# TEETH, TALK, & TLC:
# A COMMUNICATION HANDBOOK FOR DENTAL HYGIENISTS

Toni Siegrist Adams
B.A., San Jose State University, 2001

PROJECT

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF ARTS

in

COMMUNICATION STUDIES

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

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A Project

by

Toni Siegrist Adams

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Abstract

of

TEETH, TALK, & TLC:
A COMMUNICATION HANDBOOK FOR DENTAL HYGIENISTS

by

Toni Siegrist Adams

*Compared to the majority, minority people in the United States face disproportionate barriers to receiving health care, including dental care, in part because health professionals lack communication and intercultural communication competence. Scholars and leaders in government, medicine, dentistry, and dental hygiene have called for training of students and practicing health providers because education helps address these disparities. Current communication references for dental hygienists are dated and barely mention cultural issues. This handbook devotes one chapter to culture and addresses cultural issues throughout and has been conceived to help dental hygienists enhance their communication and intercultural communication knowledge and skill. The prospectus documents the need for such a book and outlines the theory, principles, and concepts in instructional, health, and intercultural communication that have served as its foundation. The book appears in Appendix D.*

_____, Committee Chair
Mark R. Stoner, Ph.D.

November 12, 2008
Date

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# Chapter 1

## BACKGROUND OF THE PROJECT

Teeth, Talk, & TLC:
A Communication Handbook for Dental Hygienists

Culturally effective health care is vital and a critical social value.
Committee on Pediatric Workforce, 2004, p. 1677

This isn't just politically correct, it's good medicine.
Voelker, 1995, p. 1641

Critical consciousness precedes transformative change.
Sprague, 1992, p. 196

### *Introduction*

A group of nursing professors and students presented a series of health education courses to Hmong immigrants. During the dental health unit one immigrant described his culture's belief about how dental caries (decay) occurs. "A very small bug with a big red head gets into the tooth and can only be killed by pulling the tooth out and crushing it and throwing it in the fire" (Moch, Long, Jones, Shadick, & Solheim, 1999, p. 240). One nursing professor commented, "I felt humbled by the recognition of the narrowness of my knowledge of different cultures" (p. 239). Many more cultural dental beliefs, customs, treatments, and folklore certainly exist, but dental professionals know little of them (Milgrom, Garcia, Ismail, Katz, & Weintraub, 2004). ***Dental hygienists***[1] (who may also be referred to as ***hygienists***) also seem to know little of ***culture*** in general and its impact on the delivery of dental hygiene care. This is true in large part because those topics are

[1] Words that are defined in Appendix A, a glossary, will appear in bold italics the first time they are explained. The glossary from the prospectus has been expanded for use in the book.

seldom dealt with in their training, continuing education, or academic or popular literature (Dhir, Tishk, Tira, & Holt, 2002; Fitch, 2004).

To address this lack of knowledge and void in training, I wrote a communication handbook with a focus on cultural issues for dental hygiene students and practicing dental hygienists. I hope that this book will help its readers understand an array of basic ***communication*** and ***intercultural communication*** topics, which will translate to better care for their patients and more satisfying workdays for them. I synthesized communication principles emphasizing ***health communication***, intercultural communication, and ***instructional communication*** theories and knowledge. In this prospectus I will explain the vision that inspired this project and document the need of such a book, the impact I hope it will have, how I developed it, the theoretical grounding I used, and the topics I covered.

*Literature Review*

Communication is essential to the delivery of health care. Researchers in communication studies, medicine, dentistry, and dental hygiene have stated that communication is central and fundamental to the patient-provider relationship (Magee, Darby, Connolly, & Thomson, 2004), to patient motivation (Meltzer, 1999), to prevention behavior (Rogers, 2000), and to patient satisfaction, compliance with treatments and prescriptions, and health outcomes (Betancourt, 2003). More specific benefits include the need of fewer diagnostic tests (Epstein et al., 2005), improved emotional health, symptom resolution including control of blood pressure, blood sugar, and pain; a more complete elicitation of patient information leading to improved

diagnosis and treatment (Stewart, 1995); and a decrease in malpractice litigation in both medicine (Brown, Stewart, & Ryan, 2003; Lefevre, Waters & Budetti, 2000; Lester & Smith, 1993; Levinson, Roter, Mullooly, Dull, & Frankel, 1997; Wyatt, 1991) and dentistry (Mellor & Milgrom, 1995; Milgrom, Fiset, Getz, & Conrad, 1993). The Headache Study Group (1986), in a particularly striking investigation, found that the key predictor of recovery from serious headaches after one year of numerous medical interventions was whether or not the patients felt that their physicians adequately understood and allowed discussion of their concerns at their initial appointments.

Cultural differences can create communication barriers between health providers and consumers that can limit or eliminate the benefits outlined above (Avruch & Black, 1993; Chachkes & Christ, 1996; Guay, 2004; Huff & Kline, 1999). Therefore, as the relatively new health communication field matures it is focusing more on intercultural issues (Kreps, Bonagure, & Query, 1998). Health care providers need to be competent intercultural communicators because we live in a multicultural, multiethnic, multiracial, multireligious, multilingual tapestry of a nation where diversity contributes to disparities in health care delivery.

*Diversity and health disparities in the United States.* One in ten United States residents was born outside the country, and minority groups are the fastest growing segments of the population (Milgrom et al., 2004). More than one in four United States residents are of African-American, Hispanic, or Asian/non-Hispanic descent (Kreps & Thornton, 1992), a proportion that is estimated to increase to one in three by the year 2020, and to over one in two by 2050 (Milgrom et al.). In 1999, "minorities" became the

"majority" in California (U. S. Department of Health and Human Services, Office of Minority Health, 2001). Almost 47 million Americans, 18% of our population, speak a language other than English at home, and 21 million or 8%, are limited in English proficiency (Armas, 2003; Flores, Abreu, & Tomany-Kormanb, 2005). Language differences combine with cultural differences to heighten the barriers between health care providers and their minority clientele. These barriers contribute to significant health problems among ethnic, racial, and cultural minority people.

Minority individuals of all kinds suffer disproportionately from health problems compared to members of majority groups. "All ethnic minority populations in the United States lag behind European Americans (whites) on almost every health indicator, including health care coverage, access to care, and life expectancy, while surpassing whites in almost all acute and chronic disease rates" (Kagawa-Singer & Kassim-Lakha, 2003, p. 577). Those who suffer the most seem to have access to the least and lowest quality care (U.S. Department of Health and Human Services [USDHHS], Healthy People 2010, 2000). Minority people also suffer excessively from dental diseases and lack of resources to receive care (Milgrom et al., 2004).

More than 108 million Americans lack dental insurance, over twice as many compared to the 44 million who lack medical insurance (USDHHS, National Institute, 2000). "Blacks, Hispanics and American Indians/Alaska Natives have the poorest oral health of any population group in the United States" (Milgrom et al., 2004, p. 1391). The Surgeon General's Report on Oral Health in America that was issued in 2000, the first manuscript of its kind, documented a "silent epidemic" (Thompson, 2000, p. 17;

USDHHS, 2000) of oral diseases in this country that impacts minority groups more than others. The report delineates goals to prevent and treat those diseases. Those goals emphasize the need of intercultural communication competence among oral health care providers and staff. Additionally, the U. S. Department of Health and Human Services created its own health goals for the country and they hope that these will be realized by 2010. The tome that lays out those goals contains a whole chapter on health communication and includes a goal for health professionals to acquire the ability to "interact with diverse populations and patients who may have different cultural, linguistic, educational, and socioeconomic backgrounds" (USDHHS, *Healthy People 2010*, p. 11-11). Many barriers must be overcome before such intercultural communication competence becomes common among health care providers.

*Barriers to health care.* Communication and culture are critical to patient-centeredness, yet many intervening factors can create misunderstandings and barriers to clear communication in intercultural settings. Many of those barriers to culturally competent health care feature communication issues including: language differences; providers' and consumers' poor communication skills; varying consumer communication styles that can be nonconfrontational, emotive, or direct and can differ from providers' styles; and various time orientations and attitudes toward touch, silence, and respect (Avruch & Black, 1993; Chachkes & Christ, 1996; Huff & Kline, 1999). Guay (2004) listed some barriers to dental care that can result from the health care provider's lack of intercultural knowledge and/or poor communication skills including: distrust, fear,

cultural isolation due to language, and lack of value of dental care therefore perception of need.

International exchange students in American universities listed fear as one of the most dominant barriers in regards to seeking health care (Cheng, H.-I., 2004). De Jongh and Stouthard (1993) found that 85% of dental hygiene patients experience some degree of anxiety. Unlike medical appointments, which on average are not dramatic and tend to become routine over time even in the case of severe illnesses (Roter & Hall, 1993), dental appointments are more likely to involve treatment, even pain, and fear of pain and the unknown can prevent anxious people from seeking care (Abrahamsson, Berggren, Hallberg, & Carlsson, 2002; Dunning & Lange, 1993; Newton, 1995; Smith & Heaton, 2003). These barriers impact the delivery of health/dental care because 95% of diseases are caused by environmental and lifestyle factors, many of which derive from culture. Only about 25% of medical recommendations are followed because people firmly resist changes in familiar routines. Since culture is integral to lifestyle, attention to patients' cultures can enhance health care (Kagawa-Singer & Kassim-Lakha, 2003).

These issues are further complicated by the impact of ***ethnocentrism*** as well as influences from the health care professional's personal culture and the medical culture (Betancourt, 2003; Herselman, 1996; Huff & Kline, 1999). Even when the provider and patient share ethnicity and language, their interactions are always "intercultural" due to their interpersonal differences (Sensky, 1996). Many aspects of the medical culture create such barriers, including differences in educational levels, language including medical jargon, values, socioeconomic status, gender, race, religion, and time orientation (Huff &

Kline; Kreps & Thornton, 1992). African-American lung cancer patients trusted their physicians less than white patients did due to receiving less supportive, affiliative, and informative communication from the doctors (Gordon, Street, Sharf, Kelly, & Souchek, 2006). The physiologically measured health status of ethnically diverse type 2 diabetes patients was positively related to quality communication with their physicians (Aikens, Bingham, & Piette, 2005). Gibson & Zhong (2005) surveyed 45 physicians and 91 of their patients and found that the providers considered themselves to be more interculturally competent communicators than their patients did. Vásquez & Swan (2003) concluded that dental hygienists need to learn how to deliver patient education in a culturally sensitive manner. These conclusions have been confirmed by other research that inquired of the patients' points of view in both medical (Morales, Cunningham, Brown, Liu, & Hays, 1999; Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005; Shapiro, Hollingshead, & Morrison, 2002) and dental settings (Lukes & Miller, 2002).

Taken together, lack of understanding, appreciation for, and communication of cultural differences in health encounters result in "patient dissatisfaction, poor adherence, and poorer health outcomes" (Betancourt, 2003, p. 560). The effort to set aside ethnocentricity and personal and professional cultures is a challenge to health care providers, and badly needed in a country where minorities experience the majority of health problems.

*Intercultural communication competence addresses barriers to care.* Health care providers who add to their cultural knowledge and improve their intercultural

communication ability can begin to overcome some of these barriers (Garcia, 2005; Smedley, Stith, & Nelson, 2003). ***Intercultural communication competence*** is an ideal but elusive effort to overcome one's ethnocentrism, communicate with honor and respect, and understand others in spite of diversity. It is a journey not a destination. It is an admirable but inaccessible goal because there is so much ***diversity*** in our world, both among and within groups, that no one can ever know everything about every culture and every individual. We still try, however, because we have learned that training, study, and experience can inform and advance us as we strive to become better intercultural communicators (Garcia; Gibson & Zhong, 2005; Smedley et al.). A variety of organizations and professions, including the United States government and health professionals from the nursing, medical, dental, and dental hygiene fields, have approached the problem from various angles.

The Office of Minority Health, a division of the U.S. Department of Health and Human Services (2001), in an effort to synthesize the most relevant and effective approaches to this problem, issued National Standards for Culturally and Linguistically Appropriate Services in Health Care, better known as the CLAS Standards. All entities (such as schools and clinics) that receive government funding must adhere to these standards though all individual health care providers, including dental professionals, are also urged to follow them. One of the CLAS standards mandates intercultural communication training for health care providers and their supporting staffs.

The nursing profession has been a leader in research, theory development, and application of principles in this field for many years (Brown et al., 2003; Ulrey &

Amason, 2001). Nurses began looking at intercultural health issues in the 1950s when Madeline Leininger, a Registered Nurse with a doctoral degree in anthropology, began to write about them, introduced the then new concept of "transcultural nursing" (Jenko & Moffitt, 2006), and authored the first known textbook on the topic (Leininger, 1978). She also founded the Transcultural Nursing Society in 1975 and the *Journal of Transcultural Nursing* in 1989. Since dental hygienists are often compared with nurses, nursing literature and research can serve as a both a model and a resource for the dental hygiene field.

In the medical field, communication became one of six required competencies identified by the Accreditation Council on Graduate Medical Education in 2003, and is thus included on the Medical Board Examination that all graduating medical students must pass in order to become licensed medical doctors (Shirmer et al., 2005). Additionally, the American Medical Association and the Accreditation Council for Graduate Medical Education require medical education programs to produce physicians who display "sensitivity to patients of diverse backgrounds" (Accreditation Council for Graduate Medical Education, Section *V*, Part D, Line 5). The effects of these policies are in question. Eighty-seven percent of medical schools now include cultural competence training in three or fewer courses (Champaneria & Axtell, 2004) and, as of 2003, 51% of residency programs offered physicians cultural competence training (Weissman et al., 2005). However, Rao (2003) found that most of the communication training that medical students receive is in regards to general communication rather than to intercultural communication, and Crandall, George, Marion, and Davis (2003) asserted that

undergraduate medical students do not receive enough cultural competence training. Consequently the actual amount, focus, and effect of intercultural communication training are still unknown.

Other allied health professions have not been so well studied, but according to Giger & Davidhizar (1999), such topics are rarely taught. Mercado Galvis (1995) asserted that practicing dental professionals are deficient in intercultural communication competence. Kalkwarf (1995) called for dental faculty to become culturally competent so they can pass the knowledge on to staff and students and, ultimately, to practicing dentists. Subsequent research reported that almost 51% of approximately 8000 dental programs offered cultural competence training in 2003-2004 (Betancourt, Green, Carillo, & Park, 2005). These authors added, however, that some of these statistics can be deceiving because these offerings are frequently limited to a few lectures in elective classes, so all students do not receive this instruction. This suspicion seems to be confirmed by recent research that showed that empathic ability declined significantly in dental students as they progressed through their training programs (Sherman & Cramer, 2005). Furthermore, when the American Dental Association (ADA) attempted to present three "Workshops on Diversity in Dentistry" for practicing dentists and their staffs (Fox, 2005), the series was cancelled due to lack of interest (R. Polaniecki, personal communication, October 25, 2005).

The ADA is still attempting to address the problem in other ways. According to the Accreditation Standards for Dental Education Programs (ADA, 1998a), as defined by the ADA, dental school graduates "**must** be competent in managing a diverse patient

population and have the interpersonal and communications skills to function successfully in a multicultural work environment" (their bold print, p. 13). The ADA's influence also extends to dental hygienists. According to the Accreditation Standards for Dental Hygiene Education Programs, which are also overseen by the ADA, "Graduates must be competent in interpersonal and communication skills to effectively interact with diverse population groups" (ADA, 1998b, p. 24). Unfortunately, just as in dentistry, the reality in dental hygiene does not reflect the standards.

*Dental hygienists and intercultural communication competence.* Dental hygienists are professionals licensed to provide oral health care and education in order to prevent disease and preserve or restore both oral and general health. Even though today's dental hygienists struggle with the challenge of communicating with and caring for people of all races, ethnicities, and cultural and personal backgrounds just as all health care providers do, they have little support from literature and training programs.

It appears that dental hygiene students receive very little, if any, intercultural communication instruction in their dental hygiene programs, and any that they may receive is apparently taught by professors who themselves have had negligible preparation or experience and practically no resources designed just for them (Adams, 2005; Connolly, Darby, Tolle-Watts, & Thomson-Lakey, 2000; Dhir et al., 2002; Fitch, 2004; Gaston, 2004; Howard, 1997). Intercultural communication competence courses are all but nonexistent in dental hygiene programs and continuing education, as I learned from a number of dental hygiene educators from across the country (S. Burzynski, personal communication, July 27, 2006; A.-M. DePalma, personal communication, July

27, 2006; T. Maahs, personal communication, July 26, 2006; J. Weiner, personal communication, July 26, 2006). Dental hygienists in practice receive even less help.

Several books that address communication issues for dental personnel either ignore or barely mention culture or difference. The newest of the few communication handbooks for dental professionals that I could find was published in 1992. Most of the references in all of them are from the 60s, 70s, or 80s and are not peer reviewed, none address dental hygiene in particular, and none even touch on cultural issues (Chambers & Abrams, 1992; Geboy, 1985; Wiles & Ryan, 1982). Two dental hygiene textbooks contain short chapters on communication (Daniel & Harfst, 2002; Darby & Walsh, 2003), and Darby and Walsh briefly addresses culture. Other reference books and continuing education courses generally look at communication from atheoretical viewpoints and are devoid of information about diversity, intercultural communication, and the critical issue of understanding diversity. Only sprinklings of articles have appeared in peer-reviewed and popular dental hygiene literature (Adams, 2003; Connolly et al., 2000; Dhir et al., 2002; Fitch, 2004; Gaston, 2004; Magee et al., 2004; McKane, 1995; Morey & Leung, 1993; Vázquez & Swan, 2003). Adams (2005), in an admittedly small pilot study of an homogenous group of dental hygienists, found that 75% (12 of 16) of the respondents had received no intercultural communication training while in school. Most of these articles define the problem and call for action but do not offer information to help instructors and practicing dental hygienists enhance their intercultural knowledge.

Given this lack of resources, it is no surprise that dental hygiene scholars have written that intercultural communication competence is rare among practicing dental

hygiene professionals (Morey & Leung, 1993; Vásquez & Swan, 2003). "There is little information in the literature to suggest that dental hygienists are sensitive to the cultural needs of their clients" (Dhir et al., 2002, p. 194). Furthermore, there has been little research on the topic and more is needed (Fitch, 2004; Gaston, 2004). McKane (1995) called for dissolution of stereotypes and sensitivity to diversity in the education of oral health professionals. Fitch emphasized that dental hygiene training and practice must focus on patient-centeredness, intercultural communication competence, as well as an understanding of ethnocentrism, difference, and the patients' cultures. She also called for the inclusion of cultural and intercultural communication knowledge and skills in all dental hygiene course content.

The leadership of the American Dental Hygienists' Association (ADHA), the field's professional organization, confirmed the need of intercultural communication competence at their 83rd Annual Session in Orlando, Florida in June 2006. According to their website (ADHA, 2006a), the importance of cultural competence was mentioned in drafts of both the Clinical Practice Guidelines and the Curriculum for the Advanced Dental Hygiene Practitioner. Additionally, Proposed Resolution 10 that was under revue stated,

> The ADHA does not currently have a policy statement on cultural diversity. Knowledge of cultural diversity is vital at all levels of dental practice. Knowledge about cultures and their impact on interactions with health care is essential for dental hygienists practicing in a clinical setting, education, research, or administration (ADHA, 2006b).

The conclusions are clear. Dental personnel, including dental hygiene students and practitioners, are not trained and thus are not providing culturally competent care, lagging behind medicine and nursing. "Among close to 8,000 graduate medical educational programs surveyed in the United States, 50.7% offered cultural competence training in 2003-2004, up from 35.7% in 2000-2001" (Betancourt et al., 2005, p. 502). There are no such statistics for dentistry and dental hygiene, a situation that speaks for itself. It is known that knowledge, training, and experience can improve intercultural communication competence (Gibson & Zhong, 2005; Smedley et al., 2002). I offer a project that can serve as a resource to help dental hygiene students, instructors, and practitioners enhance their intercultural communication knowledge.

*Conceptual Definition of the Project*

For my culminating experience I wrote a communication handbook for dental hygienists. The main goals of the book are (1) to fill the void in the literature as outlined above and (2) to enhance the communication and intercultural communication competence of its readers. The finished product is designed to benefit dental hygiene students, instructors, clinicians and, most of all, patients.

I propose titled the book *Teeth, Talk, & TLC: A Communication Handbook for Dental Hygienists*. The word "teeth" represents the mouth, which is the focus of dental hygiene care; the word "talk" represents spoken communication; and the term "TLC" (tender loving care) represents the nonverbal communication of listening, empathy, and respect, three important concepts within the book. The book illustrates the interrelatedness among theories, models, concepts, principles, and other information, as

well as with the possible connections that readers may make with diverse others as they apply what they learn from reading it. I have attempted to create a cross between a textbook and a handbook, so that it can be used by dental hygiene instructors and students and by practicing dental hygienists, all of whom, I hope, can find support for their daily practice.

On a more technical level, the text is readable at a lower division college level. The book includes appropriate glossaries, lists of references, recommended readings, and resources. It includes seven chapters to accommodate a college quarter or semester so an instructor could conceivably assign one chapter per week or less. I used numerous actual and realistic hypothetical examples to make the book readable and understandable. The chapters flow logically from one subject to the next. I solicited and used feedback on chapter drafts from the members of my committee as well as from dental hygiene colleagues.

These chapters are divided into an Introduction and two sections. Section 1, titled *Foundations*, includes chapters on Health Communication, Intercultural Communication, Oral Communication, and Nonverbal Communication. The information in these chapters is essential to patient-centered care, an important concept that is defined in Chapter 1. Section 2, titled *Applications*, includes chapters on, Listening, Persuasion, and Interviewing. The information from Section 1 is necessary to understand the information provided in Section 2.

This book is unique in several ways. First, it is the only book about communication that I know of to be developed exclusively for the dental hygiene field.

The examples and activities are based on dental hygiene practice. Second, the book includes a subtext of culture and intercultural communication throughout to address dental hygienists' lack of intercultural communication competence as documented earlier. Edward T. Hall (1959, 1990) wrote, "Culture is communication" (p. 94), and the assertion is more apt than ever. Culture and cultural differences in this diverse country permeate our interactions and the workdays of dental hygienists, thus the topic should also be embedded throughout their communication handbook. The major cultural concepts described in Chapter 2 are then applied and supplemented throughout the book. Third, this book is also grounded by instructional communication theories, most notably ***constructivism***, also known as ***student-centered learning***, and a "major educational philosophy and pedagogy" (Elkind, 2004). Constructivist principles have been successfully applied in a variety of educational settings (Kroll & Laboskey, 1996; Teets & Starnes, 1996) so should help readers understand communication and cultural principles. Constructivism has been used as the major overarching theory of the book in that its principles guided the writing and the preparation of suggested activities. Finally, theory and concepts from health communication, a third and important area of communication studies, support the parts of the book that deal with persuasion, adherence (formerly known as compliance), and behavior change. I hope to publish this book with perhaps the addition of one or two more chapters on patient education and emotional communication.

*Conclusion*

In Chapter One of this prospectus I have established the need of my book. We live in a diverse country and that diversity can contribute to disparities in health care delivery. Those disparities can be addressed in part if health care providers, including dental hygienists, enhance their communication and intercultural communication competence. Currently dental hygienists and dental hygiene instructors have few resources to assist them in that endeavor. To answer that need I gave an overview of the book that I hope will help dental hygienists in all areas of education and practice. In Chapter Two I will describe the research that I have completed in order to support and inform this project, summarize the main theories and principles in more detail along with how they have been applied to this project how they are related to each other, and list the titles of the book chapters.

# Chapter 2

## ORIGINAL RESEARCH AND THEORY APPLIED

In the Chapter One literature review I documented the need of a communication handbook for dental hygienists, especially a handbook that emphasizes the importance of intercultural communication competence throughout. In order to supplement this information and support and inform this project, I surveyed dental hygienists and the relationship between the presence or absence of intercultural communication training and their comfort and confidence when caring for diverse patients. This research might also be viewed as an audience analysis for the book as I used my findings to guide my choices as I wrote it. I will briefly summarize my conclusions from this study.

### *Intercultural Communication Competence Among Dental Hygienists Pilot Study*

This project, which was completed in 2005, attempted to discover whether or not the respondents, practicing dental hygienists, had had any intercultural communication training while in their dental hygiene programs and how that training or a lack of it may have influenced their comfort and confidence when caring for a diverse clientele. The research questions and hypotheses were:

RQ[1]: What proportion of responding dental hygienists received intercultural communication training during dental hygiene school?

H[1]: Very few dental hygienists received any intercultural communication training in dental hygiene school.

$H^2$: Dental hygienists who graduated from dental hygiene school within the last 5-7 years (classes of 1999-2005) are more likely to have received intercultural communication training compared to those who graduated earlier.

$RQ^2$: Are dental hygienists who received intercultural communication training during dental hygiene school more comfortable and confident treating diverse patients compared to those who received no training?

Sixteen white, female, dental hygiene practitioners aged 34-61 who had graduated from dental hygiene school between 1969 and 2005 completed surveys consisting of 23 closed questions and one open-ended question (see Appendixes B, C, and D for copies of the survey, cover letter, and consent form). I found that only 4 of the 16 respondents (25%) had received any kind of intercultural communication training while in dental hygiene school and three of those four had graduated in 1999 or later. The statistical analysis revealed probably the most interesting finding of this study. A two-tailed independent groups *t*-test indicated a statistically significant relationship ($t = 2.89$; $p < .01$) between intercultural communication training and comfort/confidence in working with diverse patients. Therefore, dental hygienists in this study with intercultural communication training were *less* comfortable/confident in their interactions with diverse patients compared to those without such training.

In addition to the statistical data and many positive observations about working with diverse patients, three other main issues were raised in the answers to the open-ended questions. Half of the respondents were concerned with the difficulty of communicating with people who do not speak English well, and one fourth each were

concerned with both gender issues and lack of appreciation of the importance of dental health. The issues raised by these respondents echoed similar concerns expressed in the literature (Gibson & Zhong, 2005; Nápoles-Springer et al., 2005; Shapiro et al., 2002). However, the data from this survey also point out a potential new issue. Do dental hygienists, and by extension other health care providers, become less confident treating diverse people after training? While the small, homogenous pool of respondents limited this pilot study, I hope to eventually conduct a wider project to illuminate the answer to this question. The goal for the expanded study will be to survey at least 100 dental hygiene practitioners from a variety of races, ethnicities, cultures, and practices, male as well as female, in at least 20 different states. This will be difficult because the study was an accurate representation of the fact that dental hygienists are overall a racially, ethnically, and sexually homogenous group (Dhir et al., 2002; Howard, 1997).

I believe that this study and this project explored an important area of research for three main reasons. First, as I have established, communication is a critical component of patient-centeredness in the delivery of health care and is often confounded by cultural differences. Americans live in a diverse society. Diverse people suffer from disparities in health care delivery, including dental health care, often because providers lack intercultural communication knowledge and skill. Leaders and scholars in government, nursing, medicine, dentistry, and dental hygiene have called for attention to this problem. Second, these topics have never before been investigated in this way in regards to dental hygienists. Third, this research can help answer questions that, to my knowledge, have never before been asked. Those answers informed my project and guided me to address

the most relevant and pressing issues in this book, which were of course guided by communication principles.

*The Use of Theories, Concepts, Models, and a Taxonomy in This Project*

***Theory*** is the foundation of scholarly pursuits. Theories are ideas of how and why things happen; they are summaries and descriptions of common experiences. West & Turner (2004) define *theory* as "an abstract system of concepts with indications of the relationships among (them)" (p. 44). Theories help us explain, understand, and predict phenomena (Littlejohn, 2002; West & Turner). In the communication field they provide lenses that help focus our understanding of human interaction (M. M. von Friederichs-Fitzwater, lecture, September 13, 2004). I also drew upon models, concepts, and a taxonomy. ***Concepts*** are the main elements or categories of a given theory and can themselves be useful descriptors. ***Models*** are "simplified representations of complex interrelationships among elements" (West & Turner, p. 9), or schematic representations of theories (S. D. Zuckerman, personal communication, February, 13, 2007). ***Taxonomies*** are systems of concepts or classifications of principles that, like models, are somewhat simplified theories that mainly list concepts but do not explain or predict (Littlejohn). Though less complicated and less developed than theories, both models and taxonomies are useful in describing phenomena.

There are no perfect or universal theories, models, taxonomies, or concepts. Each can be useful in different contexts. Accordingly, because I developed a book that covers a wide variety of topics, I needed to draw upon an assortment of these elements both to guide my writing and to explain phenomena. Thus my readers will benefit from the work

of numerous scholars from different fields. I drew mainly from the fields of instructional communication, health communication, and intercultural communication.

*Instructional Communication and Theories*

*Instructional communication.* Instructional communication, or the study of communication in teaching and learning contexts, has been a major subdiscipline within Communication Studies for over fifty years. Its main goal is to assist instructors to become better teachers of all topics at all levels of education and in all contexts (McCroskey, Richmond, & McCroskey, 2002; Staton, 1989). I will draw upon three major components of instructional communication as I write this book: the theory of ***constructivism***, ***Bloom's taxonomy***, and ***Gardner's theory of multiple intelligences***. Constructivism has been the major overarching theory that guided the development of this book and Bloom and Gardner's ideas supported and supplemented its use throughout. I will further explain their use and interrelationships after outlining each.

*Constructivism.* Constructivism is both an educational theory and a method of teaching. Advocates of constructivist teaching assert that students who participate in, construct, their own learning, as opposed to trying to consume and memorize lectures, are more motivated and positive about the process and retain and understand information at deeper levels (Felder & Brent, 1996; Henson, 2003). The theory has a long history that has drawn on the scholarship of such distinguished individuals as John Dewey, Jean Piaget, Lev Vygotsky, Paulo Friere, Reuven Feuerstein, and others. *Constructivism*, also known as ***student-centered education***, as opposed to instructivism, also called the transmission view, is based on the assumption that knowledge is developed through

interaction and individually constructed by students as they make connections to their own knowledge and past experiences. In this method students have more choice and responsibility regarding their assignments and spend a large portion of their time in collaboration with other students. Instructors emphasize higher order thinking and synthesizing ideas as opposed to drill and memorization, and focus on process (the act of learning) as opposed to products (tests, papers) (Brophy, 2002; Iran-Nejad, 1995; Vermette et al., 2001). Cooperative learning, a constructivist method that employs group activities, also relies on intrinsic, as opposed to extrinsic motivation for learning. Instructors act as mentors or guides rather than as experts, and consider themselves co-learners and researchers and equal with their students (Panitz, 2005). At least two teacher-training programs operate on the assumption that constructivist education produces constructivist teachers.

Mills College in California offers a constructivist-based, post-graduate teacher training program that emphasizes that teachers are also learners and researchers as they continually study and reflect upon their practices and their students to find better ways to guide learning (Kroll & LaBoskey, 1996). The Foxfire Program also offers teacher training in constructivism with similar but broader guidelines (Teets & Starnes, 1996). This program's 10 core practices form its base and outline constructivist principles: (1) *student interest*, teachers encourage autonomy, initiative, questioning, and listening; (2) *teacher as collaborator*, teachers and students are equal and each can learn from the other; (3) *academic integrity*, learning must be productive and not "planless improvisation" (Core Practice 3 section, ¶ 2); (4) *active involvement of students*, they

participate in their own learning as opposed to passively listening to lectures; (5) *peer interaction and group work*, this reflects Dewey, Vogotsky, and Piaget's notions of the relationship between social interaction and cognitive development; (6) *involvement with the community*, connect learning with the real world; (7) *audience for student work*, consider multiple views; (8) *spiraling*, based on Dance's notion that information and ideas build and grow in a spiral as a result of interaction/communication; (9) *aesthetics*, teachers and students use creativity and imagination to stimulate higher order thinking; (10) *reflection and evaluation*, students and teachers continually assess their activities to try to make them better. Table 1 synthesizes the main principles of constructivism in comparison with the practices of instructivism.

Table 1: Characteristics of Instructivism and Constructivism

| **Instructivism** | **Constructivism** |
|---|---|
| Teacher as expert, sage | Teacher as intellectual, guide, mentor, researcher, learner |
| Instructor centered, dependent students | Learner centered, autonomous students |
| Transmission of knowledge, banking model | Co-creation of knowledge through interaction |
| Acquiring factual knowledge through drill and memorization | Solving problems, learning how to learn, synthesizing ideas |
| Answering questions, searching for (right) answers | Questioning answers, searching for meaning |
| Isolated learning | Holistic, contextual, historical learning |
| Focus on product | Focus on process |
| Judgment | Reflection and self-evaluation |
| Focus on extrinsic motivation | Focus on intrinsic motivation |

Constructivism is the overarching theme of this book in that writing it has been an effort to apply constructivist principles in a written format. The summary of the Foxfire program's 10 core practices along with my own outline in Table 1 guided me. Obviously

the parts of constructivist teaching methods that require face-to-face interactions cannot be employed in a book, but a book can impart necessary foundational information and suggest topics and methods of interaction. The information in each chapter under girds the development of knowledge that readers can construct themselves. Vygotsky acknowledged this need with two of his concepts. The *zone of proximal development* describes the difference between what students can learn alone and what they can learn with guidance from others, including both teachers and peers. A book can act as a guide for much of this information. *Scaffolding* is a temporary support that teachers give students as they try to gain knowledge (Hausfather, 1996; Vermette et al., 2001). A book can introduce new information and then act as a reference thereafter. A book resembles a lecture in written form, and Kougl (1997) argues that lecture has an important place in constructivism and should be used judiciously when information needs to be introduced, clarified, summarized, synthesized, organized, framed, or updated in ways students cannot easily accomplish on their own. So there is definitely a place for books in constructivism. There are at least two ways that I applied constructivist principles in this book. First, suggested activities and thought provoking statements are meant to stimulate reflection, self-evaluation, synthesis of ideas, problem solving, and creativity. Second, readers are directed to interact, to discuss, and thus solve problems together in pairs or small groups. Thoughtful questioning can facilitate the application of constructivism to this book and Bloom's Taxonomy can inform that effort.

*Bloom's taxonomy.* Each chapter in my book includes several activities designed to stimulate reflection and conversation. I used Bloom's taxonomy to guide me to write

provocative questions that are meant to elevate students' thinking and learning. Bloom's taxonomy, developed by Benjamin Bloom, a prominent educational psychologist, is a philosophy of learning that encompasses two parts. First, Bloom asserts that there are three domains or categories of learning: (1) cognitive, or knowledge and intellectual development, (2) affective, or emotional responses such as feelings, values, and attitudes, and (3) psychomotor, or the acquisition of mechanical skill (Kougl, 1997; Clark, 2000).

