

MODULE 3

Overcoming Communication Barriers

MODULE OVERVIEW

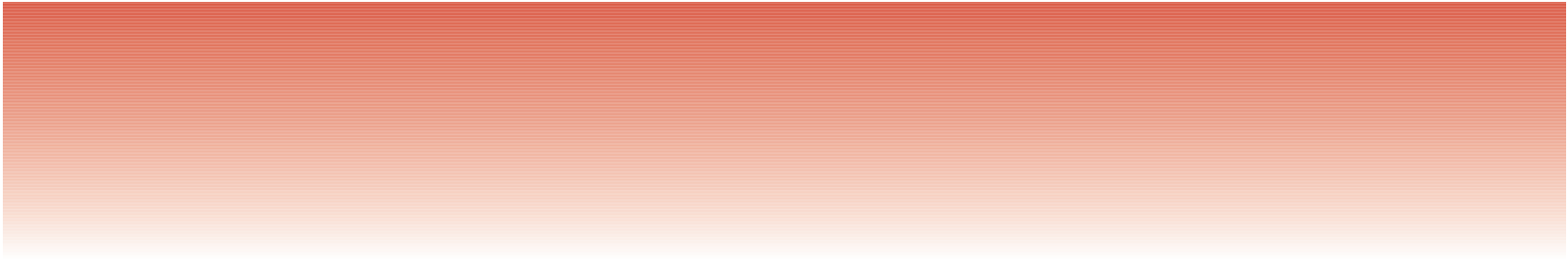
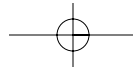
Being able to effectively communicate—or participate in the exchange of information—is an essential skill for dental health care providers. For many dental health care providers in the United States today, providing patient-centered care involves learning to communicate effectively with patients even when various barriers to communication are present.

This module presents strategies for effectively communicating with:

- Patients who speak a different language than that of the dental health care provider
- Patients with culturally influenced health behaviors that differ from the health care beliefs of the dental clinician
- Young and school age children
- Adolescents
- Older adults
- Vision, hearing, or speech impaired individuals

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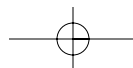
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Communication Skill Checklist: Communications Role-Play

SKILL GOALS

- Explain how the U.S. population has changed between 1980 and 2000 and describe how these changes affect dental health care.
- Give an example of how cultural differences could affect communication.
- Define cultural competence.
- Discuss effective communication techniques for interacting with patients from different cultures.
- Discuss strategies that you can use to improve communication with a child.
- Discuss strategies that you can use to improve communication with an adolescent.
- Discuss strategies that you can use to improve communication with older adults.
- Discuss strategies that you can use to improve communication with visually, hearing-, and speech-impaired patients.



SECTION 1 LANGUAGE BARRIERS

CROSS-CULTURAL COMMUNICATION

Multiculturalism

- For many dental health care providers in the United States today, providing patient-centered care involves learning to communicate effectively with patients from non-English-speaking communities and with cultural backgrounds that may be unfamiliar.
- The United States has always had a significant foreign-born population, but the number of foreign born reached an all-time high of 32.5 million in 2002—equal to 11.5% of the U.S. population—according to the Current Population Survey (CPS) .[1]
- The Canadian 2001 population census indicates that 18.5% of the population in Canada is foreign-born.
- More than one-half of the 2002 foreign-born residents in the United States were born in Latin America—with 30% from Mexico alone.
- 26% were born in Asia, 14% in Europe, and 8% in Africa and other regions.
- 2000 Census data show that over 47 million persons speak a language other than English at home, up nearly 48% since 1990. Although the majority are able to speak English, over 21 million speak English less than “very well,” up 52% from 14 million in 1990.[2,3]
- By the year 2030, the Census Bureau predicts that 60% of the U.S. population will self-identify as white, non-Hispanic, and 40% will self-identify as members of other diverse racial and ethnic groups. Being competent to meet this communication challenge requires a set of skills, knowledge, and attitudes that enable the clinician to understand and respect patients’ values, beliefs, and expectations.
- Communication problems can easily occur if a patient is not fluent in English. An individual who is just learning the language may communicate well in everyday situations. In the dental setting, however, the same person may not fully understand what is being discussed.

TABLE 3-1. U.S.- and Foreign-Born Population, 1980 to 2000 [2,3]

	U.S.-Born	Foreign-Born
Number in millions		
1980	226.5	14.1
1990	248.7	19.8
2000	281.4	31.1
Percent change		
1980–1990	9.8	40.4
1990–2000	13.1	57.1

The Minority Population

According to the Census Bureau [1,2], the proportion of the overall population in the United States considered to be minority will increase from 26.4% in 1995 to 47.2% in 2050 (Fig. 3-1). According to the U.S. census data, between 1980 and 1990:

- African Americans increased from 26.5 million to 30 million
- Asian Americans/Pacific Islanders increased from 3.7 million to 7.2 million
- Hispanics/Latinos increased from 15.7 million to 22.3 million
- Native Americans/Alaskan Natives increased from 1.5 million to 2 million

