

Factors that enable nurse–patient communication in a family planning context: A positive deviance study

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Abstract

Background: Family planning programmes in developing countries need a better understanding of nurse–patient communication in order to improve the quality of counselling.

Objectives: To identify factors in the clinic and in the community that enable nurses and patients to communicate effectively with one another.

Design: The study explored the personal experiences of nurses and patients who communicate especially effectively during family planning consultations (so-called “positive deviants”).

Setting: Sixty-four randomly selected public clinics located in East Java, Indonesia.

Participants: Seven positive deviant nurses and 32 positive deviant patients were identified from among 64 nurses and 768 patients who participated in an earlier patient coaching study. Flooding prevented 5 patients from participating in the study, reducing their number to 27.

Methods: Investigators conducted: (1) a content analysis of qualitative data collected by structured in-depth interviews and focus-group discussions (FGDs) with positive deviant nurses and patients, and (2) analyses of variance (ANOVA) of quantitative data on clinic, nurse, and patient characteristics.

Results: Positive deviant nurses identified four factors, listed in rough order of importance, that helped them communicate effectively: independent study to strengthen their knowledge and skills; communication aids; feedback from colleagues; and motivation stemming from a desire to help people, patients’ appreciation, husband’s support, and increased income. Positive deviant patients identified five enabling factors: motivation due to their need for a service; confidence in their own communication skills; positive feedback from nurses; belief in patients’ right and responsibility to communicate with nurses; and communication aids.

Conclusions: Insights from positive deviant nurses and patients suggest that efforts to improve nurse–patient communication should go beyond conventional communication skills training. Managers should consider a mix of clinic-based interventions (such as peer feedback, communication aids, and better management of patient flow) and community-based interventions (such as patient education and mass media).

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Keywords: Counselling; Family planning; Nurse–patient communication; Positive deviance; Qualitative research

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What is already known about the topic?

- Effective nurse–patient communication is challenging.
- Most patients participate little in family planning consultations.

What this paper adds

- In low-resource settings, independent learning and peer feedback offer practical and effective alternatives to costly formal training on communication skills.
- Training is important but insufficient to improve the quality of nurse–patient communication; other clinic interventions, such as providing communication aids and managing patient flow can also contribute.
- By changing social norms and narrowing the social distance between nurses and patients, community interventions can improve nurse–patient communication.

1. Introduction

1.1. Nurse–patient communication

Communicating with patients is an essential part of nursing care. In family planning, it contributes to sound decision-making and can help patients use their chosen contraceptive method appropriately and effectively (Rudy et al., 2003). Studies show, however, that even well trained and experienced nurses may find communicating with patients difficult (Fallowfield et al., 2001). While nurses may accept the theory of patient-centred care, their actions often discourage patient communication and participation (Wellard et al., 2003). Ineffective nurse–patient communication has been blamed largely on nurses' weak communication skills, but other factors also contribute to the problem. These include a task-oriented approach to nursing, workplace policies and practices, lack of time and privacy, and work-related stress (Bowles et al., 2001; Chant et al., 2002a; Wellard et al., 2003).

Family planning poses special challenges for nurse–patient communication because it involves discussing sensitive topics, such as sexual practices and personal relationships. The nursing and family planning literature suggests that several kinds of behaviour can facilitate open and honest communication on difficult issues like these (McCabe, 2004; McCann and Baker, 2001; Murphy and Steele, 2000; Rudy et al., 2003). Patient-centred care involves talking to patients as individuals, seeking to understand and respond to their needs and preferences, and inviting them to participate and help make decisions. Attending behaviours help establish an atmosphere of trust; they include showing concern and empathy, treating patients respectfully, proceeding without hurry, and assuring confidentiality. Warmth and friendliness helps nurses establish a rapport with patients and ease their anxiety. Non-verbal communication – such as eye contact, facial expressions, gesture, and touch – is as essential as words to all of these behaviours.

In developing countries – where most health care providers are nurses – many service delivery systems are struggling to meet basic standards for family planning counselling despite significant investments to improve the quality of care. A narrow focus on training nurses often hampers these efforts. Health organisations tend to:

1. Concentrate on the provider almost to the exclusion of the patient, even though successful family planning consultations are a dialogue in which patients participate by volunteering information, voicing concerns, asking questions, seeking clarification, expressing preferences, and making choices (Rudy et al., 2003).
2. Overemphasize training and ignore other factors in the workplace that influence nurses' ability to communicate with patients, including policies and protocols, feedback and support, environmental distractions, and organisational culture (Chant et al., 2002a; Lande, 2002).
3. Ignore factors outside the clinic, even though both nurses' and patients' behaviour is deeply influenced by the attitudes and actions of family members, friends, and community members and by social norms (Rudy et al., 2003).

