B.PHARM THEORY

BP103T HEALTHCARE PSYCHOLOGY AND COMMUNICATION SKILLS

Unit III — Foundations of Health Communication

3 HOURS · THEORY

Pills & Python Notes
From-zero teaching standard: every technical term is defined before use.
Syllabus coverage: Unit III.

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UNIT III — FOUNDATIONS OF HEALTH COMMUNICATION

CHAPTER 3: FOUNDATIONS OF HEALTH COMMUNICATION

Unit III · ~3 hours

3.1 Introduction

A doctor prescribes the right drug. The pharmacist dispenses the right drug. The patient takes it wrongly — and is harmed. Where did the treatment fail? In the *space between* the professionals and the patient: **communication**. Studies of healthcare errors repeatedly find that poor communication — not poor knowledge — is behind a large share of mistakes. For a pharmacist, communication is not a "soft skill"; it is a clinical tool as real as a dispensing balance. This chapter builds it from zero: what communication is, how it flows, where it breaks, and how to make it work — especially across India's languages and cultures.

Learning objectives — after studying this chapter, you should be able to:

- list the elements of communication and explain major models (Shannon–Weaver, Berlo's SMCR, transactional model);
- describe the types of communication in healthcare — interpersonal, group, mass, telehealth;
- identify barriers to effective communication in clinical settings and how to overcome them;
- demonstrate active listening, effective questioning techniques, and empathy;
- explain culturally appropriate and inclusive communication with Indian examples.

3.2 Definition

Scientific definition: Communication is the process of exchanging information, ideas, and feelings between a sender and a receiver through a shared system of symbols (words, gestures, images), with the goal of creating shared understanding.

Simple explanation: Communication is *making sure the other person understands what you mean* — not just speaking, but being understood. If the patient nods but takes the medicine wrongly, communication failed even though words were spoken.

Health communication applies this to health: between professionals and patients, among the healthcare team, and from health authorities to the public.

3.3 Key Terminology

Term	Meaning	Simple explanation
Sender	The one who initiates the message	The speaker — pharmacist, doctor
Message	The content being communicated	What you want to say
Encoding	Turning ideas into words/gestures	"Putting thoughts into words"
Channel	The medium carrying the message	Speech, phone, poster, WhatsApp
Decoding	The receiver's interpretation	"What the listener understood"
Receiver	The one the message is for	The listener — patient, nurse
Feedback	The receiver's response	The reply that shows understanding
Noise	Anything that distorts the message	Disturbance — literally or figuratively
Empathy	Understanding and sharing another's feelings	"Feeling *with*" the patient
Health literacy	Ability to understand health information and act on it	Can the patient read and use the prescription?

3.4 Detailed Explanation

3.4.1 Elements and models of communication

Every communication act has the same skeleton: **Sender → encodes Message → sends through a Channel → Receiver decodes → gives Feedback**, with **Noise** attacking at every step and **Context** (place, culture, relationship) colouring everything.

Three classic models:

Model	Picture	Key insight
Shannon–Weaver (sender-message-channel-receiver)	A straight line, like a pipeline	Introduced the idea of **noise** — the message that arrives is not always the message sent
Berlo's SMCR	Four columns: **S**ource–**M**essage–**C**hannel–**R**eceiver	Each element has qualities that matter — the *source's* knowledge and attitude, the *message's* clarity, the *channel's* suitability, the *receiver's* health literacy
Transactional model	Two-way, simultaneous — both people are sender *and* receiver at once	Communication is not a pipeline but a **conversation**: both sides constantly send, receive, and adjust; context and relationship shape meaning

Simple version: Shannon–Weaver warns you about noise; Berlo tells you to check all four parts; the transactional model reminds you the patient is *talking back* the whole time — through words, face, and body.

3.4.2 Types of communication in healthcare

Type	Who talks to whom	Pharmacy examples
Interpersonal	One person to another	Counselling a patient; calling a doctor about a prescription error
Group	One to a small group, with interaction	A diabetes education session for 10 patients; a ward team meeting
Mass	One to a large public audience	Anti-tobacco TV ads; polio immunisation posters; radio health jingles
Telehealth	Healthcare at a distance via technology	Phone/video consultation; WhatsApp follow-ups; online prescription review

Each suits different goals: interpersonal for personal counselling, group for shared learning, mass for awareness, telehealth for reach.