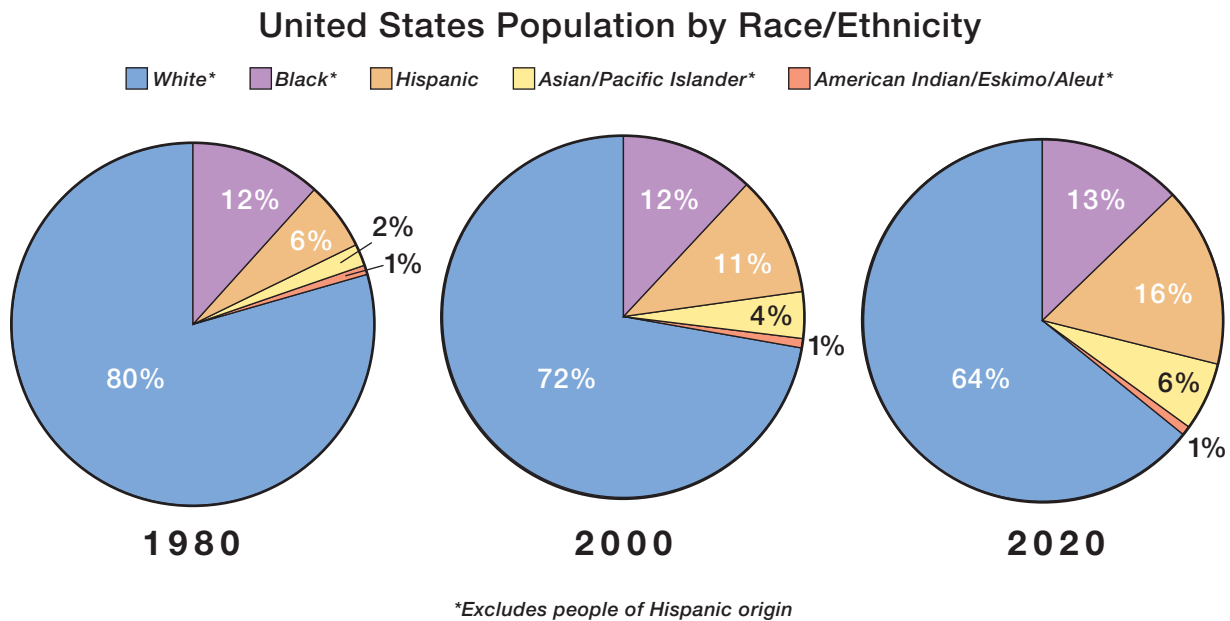


Figure 3-1. Demographics of the United States. The pie charts depict the changing demographics of the United States population from 1980 to 2020.[1,2]

CULTURAL COMPETENCE

Cultural competence is the application of cultural knowledge, behaviors, interpersonal, and clinical skills to enhance a dental health care provider's effectiveness in managing patient care.

- Cultural competence indicates an understanding of important differences that exist among various ethnic and cultural groups in our country.
- Understanding patients' diverse cultures—their values, traditions, history, and institutions—is not simply political correctness. It is essential in providing quality patient care.
- Culture shapes individuals' experiences, perceptions, decisions, and how they relate to others. It influences the way patients respond to dental services, preventive interventions, and impacts the way dental health care providers deliver dental care.
- In a culturally diverse society, dental professionals need to increase their awareness of and sensitivity toward diverse patient populations and work to understand culturally influenced health behaviors.

Cultural Differences

Dental professionals interact with people from varied ethnic backgrounds and cultural origins who bring with them beliefs and values that may differ from the health care provider's own.

- Understanding cultural differences can aid communication and thereby improve patient care.
- Preconceived ideas about a given culture can hinder a clinician from providing good care.
- Each patient is unique and his or her dental care needs differ. Some cultures may be offended by the intensely personal questions necessary for a health history and may perceive them as an inexcusable invasion of privacy.
- People of various backgrounds also perceive the desirability of making direct eye contact differently.
- To help avoid miscommunication and offending patients, dental health care providers must be sensitive to these cultural differences.

Box 3-1. Ways to Develop Cultural Competence

- Recognize your own assumptions.
- Value diversity. Demonstrate an appreciation for the customs, values, and beliefs of people from different cultural and language backgrounds.
- Demonstrate flexibility. Carry out changes to meet the needs of your diverse patients.
- Communicate respect. Do not judge. Show empathy.

Tips for Improving Cross-Cultural Communication

Cross-cultural communication is about dealing with people from other cultures in a way that minimizes misunderstandings and maximizes trust between patients and health care providers. The following simple tips will improve communication.

- 1. Speak slowly, not loudly.** Slow down and be careful to pronounce words clearly. Do not speak loudly. A loud voice implies anger in many cultures. Speaking loudly might cause the patient to become nervous. Use a caring tone of voice and facial expressions to convey your message.
- 2. Separate questions.** Try not to ask double questions. Let the patient answer one question at a time.
- 3. Repeat the message in different ways.** If the patient does not understand a statement, try repeating the message using different words. Be alert to words the patient understands and use them frequently.
- 4. Avoid idiomatic expressions or slang.** American English is full of idioms. An idiom is a distinctive, often colorful expression whose meaning cannot be understood from the combined meaning of its individual words, for example, the phrase “to kill two birds with one stone.”
- 5. Avoid difficult words and unnecessary information.** Use short, simple sentences. Do not overwhelm the patient with too many facts and lengthy, complicated explanations.
- 6. Check meanings.** When communicating across cultures, never assume that the other person has understood. Be an active listener. Summarize what has been said in order to verify it. This is a very effective way of ensuring that accurate cross-cultural communication has taken place.

7. **Use visuals where possible.** A picture really is worth a thousand words; the universal language of pictures can make communication easier. Picture boards (Fig. 3-2) with medical/dental images are helpful in getting your message across.



Figure 3-2. Picture board. A picture board can be used to communicate when pictures are more effective than words. (From Carter PJ, Lewsen S. *Lippincott's Textbook for Nursing Assistants*. Philadelphia: Lippincott Williams & Wilkins; 2005, Chapter 5, Fig. 5-4.)

