Collaborative communication: learning from advanced clinical practice patient consultations

Julian Barratt

Abstract
Advanced nurse practitioners, and nurses aspiring to this role, are required to understand how to communicate effectively and on a collaborative basis with patients and carers during consultations, with the aim of enhancing patient outcomes such as improved patient satisfaction, ability to self-manage healthcare needs and adherence to care plans. This article explores collaborative communication in consultations and how best to achieve this, using the author’s doctoral observational research based on the findings of a mixed methods observational study of communication in advanced clinical practice patient consultations.

Introduction
Effective communication during consultations with patients and carers in hospitals and primary care settings is essential to optimise patient outcomes, such as improved patient satisfaction, ability to self-manage healthcare needs and adherence to care plans. The prevalence of advanced clinical practice patient consultations has increased over the past 20 years, in response to individuals’ increasing and complex healthcare needs and health policy initiatives supporting the ongoing development of advanced clinical practice (Health Education England 2017), such as the advent of nurse independent prescribing (Courtenay and Carey 2008).

Advanced nurse practitioners (ANPs) are increasingly expected to deliver both initial contact and ongoing healthcare for patients, to bridge the gap between workload demands and service provision (Bonsall and Cheater 2008, Hill 2017). Inherent in this provision is
the requirement for ANPs to direct clinical consultations, akin to those conducted by medical doctors, whereby a person presents with a health issue, which is autonomously assessed and managed by the ANP (Barratt 2005). Therefore, it is essential that ANPs communicate effectively during consultations to ensure positive patient outcomes.

It should be noted that the approach to collaborative communication discussed in this article is derived from the author’s doctoral observational research, based on the findings of a mixed methods observational study of communication in advanced clinical practice patient consultations (Barratt 2016). While this article focuses on collaborative communication in advanced clinical practice patient consultations, several of the principles discussed will be applicable to all nurse-patient interactions.

**Defining an advanced nurse practitioner**

To fully understand the context of advanced nursing roles within consultations, it is important to define an ANP. In the UK, the Royal College of Nursing (RCN) (2012) refer to ANPs as registered nurses who practise nursing at a level beyond that for which their initial training has prepared them, and who have been further prepared via a university-based programme of advanced clinical practice education.

Typically, education programmes for advanced clinical practice in the UK comprise clinical academic modules pertaining to advanced clinical practice, such as health assessment, pathophysiology, clinical reasoning and applied pharmacology. These clinical academic modules are specifically designed to enable individuals to develop the full range of competencies required for advanced clinical practice, as described in the competencies of practice for ANPs published by the RCN (2012). Following successful completion of these modules, qualified ANPs will possess a unique mix of medical and nursing knowledge, which enables them to conduct clinical consultations and to assess patients with undifferentiated and undiagnosed medical conditions.

ANPs can assess the patient’s healthcare needs and provide appropriate treatment or referral on much the same basis as medical doctors, with similar levels of autonomy and clinical liability (Griffith 2008).

In the UK, while policy initiatives support the development of advanced clinical practice (Department of Health 2010, Health Education England 2017), statutory regulation of advanced nursing practice has not yet occurred; this is in contrast to the regulation of advanced nursing practice in several other countries across the world, such as the US, Canada and Australia (Pulcini et al 2010).

At present in the UK, any registered nurse can refer to themselves as a ‘nurse practitioner’ or an ‘ANP’ because these titles are not protected, with the only regulatory requirements being to record their nurse prescribing qualification with the Nursing and Midwifery Council (NMC) (2006), and to participate in the NMC (2017) revalidation process for renewal of registration, which all UK registered nurses, regardless of their level of practice, must undertake every three years. In relation to the regulation of advanced nursing practice in the UK, the RCN (2017) provides a mechanism for credentialing advanced-level nursing practice, although its credentialing scheme does not have any statutory links to the NMC register since there is no legislation to enable this, at present.

