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Communication Competences are the Key! A Model of Communication for the Health Professional to Optimize the Health Literacy – Assertiveness, Clear Language and Positivity

Célia Belim[1]* and Cristina Vaz De Almeida[2]

1 School of Social and Political Sciences, University of Lisbon, Portugal
2 ISCSP, Instituto de Ciencias Sociais e Politicas, UL - Lisboa, Portugal

***Corresponding author:** Célia Belim

celiabelim@gmail.com

Assistant Professor, School of Social and Political Sciences, University of Lisbon, Portugal.

Tel: +965487852

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Abstract

Background: Communication is an essential dimension of human life and of social spheres, such as health sphere, and concretely of therapeutic relations. And having health decides the human well-being. However, Europeans face an urging problem related with low levels of health literacy and human communication in doctor-patient relationship has not concentrated in doses of an effective comprehension, indispensable to the health treatment. There are several studies on the need to use communication competences due to better health outcomes are based on the ability to communicate with patients. And studies show that a fragile communication quality within health professional influences the relationship between low health literacy and a deficient health. This article focuses on the contribution of communication competences, used by healthcare professionals in the clinical relationship with patients, to improve therapeutic adherence through a better understanding of health instructions and, hence, higher competences in health literacy. It is a main and specific goal to construct and validate by health specialists a model of communication competences, that includes the interdependent use of assertiveness, clear language and positivity by the healthcare professional.

Methods and findings: The research is based on the literature review and on technique of focus group (FG), used to obtain validation of the 3-factor model of communication by health specialists. The four focus groups are composed by Portuguese medical doctors, nurses, other healthcare professionals and specialized professors on health literacy. A semi-structured script and a 40-item list, that configures the quantitative form to complete the qualitative approach, allows to ascertain the items / indicators that the participants most associate with the three interdependent variables / factors of health communication. Operationalizing the model and decomposing the three key factors / variables of model, all the participants in focus group validate the model and most punctuate, in assertiveness, active behavior, ability to listen and ability to openly speak; in clarity, the simple language, utilization of verbs; and, in positivity, orientation to a positive behavior of the patient.

Conclusion: The results confirm that the investment in the communication competences by the health professional is reflected in the optimization of the results on the health literacy of the patient. Concretely, the concerted use of assertiveness, clarity (of language) and positivity are a key solution to the optimization of health literacy and clinical practices, recognized and validated by the participants in the focus groups.

Keywords: Health communication; Health literacy; Communication competences; Assertiveness; Clarity; Positivity; Therapeutic relationship

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Introduction

Human communication reveals the essence of Man [1,2]. And, in the health field, the type and quality of communication adopted conditions the results. However, a pressing problem is overshadowing the health results since in current practice human communication is often poorly utilized which weakens the efficiency of therapeutic relationship [3].

Health communication is described as: "interpersonal or mass communication activities which are directed towards improving the health status of individuals and populations" [4]. The Centers for Disease Control and Prevention (CDC) (2011) adds to the composition of concept "the study and use of communication strategies to inform and influence individual decisions that enhance health".

We assume as bases of health communication: a) healthcare professionals depend upon communication to provide their patients information on prescribed treatment strategies; b) the human communication is the primary tool that patients have for gathering relevant information; c) the quality of communication between healthcare providers and patients strongly influences the effectiveness of modern healthcare [5-8]. Admitting these premises, How is the most effective model of communication in health? Which are the communication competences required to the health professional?

Competence is defined by the presence or absence of specific verbal and nonverbal behaviors within the context of individual interactions with patients or families [9]. Communication competences are the behavioral repertories or set of behaviors that support the attainment of organizational goals and that allow to successfully accomplish tasks and responsibilities over time and in a stable way [10,11]. The concept means the "perceived tendency to seek out meaningful interaction with others" and integrates along three dimensions of cognitive (information interpretation, exchanges skills of individuals across contexts), behavioral (skills which individuals employ to select and implement goal-oriented strategies while maintaining the integrity of other interactants) and affective skills (influence of locus of control orientations upon interpersonal interaction) [12,13].

Communication competences are vital to the optimization of therapeutic relationship and of the health literacy due to better health results are based on the ability to communicate with patients [14-16].

The World Health Organization (WHO) (1998) defines "health literacy" as the set of "cognitive and social skills which determine the motivation and the ability of individuals to gain access to, understand and use information in ways which promote and maintain good health".

"Building health literacy is more than providing health information" and research and evidence confirm that mere provision of information is insufficient to enhance active and informed health behavior [17-20].

The persuasion theory (e.g. Hovland, Janis & Kelley 1953) advocates that persuasive communication, transmitting the why, is pivotal when communicating a message to ignite behavior [21]. Hovland group confirmed that communicators high in expertise and trustworthiness tend to be more persuasive [22]. In this theoretical anchorage in the field of communication, it is worthy of note the Hall's concepts of "hegemony" and "preferred reading", which alludes to the symmetry and perfect fit between the encoding (of the health professional) and the decoding (patient) [23,24]. It means that the interpreter's decoding strategies proceed along the same logic as the producer's encoding strategies. The encoding of a message is the production of the message, a system of coded meanings [24]. The decoding of a message is how an audience member is able to understand, and interpret the message. It is a process of interpretation and translation of coded information into a comprehensible form [23]. Without conflict, the meaning is secured hegemonically i.e., fully and straightly perceived. "When the viewer takes the connoted meaning full and straight and decodes the message in terms of the reference-code in which it has been coded, it operates inside the dominant code" [24].

