May 22, 2012, accessed June 28, 2012, http://www.nj.com/news/index.ssf/2012/05/new_airport_service_rep_is_sti.html.

Tecca, “New York City Airports Install New, Expensive Holograms to Help You Find Your Way,” Y! Tech: A Yahoo! News Blog, May 22, 2012, accessed June 28, 2012, http://news.yahoo.com/blogs/technology-blog/york-city-airports-install-expensive-holograms-help-way-024937526.html.

Thomas, A. R., Soft Landing: Airline Industry Strategy, Service, and Safety (New York, NY: Apress, 2011), 117–23.

Communication in the Real World by University of Minnesota, https://open.lib.umn.edu/communication/chapter/4-2-types-of-nonverbal-communication/

https://www.tutorialspoint.com/effective_communication/effective_communication_introduction.htm - Effective Communication - Introduction

Allmendinger, K., “Social Presence in Synchronous Virtual Learning Situations: The Role of Nonverbal Signals Displayed by Avatars,” Educational Psychology Review 22, no. 1 (2010): 42.

Andersen, P. A., Nonverbal Communication: Forms and Functions (Mountain View, CA: Mayfield, 1999), 36.

Baylor, A. L., “The Design of Motivational Agents and Avatars,” Educational Technology Research and Development 59, no. 2 (2011): 291–300.

Buller, D. B. and Judee K. Burgoon, “The Effects of Vocalics and Nonverbal Sensitivity on Compliance,” Human Communication Research 13, no. 1 (1986): 126–44.

Evans, D., Emotion: The Science of Sentiment (New York: Oxford University Press, 2001), 107.

Floyd, K., Communicating Affection: Interpersonal Behavior and Social Context(Cambridge: Cambridge University Press, 2006), 33–34.

Fox, J. and Jeremy M. Bailenson, “Virtual Self-Modeling: The Effects of Vicarious Reinforcement and Identification on Exercise Behaviors,” Media Psychology 12, no. 1 (2009): 1–25.

Guerrero, L. K. and Kory Floyd, Nonverbal Communication in Close Relationships(Mahwah, NJ: Lawrence Erlbaum, 2006): 176.
Hall, E. T., “Proxemics,” Current Anthropology 9, no. 2 (1968): 83–95.

Hargie, O., Skilled Interpersonal Interaction: Research, Theory, and Practice, 5th ed. (London: Routledge, 2011), 63.

Heslin, R. and Tari Apler, “Touch: A Bonding Gesture,” in Nonverbal Interaction, eds. John M. Weimann and Randall Harrison (Longon: Sage, 1983), 47–76.

Jones, S. E., “Communicating with Touch,” in The Nonverbal Communication Reader: Classic and Contemporary Readings, 2nd ed., eds. Laura K. Guerrero, Joseph A. Devito, and Michael L. Hecht (Prospect Heights, IL: Waveland Press, 1999).

Kim, C., Sang-Gun Lee, and Minchoel Kang, “I Became an Attractive Person in the Virtual World: Users’ Identification with Virtual Communities and Avatars,” Computers in Human Behavior, 28, no. 5 (2012): 1663–69

Kravitz, D., “Airport ‘Pat-Downs’ Cause Growing Passenger Backlash,” The Washington Post, November 13, 2010, accessed June 23, 2012, http://www.washingtonpost.com/wp-dyn/content/article/2010/11/12/AR2010111206580.html?sid=ST2010113005385.

Martin, J. N. and Thomas K. Nakayama, Intercultural Communication in Contexts, 5th ed. (Boston, MA: McGraw-Hill, 2010), 276.

McKay, M., Martha Davis, and Patrick Fanning, Messages: Communication Skills Book, 2nd ed. (Oakland, CA: New Harbinger Publications, 1995), 59.

Pease, A. and Barbara Pease, The Definitive Book of Body Language (New York, NY: Bantam, 2004), 121.

Strunksy, S., "New Airport Service Rep Is Stiff and Phony, but She's Friendly," NJ.COM, May 22, 2012, accessed June 28, 2012, http://www.nj.com/news/index.ssf/2012/05/new_airport_service_rep_is_sti.html.

Tecca, "New York City Airports Install New, Expensive Holograms to Help You Find Your Way," Y! Tech: A Yahoo! News Blog, May 22, 2012, accessed June 28, 2012, http://news.yahoo.com/blogs/technology-blog/york-city-airports-install-expensive-holograms-help-way-024937526.html.