In Indonesia, chronic underfunding of the health care system aggravates the situation. Equipment, facilities, and health care professionals are all in short supply. The country's extensive primary care system is staffed by nurses and midwives, who provide a wide range of services – including family planning – at community health centres. Limited training and preparation, inadequately defined job responsibilities, and a lack of formal practice standards and regulatory frameworks contribute to poor and inconsistent performance by nurses and midwives (Hennessy et al., 2006).

Cultural norms and the social setting in Indonesia also reinforce unequal relationships between patients and health care providers, which are typical of medical interactions worldwide: patients tend to defer to providers' medical expertise and higher social standing while both doctors and nurses often assume an authoritarian role (Roter and Hall, 1992; Shattell, 2004). Social interactions in Indonesia are governed by two basic principles: conflict avoidance (as a way to preserve social harmony or *rukun*) and respect for people of higher status, which includes nurses and other providers (Magnis-Suseno, 1987). As a result, patients tend to be passive and deferential during family planning consultations. An analysis of the communication style of Indonesian family planning patients found that they do not feel free to voice opinions, concerns, or confusion to nurses (Kim et al., 2001). Wide disparities in education and social class also create a profound social distance between patients and providers in Indonesia, which further constrains patients' efforts to communicate (Kim et al., 2003).

1.2. The positive deviance approach

To gain a deeper understanding of the factors that promote effective communication between nurses and family planning patients in Indonesia, this study employed a positive deviance (PD) approach. While PD methodology was originally developed to address childhood malnutrition, it has since been applied to a variety of health and social issues in developing countries (Lapping et al., 2002; Masterson and Swanson, 2000). PD inquiries focus on individuals who behave differently from the rest of the community and, in so doing, succeed where others fail. These superior performers, who are termed “positive deviants,” may include poor mothers who feed their young children a nutritious diet, teenagers who successfully negotiate condom use, or parents who resist social pressures to circumcise their daughters (Marsh et al., 2004; Sternin, 2004).

Insights into how and why PD individuals behave differently from their neighbours can help health programmes develop effective strategies to promote desirable behaviours (Marsh et al., 2004). For example, an Egyptian campaign against female circumcision focused on the procedure’s emotional and psychological trauma, rather than its physical harm, after a PD inquiry found this was the most compelling argument against it (Masterson and Swanson, 2000). Similarly, childhood nutrition programmes have encouraged widespread adoption of the feeding practices employed by PD parents (McNulty, 2005). Because PD solutions like these come from within the community, they are by definition affordable, accessible, culturally acceptable, and sustainable.

Research suggests the usefulness of the PD approach in Indonesia, where improving the quality of nurse–patient communication is a major goal of the national family planning programme. Although the quality of communication during Indonesian family planning consultations is generally poor, some nurses and patients have proven to be effective communicators (Kim et al., 2000; Kim et al., 2001). In other words, positive deviants do exist. Indonesia’s Sustaining Technical Achievements in Reproductive Health/Family Planning (STARH) project sought to capture the insights of these positive deviants in order to help design practical interventions to improve nurse–patient communication. The study posed two research questions:

- How do positive deviants – that is, nurses and patients who communicate especially effectively – differ from average performers?
- What factors enable their superior performance?

2. Methods

2.1. Identifying PD nurses and PD patients from an earlier study

PD nurses and patients were identified from an earlier study of patient coaching in Indonesia (Kim et al., 2003).

This study took place in 64 randomly selected public clinics located in two districts of East Java province: Jombang and Mojokerto. (A description of the initial randomisation of clinics can be found in Kim et al., 2000.) One nurse from each clinic participated in the study, and data were collected in November–December 2000. Each of the 64 nurses was audio taped with 12 randomly selected family planning patients, for a total of 768 patients. Half of these patients were assigned to the intervention group and received individual coaching on communication skills in the clinic waiting room before seeing a nurse. The remainder, who were assigned to the control group, received a booklet on HIV/AIDS to read while waiting to see the nurse.

Investigators re-examined data from the audio taped consultations to identify PD nurses and PD patients in both the intervention and control groups. As part of the earlier study, the audio taped conversations were coded with the Roter Interaction Analysis System (RIAS) (Roter, 1997) and with patient communication codes developed by Cegala et al. (2000) and Socha McGee and Cegala (1998). (See Kim et al., 2003 for a detailed description of the coding process.) Although little used in nursing research, conversation analysis of this kind holds great promise for studies of nurse–patient communication (Jones, 2003). Because the coding relied on audiotapes, it reflects only spoken conversation and does not include non-verbal communication.