3.4.3 Barriers to effective communication in clinical settings

Barrier	What it looks like	How to overcome it
Semantic (language)	Medical jargon — "take BID on an empty stomach" means nothing to the patient	Use plain words: "take one tablet two times a day, before food"
Psychological	Fear, anxiety, grief block understanding — a shocked patient hears nothing	Calm first, inform second; repeat later
Physical/environmental	Noise, crowding, no privacy at the counter	Create a small counselling corner; lower your voice
Cultural	Different beliefs, taboos, family decision-making	Ask, don't assume; involve the family decision-maker respectfully
Health-literacy	Patient cannot read the label or do the maths of dosing	Pictorial labels, teach-back, demonstration
Organisational	Rush, understaffing, hierarchy ("don't question the doctor")	SBAR-style structured handovers; protected counselling time
Non-verbal mismatch	Saying "take your time" while glancing at the queue	Match body language to words — face the patient, uncross arms

Exam Pearl: The commonest barrier in Indian pharmacies is **semantic + health-literacy**: jargon spoken fast to a patient who cannot read the label.

3.4.4 Active listening, questioning techniques, empathy

Active listening = listening with your whole body to *understand*, not just to reply. The **SOLER** posture helps:

- **S** — face the patient **Squarely**
- **O** — adopt an **Open** posture (uncrossed arms)
- **L** — **Lean** slightly forward
- **E** — maintain comfortable **Eye** contact
- **R** — stay **Relaxed**, unhurried

Add the *verbal* tools: **paraphrasing** ("So the dizziness started after the new tablet — is that right?"), **reflecting feelings** ("That sounds frightening"), **summarising** at the end, and **minimal encouragers** ("Hmm," "Go on," a nod).

Questioning techniques:

Technique	Form	Use
Open questions	"How have you been taking your tablets?"	Start — gets the full story
Closed questions	"Did you take it this morning — yes or no?"	Pin down facts
Probing	"You said 'sometimes' — about how many days a week?"	Clarify vague answers
Funnel	Open → probing → closed	Start wide, end precise

Empathy = understanding the patient's feelings *from their side* and showing it. Formula: **name the feeling + show understanding + offer help** — "You seem worried about the side effects *(name)* — that's completely reasonable with a new medicine *(understand)* — let me explain exactly what to watch for *(help)*." **Sympathy** ("poor you") keeps distance; empathy closes it. Empathy is a *skill*, not just a trait — it can be practised.

3.4.5 Culturally appropriate and inclusive communication

India's pharmacy counter is a crossroads of languages, religions, castes, genders, and literacy levels. Culturally appropriate communication means:

1. **Language:** speak the patient's language where possible; use simple words, never jargon; for illiterate patients use pictures, colours, and demonstration (morning = sun sticker, night = moon sticker).
2. **Family:** in India, health decisions are often family decisions — with the patient's permission, include the spouse, parent, or eldest son who will actually supervise the medicines.
3. **Gender and modesty:** some women prefer a female counsellor for intimate topics; offer privacy without being asked.
4. **Beliefs:** respect traditional beliefs ("hot/cold" foods, fasting, evil eye) — work *with* them where harmless ("take the tablet with your usual food"), correct gently where dangerous.
5. **Inclusive language:** address every patient with the same respect — rich or poor, any caste or religion; avoid terms that shame ("you people never listen"); use the patient's name.
6. **Disability:** face a hearing-impaired patient, speak clearly (don't shout), write key points; allow extra time for elderly or cognitively slow patients.

3.5 Easy Analogy

- **Communication models:** Shannon–Weaver is a *water pipe* — check for leaks (noise). Berlo's SMCR is a *four-legged table* — if any leg (source, message, channel, receiver) is short, the table wobbles. The transactional model is a *dance* — both partners move together, adjusting step by step.
- **Active listening:** Normal listening is like *taking a photo* — quick and shallow. Active listening is like *painting a portrait* — slow, attentive, capturing what matters.