Second, the taxonomy includes a six-level hierarchy of questioning designed to stimulate critical thinking (Granello, 2000). Listed from simple to complex, these are: (1) *knowledge*, or eliciting facts; (2) *comprehension*, or understanding and interpreting facts; (3) *application*, or relating facts in new situations; (4) *analysis*, or dissecting facts into their component parts; (5) *synthesis*, or combining disparate facts to create new knowledge; and (6) *evaluation*, or applying certain criteria to judge the value of concepts. These levels are applied to sequential questioning that is meant to raise the complexity of cognitive output. This structure has been employed in such varying educational contexts as medical education (Shannon, 2003), counselor supervision of clients (Granello), and the writing of graduate level literature reviews (Granello, 2001). The majority of education today rests at the levels of knowledge and comprehension (Kougl; M. R. Stoner, lecture, September 15, 2004). Accordingly, my goal for the activities that I included in each chapter has been to employ Bloom's taxonomy to lead readers toward higher levels of thinking in both the cognitive and affective domains. Bloom's system has also been applied to curriculum development in conjunction with the theory of multiple

intelligences (Noble, 2004), which is the third main instructional theory that will assist in the application of constructivism to this book.

*Gardner's theory of multiple intelligences.* In order to counter the long held almost exclusive focus on literate and mathematical skills in our schools, Howard Gardener, a Harvard professor of psychology, developed a multidisciplinary theory of human intelligence out of his belief that there are many ways for people to be smart (Gardner, 2004). He listed seven main intelligences. (1) *Linguistic intelligence* refers to the ability to use and understanding of the oral and written word. (2) *Logical-mathematical intelligence* is an ability to work with numbers, reasoning, statistics, and other similar data. (3) People with *musical/auditory intelligence* can understand rhythm and pitch and create music. (4) *Spatial intelligence* is the ability to think in pictures and abstractions and is found in people with good eye-hand coordination. (5) *Kinesthetic intelligence* is a talent for movement and muscular coordination. (6) People with *interpersonal intelligence* are perceptive about others, good with relationships, often charismatic and diplomatic, and are able to understand and interact with people. (7) *Intrapersonal intelligence* indicates self-awareness and an understanding of one's own feelings, thoughts, beliefs, and values.

These categories are not mutually exclusive; most people are strong in one or a few areas but also have some degree of ability in all of them. As stated, the first two intelligences are most valued in our schools, so students who are gifted in these intelligences generally do well, but those who are not can be left behind. Gardner (2004) asserted that the more intelligences a person can appeal to the more effective s/he will be

in getting the message across. My challenge has been to appeal to all the intelligences as much as possible through a book format. I keep this theory in mind particularly as I developed both examples to illustrate my points and suggested activities to enhance learning.

These three systems served both the foundation and application aspects of my book. Constructivism was my base and overarching guide, but all of them helped to direct the writing. Bloom's taxonomy assisted me to construct thought-provoking questions. Gardner's theory reminded me to appeal to all kinds of learners in examples and suggested activities. I applied constructivist concepts to help provoke reflection, try to help readers relate their own knowledge and experience to a given topic, and appeal to intrinsic as opposed to extrinsic motivation. Dental hygienists pride themselves as preventive specialists, for which they employ patient education and persuasion techniques to effect behavior change. In that way, instructional theories merge with the health communication field.

*Health Communication and Theory*

*Health communication.* Health communication is the use of "communication strategically to improve health" (USDHHS, *Healthy People 2010*, 2000, p.11-3) and "the invisible helping hand" (Thompson, 1984, title) in health care. Kreps et al. (1998) declared that the information that is the product of health communication is "the most important resource in health care" (p. 3). This field emanated mostly from other social sciences, especially psychology with its emphases on therapeutic communication (psychological counseling) and persuasion, and medical sociology with its foci on the

doctor-patient relationship and the structure of health care systems, and has developed mainly in the last quarter of the 20th century (Kreps et al.). The field has grown exponentially in its short lifespan, and, possibly because of its rapid growth, still relies almost completely on theories and models of behavioral change that have emanated from other disciplines (du Pré, 2000; Lapinski & Witte, 1998; Northouse & Northouse, 1998). I will draw on numerous health communication models, concepts, and research findings for the chapter in the *Foundations* section devoted to that topic, and I will use the ***transtheoretical model*** (TM) to explain the stages and processes of change in the *Applications* section chapter on persuasion. This complex model is also important to my whole project because learning is change, the point of writing the book is to enhance learning, and so it is important for me to understand how change occurs. Accordingly, I feel it is helpful to outline TM principles here.

*Transtheoretical model.* Health care is about change. Health care providers are constantly trying to convince and motivate their patients to eliminate unwanted behaviors and/or acquire new positive ones. The Transtheoretical model (TM), also known as the "***stages of change***," describes the stages that people go through as they attempt to alter their behaviors. It originated with research by DiClemente and Prochaska on smokers and addiction in the 1980s (Purdie & McCrindle, 2002), and has since been applied to multiple health contexts and has been used to successfully modify behavior in "smoking cessation, exercise, low fat diet, radon testing, alcohol abuse, weight control, condom use for HIV protection, organizational change, use of sunscreens to prevent skin cancer, drug abuse, medical compliance, mammography screening, and stress management" (Velicer,

Prochaska, Fava, Norman, & Redding, 1998, ¶ 4). Thus it has been used to help cease unwanted behavior and to begin new desirable behavior, both of which are important in dentistry. Furthermore, TM is particularly appropriate for my project because it has been applied to an oral health campaign (Tilliss et al., 2003), was mentioned twice as a valuable guide in dental hygiene contexts (Hollister & Anema, 2004; Long, 2006), and has also been used in multicultural contexts (Etter, Perneger, & Ronchi, 1997; Frankish, Lovato, & Shannon, 1999). This model predicts that a person will change behaviors in a foreseeable progression of five stages (Prochaska & DiClemente, 1983) and forecasts major factors that can influence the process (Prochaska, DiClemente, & Norcross, 1992; Purdie & McCrindle, 2002).

The five stages of change are: *Precontemplation*, *contemplation*, *preparation*, *action*, and *maintenance*. In the *precontemplation* stage the person has no intention to change within the foreseeable future (usually defined as the next six months) and, due to being under informed, uninformed, or uninterested in the topic, is almost in denial about his or her risky behavior. A person in the *contemplation* stage is aware of the positive and negative reasons to change and intends to begin the change process within six months. In the *preparation* stage, a person has decided to begin the change process within one month and has often already taken some preliminary actions for up to a year. A person in this stage is most inclined to act on a health message. The *action* stage occurs when the person has continued with the positive health behavior change for about six months. Finally, in *maintenance* the person continues with the positive behavior change and becomes increasingly confident and less likely to relapse to an old negative behavior thus

*regressing* to a less-advanced stage. As time in the maintenance stage passes, *self-efficacy*, or a feeling of confidence in one's ability to resist regression, increases and *temptation*, or an attraction to the old negative behavior, decreases (Prochaska & DiClemente, 1983; Prochaska et al., 1992; Velicer et al., 1998). Movement through the stages is not always linear, repeated attempts may become cyclical, and people can get stuck in certain stages.

There are also 10 ***processes of change***, or activities that contribute to forward movement through the stages. These are divided into experiential and behavioral processes (Velicer et al., 1998). The five experiential processes, which are mostly cognitive and have the greatest influence in the early stages of change are: *consciousness raising*, or the acquisition of information and awareness; *dramatic relief*, or the increase of affect and expression of one's emotional reaction to the health messages; *environmental reevaluation*, or an increasing awareness of the impact of the negative behavior on one's environment; *social liberation*, or becoming aware of the ways in which society supports the behavior change; and *self-reevaluation*, or assessing personal feelings about the problem and/or an increasing disappointment in oneself for continuing the negative behavior and/or for not adopting a new positive behavior. The five behavioral processes, which also include some cognitive elements and are more likely to appear during the latter stages of change are: *stimulus control*, or altering one's environment to support the change; *helping relationship*, or accepting support from caring and sympathetic others; *counter-conditioning*, or substituting positive stimuli to perform the new behavior for negative stimuli that might prompt the old behavior;

*reinforcement management*, or rewarding oneself or accepting rewards from others for maintaining the positive behavior; and *self liberation*, or self-commitment to and belief in ones ability to maintain the new behavior (Frankish et al., 1999; Velicer et al.).

The model is strong because it matches the person's stage of change with the communication intervention appropriate for both the person and the stage (Purdie & McCrindle, 2002). It is important in health because it reminds us that many factors are involved in behavior change, so the mere acquisition of information alone is usually not enough to stimulate that change (du Pré, 2000). Dental hygienists, because they work almost exclusively in one-on-one contexts and see individuals up to three or four times per year, are known for their ability to establish relationships with patients. Thus when they become aware of this model and its elements they will likely be able to assess stages of change and apply appropriate communication strategies to help individuals initiate health improvement (Hollister & Anema, 2004). So, even though TM has been used mostly in public health campaigns, its principles can also support patient-centered care and individualized patient education, both of which are hallmarks of dental hygiene practice.

I include an overview of the transtheoretical model here because of its prominence in the health communication field. TM was summarized in the chapter on persuasion to help explain and explore the processes of change as well as the communication that can influence that change, critical concepts that dental hygienists should understand. Additionally, knowledge of how change occurs had a significant

intellectual influence on me as I wrote. Of course one factor that can influence change and communication is culture, which is the focus of the next section.

*Intercultural Communication and Theories*

*Intercultural communication.* Intercultural communication (IC) is another relatively new field of study within Communication Studies. Though Benedict was credited with coining the term *intercultural* in 1941(Leeds-Hurwitz, 1990), Edward T. Hall, an anthropologist, was named the field's founding father due to his work at the Foreign Service Institute (FSI) of the United States Department of State from 1946-1956 (Leeds-Hurwitz; Rogers, Hart, & Miike, 2002). Hall first connected the concepts of communication and culture in his landmark book, *The Silent Language* (1959, 1990), which Leeds-Hurwitz designated the field's "founding document" and "intellectual foundation" (Rogers et al., p. 13). One chapter was titled, "Culture is communication" (p. 94). Hall's writings are still among the most cited in IC today. Various other prominent scholars have also contributed to the discipline with research, teaching, and numerous publications. Notable among them is psychologist Geert Hofstede, whose explanation of cultural dimensions is included in many current summaries of IC concepts.

Like health communication, the intercultural communication field also draws on many sources for its concepts and theories and, as a result, literally dozens of them exist today. Though my book includes a foundational chapter on intercultural communication that describes many cultural concepts, I have chosen to briefly outline two of them here because they relate particularly to health care. These are Hall's high and low context and Hofstede's individualism and collectivism. I must emphasize, as I did in the book, that

neither of these categories are absolute. Most people's beliefs and practices fall somewhere on a spectrum between the two extremes and combine with genetics, personalities, and life experiences to form unique individuals. These categories do, however, give intercultural communication novices an introductory grounding in the principles of difference.

*Hall's high and low context.* Hall defined ***context*** as the degree to which the setting influences the message (Hall, 2000; Hall & Hall, 2002). However, Hall's notion of context means more than just the physical environment. It also includes the people who are involved, their relationships with the environment, their relationships with each other, the time and timing of a given interaction, and other factors. Storti (1999) referred to these dimensions as ***direct*** and ***indirect communication*** respectively. In high context cultures that employ indirect communication, "most of the information is already in the person" (Hall & Hall, p. 166), therefore much of the meaning is implied and the listener must fill in the blanks. Direct communication or low context messages must be more verbally precise and give more detail because less information is available from the surroundings, event, participants, and other nonverbal features. Context is often related to the concepts of individualism and collectivism.

*Hofstede's individualism and collectivism.* The notions of ***individualism*** and ***collectivism*** are components of one of Hofstede's (1997) five cultural dimensions, which are well known and often cited in IC literature. He is famous for his 1970s empirical research of IBM employees throughout the world. Though this research is also criticized for its corporate origins and Western bias, the concepts are nevertheless highly regarded

(Klyukanov, 2005). Hofstede defined individualism and collectivism as the degree to which the preferences, interests, customs, and priorities of the group (society, country, family, or organization) predominate in relation to those of the individual. In collectivist societies the group takes precedence; in individualistic societies the person is central. Hofstede named the United States the most individualistic country in the world, whereas most minority groups within the US and those that immigrate here tend to be more collectivistic (Klyukanov). I chose to describe this dimension here because when I first learned of it after retiring from dental hygiene practice, I immediately resonated with its principles and wished I had understood them while still caring for a diverse clientele. I immediately understood why collectivists came to the office in a group for one person's appointment or needed group consensus before making treatment decisions for an individual. High context cultures tend to be collectivistic, low context cultures tend to be individualistic.

These two concepts, Hall's high and low context and Hofstede's individualism and collectivism, are defined in the intercultural communication chapter along with *ethnocentrism*, *time*, and *locus of control* and then are revisited throughout the book through examples and thought-provoking questions. For instance, in Chapter 3 I describe a ***critical incident*** (brief case study) regarding a sick immigrant who died due to, in part, the lack of a translator. I then ask what cultural theories/concepts from Chapter 2 the incident illustrates. This is one way that I have demonstrated the relationships among these key theories and concepts.

*Relationships Among the Theories, Models, and the Taxonomy*

In this project, all concepts are connected to constructivism and many are also connected to each other, if not epistemologically at least intellectually. I find the intellectual connections to be the most salient for the purposes of this project. This book was written at a lower division college level, so I needed to present each concept with that in mind and make connections that the readers could understand rather than those that only scholars could appreciate. In constructivism all perspectives are valued and truth emanates from mutually agreed-upon conclusions. However, students need a foundation of knowledge in order to prompt thought and creativity as well as to support arguments. That is where my book fits in constructivism, as documented earlier.

To review, the principles of constructivism include: promotion of higher order, critical thinking; emphasis on learner centered, autonomous students/readers; contextual, holistic learning with respect for students'/readers' knowledge and experience; creativity, problem solving, synthesizing ideas; reflection and self-evaluation for both students/readers and instructors; emphasis on intrinsic as opposed to extrinsic motivation; focus on the process of learning rather than on its tangible product; and, perhaps most of all, student/reader interaction to facilitate the application of the other principles. Constructivism is the landscape that under girds the entire book. Each of the other components relates to constructivism and many also relate to each other.

Bloom's taxonomy promotes the higher order thinking that is a critical component of constructivism and also recognizes the value of affective and psychomotor as well as cognitive skills. Gardner's theory of multiple intelligences also promotes thought and,

additionally, aids understanding of how to appeal to different kinds of learners and make the most of natural intrinsic motivation.

Constructivism and collectivism both emphasize the importance of groups, harmony, relationships, collaboration, and interdependence. According to constructivism, students learn best when they are interacting with each other, but most of us who grew up in the United States tend toward the individualist end of the spectrum so may have trouble appreciating the value of group work. Learning about collectivism helped me understand that value and I have tried to impart that appreciation to my readers. Constructivism also promotes an understanding of context, which creates many connections with Hall's notions of high and low context. Dental hygienists need to understand, for example, the significance of the unique context of a dental appointment.

The transtheoretical model (TM) and constructivism share emphases on solving problems, synthesizing ideas, reflection, self-evaluation, and the value of self-efficacy, which is also related to an internal locus of control. Beyond that, it is critical for my readers, and for me, to understand the processes of change and the factors that influence it. Even though TM was developed in the health context, I believe that it can be adapted and applied to any purposeful change. I sense a subtext of change running throughout this book. Enhanced health is change. Learning is change. Contexts change constantly. Bloom's taxonomy advocates a change in traditional questioning and evaluation of students. Gardner's theory promotes changes in teaching methods to appeal to all kinds of learners. Most of all, constructivism promotes numerous changes in education to enhance

learning. I tried to apply those principles in a written format, which has been a challenge that certainly required changes and growth in my own thought processes.

I used the theories and concepts relating to instructional communication, health communication, and intercultural communication that I have outlined here to guide the development of my book. Some notions are described directly in the book, others guided its development, but all strongly influenced my decisions as I wrote about numerous topics.

### *Chapters in the Book*

I wrote seven chapters divided between two sections. Section I, titled "Foundations," overviews fundamental knowledge from the communication studies field, and Section II, titled "Applications," addresses ways to use the foundational information in the delivery of dental hygiene care. The sections and chapters are:

- Section I: Foundations
    - Chapter 1: Health Communication: The Heart of Health Care
    - Chapter 2: Intercultural Communication: The Soul of Health Care
    - Chapter 3: Verbal Communication: The Voice of Health Care
    - Chapter 4: Nonverbal Communication: The Eyes of Health Care
- Section II: Applications
    - Chapter 5: Listening: The Responsibility of Health Care
    - Chapter 6: Persuasion: The Challenge of Health Care
    - Chapter 7: Interviewing: The Art of Health Care

## *Conclusion*

This prospectus has established the need of this project and outlined its evolution. This has been a challenging yet personally enriching process of learning and change. I chose this project because I wanted to create a book that could fulfill a need and be a valuable and practical resource for dental hygienists. The topic of communication, and intercultural communication in particular, is practically omitted from dental hygiene training and practice. The information that is currently available is dated, non-academic, atheoretical, and has emanated mainly from the fields of psychology and the popular press. I offer this book as my attempt to add the communication perspective. As Sprague (1992) so eloquently stated, "Critical consciousness precedes transformative change" (p. 196). This book grew out of my own evolving critical consciousness regarding communication studies, health communication, and intercultural communication, and I hope that it will convey my passion for these topics to my colleagues in the dental hygiene field and help them improve their knowledge and skill.

# APPENDICES

# APPENDIX A

## Glossary

*Bloom's Taxonomy*: A philosophy of learning developed by Benjamin Bloom, an educational psychologist. This theory applies a six-level hierarchy of questioning to stimulate and develop the cognitive, affective, and psychomotor components of learning.

*Collectivism* and *Individualism*: Concepts developed by Hofstede describing the degree to which the preferences, interests, customs, and priorities of the group (society, country, family, or organization) predominate in relation to those of the individual.

*Communication*: The creation and sharing of meaning between and among individuals and groups.

*Constructivism (student-centered learning/education)*: A student-centered approach to education based on the assumption that knowledge is developed through interaction and individually constructed by students as they make connections to their own knowledge and past experiences.

*Context*: Defined by Edward T. Hall as the degree to which the setting influences the message. Low context messages depend more on words to convey meaning, whereas high context messages are largely implied by the participants, surroundings, events, and other factors.

*Cultural diversity*: see *diversity*

*Culture*: A composite of learned beliefs, values, attitudes, assumptions, and behaviors that are characteristic of groups of people. These include various thoughts, styles of communicating, social and religious structures, history, roles, rules, and customs (Betancourt, 2003; Denoba, Bragdon, Epstein, Garthright, & Goldman, 1998; Gaston, 2004; Giger & Davidhizar, 1998; Lustig & Koester, 1999). There is as much diversity within cultures as there is among them, they evolve to meet the needs of their members, and all of their aspects can be interpreted and practiced differently by individuals. Each person is unique, and every group is multifaceted and ever changing (Kagawa-Singer & Kassim-Lakha, 2003). People, like cultures, are complex, contradictory, and constantly evolving (Carbaugh, 2005).

*Dental hygienist* (*hygienist*): Licensed professional who provides oral health education and care in order to prevent disease and preserve or restore both oral and general health.

*Direct and indirect communication*: Storti's (1999) explanation related to Hall's concepts of high and low context. High context communication is indirect and low context communication is direct.

*Diversity* (*cultural diversity*): Difference between and among members of different cultural groups. In addition to referring to race, ethnicity, culture, and language, this term can also relate to sex, age, educational level, socioeconomic status,

mental and physical ability, and many other social, psychological, affective, and cognitive variables.

*Ethnocentrism (ethnocentricity)*: A dependence upon and assumption of the predominance and rightness of one's own beliefs, values, and attitudes and the tendency to judge others based upon those assumptions (Collier, 2000; Gardenswartz & Rowe, 1998; Samovar & Porter, 2000; Spector, 2000; Sumner, 1906).

*Gardner's theory of multiple intelligences*: Theory developed by Howard Gardner (2004), Harvard professor of psychology. Gardner believes that there are many ways for people to be smart and lists seven main intelligences: linguistic, logical-mathematical, musical/auditory, spatial, kinesthetic, interpersonal, and intrapersonal, and that the more intelligences you can appeal to the more effective your educational efforts will be.

*Health communication*: The use of "communication strategically to improve health" (U.S. Department of Health & Human Services, *Healthy People 2010*, 2000, p.11-3). Health communication between health care providers and consumers should include information that is accurate, available, balanced, consistent, culturally appropriate, evidence-based, reliable, timely, and understandable.

*High context*: See *context*

*Hygienist*: see *dental hygienist*

*Indirect communication*: see *Direct and indirect communication*

*Individualism*: see *Collectivism*

*Instructional communication*: The study of interactions in school or training contexts between and among instructors and students.

*Intercultural communication* (IC): Interactions between unlike individuals and groups. Difference can relate to ethnicity, race, culture, religion, age, sex, and numerous other demographic factors (see *diversity*).

*Intercultural communication competence* (ICC): An effort to set aside one's ethnocentrism, communicate with honor and respect, and attempt to understand others in spite of diversity. It is an admirable but unachievable goal because there is so much diversity in our world both among and within groups that no one can ever know everything about every culture and every individual. However, we still try because we have learned that training, study, and experience can inform and advance us as we strive to improve our intercultural interactions (Garcia, 2005; Gibson & Zhong, 2005; Smedley et al., 2003).

*Locus of control*: The degree to which a person feels in control over life events (Luckman & Nobles, 2000). People with an internal locus of control feel in control of their environments and thus of their health, believe that they have the power and even the responsibility to make changes in themselves and the events that impact them, and thus tend to be active in their own health care. People with an external locus of control feel that their lives, including their health, are controlled by outside forces such as God, fate, chance, luck, or providence and can be more passive in regards to health care decisions and practices.

*Low context*: See *context*

*Processes of change*: The part of the transtheoretical model that describes the major influences on people attempting to alter their behavior.

*Stages of change*: The part of the transtheoretical model the describes the stages that people pass through as they attempt to purposefully change their behavior.

*Student-centered learning/education*: see *Constructivism*

*Theory*: Theories are ideas of how and why things happen. In the communication field they help us to explain, understand, and predict issues of human interaction (Littlejohn, 2002; West & Turner, 2004).

*Transtheoretical model (stages of change)*: Describes the stages of change that people go through as they try to alter their behavior and the major influences on that progression.

# APPENDIX B

Cover Letter for
Intercultural Communication Competence Among Dental Hygienists Pilot Study

Toni S. Adams, RDH, BA
5675 Ambassador Drive
Rocklin, CA 95677-4419
916-632-9848
tonisadamsrdh@earthlink.net

October 7, 2005

Dear Dental Hygiene Colleagues,

Thank you for consenting to help me with my research project. This investigation is one of several that will ultimately inform my master's thesis that will relate to communication and dental hygienists. This particular project investigates the intercultural communication training that dental hygienists may have received while in school. Please return the completed survey *as soon as possible* because I am working within a time frame, and *along with the signed consent form* because if I do not receive the consent form, I will not be able to use your survey. Feel free to contact me if you have any questions.

You received this survey because you showed an interest in helping me in my quest for a master's degree in Communication Studies. If I was in error about your interest, I apologize. You may complete the survey and return it to me anyway, pass it on to an interested colleague, or discard it. I urge you to choose one of the first two options if at all possible.

With great appreciation to all of you,

Toni

APPENDIX C

Consent Form for
Intercultural Communication Competence Among Dental Hygienists Pilot Study

**Consent to Participate in Research**

You are asked to complete a survey as a part of research being conducted by Toni S. Adams, RDH, BA, under the direction of David Zuckerman, PhD, in partial fulfillment of requirements for a master's degree in Communication Studies at California State University Sacramento. The purpose of this research is to study the effects of intercultural communication training.

Participation in this research is completely voluntary and involves no known risks. The results of this research will guide the preparation of instructional materials in intercultural communication that can ultimately benefit both dental hygienists and patients.

Surveys and release forms will be separated upon receipt, no record of their connection will be kept, all answers will be kept confidential, and all surveys will be destroyed in June 2008.

Questions can be directed to: Toni S. Adams, RDH, BA
5675 Ambassador Drive
Rocklin, CA 95677-4419
916-632-9848
toni.adams@csus.edu

Or to: David Zuckerman, PhD
916-278-6541
sdzuck@csus.edu

Please complete the enclosed survey and return ***along with this signed release form*** in the addressed and stamped envelope before November 15, 2005.

You may decline to participate at any time without any consequences. Your signature below indicates that you have read this page and agree to participate in this research.

_____

Signature of participant Date

Thank you very much for your help!

**One more thing**:
Would you be willing to be interviewed regarding your experiences with communication issues in dental hygiene practice today? Of course, your identity and our discussion would be held in strict confidence. If so, please fill in this information and I will contact you.

Name:_____
Address:_____
Phone number:_____ Email address:_____

APPENDIX D

Survey for
Intercultural Communication Competence Among Dental Hygienists Pilot Study

**Dental Hygienist Questionnaire Regarding**
**Intercultural Communication Training in Dental Hygiene School**

For the purposes of this survey, ***diversity***, refers to individuals from a variety of races, ethnicities, and cultures who may or may not speak English as their first language. ***Communication*** refers to interactions between/among individuals. This survey is concerned with diversity as it relates to interpersonal and communication issues rather than to physiological or health issues.

Do NOT write your name anywhere on this form. Please write legibly.
Mark the box, circle, or write in the appropriate answer:

1. Year you graduated from dental hygiene school:

2. Name the state in which your dental hygiene school is/was located:

3. Are you: ☐ Female ☐ Male

4. Level of your initial degree: ☐ AS ☐ BS
   ☐ Other (please name/describe):

5. Name the state or country where you were born:

6. Name the year in which you were born:

7. Describe your own ethnic, racial, and/or cultural identity (check all that apply):

☐ Black, non-Hispanic, including African American
☐ Mexican American, Mexican, Chicano
☐ Central American
☐ South American
☐ Cuban
☐ Puerto Rican
☐ Other Latino, Spanish-origin, Hispanic
☐ Chinese
☐ Japanese
☐ Korean
☐ Asian Indian
☐ Other Asian
☐ Cambodian
☐ Laotian
☐ Vietnamese
☐ Thai
☐ Other Southeast Asian
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Southeast Islander
☐ White
☐ Filipino
☐ Other
☐ No Response
☐ Decline to State

Expand on this answer if you like:

7a. Is English your first language? ☐ Yes ☐ No

7b. If not, what is your first language?_____

8. If you emigrated to the United States, in what year did you emigrate?:

**Questions 9-14 relate to your experience with diversity.**

For the purposes of this survey, use these definitions:

***Not diverse*** – less than 10% are from non-majority, or a variety of ethnic, racial, and/or cultural backgrounds

***Minimally diverse*** – 10-25% are from non-majority, or a variety of ethnic, racial, and/or cultural backgrounds

***Moderately diverse*** – 25-50% are from non-majority, or a variety of ethnic, racial, and/or cultural backgrounds

***Highly diverse*** – 50-75% are from non-majority, or a variety of ethnic, racial, and/or cultural backgrounds

***Completely diverse*** – 90% or more are from non-majority, or a variety of ethnic, racial, and/or cultural backgrounds

9. In your estimation, how diverse was your *neighborhood when you were growing up*? (If you grew up in several places, consider the totality of your experiences.)

| Not diverse | Minimally diverse | Moderately diverse | Highly diverse | Completely diverse |
|---|---|---|---|---|
| (< 10% diversity) | (10-25% diversity) | (25-50% diversity) | (50-75% diversity) | (75-100% diversity) |

10. In your estimation, how diverse was *the population of students in the schools you attended from elementary through high school*? (Consider the totality of your experiences.)

| Not diverse | Minimally diverse | Moderately diverse | Highly diverse | Completely diverse |
|---|---|---|---|---|
| (< 10% diversity) | (10-25% diversity) | (25-50% diversity) | (50-75% diversity) | (75-100% diversity) |

11. In your estimation, how diverse was your *dental hygiene faculty*?

| Not diverse | Minimally diverse | Moderately diverse | Highly diverse | Completely diverse |
|---|---|---|---|---|
| (< 10% diversity) | (10-25% diversity) | (25-50% diversity) | (50-75% diversity) | (75-100% diversity) |

12. In your estimation, how diverse was your *dental hygiene class of students*?

| Not diverse | Minimally diverse | Moderately diverse | Highly diverse | Completely diverse |
|---|---|---|---|---|
| (< 10% diversity) | (10-25% diversity) | (25-50% diversity) | (50-75% diversity) | (75-100% diversity) |

13. In your estimation, how diverse was the *population of patients/clients served by your school's dental hygiene clinic*?

| Not diverse | Minimally diverse | Moderately diverse | Highly diverse | Completely diverse |
|---|---|---|---|---|
| (< 10% diversity) | (10-25% diversity) | (25-50% diversity) | (50-75% diversity) | (75-100% diversity) |

14. In your practice today, how diverse is the *population of patients/clients you now serve*? (If you work in more than one office, consider the totality of your patients/clients.)

| Not diverse | Minimally diverse | Moderately diverse | Highly diverse | Completely diverse |
|---|---|---|---|---|
| (< 10% diversity) | (10-25% diversity) | (25-50% diversity) | (50-75% diversity) | (75-100% diversity) |

**Questions 15-19 relate to your training in intercultural communication issues:**

15. When you were a student in dental hygiene school, did you receive any instruction on intercultural *communication* (not including ethnic/racial health issues)?
    ☐ Yes ☐ No

16. **If you answered *yes* to #15**, how much intercultural communication instruction did you receive *as a part of the general school requirements* outside of the dental hygiene curriculum?
    ☐ None
    ☐ Part of one class (if this is checked, name of the class):
    ☐ One full class (if this is checked, name of the class):
    ☐ Other (please describe):

17. **If you answered *yes* to #15**, and you received intercultural communication instruction *as a part of the general school requirements*, to the best of your memory what text(s) did you use:
    ☐ Don't recall
    ☐ None
    ☐ Lecture only, no text
    ☐ Handout(s) prepared by instructor
    ☐ General communication textbook; if this answer is checked, which textbook:
    ☐ Intercultural communication textbook; if this answer is checked, which textbook:

    ☐ Other (please describe):

18. **If you answered *yes* to #15**, how much intercultural communication instruction did you receive *as a part of the dental hygiene curriculum*?
    ☐ Don't recall
    ☐ None
    ☐ One lecture or part of one lecture
    ☐ Unit of up to 2-3 weeks in one quarter or semester class
    ☐ One full quarter or semester course
    ☐ Lectures and/or units in multiple classes
    ☐ Other (please describe):

19. **If you answered *yes* to #15**, you received intercultural communication instruction *as a part of your dental hygiene curriculum*, to the best of your memory what text(s) did you use?
    ☐ Don't recall
    ☐ None
    ☐ Lecture only, no text
    ☐ Handout(s) prepared by instructor
    ☐ General communication textbook; if this answer is checked, which textbook:
    ☐ Intercultural communication textbook; if this answer is checked, which textbook:

    ☐ Other (please describe):

**For Questions 20-21, place an "X" in a section on each line to indicate the level of your experience/opinions/feelings:**

20. My experience has shown me that *upon first contact* and in general patients/clients who come from backgrounds different from my own are:

| | | |
|---|---|---|
| Understandable | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Confusing |
| Friendly | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Unfriendly |
| Interesting | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Boring |
| Delightful | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Frightening |
| Comfortable with me | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Afraid of me |

21. When treating/working with diverse patients/clients who come from backgrounds different from my own, *upon first contact*, in general I feel:

| | | |
|---|---|---|
| Competent | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Incompetent |
| Calm | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Apprehensive |
| Curious | \|___\|___\|___\|___\|___\|___\|___\|___\|___\|___\| | Indifferent |

22. When addressing *new* patients, I routinely:
    - ☐ Call them by their titles (Ms., Mrs., Mr., Dr., Capt., etc.)
    - ☐ Call them by their first names
    - ☐ Ask them how they would like to be addressed

23. How comfortable/competent do you feel treating and communicating with patients from a variety of ethnic, racial, and/or cultural backgrounds?
    - ☐ Struggling to understand different beliefs, values, and attitudes
    - ☐ Somewhat competent (I can get along with diverse patients but don't always understand their varying beliefs, values, and attitudes.)
    - ☐ Moderately competent (I get along well with a diverse population of patients, and I feel that I am beginning to understand different beliefs, values, and attitudes.)
    - ☐ Competent (I am completely comfortable with a diversity of beliefs, values, and attitudes.)

(Feel free to expand on this answer on the back of page 5.

24. Please describe some of the issues you confront when treating patients/clients from a variety of ethnic, racial, and or cultural backgrounds. This explanation could include a list of general issues, a description of a specific incident(s), or any other observations you would like to make.

25. Would you attend a continuing education lecture and/or workshop on intercultural communication issues, if it were offered?

☐ Yes ☐ No

26. Would you be interested in reading/owning a handbook on communication and intercultural issues in the dental office?

☐ Yes ☐ No

**Thank you very much for your thoughtful answers.**

APPENDIX E

Teeth, Talk, & TLC:
A Communication Handbook for Dental Hygienists

## Chapter 1
## Health Communication: The Heart of Health Care

Learning Objectives For Chapter 1

After reading this chapter you should have:

1. Been introduced to the health communication field
2. A fundamental understanding of patient-centered care
3. An appreciation for the role of competent communication in patient-centered care
4. An understanding of the relationships among competent communication, patient-centeredness, and health

"Communication skills...help you address the art of medicine, which helps you practice the science of medicine, so that the business of medicine can support your art and science"

Desmond & Copeland, 2000

### Introduction

Our job as health care providers is to enhance the well being of those who seek our care, and the ability to communicate well has always been a critical component of that effort. "In antiquity, a physician may not, in truth, have had much to offer an ill patient other than his communication skills" (Innui & Carter, 1985, p. 521). Fast forward to modern times and, while the technologies of medicine and communication have advanced, we can see that the art of communication is just as important in health care today, which of course includes the dental field. The opening quote is just as valid if we substitute the word "dentistry" for the word "medicine". We think we know how to communicate (We can talk, can't we?), but there is always much to learn about both what communication is and how it impacts practice. This first chapter is a brief summary of the

research into the influence of communication in health care and dentistry, beginning with some fundamentals of the health communication field, followed by a discussion of communication's role in health care and a definition of patient-centered care, and then ending with an overview of its impact on health practice.

***Communication***[2] is more than just the exchange of information, though sharing knowledge is an important part. When we communicate well we generate interactions that allow the expression of thoughts, emotions, and ideas and the creation of meaning between and among individuals and groups. It is through communication that we learn about others and also discover and define ourselves. Competent communicators recognize that interactions are multi-layered and complex, a realization that can help them create comprehensible messages and understand messages that others send—or at least aid them in asking the right questions to achieve clarity. The term ***Health Communication*** (HC) describes, most simply, those interactions that occur in health contexts, or the use of "communication strategically to improve health" (USDHHS, *Healthy People 2010*, 2000, p.11-3). HC has been called health care's "invisible helping hand" (Thompson, 1984, title) and its "most important resource" (Kreps, Bonaguro, and Query, 1998, p. 3).

