REVIEW ARTICLE

Professional communication competences of nurses – a review of current practice and educational problems

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▌ Abstract

Background: A dissonance between high 'technical' professionalism of nurses and a relatively low level of patient satisfaction with received care is a phenomenon observed in many countries.

Method: Theoretical concept and review of current published studies.

Discussion: Most reviewed studies show that a low level of patient satisfaction occurs in the case of an inadequate interpersonal communication between nurses and patients. Most studies indicate poor effectiveness of shaping communication competences of nurses based on standard education in the area of general psychology and communication knowledge, because this knowledge does not convert itself 'spontaneously' into communication competences during occupational activity.

Conclusions: It is necessary to supplement educational programmes for nurses with practical courses in professional interpersonal communication. International experience exchange concerning the shaping of nurses' communication competences may be limited due to cultural, organizational and systems factors.

▌ Key words

nursing, interpersonal communication, education, patient satisfaction

INTRODUCTION

In our Age, nursing is understood as care of an individual from conception to dignified death. An important competence of a nurse, apart from performing medical procedures, is taking care of patients by showing concern, supporting with a 'good word', i.e. offering things which bring relief in suffering. The cooperation of nursing education institutions in different countries should consist at least in the exchange of information and experiences in order to bring into line the standards of education and obtaining qualifications, also with respect to professional communication competences of nurses.

In the UK, according to the publication of the new Nursing and Midwifery Council (NMC) standards for pre-registration nursing education, undergraduate curricula are being written in universities. Technical competence, knowledge and willingness to search for information are required, but overwhelmingly 'a caring professional attitude' is being prioritized. This is articulated as empathy, communication skills and non-judgmental patient-centred care – major themes in the new NMC standards [1].

Plans to implement a quality measurement framework that will allow nurses to be rated according to the level of care and compassion they demonstrate (the emotional capacities of empathy and sympathy for the suffering of others) have been proposed recently and discussed in a number of the UK

Department of Health documents [2]. Similarly, in the USA, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a national standardized survey instrument designed to assess the patient's perspective of hospital care. One of the key measures, 'communication with nurses', can directly affect both patient satisfaction and patient safety scores [3].

Nurses often face the problem of how to serve patients, respect their dignity and rights while using modern medical technologies which often dehumanize the object of a nurse's actions – making the patient an object of technical medical interventions. Also, approaching the medical sector primarily or exclusively in the market categories may intensify the phenomenon of patient depowerment and dehumanization making him/her an object of transaction, i.e. 'a client'.

Unfortunately, a similar phenomenon affects the societies which selected a social (budget-bureaucratic) model of health care system. In this model, a person who is ill, while assuming the role of a patient, may be treated as a 'bothersome' petitioner in an office. Thus, the problem of a proper relationship – patient-medical professional – is equally important in the countries which have undergone or are undergoing political transformation towards a free market economy, or are at the phase of subsequent reform of the health care system in the direction of market-driven or planned economy.

In a similar context, D. Sturgeon discussed how the adoption of targets to evaluate care and compassion seems to reflect a market-driven or bureaucratic approach to health care, resulting in a system in which measurability and outcome are considered the most important indicators of quality [2]. Such a situation negatively affects not only the performance of the

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profession and fulfilling the role of a nurse, but also exerts an unfavourable effect on those who are ill in their fulfilment of the role of patients. Therefore, the construction of procedural (technical) qualifications of nurses must be accompanied by developing communication competences indispensable for adequate, empathic relationships with others [4].

The extent to which this emphatic 'sensitization' exists and the level of nurses' professionalism is evaluated today by the patients, and the care cannot be considered as being of high quality unless the patient is satisfied [5]. Obviously, it is relatively difficult to define what patient satisfaction is. It is certain that it comes from the realm of subjectivity which, however, does not in any way decrease its importance in the shaping of the professional attitudes of nurses. The perception of this relationship exerts a very significant effect on the planning of patient care, and more comprehensively, on education in this respect of the students of nursing and improvement of the nursing staff already performing the profession. A patient's sense of satisfaction from the care received has very many sources, including previous contacts with medical professionals, course of the disease, behaviours related with the feeling of helplessness and impotence, self-evaluation, level of support from significant others, religious beliefs, or general attitude towards life. Considering the communication skills in the work of a nurse, as well as in education in this profession, facilitates work and at the same time, elevates the level of both nurse and patient satisfaction which, in turn, affects the level of a patient's activity in the process of treatment and the intensity of cooperation with a nurse. As a result, this all translates into the ultimate effectiveness of a medical intervention [6].

THEORETICAL BACKGROUND

In nursing, similarly to other domains, three scopes of competences contribute to the professionalism in the area of communication: 1) motivation, 2) knowledge and 3) skills.