8. **Avoid negative questions.** For example, “So, then, you don’t want an appointment on Monday?” A better question would be “What day of the week is best for you?” Questions with negative verbs such as “don’t” or “can’t” are particularly confusing to Asian patients.
9. **Take turns.** Give the patient time to answer and explain his or her response.
10. **Be supportive.** Giving encouragement to those with weak English skills gives them confidence and a trust in you.
11. **Use humor with caution.** In many cultures, health care is taken very seriously. Some foreign-born patients may not appreciate the use of humor or jokes in the dental office setting.
12. **Watch for nonverbal cues.** Be attentive for signs of fear, anxiety, or confusion in the patient.
13. **Use interpreters to improve communication.** If the patient speaks no English or has limited understanding, use a trained clinical interpreter who is fluent in the patient’s native language, as well as in medical and dental terminology. When using an interpreter, speak directly to the patient rather than to the interpreter.
14. **Don’t use family members as translators.** A family member who is not knowledgeable in medical and dental terminology is likely to incorrectly translate your message. The presence of a family member or friend may also constitute a serious breach of patient confidentiality.
15. **Ask permission to touch the patient.** Ask permission to examine the patient and do not touch the patient until permission is granted.
16. **Check for understanding.** Ask the patient to repeat instructions. Correct any misunderstandings. This can be done diplomatically by saying something like, “Will you repeat the instructions that I gave you to make sure that I did not forget anything?”
17. **Provide written material.** When possible, provide simple, illustrated materials for the patient to take home.

SECTION 2 AGE BARRIERS

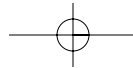
Young children, adolescents, and older patients present unique communication concerns.

- Even experienced health care providers can find it challenging to communicate effectively with individuals who are much younger or older in age.
- It can be difficult to relate to the life experiences or health problems of someone who is 30 or 40 years older.
- Some health care providers with limited experience with young children find it difficult to know what to say and what not to say when speaking with young children.
- Children and adolescents frequently are accompanied to the office by a parent. An adult child or caregiver may accompany older adults. Parents, adult children, and caregivers add a unique aspect to the communication process. The patient should always be the focus of the clinician's attention and, when possible, information should be exchanged directly with the patient.

COMMUNICATING WITH CHILDREN

Box 3-2. Communicating with Young and School Age Children

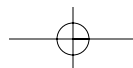
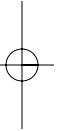
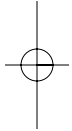
- Introduce yourself to the child. Speak softly; use simple words and the child's name.
- Adjust your height to that of the child.
- Treat children with respect—over the age of four they can understand a lot.
- Describe actions before carrying them out.
- Make contact with the child (e.g., "I promise to tell you everything I'm going to do if you'll help me by cooperating.").
- Talk to young children throughout the assessment procedure.
- Give praise during each stage of the assessment, such as, "that's good," "well done," etc.
- Be aware of needs and concerns that are unique to children. For example, children may avoid wearing orthodontic head gear due to pressures and comments from peers.
- Do not ask the child's permission to perform a procedure if it must be performed in any case.
- Do not talk about procedures that will be done later in the appointment to children who are younger than 5 years of age. Very young children have no clear concept of future events and will imagine the worst about what could happen.
- Communicate all information directly to the child or to both child and the parent, ensuring that the child remains the center of your attention. If complex information must be communicated to the parent, arrange to speak to the parent alone (without the child's presence).



COMMUNICATING WITH ADOLESCENTS

Box 3-3. Communicating with Teens

- Speak in a respectful, friendly manner, as to an adult.
- Respect independence; address the teenager directly rather than the parent.
- Obtain health history information directly from the teenager, rather than the parent, if possible.
- Recognize that a teenager may be reluctant to answer certain questions honestly in the parent's presence.
- Ask questions about tobacco, drug, or alcohol use privately.
- Some teenagers may be intensely shy or self-conscious; others may be overconfident and boastful. Allow silence so that the teenager can express opinions and concerns.



COMMUNICATING WITH OLDER ADULTS

- The United States population is aging at a dramatic rate.
- The U.S. population of persons 65 and older will increase by 76% from 2010 to 2030.
- The numbers of persons 85 and older in the United States will increase by 116% from 2010 to 2030.
- This tremendous demographic shift will have a profound effect on the health care sector. Over the next 50 years or so, there will most likely be an increased demand for dental health care providers skilled in caring for the geriatric population.[9]
- Communicating with older people often requires extra time and patience because of the physical, psychological, and social changes of normal aging.
- Even more effort is needed when an elderly person has a communication disorder.
- Communicating with older adults requires many of the same rules as for children—the patient should always be the focus of the dental health care provider’s attention.

Box 3-4. Communicating with Older Adults

- Before you begin your conversation, reduce background noises that may be distracting (close the examination room door; move from a noisy reception area to a quieter place).
- Begin the conversation with casual topics such as the weather or special interests of the person.
- Keep your sentences and questions short. Avoid quick shifts from topic to topic.
- Allow extra time for responding. As people age, they function better at a slower pace; do not hurry them.
- Take time to understand the patient’s true concerns. Some older people will hold back information feeling that nothing can be done or not wanting to “waste your time.”
- Take time to explain, in easy to understand language, the findings of your examination.
- Look for hints from eye gaze and gestures that your message is being understood.
- Speak plainly and make sure that the patient understands by having him or her repeat instructions. For example, say: “*I may have forgotten to tell you something important. Would you please repeat what I told you?*”

SECTION 3 VISION AND HEARING BARRIERS

COMMUNICATION WITH THE VISUALLY IMPAIRED

Although estimates vary, there are approximately 10 million blind and visually impaired people in the United States. Approximately 1.3 million Americans are legally blind. There are approximately 5.5 million elderly individuals who are blind or visually impaired. There are approximately 55,200 legally blind children.