Thomas, A. R., Soft Landing: Airline Industry Strategy, Service, and Safety (New York, NY: Apress, 2011), 117–23.

Andersen, P. A., Nonverbal Communication: Forms and Functions (Mountain View, CA: Mayfield, 1999), 125.

DePaulo, P. J., "Applications of Nonverbal Behavior Research in Marketing and Management," Applications of Nonverbal Behavior Theories and Research, ed. Robert S. Feldman (Hillsdale, NJ: Lawrence Erlbaum, 1992), 64.

Goffman, E., Relations in Public: Microstudies of the Public Order (New Brunswick, NJ: Transaction Publishers, 2010), 322–31.

Hargie, O., Skilled Interpersonal Interaction: Research, Theory, and Practice, 5th ed. (London: Routledge, 2011), 81.

McKay, M., Martha Davis, and Patrick Fanning, Messages: Communication Skills Book, 2nd ed. (Oakland, CA: New Harbinger Publications, 1995), 54.

Metts, S. and Sally Planlap, "Emotional Communication," in Handbook of Interpersonal Communication, 3rd ed., eds. Mark L. Knapp and Kerry J. Daly (Thousand Oaks, CA: Sage, 2002): 339–73.

Mottet, T. P., Steven A. Beebe, Paul C. Raffeld, and Michelle L. Paulsel, "The Effects of Student Verbal and Nonverbal Responsiveness on Teachers' Liking of Students and Willingness to Comply with Student Requests," Communication Quarterly 52, no. 1 (2004): 27–38.

Pease, A. and Barbara Pease, The Definitive Book of Body Language (New York, NY: Bantam, 2004), 21.

Riggio, R. E., “Social Interaction Skills and Nonverbal Behavior,” in Applications of Nonverbal Behavior Theories and Research, ed. Robert S. Feldman (Hillsdale, NJ: Lawrence Erlbaum, 1992), 23.

"What Is Visual Communication? - Definition, History, Theory & Examples." Study.com. August 17, 2016. https://study.com/academy/lesson/what-is-visual-communication-definition-history-theory-examples.html.

Contents of Functional Areas of the Cerebral Cortex
https://cdn.citl.illinois.edu/courses/PSYCH100/chapter3/pt3-html/web_data/file7contents.htm

Why your brain loves visual information
Author: Chloe Edgley | Posted on: 30 May 2018

Show, don’t tell: how visuals improve healthcare visits Apr 23, 2017·9 min read By Katie McCurdy and Chethan Sarabu, MD

Why Your Brain Loves Visual Content [Infographic]
by Katy French

What Is Visual Communication and Why Is It Important ,Brian Nuckols
https://visme.co/blog/visual-communication/

Written Communication - Meaning, Advantages and Disadvantages
“Prachi Juneja” and Reviewed By Management Study Guide Content Team.
https://www.managementstudyguide.com/written-communication.htm

Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., Hallaert, G., Van Daele, S., Buylaert, W., & Vogelaers, D. (2015). Communication in healthcare: a narrative review of the literature and practical recommendations. International journal of clinical practice, 69(11), 1257–1267. https://doi.org/10.1111/ijcp.12686

Written Communication Skills: Definitions and Examples
November 25, 2020
https://www.indeed.com/career-advice/career-development/written-communication-skills

The Generational Cheat Sheet – Best Ways To Communicate With Each One
Posted on August 12, 2019, updated on September 9, 2019 by Janice Zaltman
https://www.formsimplicity.com/uncategorized/generational-cheat-sheet/

The Business Leader's Guide To Communication Across Generations.David Galowich.Forbes Councils Member. Forbes Coaches Council COUNCIL POST| Membership (fee-based) https://www.forbes.com/sites/forbescoachescouncil/2018/07/16/the-business-leaders-guide-to-communication-across-generations/?sh=513e445d6656

Communication Barriers.What is Communication?.http://phicare.com/competencies/communicationbarriers.php

14 Communication Strategies to Overcome Communication Barriers in the Workplace.November 25, 2020
https://www.indeed.com/career-advice/career-development/communication-strategies

8 Communication Skills to Overcome the Generation Gap
Elizabeth Andal https://www.lifehack.org/articles/communication/8-communication-skills-overcome-the-generation-gap.html

Ratna H. The importance of effective communication in healthcare practice. Harvard Public Health Review. 2019;23.
GREGG K. VANDEKIEFT, M.D., Michigan State University College of Human Medicine, East Lansing, Michigan. Am Fam Physician. 2001 Dec 15;64(12):1975-1979.