3.6 Diagram — Berlo's SMCR Model

```
 SOURCE            MESSAGE           CHANNEL          RECEIVER
(pharmacist)    (the content)     (how it travels)   (patient)
    |               |                 |                 |
knowledge        content             speech          health literacy
attitude         clarity             writing         attitude
(caring?)       (simple words?)      phone/WhatsApp  (trust? fear?)
communication   structure           visuals         culture/
skills          (step by step?)     demonstration   language
    |               |                 |                 |
    +---------------+-----------------+-----------------+
                    |
            All four must work,
          or understanding breaks
```

AI Image Prompt: "Clean educational textbook diagram, white background, four vertical columns labelled SOURCE (pharmacist icon), MESSAGE (speech bubble icon), CHANNEL (phone and poster icons), RECEIVER (patient icon), each column listing 3-4 short bullet qualities, arrows connecting the columns left to right, a red lightning symbol labelled 'NOISE' striking the arrows, clean black labels, minimal decoration, professional pharmacy textbook style."

3.7 Flowchart — The Teach-Back Counselling Loop

```
Explain ONE point simply ("Take one tablet every morning after breakfast")
       ↓
Ask: "Can you tell me in your own words how you'll take it?"
       ↓
Patient repeats correctly? → YES → praise → move to NEXT point
       ↓ NO
Re-explain differently (simpler words / demonstration / picture)
       ↓
Ask again → repeat until correct
       ↓
Write it on the box + give a written/pictorial schedule
```

3.8 Examples

- **Jargon fail:** "Take 1 tab BD PC" → patient takes two tablets together before coffee. **Fixed:** "Take one tablet two times a day — after breakfast and after dinner."
- **Open question win:** "How have you been managing your sugar tablets?" reveals the patient splits doses with her husband to "save money" — a closed "Are you taking them regularly?" would have got a "yes."
- **Cultural win:** marking an illiterate patient's strip with ☀️ (morning) and 🌙 (night) stickers — zero reading needed.
- **Telehealth:** a pharmacist video-calls an elderly patient to watch her use the inhaler and corrects the technique live.

3.9 Pharmacy Relevance — Counselling Scenarios

Scenario 1 — Active listening + empathy with a frightened patient:

Patient: *(hands shaking)* "The doctor said… said it might be… you know… *cancer*. These tablets — will they even help?"
Pharmacist: *(SOLER posture, unhurried)* "Hearing that word is frightening — anyone would feel shaken. *(empathy: name + normalise)* These medicines are part of the treatment plan your doctor chose carefully. Would it help if I explain, slowly, what each one does? We can also write everything down for your family."
Why it works: feelings acknowledged before facts; permission asked; family included.

Scenario 2 — Overcoming the literacy barrier:

Pharmacist: *(drawing)* "See — sun picture means morning tablet, moon picture means night tablet. Now you tell me: when will you take the sun tablet?"
Patient: "After morning tea."
Pharmacist: "Perfect. And the moon one?"
Patient: "After dinner." *(teach-back complete)*
Why it works: pictures replace reading; teach-back confirms real understanding.

3.10 Important Points to Remember

1. **Remember:** Communication = creating *shared understanding*, not just speaking.
2. **Exam Pearl:** Elements — sender → encode → message → channel → decode → receiver → feedback; **noise** attacks everywhere.
3. **Exam Pearl:** Shannon–Weaver = pipeline + noise; Berlo's **SMCR** = Source–Message–Channel–Receiver; transactional = two-way simultaneous conversation.
4. Types: interpersonal (one-to-one), group (small group), mass (public), telehealth (distance + technology).
5. Barriers: semantic, psychological, physical, cultural, health-literacy, organisational, non-verbal mismatch — with matching solutions.
6. **Exam Pearl:** SOLER — Squarely, Open posture, Lean, Eye contact, Relaxed; plus paraphrasing, reflecting, summarising.
7. Questioning funnel: open → probing → closed.
8. Empathy = name the feeling + show understanding + offer help; empathy *connects*, sympathy *distances*.
9. Culturally appropriate care: patient's language, family inclusion, modesty/privacy, respect for beliefs, inclusive language, disability-friendly.

3.11 Common Confusions & Common Mistakes

Do not confuse:

- **Hearing ≠ Listening:** hearing is automatic; active listening is deliberate effort to understand.
- **Empathy ≠ Sympathy:** empathy = "I understand how you feel" (with the patient); sympathy = "I feel sorry for you" (above the patient).
- **Open ≠ Closed questions:** open questions invite stories ("How…?"); closed questions invite yes/no — use each at the right stage.
- **Mass ≠ Group communication:** group is small and interactive (a class); mass is one-way to the public (a TV ad).