Box 3-5. Effective Communication with a Person Who Is Blind or Visually Impaired

- As soon as you enter the room, be sure to greet the person. This alerts the person to your presence, avoids startling him or her, and eliminates uncomfortable silences. Address the person by name, so he or she will immediately know that you are talking to him or her rather than someone who happens to be nearby. When greeting a person who is blind or visually impaired, do not forget to identify yourself. For example, “Hello, Mrs. Jones. I am Robin Shiffer, the dental hygienist here in Dr. Rolfs’ office.”
- Speak directly to the person who is visually impaired, not through an intermediary, such as a relative or caregiver.
- Speak distinctly, using a natural conversational tone and speed. Unless the person has a hearing impairment, you do not need to raise your voice.
- Explain the reason for touching the person before doing so.
- Be an active listener. Give the person opportunities to talk. Respond with questions and comments to keep the conversation going. A person who is visually impaired cannot necessarily see the look of interest on your face, so give verbal cues to let him or her know that you are actively listening.
- Always answer questions and be specific or descriptive in your responses.
- Orient the person to sounds in the environment. For example, explain and demonstrate the sound that an ultrasonic instrument makes before using it in the patient’s mouth.
- Tell the patient when you are leaving the room and where you are going (e.g., I am going to develop the x-rays that we just took).
- Be precise and thorough when you describe people, places, or things to someone who is blind. Do not leave out things or change a description because you think it is unimportant or unpleasant.
- Feel free to use words that refer to vision during the course of a conversation. Vision-oriented words such as look, see, and watching TV are parts of everyday verbal communication. Making reference to colors, patterns, designs, and shapes is perfectly acceptable. The words *blind* and *visually impaired* are also acceptable in conversation.
- Indicate the end of a conversation with a person who is blind or severely visually impaired to avoid the embarrassment of leaving the person speaking when no one is actually there.
- When you speak about someone with a disability, refer to the person and then to the disability. For example, refer to “a person who is blind” rather than to “a blind person.”

Providing Directions to a Blind or Visually Impaired Individual

When giving directions from one place to another, people who are not visually impaired tend to use gestures—pointing, looking in the direction referred to, etc.—at least as much as they use verbal cues. This is not helpful to a person who is blind or has a visual impairment. And often even verbal directions are not precise enough for a person who cannot see—for example, “*It’s right over there*” or “*It’s just around the next corner.*” Where is “there?” Where is “the next corner?” In the dental office you might say something like: “*Walk along the wall to your left past three doorways. The room that we want is at the fourth doorway; make a sharp turn to the right to enter the room.*”

The Americans with Disabilities Act (ADA) prohibits businesses that serve the public from banning service animals. A service animal is defined as any guide dog or other animal that is trained to provide assistance to a person with a disability. The animal does not have to be licensed or certified by the state as a service animal. The service animal should not be separated from its owner and must be allowed to enter the treatment room with the patient. The ADA law supersedes local health department regulations that ban animals in health care facilities.

Box 3-6. Acting as a Sighted Guide

- Sighted guide technique enables a person who is blind to use a person with sight as a guide. The technique follows a specific form and has specific applications.
- Offer to guide a person who is blind or visually impaired by asking if he or she would like assistance. Be aware that the person may not need or want guided help; in some instances it can be disorienting and disruptive. Respect the wishes of the person you are with.
- If your help is accepted, offer the person your arm. To do so, tap the back of your hand against the palm of his or her hand. The person will then grasp your arm directly above the elbow. Never grab the person’s arm or try to direct him or her by pushing or pulling.
- Relax and walk at a comfortable normal pace. Stay one step ahead of the person you are guiding, except at the top and bottom of stairs. At these places, pause and stand alongside the person. Then resume travel, walking one step ahead. Always pause when you change directions, step up, or step down.
- It is helpful, but not necessary, to tell the person you are guiding about stairs, narrow spaces, elevators, and escalators.
- The standard form of sighted guide technique may have to be modified because of other disabilities or for someone who is exceptionally tall or short. Be sure to ask the person you are guiding what, if any, modifications he or she would like you to use.
- When acting as a guide, never leave the person in “free space.” When walking, always be sure that the person has a firm grasp on your arm. If you have to be separated briefly, be sure the person is in contact with a wall, railing, or some other stable object until you return.
- To guide a person to a seat, place the hand of your guiding arm on the seat. The person you are guiding will find the seat by following along your arm.

COMMUNICATION WITH THE HEARING IMPAIRED

Approximately one out of every ten people has a significant hearing loss. Within the population of individuals who are hearing impaired, most are hard of hearing. Only a small proportion of this group is deaf. In describing hearing loss, people who are hard of hearing may say that they can hear sounds but cannot understand what is being said. For many people who are hard of hearing, low-frequency speech sounds such as “a,” “o,” and “u” may be clearly heard, while other high-frequency sounds such as “s,” “th,” and “sh” may be much less distinct. In this situation, speech is heard but often misunderstood. “Watch” may be mistaken for “wash” and “pen” for “spent.” A clearer comprehension of speech may be gained with a hearing aid or a cochlear implant. However, use of these devices does not restore normal hearing.

Presbycusis (presby = elder, cusic = hearing) is the loss of hearing that gradually occurs in most individuals as they grow old. Everyone who lives long enough will develop some degree of presbycusis, some sooner than others. Those who damage their ears from loud noise exposure will develop it sooner. It is estimated that 40% to 50% of people 75 and older have some degree of hearing loss. It involves a progressive loss of hearing, beginning with high-frequency sounds such as speech. The loss associated with presbycusis is usually greater for high-pitched sounds. It may be difficult for someone to hear the nearby chirping of a bird or the ringing of a telephone, whereas they would be able to hear low-pitched voices.