The literature is consensual in the idea that there is a virtuous circle where communication is the key to improve better empowerment, and empowerment conducts to a better patients' health literacy.

It is pertinent to study health literacy due to being correctly enlightened about the good health behaviours and decisions benefits health and all human well-being and to improving clinical practices, and given the findings of statistical data. The therapeutic relationship is the interaction where health literacy can be nurtured and stimulated: enlightenment, empowerment, understanding, confidence, decision-making, and pro-activity of the patient can be motivated and optimized through the communication competences of the health professional. Studies show that the relationship between limited health literacy (LHL) and poor health is due to faulty communication quality within health care delivery organizations [25]. Wynia and Osborn's study advocate that, after communicational adjustment for patient demographic characteristics and health care organization type, patients with LHL were 28% to 79% less likely than those with adequate health literacy to report that their health care organization "always" provides patient-centered communication across seven communication items [25].

LHL impacts negatively in the doctor–patient communication within the clinical encounter [26]. Patients with LHL have greater difficulty understanding clinicians' verbal explanations of medical conditions and instructions about medication changes, and they report poor satisfaction with patient–physician communication [27-29]. Therefore, the communication requirements with these patients must be doubled and communication with specific features can increase health literacy. There is a dependent relationship that needs to be explored and which is object of our research commitment.

The health context in terms of communication is both problematic and stimulating: a) the Europeans have low levels

of health literacy; b) in current medical practice, the human communication is often poorly utilized [3]; c) the research has identified that nurses overestimate their patients' health literacy [30], and that the overestimation of a patient's health literacy by nurses may contribute to the widespread problem of poor health outcomes and hospital readmission rates and increased costs to the health system [31]; d) it has been exposed that, even in non-stressful clinical encounters, patients are still reluctant to admit to any lack of understanding and feel compelled to follow the recommendations as they understand them, rather than ask for clarity; e) the studies on communication/interaction and health literacy remain limited [27,31-34].

Faced with this diagnosis, we identify and propose a solution: a 3-factor model of communication competences based on the contributions from the literature review. Assertiveness, clarity (of language), and positivity are interdependent keys to achieve positive outcomes.

An assertive personality has the ability to self-analyze in order to evaluate one's own feelings and to control one's personal impulses [35] and recognizes one's rights and the others' rights and does not violate them [36,37]. The assertiveness can be understood as certainty [38,39] and capacity to openly speak about desires and needs, to tell "no", and to begin, maintain and conclude a conversation [40-42]. Assertiveness is linked to self-esteem, assuming "a form of behavior characterized by a confident declaration or affirmation of a statement without need of proof" [43]. Assertive posture is a social competence and a virtue in the sense it remains in the middle between two inappropriate extremes, one for excess (aggression), another for lack (submission) [40]. The implementation of an assertive behavior conducts to self and mutual respect, benevolent perseverance, and politeness [37]. Assertiveness is also a component of the patient participation, within the utterances, in which the patient expresses an opinion, states a preference, offers a suggestion/recommendation, expresses a disagreement or some other challenge to the health professional, or issues a request [44].

Plain language makes health information more accessible and is a necessary requirement in healthcare professionals' daily practice when communicating with patients [45].

Clear language is immediately understandable and, in this sense, is based on short, simple, nonmedical words that are easily comprehensible [46,47]. Real-life analogies or stories relevant to patients' experiences are also helpful [48]. Patients misunderstand health communications more often than clinicians might think [49]. Therefore, to ensure the understanding, it is of the utmost necessity to confirm the exact decoding of the transmitted information. Using clear oral communication strategies can help the patients to better understand health information, and communicating clearly also helps patients to feel more involved in their health care and increases their likelihood of following through on their treatment plans [49].

Clear or plain language presupposes the use of the active voice, the use of second person of the verb (you), that the technical jargon must be limited, the sentences should only be up to 15 words or less and 8th grade reading level, and data should be easy to understand [50]. Some strategies for communicating clearly are: greet patients warmly, make eye contact, listen carefully, use plain, non-medical language, use the patient's words, slow down, limit and repeat content, be specific and concrete, show graphics, demonstrate how it is done, invite patient participation, encourage questions and apply teach-back [49]. The recommendations state that professionals should provide non-technical explanations, or explain carefully the technical terms, including making use of written instructions, so that the patient can remember health instructions more easily [51].

Most health literacy experts emphasize several vital behaviors to foster clear communication. Plain language is a logical and flexible response and refers to communications that engage and are accessible to the intended audience [52]. Plain language communication is part of the solution to major public health and health delivery problems [52]. Plain language is not about transmitting ''dumbing down'' information, in a condescending tone, or neglecting the need for accuracy: it is about communicating for clarity and meaning [52]. Good plain language is creative, vibrant, and emotionally resonant [52]. The process of developing plain language contents requires knowledge and skills, a clear understanding of the target audience, and the use of an evidence-based approach [52].