Communication is essential to the delivery of health care. Researchers in communication studies, medicine, dentistry, and dental hygiene have stated that the ability to communicate well is central and fundamental to the patient-provider

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[2] Words that are defined in each chapter's glossary will appear in bold italics the first time they are defined.

relationship (Magee, Darby, Connolly, & Thomson, 2004), to patient motivation (Meltzer, 1999), to prevention behavior (Rogers, 2000), and to patient satisfaction, compliance with treatments and prescriptions, and to positive health outcomes (Betancourt, 2003). Health communication as a field covers a lot of territory.

A dental patient, assistant, hygienist, and dentist share a conversation about patient care options. A hospital patient talks about her illness with a physician, nurse, therapist, technician, family member, or friend. A woman who had a nasty encounter with poison ivy seeks comfort and treatment ideas from her sister. A person recently diagnosed with periodontal disease seeks information in a book, pamphlet, or on the internet. People with cancer share stories, information, and advice in a support group. Expectant parents learn about childbirth and infant care in a lecture. Health care providers discover how to elicit key information or deliver bad news in a magazine or journal article or in a continuing education course. All of these scenarios, and many more, can be defined as health communication.

The formal study of Health Communication, an area of focus within the larger field of Communication Studies, has developed mainly in the last quarter of the 20th century and has grown exponentially in its short lifespan (Kreps, Bonagure, & Query, 1998). Many Communication Studies departments now offer courses in HC and it is even possible to earn master's and doctoral degrees in the field. In a distinctive blend of disciplines and universities, Emerson College's Communication Department and the Tuft University Medical School offer a joint health communication graduate program (Kreps et al.). In the medical field, communication became one of six required competencies

identified by the Accreditation Council on Graduate Medical Education in 2003, and is thus included on the Medical Board Examination that all graduating medical students must pass in order to become licensed medical doctors (Shirmer et al., 2005). The University of California at Davis Medical School curriculum includes communication instruction through all four years of school in a series of "doctoring" classes (M. M. von Friederichs-Fitzwater, personal communication, November 14, 2005).

A whole chapter was devoted to "Health Communication" in *Healthy People, 2010* (USDHHS, 2000), the United States health goals for the first decade of the 21st century. Research is reported in two major journals, *Health Communication* and *The Journal of Health Communication*, and numerous other peer reviewed health and social science publications. If you look at the reference lists in this book, you will of course find articles, books, and book chapters from many areas of communication studies. But you will also see citations from anthropology, sociology, public health, psychology, medicine, nursing, dental, and dental hygiene journals, magazines, bulletins, and websites, as well as from many specialty publications within those fields and from government and private institutes and foundations. Obviously, researchers look at health communication through many lenses.

We can relate health to all traditional Communication Studies topics including persuasion, interviewing, training, and team building, as well as interpersonal, intercultural, instructional, small group, business, and nonverbal communication. Those who study HC can also focus on a wide variety of other topics such as special groups (women, men, children/adolescents, seniors, people with special needs), individual

conditions and illnesses (diabetes, cancer, HIV/AIDS, mental health), and numerous other issues including but not limited to health education, risk management, social support, ethics, privacy, health disparities, health literacy, consumerism, CAM (complementary and alternative medicine), health organizations, public relations, public health, health campaigns, printed and digital health information, health in the media including the internet, international health, spirituality in health, blood and organ donation, and health information shared among individuals.

Considering the volume of possibilities, the focus of this book will be on the exchanges within a dental office between and among all dental personnel, their patients, and their patients' family members and other supporters, with special emphasis on the interactions between dental hygienists and their clientele. I will begin by outlining two fundamental axioms.

## Two Axioms of Communication

There are two common axioms in the communication field: *the message sent is seldom the message received*, which relates mostly to verbal communication, and *you cannot NOT communicate*, which relates mostly to nonverbal communication.

*The message sent is seldom the message received.* We can all think of numerous experiences in practice and in our personal lives that confirm this statement. There are many filters between the thought in one person's brain and the interpretation ultimately produced by the other person's brain. The speaker translates a thought into spoken words that may not exactly express her original idea. The words the listener hears may not hold the same meaning as they did for the speaker, so the understanding of those words may

be further altered. We may also incorrectly "read between the lines." The process is complicated even more when emotions, assumptions, lack of judgment, inattention, and numerous environmental factors get in the way.

*You cannot NOT communicate*. We can send and receive messages even when we do not mean to do so. As you will learn in the nonverbal communication chapter, if what you say and what you do contradict each other, people are more likely to believe what you do. If I frown as I tell a patient, "I am happy to see you," the patient will believe and remember the look on my face rather than my words. We find meaning in a moment of hesitation before answering, crossed arms, a wink, a blink, a stare, or a body position. We may be right, but we could also be wrong. I may have frowned for any number of reasons that have nothing to do with my patient, and a patient's frown may mean thoughtfulness or distraction or pain rather than disapproval.

One story illustrates both axioms. Senior medical students in India were required to monitor families regarding family planning and the use of birth control pills. A woman told the student at one visit that she was four days late, nauseous, and had weird food cravings. The student made sure that all the pills were used and told the woman not to worry because the pills were 99.9% effective. Three months later it was clear that the woman was pregnant. The student accused her of lying to him as she had said that she had not missed a single dose of her birth control pills. "No, doctor, you heard all wrong. I said that my husband did not miss a single dose" (Mathai, 2000, p. 188).

The problem began when the student assumed the woman understood who was to take the pills. Maybe he explained the procedure poorly, maybe she did not pay attention,

maybe both. Then, faced with the possibility that the woman might be pregnant, the medical student chose to believe his own interpretation of the woman's words over her actual words. She told him her husband was taking the pills but those words did not register with him. Or maybe her statement was unclear. Furthermore, the student selectively accepted one area of nonverbal communication, the number of pills in the bottle, over another, the woman's pregnancy symptoms. As a result, intended messages were garbled and unintended messages were sent and believed, with significant consequences.

So we are dealing with actions that can easily be misinterpreted and words that may be inadequate to express just what we want to say or how we feel and that may hold a different meaning for our listeners anyway. Between these two notions, there's a whole lotta *mis*communicatin' goin' on! This may sound pessimistic, but if we keep these axioms in mind we are less likely to be tripped up by them. They also provide reasons why we should study communication, especially in health care, where miscommunication can impact not only quality of life but even life itself. There is good news, too. Training can improve communication competence (Cegala & Broz, 2003; Wilkinson, Gambles, & Roberts, 2002). This book gives access to some of that training, and this chapter points out why it is important. Now we move to reports of some research on the importance of communication in health care.

*Take time to think*:
What situations from your own experience demonstrate the two axioms? What could you have done to communicate more effectively?

## Competent Communication in Health Care

We know from our own experience that our jobs are easier when we can communicate well with our patients. However, you may be surprised to learn that your personal conclusions are also confirmed by research. Much of the research presented in this book has been completed in the medical field mainly because comparable research has simply not been done in dentistry, with two major exceptions that will be introduced here and revisited elsewhere in this volume.

Cathy Jameson, a dental office consultant with a Ph.D. in psychology, first reported her original research in her doctoral dissertation (2000). She showed that competent communication could help control stress in the dental office, decrease burnout and dropout, improve relationships among team members, and increase productivity. She wrote about these topics from a practice management perspective in her book, *Great Communication Equals Great Production* (2002).

Suzanne Boswell, a dental writer, speaker, and consultant, is also known as the dental "Mystery Patient." Dentists hire her to act as a new patient and evaluate the way she is treated by all staff members, including the dentist(s). Of course none of the staff know that she is coming, but even the dentist does not know what she looks like or exactly when to expect her. Additionally, Ms. Boswell has surveyed, interviewed, and conducted focus groups with thousands of dental patients throughout the United States and thus has developed an understanding of their likes, dislikes, and desires. Her book, *The Mystery Patient's Guide to Gaining & Retaining Patients* (1997), is a valuable resource for all dental offices.

Boswell (1997) developed a list of 14 reasons why dental patients "graze" (p. 59), or shop for another dental office. Only one or two reasons relate to treatment, the others are all associated with deficits in verbal and nonverbal interpersonal communication skill. Patients will leave a practice because the dentist and staff do not listen to them, are not respectful and considerate of each patient as an individual, are poorly groomed and/or keep a messy workplace, lack cohesive interpersonal relationships among themselves, do not clarify treatment plans and financial arrangements before beginning therapy, focus more on the schedule than the person, and do not explain and apologize when they make mistakes.

Two main conclusions are repeated throughout Boswell's book. First, the most common complaint among the dental patients is that they are not listened to. Second, dental clientele want a combination of "high tech and high touch" (p. 138). That is, they want cutting edge technology combined with personalized care. Many of these reasons and conclusions are echoed and expanded upon in the more formal research into the strong relationship between communication and health care, and they highlight the importance of patient-centered care.

*Take time to talk*:
With a coworker or in a staff meeting discuss how you think your office would measure up to Boswell's standards of a patient-friendly office.

## What is Patient-Centered Care?

Communication is the defining component of patient-centeredness, the current standard of care in health practice. I will outline the concept of ***patient-centered care***, discuss how it came to prominence, and summarize some implications of its use. We talk

about this notion rather casually, as if we know what it is. It is actually a complex concept with numerous definitions. Moira Stewart and her colleagues (1995) authored a definitive volume on the topic where they outlined its development and described it in terms of six components. The ability to communicate well is essential to achieving all of them. In fact, proficient communication and patient-centeredness are virtually synonymous.

The first element of patient-centered care has to do with building relationships with our patients. This is the foundation of all we do. Stewart and colleagues (1995) discuss the complex process of learning to relate with each other so that we can reach a "therapeutic alliance" (p. 91). One crucial component of the process has to do with leveling the inherent imbalance of power that exists between a caregiver and a patient. This disparity is more pronounced, of course, in the case of physicians, but many people look up to all health providers including us. We are the professionals, we wear the white coats, we have the training and clinical abilities, and we wield the sharp instruments. Both parties have responsibilities for relationship building and for smoothing out the power differences. We as clinicians need to relinquish some of our power by acknowledging that patients also have valuable information and unique insights and by doing our best to draw out that information. Patients need to accept an increased responsibility for their own care and freely share their opinions and preferences. Relationships that include liking and trust evolve as we work back and forth, and it is those relationships that assist us in applying the other components of patient-centeredness.

Second, patient-centered care attends to the *illness*, or the patient's personal health experience, as well as the *disease*, or its physiological manifestations. A small shallow spot of decay on a tooth may be easily treated and not seem too serious to clinicians who encounter such lesions all the time. But if it causes pain it can be an emergency to the patient. On the other hand, a person with fairly advanced periodontal disease may feel no pain and as a result not understand the seriousness of her condition. I worked with a dentist who often told this story. Two apparently similar young women had wisdom teeth extracted on the same day. When the dentist called both of them that evening to see how they were doing, neither could come to the phone (this was long before cell or portable phones). One was in so much distress as a result of the extractions that she was bed-ridden. The other was out dancing. We as clinicians need to understand individual reactions to each diagnosis and treatment.

Third, the patient-centered clinician attempts to achieve a holistic view of a patient. Sickness is much more than just pathology. Numerous personal, social, and cultural influences come to bear on how that pathology is perceived and experienced so we need to try to understand those influences from the patient's point of view as much as possible. My youngest son was born congested, or at least it seemed so. He suffered from many hay-fever type allergies that were difficult to treat, especially in an infant. The pediatrician suggested that I clean house twice a day to try to cut down on allergens. This physician clearly had no clue about the realities of a working mother who was also trying to care for two children under the age of three years old. His advice was no help at all because it was absolutely impractical. We must try to fit the treatment to the patient's

ability to tolerate and accomplish it as well as to personal and cultural beliefs and practices.

Fourth, patient-focused caregivers attempt to find common ground with their patients. After establishing a relationship and acquiring an understanding of both the condition and the patient's personal context, the clinician must attempt to reach a mutual understanding with the patient in order to devise a treatment plan that is acceptable to both. Implicit here is the need for each to understand the other's positions. First, listen to the patient's view of her condition. Perhaps she has an insight that you may not have considered. Then, explain your perspective, educating as you go. Compare your views and then finally come to an agreement on the best plan. Your communication skills are rigorously tested when you try to find common ground.

A fifth component of patient-centeredness focuses on preventing disease and promoting health. This is what dental hygienists are all about. We specialize in prevention. We see people who may not necessarily need any treatment but do need to be aware of the possibility of future problems. In this context, we try to find realistic prevention measures that fit a healthy patient's life style, values, and abilities. If a patient does not have the determination or dexterity to use dental floss daily, then we can recommend interdental brushes, and/or an oral irrigator, and/or an ultrasonic toothbrush, and/or the use of xylitol to help control the biofilm. Our collective preventive armamentaria give us numerous choices. Many patients are turned off when we even mention dental floss and are pleasantly surprised to learn that there are alternatives. This attempt to find what works for each individual defines patient-centeredness.

The sixth and final element of patient-centered care according to Stewart's book (1995) is the need to be realistic. We live in a real world where we practice under numerous constraints. The appointment is too short, the patient is cantankerous, the equipment is on the fritz, the supplies didn't arrive, and we may not be feeling so well on a given day. We are human beings who cannot be all things to all people all the time. The health care provider, as the half of every health care relationship that our patients rely on, also deserves attention. When we travel by air we are told that in an emergency we should put our own oxygen masks on first because if we don't we will be unable to care for others. This is true in health care, too. We must be kind, patient, and forgiving of ourselves just as we are with our patients. That does not mean, however, that we do not strive to do our best for each individual in spite of limitations, it just means that we take a practical perspective as we do it.

On the other hand, though patient-centeredness has many advantages and the vast majority of patients prefer caregivers who practice patient-centered care, we need to recognize that a few, such as the elderly or very ill and others as well, do not (Little et al., 2001). Some people just want to be cared for and told what to do and we have all seen such people. Tending to those preferences is also a part of patient-centeredness. A distinguished group of 21 health communication leaders reached similar conclusions as to the key communication elements of a patient-centered health care encounter:

> A strong, therapeutic, and effective relationship is the sine qua non of physician-patient communication. The group endorses a patient-centered, or relationship-centered, approach to care, which emphasizes both the patient's disease and his or

> her illness experience. This requires eliciting the patient's story of illness while guiding the interview through a process of diagnostic reasoning. It also requires an awareness that the ideas, feelings, and values of both the patient and the physician influence the relationship. Further, this approach regards the physician-patient relationship as a partnership, and respects patients' active participation in decision making (Makoul, 2001, p. 391).

So, to sum it up, in order to deliver patient-centered care we need to work on establishing relationships with patients, distinguish between the *disease* and the *illness*, consider a patient's lifestyle when treatment planning, attempt to reach common ground, focus on health promotion and prevention, be realistic, and remember that all patients are not necessarily interested in becoming involved in their own care. It is certainly a challenge to meet all of the objectives and attend to all of the elements of patient-centeredness, but dental hygienists are up to it. We have been doing it for years, whether we have recognized it or not, and defining the process can help us understand the value of what we do and help us do it better. The benefits of patient-centeredness have been known for centuries.

*Take time to talk*:
Reread the section covering the six components of patient-centered care. Find a friend and discuss why excellent communication skills are necessary to apply each part.

## History of Patient-Centeredness

Does the term, patient-centered care, sound unnecessarily repetitive? Isn't the patient naturally the center of health care? Actually, no, this has not been the case throughout history. In ancient times, before the discovery of the scientific bases of health,

it was important to know about patients as people and to understand their histories and experiences of illness. Plato wrote that the best physicians treated "diseases first by thoroughly discussing with the patient and his friends his ailment. This way he learns something from the sufferer" (Emanuel & Emanuel, 1992, p. 2225). Hippocrates wrote, "It is more important to know what sort of person has a disease than to know what sort of disease a person has." Ironically, Hippocrates was also responsible for establishing the roots of the scientific method that ultimately shifted the focus of health care from the patient as a person to the physician with his scientific knowledge (Adler, 2004). The more physicians learned about the science of illness, the less they depended upon patients for information.

Fortunately, due to the efforts of many sensitive and caring health care providers, patient advocates, researchers, and writers in the past 100 years, the focus has shifted back to the patient. Medical students at the University of California at Davis Medical School are required to visit chronically ill patients in their homes in order to enhance their understanding of the individuals and their circumstances (M. M. von Friederichs-Fitzwater, personal communication, September 30, 2008). Today, health care providers use communication to accomplish three main goals: create a positive interpersonal relationship between patient and provider, exchange information, and make treatment decisions, *in that order* (Cole & Bird, 2000). It is interesting to note that the 1991 edition of the Cole & Bird book placed the exchange of information first, before relationship building. These are two examples of how the importance of the interpersonal relationship and patient-centeredness in health care has evolved in the past few years. We cannot

expect patients to freely share sensitive personal information or follow through with their practitioners' recommendations without mutual trust. That trust must be established before asking for information and it develops as the relationship is built through communication.

In dental hygiene, we learn about the importance of patient-centered care in our training and through our literature. I would argue that for dental hygienists the focus has *always* been on the patient and that building relationships is our specialty. We see patients frequently and hear of their experiences with dental disease and with life. Conversation among dental hygienists often turns to a phenomenon that many of us seem to share, patients *tell* us things. They relate some surprisingly delicate personal information, even when it is not applicable to their treatment. We hear about vacations, births, marriages, deaths, arrests, promotions, rehab visits, proms, illnesses, support groups, and a profusion of other happy and sad life events. This unsolicited sharing is an indication, I believe, of both the patients' desire to build relationships and their developing trust. We expand and nurture that trust as relationships grow through the adept use of communication. The information in this book is meant to enhance those abilities so we can accrue the benefits of patient-centeredness. The effort is worth it for our patients and for us.

## Effects of patient-centeredness

Everyone benefits from patient-centered care. Besides being a key component of evidence-based decision making and playing an essential role in attending to patients' rights and responsibilities, health care providers are less likely to be sued, patients and

clinicians are more satisfied, and patients are healthier.

We should not forget the importance of maintaining a scientific perspective as we focus on patient-centered care (Kinmonth, Woodcock, Griffin, Spiegal, and Campbell, 1998). The concept of ***evidence-based decision-making*** (EBDM) marries the application of the science of health care with the notion of patient-centeredness. EBDM is "a new paradigm for medical practice" (Cobban, 2004, p. 153) and the current standard of care. It is defined as the combined use of the best scientific evidence, clinician judgment based on training and experience, and patient needs and preferences in order to improve decision-making by both clinicians and patients (Forrest & Miller, 2005; Ismail & Bader, 2004).

We might think that the easiest part of evidence-based decision-making would be learning our patients' views. Just ask them, right? After all, we don't have to read extensively in peer-reviewed journals or attend numerous continuing education courses to have a conversation with a patient. But when we consider that *the message sent is not always the message received*, especially as our clientele diversifies, we may realize a need to pay closer attention to the interpersonal communication aspect of EBDM. Focusing on the patient and enhancing our communication skills help us learn of each patient's individual circumstances, values, and preferences that are central to achieving this standard of care.

A critical component of EBDM is the patient, who, as half of each caregiver-care receiver duo, also has responsibilities in health care encounters (Ellner, Hoey, & Frisch, 2003; Fuller & Quesada, 1973; Larivaara et al., 2001; Stewart, 1984). We need to elicit

patients' opinions and preferences, but patients can also offer them. As a result of a focus on patients, many organizations have developed lists of patient rights and responsibilities. These are guidelines and not necessarily legal requirements (though some are, the laws of Informed Consent and HIPAA, the Health Insurance Portability and Accountability Act, come to mind). Those lists in the American Medical Association's *Guide to Talking to Your Doctor* (Perry, 2001) are among the most comprehensive. I have synthesized the parts of those lists that I feel apply to dentistry (refer to the book for more complete information).

Patients are entitled to consideration, information, participation, voice, choice, and privacy. In other words, patients have the right: to be treated with respect regardless of their diverse backgrounds or socioeconomic status; to be completely informed in understandable language about all aspects of their conditions and proposed treatments; to be a part of decision-making regarding their own care and/or to refuse treatment; to seek other opinions and/or to change health care providers; and to have their personal privacy respected and their health documents kept confidential.

Patients have the responsibility for information, participation, cooperation, and acknowledgment. They must provide thorough and correct information regarding their histories and current treatments, medications, and practices; ask clarifying questions and participate in decision-making regarding their own care; cooperate with their health care providers, carefully following agreed upon courses of treatment and keeping their health care providers informed of outcomes including problems; and recognize the influences that their daily routines and ways of life may have on their health.

The purpose of reporting on these lists is not so that we can expect all patients to fulfill their responsibilities. It is not so that we can shake a finger and say, "It is your responsibility to cooperate with me!" Many patients, as we know, are unaware, incapable, or unwilling to do so. My main purpose in reporting on the list of patient responsibilities is to remind dental hygienists that when we do not succeed in motivating a patient to clean interdentally, accept treatment, or see a specialist, it is not completely our fault. That does not give us an excuse to stop trying; it just helps us remember that both our patients and we have human limitations. As caregivers and trained professionals, our level of responsibility is higher than that of our patients, but it is not 100%. We do the best we can, but we are not ultimately accountable for what the patient may or may not choose to do.

Of course, communication skill enhances both the attainment of patients' rights and the exercise of their responsibilities. Patient-centered care, including the consistent application of the principles of evidence based decision-making and attention to patients' rights and responsibilities, produces a satisfied clientele.

*Satisfaction*

Numerous studies have confirmed that communication skill and patient-centeredness are fundamental to creating satisfied patients, but the concept of ***satisfaction*** is a slippery one. What satisfies one person may offend another. In general, satisfaction is what results when people agree with, approve of, and are content with their treatment in a health setting. In an early study two physician researches combined their own experiences and patient interviews to report that patients described a "very good doctor"

(Fuller & Quesada, 1973, p. 362) mostly in terms of effective communication with hardly any mention of technical skill. This makes sense because many patients, lacking scientific knowledge, tend to judge clinicians based on their interpersonal abilities; it also echoes Boswell's 14 reasons why dental patients "graze." While satisfaction alone does not guarantee better outcomes for patients, satisfied people are more likely to have more confidence in their providers (Kelly & Wykurz, 1998), be more loyal to a practice (Gordon, Baker, & Levinson, 1995), cancel fewer appointments (DiMatteo, Hays & Prince, 1986), and follow recommendations for treatments including filling and taking their prescriptions (Becker, 1985; Grüninger, 1995), all of which should contribute to helping people achieve higher levels of health and to relieving a great deal of the stress of patient care for clinicians.

In two dental studies researchers found that patients who were encouraged to ask questions and whose comments were heard and taken seriously were more satisfied than those who weren't (Corah, O'Shea, & Bissell, 1985; Corah, O'Shea, Bissell, Thines, & Mendola, 1988). Another group of researchers surveyed 647 dental patients from all 50 states and paired their findings with a 1991 Pew Commission telephone survey of 300 practicing dentists (DiMatteo, McBride, Shugars, & O'Neil, 1995). Both patients and dentists rated the ability to communicate among the top three most important characteristics of dentists (along with ethical conduct and effective diagnosis/treatment). Sensitivity to pain, another highly rated dentist characteristic, is perceived through excellent communication ability and also contributes to patient satisfaction. Kulich, Berggren, & Hallberg (2003) studied patient-centered dentists who specialize in the care

of patients suffering from ***odontophobia*** (extreme dental fear). They found that patient-centered dentists, those who had a "holistic perception and understanding of the patient" (p. 177) and who "heard" both verbal and nonverbal patient cues, were most successful at treating odontophobics. So we might conclude that if patient-centeredness helps dentists when treating dental phobics, then it should also enhance our treatment of dental patients in general. Patient satisfaction produces many benefits to both patients and clinicians, but one benefit is of special interest to practitioners.

*Decreased complaints and malpractice litigation*

Satisfied patients are much less likely to sue their health care providers. In a landmark study, Lester and Smith (1993) concluded that "The use of good communication behaviors....may prevent lawsuits, *even when something has clearly gone wrong and even when it is clearly the physician's fault*" (p. 272, italics added). In another study that surveyed patients who had sued, patients who had not sued, and physicians who had been sued, all participants agreed that the best way to prevent malpractice claims was through improved communication (Shapiro et al., 1989). Levinson (1994) found that whether or not a person files a malpractice lawsuit is often unrelated to quality of care, and Elder and Dovey (2002) concluded that up to 83% of medical malpractice lawsuits are preventable. In an analysis of a computerized database of complaints in a 717-physician facility the researchers found that ten percent of the doctors attracted two-thirds of the complaints (Hickson, Pitchert, Federspiel, & Clayton, 1997). They concluded that the main quality shared by the high-complaint and the high-

malpractice risk physicians was a lack of interpersonal communication ability and rapport with patients.

The relationship between communication and malpractice litigation in dentistry has also been studied. This is important in light of the fact that such claims are increasing, especially in regards to undiagnosed oral cancer (Rapp, 2005). Dentists who reported frequent frustration with appointments were sued for malpractice significantly more often than those who did not, and communication difficulties were key to those frustrations (Milgrom, Cullen, Whitney, Fiset, Conrad, & Getz, 1996).

Excellent communication skills used before, during, and after appointments can contribute to the prevention of complaints and legal actions. According to Graskemper (2002), dentists and staff members should pay attention to the "six Cs" (p. 754), confidence, caring, courtesy, comfort, competence, and cleanliness. Seeing to all of these qualities communicates professionalism, on the phone and in the reception area before a person first meets the dentist or hygienist, during the appointment, and through a follow-up letter or call afterward. Additionally, dental personnel should listen completely and respectfully to the patient's concerns, taking more time to do so if necessary, and carefully explain what the patient can expect in regards to treatment and cost. All of these qualities and actions, which really amount to nothing more than common courtesy and common sense, and once again reflect Boswell's (1997) conclusions, contribute to the development of liking, satisfaction, and that fragile and all-important entity, trust. "People...(seldom)...sue people they like or trust" (Graskemper, p. 754). A few studies

have reported even more profound effects of communication ability in relation to satisfaction in the delivery of health care.

*Improved patient outcomes*

Studies that look at the outcomes of health care providers' adept communication other than satisfaction are relatively rare, but the few that have been completed have reached some remarkable conclusions. Perceptive questioning and information giving can result in the need of fewer diagnostic tests (Epstein et al., 2005), improved emotional health, symptom resolution including control of blood pressure, blood sugar, and pain; and a more complete elicitation of patient information leading to improved diagnoses and treatments (Stewart, 1995). Two studies produced particularly striking findings. The Headache Study Group (1986) found that the key predictor of recovery from serious headaches after one year of numerous medical interventions was whether or not the patients felt that their physicians adequately understood and allowed discussion of their concerns at their initial appointments. Selfe, Matthews, & Stones (1998) found similar results in their study of women with severe chronic pelvic pain, a troubling condition that is seldom resolved regardless of treatments. The patients of doctors who communicated well and took the time to listen to their stories at the initial appointment consistently reported significantly greater pain reduction compared to those whose physicians did not attend so closely to initial interactions.

## Conclusion

Of course this does not mean that decay and periodontal disease will resolve on their own if only we could all be excellent communicators. But when we listen well we

get the best information from patients so we can make optimum recommendations for their care. When we are aware of some basic principles of persuasion and the roles of empathy and respect in patient interactions we are more likely to connect with people and win their trust. And when we ask the right questions we are more likely to get answers that allow us to care for each person as an individual. All of these communication skills enhance our ability to deliver top-notch care, which of course contributes to the prevention, treatment, and eventual resolution or control of dental disease and makes daily practice in a dental office much easier. Each of these topics will be covered in separate chapters in the Applications section of this book. First, however, I will continue to lay the foundation for those chapters with a look at the role of culture in our practices, as well as the important topics of verbal and nonverbal communication.

## On the Web

Emerson College's Master of Arts in Health Communication in conjunction with the Tuft University Medical School: http://admission.emerson.edu/admission/graduate/academics/hc.cfm

## Glossary for Chapter 1

*Communication*: The sharing of knowledge, thoughts, emotions, and ideas and the creation of meaning between and among individuals and groups.

*Evidence based decision-making* (EBDM): The combined use of the best scientific evidence, clinician judgment based on training and experience, and patient needs and preferences in order to improve decision-making by both clinicians and patients.

*Health communication*: Interacting and sharing information about health in a wide variety of contexts.

*Odontophobia*: Extreme dental fear.

*Patient-centered care*: The ability to build relationships with patients, distinguish between the *disease* and the *illness*, consider a patient's lifestyle when treatment planning, attempt to reach common ground, focus on health promotion and prevention, be realistic, and remember that all patients are not necessarily interested in becoming involved in their own care.

*Satisfaction*: The feeling that results when people agree with, approve of, and are content with their treatment in a health setting.

## References for Chapter 1

Adler, R. E. (2004). *Medical firsts: From Hippocrates to the human genome.* Hoboken, NJ: John Wiley & Sons, Inc.

Becker, M. H. (1985). Patient adherence to prescribed therapies. *Medical Care, 23*, 539-555.

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine, 78*, 560-569.

Boswell, S. (1997). *The mystery patient's guide to gaining and retaining patients.* Tulsa, OK: PennWell Publishing.

Cegala, D. J. & Broz, S. L. (2003). Provider and patient communication skills training. In T. L. Thompson, A. M. Dorsey, K I. Miller, & R. Parrott (Eds.), *Handbook of health communication* (pp. 95-119). Mahwah, NJ: Lawrence Erlbaum Associates.

Cobban, S. J. (2004). Evidence-based practice and the professionalization of dental hygiene. *International Journal of Dental Hygiene, 2*, 152-160.

Cole, D. J., & Bird, J. (2000). *The medical interview: The three function approach* (2nd ed.). St. Louis: Mosby.

Corah, N. L., O'Shea, R. M., & Bissell, G. D. (September, 1985). The dentist-patient relationship: Perceptions by patients of dentist behavior in relation to satisfaction and anxiety. *Journal of the American Dental Association, 111*, 443-446.

Corah, N. L., O'Shea, R. M., Bissell, G. D., Thines, T. J., & Mendola, P. (January, 1988). The dentist-patient relationship: Perceived dentist behaviors that reduce patient anxiety and increase satisfaction. *Journal of the American Dental Association, 116*, 73-76.

Desmond, J., & Copeland, L. R. (2000). *Communicating with today's patient: Essentials to save time, decrease risk, and increase patient compliance.* San Francisco: Jossey-Bass.

DiMatteo, M. R., Hays, R. D., & Prince, L. M. (1986). Relationship of physicians' nonverbal communication skill to patient satisfaction, appointment noncompliance, and physician workload. *Health Psychology, 5*, 581-594.

DiMatteo, M. R., McBride, C. A., Shugars, D. A., & O'Neil, E. H. (November, 1995). Public attitudes toward dentists: A U.S. household survey. *Journal of the American Dental Association, 126*, 1563-1570.

Elder, N. C., & Dovey, S. M. (2002). Classification of medical errors and preventable adverse events in primary care: A synthesis of the literature. *Journal of Family Practice, 51*, 924-932.

Ellner, A., Hoey, A., & Frisch, L. E. (2003). Speak up!: Can patients get better at working with their doctors? *British Medical Journal, 327*, 303-304.

Emmanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association, 267*, 2221-2226.

Epstein, R. M., Franks, P., Shields, C. G., Meldrum, S. C., Miller, K. N., Campbell, T. L., & Fiscella, K. (2005). Patient-centered communication and diagnostic testing. *Annals of Family Medicine, 3*, 415-421.

Forrest, J. L., & Miller, S. A. (2005). Evidence-based decision making: A new term for a new concept. *Dimensions of Dental Hygiene, 3*(9), 12, 14, 16-17.

Fuller, D. S., & Quesada, G. M. (December, 1973). Communication in medical therapeutics. *The Journal of Communication, 23*, 361-370.

Gordon, G. H., Baker, L., & Levinson, W. (1995). Physician-patient communication in managed care. *Western Journal of Medicine, 163*, 527-531.

Graskemper, J. P. (2002). A new perspective on dental malpractice: Practice enhancement through risk management. *Journal of the American Dental Association, 133*, 752-757.

Grüninger, U. J. (1995). Patient education: An example of one-to-one communication. *Journal of Human Hyprtension, 9*, 15-25.

Headache Study Group of the University of Western Ontario (1986). Predictors of outcome in headache patients presenting to family physicians: A one year prospective study. *Headache*, 26, 285-294.

Hickson, G. B., Pichert, J. W., Federspiel, C. F., & Clayton, E. W. (1997). Development of an early identification and response model of malpractice prevention. *Law and Contemporary Problems, 60*, 7-29.

Inui, T. S., & Carter, W. B. (1985). Problems and prospects for health services research on provider-patient communication. *Medical Care, 23*, 521-538.

Ismail, A. I., & Bader, J. D. (2004). Evidence-based dentistry in clinical practice. *Journal of the American Dental Association, 135*, 78-83.

Jameson, C. (2002). *Great Communication Equals Great Production.* Tulsa, OK: PennWell Publishing.

Jameson, C. L. (2000). *Conrolling stress in the dental profession through effective communication*. Unpublished doctoral dissertation. LaSalle University.

Kelly, D., & Wykurz, G. (1998). Patients as teachers: A new perspective in medical Education. *Education for Health: Change in Learning & Practice, 11*, 369-377.

Kinmouth, A. L., Woodcock, A., Griffin, S., Spiegal, N., & Campbell, M. J. on behalf of the Diabetes Care from Diagnosis Research Team (1998). Randomised controlled trial of patient centred care of diabetes in general practice: Impact on current wellbeing and future disease risk. *British Medical Journal, 317*, 1202-1208.

Kreps, G. L., Bonaguro, E. W., & Query, Jr., J. L. (1998). The history and development of the field of health communication. In L. D. Jackson & B. K. Duffy, *Health communication research: A guide to developments and directions* (pp. 1-15), Westport, CT: Greenwood Press.

Kulich, K. R., Berggren, U., & Hallberg. L. R.-M. (2003). A qualitative analysis of patient centered dentistry in consultations with dental phobic patients. *Journal of Health Communication, 8*, 171-187.

Larivaara, P., Kiuttu, J., & Taanila, A. (2001). The patient-centered interview: The key to biopsychosocial diagnosis and treatment. *Scandanavian Journal of Primary Health Care, 19*, 8-13.

Lester, G. W. & Smith, S. G (1993). Listening and talking to patients: A remedy for malpractice suits? [Electronic version]. *The Western Journal of Medicine, 158*, 268-272.

Levinson, W. (1994). Physician-patient communication: A key to malpractice prevention. *Journal of the American Medical Association, 272*, 1619-1620.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M. et al. (2001). Preferences of patients for patient centred approach to consultation in primary care: Observational study. *British Medical Journal, 322*, 1-7.

Magee, K. W., Darby, M. L., Connolly, I. M., & Thomson, E. (2004). Cultural adaptability of dental hygiene students in the United States: A pilot study. *The Journal of Dental Hygiene, 78*, 22-29.

Makoul, G. (2001). Essential elements of communication in medical encounters: The Kalamazoo consensus statement. *Academic Medicine, 76*, 390-393.

Mathai, G. (2000). A patient who changed my life, "You heard all wrong.": A lesson in physician/patient communication. *The Western Journal of Medicine, 173*, 188.

Meltzer, L. (1999). The dental hygienists's role in patient home-care motivation. *Access, Special Supplement Issue*, 1-12.

