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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Mind your language: lessons for practice development

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Abstract

Context: My frustration with a perceived lack of patient-centred care in my own health practice led me to enrol in postgraduate studies. An introduction to the concept of practice development enabled me to understand and develop my practice in new ways. I learned that language is integral to the implementation of practice and change. Communication through spoken language is at the heart of the relationships that exist within healthcare and its use either engages or disengages players within this realm.

Aims and objectives:

The aim of this reflection is to explore:

1. The powerful role that language choices play in health interactions
2. The practice development tools available to increase my effectiveness as a patient-centred healthcare provider

I will use the case study of Miss A to consider these aims.

Conclusions and implications for practice:

- How we construct and convey language can significantly impact on our ability as healthcare providers to deliver authentic patient-centred care
- Language choice is a powerful agent for practice change, enhancing care delivery and effect, both for provider and recipient
- Practice development tools such as reflection, positive engagement and questioning help providers to deliver patient-centred care through the conversations they create

Keywords: Language, patient-centered practice, practice development, communication, change, older persons

Why is change necessary?

The greatest challenge facing our health and social care systems is to get services right for older people (Philip, 2003). Significant shifts in mindsets and paradigms for individuals and organisations are essential if we are to deliver truly genuine person-centred care. Communication and the conversations we have in our workplaces are the connections that enable us to construct and convey meaning between our patients, their carers and ourselves, and are therefore powerful media for practice development and change. Changes in the way we use language have the potential to shift

thinking and practice from institutional, custodial and task oriented to needs responsive and relevant, underpinned by person-centred philosophies (Davis et al., 2009).

The following reflection provides a personal example of the power language can play in healthcare encounters. Miss A was a 95-year-old lady who was the subject of a discharge planning case conference. She had been admitted to hospital following a fall in her home, suffering from dehydration and exposure. At that time, she had lived alone for almost 55 years. Miss A was assessed as been cognitively competent by the staff geriatrician and had been declared medically stable for discharge. I was asked to be part of this discharge planning conference in my role as ward physiotherapist; my role was to provide input regarding Miss A's mobility. Miss A's only remaining family, two nephews, were both present at the meeting. Also present were other members of the hospital multidisciplinary team.

It had been Miss A's fervent and consistently held wish to return home to independent living. As the conference progressed I became slowly aware of the alienation of Miss A. The main source of growing frustration for me was that her opinion was becoming less relevant in the discussion; she became increasingly silent, sinking into her wheelchair and eventually dissolving into tears. This was a cathartic moment for me as I realised that Miss A was being corralled into the position that she least wanted to be in. She eventually conceded and agreed to aged care placement. Realising that I had been a part of the alienation of Miss A in this decision-making process saddened me. Afterwards, my sadness turned to embarrassment as I began to question how I could have better played an advocating role.

Engaging in a more formal reflective process sometime later reiterated how powerful the impact of the language constructed and conveyed by the healthcare team and myself in this conference situation had been. I quickly realised that we had involuntarily inhibited rather than encouraged shared communication and discussion between ourselves and Miss A, derailing attempts to provide her with a genuine voice in her own discharge planning conference. The following is my personal reflection of the ways in which the language choices the team and I used during this conference may have denied Miss A an authentic platform to engage in her own discharge planning conversation.

First, the case conference agenda was set and structured by the healthcare team without prior consultation with Miss A or her family. This is not an uncommon, nor unexpected procedure for team members in such situations. This example of procedurally driven care may, however, have had the potential to give an impression that the conference's content was either secret or exclusive to the members of the team who chaired it. Miss A and her family may have felt they had little ability to influence the agenda. Their ongoing silence may have been an expression of this exclusion. Additionally, the team and I controlled the direction and flow of the conference. This was achieved by members of the team dominating conversation, initiating discussion and questioning. In an ideal speech situation, all people would have the opportunity to start a discourse and all people involved would have an equal opportunity to participate in it. Again, in enabling procedurally driven care practices by dominating the conversation, I may have unintentionally denied Miss A and her family an equal opportunity to communicate. Furthermore, personal understanding and beliefs about professional roles, held by me and by Miss A and her family, may have been a hindrance to genuine engagement of all relevant stakeholders in this conference. My belief that patients and their families have an expectation that decisions are predominantly based on technical information provided by the expert team led me to baffle Miss A and her family with a barrage of formal assessment results.

On reflection, these results were likely to have been of little relevance to Miss A or her family. Their own beliefs that decisions are best taken by the healthcare team experts may have contributed to their silence. The result: a submission to and trust in the recommendations made by the team with

little engagement necessary. However, Miss A's dissolving into tears at the completion of the conference suggested otherwise. Traditional, procedurally driven care like this may have had the effect of failing to identify Miss A and her family's true priorities and care needs.

The predominant use of technical or medical speak during the conference by the team and me, I suspect, had the effect of ensuring any information given confirmed our position as experts. Such dominant monologues, delivering often-complex formal assessment and test results, may have resulted in our overlooking Miss A and her family members' own competencies to contribute to the conversation. An incompatibility of language between the team and Miss A and her family may have prevented them from expressing their own viewpoints and care wishes. Indeed, their lack of participation during these conversations justified my belief in their lack of competence or desire to contribute, incorrectly validating my domination of the conversation. Moreover, my own beliefs that the technical information the team and I possessed were prime pieces of this discharge planning puzzle may have blinded me to other opportunities and tools for delivering genuine patient-centred care. Such assumptions may have been a reflection of the professional and institutional cultures I was working within. The bureaucratic machine called 'health' (including myself as a willing member) may have therefore played an unwitting role in disregarding the basic needs and wants of a vulnerable member of my community and rendering her a passive recipient of our care.