Motivation biases the behaviour of an individual towards the achievement of specified states of affairs which are important for this individual. The motivation process consists of a set of individual motives. A motive may be termed an experience stimulating an individual to action, or refraining from or hindering its performance. Communication motivation is an inspiration, engagement and encouragement to contact with others (patients or co-workers). By its definition, communication encompasses respect, tolerance for dissimilarity, respect for rights, and non-violation of another person's limits.

Knowledge of interpersonal communication covers contents concerning what should be said or done in specified situations, as well as procedures based on which these contents will be introduced into practice. It is necessary to recognize the complexity of interpersonal contacts; however, only its adequate application in practice makes a person communicatively competent [7, 8]. Communication knowledge, although indispensable for a basic recognition of the scope of communication problems, is poorly occupationally useful for nurses if not accompanied by skills.

Communication **skills** include, among other things,

emotional intelligence, i.e. personal competences of an individual, understood as skills of recognizing own emotional states and the emotional states of others, as well as skills of using own emotions and coping with emotional states of others which, in spite of the common opinion, may be trained and developed. Three main models of emotional intelligence delineate the scope of communication skills. Emotional intelligence covers the capability of understanding oneself and one's own emotions, managing and controlling these emotions, capability for self-motivation, empathy and skills of a social character. Peter Salovey et al. mention four spheres contributing to emotional intelligence: perception of emotions, supporting thinking by means of emotions, understanding emotions and regulating emotions [9].

According to Rauven Baron, emotional intelligence consists of five components: intrapersonal intelligence, interpersonal intelligence, coping with stress and capability for adaptation and general mood [8].

Within emotional intelligence it is recommended that nurses should be educated, among other things, in three main groups of competences:

1. Psychological competences (relations with oneself, i.e. skills from the scope of intrapersonal intelligence):
- self-awareness: skills of recognizing own emotional states, knowledge of own feelings, values, preferences, possibilities and intuitive assessments, i.e. emotional awareness;
- self-evaluation: self-esteem, self-confidence, awareness of own capabilities, skills and one's own limitations; skills of experiencing oneself irrespective of the judgements of others;
- self-control and self-regulation: skills of consciously reacting to external stimuli and regulation of own emotional states; skill of coping with stress, shaping own emotions according to oneself, with own standards, principles and adopted values.

2. Social competences (relations with others, i.e. skills from the scope of interpersonal communication):
- empathy: skills of understanding the emotional states of others, becoming aware of their feelings, needs and adopted values, i.e. the understanding of others, sensitivity to their sensations; attitude biased towards providing assistance and supporting others; capability for perceiving and understanding social relations;
- assertiveness: possessing and expressing one's own opinion, and direct, open expression of emotions, attitudes and adopted values within limits which do not violate the rights and psychical territory of others; capability for defending own rights without violation of the rights of others to defend them;
- persuasion: skills of rousing in others the desired behaviours and reactions, i.e. exerting an effect on others; skills of winning others over on behalf of agreement, skills of alleviating conflicts (necessary in health promoting education);
- leadership: capability to create visions and stimulate human motivation for their performance; capability to win over followers.
- cooperation: capability for relationship building and cooperation with others, team working skills on behalf of the achievement of common goals, skills of collective performance of tasks and mutual problem solving.

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3. Praxeological competences (in other terms acting competences – our relation to tasks, challenges and actions):
- motivation: own involvement, emotional predispositions which lead to new goals or facilitate their achievement, i.e. striving towards achievements, initiative and optimism;
- adaptation skills: skills of managing one's own internal states; skills of coping in a changing environment, flexibility in adjustment to changes in the surroundings, capability for acting and undertaking decisions under stress;
- conscientiousness: capability of assuming responsibility for tasks and their performance; skills of drawing satisfaction from the duties performed; consistency in acting, in concordance with self-adopted standards.

Other concepts associated with medical professional interpersonal competences which are worth mentioning are: moral imagination, accord and trust, and 'therapeutic emplotment'.

Skilled communication in medical practice requires students to move beyond simply learning superficial communication techniques and behaviours. A conceptualization of **moral imagination** is usually drawn from the works of Hume, Aristotle and Gadamer. Students must exercise moral imagination on two levels: towards the direct communication exchange before them; and to the representative nature of simulation encounters. The limits of moral imagination in simulation-based education must be carefully considered [10].

Trust has been identified in the literature as being a crucial element in establishing an effective nurse- patient relationship. Before a nurse can achieve a trusting relationship with a patient, he/she first has to develop a rapport with them. Rapport is a term used to describe, in common terms, the relationship of two or more people who are '*in sync*' or '*on the same wave length*' because they feel similar and/or relate well to each other [11].