Positive language is associated with approach goals instead of avoidance goals. The use of positive language has a compelling effect on the patients [53].

The positive language can literally change the brain and contributes to have good mental and physical health. The recommendations consist in avoiding the use of negative words and phrases, such as "I cannot", "never", "I do not", "always" and "I will not", and in constructing a framing to ideas through positive sentences, such as "I choose", "I can", "I will" [54]. People influence each other. So that eventual negative acts and speeches of the healthcare professional tend to influence negatively the patient [54]. Similarly, when the healthcare professional is positive, optimistic and hopeful, the influence over the patient will be more often hopeful [54]. The health care providers can affect some sources of self-efficacy. Specially, the health care provider can manipulate self-efficacy by using positive language, which can, in turn, improve patient adherence with health care instructions [55].

The positive subject [56] is characterized by: (1) having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; (2) making a positive attribution (optimism) about succeeding now and in the future; (3) persevering toward goals and, when necessary, redirecting paths to goals (hope) in order to succeed; and (4) when beset by problems and adversity, sustaining and bouncing back and even beyond (resilience) to attain success.

Detecting and fulfilling this gap and opportunity, this article aims to evaluate the contribution of communication competences,

used by healthcare professionals in the clinical relationship with patients, to improve therapeutic adherence through a better understanding of health instructions and, hence, higher competences in health literacy. And at a more proactive level and in an attempt to solve the problem of fragile communication, with failures in patient understanding, it is a main goal to construct a model of communication competences that includes the interdependent use of assertiveness, clear language and positivity by the healthcare professional, to which we designate "ACP model and technique". Although these components of the therapeutic relationship are listed in the bibliography, they are not yet systematized and organized as an interdependent contribution to improve the therapeutic relationship, reflected in optimized outcomes in health literacy and in clinical practices. In order to confirm its value and utility, the empirical research was conducted to validate this 3-factor model of communication competences by specialists of four focus groups. All validate the 3-factor model of communication competences.

Methods

The starting question: What is the contribution of communication competences to optimizing the results of the therapeutic relationship and health literacy? Orients this research. More concretely, what is the contribution of the model of communication competences, composed of assertiveness, clarity and positivity? Based on the literature, one operational hypothesis can be formulated: The 3-factor model of communication competences, composed of assertiveness, clarity and positivity, contributes to the perfectioning of the medical relation and to the optimized results of health literacy.

We conducted a first exploratory study on March 28, 2017, comprising one focus group with key health professionals and specialists (N=9) to explore the health professionals' perception of communication to increase health literacy on patients and to obtain validation of the ACP model from the health experts. To complement the results obtained, we conducted another three focus groups: the second on March 3, 2018, the third on March 10, 2018, and the fourth on March 17, 2018. The operationalization of each focus group followed rules proposed by methodologists, consisting on average of six participants with at least one similar feature [57,58]. In this case, the connection of professional activity to the field of health.

Data (the focus group participants' discourse) was analyzed using a qualitative technique, namely "qualitative content analysis". Qualitative content analysis is "the most prevalent approach to the qualitative analysis of documents" [59]. It comprises a searching-out of underlying themes and a generation of categories (therapeutic relationship, communication competences, assertiveness, clarity and positivity) that guide the collection of data. The sections of text (quotations and ideas exposed by participants) concerning the themes of interest were identified and retrieved.

A semi-structured script (Appendix 1), with five issues (First FG) and six (the other 3 FG) focusing on the importance of communication competences and of the communicational process within the therapeutic relationship, was administered to the focus groups. The issues covered are: 1) therapeutic relation; 2) communication competences; 3) assertiveness; 4) clear language; 5) positivity; and 6) effectiveness of the ACP technique-model in the success of the therapeutic relationship. Based on a 40 items list, the whole groups were encouraged to discuss and select (either by concordance or discordance) the items included or associated to communication competencies in the therapeutic relationship (Appendix 2). Thus, we show in a quantitative form, to complete the qualitative approach, the items/indicators that the participants most associate with the components of health communication.

The participants were selected through the database of health professionals who attend and attended post-graduate training in Communication and Health Literacy, and due to their active intervention in the fields of Health Literacy. After being identified, they were invited in-person, by e-mail or telephone, having all answered affirmatively.

All participants work or worked in the health area. In socio-demographic terms there is a predominance of the female gender (motivated by the access of the researchers to the specialists) and the average age is around 42. Comparatively to the first FG and in an attempt to find some relation with the results, a characterization variable was added: the number of years of practicing of the profession, which average is 13.8 (**Table 1**).

The contribution of communication competences for the success of the therapeutic relationship and for the increase in health literacy was discussed. The evaluation and obtained results express the perception of these health specialists.

Given the need to validate the ACP (Assertiveness, Clarity and Positivity) model and technique to improve results in the therapeutic relationship, the issues related to the definition of assertiveness, clarity (of language) and positivity in the context of the therapeutic relationship were addressed. In the scope of the therapeutic relationship, the experts were asked to define and comment on what they understood by these elements of communication.

Results

Communication is for the therapeutic relationship as oxygen is for man

There is consensus among all participants in the four groups that the success of the therapeutic relationship depends on the communication competences.