Box 3-7. Effective Communication with a Person who is Hearing Impaired

- Move closer to the person. Shortening the distance between the speaker and listener will increase the loudness of sound. This approach is much more effective than raising your voice. Never shout at a person who is hard of hearing.
- Reduce background noise. Many noises that we take for granted are amplified by a hearing aid or cochlear implant.
- Talk face to face. Speak at eye level. Do not cover your mouth with a mask when you're asking the patient questions or giving instructions.
- Try rewording a message. At times a person with a hearing loss may be partially dependent on speech reading (lip reading) because some sounds may not be easily heard even with a hearing aid. Because some words are easier to speech read than others, rephrasing a message may make it easier for the person to understand.
- Use a notepad to write down important questions or directions so that the person can read them. This helps eliminate misunderstandings. If the person cannot read or reads in a language that is unfamiliar to you, a picture board (see Fig. 3-2) may be quite helpful.
- Make sure that the person fully understands what you said. Some people, especially if the hearing loss is recent, are reluctant to ask others to repeat themselves. They feel embarrassed by their hearing loss. Simply ask the person to repeat what you said. For example, say, “If you could please repeat back to me what I said, I can make sure I told you everything that I need to.”
- Show special awareness of the hearing problem. Call the person with a hearing loss by name to initiate a communication. Give a frame of reference for the discussion by mentioning the topic at the outset (“I would like to review your medications”). Be patient, particularly when the person is tired or ill and may be less able to hear.

SECTION 4 SPEECH BARRIERS

COMMUNICATION WITH THE SPEECH IMPAIRED

It is important to remember that problems with speech or language do not necessarily mean that the person has an intellectual impairment. For example, people who have suffered a stroke are often frustrated when others think that their intellect has been impaired because of their problems with communication. Difficulty with speech does not have anything to do with intelligence. If understanding is difficult, it may be useful to ask the person to write a word or phrase.

Dysarthria

Dysarthria refers to speech problems that are caused by the muscles involved with speaking or the nerves controlling them. Individuals with dysarthria have difficulty expressing certain words or sounds. Speech problems experienced include:

- Slurred speech
- Speaking softly or barely able to whisper
- Slow rate of speech
- Rapid rate of speech with a “mumbling” quality
- Limited tongue, lip, and jaw movements
- Abnormal rhythm when speaking
- Changes in vocal quality (“nasal” speech or sounding “stuffy”)
- Drooling or poor control of saliva
- Chewing and swallowing difficulty
- Common causes of dysarthria are poorly fitting dentures, stroke, any degenerative neurologic disorder, and alcohol intoxication.
- After a stroke or other brain injury, the muscles of the mouth, face, and respiratory system may become weak, move slowly, or not move at all.
- Some former severe alcoholics who have developed brain damage due to drinking may have continued problems with language, even after years of sobriety.

Aphasia

Aphasia is a disorder that results from damage to language centers of the brain.

- It can result in a reduced ability to understand what others are saying, to express ideas, or to be understood.
- Some individuals with this disorder may have no speech, whereas others may have only mild difficulties recalling names or words.
- Others may have problems putting words in their proper order in a sentence.
- The ability to understand oral directions, to read, to write, and to deal with numbers may also be disturbed.
- For almost all right-handers and for about half of left-handers, damage to the left side of the brain causes aphasia. As a result, individuals who were previously able to communicate through speaking, listening, reading, and writing become more limited in their ability to do so.
- The most common cause of aphasia is stroke, but gunshot wounds, blows to the head, other traumatic brain injury, brain tumor, Alzheimer’s disease, and transient ischemic attack (TIA) can also cause aphasia.

Box 3-8. Strategies for Communicating with Persons with Speech Impairment

- Book longer appointment times to allow for the longer time needed for communication.
- Whenever possible, speak directly to the patient; even if comprehension is limited, the patient will be more responsive if he or she is an active participant.
- Develop a tolerance for silences. Many patients require extra time to process your questions and/or to formulate a response.
- Do not talk while the patient is formulating a response—this is very distracting.
- Try not to panic when communicating with a person who has impaired speech. If you feel nervous, do not let it show.
- Never finish a sentence for someone who is struggling with his or her speech—be patient and wait for him or her to finish.
- Find out if the patient has his or her own way of indicating “yes” or “no” (e.g., looking up for “yes”).
- If you are having problems understanding the person, say so. Do not pretend you understand if you do not, as this will inevitably create problems later on. Simply apologize and ask if the patient would mind writing down what it is he or she wants to say.
- If you are having difficulties communicating with the patient, ask permission to direct your questions to the support person. Remember to look directly at the patient from time to time so that he or she still feels a part of the conversation.
- Use gestures and pictures to help the patient understand. For example, wave hello and goodbye, point to a tooth, or show simple pictures to clarify procedures.

