

Annotated Bibliography on Patient-Provider Communication

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Communication problems between patients and health care workers are far too often at the root cause of inadequate medical treatment, unnecessary errors, excess pain, and even death. There are lots of reasons for these communication problems. There are lots of (often inexpensive and simple) things that can be done about them. But far too little actually happens, with regard either to understanding these problems or applying the readily available solutions, in part because there is no single convenient place to go to gain access to information about either (1) the causes of the problems or (2) the tools available for dealing with them.

The following collection is intended as one small step towards alleviating this access problem. Hopefully, it will make it a little easier for people interested in bridging the communication gaps between patients and health care workers to know where to find useful information on the subject.

- [A. Understanding Language and Culture Issues between Patients and Providers](#)
 - [B. Overcoming Language and Cultural Communication Barriers](#)
 - [C. Understanding Communication Barriers between Providers and Communication Vulnerable Patients Not Related to Language or Culture](#)
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A. *Understanding Language and Culture Issues Between Patients and Providers*

Over the past four decades, the United States has attracted immigrants from all around the world, with the majority emigrating from Latin America, Asia and Europe. The resulting increase in ethnic, cultural and linguistic diversity has been accompanied by a great — and growing — need for language access services in health care settings. However, most health care organizations provide either inadequate interpreter services or no services at all, and patients who have limited English proficiency do not receive needed health care or quality health care. Often, persons enlisted to help patients communicate with health care providers are not trained interpreters; instead, they are fellow patients or are family members, friends, un-trained nonclinical employees, or non-fluent health care professionals. Reliance on such ad hoc services has been shown to have negative clinical consequences like longer hospital stays, patients becoming sicker because of failure to continue treatment, missed appointments, passing infectious diseases to others, misdiagnoses by doctors, and low patient satisfaction.^[1] Moreover, these adverse outcomes are often exacerbated by the vulnerability and fear patients experience when they do not speak the same language as their caregivers.^[2]

Indeed, interpretation mistakes underpin many preventable adverse outcomes in medical settings. RMarchione writes about a study involving thirteen medical visits between pediatricians and Spanish-speaking mothers at a Boston clinic to illustrate the gravity of medical interpretation errors in health care settings. The study reports that an average of thirty-one interpretation errors occurred during each of the thirteen doctor visits. Of these errors, sixty-three percent were considered serious enough to have adverse medical consequences due to altered descriptions of illnesses to doctors, misstated diagnoses or treatment options, misunderstandings about a child's condition, or misconceptions about the need for follow-up visits or referrals. The author comments that when professional interpreters are not available, health care staff often rely on nurses, social workers, friends, or family members of patients, increasing the risk of interpretation errors.

Although many preventable adverse events in health care settings occur as a result of language and cultural barriers, a study about parental reports of communication problems with health care providers showed that foreign-born parents were 11.8% more likely to report communication problems than American-born parents. This demonstrates that many patients and their families recognize that there are serious communication problems that inhibit them and their loved ones from getting the care they need. However, according to the same study, cultural and socio-economic influences and health literacy issues also affect communication in health care settings even more; 24.4% of low-income parents reported poor communication with health care providers.

As the population of the United States becomes ever more diverse and the languages spoken multiply, growing numbers of patients who speak no English are being isolated by language barriers. Moreover, cultural and socio-economic influences affect the continuum of patient-provider communication. The consequences of medical miscommunication can be severe. Patients become sicker because they fail to stick to treatment regimens that they do not understand. They miss appointments. They pass on infectious diseases because they do not know how often to take their medication or when to return for follow-up care. Doctors miss diagnoses, or get people to agree to procedures they do not fully understand. To compensate for their sketchy knowledge of patients' symptoms, doctors order too many tests, some very expensive, others potentially risky.

However, according to a 2002 report from the Office of Management and Budget it would cost, on average, only \$4.04 (0.5 percent) more per physician visit to provide all U.S. patients who have limited English proficiency with appropriate language services for emergency-department, inpatient, outpatient, and dental visits. This seems like a small price to pay to ensure safe, high-quality health care for the 49.6 million Americans who have limited English proficiency.

The following articles provide additional help in understanding the nature of language and cultural barriers to patient: provider communication:

1. Fein, Esther B. (1997, November 23). Language Barriers Are Hindering Health Care. *The New York Times*.

[C](#)

Many years ago, Fein explores the growing likelihood that, as immigrants settle in the United States and the number of languages in the country continues to multiply, more non-English speaking patients are isolated due to communication barriers in hospitals. She discusses several of the problems that can arise due to medical miscommunication (patients becoming sicker because of failure to continue treatment, missed appointments, passing infectious diseases to others, misdiagnoses by doctors, etc). A trained medical interpreter is the best option for reducing communication barriers between caregivers and patients, but this is not always possible; sometimes children, friends, or telephone interpreting services are used instead.