The members of first group assume that an effective therapeutic relationship is dynamic, symmetrical and trustworthy, built daily and in a specific context (the patient looks for the doctor and recognizes that the professional has the authority to accompany him therapeutically). The therapeutic relationship is fueled by empathy and availability between health professional and patient. Health professional must possess both technical and communicational competences.

In this process, the first group unanimously postulates that, no

Table 1: List of participants of the four focus groups and of their demographic and socioeconomic characteristics.

Participant	Gender	Age	Education	Professional activity	Number of years of profession
First focus group (FG)					
A1	M	50-59	Degree in Medicine	Surgeon at the IPO	
B1	M	40-49	PhD in Dental Medicine	Professor	
C1	M	40-49	PhD in Dental Medicine	Professor	
D1	F	50-59	PhD in Nursing	Professor	
E1	F	50-59	PhD student in Nursing	Professor	
F1	F	30-39	PhD student in Nursing	Professor	
G1	F	30-39	M.Sc. in Nursery	Nurse in HFF	
H1	F	50-59	M.Sc. in Nursery	Retired nurse	
I1	F	30-39	M.Sc. in Chinese Medicine	Professor in ESMTC	
Second FG					
A2	F	30-39	Degree in Nursing	Community nurse	15
B2	F	50-59	Degree in Social Sciences	Clinical Trials Manager	26
C2	F	60-69	Degree in Psychology Master in Developmental Disorders	Reformed but active in health (autism)	10
D2	F	30-39	Degree in Nursing	Pediatric Nurse	10
E2	F	30-39	Master in Nursing	Community nurse	11
F2	F	20-29	Degree in Oral hygiene	Oral hygienist	2
Third FG					
A3	F	40-49	Master in Nursing	Nurse	12
B3	F	30-39	Degree in Nursing	Coordinator of the primary prevention department	3
C3	F	50-59	Degree in Nursing	Nurse	28
D3	M	40-49	Degree in Medicine	General and family doctor	12
E3	F	60-69	Degree in Nursing, specialized in Public Health since 1992	Nurse in sterilization, retired	40
Fourth FG					
A4	F	30-39	Degree in Chinese medicine	Chinese medicine clinic	13
B4	F	40-49	Degree in Social Service	Technical assistant in transition to social service career	14
C4	F	20-29	Degree in Social Work	Social Worker	4
D4	F	30-39	Degree in Speech therapist	Speech therapist	6
E4	F	40-49	Degree in Sociology	Communication and Literacy	15

Source: Own elaboration

matter how competent the healthcare professional is and how active the patient is, an easy communication, with fluidity, clarity and simplicity to be understood by the patient, must exist. A well-structured therapeutic relationship can be established, generating effective results to the health literacy.

Being a "dynamic process", the therapeutic relationship can both grow and decrease, advocates the first group of experts. It depends on the balance state of those who seek the health professional. One expert (C1) points out that the biopsychosocial state of the patient influences his/her degree of confidence in the professional. "If a person is in a weakened situation, he or she will place greater confidence in the professional. If the person is in a situation of control, sometimes may not have as much need to have a relationship of trust with the professional".

Patients, especially "those with low health literacy, come in search of authority, and often do not even question what is being transmitted to them by health professionals. They are often embarrassed to ask and often they do not even know what to ask and want to be told what to do". The elements of first focus group also reinforce and question a very recurring issue: "There is much talk today about empowerment. But how do we empower people? How do we require the person's training when he/she has very low ability to understand?"

In the dialogical relationship, it is real the need for interaction, where communication is pivotal (H1 and A1, with the agreement of the whole group). It is necessary to understand what another wants to explain. During a genuine empathic process, the patient must believe in what the professional says, with a biopsychosocial and also a spiritual alignment. C1 exposed that: "We teach our students that, even we may be on the worst day of our life, but the patient is not guilty. We should smile and serve the patient the best we can. We know that the patient's situation is very specific and delicate. The professional must open this "door of communication". When the professional does not make this effort to communicate, there is the abandonment of therapy. Inherently, in what do we have to invest? The answer is: in the (communicational) capacitation of the health professional". All agree and verbalize this agreement.

The communication competences allow the health professional to place himself/herself in the role of the other (empathy) without judgments. This exercise of projection avoids the inequality that exists in this relation (A2, B2) and also allow to overcome the barriers (C2, F2). The availability of the professional for this communication is fundamental (D2).

All elements of the second group assume that the therapeutic relationship is an interaction, a relationship of trust, whose success depends on the attention of the healthcare professional to the signals given by the patient. Therefore, there is the requirement that the professional be a "good listener".

There is a meeting of wills in a relation that assumes an objective (all respondents of the second group agree) that is therapeutic. It is not a convivial relationship (A2). This relationship is directed towards the patient but involves both interlocutors in a positive and active interaction, integrating also the family and the community (F2). It is a win-win relationship (both come out winners) (B). It is dominated by healthcare professionals, which involves a particular language that is not just a debit of information (C). It would be a very poor relationship if it were just to send information (E2). It is necessary that this relationship integrates a feedback, especially of the patient (A2, C2).

