ENHANCING CULTURAL AWARENESS
AND
COMMUNICATION SKILLS

A Training Program for Health Care
Providers and Educators

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ENHANCING CULTURAL AWARENESS AND COMMUNICATION SKILLS

A Training Program For HealthStart Providers

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HOW TO USE THIS MODULE

This module includes units which are designed to be presented together as a whole in a half-day training session. There is enough material to serve as the basis of one or more additional sessions. Trainers will have to select the optional sections of the module based on their understanding of the interests of the group and on their time limitations.

For the introductory HealthStart training session, trainers are asked to cover the key elements in each unit. These elements are indicated by an asterisk (*) preceding the paragraph. Optional sections are labeled and may be used for longer presentations. In some sections the trainer may select one or more examples which seem especially relevant in the setting. These choices are indicated by the heading.

Background details for the trainer are shown in italics. This material would not usually be presented, but could be used by the trainer for his or her own expanded knowledge of the subject and to answer questions or engage in dialogue with participants. NOTES includes additional information for the trainer related to teaching methods, strategies, handouts. To summarize how these elements are marked in the module:

* Basic part of module to present.
Scripted sections are boldfaced

OPTIONAL Use for longer presentations or more in-depth units on this topic.

BACKGROUND Use for trainer's own expanded knowledge, discussion.

NOTES Methods, Strategies, procedures
I. INTRODUCTION OF TRAINERS AND PARTICIPANTS

OBJECTIVES:
- Gain background information about participants and trainers to foster familiarity within the group.
- Encourage initial interaction between participants and trainers.
- Elicit goals and expectations participants bring to the session.

NOTES
Although health care team members may work together routinely, time schedules and other constraints within the setting often limit the frequency and scope of interactions. This workshop is designed to bring together all the members of the HealthStart team to strengthen relationships across professional and paraprofessional lines.

* INTRODUCING THE TRAINER

You may choose to introduce yourself or ask the highest level person at the training site to introduce you. Your agency host may preceded the introduction with some comments about the training session. Be sure to give the person who will introduce you a brief written statement that includes your name, current position, areas of expertise relevant to the HealthStart Program, and any other information about yourself which you feel would help you establish rapport with your group members.

* ASKING PARTICIPANTS TO INTRODUCE THEMSELVES

After you introduce yourself or have been introduced and made a few comments about the session you are presenting, ask (in your own words) the following:

- Could you each please tell us your name, what your HealthStart responsibilities are, and anything else you would like to share with all of us?

- Some of you may have some expectations or goals for today’s session. It would help us if you mentioned these.

NOTES
In a small group, ask each person to state an expectation. In a large group, ask for a few volunteers to share expectations.
II. ENHANCING AWARENESS OF ETHNICITY

OBJECTIVES

- To sensitize participants to the complexity of individuals' ethnic identity.

- To encourage participants to reveal aspects of their own backgrounds which they may not have shared with co-workers. This is designed to encourage them to be able to hear and respond to cultural diversity in a positive manner with peers.

- To increase awareness of how current and past cultural values and expectations may influence present behavior in health care.

- To raise into conscious open discussion the personal effects of racism and elitism on patient-provider encounters.

- To increase awareness of how to influence beliefs and behaviors which are rooted in cultural values when appropriate.

- To increase sensitivity to the importance of accepting culturally different practices when they are not harmful, even if they do not conform to western medical beliefs or practices.

* THE COMPLEXITY OF ETHNIC IDENTITY

Health care providers need to be aware of the complexity of ethnic identities which their patients bring to medical encounters. Some will say they are Italian-American or just American. In some groups there are many different ways of expressing both the commonalities and differences within the ethnic or racial group. For example, individuals whose families come from Spanish speaking countries may call themselves Latinos, Chicanos, or refer more specifically to being Puerto Ricans or Mexicans. All of these ethnic identities convey more specificity than the term Hispanic which is used by the Census Bureau and other organizations. Similarly, Black Americans may identify themselves as being Afro-American, African-American, or West Indian or Jamaican. Similarly the terms Asian and Asian-American include persons whose ethnic identity is often far more specific in regard to country of origin — e.g. Japanese, Chinese, Cambodian, Laotian, Vietnamese. We see the complexity of ethnic identity when we try to define ourselves. For example, when I think about my own ethnicity, I describe myself as:

Let's spend a few minutes describing ourselves ethnically.

Notes

Insert your own ethnic description above keeping in mind that group members will model their own descriptions after yours in terms of complexity and length. Depending on the size of the group, ask everyone or every other person to share his or her ethnic self-definition. If the group is larger than 8-10, ask participants to count off from 1-3 or 1-5 or more. Then ask all the "threes" or "fives" or whatever number you select to share their definitions. This exercise can
be a good "ice-breaker" but you will need a time limit. It may also be possible to combine this exercise with the discussion of how health behavior is influenced by culture and family experiences. The "count-off", for example, may be used to continue, asking other numbers to share experiences.

BACKGROUND

Attitudes towards one's ethnic backgrounds may also be affected by the migration experience. Migration patterns and experiences do affect adaptation to life in the United States. Providers must be aware of the massive northern migration of Blacks since World War II as well as the radical shift from rural to urban life. Moreover we must recognize lifestyle and psychological issues associated with urban overcrowding where these are issues. The health provider might consider whether an individual migrated alone, with a family, or with a whole community. When large groups migrate together members of the group may be viewed negatively in the community or communities where they relocate and this experience may affect a patient's attitude towards seeking health care. During each period of migration in American history, new immigrant groups have suffered discrimination and unfair treatment. The Irish, Italians, Jews, and Poles all experienced discrimination and prejudice. Blacks continue to suffer disproportionately from the economic consequences of racism. Blacks whose ancestry in this country dates back several centuries also may have strong feelings about the rapid acceptance and ascendancy of newly migrated groups into society while they remain the subjects of discrimination.