PD nurses were identified from RIAS data on facilitative communication. This is a cluster of behaviours believed to foster dialogue, rapport, and patient participation. It includes RIAS codes for asking lifestyle and psychosocial questions, giving information and counselling on lifestyle and psychosocial matters, building a partnership with patients (self-disclosure, checking for understanding, asking for opinion, stating opinion), expressing positive emotion (approval, empathy, concern, reassurance), showing agreement or understanding, and making personal or social remarks (Kim et al., 2000). The investigators’ goal was to identify the top 10% of nurses (about 6 or 7 individuals) based on facilitative communication scores. Since each nurse was recorded with 12 different patients, investigators assessed: (1) how well nurses performed, as measured by their average facilitative communication score across all 12 consultations; and (2) how consistently nurses performed, as measured by the range of variation in their facilitative communication scores for each consultation. Among the nine nurses with the highest average facilitative communication scores, two were dropped because they performed inconsistently; that is, their facilitative communication scores varied widely between consultations. The remaining seven nurses, whose scores varied little between consultations, were identified as positive deviants.

Criteria from both coding systems were used to identify PD patients. Investigators identified (1) the top 15% of patients according to Cegala codes for eliciting and supplying information and (2) the top 15% of patients according to RIAS data on active communication. Active communication

is operationally defined as the number of questions, opinions, concerns, and requests for clarification expressed by the patient. The results were cross-tabulated to identify 32 PD patients (4% of the total) who scored in the top 15% on both criteria.

Because PD nurses and patients were selected independently of one another, they did not necessarily share the same consultations. Results show, however, that PD patients were more likely than others to be attended by PD nurses. PD nurses served 78% of PD patients, compared with 20% of non-PD patients.

All of the nurses and patients identified as positive deviants agreed to participate in the study when asked for their consent. This reduces the chance of self-selection bias among the study subjects.

2.2. Qualitative data collection

Qualitative data on PD nurses and patients were collected in January–February 2002. Participating nurses and patients travelled to central locations for in-depth interviews followed by focus-group discussions (FGDs) later the same day. Time constraints prevented 2 of the 7 PD nurses from attending, so the nurses' focus group included only 5 participants. However, the 2 missing nurses were visited individually at their homes, so all 7 nurses were interviewed. Unexpected and serious flooding also prevented 5 of the 32 PD patients from attending, so a total of 27 patients participated in those interviews and FGDs. Five patient focus groups were held, each with 5 or 6 women who were grouped together based on geographical convenience.

The individual interviews lasted 45–60 min. At the beginning of each interview, the participants listened to an audiotape of one of their own counselling sessions. Then the interviewer asked about a series of factors that might have enabled their communication, including interpersonal communication skills, the clinic environment, feedback, motivation, and expectations about appropriate behaviour. Nurses and patients explained whether and how each factor influenced their communication and ranked them in order of importance. The interviewers took notes on each participant's responses. The FGDs followed a similar pattern to the interviews, with facilitators raising potential enabling factors for discussion one at a time. While the facilitators were not specially trained for this study, they were highly experienced in conducting FGDs on reproductive health issues. Each FGD lasted 2 h and was recorded verbatim. The FGDs were later translated into English and transcribed. While the individual interviews ensured that every participant had an opportunity to voice her opinion, the focus groups served to confirm the results of the interviews and to generate additional insights from the group dynamics. According to facilitators, the women participated actively in the discussions and expressed their feelings and opinions freely.

The list of factors probed by the interview questionnaire and FGD guide was drawn from the human performance

technology framework, which is the primary model for quality improvement in Indonesia's STARH project. This framework has been widely used to analyze the performance of workers, including health care providers, in diverse settings (Lande, 2002; Stolovitch and Keeps, 1999).

2.3. Data analysis

The major findings of this study come from the qualitative dataset. Three investigators independently performed a content analysis of the interview notes and focus-group transcripts. Whenever a nurse or patient described a person, place, incident, experience, feeling, or attitude that they believed affected their ability to communicate, the investigator extracted the underlying concept, sometimes along with illustrative quotations. Each investigator then grouped these key concepts together according to themes drawn from the human performance technology framework. The final step was to organise the concepts in rough order of importance according to the nurses' and patients' own rankings.