The third group assumes that it is an authentic and genuine relationship (A3, B3), of inter-help in which the professional supports problem solving. It is a relationship based on trust (A3) and between the caregiver and the patient with a continuous feedback between the both (C3). The group three advocates that, if it were not a therapeutic relationship, it would be a "therapeutic partnership", because it makes sense to consider the patient as a partner in a therapeutic process. It is a help relationship (B3) with feedback (A3), hence the indispensability of communication as the anchor of the relationship. It is a "therapeutic consultation" (D3) because it is an act between the health professional and the patient. In a systematic confirmation, the third group recognizes the utility and indispensability of communication in this kind of relationship. A3 and E3 emphasize the need to correctly decode. If there is no good communication the relationship does not happen (all).

Participants in fourth group understand that the therapeutic relationship is: a) built based on trust between the professional and the patient and solving something and training that leads to satisfaction (C4); b) a partnership, active listening, a time of sharing and listening (D4); (c) a dynamic interaction between two parties aiming at a common objective (A4); d) an empathic relationship between professional and patient, sharing of knowledge in health (B4); e) a moment of sharing and resolving health issues (C4); f) is somewhat limiting because it provides an idea that any act of health means a therapeutic measure (E4). All participants agree on the "decisive", "extremely important", "fundamental", "very high" contribution of the health professional's communication competences for the success of the therapeutic relationship. “If I had a scale of 10, I would give 11 to the importance of communication” (A4).

ACP model and technique: Searching validation by specialists of four focus groups assertiveness

All groups agree “in unison” that assertiveness is an indispensable attribute in the therapeutic relationship.

The first group of experts advocates that the concept of assertiveness is associated with the concept of participation and depends on the cultural context in which it is used. There are people (such as the Eastern civilizations) whose feelings, attitudes or actions are not considered positive. But assertiveness must contain something straightforward and should not confuse the other part. Assertiveness is when the person makes himself/herself understandable. It is also direct and positive language and it can be measured, because assertiveness is also guiding patient behaviors.

Assertiveness can be related to clarity and objectivity that reinforce the essential information that the patient must know and understand, to the adequacy to the other to assert his/her rights. All agree that assertiveness is very useful in the therapeutic relationship.

According to these experts, the opposite of assertiveness is aggression, manipulation, confusion and insecurity. Does the assertiveness always depend on the health professional? Most of the first group confirms this dependent relation because health professional is the “stronger part” and has more information and capacity to coordinate the therapeutic relationship and therefore to influence the results. It is mainly the lack of assertiveness on the professional side that can lead to poor diagnosis, although other factors such as low levels of literacy level, culture, language skills, and socioeconomic characteristics can predict poor health outcomes.

But a patient with some cognitive ability and higher health literacy should also argue and assert his/her opinion. Although it is important that the physician guides the patient to the questions he/she should ask, the patient should ask for clarification.The first group of experts emphasizes that health professionals are the ones who have the responsibility to improve the individual's level of literacy. A person with greater literacy will know how to take better good care of his/her health and his/her life. This group agrees that there must be an investment in patient's self-efficacy through the intervention of the professional, due to the specialists of the focus group often find that patients have some knowledge but are not effective: do not know how to do and act to improve their health.

Assertiveness for the second group is essentially to put ideas clearly, to understand each other's thinking and motives before making value judgments (A2, E2). It is to respect the other, his/her individuality and culture (C2) and ensure that he/she understood the message (A2). It is to say what one has to say without offending (B2, D2, E2).

For the third group, assertiveness is also based on "clear, precise and objective" (A3) and non-offensive presentation of ideas, on understanding the other's thinking and motives, and on respect. It is to be factual, to take into account the tone of voice (D3), to

meet the user in order to he/she understands the contents (B3, C3). If the user perceives the professional, both are on the same "wavelength". Assertiveness contributes to health professional create empathy and to be credible (E3).

The members of the fourth group understand that the assertiveness is: a) transparency (B4); b) respect for myself and the other; c) clarity (A4, C4), d) motivation to act (A4); (e) at the same time, clarity, transparency and mutual respect (B4); f) show no insecurity and improve the behavior of the other for action (D4). The use of assertiveness avoids confusion, injects safety into the convalescent. It improves patient behavior by mobilizing him/her for action (B4, D4). It allows a directed action with intention (C4), a greater proximity to the user, and to stimulate a greater therapeutic adhesion (A4), and to affirm with confidence what is wanted (E4).

Clear language

The first group agrees that being “clear” also means focusing on essential and using an assertive language, which everybody understands at first time. Clear language is simple and can be enunciated in a technical way as long as an explanation of meaning is immediately made (professional jargon). This group also emphasizes that simple and clear language does not mean simplistic or infantilized one, which consider a mistake.

For the second group, clear language is perceptible (B2 and all) and understood at first (all). The professional gains with the use of this type of language, benefiting from credibility and being able to "communicate better" (F2). The technical terms can be used, in the context of an effort to adapt to a patient's stage and to his/her level of health literacy (F2). "If a patient has diabetic retinopathy, I will not confront her with this technical designation. I tell her that she has to do an “eye exam”” (D2). Although chronic patients already have a better understanding of technical language, due to habituation, it is always preferable to use clear language (D2).

The clear language is perceptible (B3, C3, D3), comprehensible (B3), adequate (A3), understood at first (all) and reinforces trust in the therapeutic relationship (E3). There are always gains with the use of this type of language (B3).