COMMUNICATION WITH THE VOICE IMPAIRED

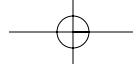
Laryngectomy

Laryngectomy—the surgical removal of the voice box due to cancer—affects approximately 9000 individuals each year; most are older adults. People who have undergone laryngectomy have several options for communication:

- **The Artificial Larynx.** Held against the neck, the artificial larynx transmits an electronic sound through the tissues, which is then shaped into speech sounds by the lips and tongue. The user articulates in the normal way.
- **Esophageal Voice.** Esophageal voice is achieved by learning to pump air from the mouth into the upper esophagus. The air is then released, causing the pharyngo-esophageal segment to vibrate to produce a hoarse low-pitched voice.
- **Surgical Voice Restoration.** Fitting a prosthesis or valve into a puncture hole between the trachea and esophagus either at the time of surgery or at a later date may restore voice. The individual occludes the stoma when he or she wishes to speak. Air then passes through the valve into the esophagus, producing voice in the same way as for esophageal voice.
- **Silent Mouthing/Writing/Gesture.** A small percentage of patients never acquire a voice and are unable to use an electronic larynx. They communicate by silently articulating words or a mixture of writing and gesture.

Box 3-9. Effective Communication with a Person with a Laryngectomy

- Give the patient plenty of time to speak. Do not hurry the person; pressure will considerably affect the ability to communicate.
- Ask the patient to repeat if you do not understand. Do not pretend you understand if you do not—it will be obvious to the patient that you do not understand.
- Watch a person's lips if you are finding it hard to understand him or her.
- Do not assume it is a hoax call or that someone is playing a joke if you hear an electronic sounding voice or someone struggling to communicate over the telephone.



SECTION 5 READY REFERENCES

Ready Reference 3-1. Internet Resources: Cultural Competence

<http://gucchd.georgetown.edu/nccc/index.html>

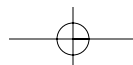
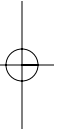
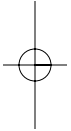
Website of the **National Center for Cultural Competence**. The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems.

<http://gucchd.georgetown.edu/nccc/topic3.html>

Information on **disparities in oral health** on the **National Center for Cultural Competence** website.

<http://www.diversityrx.org/HTML/DIVRX.html>

Promoting language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically **diverse** communities.



Ready Reference 3-2. Internet Resources: Hearing and Vision Impairment

<http://www.asha.org>

The **American Speech-Language-Hearing Association (ASHA)** website has resources on communication and communication disorders.

<http://www.nidcd.nih.gov/health/voice/index.asp>

The **National Institute on Deafness and other Communication Disorders (NIDCD)** index of resources on voice, speech, and language.

<http://www.nidcd.nih.gov/health/hearing/index.asp>

The **National Institute on Deafness and other Communication Disorders (NIDCD)** resources on hearing and deafness.

<http://medlineplus.gov/>

The **MedlinePlus** website provides health information from the world's largest medical library, the National Library of Medicine. MedlinePlus has extensive information from the National Institutes of Health and other trusted sources on over 650 diseases and conditions. The **Health Topics** section has information on hearing problems and disorders, speech communication disorders, vision impairment, and blindness.

<http://www.agbell.org/>

The **Alexander Graham Bell Association for the Deaf and Hard of Hearing** is dedicated to the mission of promoting communication for people with hearing loss. The **Information and Resources** section offers up-to-date statistics, fact sheets, and information on communication options.

<http://www.audiology.org/consumer/guides/>

The **American Academy of Audiology** offers consumer guides including "Getting Through: Talking to a Person Who is Hard of Hearing."

<http://www.raisingdeafkids.org/communicating/tips/adult.jsp>

website of the **Deafness and Family Communication Center (DFCC)** at the Children's Hospital of Philadelphia: tips on communicating with a person who is deaf.

<http://www.afb.org/Section.asp?SectionID=&DocumentID=2104>

Instructions on how to guide a person who is blind on the website of the **American Foundation for the Blind**.

<http://www.drivingvision.com/walk.html>

Protocols for interacting with individuals who are blind on the website of Larry C. Colbert, who lost his eyesight from retinitis pigmentosa.

Ready Reference 3-3. Internet Resources: Voice and Speech Impairment

<http://www.nidcd.nih.gov/health/voice/aphasia.asp>

The **National Institute on Deafness and other Communication Disorders (NIDCD)** resources on aphasia.

<http://www.nidcd.nih.gov/health/voice/dysph.asp>

The **National Institute on Deafness and other Communication Disorders (NIDCD)** resources on dysarthria.

<http://www.aphasia.org/>

The website of the **National Aphasia Association** has links to a wealth of information on aphasia. Includes links to information about aphasia in different languages, including Spanish.

<http://www.americanheart.org>

Enter “**aphasia**” in the SEARCH box on the **American Heart Association** website for many resources on this topic.

<http://www.cplqld.org.au/techsupport/techunit/information/facts/5839>

Cerebral Palsy League of Queensland, Australia website: information on complex communication needs—improving communication.

www.aphasia.org/NAAfactsheet.html

National Aphasia Association website: Aphasia Fact Sheet

www.cancer.org/docroot/MBC/content/MBC_3_2X_Speech_After_Laryngectomy.asp?sitearea=MBC

American Cancer Society website: Speech after laryngectomy

www.inhealth.com/voicerestorationwhatsalary.html

The **In Health Technologies** website: What’s a laryngectomy?

<http://um-jmh.org/body.cfm?id=1483>

Jackson Health System website: Laryngectomy Handbook

Ready Reference 3-4. English–Spanish Medical Dictionaries

McElroy OH., Grabb LL. *Spanish–English, English–Spanish Medical Dictionary*, 3rd ed. Philadelphia: Lippincott Williams & Wilkins.

Springhouse. *Medical Spanish Made Incredibly Easy*, 2nd ed. Philadelphia: Lippincott Williams & Wilkins.

Wilber CJ, Lister S. *Medical Spanish, 4th Edition—The Instant Survival Guide*. Boston: Butterworth-Heinemann, 2004.