On reflection, questioning during the case conference was often closed and negative. Questions put to Miss A such as "How do you feel about the likelihood of being left to perish next time you fall at home?" seemed to have a catastrophic orientation. Such questions are in no way inappropriate to consider but the choice of language in this instance may have served only to form a negative discourse, leading to further disengagement between Miss A and the healthcare team. My own underlying assumptions and beliefs around risk management for the older person meant that I was innately distrustful of Miss A's ability to make this decision on her own and certain that she required my expert intervention and opinion. In imposing my own narrow definition of risk around physical safety during the conference, I may have facilitated the more significant risk of loss of independence for Miss A. With time constraints a feature of many healthcare interactions, collective unspoken pressure from the team not be too expansive in our conversations with Miss A may have resulted in predominantly closed questioning techniques being used. I was acutely aware at the time that other patients were waiting elsewhere for my professional input. I may have denied both Miss A and myself an opportunity to create a space for genuine engagement around a positive, inclusive and creative solution.

The power of language choices

Orr (1990, p.50) insists '…words have power. They can enliven or deaden, elevate or degrade, but they are never neutral because they can affect our perception and ultimately our behaviour'. My own perceptions that neither Miss A nor her family had the capacity or desire to be engaged in this process along with the impact of procedurally dominant cultures, resulted in the disempowerment of Miss A. In imposing my own professional and personal beliefs around risk and safety on Miss A and her situation through the language I utilized, I denied her an opportunity for shared decision-making. If conversations and language are the building blocks of thought, meaning and ultimate collaboration, then I believe that I must be prepared to both analyse and develop my practice of language to facilitate patient-centred practice.

Where to next? Language as a tool for developing sustainable practice change

Reflection

Walsh et al., (2002) assert that reflection in practice development allows practitioners to uncover many factors influencing their behaviour, leading to insight and therefore opportunities for change. It was indeed my own 'aha' moment of reflection around Miss A that led to my journey into the

world of practice development. Clouder (2000) asserts that individual reflection may remain largely internalised, leaving the practitioner only partially aware of the potential for change and serving to maintain the status quo rather than promoting change. She proposes the use of 'dialogical reflection', whereby engaging in collective conversation(s) with a range of relevant stakeholders can engineer 'communities of practice'. Organising a team meeting after the discharge planning conference, to reflect on both process and outcome, may have provided a collective opportunity to address frustrations and uneasiness over our involvement in this conference. Moreover, the opportunity for a follow-up interview with Miss A and her family may have provided essential feedback. Such examples of critical companionship can only serve to advance professional practice by raising the consciousness of our conversation. The promise that reflection potentially provides is freedom from the traditions and practices of old, the shifting of existing paradigms and the ignition of change, with the ultimate result of advancement in healthcare practice and delivery for all.

Engagement

Miss A's example, highlights how conversation can serve as a mechanism through which power can operate by producing alternate truths. Neither the healthcare team nor I intended to disempower Miss A or her family, however alternate truths ('Miss A and her family not interested in conversation') were created when we inadvertently used language to dominate and direct conversation. Schwarz and Davidson (2005) insist that beginning a conversation well can make the rest of the conversation more productive. Agreeing on purpose and process in any healthcare interaction by jointly negotiating an agenda and an acceptable form of language for those involved is imperative. Doing this will facilitate informed choice and establish a shared roadmap of understanding.

Reframing conversation

We create and use language to provide a point of view, which is our reality, allowing us to orientate and validate our actions. The discharge planning conference of Miss A demonstrates how language was unintentionally used to alienate the patient and her family from genuine participation. Seeking to challenge my professional values and assumptions through the language choices I make should enable me better to advocate for the older person in the future. Ensuring my use of language addresses patients' issues from their own moral viewpoint(s) may assist with delivering genuine patient-centred care in instances such as Miss A's. Reframing is about changing the meaning we give to an encounter, not necessarily changing the encounter itself. By engaging in a more inclusive, positive and egoless conversation with Miss A, I could have ensured a space for more creative solution(s) to her accommodation needs was created.

Powerful questioning

Questions are the basic building blocks of verbal communication (Greene and Grant, 2003). Good and powerful questioning can open doors to dialogue, create insight and ignite change. A powerful question provokes thoughtful exploration and innovative thinking. In the case of Miss A, questions such as those below could have served to shift assumptions and beliefs and to challenge existing traditional and moral viewpoints.

'Why is it important for you to return home?'
'What may be some of the barriers to your returning home?'
'What do you need (services/aids/home modifications) to return home?'
'What other options have you thought about?'

Generative questions like these could have served to ensure Miss A had a voice and that creative possibilities were explored. The quality of Miss A's answers would likely have been in direct proportion to the quality of the questions posed by the healthcare team and me.

Conclusion

Lakoff (2004) suggests that if discourse offends us we have a moral obligation to change it, asserting we 'need to be the change we want'. Miss A's example has given me the opportunity professionally and personally to reflect on the impact of my language choices on my health practice and delivery. I can now assert the importance of: practice reflection; negotiating conference agendas; agreeing on and establishing a common language for individual consultation; ensuring adequate time and space for conversations; raising patients' personal capacity to contribute by trusting and supporting their input; and challenging existing organisational systems and philosophies. Implementing these could provide the opportunity for all involved in my health interactions to flourish.

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