'Therapeutic emplotment' develops from two philosophical strains: one emphasizing the connection of speech to actions, the other the linguistically mediated nature of human experience. 'Therapeutic emplotment' is the creation of story-like structures through therapist-patient interactions which encourage the patient to see therapy as integral to healing. Nursing 'therapeutic emplotment' may provide nurses with a way of improving communication and relationship skills [12].

CURRENT ISSUES AND DISCUSSIONS

Dissonance between the high 'technical' professionalism of nurses and a relatively low level of patient satisfaction with care received is a phenomenon observed in many countries. Some studies show that the above-mentioned situation occurs in the case of an inadequate interpersonal communication between health care professionals and patients.

Our review of literature concerning this situation was based, among other things, on the analysis of the PubMed database. Key concepts were traced related with communication competences of nurses. The search was performed without a time filter, therefore, the results concern reports which

have been published since the 40s of the last century. On the background of publications pertaining to nursing in general (the entry 'nursing'= 549,720 reports) the remaining entries were represented as follows: 'patient satisfaction' – 61,433 reports, 'communication skills'– 5,280 reports, and 'interpersonal communication' – 748 reports.

Conjunctive relation (operator AND) of the above-mentioned keywords in the PubMed database enquiries provided the following results:
- nursing AND 'patient satisfaction' – 6,699 reports;
- nursing AND 'communication skills'- 892 reports;
- nursing AND 'interpersonal communication'- 117 reports;
- nursing AND 'patient satisfaction' AND 'communication skills'- 52 reports;
- 'patient satisfaction' AND 'communication skills'- 360 reports;
- 'patient satisfaction' AND 'interpersonal communication'- 33 reports;
- nursing AND 'patient satisfaction' AND 'communication skills' AND 'interpersonal communication'- 2 reports.

Considering the above-presented combinations it is a thought-provoking fact that in the reports registered in the PubMed database the entries 'patient satisfaction' and 'communication skills' are relatively poorly related (only 360 reports), and the entries 'patient satisfaction' and 'interpersonal communication' are even less related (only 33 reports). Furthermore, the conjunction of the entries: 'nursing' + 'patient satisfaction'+ 'interpersonal communication' + 'communication skills' resulted in paucity of reports, despite the fact that these entries do not seem to be very distant with respect to their content. In consequence, we applied the method of searching 'by tracing', i.e. searching for reports concerning the investigated scope of problems in references to the reports which had been previously found based on the conjunction of the entry 'nursing' with not more than one of the above-mentioned concepts.

In this way, we found that literature concerning the scope of problems discussed is comprehensive and has been the subject of many reports of a review or meta-analysis character. At the beginning of this century, the impact of training programmes on nursing communication was called into question by Kruijveret et al. [13]. The recent meta-analysis showed a moderate effect of communication skills training (CST) on communication behaviour. Patients might benefit from specifically trained health professionals, but strong studies are lacking. Despite this, applying CST for professionals is a promising approach to change their communication behaviour and attitudes [14, 15]. Another article reports on a systematic review of qualitative studies on patients' experiences of preoperative communication with healthcare professionals. The authors conclude that communication is critical for providing efficient care to patients. However, healthcare professionals showed different needs and feelings for communication [16].

The communication skills and art associated with nursing services are neither innate nor automatic. Communication skills are acquired and refined only through practice.[3] Some results suggest that a communication skills training programme could be valuable for reinforcing basic/intuitive communication strategies, assisting in the acquisition of new skills, and ensuring communication supply availability [17, 18, 19].

Effective communication is a vital component of nursing care; however, nurses often lack the skills to communicate with patients and other health care professionals. Communication skills training programmes are frequently used to develop these skills. However, there is a paucity of data on how to evaluate such courses in the best way [20]. A number of recent developments in medical and nursing education have highlighted the importance of communication and consultation skills (CCS). Although such skills are taught in all medical and nursing undergraduate curriculums, there is no comprehensive screening or assessment programme of CCS [21].

Empathic communication skills are critical for providing high-quality nursing care to holistically understand the patient's perspective. Implications for practice explore the utility of empathy instruments in nurse education, such as empathy progression through the curriculum. For nursing educators, the development of instruments to measure the effectiveness of teaching strategies and pedagogy for empathy enhancement in practice is important [22]. Some authors use the Empathic Communication Skills Scale (ECSS) and the Empathic Tendency Scale (ETS) to evaluate the empathic skills and the empathetic tendency of nursing students. Their findings have shown that empathic skills are developed during undergraduate nursing education. However, at the same time, the empathetic tendency has been in decline [23].

The aim of another study was to evaluate the relationship between students' self rating of their own communication ability and their satisfaction with a nurse training course, compared with an objective measure of communication skills [20]. A similar survey was conducted to gain insight into the role of European haematology nurses and identify their learning needs. The respondents believed that they were well trained, possessed good communication skills and played a key role within the multidisciplinary team. However, a small but significant number of nurses indicated that they had a limited role to play in patient education (42%), and only 38% agreed that they played an important role in facilitating patient choice [24]. Measuring patient-centred communication is notoriously difficult. There is a need for several measures as proxies for patient centeredness: empathetic behaviours, 'reciprocity', decreased biomedical talk, 'appropriate responses' and length of uninterrupted patient talk. Using real patients and assessing their satisfaction with communication may be the ideal method [25].