**TIME OUT**

Investigate how advanced nursing practice is defined and regulated worldwide, including the associated educational underpinning. Compare and contrast this with the country in which you practise. You may wish to access a variety of resources to support this activity, such as Pulcini et al (2010)

**Defining a consultation**

Alongside defining an ANP, it is important to define a consultation in the healthcare context. In simple terms, a consultation can be understood as a meeting between the practitioner and patient, so it is therefore a fundamental activity of clinical practice, since without that meeting it is challenging to reliably ascertain what health issues a patient has, what they want to do about these issues, and what is clinically required to support them (Hastings et al 2003). A consultation can specifically be defined as: a health-related interview involving an interpersonal relationship, whereby a person with a health and/or social care issue or issues, presents or is presented to a clinician, seeking either an explanation and/or possible improvement or review of the identified concern or concerns (Barratt 2015, 2016).

This definition of a consultation acknowledges its interpersonal nature, recognises that patients may attend the consultation on their own or may be accompanied by a carer, and that multiple healthcare needs and preferences of the patient or their carer.

Consultations may occur in a range of settings, including clinics, patients’ homes, hospitals and public spaces. Additionally, patient meetings in different settings are not necessarily referred to as consultations; for example, a variety of terms are often used to describe nurse-patient meetings, such as completing an ‘admission’ when a patient is admitted to a ward (Redsell 2006). This article focuses on face-to-face nurse-patient meetings, where ANPs have comparable levels of clinical responsibility to that of medical doctors in terms of assessing, diagnosing and treating the health issues that patients present with.

**Biomedical versus patient-centred interaction styles in consultations**

Interactions in consultations can be divided into two broad categories: ‘care’ talk, comprising socio-emotional patient-centred interactions, which foster a therapeutic relationship; and ‘cure’ talk, compromising biomedical task-focused interactions related to the clinical assessment of health issues (Greenhalgh and Heath 2010). Research on communication in advanced clinical practice patient consultations has shown that effective communication occurs...
when ANPs adopt a hybrid style of communication, combining discussion of objective biomedical information with subjective information from everyday life (Barratt 2005, Paniagua 2011). This hybrid approach may include ‘exploring the patient’s illness experience and the disease, understanding the whole person, finding common ground, incorporating health promotion and prevention, enhancing the participants’ relationship and using resources realistically’ (Pawlikowska et al 2012), which in turn may enhance patient outcomes such as patient satisfaction, ability to self-manage healthcare needs and adherence to care plans (Agosta 2009, Pawlikowska et al 2012).

While patient-centredness is fundamental to healthcare delivery, the extent to which it occurs or is enabled in clinical consultations has been debated (Pilnick and Dingwall 2010). Pilnick and Dingwall (2010) recognised the practical necessity for clinicians to exert their clinical and experiential knowledge when consulting with patients to ensure effective and safe treatment of the presenting health issues. This power balance in favour of clinicians means that the extent to which patients can participate in clinical decision-making during consultations is limited. For example, a degree of passivity occurs even among healthcare professionals when they themselves require healthcare. Self-prescribing of prescription-only medicines is prohibited for nurse prescribers, and is strongly discouraged for medical doctors, and while a clinician attending a consultation for their own healthcare can suggest what medicines they think they require, the clinician they are consulting with will ultimately make and be accountable for that decision (NMC 2006, General Medical Council 2013). Therefore, it could be surmised that similar levels of passivity, if not more, occur in lay consultations.

Five interaction activity phases of consultations

According to Roter (2011), interactions in consultations can be conceptually categorised into five interaction activity phases:

» Opening (opening of the consultation) – where the patient and clinician greet each other and establish agendas.

» History (history-taking) – where the patient tells their story and the clinician clarifies that story and analyses relevant biomedical information.

» Examination (clinical examination) – where the patient is examined by the clinician.

» Counsel (diagnostic and therapeutic decision-making) – where differential diagnoses and care planning are discussed by the clinician and patient.

» Closing (closing of consultation) – where arrangements for return or review are confirmed, and farewells made.