All three investigators then compared and discussed their content analyses in order to achieve a consensus. Results from the interviews and focus groups were entirely consistent, making it easier to identify recurring patterns and to draw conclusions about the relative importance of various enabling factors. While the methodology was not rigorous enough to precisely rank the enabling factors, it was possible to identify a group of factors that participants agreed were most important.

To complement and amplify the qualitative findings, investigators re-examined quantitative data collected as part of the patient coaching study from which the PD nurses and PD patients were drawn. A series of analyses of variance (ANOVA) were conducted to compare PD nurses and PD patients with their peers who did not communicate as effectively. These analyses examined data on the clinics (consultation spaces, communication aids, and supervisory visits), the nurses (socio-demographic characteristics, training, experience, and motivation), and the patients (socio-demographic characteristics, self-efficacy, and assertiveness). Since these data were not collected for the purposes of this study, they offer limited insights.

3. Findings

3.1. Nurses

3.1.1. Communication patterns

The frequency of facilitative communication in sessions with PD nurses was nearly double to that in sessions with other nurses (74.4 utterances versus 38.7 utterances, $p < .001$). Although facilitative communication was the only criteria used to select PD nurses, they also performed significantly better than other nurses in giving technical and tailored information to patients (Table 1). Technical infor-

Table 1
Mean frequency of selected communication behaviours per consultation by positive deviant (PD) and other providers

Communication behaviours	Consultations with PD providers (<i>n</i> = 84)	Consultations with other providers (<i>n</i> = 684)
Facilitative communication***	74.4	38.7
Technical information-giving***	105.7	48.4
Tailored information-giving**	40.0	21.0

*** $p < .001$.

mation-giving consists of generic information on family planning and biomedical issues that is not related to the patient's personal situation. It includes RIAS codes for giving medical, family planning, and routine information. Tailored information-giving consists of information and advice related to the patient's personal needs and circumstances. It includes RIAS codes for giving personalized family planning information, giving lifestyle and psychosocial information, and counselling on medical, family planning, lifestyle, and psychosocial issues. Due to increases in facilitative communication, technical information-giving, and tailored information-giving, sessions with PD nurses were 4.5 min longer than other consultations (13.6 min versus 9.1 min, $p < .001$).

3.1.2. Socio-demographic characteristics

Like the vast majority of family planning providers in Indonesia, participants in this study were nurses, and some had additional training as midwives (Table 2). Both PD and other nurses had an average of 17 years of experience offering family planning services, and were equally likely to have a private practice (86% versus 84%). All were women, and virtually all were Javanese. There were no significant differences in age and economic status between PD and other nurses, but PD nurses were significantly more likely than others to be divorced, to have fewer children, and to be non-Moslem (Table 2). It is not clear whether these differences are meaningful, since the small number of PD nurses magnifies the impact of any one or two individuals on the analysis.

3.1.3. Knowledge and skills

PD nurses generally considered their professional knowledge and skills to be the most important factor enabling them to communicate effectively with patients. However, they stressed that few formal training opportunities were available to them. Data from the patient coaching study shows that PD nurses had similar levels of training as other nurses.

To compensate for the lack of training, PD providers described finding ways to improve their knowledge and skills through independent study. As one provider explained, "Books on family planning, TV is also helpful—health programmes, they are often about family planning. It seems that I receive knowledge from many sources." Some providers reported reading reference books, guideline documents, and materials that colleagues brought back from

workshops. Others tried to improve their counselling skills by role playing with colleagues.

3.1.4. Feedback

PD nurses cited feedback on their performance at work – from peers, patients, and supervisors – as another enabling factor. Most often feedback came in the form of positive comments: "You are very patient when dealing with a patient, and when you give an explanation you are very confident and very clear." Sometimes, however, criticism or suggestions were offered: "Ma'am, when you counselled that patient, it was not clear." The way feedback was delivered could affect its value. One nurse commented, "In general I am happy getting feedback, but if the critic is too sharp, I cannot stand it. . . . I think I work hard already."

Colleagues, often friends working at the same facility, were the most consistent source of feedback for PD nurses. This is not surprising, given the sparse and irregular formal supervision documented by the quantitative data. PD nurses explained that peers understood the challenges of the work and had an accurate sense of how each other performed, making their feedback more useful. Nurses especially valued feedback from colleagues who had received training in interpersonal communication and counselling skills. PD nurses also valued feedback from supervisors and patients but did not receive it as consistently.