When considering adaptation to local conditions the reasons for migration may be important to consider. What was the cause or motive for migration -- religious, political or racial persecution? Was the migration voluntary or forced? Were past generations forced to leave because of slavery? Were the immigrants seeking success or were they making a desperate effort to overcome generations of poverty? Other factors for health providers to consider are the factors which reveal the immigrant's view and valuation of his or her country of origin. Does the family wish to visit the country of origin whether that is feasible or not? What language is spoken at home. What efforts are made to preserve traditional language and culture? Is intermarriage encouraged or discouraged? What is the actual rate of intermarriage? What is expected of children in terms of cultural preservation or assimilation into American culture?

* EXPLORING HOW HEALTH BEHAVIOR IS INFLUENCED BY CULTURE AND FAMILY EXPERIENCES

We can all see from our own experience how our health behavior is shaped and influenced by our family and the culture with which our family identifies. Let's take a few minutes to share how our own experiences shaped our health behavior or practices.

NOTES

Depending on the size of the group, ask everyone or a few people to share their experiences. Ask the first general question below and then SELECT one or two examples of very specific health behaviors which seem especially important in the setting in which you are doing the training.

Which family members influenced your health practices while you were growing up or later when you were having and raising your own children? Which family members provided the most advice, and what kinds of things did they tell you to do or not do to keep well?
(SELECT one or two of the following topics and ask)

WHAT KIND OF ADVICE DID YOU GET ABOUT ___________?

- Nutrition of babies and small children
- Breastfeeding
- Pierced Ears
- Prenatal influences on the unborn baby
- Pica
- Menstruation
- Laxatives
- Other topics known to be of interest to participants

NOTES
Here participants and trainers talk about their own family and cultural experiences. While some participants may be tempted to bring up examples from encounters with patients, it is important for participants to have the experience of discussing their own practices so that they come to understand cultural differences and diversity as close to their own experience as possible. The exercise will reveal how much diversity there is among members of the health care team itself and how many of them in fact learned or practiced behavior which is not the "standard practice" so often recommended in health care settings. This awareness is designed to increase receptivity to the concept of allowing culturally different patients to continue practices which are not harmful but which may seem strange or ineffective to health providers.

BACKGROUND — KEY ASPECTS OF SELECTED HEALTH PRACTICES
The health practices which will be discussed above include many behaviors and values which are embedded in cultural expectations. In facilitating these discussions, in a large group or in smaller sub-groups, the following key aspects of the practice might be identified or discussed. These features are just examples of what might come up in the discussion. Each trainer will probably be familiar with several of these topics.

NUTRITION OF BABIES AND CHILDREN
Examples may include when they were instructed to begin feeding their own children, stories they heard about how they were fed in childhood or infancy, attitudes toward cleanliness or sterility they heard, attitudes and practices related to the use of pacifiers, eating patterns (schedule or demand feeding), or exhortations and means to get children to "eat all your food."

BREASTFEEDING OR BOTTLEFEEDING
Women should be encouraged to share their own feeding experiences or preference. Participants might be asked to reflect on how their decision to breast or bottle feed may have been influenced by family members or others. Particular Attention
should be given to attitudes about breastfeeding held by husbands or boyfriends. If there are individuals present who grew up in the rural South or Third World countries where traditional midwives still practiced they may relate influences from midwives or other "wise women" in their communities.

PIERCING EARS

This topic may be especially relevant in areas in which ear piercing is widely practiced. There may be discussion about the range of acceptable ages at which ears are pierced. One might also consider what family and community members if any are present or participate in ear piercing of newborns.

PRENATAL INFLUENCES ON THE UNBORN BABY

Discussion may center around cultural beliefs associated with influences on the pregnant woman which affect the baby both in utero and later in life. Beliefs regarding "marking" the baby are cross-cultural. In contemporary western culture there are many scientific and pseudo-scientific theories about social and psychological factors which affect the baby's personality or development. For example, there are beliefs about the home environment, music, "talking to the fetus" etc. In cultural minority groups there may be less familiar beliefs regarding prenatal influences.

PICA

There is historical evidence that geophagy, the practice of eating earth, has existed in nearly every culture. Geophagy is no longer as prevalent as it once was among southern Black women in the United States, whose practice is a carryover from their African traditional heritage. In many cultures there are beliefs that earth has magical properties and that by ingesting it, these qualities would be transferred to the individual. It is also a substance which is viewed as an an antidiarrheic and a mineral supplement. Pica is a craving for various nonfoods including earth, ashes, laundry starch and similar substances which became more widely used than clay among some urban Blacks. Geophagia, while less prevalent than in the past, still continues in some rural and urban areas. (See Vermeer and Frate, 1979, for information on geophagia.) Participants who grew up in the South may recall practices and beliefs about eating earth. The starch substitute may be known to those who grew up in urban areas in the North.

MENSTRUATION

Virtually all women recall beliefs and practices associated with menstruation. In some cultures these may be negative, in others more neutral. Some women may have had very positive experiences and attitudes within their own families, but are nonetheless likely to be aware of some negative views of others. The trainer may need to probe to generate discussion of restrictions on behavior which women experienced during adolescence during their menstrual periods.

LAXATIVES

Some participants may recall the use of laxatives as a "cure-all" in their families or cultural milieu. Others may recall specific diseases or disorders for which laxatives were given by both lay and professional health providers.
III. NEGOTIATING DIFFERENCES IN PATIENT AND PROVIDER EXPECTATIONS

OBJECTIVES:

- Reinforce the reality that there will be differences between patients and providers in terms of values, beliefs, and expectations about appropriate health behavior during pregnancy, in the care of infants and children, and in promoting health and preventing disease.