2. Saha, Somnath and Fernandez, Alicia. (2007). Language Barriers in Health Care. *Journal of General Internal Medicine*, 22(2), 281—282.

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The article begins with a scenario in which the reader is visiting a small town in China's Yunnan Province and does not speak the native language. The reader falls ill and is taken to a clinic where he is seen by a doctor who prescribes him medication. Unable to properly explain his symptoms and allergies to certain medications, the reader leaves the clinic unable to discern what is wrong with him or if the medication will heal or harm him. This story exemplifies the daily language barriers in health care occurring in the United States by providing insight into the vulnerability and fear patients experience when they do not speak the same language as their caregivers.

3. Clemens-Cope, Lisa and Kenney, Genevieve. (2007). Low Income Parents' Reports of Communication Problems with Health Care Providers: Effects of Language and Insurance. *Public Health Reports*, 122, 206-216.

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The research article discusses a study about parental reports of communication problems with health care providers, focusing on low-income families. The researchers use literature and quantitative analysis as the primary methods in their study, and they analyze data from the 1999 and 2002 National Survey of America's Families. The results show that 24.4% of low income parents reported poor communication with health care providers, and foreign-born parents were 11.8% more likely to report communication problems than American-born parents. The authors advise using professional translating services in hospitals and clinics to reduce communication barriers and improve health care.

4. Flores, Glenn. Language Barriers to Health Care in the United States. *The New England Journal of Medicine*. Volume 355:229-231 (July 20, 2006), Number 3.

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This article discusses the grave medical miscommunications and the increased incidence of adverse clinical consequences that occur when untrained, ad hoc interpreters are used in health care settings. Despite the growing number of people who have limited English speaking abilities in the United States, many patients who need medical interpreters have no access to them. The provision of adequate language services results in optimal communication, patient satisfaction, outcomes, resource use, and patient safety. A 2002 report from the Office of Management and Budget estimated that it would cost, on average, only \$4.04 (0.5 percent) more per physician visit to provide all U.S. patients who have limited English proficiency with appropriate language services for emergency-department, inpatient, outpatient, and dental visits. This seems like a small price to pay to ensure safe, high-quality health care for 49.6 million Americans who have limited English proficiency.

5. Gregg, Jessica and Saha, Somnath. (2007). Communicative Competence: A Framework for Understanding Language Barriers in Health Care. *Journal of General Internal Medicine*, 22(2), 368-370.

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The authors make an important distinction between translation and interpretation in health care settings, indicating that translating the words doctors and patients use to communicate does not suffice. This is because the use of certain words varies dramatically between diverse languages and cultures, which may significantly impact the success or failure of clinical encounters. When health care providers and patients do not understand the intent or context of their verbal interactions, language barriers often impede care and increase the risk of medical errors. Possible ways to reduce these kinds of language barriers include increasing the linguistic and cultural diversity of health care staff and allowing patients greater choice in selecting providers with whom they can effectively communicate.

6. No author. (2008, June 11). Children In Non-English-speaking Households Face Many Health Disparities, Researcher Concludes. *ScienceDaily*.

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This article discusses Dr. Glenn Flores's study in which he analyzed statistics from the National Survey of Children's Health to examine disparities between health care for English-speaking and non-English primary language (NEPL) children. The survey used nationwide random sampling to interview 102,353 children (and their caregivers) in both English and Spanish between 2003 and 2004. The study found that children in households where English was not the primary language were more likely to be poor, overweight, have only fair or poor dental health, be uninsured, have made no medical visits during the previous year, and to be dissatisfied with physicians and health care providers. While this article was mainly written to address disparities in health care due to language barriers, it also discusses some strategies to eliminate barriers to care.

7. No author. (2005, 17 August). UCSF Study Finds English Proficiency A Major Hurdle In Patient Comprehension. *ScienceDaily*.

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The article describes a University of California, San Francisco (UCSF) study in which researchers conducted telephone surveys with 1,200 Californians in eleven different languages. Researchers asked respondents forty-eight questions to find out about their experiences with health care access, satisfaction and comprehension. Limited English proficient (LEP) respondents were significantly more likely than their English-speaking counterparts to misunderstand medical situations, experience confusion in taking medication, and have trouble understanding medication labels. In addition to poorer comprehension, LEP respondents were more likely than English-speaking respondents to be female, elderly, uninsured, less educated, and have lower incomes. The results highlight the adverse outcomes resulting from communication barriers between patients and physicians, indicating a need for greater cultural and linguistic competence in the U.S. health care system.

B. Overcoming Language and Cultural Communication Barriers

Communication is a critical element of patient safety and quality care. Addressing communication barriers is also an important component of an organization's safety strategy and risk management activities, and is often a legal requirement. Language access services, including interpreters, translators, using written materials or communication boards, and using sign language in the most frequently encountered languages, are essential to meeting many of the communication needs encountered by health care organizations. The benefits of including language access services in health care settings include increased access to health care, more preventive health activities, higher quality care, increased patient satisfaction, and ensuring appropriate resource utilization.

