Let’s talk about Nutrition: Communication skills for Health Care Professionals

Module 39.3
From Theory to Practice: Communication Skills for Health Care Professionals (HCPs)

Joelle Singer M.D.
Endocrine Institute,
Rabin Medical Center,
Belinson Hospital,
Petach Tikva, Israel

Learning Objectives

- Apprehend the process of change;
- Review the different models of communication;
- Learn how to implement effective team work;
- Learn how to motivate and lead to promote acceptance and implementation of nutrition in the health care system;
- Recognize the barriers to promotion of nutrition in different clinical settings and learn tools to overcome these barriers.

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Key Messages

- Nutrition should be an integral part of treatment in the health care system;
- Communication is a basic skill that we all practice in our everyday life;
- In the nutrition field team work is key for success;
- Motivation could be influenced by personal beliefs, perceived cost/benefit, and perceived efficacy.
1. Why do We Need to Learn How to Communicate?

As a health care professional working in the field of nutrition, you are convinced that nutrition should be an integral part of treatment in the health care system. You are probably right!!!! Well, your colleague in the room next door and the policy makers of your country are not convinced. You are an expert, you know how important nutrition is, you know how to deliver it, but all that evidence hasn't yet changed the position of your colleague and of the policy makers. You already tried to convince them and you are the specialist in your field, so no doubt that your colleague and the policy makers are the ones who need to change. For the second time you are right!!!

The policy makers are the specialists in making policies. Maybe, right?
You and the policy makers are different persons, working in a similar health system. Do you see the same things?

This chapter is about using knowledge in the communication field to promote change.

2. Process of Change

2.1 Transtheoretical Model of Change

James Prochaska of the University of Rhode Island with Carlo Di Clemente and other colleagues in 1977 developed a model to apprehend the process of change (1). Their new model was based on different theories of psychotherapy and that's why they called their model the "Transtheoretical model of change". This model contains five steps (2). After the elaboration of this new model, Prochaska and Di Clemente applied it in different disease settings.

The five steps are the following:
- **Pre-contemplation**: not currently considering change (ignorance is bliss)
- **Contemplation**: ambivalent about change (sitting on the fence)
- **Preparation**: some experience with change and trying to change (testing the water)
- **Change**: practicing new behavior
- **Maintenance**: continued commitment to sustaining new behavior

These stages of change are dynamic and sometimes there are relapses: resumption of old behaviors (fall from grace).
There have been different graphic representations of this model but all of them stress the continuity of the changing process, sometimes in slippery conditions (Fig. 1).
This model has been and still is widely used in many medical fields: fat reduction, sun protection over 24 months, smoking cessation, weight management and obesity prevention, alcohol, tobacco and other drug intervention, intervention in patients with depression, anti-hypertensive treatment and lipid lowering drug adherence, arthritis self management.

2.2 How to Adapt Conversation to the Different Stages of Change?

While you want to change an attitude, you need to evaluate the stage of change of the person in front of you.

If your administrator isn't aware of the discipline of clinical nutrition (Pre-contemplation stage) you should help him to become aware of the existence of the problem and the consequences of not taking care of the patient's nutrition through sharing neutrally the information about your discipline. Ask him about his knowledge of the subject & the benefits he perceives for his institution, ask if he would like to know more about the subject and the benefits. At no time should you suggest that he must change behaviour.

If your administrator has recognized the existence of the problem and is seriously considering changing the delivery of nutrition care but has not yet made the commitment (Contemplation stage), but is open to new information, emphasize the pros & cons of changing the process of nutrition support in your institution (speak the ambivalence) and tip the ambivalence in favour of change. Help him/her to make an environmental re-evaluation (Where nutrition support is needed? What resources already exist?). Correct
wrong or confusing messages. Do not oversimplify the difficulty of the task and focus on the available strategies.

If your administrator has already made a commitment to change and is likely to take action in the near future (Preparation stage) and has already promoted some changes in the field of nutrition support (e.g. training in clinical nutrition for the institution's nurses) but still has a degree of ambivalence and considers that barriers are too high, he may lack the skills to select a suitable plan or lack skills for the inevitable difficulties. You should help him to explore the available strategies and negotiate a plan of action. At this stage you should use the SMART method (Specific -Measurable -Achievable -Realistic -Time oriented) for the action plan. Help him to feel that the change is possible, that he has the capacity to realize it, use open-ended questions, and emphasize the positive outcomes of the change.