- Emphasize that the system is here to promote health and wellness and not only to treat disease.

- Reinforce the perspective that wellness, health promotion, and the social context within which the client lives are all as critical for the clinician to address as is the diagnosis of specific disease states.

- Identify strategies for recognizing and clarifying potential areas of conflict between providers and patients.

- Model ways of eliciting information from patients which create therapeutic alliances between providers and patients.

- Show how negotiation can be used as a therapeutic tool to encourage behavioral change in the direction desired by the health provider.

- Identify strategies for handling real conflicts and letting go of other issues which have little impact on health status or outcomes.

BACKGROUND - LAY MANAGEMENT OF SICKNESS EPISODES

Patienthood is as much a social state as a biological one. It is important to remember that the majority of all recognized episodes of sickness are managed outside the formal health care system. Patients typically make a self-diagnosis of being ill and parents or other caretakers diagnose illness in babies and children. Except in obvious emergencies or severe accidents, lay people often discuss how to manage illness episodes with other lay people and seek and implement informal care. Some make extended use of health resources outside what we generally view as the official health care system.

Providers need to understand that the decision to seek care is made on the basis of the patient's or patient's caretakers' definition of the situation as one which warrants medical attention. HealthStart clients who have had limited access to medical services may be accustomed to seeking care in the formal system only when a problem seems serious. The concept of preventive care may be less familiar and they may not understand why some procedures are recommended or why regular visits are important.

Too often wellness is identified as a white middle class phenomenon. It is imperative that people understand that wellness is a universal concept that needs to be embraced by all. Practitioners need to shift their focus away from individual diagnostic entities and include an assessment of psychological, social, spiritual, political and economic components of community and individual experience. Health in many cultures is based on holistic practices and these may be a natural bridge from the past to the future as it may affect current health practices.

Once a person decides to come for care, he or she does not relinquish pre-existing beliefs and understandings about appropriate treatments and likely causes of the problem. It is probably reasonable to assume that the health provider and patient will start with very different expectations and thus the first task of the provider must be to identify these understandings and expectations and learn to guide the patient into a course of action which will benefit his or her health. Rather than attempting to bring about complete compliance with the provider's view of what is "best," the provider may bring about more positive behavior if he or she attempts to move the patient towards the ideal behavior. Collaboration to reach some compromise rather than complete compliance may be the most satisfactory expectation. Holding appropriate
expectations may help prevent the provider turn potentially unsatisfying relationships into more satisfactory ones. In short, the provider may need to define partial compliance or partial adoption of recommended regimens as "success" rather than "failure" with a particular client. Learning to do this requires getting enough information from the patient to allow effective assessment and negotiation.

* ASKING QUESTIONS TO PROVIDE OPPORTUNITIES FOR PATIENT-PROVIDER NEGOTIATION

NOTES

At this point in the session the trainer illustrates the way in which questions can be formulated to encourage negotiation and to forge a therapeutic alliance. The trainer may use the scripted material below or substitute questions and examples from his or her own experience.

Rather than focusing immediately on diagnosing a problem or prescribing treatments or regimens, the provider can ask questions which provide information about patients' beliefs, expectations, and goals. With this added information the provider will be in a better position to identify major differences which are likely to cause problems in case management. For example, the clinician may ask:

What do you do to keep yourself well?

How do you control your weight?

How do you get enough sleep?

How do you take care of your baby's skin?

Who helps with other children so you can bring your baby to the clinic?

What do you think is making the baby sick?

Who helps you with the baby?

Can you think of other questions that would help you get information from your client or patient?

* PATIENTS NEED OPPORTUNITIES TO ASK QUESTIONS

Patients need opportunities to ask questions throughout the medical visit. Their questions often reveal underlying beliefs and expectations if the health provider listens carefully to what is really being asked.
Can you think of situations in which a question revealed important information to you?

* NEGOTIATING A COMPROMISE

Providers can negotiate with patients about their behavior and therapies and can even negotiate what kind of outcome to expect. This negotiation may be the single most important step in establishing trust and encouraging return visits when appropriate.

Let us consider the difference between a prescriptive approach and negotiating a compromise in some common situations.

Example: Pregnant teenager who eats poorly.

The provider can choose to respond prescriptively—by telling her to eat, that it's good for her and for the baby.

Or, the clinician can negotiate and discuss why the teen doesn't eat breakfast. Some negotiated compromises might be eating a snack later in the morning or having a very early lunch—both of which would improve her nutrition.

Example: A pregnant woman eats too much junk food.

A prescriptive approach would exhort her to pack a nutritious lunch or cook balanced meals. A negotiated approach would be to explore when she ate the junk food and where. Perhaps a compromise would involve getting her to select more nutritious items from fast food chains more often. Identifying simple steps to take is more likely to bring about change than expecting drastic alterations of behavior or lifestyle all at once without ongoing support.

Example: Patient is not getting adequate exercise.

A prescriptive approach would involve scolding or exhorting the woman to exercise, perhaps handing her a booklet on the importance of exercise. A negotiated compromise would involve discussing her daily habits and looking for small steps she could take to increase exercise such as taking stairs instead of elevators for a few floors or walking an extra block or two to work.
NOTES

This section may be ended with discussion or further examples from the participants or trainer's experience if time permits. Then end with a transition into the next unit. The trainer may use any appropriate transitional approach such as the following:

Let's turn now to some reasons why we fail to communicate effectively and then we will explore some strategies for improving the effectiveness of our communication.
IV. IMPROVING PROVIDER-CLIENT COMMUNICATION

OBJECTIVES:

- Reinforce the importance of good communication skills, especially with HealthStart clients.
- Clarify that patients and providers may have different priorities and definitions of what is important in a medical visit.
- Identify sources of strain in medical communication.
- Reinforce that the provider's communication pattern can be altered in ways which promote or impede effective communication and affect the quality of medical care.