In order to execute the most effective and wide-reaching language access services, many experts suggest that the first step in addressing communication barriers in health care facilities is to assess the language and communication needs of the population served. For example, St. Vincent's Hospital in Manhattan has made efforts to bridge language barriers, using Asian artwork, food, signs, and Chinese staff to cater to the population living in nearby Chinatown. The implementation of language access services that concentrate on the population's language and culture has been proved very successful in this instance. Indeed, picture boards and other low-tech tools help in facilitating communication in all medical settings, including but not limited to ambulances, hospitals, emergency rooms, and health clinics. Many U.S. residents do not speak proficient English, and such tools bridge the communication gap.

In addition to using alternative, low-tech tools, health care facilities can also utilize trained interpreters and translators to mitigate language and cultural barriers. Grace Plaza of Great Neck Comprehensive Care Center's language bank program, which uses staff members and volunteer interpreters to communicate with patients and family members who do not speak English, is an interesting example of this approach. Before the program was implemented, the medical center used language boards with pictures and symbols to communicate with patients. The new language program uses a schedule showing when staff members who speak foreign languages are available to interpret, and employment applications include questions regarding prospective staff members' foreign language skills. The example of the language bank program exemplifies that using interpreting services in medical establishments enables patients to communicate their questions and needs to physicians and staff more effectively. Trained interpreters can also effectively convey messages regarding diagnosis, treatment, and payment options to patients to avoid communication errors and misunderstandings.

The following articles provide additional clues to ways to overcome language and cultural barriers to patient: provider communication:

1. Shafer, Emily. (April, 2007). Doctor-patient communication critical to patient care, expectations often not met. *HemOnc Today*.

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Emily Shafer advocates the importance of doctor-patient communication throughout the diagnosis, treatment, and recovery processes in order for health care professionals to provide quality care. She examines Walter Baile's (a doctor and professor of behavioral science and psychiatry) claim that it is essential for doctors to understand their patients' emotions, as well as their own, when discussing diagnoses and

treatment options. The author discusses various programs that train physicians, nurses, and social workers to relay difficult messages to patients, enhancing their necessary communication skills.

2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (October, 2017). Facts about patient-centered communications.

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The Joint Commission supports efforts to improve communication between health care professionals and patients. It's been estimated that there are more than 300 languages spoken in the United States and more than 90 million Americans have low health literacy, meaning they have difficulty understanding and using health information. The Joint Commission recommends an approach to communicating health information that encompasses language needs, individual understanding, and cultural and other communication issues. The Joint Commission's [Health Equity portal](#) provides extensive information and resources about patient-centered communications, including: monographs, white papers, reports, podcasts, videos and other advocacy-related resources.

3. Pacheco, Guadalupe. (2005). A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations. *Office of Minority Health (OMH), U.S. Department of Health and Human Services (DHHS) by the American Institutes for Research (AIR)*, 1-5.

[Web Link \(PDF\) >](#)

The introduction to this guide addresses the importance of language access services (LAS) for limited English proficient (LEP) patients in health care organizations. The author illustrates several benefits of LAS, including increased access to health care, higher quality care, increased patient satisfaction, and ensuring appropriate resource utilization. The Office of Minority Health issued the National Standards for Culturally and Linguistically Appropriate Services in Health Care in 2000 to address existing inequalities in health care services. These standards are categorized into three categories: culturally competent care, language access services, and organizational supports.

4. Johnson, Linda A. (2007, September 2). Picture boards help bridge language gap in health emergencies. *USA Today, Associated Press*.

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This article illustrates the importance of picture boards in facilitating communication in all medical settings, including but not limited to ambulances, hospitals, emergency rooms, and health clinics. Many U.S. residents do not speak proficient English, and the author advocates using the boards to bridge the communication gap, especially since 48% of hospitals treat patients with limited English every day. The article concludes by explaining the origins of picture boards and showing how people with communication difficulties can use them to get help during emergencies and disaster drills.

5. Cogill, J., Bolek, J. & JRC Design. (April, 2003). Symbol usage in health-care settings for people with limited English proficiency. *Hablamos Juntos A Program of The Robert Wood Johnson Foundation*

In 2003, JRC Design was tasked by Hablamos Juntos with developing recommendations for program standards for signage to best serve Limited English Proficiency (LEP) patients in a variety of health care settings across the health care delivery system. While the national program specifically mentions "Communication for Latinos", JRC Design's scope included that "these signage materials should not require literacy in order to be understood, and should be understandable to people regardless of their country of origin, primary language, education, socio-economic status, etc." The report is in two parts. The first part provides research and background information regarding the use of symbols in health care facilities in the United States. The second part describes processes for implementation (if any, based upon findings in the first report) of symbols within the 10 grantee demonstration environments.