Other authors have underlined that a short course for nurses on handling difficult communication situations resulted in significant improvements in self-efficacy, but not in performance. Teaching communication skills in community-based settings is important for the safety and effectiveness of patient care. One possible approach is to focus on specific communication skills rather than a full suite of skills [26].

Many researchers and educators focus on psychiatric, oncologic and terminal care nursing. Some of them underline that psychiatric nursing is a specialty that emphasizes utilization of communication skills to develop therapeutic relationships. Patient simulation, including high fidelity human simulation (HFHS), is one method that may be used for students to practice and become proficient with communication skills in a simulated environment [27, 28, 29]. However, other findings indicate that training communicative skills using the group psycho-education method can decrease the occupational stress of psychiatry ward nurses [30].

In oncology practice, communication skill (CS) training is useful for improving a nurse's ability to recognize the distress of patients diagnosed with cancer [31, 32]. Oncologic nurses have found educational intervention highly acceptable, and reported increased confidence in their ability to provide information and support for patient's parents, and to initiate discussion about emotional issues, as well as reduced use of blocking [33]. Communication skills are the key to quality end-of-life care. While learning general, transferable communication skills, such as therapeutic listening, has been common in nursing education, learning specific communication tools, such as breaking bad news, should also be the norm for nursing education [34]. An interactive educational workshop can improve end-of-life communication skills [35].

Depression is a common response among cancer and long-term care patients to their diagnosis and treatment; however, in about 50% of cases it remains undetected. The short training programme demonstrated success in improving nurse communication skills and confidence in dealing with patient depression [36].

Regardless of the nursing specialty, published studies have shown that a communication skills training course can improve the self-efficacy of health care professionals, and has shown a significant increase in patient-centredness and patient satisfaction concerning information and continuity of care, as well as high satisfaction of family members [37, 38]. At the same time, increase in self-control and communication skills and problem solving skills at the time of dealing with the patients and their relatives is a step in reducing one of the factors of violence at the workplace [39].

The taught and required scope of communication knowledge and skills, as well as the methods of discovering and developing communication motivations among pre-graduate and post-graduate students of nursing, is an important issue. Some findings suggest that 'role-play' may have a place in teaching communication skills in nursing schools, as well as continuing education. Interdisciplinary communication training may provide even more effective learning [40]. Controversially, assessments by clinical supervisors indicate that communication training modules, including standardized patients and an Objective Structured Clinical Examination (OSCE), are superior to communication training modules with peer role-playing [41].

A learning experience which incorporates standardized patients and feedback from faculty facilitators can promote authentic inter-professional learning, and develop students' confidence to communicate in a team environment [42]. Similarly, another paper describes the implementation of a practice-change project for simultaneously developing collaboration and communication skills by pairing pre-licensure student nurses in clinical assignments [43].

There are also more innovative and challenging proposals. One study describes an innovative assessment approach for first year nursing students which addressed the development of a beginning knowledge base in therapeutic communication. Use of a creative assessment approach, incorporating art creation, shows much promise in bridging the gap between a superficial understanding of concepts and an understanding characterised by deeper learning [44]. Another study assessed the effectiveness of a learner-

centred simulation intervention designed to improve the communication skills of pre-professional sophomore nursing students. An innovative teaching strategy has been evaluated in which communication skills are taught to nursing students by using trained actors who serve as standardized family members in a clinical learning laboratory setting [45].

The central focus of another study was investigation of the effects of the introduction of a new system of formative assessment on students' perceptions of their communication skills, by recruiting patients to assess the student who provided their treatment on that day. The students who were interviewed all stated that they were comfortable with the patients assessing them, and for some it made them feel more confident. Some students were surprised by the marks that the patients gave on some aspects of their communication, particularly pertaining to maintaining eye contact [46].

CONCLUSIONS

The presented review of works concerning professional nursing communication competences indicate that the efficiency of shaping communication competences among students of nursing, based on standard education within the scope of psychology and psychotherapy, is relatively low. Knowledge obtained in the area of psychology and psychotherapy is not spontaneously translated into the anticipated communication competences while practicing the occupation.

There are many methods of shaping and evaluating professional nursing communication. Most of the reviewed results indicate the necessity to systematically supplement knowledge and skills, both among student nurses and occupationally active nurses. However, one should be aware of the systemic, organizational and cultural differences which may considerably limit the scope of information exchange in such a sphere so sensitive to cultural factors as interpersonal communication.

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