* COMMUNICATION IN MEDICAL SETTINGS

Communication is a key to patient participation, retention, adherence to preventive health practices and medical regimens. Despite widespread acknowledgment of the importance of communication, relatively little research and professional education focus on key elements needed to establish effective communication or analysis of how and why communication succeeds or fails.

Communication involves a complex interplay between the expectations, values, and language skills of clients and all health care personnel — telephone appointment clerks, nurses, receptionists, doctors, and laboratory technicians and others.

Effective communication involves both the skills of individuals and the basic organization and physical arrangements which affect people's ability to communicate. No matter how good a communicator you are, you are not likely to convey caring to the patient if you have three telephones ringing off the hook, know you have a waiting room jammed with more patients than you can comfortably see in one day, or feel overburdened by organizational problems.

* MEDIATING TIME PRESSURES

Few health professionals are trained to view allowing time for effective communication as being as critical as allowing time and resources for laboratory tests, drugs, or medical equipment. Yet failed communication is very costly for both health providers and patients. With HealthStart patients the need for effective communication between all health workers and patients is of particular importance. Many HealthStart clients may be particularly at risk of experiencing miscommunication.
The costs of miscommunication are great for both HealthStart patients and
providers. Improving communication should reduce costs, improve both patient and
provider satisfaction with medical services, and improve patient health practices in
ways which will improve health outcomes for pregnant women and infants in New
Jersey.

(BACKGROUND) — HEALTHSTART CLIENTS' BACKGROUND

Some HealthStart clients are appropriately viewed as being at high risk for medical miscom-
munication because:

- English may not be their first language.

- Their socioeconomic status and cultural experiences are very different from those
  of most health care providers.

- Their previous health care experiences in large, impersonal health training
  institutions may make them wary of health professionals.

- Internalized feelings of racial superiority and class consciousness are manifested
  by elitist language which too often separates patients and providers. Derogatory
  comments about race and class are not uncommon in ambulatory settings.

* HOW MUCH TIME DOES IT TAKE TO COMMUNICATE EFFECTIVELY?

Proponents of communication skills often strike fear in the hearts of health care
providers who already feel overburdened by too few workers to care for too many
patients. Often the assumption is that good communication entails "spending a lot
of time with the patient — a lot more time than I have". It need not. In fact, improving
communication may actually reduce time pressures on health workers by reducing
conflicts with patients, reducing problems related to lack of compliance with medical
recommendations, and reducing errors directly related to misunderstandings be-
tween patients and workers.

Research demonstrates that it is not the ACTUAL AMOUNT of time doctors spend
with patients that makes them feel cared for and more likely to comply with recom-
mended treatments and behaviors, but the patient's PERCEPTION that the doctor
cares and understands and addresses what the PATIENT regards as "most
important."

For example, in Korsch and Negrete's classic study of 800 pediatric consultations
(In a walk-in clinic at Children's Hospital in Los Angeles), the investigators found that
in these exams which varied in length from two to 45 minutes they could find no
significant correlation between the length of the session and the patient's satisfac-
tion or the clarity of the diagnosis of the child's illness. Indeed, in some of the longest
sessions, time was consumed largely by failures in communication: The doctor and patient were spending the time trying to get on the same wavelength. (Scientific American 227: p. 71)

* "GETTING ON THE SAME WAVELENGTH"

Getting on the same wavelength isn’t always easy because patients and health providers often have different priorities, different expectations, and different ideas about WHAT IS IMPORTANT AND WHY. Overall, the research on failed communication suggests that problems arise when the patient feels that the health worker:

- Did not understand his or her concerns.
- Did not show friendly, personal concern.
- Did not give a clear diagnosis or explanation of a problem.

(BACKGROUND) — COMMUNICATION RESEARCH

Neither language barriers nor socioeconomic status were the most serious problems in communication uncovered by Korsch and Negrete. In their 800 pediatric consultations:

The severest and most common complaint of the dissatisfied mothers was that the physician had shown too little interest in their great concern about their child. High among the expectations of mothers in coming to the clinic was that the doctor would be friendly and sympathetic not only to the child but also to the worried parent. The recordings show, however, that less than 5 percent of the physician’s conversations were personal or friendly in nature. In most of the visits the physician gave no attention to the mother’s own feelings and devoted himself solely to the child’s illness. Among the 800 mothers, 26 percent told interviewers after the session with the doctor that they had not mentioned their greatest concern to the physician because they did not have an opportunity or were not encouraged to do so.

Under such circumstances there was frequently a complete breakdown of communication. Some patients were so preoccupied with their dominant concerns that they were unable to listen to the physician. Some even reported that the physician had failed to examine the child adequately or to give a prescription, although the tape recorded account of the visit attests that he did in fact do so. (p. 72)

Overall, patients who felt that the doctor had not understood their concerns, had not given a clear diagnosis, or had failed to show friendly interest were less satisfied and less compliant with treatment than patients who perceived the doctor to be friendly, understanding, and clear about their child’s diagnosis. Korsch and Negrete emphasize that while most of the doctors believed they had been friendly, less than half of the mothers had this impression. Since perceived friendliness and attention to the mother’s worries had such high correlations with success in satisfying her and obtaining her compliance with advice, they believe that practitioners can quickly establish fruitful communication with the patient by opening medical encounters with open ended questions which allow the mother to voice concerns.
PATIENT SATISFACTION AND FOLLOWING MEDICAL ADVICE ARE HIGHEST UNDER THE FOLLOWING CONDITIONS:

- When there is two-way communication with the practitioner speaking WITH the client rather than asking a seemingly endless list of questions.