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6. Jacobs, Elizabeth A., Shepard, Donald S., Suaya, Jose A., & Stone, Esta-Lee. (2004, May). Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services. *American Journal of Public Health*, 94(5), 866-869.

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The research team conducted a study from June 1, 1995 to May 31, 1997 in four health centers in Massachusetts to assess two groups of non-English speaking patients: one constituted the interpreter service group and the other was a comparison group whose members did not receive interpretation services. After two years of studying 4,499 patients, the authors found that emergency department costs increased among the comparison group and decreased among the interpreter service group. The cost of primary care was more expensive for the interpreter service group because interpretation services cost \$279 per patient for one year. However, the researchers reasoned that improving language access for patients who have limited English proficiency may lower the cost of care in the long run because improved communication tends to reduce medical errors and increase access to preventive care.

7. Chen, Alice Hm, Ramos, Eric, Mutha, Sunita, Rodriquez, Michael E., Dressner, Mark, Jafri, Asma, & Rodrigues, Shelly B. (2007). Addressing Language and Culture: A Practice Assessment for Health Care Professionals. *California Academy of Family Physicians Foundation*, 1-36.

[Web Link >](#) Access website to view complete booklet

The California Academy of Family Physicians (CAFP) Foundation created a new toolkit in 2007 to help health care professionals incorporate language and cultural proficiency into their practices. The guide is intended to assist nurses and physicians in creating a complete and functional language access system for limited English proficient (LEP) patients. The publication starts by demonstrating why the issue is important, insisting that communication is central to medical practice. The majority of the guide gives advice about how to reach out to LEP patients and improve communication between doctors and patients in health care settings. It also illustrates ways in which doctors can assess their own language skills and those of their staff, as well as how to effectively work with professional interpreters.

8. "Overcoming Communication Barriers in Emergency Situations: Some Basic Tools." *Central Coast Children's Foundation, Inc.*

Available on the Patient-Provider website.

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This compilation of resources offers advice to first responders in emergency situations about how to minimize communication breakdowns. The article demonstrates the gravity of communication barriers between caregivers and victims, which often lead to misdiagnoses, treatment errors, unnecessary pain, and even death. The author discusses the importance of communication in emergency situations since first responders reach victims first and must be able to accurately assess the type of care needed. In the next section, the author provides a list of common communication tools that first responder personnel can use to facilitate communication while in the field. Each resource is accompanied with a link where readers can retrieve more information about their use.

9. Hasselkus, A., & Moxley, A. (2009, March 24). *Health literacy: Health literacy at the intersection of cultures. The ASHA Leader*, 14(4), 30—31.

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Speech, language, and hearing professionals must be culturally sensitive in order to provide clinically competent services. Culturally competent providers not only have clinical knowledge of disorders and recommended treatments, but also acknowledge the beliefs and values unique to their clients. This article describes issues relevant to SLPs and audiologists.

C. Understanding Communication Barriers Between Providers and Communication Vulnerable Patients Not Related to Language or Culture

Health care delivery flaws occur today regardless of language and cultural barriers and arise across the entire continuum of care. People who are unable to use their natural speech, those who have limited speech due to surgery or other circumstances, those with brain injuries, the elderly, young children, etc. are far too often victimized by inadequate patient: provider communications. Even more troubling is the known fact that the vast majority of medical professionals have not had the requisite training to communicate effectively with their patients. As a result of these compounding factors, preventable adverse events in health care settings are often a function of poor patient-provider communication and the underutilization of inexpensive, low-tech tools and strategies.

The articles below suggest a variety of interrelated factors that contribute to poor communication in health care settings. Many propose that the main factors that lead to preventable adverse events in health care settings are communication problems and poor clinical management. Others suggest that obstacles to effective communication include the vast gap between the healthcare world and that of the average patient, low health literacy, and low standard literacy rates. Another article attributes preventable adverse events in health care settings to cognitive doctor mistakes, which are classified into three categories: (1) anchoring, or making snap judgments based on initial findings; (2) "availability," or assuming that recent experiences can explain new situations; (3) "attribution," or attributing symptoms to a preconceived stereotype about the patient.

In addition to poor management and cognitive doctor mistakes, the underutilization of alternative and augmentative communication tools contributes to the incidence of preventable adverse events in health care settings. For example, one article describes a study conducted by a group of doctors and nurses to determine the level of frustration patients experience when trying to communicate during mechanical ventilation, their level of frustration with the use of a communication board, and their perceptions of the appropriate format and content of this communication tool. Sixty-nine percent of patients in the study said that they would have experienced less frustration during mechanical ventilation if they had used a communication board.