There are questions related to the cultural context (A3). "I live in a rural area and often have to adapt to the type of language people have" (C3). The participant A tells two cases: "When a person in Alentejo (a Portuguese region) told me that she had “feces", I thought she had a physical problem, but, in fact, she wanted to say that she “was in trouble". "Through communication and understanding, I realized that a homeless person did not want to sleep in bed, that he felt good sleeping on the floor" (A3). The participant C3 shares that naturally she adapted to the people to make herself understood (C3).

Clear language is accessible, simple (A4), without background noise, essential and objective (E4), aiming at improving the understanding of the message (E4). It is related with to perceive the reason for health decisions (C4), to do to obtain the results (D4).

Positivity

The experts of first group consider that this concept is critical and dispersed in literature. Positivity is focused on the action that the patient performs, which should have effectiveness. Thus, when the patient is focused on a positive aspect related to his/her behavior, he/she becomes more available for the action he/she must take in order to achieve the best health results. For example, a patient may have all his/her teeth poorly washed or sanitized, but there is one in good state. “We must start there by valuing what people already do effectively and with positive results”, says one of the experts of first group.

Motivation should be triggered by the communicational process, where the form and content of the language used influence the patient as a decoder. In this sense, the patient’s motivation should be done without using the word “no”, such as “do not do it, do not do that”. It is preferable to enunciate the positive behavior that the individual is supposed to have: “To heal your wound you must have your arm dry” instead of “You cannot dip your arm”.

One participant of first group advocates that the medical professional should not constrain the patient, arguing that the self-efficacy and the trust of both actors in the relationship are significant. If the professional believes in the results and in the capacity of the patient to be able to operationalize the action, this trust factor in the other has an impact on the increase of his self-esteem and his effectiveness to do the action that leads to a greater therapeutic adherence.

The second group agrees that positivity is always speaking or talking positively when interacting with the patient. All participants of this group also are consonants that positivity is essential for change, and that it consists not in criticizing what the patient has done wrong but in highlighting what he/she has done well. The question that arises is: "What is the positive action you want the patient to have so that he can improve his/her health? (E2,F2). Positivity is motivational and can influence the patient's level of self-esteem (A2,B2). It is the valuation of the patient's action (E2) and allows to lead to small gains that are favorable to the patient (F2).

Positivity is to speak positively (A3,B3), to transmit the negative aspects from a positive point of view (A3), to do not create false expectations in the user. Positivity is based on the perception of reality (E3) and professionals in the field must know how to read reality and to adapt to it (A3).

The professionals of the fourth group understand positivity as: empowerment (B4), affirmative communication and positive reinforcement to the patient (A4), explanation of positive action, which leads to results (D4), reinforcement of competencies (C4), autonomy and motivation of both involved in the relationship (B4), education for optimism, even the patients with low health literacy (A4). To be positive is to always transmit the part of the glass half full (and not half empty). Positivity contributes to a greater commitment and optimism of the individual (E4). Professional C warns of the connection between positivity and realism, due to the need for "realistic positivity" (C4).

Building the concepts: What indicators better characterize assertiveness, clarity (of language) and positivity?

The participants in the first focus (**Table 2**) group most punctuate, in assertiveness, active behavior, ability to listen and ability to openly speak; in clarity, the simple language, utilization of verbs; and, in positivity, orientation to a positive behavior of the patient. Recognition of one's rights and the rights of others, control of individual pulses, knowing how to say "no", contact control, personal attributes, silences of the professional and conflict management better characterize the assertiveness, according to the second group. Simple language, use of technical jargon, intonation or tone, direct language, simple words, and teach-back method are proposed to better characterize clarity (of

Table 2: Highest scores to the items / indicators that make up the assertiveness, clear language and positivity.

	First FG	Second FG	Third FG	Fourth FG
Ability to listen	9	5	5	
Ability to openly speak	9	4	3	4
Acceptance of criticism	7	4	3	3
Active behavior	9	5	4 (assertiveness), 3(positivity)	3
Affirmation without the need for proof	8	5 (negatively)	4	4
Aggressiveness and imposition	8		4 (negatively)	3 (negatively)
Certainty			3	4
Clear instructions		4	3 (assertiveness), 4(clear language)	5
Commitment in relation		5	4	
Conflict management	7	6	3	5
Contact control	7	6	4	4
Control of individual pulses		6	3	4
Courage		5	3	3
Direct language		6	3	3
Empathy		4	4	3
Encouragement of cooperation	7	5		4
Guidance for action	7	5	4	
Guidance for positive patient behavior	8	6	3	4
Guilt and shame	7	5 (negatively)	3 (negatively)	4 (negatively)
Intonation or tone		6	3	4
Knowing how to say “no”		6	4	4
Leadership	7		5	4
Motivation		5	4	5
Non-aggressiveness	8	4	4	
Personal attributes		6	4	4
Recognition of one’s rights and the rights of others		6	5	3
Respect for others	7	5	4	4
Silences of the professional		6 (2 negatively)		4
Simple language	9	6	3	5
Simple words	8	6	4	5
Specific action leading to better health		4	3	3
Strengthening of attitudes towards the disease prevention and treatment		5	5	4
Teach-back method (confirmation of correct perception)	7	6	4	5
Trust		4	4	4
Uncertainty	7 (negatively)	5 (negatively)		
Understanding the mistakes of others		4	3	3 (assertiveness), 4 (positivity)
Understanding the other		5	4	3
Use of technical jargon		6	4 (negatively)	3
Use of the first person “I” in the speech		4	4	4
Use of verbs	9	4	5	4

Source: Own elaboration

language). Guidance for positive patient behavior stands out in the positivity.