World Health Organization. (2003) Adherence to long-term therapies: Evidence for action. Switzerland: WHO Library Cataloguing. World Health Organization

Team strategies and tools to enhance performance and patient safety (TeamSTEPPS), Department of Defense and Agency for Healthcare Research and Quality http://www.ahrq.gov/qual/teamstepps/

Beckman, H. B., Markakis, K. M., Suchman, A. L., & Frankel, R. M. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Archives of Internal Medicine, 154(12) 1365-1370. pubmed

Impact of Communication in Healthcare July 2011 Institute for Healthcare Communication
https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/

Pacak K, Palkovits M, Kopin IJ, Goldstein DS. Stress- induced norepinephrine release in the hypothalamic paraventricular nucleus and pituitary-adrenocortical and sympathoadrenal activity: in vivo microdialysis studies. Front Neuroendocrinol. 1995;16(2):89-150. Available from: http://dx.doi.org/10.1006/frne.1995.1004

SIX BARRIERS TO CROSS-CULTURAL COMMUNICATIONS (PART 2 OF 3)
Déclic International / Cultural intelligence / Six barriers to cross-cultural communications (Part 2 of 3) 2018, https://declicinternational.com/6-barriers-to-cross-cultural-communications/

Cultural Barriers of Communication
in COMMUNICATION BARRIERS https://www.communicationtheory.org/cultural-barriers/

Ali M (2017) Communication skills 2: overcoming barriers to effective communication Nursing Times; 114: 1, 40-42. https://www.nursingtimes.net/clinical-archive/assessment-skills/communication-skills-2-overcoming-the-barriers-to-effective-communication-18-12-2017/

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of Language Barriers for Healthcare: A Systematic Review. Oman medical journal, 35(2), e122. https://doi.org/10.5001/omj.2020.40

What are the Barriers to Effective Healthcare Communication?
Posted by Todd Macey on Tue, Dec 20, 2016 @ 1:57 PM
https://www.vital-learning.com/blog/barriers-healthcare-communication

File:Effective Communication Cycle.jpg. (2014, November 18). Physiopedia, . Retrieved 14:34, March 10, 2021 from https://www.physio-pedia.com/index.php?title=File:Effective_Communication_Cycle.jpg&oldid=102189.

CHICAGO: Physiopedia contributors, "File:Effective Communication Cycle.jpg," Physiopedia, , https://www.physio-pedia.com/index.php?title=File:Effective_Communication_Cycle.jpg&oldid=102189(accessed March 10, 2021).

Physiopedia contributors, https://www.physiopedia.com/index.php?title=File:Effective_Communication_Cycle.jpg&oldid=102189

Physiopedia contributors, "File:Benefits of Effective Communication Table.jpg," Physiopedia, , https://www.physio-pedia.com/index.php?title=File:Benefits_of_Effective_Communication_Table.jpg&oldid=102732 (accessed March 10, 2021).

Health Literacy: How to Communicate with Your Healthcare Team
https://www.hss.edu/conditions_health-literacy-tips-improve-communication-with-healthcare-team.asp by Juliette Kleinman, LCSW, ACSW

Physiopedia contributors, "File:Barriers.jpg," Physiopedia, ,https://www.physio-pedia.com/index.php?title=File:Barriers.jpg&oldid=103377 (accessed March 10, 2021).

Ali M (2017) Communication skills 2: overcoming barriers to effective communication Nursing Times; 114: 1, 40-42.