If your administrator has already accepted the plan of action and started to implement it (Action stage) give positive feedback, offer support and reinforce convictions about long term changes.

If nutrition support and a nutrition team are already an integral part of the care in your whole institution (Maintenance stage), help to consolidate the changes that have been made, talk through the slips or lapses of the process. Identify strategies to prevent these lapses with your administrator.

3. Models and Techniques of Communication

Communication is a basic skill that we all practice in our everyday life. We sometimes have a "gut feeling" that we had a good conversation. Why did it work well? What are the elements of effective communication? What are the factors that promote change? What are the right words, what does body language mean, how to use audio-visual support, how to adapt communication to context? These questions are the ones studied in the communication field and have lead to different theories (6, 7, 8, 9, 10, 11). We will make a short review of some of these theories and techniques.

3.1 The Shannon–Weaver Model

In 1949 this model tried to analyze communication making an analogy with the functioning of radio and telephone technologies. Their initial model consisted of three primary parts: sender, channel, and receiver. The sender was the part of a telephone a person spoke into, the channel was the telephone itself, and the receiver was the part of the phone where one could hear the other person. Shannon and Weaver (12) also recognized that often there is static that interferes with one listening to a telephone conversation, which they deemed noise. The noise could also mean the absence of signal (Fig. 2) (12).

- An information source, which produces a message.
- A transmitter, which encodes the message into signals.
- A channel, to which signals are adapted for transmission.
- A receiver, which 'decodes' (reconstructs) the message from the signal.
- A destination, where the message arrives.
Shannon and Weaver argued that there were three levels of problems for communication within this concept:

1. The technical problem: how accurately can the message be transmitted?
2. The semantic problem: how precisely is the meaning 'conveyed'?
3. The effectiveness problem: how effectively does the received meaning affect behaviour?

This model had the advantage of simplicity but has been criticized since it didn’t take into consideration that communication is not always linear, that simultaneously you can be the sender and the receiver and that interpretation by the receiver can occur at different times. Many theories have been developed since, taking into account the mechanistic, psychological, societal, cultural, systemic aspects of communication.

![Shannon-Weaver’s model of communication](image)

**Fig. 2** The Shannon-Weaver's model of communication

### 3.2 Active Listening

Empathetic listening is listening with the intent to understand. Seek first to understand, then to be understood. Carl Rogers early in 1950s described the theory and developed with Richard Farson training of the method. He described a person-centered model in therapy (13).

Active listening brings change in people’s attitudes towards themselves and others. Through all of our lives we have learned to think about ourselves in certain very definite ways, making a self- picture. All of us have experiences that fit in this self-picture but some may not. The denial of experience that doesn't fit in the self picture may lead to rigidity and difficulties in adapting. Active listening is not a threat to change the self-picture and when practiced in a calm, non-judgmental atmosphere, can make the individual safe enough to incorporate new experiences or values into his concept of himself.

Do's and don'ts in active listening.
What to avoid? When we encounter a person with a problem our usual response is to try to change his way of looking at things- to get to see the situation the way we see it.
attitude responds to our need to see the world in certain ways. We should try to free ourselves from the need to influence or direct others in our own paths. By doing this we enable ourselves to listen with understanding and thereby employ the most potent available agent of change. The listener is constantly called upon to agree or disagree with someone or something. Passing judgment, whether critical or favorable, makes free expression difficult (14, 15).

What to do? To get inside the speaker and to grasp, from his point of view, just what it is he is communicating to us. We must convey to the speaker that we are seeing things from his point of view. We should look for the total meaning of the message: both the content and the feeling or attitude underlying the content. The listener has to respond to feelings and note both verbal and non-verbal parts of the message (inflection of the voice, eye movements, breathing, hesitation...). During the conversation, rephrasing and checking that you (the listener) accurately get the message, before the listener can speak for himself. A good rule of thumb is to assume that you never really understand until you can communicate this understanding to the other’s satisfaction.

Active listening conveys that you respect the person in front of you in a more effective way than just saying your respect. It is a constructive way of communication since, very often, it is contagious, and the one who is actively listening is often the one most likely to be listened to.

Active listening is not an easy skill to acquire and demands practice. To be effective at all in active listening, one must have a sincere interest in the speaker. If this is not the case, the speaker will feel you are making a pretense of interest and will soon stop speaking freely.