Among the third group, recognition of one's rights and the rights of others, leadership and ability to listen stand out in assertiveness, the use of verbs stands out in clear language, and strengthening of attitudes toward disease prevention and treatment is more expressive within positivity.

Conflict management, in context of assertiveness; simple language and words, the teach-back method and clear instructions, in the meaning of clarity; and the motivation between positivity are the most expressive elements among the participants in the fourth group.

ACP model: Is it the ideal model of health communication?

All focus groups participants, independently of their sociodemographic characterization, agree that the aggregate use of assertiveness, clarity (of language) and positivity in the therapeutic relationship is effective in the success of the therapeutic relationship and in improving patient health literacy.

When asked to add some communication competences, the experts suggest attributes, such as comprehension, empathy, having more time for each other, better understanding of the patient, knowing the other and being available, clear and accessible language, authenticity, respect, motivation, trust, identification of beliefs, flexibility, ponderation, presence, listening, direction, which fit the ACP technical model. That is to say, it seems that the three components of the model – assertiveness, clarity (of language) and positivity – cover the essence of what should be the ideal communicational and relational practice within the therapeutic relationship.

The 3-factor model constructed and inspired by the literature analyzed, validated and enriched by the health specialists of the focus groups constitutes a solution and a recommendation for medical or health practice. This 2 in 1 solution (both model and technique) can be a communicational practice that contributes to improve clinical practices, since, based on quality communication and based on specific assumptions, the patient's understanding of the message is ensured and, thus, the therapeutic adherence and health literacy and health outcomes increase.

There are also some recommendations or indicators within each of the competencies that the health professional must comply with (**Table 3**).

Discussion

The literature and the four focus groups are in harmony on the defense on the importance of health professionals developing communication competences, namely the assertiveness, the clarity and the positivity, to enhance patient health literacy level– the hypothesis formulated was confirmed. These communication competences include verbal and non-verbal forms, attitude and behavior able to generate patients' confidence and higher therapeutic adherence, as well as the positive consolidation of the therapeutic relationship. Therefore, our objectives are achieved: we assess the importance and contributions of communication competences for the health relationship and health literacy and construct a model, which was discussed and validated by a panel of experts within the four focus groups.

A person with greater literacy will know how to take better care of his/her health and life, but the reality presents us a rate of more than 50% with problematic or inadequate literacy. Reinforcing with literature, Tu and Hargraves say that education is the key to explain the differences in information demand. Concretely in the therapeutic relationship, the health professionals assume a strategic function, in which the communication competences can make the difference. The investment must be centralized specially on communication competences of healthcare professionals, that can contribute to motivate the patient to act and to be empowered.

The communication is a key dimension in the therapeutic relationship [14]. The technical competences required for clinical practice are enriched by the professional's communication competences. The literature on the subject also confirms that the patients' judgment about the professionals' competences, that is, the confidence the patients have in them, is not usually based on a technical nature, but mainly based on the socio-emotional dimension of the relationship, which includes interpersonal communication [60].

The focus groups refer the importance and difficulties of empowering the patients, possible thanks to communication [34]. It is still necessary to give hypotheses to the person, and to know what this person can do, according to his/her illness situation. People having more or less therapeutic adherence are influenced by various social, economic, cultural determinants of health (Wilkinson & Marmot, 2003). There are recommendations of strengthening communication skills among patients with low health literacy (The Institute of Medicine, 2004) and to consider health literacy not only in terms of the characteristics of individuals, but also in terms of the interactional processes [34].

The therapeutic relationship has to be endowed with certain requirements that will optimize the health outcomes: trust, empathy, understanding, firmness, determination. These requirements can be condensed into a communication model composed of three components: assertiveness, clarity and positivity.

An assertive affirmation or response can include empathy, where the person manifests understanding with the situation or position of his/her interlocutor [61]. Clinical and care competences are required. There are studies that affirm that the patient has more therapeutic adherence, if there is a better communication relationship and a doctor-patient eye contact. Looking directly into the patient's eyes, giving him attention, show that the doctor cares with him [62]. In practice, good eye contact suggests confidence and honesty, also a more meaningful therapeutic relationship, and a doctor creates a positive atmosphere with their patients by simply looking at them. Communication research suggests that a doctor's message will be decoded as being more favorable when associated with more eye contact than with less

Table 3: Recommendations or indicators of the 3-factor model of communication competences: assertiveness, clarity and positivity