Keefe-Cooperman, K., Savitsky, D., Koshel, W. et al. The PEWTER Study: Breaking Bad News Communication Skills Training for Counseling Programs. Int J Adv Counselling 40, 72–87 (2018). https://doi.org/10.1007/s10447-017-9313-z

R Buckman 1992 How to Break Bad News, Paperback ISBN 0-333 54564-7
Commincating with Dying People and their Relatives by Jean Lugton, Radcliffe Medical Press, 2002, ISBN 1 85775 584 7 £19.95

HFH Competence and Compassion End of Life Care Map

BMJ 2020; 369 doi: https://doi.org/10.1136/bmj.m1876(Published 12 May 2020)Cite this as: BMJ 2020;369:m1876

BMA Tough calls – how best to break bad news Published: Wednesday 10 June 2020
https://www.bma.org.uk/news-and-opinion/tough-calls-how-best-to-break-bad-news

Nursing times, Communication skills 2: overcoming the barriers to effective communication
https://www.nursingtimes.net/clinical-archive/assessment-skills/communication-skills-2-overcoming-the-barriers-to-effective-communication-18-12-2017/ 18 DECEMBER, 2017

Norouzinia, R., Aghabarari, M., Shiri, M., Karimi, M., & Samami, E. (2015). Communication Barriers Perceived by Nurses and Patients. Global journal of health science, 8(6), 65–74. https://doi.org/10.5539/gjhs.v8n6p65

Zielińska, Paulina & Jarosz, Magdalena & Kwiecińska, Agnieszka & Bętkowska-Korpała, Barbara. (2017). Main communication barriers in the process of delivering bad news to oncological patients - medical perspective. Folia medica Cracoviensia. 57. 101-112.

Sobczak K, Leoniuk K, Janaszczyk A. Delivering bad news: patient's perspective and opinions. Patient Prefer Adherence. 2018;12:2397-2404 https://doi.org/10.2147/PPA.S183106

VandeKieft GK. Breaking bad news. Am Fam Physician. 2001 Dec 15;64(12):1975-8. PMID: 11775763.

Koul P. A. (2017). Effective communication, the heart of the art of medicine. Lung India : official organ of Indian Chest Society, 34(1), 95–96. https://doi.org/10.4103/0970-2113.197122

January 2010, Breaking Bad News: Effect Of Physician Communication On Analog Patients' Response, Emily Porensky, Washington University in St. Louis

Ameritech College of Healthcare, A HEALTHCARE PROFESSIONAL'S GUIDE TO CLEAR PATIENT COMMUNICATION https://www.ameritech.edu/blog/clear-patient-communication-guide/

Baile, W.F., Buckman, R., Lenzi, R., Glober, G., Beale, E.A. and Kudelka, A.P. (2000), SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. The Oncologist, 5: 302-311. https://doi.org/10.1634/theoncologist.5-4-302

Old J. Communicating bad news to your patients. Fam Pract Manag. 2011 Nov-Dec;18(6):31-5. PMID: 22150733.

Rosenzweig M. Q. (2012). Breaking bad news: a guide for effective and empathetic communication. The Nurse practitioner, 37(2), 1–4. https://doi.org/10.1097/01.NPR.0000408626.24599.9e

How Effective Communication Can Save Lives in the Healthcare Industry
Posted by PCC Institute for Health Professionals on January 25, 2016
https://climb.pcc.edu/blog/how-effective-communication-can-save-lives-in-the-healthcare-industry

Prado AJF, Silva EA, Almeida VA, Fráguas Júnior R. Ambiente médico: o impacto da má notícia em pacientes e médicos – em direção a um modelo de comunicação mais efetivo / Medical environment: bad news' impact on patients and doctors – towards an effective model of communication. Rev Med (São Paulo). 2013 jan.-mar.;92(1):13-24.

Institute for healthcare communication - Impact of Communication in Healthcare https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/

Communication Skills Training for Physicians Improves Patient Satisfaction
Adrienne Boissy, MD, MA1, Amy K. Windover, PhD1, Dan Bokar1, Matthew Karafa, PhD2,
Katie Neuendorf, MD1, Richard M. Frankel, PhD1,3, James Merlino, MD4, and Michael B. Rothberg, MD, MPH5
1Office of Patient Experience, Center for Excellence in Healthcare Communication, Cleveland Clinic, Cleveland, OH, USA; 2Quantitative Health Sciences, Cleveland Clinic, Cleveland, OH, USA; 3Indiana University School of Medicine, Indianapolis, IN, USA; 4Press Ganey Associates, Inc., Chicago, IL, USA; 5Center for Value-Based Care Research, Medicine Institute, Cleveland Clinic, Cleveland, OH, USA.