Opening phase

Observational research of communication processes and interactions in advanced clinical practice patient consultations has shown that patient-centred interaction styles are used significantly more frequently than biomedical interaction styles in the opening phase of the consultation (Barratt 2016). The typical types of interaction occurring in the opening phase are personal remarks or social conversation and open-ended questions used by ANPs to establish the agenda of the consultation. ANPs can elicit multiple agenda items from patients by using open-ended questions, such as ‘How can I help?’, reinforced by attentive listening when patients speak. This encourages patients to raise any issues that they wish to discuss and ensures that ANPs are prepared for, and receptive to, patients’ concerns (Kleiman 2004).

During the opening phase, it is important for those participating in the consultation to establish a social affinity with each other, for example by remembering and commenting on previous meetings, if applicable. It has been noted that when ANPs remember patients on a personal level, there is a sense of continuity of care, with a supportive relationship and trust being developed over time (Kleiman 2004, Bryczynski 2012). This assists in ensuring a sustained shared understanding of the patient’s perspective (Bryczynski 1989, Johnson 1993).

History phase

Observational research of advanced clinical practice patient consultations has shown that patient-centred interaction styles occur more frequently than biomedical interaction styles in the history phase of consultations (Barratt 2016). ANPs were found to use patient-centred interaction styles significantly more frequently than patients did (Barratt 2016). Examples of such patient-centred interaction styles used by ANPs included showing agreement or understanding, attentive listening and encouragement, all of which are communication strategies used to encourage the patient to continue...
Speaking (Barratt 2016). This patient-centred interaction style is particularly important for ANPs in the history phase of consultations, when attempting to elicit a coherent history from patients or their carers. Encouraging patients to speak enables them to discuss fully information about their presenting health issue and any concerns they have (Launer 2002).

During the history phase, patients should also be given time to discuss the agenda items raised in the opening phase of the consultation. When discussing these agenda items in the history phase, patients will often use biomedical interaction styles more frequently than ANPs; they do this mainly to provide information about their medical conditions and medicines they are taking or treatment they are receiving (Barratt 2016). Patients should be encouraged to engage in a two-way conversation as opposed to consultations being history-taking sessions solely focused on ANPs asking questions and patients providing answers. A two-way conversation can be encouraged through effective verbal and non-verbal communication.

Active listening is particularly important since it demonstrates that the clinician is interested in what the patient has to say and may encourage them to make revelatory comments. Active listening can be demonstrated to patients through body language such as head-nodding and smiling, where appropriate, in conjunction with brief verbal indicators of sustained interest, attentive listening or encouragement when a patient is speaking, such as saying ‘right’, which sustains the conversation (Roter 2011). Such communication strategies have been characterised in previous exemplars of ANP practice as ‘healing begins with listening’ (Brykczynski 2012), in which patient assessments are attuned to patients relating what is occurring in their lives, with ANPs asking for clarification as required, rather than appearing to interrogate patients. Focusing on effective communication strategies in consultations, as opposed to the sole application of medical knowledge, is central to promoting patient-centred consultations.

Examination phase
Observational research of advanced clinical practice patient consultations has shown that in the examination phase of consultations, ANPs and patients use similar frequencies of patient-centred interaction styles, such as showing agreement or understanding (Barratt 2016). However, ANPs increasingly use biomedical interaction styles in the examination phase, in particular when providing orientation or instructions to guide patients during clinical examinations (Barratt 2016). These examinations are often concurrently supported by what is known as ‘online commentary’ (Mangione-Smith et al 2003) or ‘integrated clinical reasoning’ (Barratt 2016), whereby ANPs verbally report to patients what they are doing and what they identify during a physical examination. The reporting of negative examination findings – that is, findings where minimal or no clinical signs are noted – may assist in reassuring patients (Barratt 2016).

Providing reassurance through the use of integrated clinical reasoning or online commentary has been found to assist in the management of patients’ expectations of receiving certain medicines. For example, the sharing of clinical reasoning can effectively counter patients’ unrealistic expectations of receiving antibiotics by informing them they do not have an infection that requires this treatment (Mangione-Smith et al 2003).