Milgrom, P., Cullen, T., Whitney, C., Fiset, L., Conrad, D., & Getz, T. (1996). Frustrating patient visits. *Journal of Public Health Dentistry, 56*, 6-11.

Perry, A. (Ed.) (2001). *American Medical Association guide to talking to your doctor*. New York: John Wiley & Sons, Inc.

Rapp, C. (2005). *Oral cancer malpractice claims increasing*. [Brochure]. Tallahassee, FL: Florida Dental Association.

Rogers, E. M. (2000). Introduction. *Journal of Health Communication, 5*(Suppl.). 1-3.

Selfe, S. A., Matthews, Z., & Stones, R. W. (1998). Factors influencing outcomes in consultations for chronic pelvic pain. *Journal of Women's Health, 7*, 1041-1048.

Shapiro, R. S., Simpson, D. E., Lawrence, S. L., Talsky, A. M., Sobocinski, K. A., & Schiedermayer, D. L. (1989). A survey of sued and nonsued physicians and suing patients. *Archives of Internal Medicine, 149*, 2190-2196.

Stewart, M. (1984). What is a successful doctor-patient interview? A study of interactions and outcomes. *Social Science & Medicine, 19*, 167-175.

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal, 152*, 1423-1433.

Stewart, M., Brown, J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L, & Freeman, T. R. (1995). *Patient-centered medicine: Transforming the clinical method*. Thousand Oaks, CA: Sage Publications.

Thompson, T. L. (1984). The invisible helping hand: The roles of communication in the health and social service professions. *Communication Quarterly, 32*, 148-163.

U. S. Department of Health and Human Services (2000). *Healthy people 2010: Understanding and improving health (2nd ed.)*. Washington, DC: U. S. Government Printing Office.

Wilkinson, S. M., Gambles, M., & Roberts, A. (2002). The essence of cancer care: The impact of training on nurses' ability to communicate effectively. *Journal of Advanced Nursing, 40*, 731-738.

# Chapter 2
# Intercultural Communication: The Soul of Health Care

Learning Objectives For Chapter 2

After reading this chapter you should have:

1. Been introduced to the intercultural communication field.
2. Acquired a fundamental understanding of culture's role in health care.
3. Gained insight into the influence of communication in intercultural health settings.
4. Initiated cultural self-awareness investigation.

Culturally effective health care is vital and a critical social value.
Committee on Pediatric Workforce, 2004, p. 1677

This isn't just politically correct, it's good medicine.
Voelker, *Journal of the American Medical Association*, 1995, p. 1641

## Introduction

A group of students and professors from the University of Wisconsin at Eau Claire School of Nursing presented a series of health education courses to Hmong immigrants. During the dental health unit one immigrant described his culture's belief about how dental caries occurs. "A very small bug with a big red head gets into the tooth and can only be killed by pulling the tooth out and crushing it and throwing it in the fire" (Moch, Long, Jones, Shadick, & Solheim, 1999, p. 240). One nursing professor commented, "I felt humbled by the recognition of the narrowness of my knowledge of different cultures" (p. 239). Many more cultural dental beliefs, customs, treatments, and folklore certainly exist, but dental professionals in general (Milgrom et al., 2004) and dental hygienists in particular (Fitch, 2004; Magee, Darby, Connolly, & Thomson, 2004; Morey & Leung, 1993) know little of them.

Dental hygienists struggle with the challenge of communicating with and caring for people of all races, ethnicities, and cultural and personal backgrounds, just as all health care providers do, but we seem to know little of ***culture*** and its impact on the delivery of dental hygiene care. Three studies revealed a lack of intercultural knowledge among practicing dental hygienists (Morey & Leung, 1993), dental hygiene faculty members (Connolly, Darby, Tolle-Watts, & Thomson-Lakey, 2000), and dental hygiene students (Magee, Darby, Connolly, & Thomson, 2004). This is true in large part because, according to our own literature, those topics are seldom taught in our training or continuing education courses nor are they covered in our academic or popular literature (Dhir, Tishk, Tira, & Holt, 2002; Fitch, 2004). This fact was further confirmed by a number of dental hygiene educators from across the country (S. Burzynski, personal communication, July 27, 2006; A.-M. DePalma, personal communication, July 27, 2006; T. Maahs, personal communication, July 26, 2006; J. Weiner, personal communication, July 26, 2006). My own research, in which I surveyed 551 dental hygienists across the United States, revealed that less than 42% had had any cultural training in dental hygiene school at all, and half of those reported having had only one lecture in their entire educational experiences. Fitch, quoting Zarkowski, summed up the situation, "At present, *cultural competence in dental hygiene practice is at best unexplored and, more accurately, neglected*" (p. 19, italics added).

The issue is not about caring, or sensitivity, or political correctness. Rather, the concern is about a lack of training in recognizing difference and communicating with diverse individuals. As you read this chapter and do the exercises you will enhance your

understanding of ***diversity*** and expand your ***intercultural communication competence***. However, I have two cautions. First, do not assume that culture explains all behaviors. It is a huge part of life and explains a lot, but not everything. If someone is rude, insensitive, overbearing, or just plain nasty, perhaps it is because he actually is that kind of a person and not necessarily due to his cultural learning. Second, do not expect to become experts by reading these few pages. The pursuit of intercultural communication competence is a lifelong journey, not a single destination. No one can ever know everything about even a single culture, let alone all cultures or all people in them. We still try, however, because we have learned that the combination of study and experience bring us closer to the goal of understanding each other (Garcia, 2005; Gibson & Zhong, 2005; Smedley, Stith, & Nelson, 2003). To that end, this chapter outlines some basic cultural concepts after first explaining in a little more detail why we need to know them.

## Diversity and Health Disparities in the USA

We need only look around to realize that the world is changing. People travel more, move more, and immigrate more easily and more frequently than ever before. One in ten residents in the United States was born outside the country, and minority groups are the fastest growing segments of the population (Milgrom, Garcia, Ismail, Katz, & Weintraub, 2004). More than one in four are African-American, Hispanic, or Asian/non-Hispanic (Kreps & Thornton, 1992), a proportion that is estimated to increase to one in three by the year 2020, and to over one in two by 2050 (Milgrom et al.). In 1999, "minorities" became the "majority" in California (U. S. Department of Health and Human Services, Office of Minority Health, 2001). Almost 47 million Americans, 18%

of our population, speak a language other than English at home, and 21 million or 8%, are limited in English proficiency (Shin & Bruno, 2003). This diversification is not limited to the eastern, western, and southern edges of the country any more. It is becoming more prevalent throughout the nation, including the upper Midwest, New England, and the Rocky Mountain States (Lyman, 2006).

Culture has a major influence on how health care is perceived and delivered, especially in this multicultural, multiethnic, multiracial, multireligious, multilingual tapestry of a nation where minority groups suffer a disproportionate number of health problems compared to the majority. "All ethnic minority populations in the United States lag behind European Americans (whites) on almost every health indicator, including health care coverage, access to care, and life expectancy, while surpassing whites in almost all acute and chronic disease rates" (Kagawa-Singer & Kassim-Lakha, 2003, p. 577). Minority people also suffer excessively from dental diseases and lack of resources to receive care. "Blacks, Hispanics and American Indians/Alaska Natives have the poorest oral health of any population group in the United States" (Milgrom et al., 2004, p. 1391). Certainly many factors that contribute to these disparities are far beyond our control, but we can address them in part by enhancing our cultural knowledge and intercultural communication competence (Garcia, 2005; Gibson & Zhong, 2005; Smedley, Stith, & Nelson, 2003).

The extensive research on this topic has been reported in a wide variety of health literature and synthesized in numerous government reports. Four reports are among the most prominent. The landmark Surgeon General's Report on *Oral Health in America*

(2000) documented a "silent epidemic" (USDHHS, NIDCR, p. 17) of oral diseases in the United States that impacts minority groups more than others. *Healthy People 2010* (USDHHS, 2000), the publication that enumerates the United States national health goals for the 2000-2010 decade, includes a chapter on health communication. Health professionals are urged to acquire the ability to "interact with diverse populations and patients who may have different cultural, linguistic, educational, and socioeconomic backgrounds" (p. 11-11). The Office of Minority Health (USDHHS, 2001) issued *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, better known as the CLAS Standards. All entities such as schools, hospitals, and clinics that receive government funding must adhere to these standards, though all health care providers, including dental professionals, are also urged to follow them. Finally, The Health Resources and Services Administration (2005) produced an extensive report, *Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education.* This document focused on dentistry as well as medicine and concluded that health care disparities in the USA are not due entirely to access to care issues; culture also plays a significant role. All of these reports mandate intercultural communication training for health care providers and their supporting staffs in order to prevent and treat disease.

If national standards, policies, and recommendations are not enough, some health providers are being legally compelled to learn about culture. As of this writing, California, New Jersey, and Washington have passed laws that obligate various health care providers to enhance their cultural knowledge and intercultural communication

competence. California Assembly Bill 1195, that took effect on July 1, 2006, requires *all* continuing medical education, unless exempt, to include cultural and linguistic competence materials in their curricula. New Jersey Senate Bill 144, 2004, requires cultural competence training as a condition of medical licensure. Washington Senate Bill 6194, 2005, requires that courses in multicultural health in basic education and continuing education be instituted by June 6, 2006, for *all health professionals* licensed in that state. This of course includes dental hygienists. Similar legislation has been introduced in Arizona, Illinois, and New York. New York's proposal specifically mentions dental hygienists (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006; Network Omni, 2006). These are not recommendations or even policies; they are *laws*. If this is happening in medicine, it is just a matter of time before it happens in dentistry. If it is happening in a few states, it is just a matter of time before it extends to other states.

So, we have numerous ethical, professional, educational, personal, and, increasingly, legal reasons to learn about and understand diversity, culture, and intercultural communication and to enhance our intercultural communication competence. These topics will be introduced in this chapter, but they will also be integrated throughout the book. In this chapter I will share my definition of culture and discuss its characteristics, get you started on your own cultural self-awareness journey, explain five cultural principals, and then summarize some research into specific cultures. However, before proceeding, I will take a little detour. I believe that it is important for readers to understand that, even though I try to be objective, my prejudices may seep out, so at this point I want to share some of my own culture story.

## My Personal Experience With Culture

I am a white woman who at this writing is 63 years old. I grew up in a military family, so during my childhood I lived all over the United States as well as in Germany and Turkey. As a young woman I was a flight attendant for an international airline and was fortunate to travel around the South Pacific and the Far East and work with people from all over the world. All in all, I have lived in 23 cities in 9 states and two other countries. I spoke German as a child and have studied Latin and French. I practiced as a dental hygienist for 26 years in San Jose, California, during the time it was developing into one of the most diverse areas in the United States, so I worked with and cared for a multiplicity of individuals throughout my clinical career.

My purpose in sharing this information is not to toot my own horn. It is to make the point that, even though I had had extensive experience with many kinds of people in a variety of locations and contexts, *I still did not understand diversity until I began to study it*. This is a critical point that I want to reiterate. Mere exposure to diverse individuals, while it may enhance sensitivity to difference, does not necessarily develop deep *understanding*. And, as it turns out, I am not alone; this is a common experience that is confirmed by both intercultural communication research (Hall, 1959, 1990) and experience in dental hygiene (Sisty-LePeau, 1993). We cannot intuit cultural principles; they must be learned.

That learning began for me when I retired from the clinical practice of dental hygiene and returned to school to earn bachelors and masters degrees in Communication Studies. Every course that I took included some cultural content and five courses

addressed culture and intercultural communication exclusively. I found these topics both fascinating and personally enriching and finally realized how limited my own understanding had been. I encountered numerous "ah-ha" moments regarding past and current experiences and in the process came to know myself better as well. I hope that this chapter and this book help you embark on a similar journey of discovery. I will begin with the basics.

## What is Culture?

What is culture? Definitions are plentiful. A search for "culture definition" on Google produced over 3.8 million results! Edward T. Hall, considered the founding father of the study of intercultural communication (Leeds-Hurwitz, 1990; Rogers, Hart, & Miike, 2002), wrote simply, "Culture is communication" (Hall, 1959, 1990, p. 94). This elegant definition is more complex than it appears, so, for the purpose of learning, I have synthesized an expanded definition. ***Culture*** is a subtle and constantly evolving pattern of learning that guides behavior, is passed from generation to generation, and includes social and religious structures, ways of communicating, thoughts, history, beliefs, values, roles, rules, and customs that are characteristic of groups of people. This description defines culture broadly so that it is not necessarily limited to ethnic groups. Any group that shares the components could be called a culture, and that would include dentistry. We are both a subculture of medicine and host to numerous other subcultures of our own, which could include each specialty, each occupation, and even each individual office. Our field constantly evolves as new knowledge is incorporated into our training and practice and that learning guides our behavior. Our history, language, beliefs, values, roles, rules, and

customs are unique and set us apart from other groups. I will carry out this analogy as I discuss various characteristics of culture.

The most famous metaphor for culture is the iceberg (Hall, 1959, 1990). The obvious parts, such as food and dress preferences, manners, customs, rituals, celebrations, taste, and even languages, are only the tip of the iceberg. The vast expanse of deeper and more meaningful cultural beliefs, values, attitudes, and assumptions that motivate the behaviors are mostly unseen and unknown, even to a group's own members. We may notice that patients from some cultures will not make direct eye contact with us and then assume that this is a sign of deception or lack of connection, while for the patient it may be a sign of respect. A dental patient sees our lab jackets, masks, face shields, gloves, and other paraphernalia and may have a vague idea why we wear them, but is unlikely to have a deep understanding of infection control. A patient once told me that he believed the reason I used so many barriers and washed my hands so much was because I thought he was dirty. Yet infection control practices are second nature to us and instantly understood by our dental colleagues. In both examples, observations of the tip of the iceberg combined with a lack of training resulted in misunderstandings.

Many articles and even courses that teach about culture focus mainly on surface characteristics. They may concentrate on lists of national and ethnic customs, rituals, foods, language, and other observable practices, but seldom touch on the immense unseen part of the iceberg. This information *is* important, even critical, for those who interact regularly with individuals from specific groups. However, I feel that this explicit learning should be preceded by a foundation of knowledge of a few general cultural characteristics

and principles. Therefore, in this chapter I will employ the ***culture general*** approach. That is, I will focus on the underside of the iceberg, which will form a foundation from which you can pursue further study of ***culture specific*** (Brislin, 1993) information regarding individual groups (see the end of the chapter for some suggested resources). Of course the two approaches often overlap, but for the most part you will find culture general information in this chapter, beginning with its main characteristics.

## Characteristics of Culture

There are innumerable facets to culture, but among the most important are: culture is learned, subtle, deeply ingrained, dynamic, and variable. Culture is *learned*, which is perhaps its most fundamental characteristic. It is not genetic or innate, but is passed from generation to generation. Initiates gain knowledge from wiser and more experienced individuals as they grow up or grow into various cultures As we became acculturated into the dental field, we learned about its history, founders, the evolution of various techniques and philosophies, and even a new language. Ultimately, we graduated and thus participated in this ceremonial rite of passage to indicate that we had learned and matured enough to be recognized as full-fledged members. After we graduated and passed our board exams, we were allowed to participate in another cultural ritual in which we changed our names by adding RDH or LDH and began, literally, to expand our identities. The analogies are striking and they do not stop here.

Culture is also *subtle* and *deeply ingrained.* Erich Fromme, the prominent social psychologist wrote, "Culture effects us behind our backs without our knowledge" (Hall, 1959, 1990, cover). Prominent intercultural researcher Geert Hofstede (1997) called

culture "the software of the mind" (title). As a white American, I believed that I did not have a culture. I thought that the idea of culture applied only to those who identified with particular ethnic, racial, religious, or national groups. I was wrong. *Everyone* has a culture. I just did not recognize my own culture precisely because it is so subtle and entrenched. Likewise, we who work in the dental field may not recognize that culture. Dental colleagues have comparable values and ascribe to similar practices that have become second nature to us. We dress similarly for work, place greater value on dental health, and are often more fanatic about our personal oral care compared to the uninitiated. Our language includes formal terminology (microorganisms, bacteria), informal terminology (germs), and even slang (bugs). Sometimes we forget that not everyone understands our language or has the same values, so I think it is wise for us to occasionally step back and examine our dental culture.

*Take time to think*:
How have your personal beliefs, values, attitudes, and assumptions changed as a result of your association with the dental field?

Culture is *dynamic*; it constantly evolves. The Greek philosopher Heraclitus (535-475 BCE) wrote "You can't step in the same river twice," and Thomas Wolfe (1900-1938) wrote a book titled, *You Can't Go Home Again.* These authors, one ancient and one contemporary, did not mean that the river or the home necessarily disappear, but rather that everyone and everything constantly change so the exact person can never again find the exact river or home. Anyone who has ever moved from one place to another and then returned to visit "home" can confirm this notion. People change and come and go, structures are built and torn down, innovative technologies are introduced, new

knowledge is applied, language evolves, and values are altered. Some may argue whether or not this constant evolution is "progress," but none can argue whether or not it occurs.

Dentistry has changed dramatically since I entered my first dental hygiene classroom in 1971. We follow a host of newer infection control protocols, wear loupes and lights, make greater use of ultrasonic and piezo scalers, recommend powered toothbrushes and xylitol, take digital X-rays and intraoral photos, use antimicrobials to treat periodontal disease, care for implants, and use computers and lasers. Many of the changes are reflected in our language. We remove *biofilm* rather than *plaque*, we talk about *interdental care* rather than *flossing*, and we perform *debridement* rather than *root planning*. This list is long and I'm just getting warmed up, but you get the picture. I could never go back to my original dental "home." The school is still there, but it is not the same school and I am not the same person.

*Take time to talk*: Ask someone who has been in the field longer than you to describe some of the changes s/he has experienced. Then discuss how those changes have contributed to the evolution of the dental culture.

Finally, culture is *variable*. There is as much ***diversity*** within cultures as there is among them (Kagawa-Singer & Kassim-Lakha, 2003; Hall, 2000; Hall & Hall, 2002). *Diversity* refers to difference between and among members of a variety of cultures and can refer to sex, age, educational level, educational specialty, socioeconomic status, mental and physical ability, and many other variables in addition to race, ethnicity, culture, and language. Each person is unique, and they, like cultures, are complex, contradictory, and constantly evolving. We all belong to numerous cultures that mesh with each other, or not. They combine and separate, intersect and interact to create

distinct individuals. A person who belongs to a certain group can share race, ethnicity, national origin, geographic origin, history, *and* religion and yet still be different because of gender, age, personality, family, education, profession, and life experience. Just as individuals who were born and grew up in the United States vary greatly, so do those who travel and emigrate here. Additionally, people today are exposed to and influenced by numerous cultures. We enjoy food from all over the world, incorporate words from many languages, and adopt practices that originated in other countries. Witness the interest in Asian philosophies such as yoga and the martial arts. So we are all unique in our blend of personal characteristics, cultural assumptions, beliefs, values, attitudes, and practices.

***Acculturation***, or the degree to which a newcomer assimilates and adapts to a new environment, is another important variable that relates to culture. It is difficult to be the new kid on the block, whether you move across town or around the world. We refer to the distress that people feel upon entering a new environment as ***culture shock*** (Kluykanov, 2005). This is a state of confusion, uncertainty, and anxiety that may cause us to long for familiar surroundings where things are done "right." Ultimately we adjust and adapt to the new place to some degree or other and in the process may change our behavior and/or our attitudes and evolve into different individuals. Every person will change in a different way and thus acculturation is a major element that contributes to the variability within cultures.

We can experience a kind of culture shock when we change jobs in the dental field. At first we are thrilled with the new environment and the positive differences

compared to the previous position. Then we begin to have problems. We may find that our new coworkers use variations of the language and apply the art and science of patient care differently. The new office may be unorganized where we had been organized, or out of date where we had worked hard to stay current. We gradually adapt, perhaps finding that the new ways are preferable in some cases or changeable in others. In the process we learn and grow as professionals and as individuals. This same progression occurs more or less whenever people are faced with change.

So far we have found that culture is acquired through learning, and that it is subtle, deeply ingrained, constantly changing, and filled with difference. Now you may be surprised to learn that the next step in increasing cultural knowledge involves looking inward.

## Cultural Self-Awareness and the United States Culture

If we want to understand other cultures, we must first understand our own. "All that one ever gets from studying foreign culture is a token understanding. The ultimate reason for such study is to learn more about how one's own system works....an achievement of gargantuan proportions for anyone" (Hall, 1959, 1990, p. 30). The effort is worth it. Thiederman (2005) states that such study enhances our pride, helps us recognize our core values and assumptions, and thus solidifies a sense of identity. This important exploration results in two main outcomes. First, we begin to realize how profoundly cultural assumptions influence behavior, and second, we come to appreciate that others may have different assumptions so we are less likely to judge their behavior based on our values. Since the full exploration of our own cultural identities is an

enormous task, the purpose of this section is merely to introduce the topic. Here I will discuss why we know so little about the American culture, briefly summarize some of what we do know, and refer you to two websites with exercises that can start you on your pursuit of cultural self-awareness. I hope that this brief discussion offers insight to Americans as well as to those who are trying to understand us.

Side Bar: Please note that I use the term "American" advisedly and for the sake of brevity. I do not mean to offend our Canadian, Mexican, and Central and South American friends, who of course are also Americans. But because the term is commonly used to refer to United States residents, this book is written by a United States American, and is published in the United States, I will use the term "American" in that way here.

There are two main reasons why we don't know very much about our own culture. First, we tend to think of culture as something that belongs only to others and as a result do not think of it as worthy of our attention. As I stated earlier, for most of my life I did not think that I personally had a culture or that we as Americans had a culture. I was wrong on both counts. Second, we have seen very little information in our literature or public press about the American culture. That is because it is only relatively recently that social scientists have begun to focus on this "new" topic. Furthermore, "This neglect implies that Americans do not have rituals, magic, elaborate kinship systems, reciprocal gift-giving customs, child-rearing practices, curing rites, feuds, disputes, myths, legends, beliefs about ghosts, or any other behaviors and beliefs common to cultures in the rest of

the world" (Rynkiewich & Spradley, 1975, pp. 1-2). But of course our culture includes all of these cultural elements and more. We may not view them as such just because practices seem less exotic from the inside than they do from the outside.

What are some American values? What traits do we admire and what personal characteristics do we think are valuable? Several authors who have tried to define the American culture have concluded that we value: independence, individuality, freedom, self-reliance, equality, friendliness, hard work, diligence, education, generosity, wealth, privacy, cleanliness, efficiency, initiative, "can do" attitude, competition, and fair play, among many other traits (Datesman & Kearney, 1997; Wanning, 2000). Do we *all* value all of these traits to a similar degree? Of course we don't. This is the same in every culture and illustrates what I already discussed; there is as much diversity within a given culture as there is among different cultures. Are all of these values applied uniformly? Of course they aren't. We say we value equality, but we know that all is not equal in this country and certainly not in the provision of health care. Even though these general terms have their descriptive limitations, they do ring true most of the time to most Americans. Please note the presence of these characteristics and their counterparts in the discussion of cultural principles later in this chapter.

*Take time to read and think and talk.* This three-part exercise will take some time, but the investment is well worth it.

1. Reread the list of American values from the previous paragraph. Do you agree with this list? What values would you add or remove? Discuss your choices with friends.
2. Visit the following websites and answer some of their questions regarding your personal culture. Compare notes with friends from the same and different cultures.

   a. Look at this excerpt from the book, *Developing Cross-Cultural Competence: A Guide to Working With Children and Their Families* edited by Eleanor Lynch and Marci Hanson (1998, 2nd ed.). Scroll to the bottom of the page, or read all of this insightful and informative writing: http://clas.uiuc.edu/fulltext/cl08481/cl08481.html#3
   b. Look at Sondra Thiederman's perceptive article on why and how to become more culturally self-aware: http://www.thiederman.com/articles_detail.php?id=37
3. Read more about the American culture. Choose from among the three references that are listed at the end of this chapter.

There is another path to cultural self-awareness. "One of the most effective ways to learn about oneself is by taking seriously the cultures of others. It forces you to pay attention to those details of life which differentiate them from you" (Hall, 1959, 1990, p. 31). So I conclude that the process of becoming culturally self-aware is reciprocal. The study of personal cultures helps us understand others, and the study of other cultures helps us understand ourselves. Win-win. Now that we have begun to heighten our personal cultural awareness, we are ready to study some basic ideas about culture. Scholars from all over the world have developed dozens of cultural principles, theories, models, and concepts. I have chosen to write about the five of these that I feel are most related to dental health care: *ethnocentrism*; *individualism and collectivism*; *context* or *direct* and *indirect communication*; *time*; and *locus of control*.

## Cultural Principles

### *Ethnocentrism*

***Ethnocentrism***, the idea that a person's own beliefs, values, attitudes, and practices are superlative and preferable to those of any other person or group, is probably the only trait that is universal throughout cultures. This idea is also timeless. At around

400 BCE, Aeschylus wrote, "Everyone's quick to blame the alien" (Knowles, 1999, p. 6). William Sumner, an American anthropologist, appears to have coined the term and published the first formal definition in 1906:

> Ethnocentrism is the technical name for this view of things in which one's own group is the center of everything, and all others are scaled and rated with reference to it....Each group nourishes its own pride and vanity, boasts itself superior, exalts its own divinities, and looks with contempt on outsiders. Each group thinks its own folkways the only right ones, and if it observes that other groups have other folkways, these excite its scorn (p. 13).

Sumner argued that ethnocentric beliefs are central to the survival of a culture and to understanding difference among cultures. After all, if we did not think that our beliefs, values, and practices were right, true, and good, then we would change them and they would eventually evolve in some way or die out completely.

Sumner (1906) listed numerous examples. Many cultures refer to their members as "human beings" or "the people," implying that others are not human. The early Chinese called themselves "The Middle Kingdom" because those in the center are the most important. Ancient Greeks, Romans, and Middle Easterners referred to all outsiders as "barbarians," and Jewish people have traditionally referred to themselves as "the chosen people." The early natives in Greenland thought that Europeans were sent to them to learn proper manners. "Each state regards itself as the leader of civilization, the best, the freest, and the wisest, and all others as inferior" (p. 14). As a result, most cultural groups believe that the reason for their existence is to civilize the rest of humanity.

Ethnocentrism is also personal. My grandmother used to say, only half jokingly, "Everyone's crazy but me and thee, and sometimes I'm not too sure about thee!" In other words, if you don't believe and do as I believe and do then you are crazy. How ethnocentric! We can imagine the difficulties that may result in health care when both patient and caregiver feel that their views are right and true and the other's opinions are wrong and false. Authors of a culture textbook for nurses were more blunt, "Health care professionals must recognize that their way may not necessarily be the best for the client and should not disregard other people's ideas as 'ignorant'" (Dowd, Giger, & Davidhizar, 1998, p. 119). We who have been trained in Western health care systems tend to value science over intuition, whereas in many other cultures it is the opposite, and those two orientations can collide. Therefore, it is important to understand the concept of ethnocentrism, and especially to recognize it in ourselves, in order to deliver patient-centered care. When we do not understand this concept we limit our ability to build relationships with patients, comprehend their views, and find common ground.

Other cultural concepts expand on the notion of ethnocentrism and describe some of the specific differences that "excite our scorn." The following four cultural descriptions consist of polar opposites. I will describe the far ends of each spectrum for the purpose of learning about the concepts, but also caution against assuming that any individual falls neatly into any category. That would be stereotyping. Additionally, in this time of globalization it is impossible to know how life experiences have influenced the values and preferences of any individual. The purpose of studying these distinctions is to heighten awareness of their existence so we can begin to comprehend different views.

*Individualism & Collectivism*

Geert Hofstede (1997), a Dutch social scientist and pioneer intercultural communication researcher, developed the cultural dimensions of ***individualism*** and ***collectivism.*** These concepts together are described as the degree to which the preferences, interests, customs, rules, and goals of the group prevail in relation to those of the individual. Individualists place more emphasis on each person and collectivists focus more on the desires and preferences of the group. Individualists do belong to groups, of course, but the ties to those groups are not bound as tightly as they are for collectivists. Individualists comprise a small minority of the world compared to collectivists. Collectivism predominates in Asia, Africa, the Middle East, southern Europe, Latin and South America, as well as in island and native cultures, whereas individualism is seen mostly in North America and northern Europe (Airhihenbuwa & Obregon, 2000; Triandis, 2003). The United States is considered to be an individualistic culture, whereas most minority groups within the US and those that immigrate here tend to be more collectivistic (Klyukanov, 2005).

Individualistic cultures focus on "I." They value independence, uniqueness, and competition, so that the needs and preferences of each person usually come before those of the group. Self-sufficiency is an asset and dependence on others is not respected. Association with a particular group is not central to a person's identity, survival, or success and, even more, individualists are *expected* to have strong personal identities. Since equality is valued, people feel that everyone should be treated alike (Hofstede, 1997; Storti, 1999).

Collectivistic cultures focus on "we." Groups in these cultures are strong and cohesive and offer security and acceptance in exchange for absolute loyalty from members. The needs and interests of the group are central to life and always take priority over those of any single member, so the focus is more on interdependence, harmony, conformity, and collaboration. Group affiliations are essential to each member's identity, survival, and success. Without the group, the individual is insignificant (Hofstede, 1997; Storti, 1999). All outsiders are judged against the beliefs, practices, and values of the group and strangers are not trusted until they can prove themselves worthy, which may take years (Beebe & Biggers, 1986; Rhine, 1989).

Collectivist ingroups can differ from culture to culture. In Africa the group is the community, in Japan it is the company, and in Latin and Asian cultures it is the family. The term "family" includes both nuclear and extended families and may even incorporate ancestors in some Asian families and honorary family members such as Godparents in Latin families (Gudykunst & Lee, 2002). A Mexican-American friend stated that she could not understand why many American families move to other places so easily, even to accept a better job or upgrade a home. She would not consider living away from her extended family for any reason.

Collectivist cultures tend to be hierarchical so preference is given to members of the ingroup, especially those of higher rank who are usually older males. The concept of "first come, first served," common among individualists, translates in collectivist cultures to the higher status or ingroup person coming first. In the dental office this could mean that a high status person from a collectivist culture might expect preferential treatment.

Individualists value personal opinions and feel comfortable voicing them. Collectivists strongly prefer consensus and so state the group's feelings only after agreement is reached (Northouse & Northouse, 1998). That is why collectivists may not make immediate decisions about dental treatment but wait instead until they can consult with other group members, especially those on the upper levels of their hierarchies.

The notion of pride is also seen differently. Individualists generally appreciate personal acknowledgement and awards. Collectivists, on the other hand, may be uncomfortable with individual praise, which they feel should reflect upon and honor only their groups (Hofstede, 1997). A friend who immigrated from an Asian country told me that it would make her uncomfortable to hear someone tell her that she has pretty eyes, but she would be very happy to hear that all the women in her family have pretty eyes. In the dental office a collectivist child who has done well with his home care might be embarrassed to hear, "You can be proud of yourself," but might respond more positively to, "Your family can be proud of you."

It is critical to reemphasize that these distinctions are not absolute. They exist on a continuum, both are present in all cultures in varying degrees, and times are changing. Vandello and Cohen (1999) studied collectivism in the United States, where individualism predominates. They concluded that Alaska, Hawaii, California, and the southern states from coast to coast show a much stronger tendency toward collectivism compared to the rest of the country. On the other hand, Davis and Konishi (2007) studied whistle blowing among Japanese nurses, where strong collectivist loyalties might prevent such behavior because it could interfere with group harmony. The practice has increased

to the extent that laws now protect whistle blowers. Globalization and international business experience have changed the corporate culture and conflict resolution styles in China and Taiwan. Twenty years ago the style was more yielding and compromising, as is usual in collectivist cultures, but now the style is much more confrontational as is commonly found in individualistic societies. Young people in Japan, rather than conforming to group norms as their collectivist parents expect, are increasingly asserting their individuality in such ways as wearing Mohawk hairstyles or dying their hair different colors so that older people have taken to calling them *foreigners* (J. Hwang, lecture, October 26, 2005). So the purpose of learning about these distinctions is not to label people, but rather to draw attention to possible differences. This is only the beginning of many ways that people can be different.

*Context/Direct Versus Indirect Communication*

Culture has a profound influence on the way we communicate. Edward T. Hall defined the extremes of that difference as ***high context*** and ***low context***. He described ***context*** as the degree to which the setting influences the message (Hall, 2000; Hall & Hall, 2002). This notion involves more than just the physical surroundings, but also includes the people who are involved, their relationships with the environment and each other, the time and timing of a given interaction, and other factors. Storti (1999) renamed these dimensions ***direct*** and ***indirect communication***, which are the terms I will use here. Direct and indirect communication, like individualism and collectivism, are opposite ends of a spectrum with innumerable variations in between. Indirect communication is associated with collectivism and direct communication generally predominates in

individualistic cultures, so each is associated with the same areas of the world noted in the previous section.

Where indirect communication predominates, much of the meaning in a given interaction is implied rather than stated outright, and participants must fill in the blanks. Not surprisingly, a great deal of this communication is nonverbal, the "unspoken dialogue" (Burgoon, Buller, & Woodall, 1996, p. 3) that passes among people, so is transmitted mainly through physical appearance, movement, touch, and vocal expression, as well as the use of time, space, and distance. The ultimate goal in an encounter is to maintain harmony (a collectivistic characteristic), so confrontation is avoided and people may or may not say what they mean or mean what they say. Robinson (2003) describes a Korean concept called *nunch'i*; the literal translation is "eye measured" (p. 57), which refers to the ability to instinctively size up a situation or a person. Beyond "reading" actions and grasping messages, it also includes deeply understanding the underlying motivations and emotions. *Nunch'i* must be reciprocal; the first person must send a comprehensible message and the second person must correctly interpret it. This concept defines indirect communication.

People who prefer direct communication tend to be more explicit and precise and give more detail when they converse because less information is available from the surroundings, event, participants, and other nonverbal features. Most meaning is in the words that are spoken, so it is important to express disagreement, say what you mean, and mean what you say. We in North American and northern European cultures tend to communicate directly. In the United States we prefer to "tell it like it is" and "give the

facts, Ma'am, just the facts." This characteristic is even more pronounced in scientific fields such as dentistry. We cannot imply scientific data, but must articulate information as clearly and completely as possible. Those who favor direct communication do use indirect communication as well, but to a lesser degree. Say, "I hate you" as if you mean it and then sarcastically as a joke. Same words, opposite meanings, all implied through vocal inflection. But the majority of our communication is direct.

In cultures that rely heavily on indirect messages certain words may mean the opposite of their dictionary definitions. "No" is only implied, and "yes" can mean "no." When I visited Japan and asked a taxi driver to take me to a certain attraction that he knew had been closed, he replied, "Ahhhh, this is difficult." If I had understood the Japanese culture and the concept of indirect communication, I would have realized that this meant, "no." According to several friends who speak Chinese, there is no single, direct way to say "no" in the Chinese language, though there are numerous indirect ways. On the other hand, "yes" may mean "I hear you but I don't agree," or "I do not understand but I don't want to embarrass myself by saying so," and not necessarily, "I understand" or "I will do as you ask." (Katalanos, 1994). Cambodian people tend to answer "no" to a negative question because to them it confirms the statement. Katalanos reported this conversation:

> Health care provider: You didn't take your pills.
> Cambodian patient: No. (That is not right, I did take them.)
> Health care provider: Don't you want to get well?
> Cambodian patient: No. (That is not right, I do want to get well) (p. 37).