3.3 Motivational Interviewing

Stephen Rollnick and William R Miller analyzed the different techniques of communication (16, 17) and part them into three main techniques: the "Direct" way (teach-instruct-lead), the "Guide" way (draw out-encourage-motivate), the "Follow" way (listen, understand, go along with). The technique of motivational interviewing (MI), first published in 1991, is based on a guiding style since it is suitable to help somebody to change. This method is also called a "Change talk" method. A good guide will: - Ask where the person wants to go and get to know him or her a bit; - Inform the person about options and see what makes sense to them; - Listen to and respect what the person wants to do and offer help accordingly. This method was first used in the field of addiction but soon was recognized and used in long term conditions. The principles of MI are applicable to any situation where you think there is a place to change behaviors.

Three main principles form the spirit of MI:
- Use of a collaborative way of decision making
- Evocation of the motivation existing in the person we are talking to (no person is completely unmotivated)
- Respect of the autonomy of the person we are talking to in the decision to make a change

Refrain from the righting reflex, understand the other's side motivation, listen to the other side and empower him. These are the strategies of MI or "Change talk". Rollnick uses an acronym to better remember these principles: **RULE-R** - Resist the righting reflex **U**-Understand your client’s motivation. **L**-Listen to your client. **E**-Empower your client.
Asking, listening and informing are skills that we use in our everyday life. These three skills could be used in the "Direct" way as well as the "Guide" way or "Follow" way, but in a different percentage during a conversation, as was shown by Barbara B. Walker’s work (Fig. 3).

![Fig. 3 Comparison of three communication techniques: percentage of informing, asking and listening. Barbara B Walker](image)

The MI method is also to be practiced and is taught in workshops. The principles of the guiding method are to use skills that you already have. Miller and Rollnick use an acronym to remember these principles: OARS - open ended questions - affirmations - reflective listening - summaries. "Building Motivational Interviewing Skills" the practitioner workbook of David Rosengren summarizes these principles and gives an opportunity to apprehend different situations in the light of MI (18, 19, 20).

4. Team Work

"Talent wins games, but teamwork and intelligence win championships."  
Michael Jordan

In the nutrition field team work is key for success. In the process of convincing policy makers that a nutrition team is essential for the hospital/community or any health care system we can use the strength of team work to promote our goal. Team work involves two or more persons, working collaboratively, in order to achieve a goal. This means that people will try to cooperate, using their individual skills and provide constructive feedback, despite any personal conflict between individuals. Teams take decisions to solve problems or promote behaviours or ideas and use steps to implement them:
- Define objectives (i.e. Convince the policy makers that a nutrition team should be part of the system and of the budget)
- Make an evaluation planning in line with the program construction (i.e. Prepare a presentation about what has been done in the last year, what was the impact of the nutrition team on the treatment of patients in different wards, how it affected admissions and length of stay, quality of life and response to treatment, choose the key persons to speak to, who will approach them and in which set up, look for other HCP you are working with and who could speak about their experience with the nutrition team, define the time table of your strategy, what each team member will do up to the next evaluation of the process, ......)
- Implement the evaluation (What will be considered as a success, how and when to measure it, when will be the team’s next meeting ......)
In health care, a systematic concept analysis in 2008 concluded teamwork to be "a dynamic process involving two or more healthcare professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care (21, 22).

5. Motivation and Leadership

Motivation could be defined as a spontaneous interest in a particular goal or a movement to arrive somewhere (from will to action). We can influence it in different ways using success as a promoter of motivation and leadership to inspire and cultivate this motivation. Motivation could be influenced by personal beliefs, perceived cost/benefit, and perceived efficacy.

About leadership as a whole, acts work better than words. Good communication is a key factor to leadership along with good ideas and relevant goals.

6. Overcoming Barriers

Look around and anticipate since barriers are always part of a process. These barriers could be personal (e.g. burn out, difficulty in communicating or in collaborating) or external (system, persons, beliefs, culture.....).

Look around: - what are the health problems of the hospital/community? - What are the overall goals of national health policy? -what are the support systems already in place?- what are your institutional goals, - who are the players?

A good overview will help to anticipate barriers, since ignoring them usually won’t make them disappear. Barriers could be overcome or contoured but should be looked as part of the process of change.

7. References


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