Integrated clinical reasoning can also be used by ANPs to verbalise their cognitive clinical reasoning to patients and carers by, for example, thinking out loud (Paniagua 2011) or discussing clinical uncertainties with patients (Brykczynski 1989). In this way, clinical reasoning can be used during consultations to improve the patient’s understanding of the challenges involved in establishing differential diagnoses and, in particular, that diagnoses can alter and may not be definitive. It can also assist in reassuring the patient about medical conditions and care plans.

Counsel phase
Observational research of advanced clinical practice patient consultations has shown that in the counsel phase of consultations, where diagnosis and care planning occurs, patient-centred interaction styles occur overall more frequently than biomedical interaction styles (Barratt 2016). This typically involves ANPs and patients showing agreement or understanding, or making personal remarks and social conversation. In comparison with patients, ANPs use biomedical interaction styles more frequently in the counsel phase to provide information about medical conditions and treatments, and counselling regarding therapeutic regimens, such as discussing a medicine to be prescribed (Barratt 2016).

As with the examination phase of consultations, the counsel phase often incorporates integrated clinical reasoning, particularly when ANPs overtly discuss their clinical reasoning related to differential diagnoses with patients and carers (Barratt 2016). The counsel phase should also include negotiation regarding care plans, rather than the ANP dictating what treatment is required. For example, in an observational study of advanced clinical practice patient consultations, one patient described negotiating with one of the ANPs to delay taking a statin for the treatment of hyperlipidaemia in favour of alternative therapies and lifestyle interventions (Barratt 2016). Negotiation of this nature is important to encourage patient participation, and subsequent adherence to treatment regimens, and relies on the ANP’s ability to make patients feel at ease and comfortable to express their ideas, concerns and expectations in consultations (Pendleton et al 2003).

The main aim of a clinical consultation is for the ANP and patient to engage in collaborative communication and shared decision-making that benefits the patient and results in optimal outcomes. This can be achieved through shared clinical reasoning, negotiation and explanation (Barratt 2016). Clinical reasoning can also assist patients to understand differential diagnoses and the nature of their presenting condition. In addition,
clear explanations can improve the patient’s knowledge and understanding of their medical conditions and related treatments, thus enabling them to make informed decisions (Barratt 2016).

CLOSING PHASE

Observational research indicates that in the closing phase of advanced clinical practice patient consultations, as with the opening phase, patient-centred interaction styles predominate (Barratt 2016). Such patient-centred interaction styles include personal remarks or social conversation related to friendly gestures and goodbyes (Barratt 2016). Some biomedical interaction styles should still occur in the closing phase, for example when giving advice to patients regarding their medical conditions and treatments, follow-up care, worsening and persisting symptoms, and when and where to seek further advice (Neighbour 2005, Barratt 2016).

ENABLING SHARED DECISION-MAKING IN CONSULTATIONS

The features of ANP communication and social interaction styles discussed in this article can be compared with the process of shared decision-making in clinical practice discussed in the government health policy ‘No Decision About Me, Without Me’ (Department of Health 2012). In this policy, shared decision-making is ‘a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences’ (Coulter and Collins 2011).

Shared decision-making requires clinicians to adopt a consulting style that emphasises partnership and support, and is curious, supportive and non-judgemental (Coulter and Collins 2011). A shared decision-making consulting style involves: ‘developing empathy and trust; negotiated agenda-setting and prioritising; information sharing; re-attribution (if appropriate); communicating and managing risk; supporting deliberation; and summarising and making the decision’ (Coulter and Collins 2011). Developing trust and empathy involves ANPs asking open-ended questions to encourage patients and carers to discuss and share their stories, concerns and health issues.

Negotiated agenda-setting and prioritising involves ANPs being open to the patients’ or their carers’ agenda items. Information sharing involves asking patients what they already know about their health issues and what concerns they have. This often involves using open-ended questions, and providing clear information about medical conditions and treatment.

Re-attribution ascertains and realigns patients’ beliefs about the cause of their condition or symptoms that may be unhelpful or incorrect (misattributed) (Coulter and Collins 2011) in the context of their presenting health issue. A central aspect of the re-attribution process is eliciting patients’ or carers’ beliefs about medical conditions, which requires them to feel at ease and comfortable to make such disclosures.