You can imagine the difficulty that this type of interaction can cause in the dental office. An indirect communicator may also appear to agree to follow through with home care instructions when in fact that was not what he meant at all. A dentist from a high context culture was having trouble with several of his staff members who were dressing too informally for his taste. The office manager spoke with them but nothing changed, so she suggested that the dentist himself should speak with them. The dentist's reply when confronted with this plan reveals a person who relies on indirect communication. He said, "they should just know." That statement expresses the essence of indirect communication.

Of course we can have indirect communication relationships in a direct communication culture and vice versa. My husband and I have been married 40 years and can convey a wealth of information with a mere look or raised eyebrow. Some long-time dental colleagues may similarly be on the same wavelength. On the other hand, even where indirect communication prevails some information must be exact, such as in business or science. So, as with individualism and collectivism, the concept of directness of communication is imprecise. There are many examples of direct and indirect communication in the way we use a precious commodity, our time.

*Chronemics and Cultural Time*

The way we use time is a form of nonverbal communication and its study is called ***chronemics***. In most individualistic cultures time is thought of as a commodity, an actual thing that we can give, take, invest, budget, spend, spare, save, waste, use, lose, or lend. The same verbs could be applied to money. But in North American dental offices time *is*

money, time flies, and we always seem to be in a time crunch. We have specific rules about being on time, who can be kept waiting, and for how long. The rules differ for higher status people. It is all right for the employer or the professor to be late for work or class but not all right for the employee or student. If you have a dental appointment at 2:30, regardless of your status, you are expected to show up by 2:30. But not everyone thinks of time this way. Here I will briefly summarize two cultural notions of time developed by Edward T. Hall (1983, 1989): monochronic and polychronic orientations.

Time could arguably be called *the* most precious commodity in the practice of health care. The amount of time needed to wait for the caregiver or patient, to conduct an interview, to receive treatment, for treatment to take effect, to get a prescription, to see a specialist, to feel better, and to heal are all of intense interest to patients and practitioners. The way we use time is often a function of our cultures. Edward T. Hall (1959, 1990; 1983, 1989; 2000), an anthropologist who lived and worked in many different parts of the world, developed the concepts of monochronic and polychronic time. ***Monochronic time orientation,*** or ***M-time***, found generally in individualistic cultures such as those in northern Europe and North America, is a more linear view that focuses on accomplishing tasks one at a time. ***Polychronic*** or ***P-time orientation***, more commonly seen in collectivistic Eastern, Latin, island, native, American Indian, African, Mediterranean, and Middle Eastern cultures, tends toward a more circular or holistic perspective and focuses on personal relationships.

M-time people think of time as a commodity and therefore it is limited and must be "budgeted." As such we expect rigid adherence to timetables and we think of

interruptions as bothersome annoyances that interfere with those schedules. We say, "business before pleasure," meaning that task and social needs are usually separated and we usually give priority to tasks. We tend to do one thing at a time with one person at a time, at least in business, and the focus is more on privacy and individuality. M-timers are ruled by an outer clock and are more concerned with being "on" time. People with a P-time orientation tend to think of time as more fluid and almost limitless. Task and social needs are combined and several events can occur simultaneously. Schedules are flexible and there is no such thing as an interruption because relationships with people come before agendas. P-timers are ruled by an internal clock and are more concerned with being "in" time (Storti, 1999).

We in the United States live in an M-time culture that is embodied in our omnipresent clock. I recently noticed that we have seventeen clocks in our house, seven in our kitchen alone. We didn't actually go out and buy all of those clocks as such, though we did buy a few. The reason we have so many clocks is because in this monochromic culture every appliance and gadget that we purchase comes with one. The clock seems to rule our lives. It dictates when we rise in the morning, when we go to sleep at night, and most of what we do in between. We are even a bit disoriented when we cannot find a clock such as in theaters, malls, and restaurants. The clock dictates that appointment times must be honored almost to the second or at least that the rule, "first come, first served," must be followed. And as we are served we expect to have the exclusive attention of the clerk or businessperson.

In polychronic cultures business is conducted very differently. An appointment at

1:00 doesn't necessarily mean 1:00. A P-time person just "knows" (*indirect communication*) that a 1:00 appointment really means 1:30 or 2:00 or later and does not expect undivided attention from a proprietor. The businessperson greets and converses with several people at a time, deals with both personal and business issues simultaneously, and seems in no hurry to conclude any deals. There is very little privacy in this scenario. Since multiple matters are attended to at once in the presence of all, everyone's business often becomes everyone's business (Hall, 1959, 1990).

M-time and P-time orientations are not always distinct or exclusive to certain cultures. Even in the predominately monochronic United States, we tend toward M-time in business and P-time in the home and in social situations, and women and men tend toward P-time and M-time orientations respectively (Storti, 1999). Japan is an exception among Asian cultures and can be even more M-time oriented than we are in the United States, tightly scheduling events with hardly a moment to take a breath. In spite of these exceptions, most people usually identify more strongly with one orientation over the other, the difference is usually one of degrees, and the important thing is to recognize that there is a difference (Hall, 1959, 1990).

Not surprisingly, both M-time and P-time people are frustrated when trying to function in the other person's culture. My husband and I became friends with a couple who had recently moved from Hong Kong and we were invited to their home for dinner. We arrived at what we thought was the appointed time, 6 PM sharp, carrying flowers and a box of candy. Both of our hosts were startled, even astonished, to see us. The husband was vacuuming the living room, the wife was wearing curlers and a robe, and dinner had

not been started. There was plenty of embarrassment to go around. Janet MacLennan (2002), a Canadian, wrote of her experience living and teaching at a university in Puerto Rico, including her adjustment to a polychronic culture. She felt she was making progress when she purposely arrived one hour "late" for her dog's appointment with the veterinarian. No one at the vet's office even noticed and she and the dog were seen almost immediately.

In North American dental offices we earn our livings with appointments as we try to adhere to demanding schedules. All parties expect promptness. Patients can become annoyed, offended, or even angry when they are kept waiting past their scheduled appointment times. We practitioners exist in the tension between trying to be on time and fulfilling our ethical and legal responsibilities to provide excellent care. People who arrive late compromise our ability to carry out those obligations. I cared for four sisters who had emigrated from the Philippines. These charming women also became personal friends, but, from my M-time perspective, they were eternally late for their dental appointments. They would joke with me that they were on "Philippino time."

I did not always appreciate the humor, especially when I was delayed in seeing my other patients. I don't know the solution to the conflict between M-time and P-time orientations in the dental office. However, I did find that as my friends became more acculturated to life in the United States they began to understand my predicament and to arrive more promptly, though the process took years. I have subsequently begun to lose some of my angst over the issue since studying and beginning to understand the differences between monochronic and polychronic time orientations.

We have seen that the cultural concepts discussed so far are related to each other. Individualism, direct communication, and an m-time orientation are usually found in the same cultural groups, as are collectivism, indirect communication, and a p-time orientation. The same can be said for the last set of concepts.

*Locus of Control*

***Locus of control*** is defined as the degree to which a person feels in control of life events (Luckman & Nobles, 2000), and is an important cultural concept that can have a great influence in health care. People with an ***internal locus of control*** (ILC), common in individualistic cultures, feel in control of their environments and thus of their health, believe that they have the power and even the responsibility to make changes in themselves and the events that impact them, and thus tend to be active in their own health care. People with an ***external locus of control*** (ELC), common in collectivistic cultures, feel that their lives, including their health, are controlled by outside forces such as God, fate, chance, or luck, and can be more passive in regards to health care decisions and practices. As with all the cultural concepts that have been introduced, these views are not mutually exclusive but rather exist on a continuum and most people will exhibit both to some degree (Roter & Hall, 1993; Yamaguchi & Wiseman, 2003). Furthermore, Roter and Hall found that life experience could alter a person's locus of control orientation in regards to health.

Locus of control is an important issue that should be considered when treating and trying to motivate dental patients. Regis, Macgregor, and Balding (1994) found that 14 and 15-year-old boys with an ILC tended to brush their teeth more often. Dental phobics

lean more toward an external locus of control orientation (Sartory, Heinen, Pundt, & Johren, 2006), and conversely, ELC people are inclined to be more anxious dental patients. Additionally, older and lower income patients also tend toward an ELC orientation, regardless of their cultures (Ludenia & Donham, 1983).

The next logical question is, "How do you determine a person's locus of control?" The answer is, of course, that you cannot, just as it is impossible to determine precisely where a person may fall on the ethnocentrism, individualism-collectivism, directness of communication, or M-time-P-time continua. We can never know what even the individual may not know, especially due to the inconsistent, complex, and constantly evolving nature of culture. Moreover, these categories and definitions represent only a few of the cultural principles that scholars have described, there are many more ways to be different, but even these five can combine and interact to create a diversity of possible orientations in any single person. The important thing to remember is that, just as heredity or diet or homecare may or may not influence certain dental conditions, these concepts may or may not influence behavior and decision-making processes in the dental office. They are, however, significant factors to consider, and, when understood, can offer added insight for patient care.

## Bringing It All Together

In order to further demonstrate the principles at work, I will temporarily switch to a culture specific approach and overview three sources that compared specific cultures: Rao's (2003) survey of physicians in three collectivistic cultures; Payer's (1988, 1996)

comparisons of health care in four individualistic cultures; and Katalanos' (1994) study of the health beliefs and practices of recent refugees from Southeast Asia.

*Rao and Physicians from Collectivist Countries*

During a five-year study in which he interviewed 91 physicians in Argentina, Brazil, and India, Rao (2003) asked the question, "How do physicians in different countries communicate with culturally diverse patients?" (p. 313). He developed one argument and three main conclusions. Rao argued that the interaction between a physician and a patient is inherently intercultural, even when both are of the same ethnic or national culture. Other researchers have come to the same conclusion, calling the medical culture a barrier to physician/patient communication, especially in intercultural settings, due to differences in educational levels, language including medical jargon, values, socioeconomic status, gender, race, religion, and time orientation (Huff & Kline, 1999; Kreps & Thornton, 1992). Of course this can also be an issue in dentistry. The effort to set aside our ethnocentrism and personal and professional cultures when treating people with different beliefs is certainly a challenge.

All five of the cultural principles that I discussed are represented in Rao's (2003) three conclusions. First, he noted that the physicians unanimously described their countries as heterogenous. One Brazilian doctor expressed the notion well, "You have many countries inside a country" (p. 313). The presence of *ethnocentrism*, a nearly universal trait that is magnified in the midst of diversity, is implicit in this statement. Second, Rao reported that 90 percent of the physicians stated that if a patient's life were threatened by an illness or injury, they would not immediately tell the patient. They

reasoned that to do so would harm the patient psychologically and thus reduce his or her ability to cope with the condition. The doctors preferred instead to inform family members first so that they could support the patient and/or reveal the information gradually over a span of several visits. Rao called this strategy "half-truths" (p. 314), another way to say *indirect communication.* The assumption that the patient will give up when informed represents an *external locus of control,* and the fact that there seems to be no hurry to reveal the diagnosis reflects a *P-time orientation.* In his third conclusion Rao noted that the physicians treated the family as the patient because they felt that personal and family identities were inextricably mixed, reflecting the interdependence of *collectivism.*

A further finding is related to how the physicians in these collectivistic cultures defined success in medical care. As opposed to American physicians, who had been interviewed as a preliminary part of this study and who saw a patient's death as a failure on the physician's part, these external locus of control oriented doctors did not see a patient's death as a failure as long as they felt they had done all they could. Because we in individualistic cultures tend toward an internal locus of control, we think there must be a solution to every problem, and if we do not find the solution then it is our fault. We barely consider the possibility that the solution is unattainable or even that no solution exists.

We could apply this finding to our treatment of periodontal disease. How many of us take on our patient's problems as our own? How many of us agonize and lose sleep when our recommendations and treatments don't produce the desired results? I

experienced this very phenomenon and it took many years for me to conclude that, as long as I had done my best, I need not assume all responsibility for my patients' outcomes. It was only after I studied cultural principles that I realized I had evolved on the continuum from an external locus of control to what I hope is a more balanced position between external and internal. Now I turn to the opposite ends of the spectra to look at reports on health in countries with external locus of control, individualism, direct communication, and m-time orientations.

*Payer's Description of Health Care in Individualist Countries*

Lynn Payer (1988, 1996) was an American biologist, physiologist, and medical journalist based in Europe. She spent ten years studying cultural influences in health care in four first world countries and documented her findings and conclusions in her book, *Medicine and Culture*. She chose to focus on England, France, West Germany, and the United States because of their similar life expectancy and infant mortality rates and because she could speak all of the languages. Her research, though admittedly anecdotal, was still exhaustive and made use of numerous interviews in addition to all available documentation. She was highly regarded within the medical community, which was evident in her prominent obituary in the *British Medical Journal*: Payer "challenged the popular view that medicine was grounded in objective science....(and) showed how cultural values and opinion profoundly influenced medical practices" (Newman, 2001, p. 871).

Payer's (1988, 1996) investigation began when she was diagnosed with a grapefruit-sized uterine fibroid tumor while in France. Her French physicians

recommended a myomectomy (removal of the tumor only, a procedure that could take up to six surgeries but would preserve her uterus), whereas her American physicians automatically recommended a complete hysterectomy. This striking difference of medical opinions piqued her interest so she began her research. Payer ultimately found that French doctors performed about one third the number of hysterectomies per capita compared to American doctors.

According to what we have learned so far, England, France, Germany, and the United States all tend toward individualism, direct communication, m-time orientation, and internal locus of control, but Payer (1988, 1996) found many shades of difference within those categories. While conceding that there were many similarities among the countries, she contended that the differences were more interesting and revealing. She discovered that, among many other variations, the same symptoms might be diagnosed differently depending on the country in which they were found.

I will focus on three main areas of difference discussed in the book: each country's general philosophy toward health care represented by its most valued action; the main focus of health concern; and their ***wastebasket diagnoses***. Payer (1988, 1996) coined the term *wastebasket diagnosis* and defined it as a catch-all cause or condition that people think explains most of their vague and relatively mild symptoms, such as aches and fatigue, that cannot be attributed to any other cause. This book was originally published in 1988 with an update in 1996. I will discuss the 1988 findings for each country and then note if changes were reported in the newer edition. Please remember

that there is as much difference within cultures as there is among them and that the generalizations summarized here are far from absolute.

*United States.*

Probably the best single modifier to describe American health care is *aggressive*. We Americans want to *do*, we focus on germs, and we usually blame unexplained symptoms on viruses. Doing something is always better than doing nothing and most of us do not value physicians or patients who want to wait and see. We commonly say, "There must be something that we can *do*," and "What are we waiting for, let's *do* something." We prefer surgery to medication, but if we use medication we tend to use high doses of the strongest drugs.

Americans use two metaphors that relate to the notion of aggressiveness in health care. First, illness is war. War requires strong measures that are reflected in our language. Illness is the "enemy" that we want to "fight" and "conquer" and we look down on people who don't "battle" the "opponent," and in order to do that we use an "armamentarium." "The patient who 'beats' cancer is considered superior to the patient who fights but succumbs, who is in turn superior to the patient who refuses to fight" (Payer, 1988, 1996, pp. 132-133). Second, the body is a machine. A machine must be maintained with regular check-ups and the components can be fixed or replaced. We have developed the ability to transplant and implant many body parts including artificial teeth. The heart is the ultimate machine and in the United States coronary bypass surgery is performed up to 28 times as often as it is in some parts of Europe.

Americans focus on germs and our *wastebasket diagnosis* is *a virus*. When we have the sniffles or general malaise we say, "I just have a little virus," which usually means, "I have something but I don't know exactly what it is." Implicit in these statements is the notion that these problems are not our fault since they came from the outside. We think that when we cannot "beat" the "invaders" that we have "failed." When a patient doesn't show up for an appointment, we call that a "failure." A cancer patient who does not improve after chemotherapy is said to have "failed." As mentioned earlier, an American physician is likely to think of a patient's death as a "failure" (Payer, 1988, 1996; Rao, 2003). And we dental hygienists tend to think that if our patients don't improve then either they or we have "failed." Since we are as ethnocentric as the rest of the world, this approach to health care seems natural to us. However, it is not the same in Europe.

*France.*

Where Americans are aggressive and favor *doing*, the French favor *thinking*. They minimize reliance on empirical findings in favor of reflecting and theorizing, a legacy of their Cartesian heritage. René Descartes was the famous French philosopher who said, "Cogito ergo sum," (I think therefore I am), thus placing "intellectual elegance" (Payer, 1988, 1996, p. 40) above systematic research in the French medical psyche. Cartesianism in French medicine was explained to Payer, "If the idea is good, the body has to follow" (p. 40). A new, supposedly revolutionary flu vaccine had been introduced while Payer was researching in France, but was criticized by American doctors because randomized controlled trials had not been done. Jacques Monod, then head of the Pasteur Institute that

had developed the drug, told Payer, "I am very confident about vaccinating large numbers of people without challenge experiments" (p. 39).

According to Payer (1988, 1996), the French *wastebasket diagnosis* has to do with liver problems. The national illness before the 1980s was *crise de foie* (liver crisis, p. 59) and, though this emphasis has softened some, the liver and bile duct are still considered sources of many health problems. "Fragile liver" and "fragile bile duct" (p. 61) are still common diagnoses, and many drugs including aspirin and antibiotics are dispensed as suppositories so the medications won't pass through the liver.

The French also place great emphasis on the ***terrain***. This difficult to translate term relates to a person's constitution and the body's natural ability to fend off disease, but is more than what we call the immune system. In France, a great deal of effort is placed on bolstering the terrain by taking tonics and vitamins and by making sure the body is rested. French doctors tend to be more conservative in all of their treatments compared to American doctors, preferring instead "***medicines douces***" (gentle therapies, Payer, 1988, 1996, p. 65). A "French dose" of medicine is about half that of an "American dose" (p. 66), but doctors are still likely to recommend homeopathy, aromatherapy, or a stay at a spa before prescribing antibiotics. United States and French cultural approaches to medicine contrast with each other and with the German and British approaches.

*West Germany.*

German medicine[3], according to Payer (1988, 1996), has been strongly influenced by Romanticism, a philosophical, musical, and artistic movement from the 1800s that emphasized feeling over thinking. So, the Americans *do*, the French ***think***, and the Germans *feel*. Payer was told that Germans, contrary to the stereotype, are emotional and romantic but just don't show it. This view includes a belief in the healing powers of nature and so Payer found that the use of spas, homeopathy, and herbalism are even more common than in France and also include other "natural" treatments such as long walks in the forest and mud baths.

Problems with the heart and blood pressure are of great concern to Germans. Their wastebasket diagnosis is ***hersinsuffizienz***, a mild heart insufficiency that, in its more advanced stages, might be called heart failure, but really has no exact translation into other languages. A companion problem to hersinsuffizienz is low blood pressure. During the time Payer (1988, 1996) was conducting her research, the Germans had access to 85 drugs to treat *low* blood pressure. Most Americans are happy to have blood pressure readings that are considered pathological and treated with medications in Germany.

The Germans also use an extraordinary number of prescription drugs. Payer (1988, 1996) reported that at the time of her research the German formulary included 120,000 medications compared to 1,180 in Iceland. No statistics for other countries were given, but this meant that Icelanders had access to less than 1% the number of

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[3] Payer studied West Germany before the breakup of the Soviet Union and the reunification of West and East Germany. For brevity, I will refer to "Germany."

medications compared to Germans. German doctors also commonly prescribe medications in combination; it is not unusual for a patient to be taking 15 drugs to treat one condition. Patients have more opportunity to receive prescriptions because they visit their doctors more than twice as often (about 12 times per year) compared to patients in Britain (5.4 times per year), France (5.2 times per year), and the United States (4.8 times per year). Of those drugs, digitalis (as of 1988) was one of the most prescribed; it was used not only to treat heart disease, but also "as a general tonic" (p. 84) to prevent it. The view of health in Great Britain offers a different perspective.

*Great Britain.*

Payer's (1988, 1996) research on Great Britain revealed yet another unique national health character. The British tend to take a *wait and see* attitude in regards to health, focus on their bowels, and are concerned about constipation and ***autointoxication***. They approach health care with the same reserved stereotype for which they are famous, and "do less of nearly everything" (p. 101), fewer screening exams, tests, Xrays, and surgeries. Because they do less screening, fewer people are considered sick. They prescribe fewer drugs and in lower doses compared to Americans, including recommending lower doses of vitamins. Payer found that the economy of the National Health Service *reflected* a national tendency to be conservative, to keep a stiff upper lip, and to feel that the good of the society should come before individual needs, not the other way around.

British people tend to be stoic and expect self-control of themselves and others. Even though drug use overall in Britain is lower, tranquilizers are actually prescribed

more compared to the other countries. They are dispensed for the most part to help "overactive" people, but are even prescribed for depression. Many of those "overactive" people actually want tranquilizers to help them fit in with an ascetic and self-reserved society. An offshoot of the self-control issue has led to exceptional skill in the fields of anesthesiology and control of pain. British anesthesiologists are internationally known and respected and looked to as leaders in the field.

Another issue related to self-control is concern about the bowels. Payer (1988, 1996) quoted an editorial from the *British Medical Journal*, "From infancy, the British are brought up to regard a daily bowel action as almost a religious necessity" (p. 116) and people take pride in such control. So the British wastebasket diagnoses is constipation, defined as anything less than a daily emptying of the bowels. It is believed that constipation brings on a condition called *autointoxication*, or absorption into the body of the "toxins" from bowels. Payer told the story of a British prep school where every morning the boys were required to answer the matron's question, "Been?" (p. 118). Those who were honest or stupid enough to answer "no" were treated to a laxative.

Payer (1988, 1996) found many fundamental differences among the four groups that she studied. Without her insights, we might have gone on thinking that health care in these countries that are usually lumped together and called individualistic was mostly similar. To summarize, the Americans want to *do* and focus on viruses and germs; the French prefer to *think* and are most concerned about the liver and the terrain; the Germans *feel* and tend to blame many ills on heart, blood pressure and circulation issues along with Hersisuffizienz; and the British like to *wait and see* and are fastidious about

bowel actions, constipation, and autointoxication. Payer's newer edition reported relatively few changes in her original conclusions. Americans were beginning to turn to alternative types of medicines more frequently and women with breast cancer were more likely to be offered relatively conservative treatments. But overall the Americans were still aggressive and the British still conservative and the foci of the four countries remained virtually the same. Now, for further contrast, I will turn to a study of people from the opposite side of the world.

*Katalanos' Study of Southeast Asian Refugees*

Katalanos (1994) studied the health beliefs and practices of Southeast Asians who settled in New Mexico, with a focus on the Vietnamese, Cambodian, and Laotian/Hmong groups. Most were newly arrived refugees who had lived through horrors to get to the United States, so they were relatively unacculturated and still reeling from their experiences. Other patients from the same areas may have been here longer and had a greater chance to adjust to their new country, or may have been the children of the original refugees, so, once again, don't assume that everyone from these countries shares the same characteristics that Katalanos describes. I summarize her study here to illustrate the similarities and differences among a group of people who we usually lump together as collectivists, "Asians," and "Southeast Asians" (SEA).

All of the refugees that Katalanos (1994) studied shared the experience of losing their homes and many family members before coming to the United States and they all had difficulty adjusting to our way of delivering health care. Because of financial limitations, lack of transportation, inability to take time off work, or other barriers, and

because of their cultural history of not having access to health care, many Southeast Asians sought professional health care only as a last resort. As a result, they were usually sicker when they finally saw a physician.

Paying for health care was also different and difficult. Many lacked funds or insurance and were used to bartering or giving food as a gift in return for services. They may have thought that the food gift they brought to the caregiver was payment for the service, whereas the caregiver may have thought of it as a nice gift but then sent them to collections for nonpayment. A subsequent notice from a collection agency may have been such a source of shame that they never returned.

The idea of a prescription was a foreign one. When they did go to a doctor who recommended a medication, they were used to receiving it on the spot and not having to go to another place and pay extra for it. They may also have been disappointed when no medication was dispensed at an appointment, regardless of the diagnosis or lack of one. They tended to think of American medications as too potent for them, so they may have taken less than the prescribed dose, resulting in a lack of improvement and/or being prescribed a larger dose or a stronger medication. A lot of them preferred home remedies to medical remedies, many of which were ancient and either worked well or were harmless and may have helped them feel better emotionally and psychologically.

They looked at disease differently. Ideas about the causes of disease were derived from a combination of Animism, Buddhism, and ancient Chinese medicine. Physical illness resulted from accidents (causing such problems as broken bones, cuts, food poisoning), and infections (resulting in malaria, tuberculosis, cholera, and so forth).

Metaphysical illnesses, related to the principles of Yin and Yang, were caused by bad wind, hot and cold energy imbalances, poor diet, and excessive emotion. Supernatural illnesses resulted from soul loss or the influence of bad spirits. Soul loss in particular was a major cause of supernatural illness within the Hmong community.

They viewed certain parts of the body, including the eyes, the blood, and the head, differently compared to Western views. They believed that direct eye contact was a sign of aggression, or at least rudeness, and Cambodians especially thought that it caused illness. To the SEA, blood represented energy, and some believed that it could not be replenished, so wanted to avoid any kind of blood loss at all. Katalanos (1994) found that the head was a source of life for all of these groups, and that it was extremely personal and mostly untouchable. The Lao/Hmong in particular believed that to touch the head was to cause soul loss and the Vietnamese believed that only an elderly person could touch a child's head. A casual acquaintance, even a health care provider who has extra latitude, should not ruffle a child's hair or pat her on the head.

*Take time to think and talk*:
What implications do these beliefs about the body have in the dental office? Also ask friends for their ideas and compare and contrast yours and theirs.

The groups also differed in regards to naming. For all groups, the family name came before the given name, a representation of the importance of the family over the individual (collectivism), but each culture differed in other ways. Cambodians historically had only one name, but were forced to take second names by the French. For the Vietnamese the middle name may have revealed the person's sex. For the Hmong, women may or may not have taken their husbands' names when they were married, and

titles were used with given names. So Diana Jones would have been called, "Dr. Diana" or "Mrs. Diana" rather than "Dr. Jones" or "Mrs. Jones." This was a sign of respect because personal names had great meaning. But these naming customs were not universal among the Hmong because different tribes may have done things differently, another example of the heterogeneity within groups.

The Cambodians suffered perhaps the most devastating traumas of the three groups, so were more likely to be depressed, which they may have denied because to them it was a shameful condition. Overall, they tended to be formal but friendly, "slow moving, patient, and easy-going," (Katalanos, p. 36). They were the most class conscious of the three groups, having immigrated from a country that had historically had four classes: royalty, upper class, middle class, and lower class, each with a different language. So when trying to find an interpreter for traditional Cambodians, it was necessary to find someone from the same class. They revered the right hand but didn't value the left hand, so found it rude to hand something to another person with the left hand. They tended to answer *no* to a negative question. To them, it confirmed a statement. (See the conversation transcribed in the Context/Direct Versus Indirect Communication section of this chapter.)

The Lao, mostly Hmong, had the strongest belief in American medicine of the three groups. The major difference when comparing them to Cambodians and Vietnamese was that there was less male domination among the Hmong and so they valued having a girl child more than the others. Women were respected as the moral and ethical experts and family treasurers. They believed that each person had 36 souls. The

most inferior soul lived in the feet, the next most important was just above, moving up the body so that the most important soul resided in the head. One of the rudest things a person could do was to touch another person with an inferior part of your own body. So they would not touch a shoulder with a hand, and would never put a hand on a head. Fortunately, exceptions were made for health care providers. They also felt that pointing a finger was rude, but that pointing or even showing the bottom of a person's foot was the highest insult.

Of the three groups, the Vietnamese were the most likely to use Chinese health care practices and folk medicines. They believed that voices should be modulated, and a loud voice was considered disrespectful and even aggressive and would leave a lasting impression. The Vietnamese had strict customs regarding intersexual touching. A man could not offer to shake a woman's hand, and could only shake if she offered first. Strangers and slight acquaintances, even health care providers, should not put their arms around a person's shoulders (such as when leading a person to an operatory) because this was considered disrespectful, especially if a man touched a woman in this way. Husbands would not even touch their wives in public, yet it was commonplace for same sex friends to hug and hold hands, which did not imply homosexuality as it did in the United States. Direct communication was considered rude, embarrassing, and disrespectful; Vietnamese preferred indirect communication. So Katalanos (1994) suggested using "a soft voice and....innuendos" (p. 29). On the other hand, it was not considered rude to ask a person's age or salary or the price of an item. These questions represented interest in and respect for the person and helped the asker to gauge the other person's character. However, the

direct question could be answered indirectly. Smiles could mean anything, happiness/sadness, understanding/misunderstanding, agreement/disagreement, sickness, fear, "stoic self protection" (p. 32), or all of these at once. Dressing up for a doctor's appointment was considered a sign of respect, and a health care provider who dressed too casually may have been thought to show disrespect to the patient. All in all, Katalanos found numerous similarities and differences among the Southeast Asian refugees that she worked with and studied, and her insights add to our own understanding.

We have looked at a wide variety of people and cultures. Rao (2003) studied physicians from mostly collectivist cultures; Payer (1988, 1996) studied patients and physicians in mostly individualist cultures; and Katalanos (1994) looked at traditional people who had immigrated from and were still very close to their collectivist roots. The findings and conclusions from these three researchers have provided excellent illustrations of the differences both among and within groups. I have included only brief summaries of their findings and strongly urge you to explore more about any individual culture that interests you, including and perhaps beginning with your own. As Hammerschlag (1988), a physician and psychiatrist who cared for and lived among American Indians for most of his career, wrote,

> What we see as science, the Indians see as magic. What we see as magic, they see as science. I don't find this a hopeless contradiction. If we can appreciate each other's views, we can see the whole picture more clearly (p. 14).

## Conclusion

I conclude this chapter with a quote from Irene Gonzales, RN, PhD, CNP (2002), a nursing professor at San Jose State University. She wrote a letter from the viewpoint of

a minority patient from a collectivist culture who had been severely injured in a car accident and had just been released from the hospital after five weeks. Though this letter does not refer to a dental patient, there are many parallels that apply to our care. Dr. Gonzales' last two paragraphs are especially poignant:

> Thank you for treating me and my family as a unique and vital part of the healthcare team. Even though I may appear very different from you on the outside or may respond to situations in a different way, I am still very much the same on the inside. You have demonstrated your care for me by how you treated my family and me during this very stressful time.
>
> Yes, even though I can't speak or understand English, I can definitely tell you how very grateful I am—with every fiber of my being—that you have given a piece of your life to me. Maybe someday you will need my help and I can be there for you. Stop and listen carefully. What you hear is our hearts and spirits connecting forever.
>
> Respectfully and gratefully,
>
> Your Patient for Today (p. 49)

That sums up what we are all about when we care for all kinds of people. Culture frames our lives and gives us rules to live by. We are mistaken when we assume that everyone has the same rules and then judge others based on that assumption. Culture is an integral part of and profoundly influences how illness is experienced and how we practice as health care providers. It is not a garment that we can put on and take off as we wish. It is with us always, even at work, so it is critical to understand our own and other cultures

as well as possible. To further understand, let's look more closely at how we communicate both with and without words.

## Glossary for Chapter 2

*Acculturation*: The degree to which a newcomer assimilates and adapts to a new environment.

*Autointoxication*: According to Payer (1988, 1996), to a British person this is a condition brought on by constipation in which toxins from the bowel are absorbed into the body.

*Chronemics*: The study of time in relation to culture. (Also see *Monochronic Time Orientation* and *Polychronic Time Orientation*)

*Collectivism*: Cultures in which the needs and interests of the group take priority over those of the individual people. (See *Individualism.*)

*Context*: The degree to which the participants and the setting influence communication. (See *High Context* and *Low Context.*)

*Cultural General Approach to study*: A broad approach to studying culture with a focus on understanding general characteristics and principles.

*Cultural Specific Approach to study*: A focus on studying individual cultures separately.

*Culture*: A subtle and constantly evolving pattern of learning that guides behavior, is passed from generation to generation, and includes social and religious structures, ways of communicating, thoughts, history, beliefs, values, roles, rules, and customs that are characteristic of groups of people.

*Culture Shock*: The distress that people feel upon entering a new environment.

*Direct Communication*: Interaction in which much of the message are verbally precise and detailed because less information is implied by the surroundings. (Also known as *Low Context.* Also see *High Context* and *Indirect Communication.*)

*Diversity*: Refers to difference between and among members of a variety of cultures and can refer to sex, age, educational level, educational specialty, socioeconomic status, mental and physical ability, and many other variables in addition to race, ethnicity, culture, and language.

*Ethnocentrism*: The concept that a person's own beliefs, values, attitudes, and practices are superlative and preferable to those of any other person or group.

*External Locus of Control*: A view that a person's life and health are controlled by outside forces such as God, fate, chance, or luck. Common in collectivistic cultures. (See *Internal Locus of Control*)

*Hersinsuffizienz*: According to Payer (1988, 1996), to a German person this is a mild heart insufficiency, that in its more advanced stages might be called heart failure.

*High Context*: Cultures in which much of the message is implied by the participants, their relationships, the setting, and other nonverbal features. (Also known as *Indirect Communication*. Also see *Low Context* and *Direct Communication*.)

*Indirect Communication*: Interactions in which much of the message is implied by the participants, their relationships, the setting, and other nonverbal features. (Also known as *High Context*. Also see *Low Context* and *Direct Communication*.)

*Individualism*: Cultures in which the needs and interests of individual people take priority over those of the group as a whole. (See *Collectivism*.)

*Intercultural Communication Competence*: The ability to set aside one's ethnocentrism, communicate with honor and respect, and attempt to understand others in spite of diversity.

*Internal Locus of Control*: A view that the individual person is in control of her/his environment and health and so has the ability to make changes in themselves and the events that impact them. (See also *External Locus of Control*)

*Locus of Control*: The degree to which a person feels in control of life events. (See *External Locus of Control* and *Internal Locus of Control*)

*Low Context*: Cultures in which much of the message must be more verbally precise and detailed because less information is implied by the surroundings. (Also known as *Direct Communication*. See *High Context* and *Indirect Communication*.)

*Monochronic Time Orientation* (*M-time*): A linear view of time that focuses on accomplishing tasks one at a time. (See *Polychronic Time Orientation*)

*Polychronic Time Orientation* (*P-time*): A circular, holistic view of time more commonly seen in collectivistic cultures. (See *Monochronic Time Orientation*)

*Terrain*: According to Payer (1988, 1996), to a French person this means constitution, or the body's natural ability to fend off disease.

*Wastebasket Diagnosis*: According to Payer (1988, 1996), a catch-all cause or condition that people think explains most of their vague and relatively mild health symptoms, such as aches and fatigue, that cannot be attributed to any other cause.