MODULE REFERENCES

1. United States Census Bureau. *The Foreign-Born Population in the United States: March 2001*. U.S. Department of Commerce (March 2003):1–161.
2. Hobbs F, Stoops N. *Demographic trends in the 20th century: [Census 2000 special reports]*. Washington D.C.: U.S. Department of Commerce, Economics, and Statistics Administration, 2002;163:67.
3. United States Census Bureau. *Census 2000. Modified Race Data Summary File*. Washington D.C.: U.S. Department of Commerce, Economics, and Statistics Administration, 2002:1.

ADDITIONAL SUGGESTED READINGS**Cultural Competency**

Geburu K, Willman A. A research-based didactic model for education to promote culturally competent nursing care in Sweden. *J Transcult Nurs* 2003;14(1):55–61.

Narayan MC. Cultural assessment in home health care. *Home Health Nurse* 1997;15(10):663–670; quiz 671–672.

Purnell L. (2000). A description of the Purnell Model for Cultural Competence. *J Transcult Nurs* 2000;11(1):40–46.

Watts RJ. “Race consciousness and the health of African Americans.” *Online J Issues Nurs* 2003;8(1):4.

Hearing Impaired

Nattinger AB. Communicating with deaf patients. *JAMA* 1995;274(10):795.

SECTION 6 THE HUMAN ELEMENT

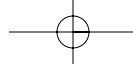
Box 3-10. Through the Eyes of a Student: Helping Patients with Special Needs

I have this 92-year-old patient, Mrs. W., who always comes with her daughter. Mrs. W. lives in an assisted living facility. I saw Mrs. W. in the dental clinic last year, too, and she always has a heavy amount of plaque when she comes in. I talked to her daughter about this in the past. The daughter lives an hour away from her mother and so cannot be there to brush her mother's teeth every day. Today the daughter said that she asked the staff at the assisted living facility to assist her mother in brushing her teeth, but she doesn't think that they have been helping her. I felt a little bad for Mrs. W. because I know these places are commonly under-staffed and oral hygiene care is not a priority.

The daughter said that there is a problem getting the staff to do things for her mother, as they are so busy. She said that her mother has low blood sugar and is supposed to have a protein snack each afternoon. Her mother didn't get her needed snack until her physician wrote it as "a prescription" to the staff.

For me, her story about the snack was like a light bulb going off in my head! What a great idea! So I talked with our clinic's dentist and he wrote "brush teeth after evening meal" on a prescription and signed it. Mrs. W.'s daughter was very pleased that we cared enough about her mother to write this "prescription."

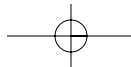
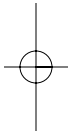
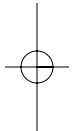
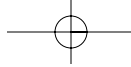
Melissa, recent graduate
East Tennessee State University



SECTION 7 QUICK QUESTIONS

1. According to the 2000 census data, fewer than 1 million people in the United States speak a language other than English at home.
 - A. True
 - B. False
2. An individual who communicates well in everyday situations, such as work, will most likely have no communication problems in the dental office. In the dental office, communication problems can easily occur if a patient is not fluent in English.
 - A. Both statements are true.
 - B. Both statements are false.
 - C. The first statement is true. The second statement is false.
 - D. The first statement is false. The second statement is true.
3. _____ is defined as the application of cultural knowledge, behaviors, interpersonal, and clinical skills to enhance communication.
 - A. Health care literacy
 - B. Cultural competence
 - C. Stereotyping
 - D. Cultural blindness
4. All of the following are effective strategies for improving cross-cultural communication, EXCEPT:
 - A. Speaking slowly, not loudly.
 - B. Using a family member as a translator when explaining the patient's dental problems.
 - C. Using visuals, such as a picture board.
 - D. Repeating your message using different words from those that you used the first time.
5. Most clinicians find it very easy to relate to the life experiences of someone who is 40 years older. When treating a child, the patient should always be the focus of the clinician's attention and where possible, information should be exchanged directly with the child.
 - A. Both statements are true.
 - B. Both statements are false.
 - C. The first statement is true. The second statement is false.
 - D. The first statement is false. The second statement is true.
6. Children who are under 5 years of age have no clear concept of future events. When treating a child who is 3 years old, it is best not to talk about procedures that will be done later in the appointment.
 - A. Both statements are true.
 - B. Both statements are false.
 - C. The first statement is true. The second statement is false.
 - D. The first statement is false. The second statement is true.

7. A teenager may be reluctant to answer certain medical history questions—such as drug use—in the presence of a parent or guardian. For a teenage patient, the most accurate medical history information can be obtained from the teenager’s parent.
- A. Both statements are true.
 - B. Both statements are false.
 - C. The first statement is true. The second statement is false.
 - D. The first statement is false. The second statement is true.
8. Background noises may be distracting to older adults engaged in a conversation. Some older people may be reluctant to discuss their dental concerns because they feel that nothing can be done to help them.
- A. Both statements are true.
 - B. Both statements are false.
 - C. The first statement is true. The second statement is false.
 - D. The first statement is false. The second statement is true.
9. When explaining your assessment findings to a person who is blind, it is best to speak to the relative or caregiver who accompanied the patient to the office. When speaking to a blind person, it is perfectly acceptable to use visually oriented words such as colors or shapes in the conversation.
- A. Both statements are true.
 - B. Both statements are false.
 - C. The first statement is true. The second statement is false.
 - D. The first statement is false. The second statement is true.
10. All of the following are helpful when communicating with a patient who has a speech impairment, EXCEPT
- A. Booking longer appointments
 - B. Helping the patient by supplying the words that he or she is struggling to convey
 - C. Staying calm and taking the time to listen patiently while the patient communicates
 - D. Finding out if the patient has his or her own special ways of communicating



SECTION 8 SKILL CHECK

SKILL CHECKLIST COMMUNICATIONS ROLE-PLAY

Student: _____

Evaluator: _____

Date: _____

Roles:

Student 1 = Plays the role of the patient.