3.1.5. Communication aids

Most PD nurses credited communication aids with facilitating nurse–patient communication and used them regularly: "When I pass on information, I always use pictures or posters or I can use the actual contraceptive device." Nurses said the communication aids increased their confidence in their ability to give accurate information to patients and also helped patients understand and ask questions. As one participant said, "Using these tools helps us explain things to patients during counselling, and they also make us feel confident." Communication aids were equally available at clinics where PD and non-PD nurses worked.

3.1.6. Motivation

PD nurses said that the satisfaction of being able to help and the appreciation expressed by others motivated them to perform as well as possible. As one respondent explained, a nurse "is pleased if she can help patients, and very happy if patients appreciate her. Proud if her supervisor and friends

Table 2
Percent distribution of selected professional and socio-demographic characteristics among positive deviant (PD) and other providers

Characteristics	PD providers (n = 7)	Other providers (n = 57)
Qualifications		
Nurse	71.4	84.2
Nurse-midwife	28.6	15.8
Age		
25–34	14.3	28.2
35–53	85.7	70.2
Number of children*		
0–1	42.9	17.5
2	42.9	50.9
3 or more	14.3	31.6
Marital status**		
Married	71.4	96.5
Divorced	28.6	3.5
Monthly expenses per family member ^a		
Low (100–200,000 rupiah)	14.3	31.6
Medium (210–340,000 rupiah)	57.1	31.6
High (>350,000 rupiah)	28.6	36.8
Religion		
Moslem	71.4	94.8
Catholic	14.3	1.8
Protestant	14.3	3.5

* $p < .05$.

** $p < .01$.

^a The exchange rate at the time of the study was: US\$ 1 = 10,000 rupiah.

appreciate her.” While the patient coaching study did not find any difference in the value that PD and other nurses placed on helping others, that data could be biased by nurses’ desire to give socially acceptable answers.

Unexpectedly, PD nurses repeatedly cited their husbands’ support as a motivator. Husbands appear to have an interest in their wives’ performance because it can improve the family’s social status in the community and increase the family’s income. PD nurses also mentioned increased income as a motivation: they note that satisfied patients will come back for additional visits and that a

reputation for good counselling will attract additional patients. However, their economic status was no different from that of other nurses (Table 2).

3.2. Patients

3.2.1. Communication patterns

As Table 3 shows, PD patients communicated far more actively than other patients, for example, asking five times as many questions and volunteering almost four times as much unsolicited information. As a result, sessions with PD patients lasted twice as long as other consultations (19.8 min versus 9.3 min, $p < .001$). In addition, PD patients had a significantly larger share of the conversation than other patients (37% versus 32% of all utterances, $p < .01$).

Because the patient coaching intervention tested by the original study was designed to increase patient participation, it might be expected that a disproportionate number of PD patients received coaching. There was no significant difference, however, in the proportion of PD and non-PD patients who were in the intervention group (59% versus 50%, ns).

3.2.2. Socio-demographic characteristics

Both PD and other patients were married women with children, and over 97% of both groups were Moslem and Javanese. As Table 4 shows, there were no significant differences in age, number of children, or economic status. However, PD patients were significantly better educated than other patients and were more likely to choose the pill or IUD.

3.2.3. Feedback

Data from the patient coaching study suggest that nurses’ behaviour influences patients’ behaviour: PD patients were more likely than others to be attended by PD nurses, and they were also more likely than other patients to report receiving positive feedback from nurses.

In focus groups and interviews, PD patients consistently emphasized the importance of providers being responsive and encouraging them to talk. Patients said that nurses encouraged patients to communicate by being friendly; making it clear that patients’ concerns and satisfaction are important; welcoming patients’ questions and giving relevant, clear, and complete answers; allowing patients suffi-

Table 3
Mean frequency of selected communication behaviours per consultation by positive deviant (PD) and other patients

Communication behaviours	Consultations with PD patients (n = 32)	Consultations with other patients (n = 736)
Communicates actively***	49.1	11.7
Asks questions***	24.6	4.8
Gives solicited information***	43.3	23.6
Gives elaborated information***	16.4	5.1
Gives unsolicited information***	27.6	7.4

*** $p < .001$.

cient time to express themselves; making eye contact with patients; making appropriate gestures; thanking patients for the visit; praising patients' ability to communicate; and praising patients' personal attributes. One patient described how a nurse encouraged her to ask questions: "She asked 'What's the problem?' so it seems that she cares. And after I

asked several questions and she answered them well, she also said, 'If you still have any questions, please ask.' So it makes me dare to ask." In contrast, negative feedback from nurses may discourage patients from communicating. Patients complained about nurses and doctors who were unfriendly, impatient, or in a hurry and allowed no time to ask questions.