- When a high proportion of the provider's statements are made in a positive tone.

- When the proportion of nonmedical statements is high, a finding which underscores the importance of addressing nonmedical concerns in medical visits. Such talk is important.

- When the relative proportion of statements involving medical history are small relative to other communication.

In sum, while health care PROVIDERS need information to make a diagnosis and treatment plan, PATIENTS need to feel understood, to experience positive affect, and to be regarded as individuals. This process starts from the time a client makes a first telephone or walk-in contact and continues through the experience of registering, waiting, and making future appointments. The behavior of every member of the health care team affects the client's experience. How the client is treated by the security guard, the receptionist, the nurse, the doctor, and every member of the health care team influences whether or not the client will feel satisfied and be motivated to engage in positive health actions including returning for needed visits. WITH HEALTHSTART CLIENTS in particular, who often have many difficulties in their lives with which to cope, MAKING THE MEDICAL VISIT A POSITIVE EXPERIENCE IS OF UTMOST IMPORTANCE.

NOTES

Each group of health care worker will have different roles to play in communicating effectively. Most of the research on medical communication is between patients and doctors or nurses. The principles of good communication, which will be reviewed later in the module, apply equally to other staff — receptionists, nutritionists, social workers, exercise physiologists, and family therapists. Professionals in fields which emphasize counseling skills — such as social work, midwifery, mental health nursing, nutrition counseling — may not need much information on communication skills. These health providers may know how to communicate well but feel frustrated and unable to do so because of organizational constraints such as lack of time, lack of privacy, or other barriers to good communication. Other professionals, some nurses and many physicians, received little formal training in communication skills. In some settings, expanded workshops on improving clinical communication skills may be desirable. Office staff, especially appointment clerks and receptionists, may or may not have received any special training on good communication skills. If such training is needed, additional workshops may be recommended. Here, a few examples of communication skills are noted for illustrative purposes.
(OPTIONAL): ASKING QUESTIONS EFFECTIVELY

Research indicates that the way in which questions are phrased shapes the type of response one will receive. Korsch and Negrete believe that practitioners could improve medical communication significantly if they asked a few simple questions which elicit the client's perception of what is "wrong." For example in pediatric visits, they suggest the provider ask:

"Why did you bring Johnney to the Clinic?"

"What worried you the most about him?"

"Why did that worry you?"

Korsch and Negrete conclude that even brief, if friendly, discussions of mothers' concerns, however seemingly irrelevant or irrational they may seem, can perform wonders in reassuring them and winning their cooperation. In contrast, mothers react poorly to impersonal or institutional expressions such as:

"We don't hospitalized children with impetigo"

or

"We keep most cases of pneumonia under observation in the clinic."

Patient rapport and cooperation thrives not on these generalities, but on specific instructions, expressions of trust in the mother's caretaking ability, and offers of continued interest such as "Call me anytime" or "We'll check Johnney again tomorrow."

These findings are consistent with the popularity of self-help groups, hot lines, and "warm lines" for all kinds of health care consultations where patients appear to have deep needs to be understood and to be treated as an individual, not as a "case."
(BACKGROUND) THE BENEFITS OF EFFECTIVE COMMUNICATION

In a detailed analysis of 285 pediatric visits out of the 800 described above, Freeman, Negrete, Davis and Korsch (Pediatric Research 5: 298-311, 1971) identified the interaction factors associated with patient satisfaction and compliance. Patient compliance with treatment increases when:

- The doctors speak as often or more frequently than the mother in the consultation — indicating more communication than in consultations where the client is pushed through a series of questions which seem to be endless checklists and interrogations.

- When a substantial percentage of the doctor's statements are made in a highly positive tone.

- When the percentage of general nonmedical statements is high — indicating the importance of nonmedical concerns in medical encounters.

- When the percentage of statements involving medical history are small. This finding is particularly important because to many clinicians, taking the medical history is viewed as of primary importance. These data suggest that devoting a large proportion of the medical encounter to medical history taking does not pay off in terms of patient compliance. That is not to say that an adequate history is not necessary. Rather, it implies that medical history taking is perhaps more effective when embedded in a complex interpersonal encounter where other forms of communication are included.

In sum, practitioners need information to make a diagnosis and develop a plan for treatment. Patients need to feel understood, to experience positive affect from their providers, and to be regarded as individual persons.

NOTES

To meet the needs of both patients and providers, medical encounters need to allow for two-way communication. Each needs to have his or her respective needs for understanding and information met. In recent years there has been increasing emphasis on "two-way communication" in medical encounters. If the trainer believes that the group receiving the training is not familiar with the term two-way communication, the basic module above might be modified by stopping after introducing the concept of two-way communication and asking, "What does this mean to you?" This will both elicit their understanding of the concept and model asking a question in an open-ended format which allows greater exploration of understanding.

(BACKGROUND) — TWO-WAY COMMUNICATION

Two-way communication entails more than questions and answers being exchanged. It involves qualitative aspects of interaction as well as quantity. However it is interesting to see how Korsch, Negrete and their associates illustrate this by graphing actual observations of pediatric consultations. On the second figure in Appendix A: Handouts and Background Material for Trainers, we see in Case A at the top, both the mother and doctor "changed places" or took on different roles in the interaction. In contrast, in case B below, the mother's interaction (illustrated by the heavy line) consisted largely of silence punctuated by a few statements of information and two indications of disagreement. The doctor's contribution was largely giving information, disagreeing, showing antagonism and hostility. The "give and take" seen in case A and characteristic of two way communication is noticeably absent. Not surprisingly, the mother interviewed about her experience in encounter A reported being very satisfied and was compliant with medical recommendations. She described the doctor as being friendly and
reassuring, felt his attitude really indicated he understood her concerns and was especially helpful with treatment instructions. In case B, where the mother’s contributions amounted to only 20% of the total conversation, the mother told the interviewer afterwards that “she felt the doctor was ‘lousy’, that he showed no interest, and did not relieve her worries at all.” Satisfaction was low and although she actually received adequate information for treatment, the mother was only partly compliant with the regimen. (Freemon et. al. p. 304).