Common mistakes: counselling in jargon ("BID, TID, SOS"); asking only closed questions and missing the real story; nodding while looking at the computer (non-verbal mismatch); assuming the literate-looking patient can read English labels; lecturing instead of listening.

3.12 Memory Tricks

- "SOLER — **S**it **S**quarely, **O**pen arms, **L**ean in, **E**ye contact, **R**elax."
- "SMCR — **S**ender **M**akes **C**lear **R**eception (Source–Message–Channel–Receiver)."
- "Empathy in 3: **N**ame it, **N**ormalise it, **N**avigate (offer help)."

3.13 Exam-Oriented Summary

Communication is shared understanding via sender–message–channel–receiver with feedback, always threatened by noise. Models: Shannon–Weaver (noise), Berlo's SMCR (four qualities), transactional (two-way dance). Types: interpersonal, group, mass, telehealth. Barriers — semantic, psychological, physical, cultural, literacy, organisational — each has a fix; plain language + teach-back is the master key. Active listening (SOLER, paraphrase, reflect, summarise), questioning funnel (open → probing → closed), and empathy (name–normalise–navigate) are core clinical skills. In India: use the patient's language, pictures for illiteracy, include family, respect modesty and beliefs, keep language inclusive.

One-Minute Revision: Sender → message → channel → receiver → feedback; noise everywhere. Shannon = pipeline; SMCR = four columns; transactional = dance. Types: 1-to-1, group, mass, telehealth. Barriers: jargon, fear, noise, culture, illiteracy — fix with plain words + teach-back. SOLER listening; open → closed funnel; empathy = name + normalise + help.

3.14 Questions

Very Short Answer (1–2 marks)

1. Define communication. 2. List the elements of communication. 3. Expand SMCR and SOLER. 4. Distinguish empathy from sympathy. 5. What is health literacy?

Short Answer (3–5 marks)

1. Explain the Shannon–Weaver, Berlo's SMCR, and transactional models with a pharmacy example each.
2. Describe the barriers to communication in clinical settings and suggest one solution for each.
3. Explain active listening with the SOLER technique.
4. How would you make counselling culturally appropriate for an illiterate elderly patient?

Long Answer (5–10 marks)

1. Define health communication. Describe its types and explain the models of communication with suitable diagrams.
2. Discuss the barriers to effective communication in clinical settings. As a pharmacist, how would you use listening, questioning, and empathy to overcome them?

MCQs

1. In Berlo's model, the "C" stands for: (a) Context (b) Channel (c) Culture (d) Code — **Ans: (b)**. SMCR = Source–Message–Channel–Receiver.
2. Which model treats both participants as simultaneous senders and receivers? (a) Shannon–Weaver (b) Transactional (c) SMCR (d) Linear — **Ans: (b)**.
3. "How have you been taking your tablets?" is a: (a) closed question (b) open question (c) leading question (d) rhetorical question — **Ans: (b)**. It invites a full story.
4. In SOLER, "O" stands for: (a) Observe (b) Open posture (c) Offer help (d) Oral clarity — **Ans: (b)**. Uncrossed arms, open body.
5. The best response to "I can't read the label" is: (a) speak louder (b) use pictorial stickers + teach-back (c) ask a relative to read it later (d) skip counselling — **Ans: (b)**. Pictures replace reading; teach-back confirms understanding.

Viva

1. Why is communication called a clinical tool and not just a soft skill?
2. Demonstrate the difference between an open and a closed question on the same topic.
3. Your words say "take your time" but your body rushes — what is this barrier?
4. How does the transactional model change the way you counsel compared to the pipeline model?
5. Give one example of respecting a cultural belief while keeping treatment safe.

Application-based

1. *A newly diagnosed hypertensive patient, a 45-year-old autorickshaw driver who reads only Hindi, has been given three medicines with English labels. Plan your complete 5-minute counselling: language, tools, questioning sequence, teach-back, and family involvement.*
2. *During a busy evening, a tearful woman says her reports "show something bad" but she "can't understand the doctor's English." Walk through exactly how you would apply active listening, empathy, and the questioning funnel before giving any information.*

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