Difficulties experienced by nurses, doctors and allied healthcare professionals when communicating bad news, Clare Warnock, Jean Buchanan, Sister Angela Tod, Cathy Soreny, Julie Foster

¿Cómo comunicar malas noticias a nuestros pacientes y no morir en el intento?
ALBERTO E. ALVES DE LIMA http://www.hospital-sanjuandedios.es/upload/cuidando/doc/como_comunicar_malas_noticias.pdf

"An Overview Of Communication". 2021. Catalogue.Pearsoned.Ca.
http://catalogue.pearsoned.ca/assets/hip/us/hip_us_pearsonhighered/samplechapter/0205943667.pdf

Choe, E. K., Duarte, M. E., Suh, H., Pratt, W., & Kientz, J. A. (2019). Communicating Bad News: Insights for the Design of Consumer Health Technologies. JMIR human factors, 6(2), e8885. https://doi.org/10.2196/humanfactors.8885

Monden, K. R., Gentry, L., & Cox, T. R. (2016). Delivering bad news to patients. Proceedings (Baylor University. Medical Center), 29(1), 101–102. https://doi.org/10.1080/08998280.2016.11929380

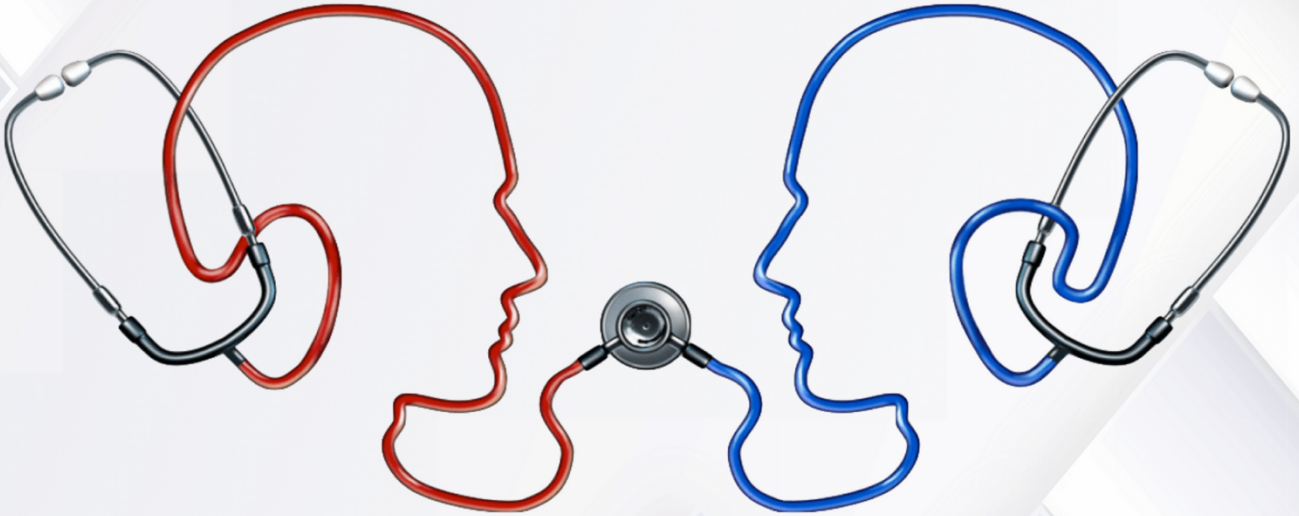
Ratna H. The importance of effective communication in healthcare practice. Harvard Public Health Review. 2019;23.

Luck, Lauretta, Debra Jackson, and Kim Usher. “STAMP: Components of Observable Behaviour That Indicate Potential for Patient Violence in Emergency Departments.” Journal of Advanced Nursing 59, no. 1 (2007): 11–19. doi:10.1111/J.1365-2648.2007.04308.X.

"Practice Development Improving Patient And Staff Safety". 2021. Rcpsych.Ac.Uk. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/reducing-restrictive-practice/resources/dasa-information.pdf?sfvrsn=d779798b_2.

MacDonald, Dustin K. 2021. "Dynamic Appraisal Of Situational Aggression (DASA) - Dustin K Macdonald". Dustin K Macdonald. http://dustinkmacdonald.com/dynamic-appraisal-situational-aggression-dasa/.

The Broset Violence checklist ,The Linaker & Bush Iversen, 1995. Almvik & Woods, 2000, http://riskassessment.no/files/BVC-English-version.pdf



Bad News Communication Protocols

in the Medical Field

Erasmus+

This project (2019-1-RO01-KA202-064021) has been funded with support from the European Commission. This publication reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information contained therein