* HOW DO WE FALL INTO ONE-WAY COMMUNICATION?

Even providers who are sensitive to effective communication skills can fall into one way communication or less effective communication patterns when they are:

- Hurried
- Preoccupied
- Placed in stressful work situations where there are inadequate supports for meeting the social and psychological needs of patients.

*(BACKGROUND) — CAUSES OF POOR COMMUNICATION

In short, situational pressures may make otherwise very caring health care providers less sensitive and effective communicators than they might be under more favorable circumstances.

Others, however, may over-value the technical aspects of medical care and under-value the human aspects of medical communication. When such practitioners hold supervisory roles in health care settings, fewer resources may be allocated for providing social and psychological support and in some settings practitioners who emphasize the non-technical aspects of medical communication may be viewed with disdain by their colleagues.

*(OPTIONAL) BEHAVIORAL FEATURES OF POOR COMMUNICATION

Health providers can undermine effective communication in many ways. They may:

- Fail to listen — and convey that failure to listen to the patient very directly — e.g. prescribing the same medicine which the patient has come in to report is causing a severe allergic reaction.

- Interrupt inappropriately — cutting the patient off conveys lack of respect and impatience.

- Use body language which conveys lack of interest or boredom — e.g.
  — Lack of eye contact
  — Fidgeting
  — Looking around the room or shuffling notes
• Using words carelessly and without thoughtfully considering if the patient will actually understand. Or, the provider may "talk down" and insult the patient's sense of intelligence or dignity. Both show failure to "connect" with the patient as an individual and reduce the patient's willingness to communicate.

• Speak critically, evaluatively, and judgementally in ways which shut off communication. Because mothers frequently "blame themselves" for their children's illnesses, thoughtless "jokes" about what mothers must have done wrong are especially inappropriate because they evoke guilt and hostility.

Everyone who has ever worked in a busy medical setting or school knows that at times we have all done some of these things which reduce the effectiveness of our communication with our patients or students. Changing provider attitudes and beliefs towards their clients and improving communication skills are needed. Yet these changes alone will not remedy certain underlying problems. It is critical to create an environment where staff can discuss what they perceive are the problems with the system and propose change and learn stress management strategies.
V. MODES OF COMMUNICATION: VIDEO TAPE

OBJECTIVES:

- Illustrate less effective and more effective communication in a familiar medical setting.
- Provide specific examples of communication behavior which participants can use to identify general principles of good communication.
- Raise awareness of the complexity of communicating with clients from different cultural backgrounds and experiences.
- Provide a shared experience around which discussion can be focused.

* AN ILLUSTRATION OF TWO MODES OF COMMUNICATION: VIDEOTAPE AND DISCUSSION OF MRS. CARDONES’ VISIT

There are general principles of effective communication which can be used to improve service to HealthStart clients. Today we shall see a videotaped medical encounter in which the same medical problem is managed in two very different ways by a clinician. In the first scenario, neither the patient nor the provider feels satisfied with the outcome. In the second, both feel that they are able to respond to each other more effectively. After we view this video tape, we will have a discussion of the key factors which improved the outcome of the medical visit for both the client and the provider.

NOTES

Discussion may be organized according to the needs and size of the group. The following are suggestions for particular types of groups.

- **KEEP ENTIRE GROUP TOGETHER.** This is most effective for small groups (i.e. 12 or fewer participants). It may also be necessary if you are training alone without another staff member who is prepared to facilitate a group discussion.

- **DIVIDE GROUP INTO TWO OR MORE GROUPS BY TYPE OF OCCUPATION.** This is most effective where there is a substantial mix of staff who are involved in different aspects of patient care. The most usual division is between clinicians (e.g. doctors, nurses, social workers etc.) and administrative service staff (e.g. administrators, clerical staff, support staff). Groups are most effective when they include at least six but no more than fifteen participants.
• DIVIDE GROUPS INTO PROBLEM SOLVING GROUPS. This is effective when there are already well defined barriers to communication in the setting (e.g. language problems, organizational problems). In this situation the facilitator needs to balance the needs of participants to complain about conditions versus looking for positive and creative solutions which can be implemented as quickly as possible as well as planning for longer term solutions to organizational problems (e.g. space, staffing patterns etc.) PRELIMINARY DISCUSSIONS WITH SITE STAFF SHOULD ALERT THE TRAINER FOR THE NEED FOR THIS TYPE OF DISCUSSION.

(OPTIONAL) DISCUSSION QUESTIONS FOR CLINICIANS

Clinicians may wish to discuss specific aspects of the two medical encounters. A good general opening question to facilitate the discussion is:

• What makes one encounter more effective than the other? The facilitator may then ask additional questions to bring out aspects of the encounters that are not brought up by the first question. Thus, for example, the facilitator may ask:

  • How does the clinician show respect or lack of respect for the client’s belief system?

  • How did the clinician enable the client to ask clarifying questions?

  • How was the clinician empathetic in communicating and sensitive to the client’s feelings?

  • How was attention directed to the psychological, social, cultural history of the client?