Table 4
Percent distribution of selected socio-demographic characteristics among PD and other patients

Characteristics	PD patients (n = 32)	Other patients (n = 736)
Age		
17–24	18.8	20.4
25–34	50.0	51.8
35–50	31.3	27.8
Number of children		
0–1	28.1	30.8
2	46.9	39.6
3 or more	25.0	29.6
Education*		
Elementary or less	21.9	45.0
Completed junior high school	34.4	29.1
Senior high school and beyond	43.8	26.0
Monthly expenses per family member ^a		
Less than 60,000 rupiah	34.4	48.3
60,000–375,000 rupiah	65.6	51.7
Assertiveness ^b		
Low (<15)	3.1	10.6
Medium low (15–19)	28.1	39.0
Medium high (20–24)	56.3	37.4
High (>25)	12.5	12.9
Reason for visit*		
New client, never user	25.0	12.7
New client, restarting	25.0	20.3
Continuing client, no problems	3.1	15.6
Continuing client with problems	46.9	51.4
Contraceptive method used or adopted*		
Pill	25.0	20.7
Injectable	31.3	45.9
IUD	28.1	21.2
Implant	9.4	10.9
Other	6.3	1.4

* $p < .05$.

^a The exchange rate at the time of the study was: US\$ 1 = 10,000 rupiah.

^b Assertiveness was assessed by asking clients how comfortable they felt in the following seven potentially difficult social situations and totaling the responses: asking someone to repeat what they said when you do not hear clearly, asking for clarification when you are confused by what someone says, telling a friend that she/he has disappointed you or let you down, telling a friend that she/he has said or done something that bothers you, turning down a friend's request to borrow money, turning down a social invitation, and requested the return of a borrowed item.

3.2.4. Communication aids and the clinic environment

PD patients highly valued the communication aids available at the clinics. They said the pictures and contraceptive samples helped them understand the nurse's explanations and formulate questions. As one patient explained, "If we can see the picture, it is clearer for us so we can feel steady. We can understand more, so we can ask more."

PD patients also were sensitive to the number of patients waiting to be served. They strongly believed that they should not monopolize a nurse's time if the clinic was busy: "I think it is appropriate [to ask as many questions as needed], but we have to consider whether the nurse is busy or not. If she is busy and she has a lot of patients, we can ask the questions another time."

While experts have stressed the importance of privacy for nurse–patient communication on family planning, PD patients said privacy was not a key factor.

3.2.5. Motivation

PD patients felt that the gravity of their situation, that is, their need for a service or to resolve a problem, motivated them to communicate proactively. In particular, continuing patients said they were more persistent in seeking information and attention when they experienced side effects or other problems. They understood the importance of full disclosure in this situation: "If I hide my problem and do not explain it completely, the nurse will not know exactly what my problem is and will make the wrong suggestion." Indeed, when compared with other patients, PD patients were less likely to be continuing patients without problems, who generally have little to discuss with nurses. They were more likely to be new patients without prior family planning experience, who are in greater need of information and discussion than other women (Table 4).

Encouragement from family and friends also motivated some PD patients. Some described how a husband, a local school principal, or a fellow member of an Islamic organisation encouraged them to ask the nurse about their concerns.

3.2.6. Self-efficacy

PD patients expressed confidence in their ability to communicate with nurses. They attributed it to:

- Their natural temperament, although differences in assertiveness between PD and other patients did not prove significant (see Table 4 for the operational definition of assertiveness and the data),

- Experience interacting with people outside of the home, for example, as members of community organisations, and
- Familiarity with the provider: “If I already know the nurse, I feel confident, but if I don’t, I feel doubtful or afraid.”

Knowing providers is described not only in terms of having visited a particular clinic or nurse before, but also in having positive interactions with the nurse in the community, outside the clinic setting.

Patients noted that socioeconomic disparities between the patient and nurse could present barriers to communication. This was considered less of a problem when patients were familiar with the nurse or clinic. Lack of familiarity and wider social disparities made patients feel less confident in urban than in rural clinics.

3.2.7. *Role expectations*

PD patients talked in terms of their “rights” and “responsibilities” for communicating their needs to providers, perhaps because of the coaching intervention. That intervention may explain why there was no difference in the opinions of PD and other patients regarding the right to ask questions and speak out during consultations.

Many PD patients mentioned the importance of preparing questions in advance and speaking out proactively, which were key messages in the coaching. Others thought it equally important for patients to be able to formulate additional questions as issues naturally arise during the consultation.