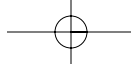
Student 2 = Plays the role of the clinician.

DIRECTIONS FOR STUDENT CLINICIAN: Use **Column S**, evaluate your skill level as: **S** (satisfactory) or **U** (unsatisfactory).

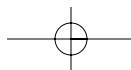
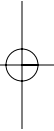
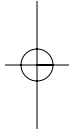
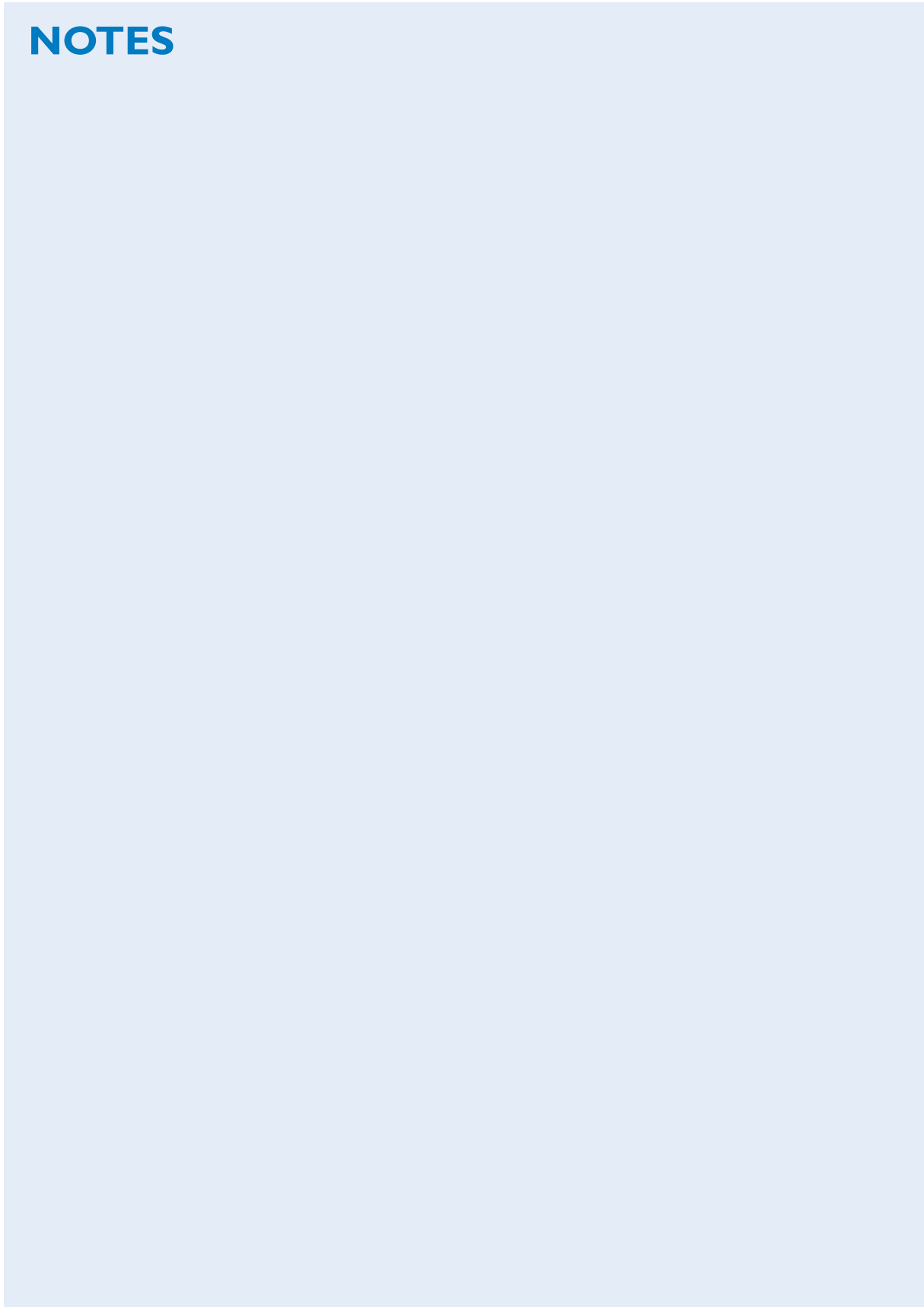
DIRECTIONS FOR EVALUATOR: Use **Column E** to record your evaluation of the student clinician's communication skills during the role-play.

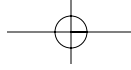
Indicate: **S** (satisfactory) or **U** (unsatisfactory). Each **S** equals 1 point, each **U** equals 0 points.

Criteria:	S	E
Uses appropriate nonverbal behavior such as maintaining eye contact, sitting at the same level as the patient, nodding head when listening to patient, etc.		
Interacts with the patient as a peer; avoids a condescending approach. Collaborates with the patient and provides advice.		
Communicates using common, everyday words. Avoids dental terminology.		
Listens attentively to the patient's comments. Respects the patient's point of view.		
Listens attentively to the patient's questions. Encourages patient questions. Clarifies for understanding, when necessary.		
Answers the patient's questions fully and accurately.		
Checks for understanding by the patient. Clarifies information.		
OPTIONAL GRADE PERCENTAGE CALCULATION		
Total " S "s in each column.		
Sum of " S "s _____ divided by total points possible (6) equals the percentage Grade _____		



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