  • What would have made each a better scenario in terms of effective communication?
(OPTIONAL) DISCUSSION QUESTIONS ON MONITORING OUR EFFORTS AT EFFECTIVE COMMUNICATION

Each of us already knows signs and symptoms of our lack of communication. In medical encounters it is useful to develop our own personal "check-list" of indicators that we are not communicating well. The trainer then may ask:

*What are some of the signs you take as evidence of communicating effectively and ineffectively?*  
*Or, ask, Who can give an example of when he or she knew the communication was effective?, What were the behavioral indicators?*

NOTES
Put participants' responses to these questions on a Flip-chart if time allows

<table>
<thead>
<tr>
<th>ANALYZING COMMUNICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs of Effectiveness</td>
</tr>
<tr>
<td>(list)</td>
</tr>
</tbody>
</table>

NOTES

*Reconvene training group into one group for final session.*
VI. TOWARDS MORE EFFECTIVE COMMUNICATION MORE OFTEN

OBJECTIVES:

- Reinforce principles of effective medical communication.

- Increase participants' awareness of opportunities for more effective communication using specific examples.

- Encourage participants to identify for themselves signs of effective and ineffective communication which can serve as personal cues to identify the need for improved communication with specific clients.

- Provide participants with a written sheet to refer to in the future when they wish to review principles of good communication. This handout may also encourage further group on-site discussions of communication skills.

* LEARNING TO IDENTIFY GOOD COMMUNICATION

If we train ourselves to be self-reflective, we can reduce the frequency of failures of communication such as the ones we have seen today in the video presentation. We can also strive to communicate with clients more effectively by focusing our awareness on techniques to enhance communication. These techniques are suggested by the research on medical communication and on Interpersonal relations. Many were illustrated in the scenarios of Mrs. Cardones and her doctor. WE ARE DISTRIBUTING A HANDOUT, "A SUMMARY OF STRATEGIES TO IMPROVE TWO-WAY COMMUNICATION"

NOTES

Distribute the handout now, not earlier, to keep participants' attention. You may use the handout, "Strategies To Improve Two-way Communication," in the appendix, as an outline or guide for your presentation or as a "take-off" point for discussion. Or, you may wish to use the following scripted material.
STRATEGIES TO IMPROVE TWO-WAY COMMUNICATION

We can improve communication by attending to the following:

PUT THE PATIENT AT EASE

Given the value patients place on non-medical aspects of interaction, we can open encounters with patients by conveying personal interest in the patient. Addressing the patient by name — Mrs., Miss., Ms. or by first name depending on what you have discovered this patient prefers, personalizes what follows. Rather than viewing these preliminary remarks as trivial, we might remind ourselves that they lay the groundwork for building trust, confidence, and satisfaction which may improve patient care and compliance with critical treatments.

CLARIFY WHAT YOU INTEND TO DO OR DISCUSS

Patients are often uncertain about what will happen at medical visits. Pregnant women and mothers of children coming for routine well-baby care particularly need to be told what the visit will entail because unlike most medical encounters, these are generally recommended to women by doctors, midwives, or nurses who have a concept of screening, early diagnosis, and preventive measures. Women themselves are less likely to be familiar with coming to see the doctor or nurse unless she has some specific health problem. HealthStart patients, who frequently have limited experience with preventive care, especially need to be told what the provider expects of the visit. For example, the patient may be told:

"Today we will go over your diet to be sure you understand what to eat to help make your baby healthy".

Telling the patient this first, rather than asking a series of questions about her dietary habits, will engender cooperation rather than fear.

USE PATIENT-CENTERED BEHAVIOR TO ESTABLISH RAPPORT

Rapport is established through both verbal and non-verbal communication. Providers may direct attention towards establishing good eye contact, moving closer to the patient, seating self at patient's eye level if she is sitting
or lying down, and smiling. What a patient-centered provider tries to convey is that this patient, right here and now in this room, is the most important person in this setting. The patient's importance is established by:

- Avoiding unnecessary interruptions such as phone calls, lengthy discussions with other workers about matters not related to **THIS PATIENT**.

- Maintaining privacy and the patient's sense of modesty. When possible, allowing the patient to discuss matters while dressed and sitting in a chair is preferable to talking with her only when she is wearing a paper gown or covered by a sheet.

**USE APPROPRIATE AND UNDERSTANDABLE LANGUAGE**

Avoid medical jargon and check to see that the patient really understands both your questions and recommendations. For those providers who have had limited experience with HealthStart patients, some attention may need to be directed to determining what the actual literacy level of your patients is in relation to your oral communication and any written instructions or health education material you may provide. The "Fry Readability Formula" enclosed in your Communication Packet provides a simple means for evaluating the readability of material. If your clients need written material in Spanish, French, Vietnamese or some other language, you might wish to determine whether or not the patient is herself literate, and at what reading level, and also find out if she has relatives or friends who can and will read for her.

**USE ACTIVE LISTENING SKILLS**

Active listening skills are readily learned and are effective to elicit and feed back both the content of medical information and the feelings patients have about themselves and their health conditions.

**(OPTIONAL) — DETAILS ON ACTIVE LISTENING SKILLS**

**LISTEN FOR FEELINGS AS WELL AS CONTENT**

Often just listening to and feeding back the feelings of the patient will satisfy her or his need to feel heard and understood. We do not need to agree with the patient's feelings to acknowledge them and demonstrate that we understand them. In feeding
back the patient's feelings, we must take care to avoid inferences or judgements, advice, or opinions, especially if we have negative feelings about them. For example, we might say

"I sense that you don't like your new diet."

or

"I can see that you're upset with this diet."

Both of these statements will likely reflect the patient's feelings and hopefully encourage the patient to say more about why she feels as she does.