# Resource Lists for Chapter 2

## *Note Regarding Resource Lists*

*Disclaimer*: Though I try to list materials from reliable sources only, I do not endorse and cannot guarantee the accuracy or comprehensiveness of any information or service.

*Also*: This list is by no means complete and it can never be 100% accurate due to the changeable nature of websites. Nevertheless, there should be many helpful publications and active links to help you find what you need. Please let me know which sites are most helpful, and/or which other sites you like so I may add them to this list: tonisadamsrdh@earthlink.net

## *Online Cultural Resources*

American Indian Health information at www.ldb.org/vl/geo/america/2usa-ind.htm

Culture Clues, 2-page communication tip sheets for 10 different cultures (including deaf and hard-of-hearing) from the University of Washington Medical Center at http://depts.washington.edu/pfes/cultureclues.html

Culture, Health and Literacy, health education materials for caregivers and adults with limited English literacy skills, listed by topic and group from World Education at http://healthliteracy.worlded.org/docs/culture/index.html

Culturegrams, series of 4-page cultural summaries of over 200 countries, all US states, and 13 Canadian provinces and territories, available for purchase/download, US$4.00 each as of 8/08 at http://www.culturegrams.com/

CulturedMed, resource of cultural information sponsored by the SUNYIT (State University of New York Institute of Technology), highly recommended site with extensive lists and links to a variety of other resources at http://web2.sunyit.edu/library/culturedmed/

Diversity Rx, sponsored by The National Conference of State Legislatures, Resources for Cross Cultural Health Care, and the Henry J. Kaiser Family Foundation at http://www.diversityrx.org/HTML/DIVRX.htm

Educational Programs, online learning from the United States Department of Health and Human Services at http://www.thinkculturalhealth.org/

Ethnomed, Health information about cultural issues and specific groups from the University of Washington at http://ethnomed.org/

Exploring Nonverbal Communication, from the University of California, Santa Cruz's division of Social Sciences. It is an explanation of videos that are for sale, but also includes lots of other information and some interesting self quizzes at http://nonverbal.ucsc.edu/

Mother's Wisdom Breast Health Program for American Indian/Alaska Native women at http://www.ucdmc.ucdavis.edu/synthesis/features/outreach.html

National Center for Cultural Competence, hosted by Georgetown University's Center for Child and Human Development: http://www11.georgetown.edu/research/gucchd/nccc/index.html

The Providers' Guide to Quality and Culture, excellent extensive website, resources galore at http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&group=&mgroup=

Transcultural and Multicultural Health Links from the New Mexico State University Library at http://web.nmsu.edu/~ebosman/trannurs/index.shtml

US Department of Agriculture links to ethnic and specialized food pyramids at http://www.nal.usda.gov/fnic/etext/000023.html

### *Readings on the American Culture*

Datesman, M. K., Crandall, J., & Kearny, E. N. (1997). *The American Way* (2nd ed.). White Plains, NY: Longman.

Spradley, J. P., & Rynkiewich, M. A. (1975). *The Nacirema: Readings on American culture.* Boston: Little, Brown and Company.

Wanning, E. (2000). *Culture Shock! USA.* Portland, Oregon: Graphic Arts Center Publishing Company.

### *Readings on Culture and Health*

Alvord, L. A, & Van Pelt, E. C. (1999). *The scalpel and the silver bear: The first Navajo woman surgeon combines Western medicine and traditional healing.* New York: Bantam Books.

D'Avanzo, C. E. (2008). *Mosby's Pocket Guide to Cultural Health Assessment* (4th ed.). St. Louis, MO: Mosby Elsevier.

Downes, N. J. (1997). *Ethnic Americans for the health professional* (2nd ed.). DuBuque, IA: Kendall/Hunt Publishing Company.

Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures.* NY: The Noonday Press.

Galanti, G.-A. (1997). *Caring for patients from different cultures: Case studies from American hospitals* (2nd ed.). Philadelphia: University of Pennsylvania Press.

Hammerschlag, C. A. (1988). *The dancing healers: A doctor's journey of healing with Native Americans.* San Francisco: Harper.

Lipson, J. G., & Dibble, S. L. (Eds.) (2005). *Culture and nursing care: A pocket guide.* San Francisco: UCSF Nursing Press.

Storti, C. (1999). *Figuring foreigners out: A practical guide.* Boston: Intercultural Press.

## *References for Developing Cultural Self-Awareness*

Goldman, R. E., Monroe, A. D., & Dubé, C. E. (1996). Cultural self-awareness: A component of culturally responsive patient care. *Annals of Behavioral Science & Medical Education, 3*, 37-46.

Mutha, S., Allen, C., & Welch, M. (2002). *Toward culturally competent care: A toolbox for teaching communication strategies*. San Francisco, CA: Center for the Health Professions, University of California, San Francisco.

Thiederman, S. (2005). *American culture: Knowing yourself in order to understand others*. Retrieved November 7, 2005, from http://www.thiederman.com/articles_detail.php?id=37

## References for Chapter 2

Airhihenbuwa, C. O., & Obregon, R. (2000). A critical assessment of theories/models used in health communication for HIV/AIDS. *Journal of Health Communication, 5*(Suppl.), 5-15.

Beamon, C., Devisetty, V., Forcina Hill, J. M., Huang, W., & Shumate, J. A. (2005). A guide to incorporating cultural competency into medical education and training. *National Health Law Program.* Retrieved July 11, 2008, from http://www.healthlaw.org/library

Beebe, S. A, & Biggers, T. (1986). The status of the introductory intercultural communication course. *Communication Education, 35*, 56-60.

Brislin, R. (1993). *Understanding culture's influence on behavior.* Fort Worth: Harcourt Brace College Publishers.

Burgoon, J. K., Buller, D. B., & Woodall, W. G. (1996). *Nonverbal communication: The unspoken dialogue* (2nd ed.). New York: The McGraw-Hill Companies, Inc.

Committee on Pediatric Workforce (2004). Ensuring culturally effective pediatric care: Implications for education and health policy. *Pediatrics, 114*, 1677-1685.

Connolly, I. M., Darby, M. L., Tolle-Watts, L., & Thomson-Lakey, E. (2000). The cultural adaptability of health sciences faculty. *Journal of Dental Hygiene, 74*, 102-109.

Datesman, M K., Crandall, J., & Kearney, E. N. (1997). *The American Ways: An introduction to American culture* (2nd ed.). White Plains, NY: Longman.

Davis, A. J. & Konishi, E. (2007). Whistleblowing in Japan. *Nursing Ethics, 14*, 194-202.

Dhir, I., Tishk, M. N., Tira, D. E., & Holt, L. A. (2002). Ethnic and racial minority students in U.S. Entry-level dental hygiene programs: A national survey. *The Journal of Dental Hygiene, 76*, 193-201.

Dowd, S. B., Giger, J. N., & Davidhizar, R. (1998). Use of Giger and Davidhizar's transcultural assessment model by health professions. *International Nursing Review, 45*, 119-122, 128.

Fitch, P. (2004). Cultural competence and dental hygiene care delivery: Integrating cultural care into the dental hygiene process of care. *The Journal of Dental Hygiene, 78*, 11-21.

Garcia, R. I. (2005). Addressing oral health disparities in diverse populations (guest editorial). *Journal of the American Dental Association, 136*, 1210, 1212.

Gibson, S., & Zhong, M. (2005). Intercultural communication competence in the healthcare context. *International Journal of Intercultural Relations, 29*, 621-634.

Gonzales, I. (2002). Even though I don't speak English: A letter to every healthcare provider. *Critical Care Nurse, 22*(4), 47-49.

Gudykunst, W. B., & Lee, C. M. (2002). Cross-cultural communication theories. In: W. B. Gudykunst and B. Mody (Eds.), *International and intercultural communication* (2nd ed., pp. 25 50). Thousand Oaks, Ca: Sage Publications.

Hall, E. T. (1959, 1990). *The silent language*. New York: Anchor Books.

Hall, E. T. (1983; 1989). *The Dance of Life*. New York: Anchor Books.

Hall, E. T. (2000). Context and meaning. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural communication: A reader* (9th ed., pp. 34-43). Belmont, CA: Wadsworth Publishing Company.

Hall, E. T., & Hall, M. R. (2002). Key concepts: Underlying structures of culture. In J. N. Martin, T. K. Nakayama, & L. A. Flores (Eds.), *Readings in intercultural communication experiences and contexts* (2nd. ed., pp. 165-172). Boston: McGraw Hill.

Hofstede, G. (1997). *Cultures and organizations: The software of the mind.* New York: McGraw-Hill.

Huff, R. M., & Kline, M. V. (1999). Health promotion in the context of culture. In D. J. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 3-22). Thousand Oaks, CA: Sage Publications.

Katalanos, N. L. (1994). *When yes means no: Verbal and nonverbal communication of Southeast Asian refugees in the New Mexico health care system*. Unpublished masters thesis, University of New Mexico, Albuquerque.

Klyukanov, I. E. (2005). *Principles of intercultural communication*. Boston: Pearson Education, Inc.

Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine, 78*, 577-587.

Knowles, E. (Ed.). (1999). *The Oxford dictionary of quotations* (5th ed.). Oxford: University Press.

Kreps, G. L., & Thornton, B. C. (1992). *Health communication theory & practice* (2nd ed.). Prospect Heights, IL: Waveland Press, Inc.

Leeds-Hurwitz, W. (1990). Notes in the history of intercultural communication: The Foreign Service Institute and the mandate for intercultural training. *Quarterly Journal of Speech*, 76, 262-281.

Lyman, R. (2006, August 15). New data shows immigrants' growth and reach. *The New York Times*, A-1.

Luckman, J. & Nobles, S. T. (2000). *Transcultural communication in health care*. Albany, NY: Delmar.

Ludenia, K., & Donham, G. W. (1983). Dental outpatients: Health locus of control correlates. *Journal of Clinical* Psychology, 39, 854-858.

MacLennan, J. (2002). There's a lizard in my living room and a pigeon in my classroom: A personal reflection on what it takes to teach in a different culture. *Journal of Intercultural Communication Research, 32*, 13-28.

Magee, K. W., Darby, M. L., Connolly, I. M., & Thomson, E. (2004). Cultural adaptability of dental hygiene students in the United States: A pilot study. *The Journal of Dental Hygiene, 78*, 22-29.

Milgrom, P., Garcia, R. I., Ismail, A., Katz, R. V., & Weintraub, J. A. (2004). Improving America's access to care: The National Institute of Dental and Craniofacial Research addresses oral health disparities. *Journal of the American Dental Association, 135*, 1389-1396.

Moch, S. D., Long, G. L., Jones, J. W., Shadick, K., & Solheim, K. (1999). Faculty and student cross-cultural learning through teaching health promotion in the community. *Journal of Nursing Education, 38*, pp. 238-240.

Morey, D. P., & Leung, J. J. (1993). The multicultural knowledge of registered dental hygienists: A pilot study. *Journal of Dental Hygiene, 67*, 180-185.

Network Omni: Multilingual Communications (2006). *Caring with CLAS: Cultural competence in health care*. Author. Retrieved October 13, 2007, from http://www.dhh.louisiana.gov/offices/miscdocs/docs-90/Caring%20with%20CLAS%20-%20Legislative%20Fact%20Sheet.pdf

Newman, L. (2001). Lynn Payer. *British Medical Journal, 323(7317)*, 871.

Northouse, L. L., & Northouse, P. G. (1998). *Health communication: Strategies for health professionals*. Stamford, CT: Appleton & Lange.

Payer, L. (1988, 1996). *Medicine and culture: Varieties of treatment in the United States, England, West Germany, and France*. New York: Henry Holt and Company.

Rao, N. (2003). "Half-truths" in Argentina, Brazil, and India: An intercultural analysis of physician-patient communication. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (10th ed., pp. 309-319). Belmont, CA: Wadsworth.

Regis, D., Macgregor, I. D. M., & Balding, J. W. (1994). Differential prediction of dental health behaviour by self-esteem and health locus of control in young adolescents. *Journal of Clinical Periodontology, 21*, 7-12.

Rhine, R. D. (1989). William Graham Sumner's concept of ethnocentrism: Some implications for intercultural communication. *World Communication, 18*, 1-10.

Robinson, J. H. (2003). Communication in Korea: Playing things by eye. In L. A. Samovar and R. E. Porter (Eds.), *Intercultural communication: A reader* (10th ed., pp. 57-64). Belmont, CA: Wadsworth/Thomson Learning.

Rogers, E. M., Hart, W. B., & Miike, Y. (2002). Edward T. Hall and the history of intercultural communication: The United States and Japan. *Keio Communication Review*, 24, 3-26. Retrieved May 8, 2006, from http://www.mediacom.keio.ac.ip/publication/pdf2002/review24/2/pdf

Roter, D. L., & Hall, J. A. (1993). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits.* Westport, CT: Auburn House.

Rynkiewich, M. A., & Spradley, J. P. (1975). The Nacirema: A neglected culture. In: M. A. Rynkiewich & J. P. Spradley (Eds.), *The Nacirema* (pp. 1-5). Boston: Little, Brown and Company.

Sartory, G., Heinen, R., Pundt, I., & Johren, P. (2006). Predictors of behavioral avoidance in dental phobia: The role of gender, dysfunctional cognitions and the need for control. *Anxiety, Stress and Coping, 19*, 279-291.

Shin, H. B., & Bruno, R. (2003). Language use and English-speaking ability: 2000, Census 2000 brief. *U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration*. Retrieved August 12, 2008, from http://www.census.gov/prod/2003pubs/c2kbr-29.pdf

Sisty-LePeau, N. (1993). Oral healthcare and cultural barriers. *Journal of Dental Hygiene, 67*, p. 156.

Smedley, B. D., Stith, A. Y., & Nelson, A. R., 2003 (Eds.). Executive summary of *Unequal treatment: What healthcare providers need to know about racial and ethnic disparities in healthcare*. Washington, DC: The National Academies Press. Retrieved October 23, 2005, from http://www.nap.edu/catalog/10260.html

Storti, C. (1999). *Figuring foreigners out: A practical guide*. Boston: Intercultural Press.

Sumner, W. G. (1906). *Folkways*. Boston: Ginn and Company.

Thiederman, S. (2005). *American culture: Knowing yourself in order to understand others*. Retrieved November 7, 2005, from http://www.thiederman.com/articles_detail.php?id=37

Triandis, H. C. (2003). Culture and conflict. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (10th ed., pp. 18-28). Belmont, CA: Wadsworth.

U.S. Department of Health and Human Services (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health (2000). *Oral health in America: A report of the Surgeon General: Executive summary*. Rockville, MD: Author. Retrieved June 17, 2005, from http://www.nidcr.nih.gov/AboutNIDCR/SurgeonGeneral/

U.S. Department of Health and Human Services, Health Resources and Services Administration (2005). *Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence*. Rockville, MD: Author. Retrieved May 14, 2007 from http://www.hrsa.gov/culturalcompetence/curriculumguide/default.htm

U.S. Department of Health and Human Services, Office of Minority Health (2001). *National standards for culturally and linguistically appropriate services in health care: Executive summary*. Rockville, MD: Author. Retrieved October 23, 2005, from www.omhrc.gov/assets/pdf/checked/executive.pdf

Vandello, J. A. & Cohen, D. (1999). Patterns of individualism and collectivism across the United States. *Journal of Personality and Social Psychology, 77*, 279-292.

Voelker, R. (1995). Speaking the languages of medicine and culture. *Journal of the American Medical Association, 273*, 1639-1641.

Wanning, E. (2000). *Culture Shock! USA*. Portland, Oregon: Graphic Arts Center Publishing Company.

Yamaguchi, Y., & Wiseman, R. L. (2003). Locus of control, self-construals, intercultural communication effectiveness, and the psychological health of international students in the United States. *Journal of Intercultural Communication Research, 32*, 227-245.

# Chapter 3
# Verbal Communication: The Language of Health Care

Learning Objectives For Chapter 3

After reading this chapter you should have:

1. Gained basic knowledge of the history and characteristics of language
2. Been introduced to the role of language and verbal communication in the dental office
3. Acquired insight into the problem of Low Health Literacy (LHL) in dentistry
4. Learned some strategies to apply when communicating with people with Limited English Proficiency (LEP)

My young son
Came through the door,
He was cryin' like I'd never heard before.
His friend Tim
Had taunted him,
And the hateful words lay scattered on the floor.

from *Lay It Down*, lyrics and music by Linda Allen

Language is what made us human. Everything we have ever achieved originates from it.

G. Deutscher, *Unfolding of Language*

## Introduction

Words, words, words. They fascinate and confound us. They bring us together and keep us apart. They make us human but they also allow us to be inhumane. We may say, "Sticks and stones may break my bones, but words can never hurt me," yet we know that in truth, "The pen is mightier than the sword" and that words really can hurt a great deal. This is as true in health care as it is in life. Language and the ability to use it to communicate are tools, parts of our armamentarium, just as fundamental and essential to dental practice as a mouth mirror, compressed air, water, and suction. We are unable to make the best use of our fancy, expensive, manufactured tools, not to mention our knowledge, unless we are proficient with language. So it is important to understand how

we use words and language to communicate verbally. In this chapter, we will look briefly at the history of language, its characteristics, and how we make meaning with it. Then we will explore its use in health care and the challenges faced by those who are unable to use it well: people with low health literacy and/or limited English proficiency.

## History of Language

No one knows when human beings began to speak. Various scholars place the time anywhere from 40,000 to 1.5 million years ago (Bryson, 1990; Deutscher, 2005). Once language use began, it proliferated and multiplied to the current 6,900 plus languages and dialects in the world (Gordon, 2005). The beginning of English, on the other hand, is a little easier to pin down. Scholars date the earliest English, a derivative of German, to about 1500 years ago, and the beginnings of modern English to about 500 years ago (Bryson).

*Explore some more*:
For a concise summary of the development of the English language, see:
http://www.englishclub.com/english-language-history.htm

Nowadays, English is described with many superlatives derived from more than just ethnocentrism. It includes a stunningly large vocabulary, with as many as 750,000 words in an unabridged dictionary (Ling, 2001). Some scholars claim that English has, or is close to having, one million words, not including technical and scientific terms, which could easily add another million (Countdown..., 2008; Deutscher, 2005; Ling; Sheidlower, 2006). Of those, about 200,000 are in common use, many more than the 184,000 in German, and double the 100,000 in French (Deutscher). This extensive vocabulary is matched only by widespread use.

Twenty-five percent of the world's population speaks English. That's 1.35 billion people who claim it as their first, second, or subsequent language (Countdown..., 2008), and so it is spoken and written more than any other (Ling, 2001). Today, it is the common language of business, science, aeronautics, education, politics, entertainment, electronics, and medicine (Bryson, 1990; Deutscher, 2005). The six *non-English speaking* member countries of the European Free Trade Association conduct all their business in English (Bryson). A Japanese medical student who stayed in our home during an exchange in the 1980s told us that all of his medical textbooks were written in English. There are more people studying English in China than there are people in the United States (Deutscher)! Even though this is the state of English language use in the early 21st Century, history tells us that language evolution is unpredictable, so we cannot count on this trend to continue forever (Baron, 2007). Regardless of how language changes, we are forced to deal with our current circumstances. In order to gain further insight as to why our words may be misunderstood, it is important to be aware of three characteristics of language: its symbolic nature, ambiguity, and continuous development.

## Characteristics of Language

### *Language Is Symbolic*

Language is a symbol system, which Deutscher (2005) described as its "quintessential quality" (p. 14). We use symbols (words) to exchange information and create meaning. A ***symbol***, of course, is something that stands for something else. Though we may not have thought of words as symbols, we are familiar with all kinds of nonverbal symbols. Flags represent countries, certain emblems represent religions, a red

light means stop, and a green light means go. However, flags and religious emblems can arouse a variety of conflicting opinions and emotions and colors can have many meanings. In the United States, red is the color of passion and love, but when we are angry we "see red," and when we owe money we are "in the red." In China, red represents prosperity and rebirth and is used on happy occasions, but Korean Buddhists use red ink only to write the name of a person who has died (deVito, 2001; Dreyfuss, 1984).

A word symbol can be equally confusing because, like a nonverbal symbol, there is no inherent relationship between a word and its meaning. Shakespeare's Juliet said it best, "What's in a name? A rose by any other name would smell as sweet." A rose could just as easily have been called a "ball" or a "table" and it would still be the same flower. Because language is symbolic, it can be individual; different words can have different meanings for different people. As a young person, I shared an apartment with three friends, including a young woman from Finland. My Finnish friend, Eva, spoke perfect classic English, but was unfamiliar with our slang. Another roommate decided that Eva's vocabulary was not complete until she could swear in English. After very little of this "education," we were shocked to hear Eva spout swear words right and left without reservation. To her, they were just sounds and did not have the same symbolism and deep cultural meaning that left the rest of us with our mouths open. Symbolism is only one characteristic that makes language complex.

*Language Is Ambiguous*

Words often have multiple meanings. This particular problem with English can confound both native speakers and new learners alike. Individual words can have many meanings, many words can mean the same thing, and pairs of words can sound the same but not mean the same thing. We track our countless synonyms in a thesaurus, a reference that no other language has or even needs (Deutscher, 2005). We even make games out of the many meanings of English words.

I love word puzzles. For me, one of the most enjoyable challenges when completing a puzzle is trying to decide what form of the word the clue refers to. Take a simple clue like *work*. Does it refer to the noun version and thus mean labor, toil, exertion, effort, employment, occupation, profession, vocation, job, task, duty, project, assignment, or chore? Or does it refer to the verb version and possibly mean to cultivate, function, operate, succeed, arrange, stir, knead, or maneuver? Its meaning is expanded when it is used in phrases and in slang. *Work on* means to persuade, manipulate, or coach; *work out* means to develop, understand, solve, or exercise; *work up* means to excite, agitate, or create; *work over* means to threaten, intimidate, or beat someone but also to revise or improve something; and to *shoot the works* is to do everything or to bet all your money. *Grunt work* is menial labor; *legwork* is the physical part of a task; *water works* are either a public utility or tears; if you ask for *the works*, it means you want everything; and if we bring a computer with us when we take a holiday we describe it with the oxymoronic phrase, *working vacation*. It's a wonder we can communicate at all. Such is the confusion for people who endeavor to master the English language!

The specialized language of health care can be even more bewildering. Imagine having limited language or English skills and trying to complete a health history form. These forms contain numerous words that may mystify a layperson. What do *antibiotic premedication*, *immunocompromised*, *osseous surgery*, *abrasion*, *lesion*, *malignant*, *benign*, *congenital*, and *bisphosphonate* mean? What is the difference between *bladder* and *gall bladder*? Does *hormone* mean the female hormones used in hormone replacement therapy or the illegal steroid hormones used by athletes to pump up their performance? Besides the medical language of the health history form, patients must also decipher the legal language of HIPAA, insurance, and consent to treatment forms. If someone doesn't understand the language, have they really consented to treatment? This is an ethical as well as a practical issue.

The spoken language and dental office jargon can also be confounding. Your patient might hear you explain to a colleague that you had a difficult time accessing that burnished piece of calculus that was five millimeters subgingival at the distal buccal line angle of mesioverted tooth number two. What?! Many of those sounds/words/symbols have no meaning whatsoever to an outsider. Calculus is higher math and a buckle holds a belt together, right? It depends on your experience and the context in which the words are spoken. Even the words *positive* and *negative* might be confusing. A negative result from a biopsy, meaning no malignant cells were found, is a positive outcome and good news. Conversely, a positive finding is a negative outcome. So we must be aware not only of how we use words when speaking with patients and writing forms, but we also must keep

track of how those dictionary, personal, medical, legal, and dental meanings, can develop and change.

*Language Evolves*

As if it weren't confusing enough for our words to have multiple meanings, language also evolves over time. Proper pronunciation and syntax are altered, words are deleted or take on different meanings, and new words are added (Deutscher, 2005). We no longer say "thee" and "thou" and find it difficult to read the original forms of *Beowulf* or Chaucer or Shakespeare. We have vast new vocabularies that have grown out of our expanding technologies. Only a few years ago there were no such things as email, text messaging, blogs, cell phones, the internet, or Google, and a *yahoo* was a cheer of joy or a crude and violent creature in Johathan Swift's *Gulliver's Travels.*

The languages of health care and dentistry have also evolved. When I first entered the dental field in 1971 we had not heard of CPR (cardiopulmonary resuscitation), GTR (guided tissue regeneration), PPO (preferred provider organization), or HIPAA (Health Insurance Portability and Accountability Act). As recently as the 1960s, medical schools referred to the patient interview as an *interrogation* (Weston, 2001); this developed into *taking* a medical history; but the latest notion, in line with patient-centered care, is to *build* a cooperative history (Haidet & Paterniti, 2003). As mentioned earlier, the correct terms today are *biofilm* instead of *plaque* and *debridement* instead of *curettage*. The next logical question after considering the symbolic, ambiguous, and evolutionary characteristics of language, is, "How do people attach meaning to words?"

*Take time to think and talk*:
Think about how you use language. What words or terms from the past do you no longer use and what new ones do you use now? Think of terms from daily life as well as from dentistry. Now ask a friend to do the same thing and discuss your thoughts.

Making Meaning With Language: Semantic Triangle and Semantic Diamond

Several theorists have suggested how word meanings arise. Ogden and Richards developed the ***Semantic Triangle*** (Griffin, 2000) to explain the phenomenon. The best way to describe this concept is to illustrate it. Complete this exercise along with at least two other friends. First, agree upon a simple object, such as a "flower" or a "ball." Second, on separate sheets of paper and out of sight of the others, ask each person to draw a triangle with a horizontal bottom line. Sketch a picture of a face above the top angle, write the word that you all chose outside of the angle on the left, and draw a simple picture of what the word represents outside of the angle on the right.

Compare diagrams and pictures. Let's say you and your friends chose the word, "ball." Did everyone draw the same ball? Probably not. There might have been a soccer ball, football, basketball, tennis ball, beach ball, bowling ball, golf ball, ball bearing, or ball of string. That is the point that Ogden and Richards tried to make; the same word conjures up different meanings for different people. It also illustrates the symbolic nature of language; a word symbol does not necessarily have any relationship to the item it represents.

Stoner (Personal Communication, September 11, 2007) expanded this concept. He noticed that the semantic triangle represents only one person's idea. So, while it explains how individuals apply meaning to words, it does not actually represent communication

with others. To develop a model that does represent communication, Stoner added a second triangle to create the ***Semantic Diamond***. The semantic triangle represents thought, the relatively passive process of creating meaning within one person's brain. The semantic diamond represents a dynamic interaction of meaning making between and among people.

To complete the exercise, return to your original illustration. Now draw a mirror image triangle beneath the first one, using the base of the first as the top of the second. You should end up with a diamond shape. Now sketch another face beneath the new angle at the bottom of the diamond. This represents a second person, which allows for an interaction. The individuals at the top and bottom of the diamond use communication to come to agreement on the word and the word representation at the sides of the diamond. The right and left angles from the original triangle have opened up to double their original size, representing the broader spectrum of possible meanings now available to both people in an exchange.

A communication process can be challenging when using relatively concrete words such as *ball* and *flower*. Imagine now that we try to create consensus about abstract terms such as *happiness*, *fear*, *pain*, or *health*. We ask a patient, "How is your health?" If we apply this question and the conversation surrounding it to the semantic diamond, we can see the concept in action. Draw a new diamond on a fresh sheet of paper, place your patient at the top and you at the bottom and add the word *health* to the left. In this case, the point of your conversation is to determine the exact meaning of the word for this person in this context so that we can symbolically complete the picture to the right of the

diamond. This word/symbol/concept is flexible so the meaning can change depending on the person and the day. Perhaps the person is under undue stress or unable to control her diabetes. Our ultimate goal is to try to understand the other person's interpretation of the concept and then apply that understanding so we can develop and explain our treatment plans for the appointment. Sometimes we reach agreement easily; sometimes we never do. Problems happen when we incorrectly assume agreement. Our job is to enlighten patients in order to help them reach the highest possible level of health, but we cannot do that unless we understand each other's interpretations of words that represent concepts like *health.*

As with many models, this is a simplified version of what happens. Obviously, we are continuously trying to reach agreement about many words and concepts simultaneously, and sometimes more than two people are involved. Some agreements will come easily. Some people may never achieve agreement. Obviously we do not have time to follow this process for every single word we speak throughout the day. Much of the time we must assume agreement, which is when we need to choose our words carefully to be sure that the message sent is the message received.

## Language and Words in Health Care and Dentistry

Our words can be as frightening to patients as some of our other tools, or they can inform and calm. I always cringe when I hear a parent tell a child that receiving dental treatment "won't hurt." The child may never have considered the possibility of pain if s/he had not heard the word, "hurt." On the other hand, people may not take their conditions very seriously if we say, "You have 'a little bleeding.'" But if we tell them,

"Your gums are 'hemorrhaging,'" we are more likely to get their attention. Similarly, I prefer the term *reception area*, with its welcoming connotation, to the term *waiting room*; I like to say that the care we deliver for people is *treatment* instead of *work*; and I feel that dental hygienists are *educated* rather than *trained.*

Words evoke the power of suggestion, which can be used positively. Consider this anonymous quote, "The difference between crisis and opportunity is attitude," meaning that the word you use influences how you feel about and respond to an issue. So, according to this writer, if you think of a challenge as a *crisis*, then it is. If you change your view and call it an *opportunity*, then you could be on your way to creating a positive experience. When patients are tense and I see the shoulders moving toward the ears, I quietly and calmly say, "Relax your shoulders, relax your neck." And they do! It works for them and it works for me as a self-suggestion. Admit it, many of you who read this just relaxed your shoulders and necks. It is amazing what saying a few words can do. The name/label you give to a person can also influence your opinion of that person, and this is the basis of a long-standing debate in health care and dentistry.

*Patient Versus Client*

In the early 1970s, several nursing theorists suggested that the people who receive health care should be called *clients* rather than *patients* (Wing, 1997). They argued that the term, *patient*, has a passive and dependent connotation that seems inappropriate for people who we hope will become involved in their own care, and that the term, *client*, indicates a more equal relationship between caregiver and care receiver and reflects the tenets of patient-centeredness. Those who advocate for *patient* contend that *client* has a

financial and impersonal implication that demeans the special relationships that are formed in the provision of health care.

To this day nurses advocate the use of *client* (DeLaune & Ladner, 2002), while physicians tend to side in the *patient* camp (Wing, 1997). The discussion has expanded to other countries, where researchers surveyed the greatest stakeholders in the issue, the patients/clients themselves. People receiving mental health care in the United States overwhelmingly prefer to be called *clients* (Covell, McCorkle, Weissman, Summerfelt, & Essock, (2007). On the other hand, back-pain sufferers in Canada (Wing) and hospital passersby in Australia (Nair, 1998) and Trinidad (Ramdass et al., 2001) just as overwhelmingly prefer to be called *patients*. Some people are more concerned with how they are treated rather than which word is used and are happy with, "Any heading said politely" (Nair, p. 593).

This is also a topic of discussion in dental hygiene. More recent graduates who I have met tend to use, or say that they have been educated to use, the term *client*, but we seasoned practitioners seem to stick with using *patient*. (You may have noticed that I use *patient* throughout this book, so my bias is clear.) The discussion on a dental hygiene listserv revealed varying feelings about the issue. The discussion began with, "I learned in school that you are supposed to call your clients clients....(but the dentist says) that I am not supposed to call them clients but patients" (Fkitten, 2005). Two typical responses were, "Calling patients clients makes the hair stand up on the back of my neck. It bothers me no end" (Ranno, 2005); and "Regardless of whatever name is used they all still get the same treatment from me....kindness, courtesy, professionalism, (and) knowledgeable,

thorough care" (Goldman, 2005). So the debate continues. What is the answer? That is a personal decision. Perhaps the most important thing is that there *is* a debate because we recognize the power that people invest in words. That power extends to diagnosis.

*Naming Illness*

Patients seem to crave information and often do not get as much as they want (Ong, de Haes, Hoos, & Lammes, 1995). Many come with lists of questions derived from personal experience, television, publications, or the internet, and appear to soak up the information that we share with them. One of their greatest desires is to know the names of their conditions or illnesses, their diagnoses (Korsch, Gozzi, & Francis, 1968; Ogden et al., 2003; Wood, 1991). Dental hygienists don't diagnose, but we do care for people who have been diagnosed with a variety of health problems and many of them look to us for more information, so it is important to consider the possible implications of speaking the words that surround those diagnoses.

People can have mixed feelings about labeling their conditions. On the one hand, naming an illness legitimizes it, organizes the symptoms, and often defines a plan to deal with it. On the other hand, a serious diagnosis can be devastating. For many people, it is shocking and upsetting to hear the words diabetes, kidney disease, hepatitis, or cancer applied to them and some cannot even bring themselves to verbalize the name of an illness (Wood, 1991). However, one patient was actually relieved to hear that he had multiple sclerosis rather than the unnamed odd collection of symptoms that no one seemed to take seriously (Novack, 1995), and a young woman diagnosed with cervical cancer was thankful that she did not have the more stigmatized venereal disease (Wood).

Diagnostic naming can also vary among generations and cultures. My mother grew up in the 1920s and 1930s, and remembers when it was improper to say, *underwear*; you said *unmentionables* instead. I grew up in the 1950s and 1960s when people did not say the word *cancer*; we called it *The Big C*. In the Navajo tradition, "the word is equal to the thing" (Bulow, 1991, p. 115), and "speaking a thought into the air gives it more power" (Alvord, 1999, 2000, p. 36). This is also true for other American Indian and Alaska Native cultures and the reason why none of them even have a word for cancer. In a survey of physicians from 20 countries and areas of the world, oncologists from Africa, France, Hungary, Italy, Japan, Panama, Portugal, and Spain reported that they preferred not to say the word *cancer* when making a diagnosis and substituted it with words like *swelling* or *inflammation* (Holland, Geary, Marchini, & Tross, 1987). An interpreter, in the course of doing her job, revealed a Russian man's cancer diagnosis to him. The man's son was furious. "Do you understand what this means to a Russian man? It means you've just given him a death sentence. He is going to lose all hope, he's going to stop eating, he's going to stop drinking, he's just going to curl up in a corner and die. You've just ruined two years of us carefully hiding this from him" (Dohan & Levintova, 2007).

On the other hand, sometimes we must say a word in a certain way to get someone's attention. I once found a "suspicious lesion" on a 40 year-old mother of three. She had an unusual bump of bone on the buccal aspect of her maxilla around the area of teeth numbers 12 and 13. The dentist had referred her to the oral surgeon but she postponed going, no matter how much I explained its importance in every way I could

think of over a period of several months. Finally, a new hygienist who was observing me when this patient was in my chair blurted out, "It could be cancer!" For some reason, neither the dentist nor I had been that straightforward, though we had informed her that the lesion could be cancerous, we had just not said it with such emphasis, and that was what this particular woman needed to hear. She saw the oral surgeon, was diagnosed with osteosarcoma, bone cancer, received treatment, and healed. She was well when I left that practice, about 7 years after her original diagnosis. Every time I saw her after she completed treatment she thanked me for saving her life, and the experience became one of the most meaningful of my 26-year career. However, I felt that the credit and the responsibility were shared. I found the lesion, but my colleague said the word in just the right way to finally prompt the patient to do something about it.