Medical miscommunications as a result of these factors increase the incidence of adverse events and serious errors in critical care settings. In a one-year observational study using direct continuous observation throughout the time period, participating doctors studied 391 patients and found 120 adverse events in 79 of them, including 45% preventable and 55% non-preventable adverse events, as well as 223 serious errors. Among the adverse events calculated, 13% were life-threatening or fatal. They found that most serious medical errors occurred during the ordering or treatment delivery processes, especially when giving patients medicine (61%). A similar study by Groopman suggests that fifteen percent of all patients are misdiagnosed.

The following articles provide additional information regarding the nature of communication barriers not related to language or culture:

1. Patak, Lance, Gawlinski, Anna, Fung, Ng Irene, Doering, Lynn, Berg, Jill, & Henneman, Elizabeth A. (2006). Communication boards in critical care: patients' views. *Applied Nursing Research*: 19(4) 182-190.

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The article describes a study conducted by a group of doctors and nurses to determine the level of frustration patients experience when trying to communicate during mechanical ventilation, their level of frustration with the use of a communication board, and their perceptions of the appropriate format and content of this communication tool. Sixty-nine percent of patients in the study said that they would have experienced less frustration during mechanical ventilation if they had used a communication board. The same patients identified specific characteristics the communication board should exhibit to facilitate communication with health care providers.

2. Elder, Nancy C. and Dovey, Susan M. (2002). Classification of medical errors and preventable adverse events in primary care: A synthesis of the literature. *The Journal of Family Practice*, 51, 927—932.

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This study analyzes published medical data and literature to classify and describe preventable adverse events and process errors in primary care settings. The authors categorize preventable adverse events as diagnostic, treatment, and preventive care incidents; they also classify process errors into four major categories: clinician factors, *communication factors*, administration factors, and blunt end factors (insurance and government regulation errors). The study illustrates the kinds of preventable errors that occur in primary medical care settings (such as misdiagnosis or administering an incorrect dose) and explains why they occur (such as failure of clinician—patient communication).

3. Rothschild, Jeffrey M., Landrigan, Christopher P., Cronin, John W., Kaushal, Rainu, Lockley, Steven W., Burdick, Elisabeth, Stone, Peter H., Lilly, Craig M., Katz, Joel T., Czeisler, Charles A., & Bates, David W. (2005). The Critical Care Safety Study: The incidence and nature of adverse events and serious medical errors in intensive care. *Critical Care Medicine*, 33(8), 1694-1700.

Article available for purchase through the following website:

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A group of doctors report on their study about the nature and incidence of adverse events and serious errors in critical care settings. They conducted a one-year observational study using direct continuous observation throughout the time period. The doctors studied 391 patients and found 120 adverse events in 79 of them, including 45% preventable and 55% non-preventable adverse events, as well as 223 serious errors. Among the adverse events calculated, 13% were life-threatening or fatal. They found that most serious medical errors occurred during the ordering or treatment delivery processes, especially when giving patients medicine (61%).

4. Bartlett, Gillian, Blais, Régis, Tamblyn, Robyn, & Clermont, Richard J. (2008). Impact of patient communication problems on the risk of preventable adverse events in acute care settings. *Canadian Medical Association Journal*, 178 (12), 1555-1562.

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A team of doctors undertook a research project to determine whether communication problems are linked to an increased risk of preventable adverse events in medical settings. The authors discuss the context of the problem in the introduction, stating that language barriers and communication disorders decrease the quality of care patients receive, and 5-10% of the general population suffers from such disorders. The authors delineate their research methods, which include a random sample of 2,355 hospitalized patients' charts with which they assess the cause and preventability of adverse events. Their results show that patients involved in adverse events were significantly more likely than those not involved in such events to have a communication problem or psychiatric disorder.

5. Frankel, Allan. (2008). Health literacy and harm: Who is at risk? What is the fix? *Canadian Medical Association Journal*, 178 (12), 1573-1574.

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Dr. Allan Frankel uses a study conducted by Bartlett and colleagues to highlight major health care delivery flaws that occur today, regardless of disabilities or communication limitations. The two main factors that lead to preventable adverse events in health care settings are communication problems and poor clinical managements. The author discusses a solution to reducing communication barriers involving a communication framework that ensures patients are aware of how to properly care for themselves. Dr. Frankel advises that decreasing the risk of preventable adverse events will also require effective standardization and simplification of care. The article concludes with a brief comparison of health care systems in different world regions.

6. Murphy, Joan and Cameron, Lois. (2006). The Acute Hospital Experience for Adults with Complex Communication Needs. *Communication Matters*, 20(2), 7-10.

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The article summarizes a study funded by Forth Valley, Ayrshire and Arran Primary Care NHS Trusts in the U.K. that highlights the experiences of eight patients with Complex Communication Needs (CCN) in an acute hospital ward. The article discusses the aims, methodology, and results of the study, the latter of which involves feedback from patients with CCN, hospital staff members, and caregivers. The study focuses on problems that occur when people with CCN are hospitalized, such as patients' inability to describe pain and a lack of available communication resources. The article also makes recommendations for improving communication among patients, hospital staff, and caregivers in healthcare settings.