In contrast if we said:

"You are just going to have to be more cooperative about your diet"

or

"If you don't watch your diet you'll hurt your baby"

We would predict that the patient will react defensively or fall silent. Neither reaction will facilitate our learning what is really bothering the patient about the diet.

ASK OPEN ENDED QUESTIONS

Open-ended questions cannot be answered with a simple yes or no, but give her the opportunity to respond with a broader range of information. When asking the patient "what, where, how, and why?" questions, we may be surprised by the answers, many of which we could not have anticipated.

<table>
<thead>
<tr>
<th>Open Ended</th>
<th>Closed (Yes-No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Where do you feel the Pain?&quot;</td>
<td>Is This where you feel the pain (pointing)?</td>
</tr>
<tr>
<td>&quot;What else is bothering you?&quot;</td>
<td>Is there anything else bothering you?</td>
</tr>
<tr>
<td>&quot;How can I help you?&quot;</td>
<td>Do you want pain pills?</td>
</tr>
<tr>
<td>&quot;How do you feel about being pregnant?&quot;</td>
<td>Are you glad to be pregnant?</td>
</tr>
</tbody>
</table>
ASK SPECIFIC QUESTIONS FOR SPECIFIC PURPOSES

Use specific questions to zero in on particular information that you need. Try to avoid "check lists" of questions or questions which seem irrelevant to the patient. Watch for nonverbal cues from the patient that the specific questions are puzzling, threatening, or frightening.

PARAPHRASE WHAT THE PATIENT TELLS YOU AND ASK HER TO DO THE SAME FOR YOU

Paraphrasing messages enables you and the patient to check if your understanding and theirs is similar. With patients who may have limited facility with English or who you suspect may have difficulty understanding directions or explanations, be sure to ask the patient to repeat and review 1) Diagnostic Information — to be sure she understands what health condition she has 2) Treatment Information — to be sure she understands what to do and how often 3) Return for follow-up — to be sure she knows when you expect her to come back and, when appropriate, Why.

CONVEY EMPATHY

Empathizing with the patient is far more likely to encourage her to comply with treatments and return visit plans than critical judging. If personal or folk practices are not harmful, consider supporting the patient’s desire to maintain these cultural practices. You can empathize with her desire to maintain these cultural practices. You can empathize with her feelings about her cultural expectations even when they differ from your own.

* MONITOR A PRACTICE FOR SIGNS OF EFFECTIVE COMMUNICATION

In addition, we can more systematically monitor our practices for signs of failed communication by charting:

- Poor adherence to schedule of office visits.
- Poor adherence to prescribed treatments.
- Repeat visits for the same problem which are clearly related to misunderstanding previous information and instructions.
- Simple applied evaluation research designed to elicit patients’ perceptions of our communication.
VII. PLANNING HOW TO IMPROVE COMMUNICATION

OBJECTIVES

- Identify concrete steps participants can take immediately and in the future
- Conclude session on a positive note

* SUMMARY AND EVALUATION

To conclude today's workshop, let us spend a few minutes considering how we might improve communication with our clients. Considering what we have discussed here today, list on your worksheet two specific examples of what you believe you can do immediately to improve communication with your clients. We will ask some of you to share these ideas with the whole group. We would also like to have you write down two ideas for improving communication which could only be implemented in the future, perhaps with some changes in staffing, additional resources, or training. We would like you to turn in both worksheets. You do not need to put your name on the worksheet.

NOTE

Allow 3-4 minutes for participants to think about this and write. Then ask for a few volunteers to describe what they will do.

* CONCLUDE TRAINING SESSION

Thank participants for participating and collect worksheets and EVALUATIONS.
SELECTED REFERENCES


DIRECTIONS: Randomly select 3 one hundred word passages from a book or an article. Plot average number of syllables and average number of sentences per 100 words on graph to determine the grade level of the material. Choose more passages per book if great variability is observed and conclude that the book has uneven readability. Few books will fall in gray area but when they do grade level scores are invalid.

Count proper nouns, numerals and initializations as words. Count a syllable for each symbol. For example, "1945" is 1 word and 4 syllables and "IRA" is 1 word and 3 syllables.

EXAMPLE:

<table>
<thead>
<tr>
<th>SYLLABLES</th>
<th>SENTENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Hundred Words</td>
<td>124</td>
</tr>
<tr>
<td>2nd Hundred Words</td>
<td>141</td>
</tr>
<tr>
<td>3rd Hundred Words</td>
<td>158</td>
</tr>
<tr>
<td><strong>AVERAGE</strong></td>
<td><strong>141</strong></td>
</tr>
</tbody>
</table>

READABILITY 7th GRADE (see dot plotted on graph)

For further information and validity data see the Journal of Reading December, 1977.
STRATEGIES TO IMPROVE TWO-WAY COMMUNICATION

- **PUT THE PATIENT AT EASE**
- **CLARIFY WHAT YOU INTEND TO DO OR DISCUSS**
- **DEMONSTRATE PATIENT-CENTERED BEHAVIOR TO ESTABLISH RAPPORT**
- **USE APPROPRIATE AND UNDERSTANDABLE LANGUAGE**
- **USE ACTIVE LISTENING SKILLS**
- **LISTEN FOR FEELINGS AS WELL AS CONTENT**
- **ASK OPEN ENDED QUESTIONS**
- **ASK SPECIFIC QUESTIONS FOR SPECIFIC PURPOSES**
- **PARAPRASE WHAT THE PATIENT TELLS YOU AND ASK HER TO DO THE SAME FOR YOU**
- **CONVEY EMPATHY**
- **MONITOR A PRACTICE FOR SIGNS OF EFFECTIVE COMMUNICATION**