4. Discussion

As hoped, the PD inquiry was able to capture insights from family planning patients as well as nurses, and to examine enabling factors in the community as well as the clinic. The results were used to inform an array of interventions mounted by the STARH project to improve communication between nurses and family planning patients in Indonesia (Kim et al., 2007b).

4.1. *Moving beyond training*

PD nurses and patients in Indonesia agree that nurses’ communication skills are a key factor in good communication. The conventional approach to strengthening nurses’ communication skills is training, which is highly valued by PD nurses. Many studies have tested the impact of formal training programmes on nurses’ ability to communicate with patients (Chant et al., 2002b; Kruijver et al., 2000; Sheldon, 2005). The results of this PD inquiry indicate how such training can be refined to be even more effective. First, PD patients interpreted a wide and diverse range of nurses’ behaviours as positive encouragement to communicate during consultations. These behaviours go far beyond standard

health care communication skills, such as active listening, to include friendliness, gestures, and praise. Research on nurse–patient interactions in a variety of settings suggests that these types of behaviours may help build an interpersonal relationship between nurses and patients that can improve the patient care experience and facilitate open communication (Fredriksson, 1999; McCann and Baker, 2001; Shattell, 2004). This suggests that nurses should be trained to use a broad array of both verbal and non-verbal behaviours to build caring connections with patients and to encourage patients to speak out.

Second, the fact that PD patients were significantly better educated than non-PD patients suggest that less educated patients tend to be less effective communicators and may benefit from additional encouragement from nurses. Patients’ educational level may shape their communication styles and also invite social labeling, both of which can influence nurse–patient interactions (Shattell, 2004). Hence nurses should be trained to be sensitive to a patient’s educational level and to make an extra effort when communicating with those who have less schooling.

Finally, different levels of communication may be appropriate depending on a patient’s situation. PD patients said that problems with and concerns about contraceptive methods gave them a practical reason to communicate more actively with nurses and made them more likely to do so. The converse of this proposition is that family planning users making routine visits – for example, for resupply – do not really need to communicate intensively with nurses. Hence nurses should be trained to communicate differently with patients depending upon the reason for their visit and their individual needs.

In low-resource settings, formal training workshops may be unaffordable. In Indonesia, for example, a study found that the cost of a 5-day training workshop on patient-centred counselling (US\$ 70 per nurse) was almost as much as a nurse’s monthly salary (US\$ 76) (Kim et al., 2000). It is notable that PD nurses identified two effective and inexpensive alternatives to formal training that are feasible and appropriate in low-resource settings. The first strategy is independent learning, which offers nurses a way to continue expanding their knowledge and skills without attending training courses. Managers can mainstream this approach by stocking handbooks and other useful reading materials in facilities, promoting relevant radio and television programmes, setting aside time for study during the workday, and adding independent learning to nurses’ job descriptions and performance evaluations. The nurses’ second strategy was seeking feedback from colleagues. This offers nurses a way to get constructive advice about their performance in the absence of outside supervision. Clinical supervision has proven to be an effective way to heighten the impact of communication skills training on nurses’ performance on the job (Heaven et al., 2006), but regular supervision is not always economically viable in developing countries such as Indonesia. Yet another affordable strategy is self-assess-

ment, in which nurses learn to critique their own performance and reflect on what happened during specific consultations, sometimes by listening to audiotapes. Self-assessment has been successfully used to improve nurse–patient communication in Indonesia (Kim et al., 2000) as well as in the United Kingdom (Wilkinson et al., 1998).

This PD inquiry also examined the impact of the clinic environment on nurse–patient communication. Like past research (Chant et al., 2002a), the results suggest that managers should go beyond training and reform the practice setting to encourage effective communication. Both PD nurses and patients in Indonesia stressed the usefulness of communication aids. Research in Nicaragua testing a family planning counselling flipchart confirms that the use of such aids can indeed improve the quality of nurse–patient communication (Kim et al., 2007a). In Indonesia, our data shows communication aids are already stocked in all clinics, so the challenge for managers is to encourage nurses to use, and patients to request, them. Special communication aids for low-literate women, such as the picture checklist of common contraceptive concerns developed in Indonesia, also merit consideration (Kim et al., 2007b).

Indonesian patients did not consider privacy important, even though lack of privacy has proven to be an obstacle to nurse–patient communication in other settings such as Australia (Wellard et al., 2003). Instead PD patients described how long queues of waiting patients inhibited their communication with nurses. These results suggest that managers should focus their limited resources on managing patient flow rather than arranging for private exam rooms.