7. Tarkan, Laurie. (2008, September 15). E.R. Patients Often Left Confused After Visits. *The New York Times*, p. F1.

<http://www.nytimes.com/2008/09/16/health/16emer.html?emc=rss&partner=rssnyt>

This article discusses how a majority of emergency room patients are sent home without understanding the treatment they received or how to care for themselves once they are home. When patients are not properly prepared for self-care, they are more likely to be readmitted to the hospital or become more seriously ill. Hospitals are often pressured to serve many patients a day, and care givers tend to devote little time explaining diagnoses, treatments, and self-care instructions to patients. Dr. Eric Coleman, director of the Care Transitions Program at the [University of Colorado](#), claims that nearly half of all patients are considered to lack the ability to process and understand basic health information they need to make decisions. This, coupled with many doctors' failure to communicate effectively with patients, leads to misunderstandings and subsequent medical errors.

8. Pear, Robert. (2008, March 29). Study Finds Many Patients Dissatisfied With Hospitals. *The New York Times*, U.S.

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The United States government conducted a national survey in which a random sample of patients treated at more than 2,500 hospitals from October 2006 to June 2007 completed questionnaires about hospitals and their staff and cleanliness. Nationwide, 67 percent of patients said they would recommend the hospital at which they were treated to friends and relatives. However, many patients complained that they were not treated with respect by caregivers, did not receive adequate pain medication after surgery, and did not understand the instructions they received for home care once they left the hospital. Dr. Carolyn M. Clancy, director of the Agency for Healthcare Research and Quality, claimed that poor communication was a major source of medical errors, encouraging doctors and nurses to listen more carefully to their patients.

9. Hemsley, Bronwyn, Sigafoos, Jeff, Balandin, Susan, Forbes, Ralph, Taylor, Christine, Green, Vanessa A., & Parmenter, Trevor. (2001). Nursing the patient with severe communication impairment. *Journal of Advanced Nursing*, 35(6), 827-835.

[Web Link >](#) (by subscription only)

The authors of this study interviewed twenty nurses from four hospitals in Sydney, Australia who had experience communicating with patients with severe communication impairment. The aim of the study was to find out about the successes and obstacles nurses encountered during patient-nurse communication to better understand how to train nurses to effectively interact with non-verbal patients. In half of the interview responses, nurses identified a lack of access to appropriate augmentative and alternative communication (AAC) strategies as a major problem in interacting with patients. The lack of communication systems in hospital settings increased the amount of time and effort spent on communication, leading to considerable frustration for both nurses and patients.

10. Happ, Mary Beth. (2001, May). Communicating With Mechanically Ventilated Patients: State of the Science. *AACN Clinical Issues: Advanced Practice in Acute and Critical Care*, 12(2), 247-258.

Article available for purchase through the following website:

[Web Link >](#)

The author discusses the difficulties and stresses mechanically ventilated patients experience in the intensive care unit (ICU) when trying to communicate with doctors and nurses. Critical care nurses rarely receive training in effective communication with non-verbal patients, and most are unfamiliar with augmentative communication methods. Dr. Happ's article explores the existing research

D. Overcoming Communication Barriers Between Providers and Communication Vulnerable Patients Not Related to Language or Culture

Many assistive technologies and low tech tools can help to overcome communication barriers and allow patients to more effectively participate in their own treatment and rehabilitation in health care settings. Such tools are available to help people communicate more effectively in their current communication settings, as they make the transition through care in a hospital, in rehabilitation centers, and at home. These tools and strategies go well beyond "talking boxes" and picture boards—they include a comprehensive collection of communication strategies that provide external support for many different types of people in health care settings. The use of such strategies in health care settings can significantly reduce medical miscommunications and allow for more successful patient-provider communication.

People sometimes associate some of these tools and strategies only with people who enter the medical setting already burdened by complex communication needs. However, these tools and strategies can be used in a much wider range of health care settings and situations to improve communication. For example, intensive care units (ICUs) may provide an appropriate location for using both low-tech and high tech speech generating devices, as so many ICU patients temporarily cannot rely on their usual powers of speech and require aid in communicating their questions and needs to caregivers. Several articles are now available to provide concrete examples of how augmentative communication devices can prove useful in the ICU.

One article in particular exemplifies New Jersey University Hospital's use of communication picture boards to bridge communication barriers between health care professionals and patients. The New Jersey Department of Health and Senior Services (NJDHSS) has distributed more than 2,200 boards to facilities across the state in its efforts to ensure that every patient receives effective medical care. The article strongly advocates the use of communication boards, stating that they should become an integral part of the U.S. Department of Health and Human Services' "Effective Communication in Hospitals" program. Although communication boards may not be an appropriate tool for diagnosing diseases or requesting consent, they are useful for everyday communication purposes.