Communicating and managing risk engages patients in shared decision-making by ensuring they have the information to make informed decisions and supporting them in their deliberation. By using integrated clinical reasoning, ANPs can involve patients in decision-making by sharing with them their thoughts on the likelihood of differential diagnoses and the relative merits of treatments. This is as opposed to simply telling patients what to do.

Supporting deliberation involves discovering patients’ and carers’ ideas and concerns about their health issues and their expectations for treatment. ANPs can use open-ended questions to elicit such information, thereby encouraging patients to ask questions about treatment options.

Summarising and making the decision occurs at the end of the consultation and involves summarising the main content to reinforce patients’ understanding of their health issues and treatments. It is important that ANPs recognise that adopting a shared decision-making style in consultations is valuable and does not necessarily extend consultation times; observational research has shown that consultations using participatory shared decision-making do not take longer than consultations where clinicians mainly make the decisions (Barratt 2016).

TIME OUT 3

The five interaction activity phases of a consultation identified by Roter (2011) represent a simple but useful framework. How does this framework compare to your approach to consultations? Do you think the approach you currently use is better? If so, why? If you would like to use the phases described in this article in your future consultations, reflect on what has motivated you to make this decision.

APPLYING COLLABORATIVE COMMUNICATION IN CONSULTATIONS

Optimal communication in consultations can be summarised using the structured mnemonic ‘O-P-E-N’ (Barratt 2016), which states that advanced clinical practice patient consultations should comprise collaborative Openness to Peoples’ agendas and questions, Expressions of everyday lifeworld experiences, expanded impressions of time, clear explanations augmented by integrated clinical reasoning, and participatory Negotiations.

Openness to patients’ agendas can be achieved by encouraging patients to report or discuss multiple presenting health issues in the consultation and by responding positively to these issues, even if not all of them can be dealt with at the time of the consultation. Openness to patients can also be facilitated by ANPs showing an interest in patients as people, rather than focusing solely on their health issue. This may include using patient-centred interaction styles such as personal remarks and social conversation, laughing, reassurance, encouragement and optimism, and showing reassurance, encouragement and optimism, and showing.
agreement or understanding, where appropriate. Agreement and understanding are particularly important since they assist ANPs to empathise with patients. Expanded impressions of time, whereby patients feel that the ANP has more time available for them, can convey the sense that they are important and are being listened to. Clear and coherent explanations of medical conditions and treatments are an essential component of an effective consultation and can be supported by verbalised clinical reasoning, and the provision of verbal and written information. Clear explanations can also be supported by encouraging patients to ask questions to ensure that they understand what is being explained to them. Participatory negotiations can be optimised through friendly conversation styles, where appropriate, and providing time for patients to speak and opportunities for self-disclosure. Another feature of participatory negotiations is enabling patients to make self-initiated requests for medical services or medicines in negotiation with ANPs.

Using a mnemonic such as O-P-E-N during advanced clinical practice patient consultations assists in structuring and optimising communication, with the aim of engaging patients in their healthcare and enhancing patient outcomes.

**TIME OUT 5**
Reflect on a recent patient consultation and consider how well you achieved the structured mnemonic O-P-E-N, as described in this article. Which areas would you say were strongest, and which could you improve? What could you do to achieve these improvements?

**Conclusion**
Collaborative communication in advanced clinical practice patient consultations is essential to optimise patient outcomes such as improved patient satisfaction, ability to self-manage healthcare needs and adherence to care plans. Observational research has demonstrated a preference for patient-centred interaction styles among ANPs (Barratt 2016), although the optimal strategy involves a combination of patient-centred and biomedical interaction styles used to engage, involve and support the patient, while ensuring accurate and appropriate clinical information is provided in relation to differential diagnosis, medical conditions and care plans.

**TIME OUT 6**
Consider how collaborative communication in patient consultations relates to The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (NMC 2015) or, for non-UK readers, the requirements of your professional body.

**TIME OUT 7**
Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account

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**References**


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