The lesson I took from this experience is that sometimes you need to approach certain words with caution, and sometimes you need to be blunt and forceful, and it isn't always easy to determine which is which. Wood (1991) wrote, "When physicians name illness, it is helpful for them to give due philosophical consideration to the possible effect of that name on their patients. It would also be wise for them to critically appraise their communication style and the many extraneous pressures which influence their use of words" (p. 538). We are not physicians, but we do discuss intimate and potentially devastating diagnoses that patients have heard from others, so we must be aware of how we use words.

For the first half of this chapter I have discussed how language and words impact practice, referring mostly to spoken words. Now I expand to also include the written

word as I discuss health literacy, limited English proficiency, and how to work with interpreters.

## Literacy

Literate abilities are a virtual necessity for success in the modern world. In regards to the United States, ***literacy*** is defined as, "an individual's ability to read, write, and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential" (National Literacy Act, 1991). Note that spoken interactions are also components of literacy. People who are poor oral communicators are less able to express themselves clearly and remember information and instructions. People who do not read, write, and compute well are limited in their ability to comprehend printed information, and so to use and/or enjoy newspapers, novels, letters, recipes, signs, maps, bus schedules, graphs, job applications, food packages, medicine labels, appointment reminders, written directions, email messages, or most of what is on the internet. Thus, poor literacy has massive implications for their well being.

According to a report from the National Center for Education Research, even though literacy levels in the United States have continuously improved over the last 200 years, 46-51% of Americans, about 90 million people, still struggle to function with limited or severely limited literacy. About 40-44 million in that group are functionally illiterate, meaning that they cannot complete a job application or read a simple story to a child. Lower literacy tends to be associated with less education, older age (over 60 years), certain races, and birth outside the United States. However, I want to emphasize three

points. First, *the majority of the 90 million people with low literacy in the USA are native born and white*. Second, *low literacy does not necessarily mean lack of intelligence*; someone with a high school diploma and a decent job may nevertheless be reading, computing, and understanding at a low level (Kirsch, Jungeblut, Jenkins, & Kolstad, 2002). Third, because the term *illiterate* is so stigmatized, *people try to hide the problem*, making it more difficult to identify and help them (Baker et al., 1996; Osborne, 2005).

*Health Literacy*

The problems related to poor literacy are magnified in health care, where an abundance of research and comment about ***health literacy*** has appeared in recent literature; Osborne (2005) consulted over 200 sources to write her book about the topic. *Healthy People 2010* defined health literacy as, "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (U.S. Department of Health and Human Services [USDHH], 2000, p. 11-20). United States health goal number 11-2 is, "Improve the health literacy of persons with inadequate or marginal literacy skills" (p. 11-15). The United States Surgeon General's report, *Oral Health in America* (USDHH, NIDCR, 2000), challenged dental professionals to focus on this problem. The issue is also addressed in the United States Institute of Medicine report, *Health Literacy: A Prescription to End Confusion* (Neilsen-Bohlman, Panzer, & Kindig, 2004); the U.S. Department of Education's *National Assessment of Adult Literacy* (Kutner, Greenberg, Yin, & Paulsen, 2006); the Canadian Council on Learning report, *Health Literacy in*

*Canada* (2007); and a wide range of other government, professional, organization, and news literature.

Even people with average or high literate abilities can have trouble understanding complex health information, but people with low literacy are especially challenged and so they also tend to have *low health literacy* (***LHL***), limiting their access to and understanding of most printed health information, which is usually written at a 10th grade level (USDHH, 2000) and should be written below a 6th grade level (Doak, Doak, & Root, 1996). This has implications for their ability to educate themselves about health; practice preventive self-care; make informed treatment decisions; follow directions; take over-the-counter and prescription medications correctly; and understand and complete health histories, insurance, HIPAA, consent to treatment, and other forms (Kutner et al. 2006). LHL has a greater impact on health than age, income, employment, education, race, or ethnicity (Ask Me 3, n.d.) and results in lower overall health, greater chance of hospitalization, and higher mortality rates (Berkman et al., 2004; Kutner et al.).

Also consider that people are often sick, fearful, or otherwise stressed when they are seeking health care, which can further hinder their normal literate abilities. While people in the dental office are generally healthy, in some ways the average dental appointment is even more stressful than the average medical appointment, partly because dental patients are more likely to receive treatment and be fearful about facing the unknown or experiencing pain (Abrahamsson, Berggren, Hallberg, & Carlsson, 2002: Dunning & Lange, 1993; Newton, 1995; Smith & Heaton, 2003). De Jongh and Stouthard (1993) found that 85% of dental hygiene patients experience some degree of

anxiety. So in regards to fear, the medical office has nothing on the dental office; LHL people are just as likely to have communication difficulties due to stress at both.

*Take time to watch, think, and talk*:
Watch the video titled *Health Literacy and Patient Safety: Help Patients Understand* on the AMA Foundation website at (http://www.ama-assn.org/ama/pub/category/8035.html). Watch on your own and then in a staff meeting. Discuss these questions:

- What parts of the video surprised you?
- Which of the problems with low health literacy that were discussed in the video do you recognize among your own clientele?
- Will you do anything differently the next time you see those people?

*Dental/Oral Health Literacy*

The vast majority of the research into health literacy has been done in medical settings, but the topic has be addressed by both the American Dental Association (ADA) and the American Dental Hygienists' Association (ADHA), and a few important articles have appeared in the dental literature. The *ADA Community Brief on Oral Health Literacy* is on their website and offers information and links to helpful resources (ADA, 2007). In its *Standards for Clinical Dental Hygiene Practice* (2008), the ADHA calls literacy an oral disease risk factor that must be identified. Gaston (2002) and Glick (2006) drew attention to the issue in editorials in the *Journal of Dental Hygiene* and the *Journal of the American Dental Association* respectively. Glick noted that low health literacy and poor dental health are both related to chronic conditions such as heart disease and diabetes, then added, "It is not possible to evaluate the effect of low literacy on oral health from existing literature. However, extrapolating from the medical literature, it is evident that patients with low literacy likely would have more oral disease" (p. 1358).

Rudd & Horowitz (2005) agreed with Glick and also called for more research on dental health literacy. A few heard that call, and some were ahead of it.

Jones, Lee, & Rozier (2007) conducted what is apparently the first study to look at dental health literacy in the United States. They developed a patient survey, the Rapid Estimate of Adult Literacy in Dentistry-30 (REALD-30), then tested and interviewed 101 people at two private practice dental offices. Of this group, 29% were rated at a low literacy level, and thus were judged at higher risk for oral disease. The researchers conclude that "a large number of patients have low levels of oral health literacy" (p. 1207) and recommend two main actions. Clinicians should take continuing education courses in communication and also evaluate the literature they distribute to patients to be sure that it is suitable for all levels of readers. I couldn't help but notice that the people tested came to the dental office on their own and wonder about the oral health literacy of people who do not go to a dentist.

Two studies twenty years apart had already assessed dental health patient education literature (Alexander, 2000; Blinkhorn & Verrity, 1979) and another had evaluated oral cancer education materials dispensed in United States Air Force dental clinics (Mongeau & Horowitz, 2004). All concluded that most of the brochures were written at a level too high for the majority of patients. More recently, two separate sets of researchers looked at the readability of essentially identical sets of patient education pamphlets from the American Academy of Pediatric Dentistry, but came to opposing conclusions. One group found the materials *superior* (Kang, Fields, Cornett, & Beck, 2005) and the other group found them difficult to read and not suitable for low-literacy

people (Amini, Casamassimo, Lin, & Hayes, 2007). Kang et al. based their findings on one evaluation system; Amini et al. criticized the Kang et al. assessment instrument and derived their conclusions by synthesizing the findings from three other instruments. So these judgments can be difficult, and if researchers cannot agree, then how can we as clinicians evaluate the reading level of our own handouts and documents? Fortunately, help is available. We can learn to critique and even create patient education materials by becoming familiar with the principles of ***plain language*** and making use of other resources.

*Plain Language*

Legislators and others have been advocating that government documents use plain language since shortly after World War II, but President Bill Clinton finalized the issue with a Presidential Memorandum in 1998. It stated, "Plain language documents have logical organization; (and use) common, everyday words, except for necessary technical terms; 'you' and other pronouns; the active voice; and short sentences" (Locke, 2004). Vice-President Al Gore, who was put in charge of the project, called the use of plain language "a civil right" and created the "No Gobbledygook Awards," (Locke, 1990s section) which were presented monthly to government agencies that successfully simplified their bureaucratic language. Plain language, in addition to the attributes stated by President Clinton, is clear, precise, logical, brief, and relevant, and uses short words and sentences. It is simple without being patronizing, but still interesting and inviting (Wright, n.d.). Gobbledygook is also a problem in the health field.

Health care providers use a great deal of language that is difficult for LHL individuals to understand. Wolf and colleagues (2007) found that people who spoke English as their first language had trouble understanding certain words on prescription labels, including *antibiotic*, *medication*, *prescription*, *dose*, *orally*, or *teaspoonful*. Many confused the words *teaspoon* and *tablespoon*. The outcome could be tragic if a parent gives a child a tablespoon instead of a teaspoon of medication. These and other terms can be even more confusing for people who are trying to master English. The Ask Me 3 (n.d.) website lists other words that could be confusing and offers suggestions for alternatives. Instead of saying *benign*, say *not cancer* or *will not harm you*; instead of *dysfunction*, say *problem*; instead of *lesion*, say *wound* or *sore*; and instead of *oral*, try saying *by mouth*. Also say *choice* instead of *option*; *check-up* instead of *test*; *too much* instead of *excessive*; *not too much* instead of *moderate*; and *gets worse* (or *better*) instead of *progressive*. You get the picture. See the Resource list for more examples.

*Explore some more*:

- See before and after examples of government plain language documents on the winners page of the "No Gobbledygook Awards" at http://www.plainlanguage.gov/examples/award_winning/nogobbledygook.cfm
- Check out the University of Utah's substitute word list for health terms at http://uuhsc.utah.edu/pated/authors/substitute2.html
- For some writing tips, see William Safire's humorous tongue-in-cheek rules about using plain language, *How to Write Good*, at http://www.plainlanguage.gov/examples/humor/writegood.cfm
- See the Resource list under Plain Language for internet links that will further explain the concept and help you find, create, and evaluate health education materials and websites.

*Identifying Low Health Literacy Patients*

Clearly, poor health literacy in the United States is a big problem. Fortunately, many scholars and researchers offer us help in dealing with it. The first and perhaps the most challenging issue is to identify the patients who struggle with low literacy, and once we know who they are, then we need to learn how we can help them. Doak, Doak, & Root (1996), reiterating what you saw in the AMA Foundation video, tell us what illiterate people are not. They are not stupid; most have average IQs and have devised clever strategies to compensate for their limitations. They are not easy to identify because: they will not tell you they cannot read; they may have graduated from high school or gone farther with their educations; they often speak English as their first language and may be quite articulate; they come from every race and socioeconomic group; and they work in a wide variety of jobs. Remember that one of the people in the video was a pharmacist's assistant. In one study, more than half of the low literacy people who were interviewed felt such shame about not being able to read that they had never told their spouses, children, coworkers, friends, or relatives (Parikh, Parker, Nurss, Baker, & Williams, 1999). So the best we can do is to look for clues and ask questions.

Here are some of some signs to look for, but try to find patterns and repetitions. One observation is usually not enough to draw a conclusion. Remember, *these are just hints. Always keep in mind that there may be other reasons besides poor health literacy for any of these actions.* The person:

- May not follow directions posted on signs, especially if s/he is new to the practice.

- Cannot read or fill out any form because her glasses are at home or his eyes are tired.
- Fills out forms incompletely or incorrectly.
- Asks to take forms home to read later or discuss with family members.
- Doesn't seem to focus on written materials.
- Brings a companion to help with filling out forms.
- Opens the bottle and looks at the pills to identify them rather than reading the label.
- Cannot name medications.
- May appear aloof, frustrated, or impatient.
- Asks many questions about information already covered in printed literature.
- Frequently misses appointments.
- Does not comply with prescriptions, tests, referrals, or other recommendations, especially if they involve the need to read.

(Blackwell, 2005; Osborne, 2005; Weiss, 2007).

The experience of one low literacy patient illustrates one of the clues listed above:

> I had to go to the clinic for x-rays. The girl at the desk told me which room to go to and I went in and sat down. Quite a few people came in. Pretty soon I saw that those who came after me were called, but I never was. I sat there for nearly an hour before I asked the nurse when my turn was. She asked if I had signed the register. When I said, "No," she pointed to the sign at the front of her desk and she read, "Please sign the register when you come in." I didn't tell her I couldn't read. She took me next. (Doak, Doak, & Root, 1996, p. 6).

The receptionist could have saved this person embarrassment, and time, if she had been alert to the possibility of problems with literacy.

You can also find clues in answers to key questions. Ask a patient how s/he likes to learn, suggesting both oral methods such as talking with friends, watching television, or listening to radio shows, and literate methods such as reading brochures or searching the internet. Or offer different kinds of take-home information, including printed, audio, and video materials, and take note of which kind the person usually prefers (Osborne, 2005).

A controversial method to identify low literacy patients might be to administer the REALD-30 or some other test to definitely establish a person's literacy level. Some scholars suggest routinely using the equivalent test for medical patients and claim that it takes only 3 minutes (Johnson & Weiss, 2008), but others contend that asking patients to take such a test may frustrate, embarrass, and alienate them (Paasche-Orlow & Wolk, 2008). Osborne (2005) quotes Archie Willard, who learned to read at age 54, as he recalls what it was like to be asked to take a literacy test in a health setting, "People with other kinds of handicaps are not continually asked to expose their weaknesses to whatever degree they are handicapped....More written tests are seen as another step backward for us and it turns us away" (p. 9). So perhaps for now the best course to identify LEP people is to educate ourselves and then look, listen, and ask questions. The strategies that you might use to help you care for LHL patients are similar to those that will help people who speak English poorly, so will appear toward the end of this chapter.

## Limited English Proficiency

***Limited English Proficiency*** (LEP) is a major complicating factor of health literacy. Even though most low literacy patients are white and were born in the United States, there are still a significant number of people who have come to the United States from other places and speak English poorly. According to the 2000 census, approximately 47 million people in the United States over the age of five years speak a language other than English at home (Shin & Bruno, 2003). Even those with adequate English ability may struggle with language due to the stress they experience in a health setting; "When I am sick, I am not bilingual" (Canadian Association of Mental Health

quoted by Drouin & Rivet, 2003). This situation is a problem for both practitioners and patients.

*Caregiver Concerns*

Language is a huge barrier between LEP patients and dental care. In my survey of 551 dental hygienists across the country, I found that difficulty understanding LEP patients was their number one concern when working with a diverse clientele. I asked the open-ended question: "Please describe some of the issues you confront when treating patients/clients from a variety of ethnic, racial, and/or cultural backgrounds." Of the 371 practicing dental hygienists who wrote responses to this question, 234 (42% of all respondents, 63% of those who answered this question) had concerns about the English language abilities of their patients. Some comments included: "There are 72 dialects spoken in our public schools." "The main issue is the communication barrier!" "When there is a language barrier I am not able to deliver the services and care at a level that I am accustomed to." "Hardest thing is when English is limited, communicating treatment options and needs without feeling like you are pressuring or making decisions for the patient." Several showed their frustrations about the issue. "It is difficult to understand their 'English.'" "I feel they...should learn our language."

Working with LEP patients is difficult for other health care providers as well. Roberts, Moss, Wass, Sarangi, and Jones (2005) studied the problem at physicians' offices in inner London. Participants in the study spoke 30 languages other than English, only 10% of the 300 languages spoken in London at the time. One of the problems for health care providers related to understanding different accents, which is illustrated by

this interaction. (I omitted the linguistic transcription conventions and substituted traditional punctuation. "P" stands for patient, "D" stands for doctor.)

> A young Albanian woman has had a skin rash for several months and thinks it might be an allergy:
> P. I think from meat because…
> D. Milk?
> P. Meat.
> D. Mit, what is mit?
> P. Meat (laughs). I don't know, meat.
> D. Er.
> P. Mince, I think.
> D. Mice?
> P. Yeah.
> D. Like rat?
> P. Yeah.
> D. You have mice at home?
> P. What do you—mince, no but meat, to eat, erm, I can't say in English.
> D. Can you draw it?
> P. No I don't know how to write this.
> D. Is it a food?
> P. Cow.
> D. Coal?
> P. No, no. Cow.
> D. Cow. From cow?
> P. Yes.
> D. Ah, beef.
> P. Beef, yeah.
> D. Ah, beef, ah (p. 469).

We can only imagine the frustration on both sides of this conversation. The difficulty in this example grew out of pronunciation issues, and, to some extent, grammar. However, many other misunderstandings in this study occurred because of "style of self-presentation" (Roberts et al., 2005, p. 470), another way to say direct versus indirect communication (see Chapter 2). For instance, patients would show up with documents and/or empty pill bottles and then expect physicians to perceive their

problems without other explanations. The researchers contend that just listening better and avoiding medical jargon, while important, are limited solutions. They recommend that health care providers should learn all they can about the groups they work with.

That is what Katalanos (1994) did when she studied the health care of Southeast Asian refugees in New Mexico, as discussed in Chapter 2. That has been my own experience, too, from living in many different places and working with a diversity of people. It is like making new friends. The longer you know someone and the more you learn about her, the better you understand each other. The longer you listen to a particular kind of accent, the easier it is to recognize the speech patterns and pronunciation. You can also enhance your care by learning about the particular groups that you work with, and you have already begun by reading this book. Build on the culture general information that you learned in Chapter 2 by switching to the culture specific approach. Refer to the resource list at the end of the chapter to help you get started.

I believe that it is even more difficult to assess health literacy in LEP people, who, though they speak English poorly, may be highly educated and articulate in their native languages. I have cared for people who may have not have spoken English well, but were educated and had even been nurses, physicians, and other health care providers in their own countries and so were highly health literate. On the other hand, some people may have been illiterate in their own languages. Hmong (pronounced *mong*) is an entirely oral language. Linguists and anthropologists created a written version, but the more traditional people never use it and do not possess literate abilities in either English or Hmong

(Fadiman, 1997). So LEP and LHL may be mutually exclusive in some cases. This is another argument for patient-centered care.

*Consequences for Patients*

Patient language limitations may be inconvenient and frustrating for caregivers, as in the conversation transcribed above, but the resulting misunderstandings can be devastating for the patients themselves and for their families. Katalanos (1994) found that some Southeast Asian refugees who were trying to learn English had a tendency to confuse the words *test* and *taste*. Imagine the uncertainty that could result when a person is told she needs a blood test and she thinks she heard the clinician say, "blood taste." Even when the word *test* is heard correctly, someone who is unfamiliar with our culture might envision a written or school test rather than a medical procedure. The literature is full of tragic health consequences that have occurred due to miscommunication through language barriers. One of the most compelling is the true story of Bao (a pseudonym), a 14-year-old immigrant from an Asian country. Though not a dental story, this extreme case illustrates the clash among culture, language, and health care.

Bao died of hepatocellular (liver) cancer, possibly a complication of Hepatitis B, but only after enduring great physical and emotional pain. The first three times she sought medical help for her severe abdominal pain, an emergency room physician diagnosed it as menstrual cramps and advised her to take Advil. Bao was so shamed that she refused to return to a doctor until almost a year later when her brother had to carry her into the emergency room. Only emergency surgery revealed the cancer. Bao's 17-year-old sister was the only family member who spoke English, so the doctors could not

tell Bao that she was dying, and the sister believed that neither Bao nor her parents would want to know. Thus, "this sister became custodian of everyone's hope" (Hufford, 1997, p. 114), an unimaginable burden. "Bao's case is not 'a case of liver cancer,' nor is it a 'gender case,' or a 'culture case.' It is *Bao's* case and liver cancer is a part of it, as are gender, language, pain, reincarnation, shame, dreams, love, bad diagnosis, good intentions, and many other elements" (p. 122). Because of Bao and others like her, the legal system has become involved in the issue of language interpretation in health settings.

*Flashback*:
What characteristics of culture described in Chapter 2 are illustrated in Bao's story?

***Translation and Interpretation** in Health Care*[4]

*Patient ramifications.*

Residents who speak English poorly are among the ethnic minorities that suffer disproportionately from medical and dental problems compared to the majority population, as discussed in Chapter 2. We "should recognize LEP patients as a high-risk group" (Wilson et al., p. 803). Because of their linguistic isolation, LEP people have less access to health care; are less likely to seek preventive services; and are more likely to receive incorrect diagnoses and treatments. They also have more trouble understanding what is happening to them and how to use their medications; often endure excessive and expensive diagnostic tests to make up for the lack of language concordance; and are more likely to give an invalid informed consent or have their privacy invaded by inappropriate

[4] *Translation* usually refers to transferring written information from one language into another. *Interpretation* usually means mediating a spoken conversation.

interpreters (Keers-Sanchez, 2003; Wilson, Chen, Grumbach, Wong, & Fernandez, 2005). As a result, they generally have poorer than average health status.

The consequences of the inability to communicate vary and can be severe. When interviewed, two patients who spoke only Spanish said, "I would tell the doctor 'okay,' but I didn't understand anything [about taking my medications]" (Andrulis, Goodman, & Pryor, 2002, p. 1); and "I didn't buy the medicines because I didn't understand the instructions" (p. 2). "An elderly Vietnamese man...without an interpreter...made his mark on (signed) an English language consent form authorizing the extraction of many teeth" (Youdelman & Perkins, 2005, p. 1) and was shocked when he woke up to discover what had been done to him. A paramedic incorrectly told emergency room physicians that a Spanish-speaking patient was drunk because he had complained of being "intoxicado," which actually means, "nauseous." As a result, the doctors spent several days focusing on alcohol abuse and found the real problem only when the young man's brain aneurism ruptured. The patient ended up a quadriplegic and was awarded $71 million in a malpractice lawsuit (Ku & Flores, 2005). The use of trained interpreters and translators could mitigate these kinds of scenarios and their legal consequences.

*Legal ramifications.*

There are no specific United Stated federal laws that require clinicians to provide translation services to protect patients from discrimination on the basis of language, but some courts have interpreted such cases as discrimination on the basis of national origin, citing Section 601 of Title VI of the 1964 Civil Rights Act. This applies to any entity that receives federal funds and may also apply to those who do not (Keers-Sanchez, 2003; Ku

& Flores, 2005). The requirements may be modified for small dental offices that see few LEP patients (Sfikas, 2004), but individual states may have different and/or more stringent requirements (Perkins & Youdelman, 2008)[5]. Even though the federal government recognizes the negative health consequences for LEP patients and still mandates practitioners to address them, it offers no reimbursement for expenses and does not set standards for interpreters. Many care givers, scholars, health activists, and others have called for change (Keers-Sanchez; Ku & Flores).

*Explore some more*:
Find your state's requirements regarding interpretation services for LEP patients. Go to: *Addressing Language Needs in Health Care: Summary of State Law Requirements* (January 2008) from the National Health Law Program at http://www.healthlaw.org/library/item.174993

*Professionally trained versus **ad hoc interpreters**.*

Practitioners who use trained professional interpreters find that there are advantages and disadvantages to doing so. Qualified interpreters make fewer errors compared to ad hoc interpreters, which improves the patient's health and minimizes the practitioner's malpractice liability (Keers-Sanchez, 2003). Patients are also more likely to be satisfied, to trust the caregiver, to be loyal to a practice, and to become practice builders by referring friends and family. On the other hand, trained interpreters cost practitioners via service fees and the associated costs of the extra time it takes to communicate through an interpreter.

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[5] These general statements should not be taken as legal advice. Practitioners must continually monitor national and state requirements.

Therefore, the first choice when interpretation is needed is always to use a trained interpreter, whether it is an office employee or an outside person. The ideal person should be bilingual with high fluency in both English and the other language, be able to interpret smoothly and efficiently, know medical and dental terminology in both languages, understand the concepts of medical ethics and patient confidentiality, and also be bicultural (Keers-Sanchez, 2003: Ku & Flores, 2005). Medical translation is complicated and difficult and requires knowledge of culture as well as language. One clue that a cultural issue has come up is when the patient and the translator have a protracted conversation but the message to the caregiver is brief. Here is an example.

> Medical provider to pregnant patient: "Are you married?"
> Interpreter to patient: "This doctor asks if you are married. She does not mean to insult you. In America a woman can have a baby without being married. It is not a shameful matter. Please do not be offended."
> Patient to interpreter: "I do not understand. In my country this would bring great shame to my parents. My husband would be very angry if he heard this question. It shows him no respect."
> Interpreter to medical provider: "She says she is married." (Katalanos, 1994, p. 14).

This testimony from a Navajo interpreter further explains cultural translation.

> We have to think of ourselves as being part of the community. We have to think about the people that we are talking to (and our relationship with them). There is a clan system. There are certain things I can't interpret if it's for my husband's clan...or for my father's clan, especially if it is about certain sensitive things, like male parts of the body. There are certain things that I, as an interpreter, cannot interpret if the person I am interpreting for is older than me. I can't say certain things to a male that I can say to a female. There are certain things a young female interpreter can't say to a young man. There are certain things a male interpreter can't say to a woman.
>
> And, then there is spirituality. There are certain things I can't interpret to anybody because of the spiritual part of it. In our culture, there are some things you don't say. So, I have two worlds that I have to take the patient through—Western medicine that is separate from our lives, and the Indian way of life where

> we're at all the time. By knowing both sides, I bring those two forces together. I show the patient—this is what is over there. I show the provider—this is what is over there.
>
> So, it's a lot more than just saying what the doctor and patient say. You have to consider all these things (Beltran Avery, 2001, pp. 10-11).

An interpreter performs a delicate balancing act. S/he must mediate a smooth and accurate dialogue while simultaneously attending to the caregiver's point of view and the patient's cultural rules regarding hierarchy, age, gender, religion, and other issues.

For these and other reasons, experts strongly recommend *against* using ad hoc interpreters, including family, friends, whoever happens to be in the reception area, and most especially, children. Children who are asked to interpret are put in a difficult position. A child rarely has the medical vocabulary needed in either language and so is likely to make mistakes, he may become emotionally and psychologically stressed, and both the adult and the child may be embarrassed when sensitive information is involved. In the dental office this could relate to questions on a financial form or a health history, or such an innocent sounding question as, "Are you married?" Even adult ad hoc interpreters, who surely mean well, find it difficult to remain impartial, often interject their own agendas into the conversation (Rosenberg, Seller, & Leanza, 2008), are inaccurate 48% to 77% of the time, and may violate the patient's right to privacy with their involvement (Keers-Sanchez, 2003). See Table 3-2 for tips on working with interpreters.

*Finding qualified interpreters.*

If you can't use family and friends, and you do not have access to a paid professional interpreter, what do you do? You are not the first to ask this question and

others have developed some creative solutions. The most obvious choices for finding interpretation for LEP patients, along with their advantages and disadvantages, are listed in Table 3-3. Beyond that, here are some other ideas for finding, funding, and using interpretation and translation services:

- Assure that bilingual staff members are fluent in the other language as well as in medical/dental terminology, medical ethics, and confidentiality (Refer to Resource list for a link to *The National Code of Ethics for Interpreters in Health Care*). See that they are trained and/or have them evaluated by a commercial organization, language instructor, or other qualified person.
- Ask patients and/or staff family members who may agree to be trained.
- Join with other small offices to contract with professional interpreters.
- If your office is affiliated with a hospital, see if you are entitled to use their interpreters.
- Check with language departments of colleges and universities, ask for undergraduate and graduate students who might get college credit for helping with translation.
- Check with religious, civic, legal aid, immigrant, welfare assistance, and English as a Second Language programs/organizations who may offer or refer to translation services.
- Use telephone translation services. See links to specific organizations in the Resource list under Translation Aids, brief pros and cons in Table 3-2, and a more extensive explanation at http://www.cpehn.org/pdfs/ATA%20Telephone%20Interpreting.pdf
- Look into video conferencing. Professional translators speaking a variety of languages can serve multiple sites; cost is contained because they do not need to travel. Available only on hospital closed networks so far, but watch for it in the future (Goldeen, 2006).
- Be careful of computer-assisted translations. They may be helpful for individual words or brief phrases, and are developing all the time, but may not yet be accurate and clear enough for sensitive health communication (Mitka, 2001).
- Take language courses. You may not become fluent, but you can learn something about a culture along with important terms and phrases. You expand your horizons and patients appreciate and celebrate your effort.
- Put as much in writing as possible (remembering that some patients may not be able to read in their native languages):
    - Use translated documents that are online (see Resource list to get started).
    - Search commercial organization websites for other translated literature.
    - Contact commercial organizations that you do business with and let them know that you need printed information in certain languages.

  - Search foreign websites for documents that can be adapted to your office.
  - Ask competent staff or contact a local medical translation association or commercial translation service to do the translating. This may cost, but it is an infrequent expense and a sound investment.
  - Ask local hospitals if they will share generic documents such as HIPAA forms.
- You may find some reimbursement for translation services from Medicaid and/or State Children's Health Insurance Programs if you are in Hawaii, Idaho, Kansas, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah, or Washington. Check the National Health Law Program website (NHeLP; http://www/healthlaw.org) for updated information and guidance as to how to qualify and apply for those funds.
- Check with county and city governments, non-profit organizations, foundations, and other entities for additional possible funding sources.
- See Table 3-3 for guidelines to follow when working with an interpreter.

Gadon, Balch, & Jacobs, 2007; Keers-Sanchez, 2003; Youdelman & Perkins, 2005

*Back to the real world.*

Much of this discussion may seem too theoretical to dental hygienists who in real life often care for LEP patients with no translator at all. Sometimes you are forced to make do. I have done it myself. You use body language, facial expressions, gesticulations, visual demonstrations, drawings, models, disclosing solution, the few words of the other language that you may know, and anything else you can think of. In this electronic age you can access health education materials online in numerous languages. The selection is more limited for dental health materials, but they are out there (see resource list). Just keep in mind that some people may not be able to read in their native languages either.

The task of communicating with LEP patients is complicated even more if you happen to be wearing all of your infection control gear, including your facemask, when

you need to make a point. One dental hygienist in my survey had studied her patients' language to try to overcome this problem, but then she discovered another complication.

> To compensate (for language limitations), I have tried to learn the language (Spanish) and apologize to the patient in Spanish letting them know I am learning, want to learn, and to please correct me if I say something improperly (due to) many dialects and slang from various countries: i.e. a Cuban word spoken could be a total insult or absolute filth in the Columbian or Argentinean dialect which is totally different in Castilian Spanish!

Another respondent said it more succinctly, "And sometimes you just miss." Remember the sixth element of patient-centered care, the need to be realistic and that, even among people who speak the same native language, the message sent may not be the message received (see Chapter 1). We are human beings who do the best we can and if we continually try to do better that is all we can do. My experience is that most patients appreciate your efforts and do their best to help smooth the interaction regardless of the limitations.

As clinicians, we have access to countless ideas and resources to help us care for people with poor literacy and limited English skills. Much of what we should already be doing in regards to patient education applies here, just to a greater degree, especially the parts about individualized instruction and the components of patient-centered care (see Chapter 1). Refer to Table 3-1 for a summary of key points. Many of these will be expanded in the *Application* section, Chapters 5-7, of this book.

## Conclusion

We have looked at both the spoken and written aspects of verbal communication, from the evolution of language to the care of LHL and LEP patients. We have learned

that language is symbolic, ambiguous, and constantly evolving, and that the English vocabulary is especially vast and complex. We have seen how these characteristics impact the delivery of health care. I hope that this information helps to assure that the message sent is the message received. But there is much more to know. In Chapter 4, I will discuss the nonverbal aspects of language that add many more fascinating dimensions to human interaction. That will conclude our look at the Foundations of communication. Then we will move on to the Section II, Applications, where we will look at listening, persuasion, and interviewing.

Table 3-1: Tips for communicating with LHL and LEP patients

(These tips are divided into general categories to organize the information. Of course use whatever is called for and whatever works in a given situation.)

**Regarding all**

- Create a welcoming, non-judgmental, respectful, empathetic environment.
- Be patient. Caring for LHL and LEP people may take more time, especially at first, but the investment will yield dividends over time.
- Spend some social time before getting down to business.
- Use plain language and avoid jargon. If you must use a medical term, explain it, perhaps write it down or dispense easy-to-read information about it.
- Speak slowly and add pauses (Brush your teeth as we practiced – once each day – every day – in the morning and in the evening).
- Acquire or create easy-to-read forms and handouts (see Resource list).
- Limit your instruction to the 2-3 most important points. Do not overload people at one appointment. You can always add more later.
- Use pictures, diagrams, calendars, etc. (can be preprinted or drawn), as well as video and audio aids (see Resource list).
- Write down key points. Use large, legible print or preprint (name of the illness or medication, important information, telephone number to call, etc.).
- Encourage people to ask questions, understanding that some will not ask because they do not want to appear ignorant.
- Ask questions several different ways. Patients may understand certain words and not others but hesitate to say so. They may smile and nod in agreement just to save face.
- Use Teach Back and Show Me methods. Ask the person to repeat instructions or demonstrate the procedure that you taught.
- Never ask, "Do you understand?" because many will reply "yes" whether it is true or not.
- Be a **LEaDeR** in patient education (see Section II of this book for more details):
    - ***Listen.*** Hear patients' stories. Give them time to talk; learn about them as they do.
    - ***Explain.*** Share your knowledge and recommendations.
    - ***Discuss.*** Compare notes and agree on home care and treatment options.
    - ***Reconfirm*** understanding (Teach Back and Show Me).
- Be certain that patients leave with the answers to three important questions:
    - What is my main problem?
    - What do I need to do?
    - Why is it important for me to do this?

**Regarding LEP patients**

- Allow extra time to communicate through an interpreter.
- Acquire or create forms and handouts in different languages (see Resource

list).

- Use a soft, gentle tone of voice and maintain an even temperament. *Do not raise your voice*. This seems to be a natural tendency when a person doesn't understand you, but louder volume may cause some to think you are angry.
- For Southeast Asian patients, if there is more than one person in the room, and there is likely to be, *always* address the oldest person first, regardless of who the patient is.
- Recognize differences in time consciousness, but also gently explain your own time constraints.
- Ask about people's schedules. Be specific about medication and treatment times (brushing, flossing, etc.) if they are critical. Mealtimes and sleeping times may be different. Breakfast may be midmorning, dinner may be 8 or 9 or 10 PM or later. In some cultures people take a substantial midday nap so "bedtime" may mean afternoon to them.
- Use trained medical interpreters when possible. Use family members only as a last resort, especially don't ask children. Ad hoc interpreters may not understand your terminology. Some may translate incompletely or incorrectly or add their own agendas. Some may find certain topics inappropriate to discuss.
- Use your high school French, Spanish, German, etc., but be careful about guessing the meanings of words.
- If you care for many from a specific group, learn some key words in their language (please, thank you, good morning/afternoon, etc., as well as medical/dental terms).
- Do not assume that they know everything about their medical histories. In some cultures it is thought wrong to share difficult diagnoses such as cancer or terminal illnesses.
- It's OK to express ignorance of a person's culture. Ask questions and show sincere interest. Most people understand and many appreciate your curiosity.