Other articles suggest that training in effective communicating is imperative to improving patient-provider interactions. Realizing the link between how well a provider understands the communication process and patient satisfaction and outcomes, a growing number of health care systems are beginning to train employees in this critical skill.

The articles below suggest a wide variety of ways to overcome communication barriers and mitigate the incidence of preventable adverse events in health care settings:

1. Lasker, J.P, & Garrett, K.L. (2008, June 17). Aphasia and AAC: Enhancing communication across health care settings. *The ASHA Leader*, 13(8), 10-13.

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The authors advise health care professionals about how to effectively assess and treat clients suffering from aphasia by enhancing natural communication strategies and using appropriate AAC technologies. The article delineates two partner-dependent strategies, three transitional strategies, and two independent strategies patients can use depending on their needs and cognitive and speech abilities. The authors encourage the use of AAC technologies in health care settings to accomplish communication goals and allow patients to effectively participate in their own rehabilitation.

2. Communication Matters (ISAAC, UK). (2008). Communicating with Patients who have Speech/Language Difficulties: Guidance for Medical & Nursing Staff. *Communication Matters*.

Article can be accessed directly on patient provider communication website.

[Web Link >](#)

This free, downloadable leaflet provides guidelines for medical and nursing staff to communicate effectively with patients who have speech, language, or communication difficulties due to injury, illness, or learning disabilities. It discusses both general and specific tips for facilitating communication with patients, including asking questions one at a time and writing words on paper while speaking. The leaflet also defines communication aids and describes how patients can use them to communicate their needs, questions, and desires.

3. U.S. Department of Justice, Civil Rights Division. (2003). ADA Business Brief: Communicating with People who are Deaf or Hard of Hearing in Hospital Settings. *Americans with Disabilities Act*.

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The Americans with Disabilities Act mandates that all hospital programs and services provide effective communication for patients, family members, and visitors who are deaf or hard of hearing. The document briefly describes four communication methods used by such people, including sign language interpretation, oral interpretation, cued speech interpretation, and Computer Assisted Real-time Transcription (CART), explaining the conditions under which each is used. The remaining portion of the brief delineates what services hospitals are required to provide people who are deaf or hard of hearing, as well as what is not required of them.

4. Blackstone, Sarah W (editor). (2007). *Augmentative Communication News (ACN)*: 19(1) 1-2.

[Web Link \(PDF\) >](#)

This issue of ACN introduces the book, *Augmentative Communication Strategies for Adults with Acute or Chronic Medical Conditions*, which offers practical tools and strategies for providing AAC services to adults with medical conditions which hinder effective communication. Authors advocate for the use of augmentative and alternative communication (AAC) and assistive technologies (AT) for people who suffer from severe communication impairments either because of disease or injury and gives examples of people with different conditions who could benefit from AAC or AT. Included is information about why **intensive care units (ICUs)** are ideal locations for AAC technology use, as well as how to address the daily communication needs of people with **brainstem impairments**, delineating key assessment and treatment strategies. One chapter focuses on treatment guidelines for people suffering from **traumatic brain injury (TBI)** or a **spinal cord injury (SCI)**.

5. Miyasaka, Katsuyuki, Suzuki, Yasuyuki, Sakai, Hirokazu, & Kondo, Yoichi. (1997). Interactive Communication in High-technology Home Care: Videophones for Pediatric Ventilatory Care. *Pediatrics: Official Journal of the American Academy of Pediatrics*, 99(1), 1-6.

[Web Link >](#)

This article discusses a study in which Japanese doctors assess the clinical impact of a home videophone system for patients receiving home respiratory care. The doctors compare two groups of patients to whom the videophone system was introduced, evaluating its impacts on the type and quality of care. The authors conclude that using this technology significantly reduces the number of house calls by physicians, unscheduled hospital visits by patients, and hospital admission days. Furthermore, both patients and health care professionals considered the videophone system to be acceptable and beneficial. The authors strongly advocate the use of this communication tool to improve the quality of pediatric home ventilatory care.

6. Makoul, G. (2001). Essential elements of communication in medical encounters: The Kalamazoo consensus statement. *Academic Medicine: Journal of the Association of American Medical Colleges*, 76(4) 390-393.

[Web Link >](#)

This essay highlights a conference sponsored by the Bayer Institute for Health Care Communication and the Fetzer Institute. Twenty-one representatives and leaders from major medical education and professional organizations congregated to discuss the essential elements in physician—patient communication. The group collectively identified seven essential sets of communication goals for doctors and patients. These include (1) build a doctor—patient relationship; (2) facilitate open discussions; (3) gather information; (4) understand the patient's perspective; (5) share information; (6) reach an agreement on problems and plans; and (7) provide closure. These communication goals were designed to provide a coherent framework for teaching and assessing communication skills, determining relevant knowledge and attitudes, and evaluating educational programs.