Assertiveness
Approach to care; The right thing to do; Be balanced; Confirm the understanding of the interlocutor; Guide the patient to the questions he/she should ask; Initiate, maintain and conclude a conversation; Openly speak about desires and needs; Practice benevolent perseverance and politeness; Practice the certainty, a form of behavior characterized by a confident declaration of a statement without need of proof; Recognize self and hetero rights and do not violate them; Reveal self-esteem; Revel self and mutual respect; Self-analyze, e.g., evaluate one's own feeling and control one's personal impulses; Tell "no"; Use clarity and objectivity that reinforce the essential information.
Clear language
Apply teach-back; Avoid technical jargon; Be creative, vibrant, and emotionally resonant; Be immediately understandable; Be specific and concrete; Communicate for clarity and meaning; Demonstrate how it is done; Encourage questions; Greet patients warmly; Invite patient participation; Limit and repeat content; Listen carefully; Make eye contact; Match patients' vocabulary; Offer concrete advice and recommendations; Show graphics; Slow down; The level of reading should be in the 8th grade; The sentences should only be up to 15 words or less; Understand the target audience; Use of a "living room" language; Use of active voice; Use of second person of the verb (you); Use of an evidence-based approach; Use the patient's words; Use written instructions to facilitate the memory.
Positivity
Avoid the use of negative words and phrases, such as "I cannot", "never", "I do not", "always" and "I will not"; Be positive, optimistic, hopeful, and confident (self-efficacy); Believe (and exteriorize this believe) in the results and in the capacity of the patient to be able to operationalize the action; Motivate the patient for the construction of positive sentences, such as "I choose", "I can", "I will" (empowerment and self-efficacy); Make a positive attribution (optimism) about succeeding now and in the future; Motivate; Persevere toward goals and, when necessary, redirect paths to goals (hope) in order to succeed; Take on and put in the necessary effort to succeed at challenging tasks; Use positive language; When beset by problems and adversity, sustain and bounce back and even beyond (resilience) to attain success.

Source: Own elaboration

eye contact. Experts speculate that it is almost impossible for an individual to disguise eye meaning from someone who is a member of the same culture.

Salter and Wolpe were the first experts referring the concept of assertiveness applied to patients with mental diseases [38,42]. The meaning of assertiveness was associated to certainty, related to ways of treating or reducing the neurotic influence. "Where the patient has neurotic fears in interpersonal interchanges (…) is encouraged to express what he really wants. This is what is meant by assertive behavior" [39]. In opposition, the lack of assertiveness is linked to uncertainty, concretely linked to the formation of "inhibitory" behaviors that unable individuals to openly and spontaneously express their feelings, desires and

needs. They were limited in their self-realization and inherently experienced problems in social connections. Similarly, in the focus groups, the proposed opposite of assertiveness is aggression, manipulation, confusion and insecurity.

The participants of focus groups highlight that the patients are often embarrassed to ask and often do not even know what to question. Alike, previous research has identified that, for example, nurses overestimate their patients' health literacy [30], and that overestimation of a patient's health literacy may contribute to the widespread problem of poor health outcomes [31]. In sum, a trustful and open relation, a non-inhibitory environment, the confirmation of the patient's understanding of message and the motivation of the patient to question are mandatory.

Assertiveness is linked to the control of one's personal impulses, the recognition of one's own rights and the others' rights (respect) certainty capacity to openly speak self-confidence (of both professional and patient) and generates the mutual respect, benevolent perseverance and politeness [35-42]. The credibility of the health professional can reinforce the assertiveness (Hovland's orientations) and the explanation of why is crucial to assume the medical instructions (persuasion theory).

Clear language is immediately understandable and the health professionals should use strategies for confirming that the instructions that are being transmitted are accurately understood [46]. There is a basic principle in this component: the comprehension. Referring Hall, for the necessary decoding of the message by the recipient–the patient –, it was pointed out that the responsibility for the content should be in charge of the encoder–the health professional – who must ensure that the message is perceived and understood by the recipient. At the level of the decoder's understanding, Hall reflects that, before the message has an effect or satisfies a need, it must have a meaningful discourse [23,63]. And it is their senses decoded from the message, which will have a degree of influence over the decoder, with cognitive, emotional, ideological, and behavioral consequences. In this sense, the whole group agrees that language must be clear, accessible and simple in order to contribute to a better health literacy. The decoding and apprehension of the right meanings are pivotal due to the efficacy of communication and the premises of the symbolic interaction theory: humans act towards others on the basis of meanings, the meaning is created in an interaction, meanings are modified through an interpretative process, individuals develop self-concept through interaction with others.

Positive language is associated with approach goals instead of avoidance goals. The use of positive language has a compelling effect on the patients [53]. So, the motivation is important to reinforce Bandura's position on the "agent" as one who intentionally makes things happen by his/her action. Being motivated then means moving to do something [64]. The concept of self-efficacy, which consists in the person's confidence to practice certain action should be stimulated in the patient [65].

Future research paths can be to test the model presented here in an experimental context (social experiment) and to apply questionnaire surveys to patients in order to ascertain their opinion and experience in therapeutic relationships, concretely about communication tools and competences used by health professionals, and to test the influence of these tools and competences on the health literacy of patients [65].

In order to understand the importance of communicational interaction for the strengthening of therapeutic relationship and consecutively for better adherence and health outcomes, it has to be considered that human interaction is based on cognitive, emotional and social issues. Assertive, clear and positive language, attitude and behavior are the key to combat the more than 50% inadequate or problematic health literacy and consequently in the health process and inherent health communication, where the persons and their interactions are the focus [1].

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