4.2. *Moving beyond the clinic*

Unlike most nursing research, this study offers insights into community-based factors that facilitate nurse–patient communication. In Indonesia, for example, cultural norms emphasizing conflict avoidance and respect may make patients reluctant to speak out during health care consultations (Magnis-Suseno, 1987). PD patients, however, identified several conditions that may counteract these cultural norms. These include messages endorsing patients' right and responsibility to communicate their needs to providers, personal encouragement from friends and family members, and personal experience interacting with people outside the home. Similarly, PD nurses pointed to the support of husbands and friends as an important motivator.

These insights suggest that activities based in the community may be an important adjunct to clinic initiatives to improve nurse–patient communication. They have the potential to redefine what is acceptable and appropriate behaviour for patients and to generate social support for new norms governing nurse–patient interactions. Among the approaches already tested are posters and print materials asserting patients' rights, mass media campaigns modelling active patient communication, and patient education on

communication skills (Kim et al., 2003; Rudy et al., 2003). The results of this PD inquiry were used to develop posters, leaflets, and health education talks in Indonesian villages about the importance of asking questions and expressing concerns to nurses (Kim et al., 2007b).

This study also confirmed prior research suggesting that social divisions, including class, race, and gender, may be a barrier to effective nurse–patient communication (Chant et al., 2002a). In Indonesia there are often wide differences in educational level and socioeconomic status between nurses and patients, which tend to constrain patient communication (Kim et al., 2003). However, PD patients in Indonesia pointed to possible solutions: they reported that familiarity with the provider can offset the inhibiting effect of social distance between nurse and patient, perhaps because of the personal relationship established between them, as discussed above. This suggests the benefit of arranging for patients to see the same nurse each time they return to a clinic, but this poses a logistical challenge in some settings. An alternative, community-based solution is to forge greater understanding between the community and the entire staff of the local clinic. In Peru, for example, the *Puentes* Project was able to develop a positive relationship between Spanish-speaking clinic staff from urban areas and the indigenous rural communities they served by facilitating dialogue, discussion, and reciprocal social events (Heerey et al., 2003).

4.3. *Limitations*

The identification of PD patients was based on their behaviour during a single consultation, although human behaviour varies with mood and circumstances. Indeed, many of the enabling factors found during this study were situational, such as the reason for the visit or feedback from the nurse, and could change from one consultation to the next. The identification of PD nurses was stronger because it was based on their performance with twelve different patients.

The initial randomisation of the clinics included in this study, which was carried out as part of an earlier study on provider training and reinforcement, was weak (Kim et al., 2000). Although it is unlikely that this affected the later PD study, there is a chance that the randomisation created a bias.

The need to translate and transcribe the audio taped FGDs and interview notes from Bahasa Indonesian into English for analysis poses another limitation. The translation process may subtly alter content and meaning, while written transcripts eliminate clues to meaning from the speaker's tone and expression.

There was limited quantitative data available to confirm the trends that emerged from the qualitative investigation. When such data did exist, the small number of PD nurses and PD patients made it less likely that the variance between the superior and average groups would be statistically significant.

PD inquiries, by definition, focus on local behaviour patterns and local solutions to problems. The enabling factors identified in this study reflect the organisational setting and broader culture of Indonesia and cannot necessarily be extrapolated to other settings.

5. Conclusions

Insights from positive deviants, including both nurses and patients, can contribute to initiatives to improve the quality of family planning counselling and other types of nurse–patient communication. Many factors – in the community as well as the clinic – combine to enable these individuals to communicate effectively with one another during family planning consultations. Positive deviants can identify which of these enabling factors have the greatest impact on desired behaviours. They can call attention to effective, locally developed techniques that reinforce key enabling factors, such as the independent learning and peer feedback mechanisms developed by Indonesian nurses to compensate for the lack of formal training and supervision. Positive deviants also can identify false assumptions, such as the importance of privacy for open communication, and unanticipated obstacles, such as the social etiquette that comes into play when long lines of women are waiting to see a nurse.

For managers, a positive deviance inquiry offers a valuable opportunity. Managers can use the results to refine the communication skills training which forms the backbone of efforts to improve nurse–patient communication. Even more importantly, managers can consider augmenting training with a mix of clinic- and community-based interventions directed to patients as well as nurses. These interventions may range from the traditional (e.g., promoting the use of flipcharts, contraceptive samples, and other communication aids in consultations) to the unconventional (e.g., building a relationship between the clinic staff and the community as a whole in order to narrow the social distance between nurses and patients). The key is to address both halves of the nurse–patient dyad and to tackle community- as well as clinic-based factors that contribute to good communication.

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