7. MacAulay, Fiona, Etchels, Judson, Andrew, et al. ICU-Talk: A New AAC Device for Intensive Care Patients. In V. L. Hanson, & J. A. Jacko (Eds.), *Assets '02 Proceedings of the fifth international ACM conference on Assistive technologies* (pp. 226-230). New York: Association for Computing Machinery. .

[Web Link \(PDF\) >](#)

This paper describes the collaborative development of a computerized communication aid designed specifically for intubated patients in the intensive care unit (ICU). This augmentative and alternative communication (AAC) device, called ICU Talk, uses a speech synthesizer to voice phrases, sentences, or questions from a pre-stored database. It is most appropriate for ICU patients who are alert but physically limited and unable to speak. The core database has two different interfaces from which patients can choose, both consisting of eight color-coded topics and related phrases and questions. Each style supports the use of touch screens, mouse emulation, and single switch scanning. These access methods permit patients at different stages of recovery to use ICU Talk, including those with severe physical impairment.

8. Groopman, Jerome. (2007). *How Doctors Think*. U.S.A.: Houghton Mifflin.

[Web Link >](#)

Groopman's book discusses what goes on in a doctor's mind when he or she treats a patient, illustrating the potential life and death significance of doctor-patient communication. The author describes the algorithms and evidence-based therapies doctors are trained to use for typical diagnoses and treatments. He indicates that while these methods can be useful for treating easily identifiable illnesses, they are less effective when doctors are unsure of the illness from which a patient suffers. Groopman believes that openly pondering and discussing how doctors think can reduce both the frequency and severity of medical mistakes by revealing to patients how their doctors think when they examine, question, diagnose and treat them. This in turn will bridge communication barriers between patients and their caregivers.

9. Mehallow, Cindy. (2006, July). Tips for Effective Patient-Provider Communication. *Monster Health Care*.

[Web Link >](#)

This article focuses on the importance of effective patient-provider communication to improve health outcomes. Obstacles to effective communication like the vast gap between the healthcare world and that of the average patient, low health literacy, and low standard literacy rates are discussed. Tips for effective communication for health care providers like: building relationships, treating the patient as a person, and educating the patient after discovering what he already knows are also exemplified.

10. Costello, John, Patak, Lance & Pritchard, Jennifer. (2010). Communication vulnerable patients in the pediatric ICU: Enhancing care through augmentative and alternative communication. *Journal of Pediatric Rehabilitation Medicine: An Interdisciplinary Approach*, 289–301.

[Web Link \(PDF\) >](#)

This paper describes augmentative and alternative communication (AAC) interventions for patients admitted to the intensive care unit (ICU). Costello focuses on patients who undergo surgeries that render them temporarily incapable of vocal communication. He describes both preoperative and postoperative interventions, providing viable strategies patients can use to communicate. Some of these AAC interventions include technologies such as patient-directed vocabulary selection and digital voice message banking. Costello interviews patients, family members, and medical staff, using their responses to illustrate the benefits of AAC interventions for ICU patients who are temporarily unable to speak.

11. State Government, Department of Human Services, Victoria. (2003). *Improving the admission and discharge practices of acute and sub-acute care facilities in relation to people with dementia*, 52-58. (no longer an active link)

This research project demonstrates that successful communication with patients suffering from dementia is an essential component of hospital and nursing home care. The researchers interview several nurses to find out which techniques work best for them when communicating with patients. Nurses identified a variety of useful strategies, including verbal communication, body language and written messages. When there is open communication between hospital staff and family members, hospitals can obtain a detailed history about the patient that aids in providing quality care. An understanding of the patient's degree of cognitive deficit is vital in creating a comprehensive care plan, which takes into account such issues as sleeping patterns, activities the patient enjoys, and support that helps him/her cope with dementia.

12. Happ, Mary Beth, Roesch, Tricia Kenney, & Garrett, Kathryn. (2004) Electronic voice-output communication aids for temporarily nonspeaking patients in a medical intensive care unit: A feasibility study. *Heart & Lung*, 33(2), 92-101.

[Web Link >](#)

Abstract of article IS available on this site. This pilot study uses participant observation, interviews, questionnaires and clinical record review to obtain information about the use of electronic voice output communication aids (VOCAs) for patients admitted to the intensive care unit (ICU). The authors study eleven critically-ill patients who are temporarily unable to speak due to mechanical ventilation, and they find that patients attempt to communicate more frequently when VOCAs are available than when communicating with non-vocal methods. The researchers also study barriers to VOCA use, and their results show that deterioration in the patient's condition, staff unfamiliarity with the device, time constraints, poor device positioning and complex message screens are the most significant barriers. Despite these difficulties, ICU patients who use a VOCA may be able to communicate more easily during respiratory tract intubation.

[\[1\]](#) Fein

[\[2\]](#) China