From: Ask Me 3, n.d.; Desmond & Copeland, 2000; Doak, Doak, & Root, 1996; Gardenswartz & Rowe, 1998; Glick, 2006; Katalanos, 1994; Kavanaugh & Kennedy, 1992; Osborne, 2005; Weiss, 2007.

Table 3-2: Advantages and disadvantages of different kinds of interpretation/translation services in health care.

| Type of service | Advantages | Disadvantages |
|---|---|---|
| Ad hoc (family/friends or any available person) | • Available<br>• Economical<br>• Usually fluent in language<br>• Usually knowledgeable about culture | • Breach of patient privacy<br>• May omit some information<br>• May be inaccurate, not usually medically trained<br>• May not be adept at translating so may take more time<br>• May be inappropriate (i.e. child, opposite sex or younger person)<br>• Increase liability due to lack of informed consent |
| Nonclinical bilingual staff | • Mostly available<br>• Objective (usually)<br>• Can help with administrative information | • Not always available<br>• Conflict with other work<br>• Not medically trained<br>• May be inaccurate |
| Clinical bilingual staff | • Mostly available<br>• Objective (usually)<br>• Medically trained<br>• Familiar with office<br>• Usually cost effective | • Not always available<br>• Conflict with other work<br>• May be inaccurate |
| Bilingual care giver | • Most are effective & efficient<br>• Best if also bicultural | • Few available<br>• Bilingual care giver can be overwhelmed |
| On-site professional interpreter | • More complete compared to family & friends<br>• More accurate compared to family & friends<br>• Many languages available<br>• Usually knows medical language | • Expensive<br>• Also pay for travel, waiting<br>• May be unreliable<br>• No check on quality, accuracy<br>• May not be HIPAA compliant |
| Telephone interpreter | • Many languages available<br>• May know medical language<br>• Fast access | • Cost<br>• Lengthens visit<br>• Inconvenient passing phone between care giver and patient if speaker phone not |

| | | |
|---|---|---|
| | • Objective & professional | available<br>• No patient body language<br>• May not know dialect/culture |

From Gadon et al., 2007; Katalanos, 1994; Keers-Sanchez, 2003; Youdelman & Perkins, 2005.

Table 3-3: Tips for working with interpreters

Note: Professional interpreters will have learned these methods, but ad hoc interpreters may need some coaching.

- If you have a choice, choose an interpreter who is older than the patient. In many hierarchical societies older people are considered wise and are highly respected.
- If you have a choice, choose an interpreter who is the same sex as the patient.
- If possible and necessary, before the appointment ask the translator to guide you in regards to proper form of address and any other pertinent cultural issues.
- If appropriate, introduce yourself to the patient first, then to the interpreter, and/or introduce the interpreter to the patient and explain why s/he is there.
- Remind the interpreter to interpret everything directly, avoid paraphrasing as much as possible, and to ask you to slow down or clarify a point if needed.
- The interpreter should sit near and slightly behind the patient.
- You should sit directly facing the patient and speak to him/her, not to the interpreter.
- A professional interpreter will speak in the first person, as if s/he were the patient ("My tooth hurts," rather than, "She says her tooth hurts.")
- Likewise, you should speak directly to the patient, rather than to the interpreter ("When did your tooth begin to hurt," rather than "Ask her when her tooth began to hurt.")
- Speak slowly, use simple terminology, pause often, and "chunk" your information so the translator doesn't have to translate too much at once.
- Avoid slang, idiomatic language, and other expressions that are difficult to translate (under the weather, up to snuff, in the pink of health, etc.).
- Avoid medical jargon and explain medical terminology.
- Watch the patient's and the interpreter's nonverbal communication.
- If it seems that a cultural or other issue has come up and the interpreter and patient are speaking longer than expected, ask the interpreter to explain what is happening.
- Likewise, let the patient know what is happening if you should have a side conversation with the interpreter.
- If possible, ask for a debriefing from the interpreter after the patient leaves.
- Assure that staff members are aware of these guidelines for working with interpreters.
- Be aware of the *National Code of Ethics For Interpreters in Health Care* (http://hospitals.unm.edu/ILS/Documents/NCIHC.pdf)

From: Gardenswartz & Rowe, 1998; Katalanos, 1994; Mikkelson, 1995; Office guide...(2007).

## Glossary for Chapter 3

*Ad hoc interpreters*: Untrained people, usually family and friends or even anyone who is available, who are asked to interpret when clinician and patient do not speak the same language.

*Health literacy*: *Healthy People 2010* defines it as "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (U.S. Department of Health and Human Services, 2000, p. 11-20). For an expanded definition, go to http://nnlm.gov/outreach/consumer/hlthlit.html

*Interpretation*: The mediation of a conversation between two people who do not speak the same language.

*LEP*: Acronym for Limited English Proficiency

*Literacy*: "An individual's ability to read, write, and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential" (National Literacy Act, 1991).

*LHL*: Acronym for Low Health Literacy

*Plain language*: Principles by which complex documents are simplified to make them more readable for the general public, especially for people with low literacy. They should use "logical organization; common, everyday words, except for necessary technical terms; 'you' and other pronouns; the active voice; and short sentences" (Locke, 2004), and also be clear, precise, logical, brief, and relevant. For more information, go to http://www.plainlanguage.gov/index.cfm

*Semantic Diamond*: Developed by Stoner, an extension of Ogden & Richards' Semantic Triangle (see below), a diagrammatic representation of how two or more people reach agreement on the meanings of words.

*Semantic Triangle*: Developed by Ogden & Richards, a diagrammatic representation of how individual people attach meaning to words.

*Symbol*: An entity that stands for something else. Language is a symbol system that uses symbols (words) to help people exchange information and create meaning.

*Translation*: Transferring written information from one language to another.

# Resource Lists for Chapter 3

## *Notes Regarding Resource Lists*

*Disclaimer*: Though I try to list materials from reliable sources only, I do not endorse and cannot guarantee the accuracy or comprehensiveness of any information.

*Also*: This list is by no means complete and it can never be 100% accurate due to the changeable nature of websites. Nevertheless, there should be many helpful publications and active links to help you find what you need. Please let me know which sites are most helpful, and/or which other sites you like so I may add them to this list (tonisadamsrdh@earthlink.net)

## *Government, Foundation, and Other Organization Reports*

*ADA Community Brief on Oral Health Literacy* (November 2007), from the American Dental Association at http://www.ada.org/prof/resources/pubs/epubs/brief/brief_0710.html

*Eradicating Low Health Literacy: The First Public Health Movement of the 21st Century*, Overview, White Paper, March 2003, from the Partnership for Clear Health Communication at http://healthpowerforminorities.org/specific/EradicatingLowHealthcareLiteracy.pdf

*Health Literacy: A Prescription to End Confusion* (2004), report from the Institute of Medicine of the National Academies at http://www.iom.edu/?id=19750

*Healthy People 2010* (2000), USA national health goals at http://www.healthypeople.gov/

*Literacy and Health Outcomes, Summary* (2004), report from the U. S. Department of Health and Human Services, Agency for Healthcare Research and Quality at http://www.ahrq.gov/clinic/epcsums/litsum.htm

*National Call to Action to Promote Oral Health* (2003) from the U.S. Surgeon General at http://www.surgeongeneral.gov/topics/oralhealth/nationalcalltoaction.htm

*National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS Standards) (2001) from the Office of Minority Health at http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

*Oral Health in America: A Report of the Surgeon General* (2000) from the U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health at http://www.surgeongeneral.gov/library/oralhealth/

Proceedings of the Surgeon General's Workshop on Improving Health Literacy (September 7, 2006), from the National Institutes of Health at http://www.surgeongeneral.gov/topics/healthliteracy/toc.html

***Health Law***

*Addressing Language Needs in Health Care: Summary of State Law Requirements* (January 2008), from the National Health Law Program, written by Perkins & Youdelman at http://www.healthlaw.org/library/item.174993

Language Services Action Kit, Interpreter Services in Health Care Settings for People with Limited English Proficiency (2004), from the National Health Law Program (NHeLP), summary of federal laws, funding ideas, and rationale for language services at http://www.commonwealthfund.org/usr_doc/LEP_actionkit_reprint_0204.pdf?section=4039

The National Literacy Act of 1991, Public Law 102-73 at http://www.nifl.gov/public-law.html

***Health Literacy***

Ask Me 3, Resources for providers, patients, large health organizations, and the media, from the Partnership for Clear Health Communication at the National Patient Safety Foundation, at www.npsf.org/askme3/

California Health Literacy Initiative and Resource Center at http://www.cahealthliteracy.org/

Canadian Public Health Association Health Literacy Portal at http://www.cpha.ca/en/portals/h-l.aspx

Center for Health Care Strategies, Inc., nine fact sheets on health literacy at http://www.chcs.org/usr_doc/Health_Literacy_Fact_Sheets.pdf

Diabetes and You, a colorful visual, oral, and interactive explanation of all aspects of diabetes for low-literate people, from the Communication Technology Lab and the Department of Telecommunication, Information Studies and Media, Michigan State University at http://commtechlab.msu.edu/sites/diabetesandyou/

Health literacy course (free) at http://www.hrsa.gov/healthliteracy/training.htm

Health literacy resource list for educators from the Food and Nutrition Resource Center at http://www.nal.usda.gov/fnic/pubs/bibs/edu/health_literacy.pdf

*Low Health Literacy: You Can't Tell by Looking* and *Health Literacy* and *Patient Safety: Help Patients Understand*, videos that can be viewed online from the American Medical Association Foundation at http://www.ama-assn.org/ama/pub/category/8035.html

Prevalence Calculator, a tool to roughly estimate the number of patients in a practice that may have limited health literacy, from the Pfizer Clear Health Communication Initiative at http://www.pfizerhealthliteracy.org/physicians-providers/prevalence-calculator.html

Reference page to internet links, videos, and publications about health literacy from the University of North Carolina Health Sciences Library at http://www.hsl.unc.edu/Services/Guides/focusonhealthlit.cfm

*Teaching Patients With Low Literacy Skills*, by Doak, Doak, & Root, 1996. This out of print book is made available online at no cost from the Harvard School of Public Health at http://www.hsph.harvard.edu/healthliteracy/doak.html

U.S. Department of Health and Human Services Health Literacy Improvement page, links to information, tools, reports, and research at http://www.health.gov/communication/literacy/default.htm

***Multiple Language Materials***

*Note*: Not all materials are available in all languages.

Cancer Information in English or Spanish, 1-800-4-CANCER (1.800.422.6237), speak with an information specialist from the National Cancer Institute's Cancer Information Service at http://www.cancer.gov/help; or access the webpage and link to live online chat at http://www.cancer.gov/

Cancer Information Service (CIS), one-on-one cancer information and support by phone, email, or internet chat in French, German, Italian, Serbian, or Portuguese, from the International Cancer Information Service Group at http://www.icisg.org/

Colgate patient education brochures in English & Spanish at http://www.colgateprofessional.com/app/ColgateProfessional/US/EN/HomePage.cvsp

Culture, Health and Literacy, health education materials for caregivers and adults with limited English literacy skills, listed by topic and group from World Education at http://healthliteracy.worlded.org/docs/culture/index.html

*English-Spanish Dictionary of Health Related Terms*, from the California-Mexico Health Initiative at http://www.cdpr.ca.gov/docs/enforce/usmexbrd/bpdocs/engspdict.pdf

Health Care Language Services Implementation Guide, and interactive tool from the United States Department of Health and Human Services Office of Minority Health at https://hclsig.thinkculturalhealth.org/user/home.rails

Health Translation Directory from the State Government of Victoria, Australia, Department of Human Services, links to a wide variety of health information that has been translated to as many as 65 languages, including Braille, includes 10 dental publications, at http://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/CategoryDoc/PresentCategory?open

Healthy Roads Media, print, audio, and video educational materials in many languages at http://www.healthyroadsmedia.org/about_us.htm

Language Access Online Resources, links galore at http://futurehealth.ucsf.edu/pdf_files/Language%20Access%20Resources%20in%20California%209-14-07.pdf

Medline Plus, health information in over 40 languages at http://www.nlm.nih.gov/medlineplus/languages/languages.html

National Institute of Dental and Craniofacial Research, Institutes of Health, training for health professionals and patient education materials in English and Spanish at http://www.nidcr.nih.gov/EducationalResources/

National Maternal and Child Oral Health Resource Center, brochures on oral topics in up to 14 different languages at http://www.mchoralhealth.org/materials/index.lasso

New South Wales Multicultural Health Communication Service, publications on many topics in many languages, including 6 dental health publications at http://www.mhcs.health.nsw.gov.au/mhcs/topics.html

NOAH, New York Online Access to Health in English & Spanish at http://www.noah-health.org/

National Network of Libraries of Medicine, many links at http://nnlm.gov/outreach/consumer/multi.html

Spanish-English Translation References, lists mostly hard copy books, but includes specialized volumes such as references for colloquial/slang and regional Spanish, from ACEBO at http://www.acebo.com/recref.htm

SPIRAL, Selected Patient Information Resources in Asian Languages (Chinese, Hmong, Japanese, Cambodian/Khmer, Korean, Laotian, Thai, and Vietnamese), from South Cove Community Health Center and Tufts University Hirsh Health Sciences Library at http://spiral.tufts.edu

Translation: Getting It Right, how to be sure your translated documents are successful, from the American Translators Association at http://www.atanet.org/docs/Getting_it_right.pdf

24 Languages Project, health information in 24 languages in print and audio versions at http://library.med.utah.edu/24languages/

*What To Do For Health*: books in various languages, including dental health at http://www.iha4health.org/index.cfm/MenuItemID/137.htm

***Plain Language***

California Health Literacy Initiative Plain Language Health Resources, many links at http://www.cahealthliteracy.org/rc/1.html

*Directory of Plain Language Health Information* in English and French from The Canadian Public Health Association's Plain Language Service, can be downloaded from http://www.pls.cpha.ca/english/directry.htm

Easy-to-Read Beginning with "A" from MedlinePlus, extensive list of alphabetical links to health information, videos, and interactive tutorials, many also in Spanish at http://www.nlm.nih.gov/medlineplus/easytoread/easytoread_a.html

Health & Literacy Special Collection Easy-to-Read Health Info page from World Education at http://healthliteracy.worlded.org/teacher-2.htm

Health Literacy Resources: Using Plain Language from the Massachusetts General Hospital Treadwell Library at http://www.massgeneral.org/library/default.asp?page=plain_language

How to develop user-friendly websites, from the U. S. Department of Health and Human Services at http://www.usability.gov/

How to Write Easy-to-Read Health Materials by PubMed at http://www.nlm.nih.gov/medlineplus/etr.html

Medical Library Association links to references for lay people: Medspeak (glossary of medical terms), Rx Riddles Solved (glossary of prescription language), and Diagnosing Websites (how to identify quality health information) at http://www.mlanet.org/resources/medspeak/

Plain Language defined and illustrated with many links at http://www.plainlanguage.gov/

Plain Language Principles and Thesaurus for Making HIPAA Privacy Notices More Readable at http://library.med.utah.edu/24languages/

Plain Language extensive substitute word list to simplify your writing at http://www.plainlanguage.gov/howto/wordsuggestions/simplewords.cfm

Simply Put: Scientific and Technical Information, how to create easy-to-read materials from the Center for Disease Control at http://www.cdc.gov/od/oc/simpput.pdf

University of Utah, Health Science Center's Substitute Word List for health terms at http://uuhsc.utah.edu/pated/authors/substitute2.html

U. S. Department of Health and Human Services explanation of Plain Language principles and history of the movement at http://www.health.gov/communication/literacy/plainlanguage/PlainLanguage.htm

Word! A Glossary of Medical Words for Kids, from KidsHealth sponsored by the Nemours Foundation at http://kidshealth.org/kid/word/

Words to Watch Fact Sheet, health words that may be confusing to lay people and suggested alternatives from the Pfizer Clear Health Communication Initiative at http://www.pfizerhealthliteracy.com/media/words-to-watch.html

***Translation and Interpretation Issues***

American Translators Association website at http://www.ata-divisions.org/ID/

*The Art of Working With Interpreters: A Manual for Health Care Professionals* by Holly Mikkelson at http://www.acebo.com/papers/artintrp.htm

Language Help, links for Patients and Providers from the Utah Department of Health Center for Multicultural Health at http://www.health.utah.gov/cmh/language.htm

*The National Code of Ethics for Interpreters in Health Care* (2004), from The National Council on Interpreting in Health Care at http://hospitals.unm.edu/ILS/Documents/NCIHC.pdf

*Office Guide to Communicating with Limited English Proficient Patients*, from the American Medical Association at http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf

*Providing Language Services in Small Health Care Provider Settings: Examples from the Field*, examples of how small offices have creatively provided language interpretation services for their LEP patients, by Youdelman & Perkins, from the National Health Law Program and the Commonwealth Fund at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=270667

*Telephone Interpreting in Health Care Settings: Some Commonly Asked Questions*, by Nataly Kelly at http://www.cpehn.org/pdfs/ATA%20Telephone%20Interpreting.pdf

*Translation: Getting It Right*, from the American Translator's Association (also available in other languages) at http://www.atanet.org/docs/Getting_it_right.pdf

***Translation Aids***

Babelfish, online translation resource at http://babelfish.yahoo.com/ (use mainly for single words or simple phrases, may mangle more complicated translations)

*English-Spanish Dictionary of Health Related Terms* from the California Department of Health Services, download from http://hia.berkeley.edu/documents/dictionary3rd.pdf

Ethnomed nurse/patient translation pages in 16 languages at http://ethnomed.org/patient_ed/communication/index.html

Language lines, interpretation services over the phone, contact The Association of Language Companies at www.alcus.org, or individual companies: AT&T at www.languageline.com; Tele-Interpreters at www.teleinterpreters.com; or Medica at www.member.medica.com/LanguageResources/default.aspx

(*Note*: These are only suggestions. I do not endorse any of these companies.)

*Logos*, Multilanguage translating dictionary at http://www.logosdictionary.org/pls/dictionary/new_dictionary.index_p

Martindale's "Virtual" Medical Center, lists and links to medical and dental dictionaries, encyclopedias, and glossaries, some include images and videos, in different languages and on different topics at http://www.martindalecenter.com/MedicalD_Dict.html

Smoking cessation, 1-800-NO-BUTTS (1.800.662.8887). Call to get different phone numbers for Spanish, Korean, Vietnamese, Mandarin and Cantonese speakers.

*Symbol Usage in Health Care Settings for People with Limited English Proficiency*, by Cowgill & Bowlek (2003), from Hablamos Juntos and The Robert Wood Johnson Foundation at http://www.hablamosjuntos.org/signage/PDF/pt1evaluation.pdf

Southern Illinois University School of Medicine links to free online translation services at http://www.siumed.edu/lib/web/translation.html

## References for Chapter 3

Abrahamsson, K. H., Berggren, U., Hallberg, L., & Carlsson, S. G. (2002). Dental phobic patients' view of dental anxiety and experiences in dental care: A qualitative study. *Scandanavian Journal of Caring Sciences, 16*, 188-196.

ADA Community Brief: Oral health literacy (2007). *American Dental Association*. Retrieved August 23, 2008, from http://www.ada.org/prof/resources/pubs/epubs/brief/brief_0711.htm#what

Alexander, R. (2000). Readability of published dental educational materials. *Journal of the American Dental Association, 131*, 937-942.

Alvord, L., & Van Pelt, E. C. (1999, 2000). *The scalpel and the silver bear: The first Navajo woman surgeon combines western medicine and traditional healing*. New York: Bantam Books.

Amini, H., Casamassimo, P. S., Lin, H. L., & Hayes, J. R. (2007). Readability of the American Academy of Pediatric Dentistry patient education materials. *Pediatric Dentistry, 29*, 421-435.

Andrulis, D., Goodman, N., & Pryor, C. (2002). What a difference an interpreter can make: Health care experiences of uninsured with limited English proficiency. *The Access Project*. Retrieved July 9, 2002, from http://www.hhs.gov/ocr/lep/InterpreterDifference.pdf

Ask Me 3 (n.d.). *Partnership for Clear Health Communication*. Retrieved July 31, 2008, from http://www.npsf.org/askme3/

Baker, D. W., Parker, R. M., Williams, M. V., Pitkin, K., Parikh, N. S., Coates, W., et al. (1996). The health care experience of patients with low literacy. *Archives of Family Medicine, 5*, 329-334.

Baron, D. (2007). The tongue who would be king. *Science & Spirit*. Retrieved August 13, 2008, from http://www.science-spirit.org/article_detail.php?article_id=450

Beltran Avery, M.-P. (2001). The role of the health care interpreter: An evolving dialogue. *The National Council on Interpreting in Health Care, Working Paper Series*. Retrieved August 11, 2008, from http://www.ncihc.org/mc/page.do?sitePageId=57022&orgId=ncihc

Berkman, N. D., DeWalt, D. A., Pignone, M. P., Sheridan, S. L., Lohr, K. N., Lux, L, et al. (2004). Literacy and health outcomes, Summary: Evidence report/technology assessment: Number 87. *United States Department of Health and Human Services, Agency for Healthcare Research and Quality*. Retrieved August 31, 2008 from http://www.ahrq.gov/clinic/epcsums/litsum.htm

Blackwell, J. (2005). Low health literacy: How it impacts your patients and what you can do about it. *University of North Carolina Health Sciences Library*. Retrieved August 27, 2008 from http://www.mlanet.org/pdf/resources/low_hlth_literacy.pdf

Blinkhorn, A. S., & Verity, J. M. (1979). Assessment of the readability of dental health education literature. *Community Dentistry and Oral Epidemiology, 7(4)*, 195-198. Retrieved August 27, 2008 from Wiley InterScience database.

Bryson, B. (1990). *The mother tongue: English and how it got that way*. New York: HarperCollins.

Bulow, E. (1991). *Navajo taboos*. Gallup, New Mexico: Gallup Medicine Books.

Canadian Council on Learning (2007). *Health literacy in Canada: Initial results from the International Adult Literacy and Skills Survey*. Ottawa, Ontario: Author. Retrieved August 22, 2008, from: http://www.ccl-cca.ca/NR/rdonlyres/CB3135D3-5493-45FA-B870-1A3D3ABD6EC4/0/HealthLiteracyinCanada.pdf

Countdown to the 1,000,000th word (June 14, 2008). *The Global Language Monitor.* Retrieved July 10, 2008, from http://www.languagemonitor.com/

Covell, N. H., McCorkle, B. H., Weissman, E. M., Summerfelt, T., & Essock, S. M. (2007). *Administration & Policy in Mental Health & Mental Health Services Research, 34(5),* 443-447. Retrieved August 16, 2008, from Academic Search Premier (EBSCO) database.

De Jongh, A., & Stouthard, M. E. A. (1993). Anxiety about dental hygienist treatment. *Community Dental and Oral Epidemiology, 21,* 91-95.

DeLaune, S. C., & Ladner, P. K. (2002). *Fundamental of nursing standards & practice* (2nd ed.). Clinton Park, NY: Delmar.

Desmond, J., & Copeland, L. R. (2000). *Communicating with today's patient: Essentials to save time, decrease risk, and increase patient compliance.* San Francisco: Jossey-Bass.

Deutscher, G. (2005). *The unfolding of language: An evolutionary tour of mankind's greatest invention.* New York: Henry Holt and Company.

deVito, J. A. (2001). *The interpersonal communication book* (9th ed.). New York: Longman.

Doak, C. C., Doak, L. G., & Root, J. H. (1996). *Teaching patients with low literacy skills* (2nd ed.). Philadelphia: J. B. Lippincott Company. Retrieved August 27, 2008, from: http://www.hsph.harvard.edu/healthliteracy/doak.html

Dohan, D., & Levintova, M. (2007). Barriers beyond words: Cancer, culture, and translation in a community of Russian speakers. *Journal of General Internal Medicine, 22*(Supp.2), 300-305.

Dreyfuss, H. (1984). *Henry Dreyfuss symbol sourcebook: An authoritative guide to international graphic symbols.* New York: John Wiley & Sons, Inc.

Drouin, J. , & Rivet, C. (2003). Training medical students to communicate with a linguistic minority group. *Academic Medicine, 78,* 599-604.

Dunning, D. G., & Lange, B. M. (1993). "Direction" in male and female dental students' interaction with patients: A confirmation of similarities. *Health Communication, 5.* 129-136.

Fadiman, A. (1997). *The spirit catches you and you fall down.* NY: The Noonday Press.

Fkitten (April 23, 2005). Clients or patients. Message posted to *Amysrdhlist.com: A unique Dental Hygiene Community* at http://www.Amysrdhlist.com

Gadon, M., Balch, G. I., & Jacobs, E. A. (2007). Caring for patients with limited English proficiency: The perspectives of small group practitioners. *Journal of General Internal Medicine, 22(Suppl. 2)*, 341-346. Retrieved November 4, 2007, from http://www.springerlink.com/content/t744v8uptt62/?sortorder=asc&p_o=10

Gardenswartz, L., & Rowe, A. (1998). *Managing diversity in health care.* San Francisco: Josssey Bass.

Gaston, M. A. (2002). Low literacy: A problem in health care. *The Journal of Dental Hygiene, 76(3)*, 172-173.

Glick, M. (2006). The Tower of Babel and health outcomes. *Journal of the American Dental Association, 137*, 1356-1358.

Goldeen, J. (January 22, 2006). High-tech video language-interpretation service ready to roll. *Recordnet.com.* Retrieved August 31, 2008, from http://www.recordnet.com/apps/pbcs.dll/article?AID=/20060122/MONEY/601220332/1003

Goldman, J. (April 23, 2005). Clients or patients. Message posted to *Amysrdhlist.com: A unique Dental Hygiene Community* at http://www.Amysrdhlist.com

Gordon, R. G, Jr. (Ed.). (2005). *Ethnologue: Languages of the world* (15th ed.). Dallas, TX: SIL International. Retrieved November 7, 2008, from http://www.ethnologue.com/

Griffin, E. (2000). *A first look at communication theory* (4th ed.). Boston: McGraw-Hill.

Haidet, P., & Paterniti, D. A. (2003). "Building" a history rather than "taking" one: A perspective on information sharing during the medical interview. *Archives of Internal Medicine, 163*, 1134-1139.

Holland, J. C., Geary, N., Marchini, A., & Tross, S. (1987). An international survey of physician attitudes and practice in regard to revealing the diagnosis of cancer. *Cancer Investigation, 5*, 151-154.

Hufford, D. J. (1997). Gender, culture and experience: A painful case. *Southern Folklore, 54*, 114-123.

Johnson, K., & Weiss, B. D. (2008). How long does it take to assess literacy skills in clinical practice? *Journal of the American Board of Family Medicine, 21*, 211-214. Retrieved August 24, 2008 from http://www.jabfm.org/cgi/content/abstract/21/3/211

Jones, M., Lee, J. Y., & Rozier, G. (2007). Oral health literacy among adult patients seeking dental care. *Journal of the American Dental Association, 138*, 1199-1208.

Kang, E., Fields, H. W., Cornett, S., & Beck, F. M. (2005). An evaluation of pediatric dental patient education materials using contemporary health literacy measures. *Pediatric Dentistry, 27*, 409-413.

Katalanos, N. L. (1994). *When yes means no: Verbal and nonverbal communication of Southeast Asian refugees in the New Mexico health care system*. Unpublished masters thesis, University of New Mexico, Albuquerque.

Kavanaugh, K. H., & Kennedy, P. H. (1992). *Promoting cultural diversity: Strategies for health care professionals*. Newbury Park: Sage Publications.

Keers-Sanchez, A. (2003). Mandatory provision of foreign language interpreters in health care services. *The Journal of Legal Medicine, 24*, 557-578.

Ku, L., & Flores, G. (2005). Pay now or pay later: Providing interpreter services in health care. *Health Affairs, 24*, 435-444. Retrieved August 31, 2008, from Academic Search Premier (EBSCO) database.

Kirsch, I. S., Jungeblut, A., Jenkins, L., & Kolstad, A. (2002). Adult literacy in America: A first look at the findings of the National Adult Literacy Survey (3rd ed.). *National Center for Education Statistics, U.S. Department of Education, Office of Educational Research and Improvement*. Washington, DC: U.S. Government Printing Office. Retrieved August 12, 2008, from http://nces.ed.gov/Pubsearch/pubsinfo.asp?pubid=93275

Korsch, B. M., Gozzi, E. K., & Francis, V. (1968). Gaps in doctor-patient communication. *Pediatrics, 42*, 855-871.

Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy. *U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics*. Washington, DC: U.S. Government Printing Office. Retrieved July 26, 2008, from http://nces.ed.gov/pubs2006/2006483.pdf

Ling, J. (2001). Number of words in the English language. *Hypertextbook*. Retrieved July 10, 2008, from http://hypertextbook.com/facts/2001/JohnnyLing.shtml

Locke, J. (2004). A history of plain language in the United States Government. *Plain Language.gov: Improving communication from the Federal Government to the public*. Retrieved August 26, 2008, from http://www.plainlanguage.gov/whatisPL/history/locke.cfm

Mikkelson, H. (1995). The art of working with interpreters, a manual for health care professionals. *ACEBO*. Retrieved August 28, 2008, from http://www.acebo.com/index.htm

Mitka, M. (2001). Tearing down the Tower of Babel. *JAMA: Journal of the American Medical Association, 285*, 722-723.

Mongeau, S. W., & Horowitz, A. M. (2004). Assessment of reading level and content adequacy of oral cancer educational materials from USAF dental clinics. *Journal of Cancer Education, 19(1)*, 29-36.

Nair, B. R. (1998). Patient, client or customer? *The Medical Journal of Australia, 169*, p. 593.

The National Literacy Act, Public Law 102-73 (1991). *National Institute for Literacy.* Retrieved August 27, 2008, from http://www.nifl.gov/public-law.html

Newton, J. T. (1995). Dentist/patient communication: A review. *Dental Update, 22*, 118-22.

Nielsen-Bohlman, L, Panzer, A. M., & Kindig, D. A. (Eds.). (2004). Health literacy: A prescription to end confusion. *Institute of Medicine of the National Academies.* Washington, D.C.: The National Academies Press. Retrieved July 16, 2008, from http://www.iom.edu/?id=19750

Novack, D. H. (1995). Therapeutic aspects of the clinical encounter. In M. Lipkin, Jr., S. M. Putnam, & A. Lazare (Eds.), *The medical interview: Clinical care, education and research* (pp. 32-49). NY: Springer-Verlag.

Office guide to communicating with limited English proficient patients (2007). (2nd ed.). *American Medical Association.* Retrieved June 1, 2007, from http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf

Ogden, J., Branson, R., Bryett, A., Campbell, A., Febles, A., Ferguson, I., et al. (2003). What's in a name? An experimental study of patients' views of the impact and function of a diagnosis. *Family Practice, 20*, 248-253. Retrieved August 18, 2008, from http://fampra.oxfordjournals.org/cgi/content/abstract/20/3/248

Ong., L. M. L., de Haes, J. C. J. M., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: a review of the literature. *Social Science and Medicine, 40*, 903-918.

Osborne, H. (2005). *Health literacy from A to Z: Practical ways to communicate your health message*. Sudbury, MA: Jones and Bartlett Publishers.

Paasche-Orlow, M., & Wolf, M. (2008). Evidence des not support clinical screening of literacy. *Journal of General Internal Medicine, 23*, 100-102.

Parikh, N. S., Parker, R. M., Nurss, J. R., Baker, D. W., & Williams, M. V. (1996). Shame and health literacy: The unspoken connection. *Patient Education and Counseling, 27*, 33-39.

Perkins, J., & Youdelman, M. (2008). Summary of state law requirements addressing language needs in health care. *National Health Law Program*. Retrieved August 12, 2008, from http://www.healthlaw.org/library/folder.56882-Language_Access_Resources

Ranno, S. G. (April 23, 2005). Clients or patients. Message posted to *Amysrdhlist.com: A unique Dental Hygiene Community* at http://www.Amysrdhlist.com

Ramdass, M. J., Naraynsingsh, V., Muharaj, D., Badloo, K., Teelucksingh, S., & Perry, A. (2001). Question of "patients" versus " clients." *Journal of Quality in Clinical Practice, 21*, 14-15.

Roberts, C., Moss, B., Wass, V., Sarangi, S., & Jones, R. (2005). Misunderstandings: A qualitative study of primary care consultations in multilingual settings, and educational implications. *Medical Education, 39*, 465-475.

Rosenberg, E., Seller, R., & Leanza, Y. (2008). Through interpreter's eyes: Comparing roles of professional and family interpreters. *Patient Education and Counseling, 70*, 87-93.

Rudd, R., & Horowitz, A. M. (2005). The role of health literacy in achieving oral health for elders. *Journal of Dental Education, 69*, 1018-1021.

Sfikas, P. M. (2004). Serving those with little or no knowledge of English: An examination of language-assistance requirements issued by the U.S. Department of Health and Human Services. *The Journal of the American Dental Association, 135*, 1616-1618.

Sheidlower, J. (2006). Word count: Are there really 988,968 words in the English language? *Slate*. Retrieved July 10, 2008, from http://www.slate.com/id/2139611/

Shin, H. B., & Bruno, R. (2003). Language use and English-speaking ability: 2000, Census 2000 brief. *U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration*. Retrieved August 12, 2008, from http://www.census.gov/prod/2003pubs/c2kbr-29.pdf

Smith, T. A., & Heaton, L. J. (2003). Fear of dental care: Are we making any progress? *Journal of the American Dental Association, 13*, 1101-1108.

Standards for clinical dental hygiene practice (2008). *American Dental Hygienists' Association.* Retrieved May 18, 2008, from http://www.adha.org/downloads/adha_standards08.pdf

U.S. Department of Health and Human Services (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health (2000). *Oral health in America: A report of the Surgeon General: Executive summary*. Rockville, MD: Author. Retrieved June 17, 2005, from: http://www2.nidcr.nih.gov/sgr/execsumm.htm

Weiss, B. D. (2007). *Health literacy and patient safety: Help patients understand: Manual for clinicians.* Chicago, IL: The American Medical Association Foundation.

Weston, W. W. (2001). Informed and shared decision-making: The crux of patient centred care. *Canadian Medical Association Journal, 165*, 438-439.

Wilson, E., Chen, A. H., Grumbach, K., Wong, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine, 20*, 800-806.

Wing, P. D. (1997). Patient or client? If in doubt, ask. *Canadian Medical Association Journal, 157*, 287-289. Retrieved July 2, 2005, from http://www.cmaj.ca/content/vol157/issue3/

Wolf, M. S., Davis, T. C., Shrank, W., Rapp, D. N., Bass, P. F., Connor, U. M., Clayman, M., & Parker, R. M. (2007). To err is human: patient misinterpretations of prescription drug label instructions. *Patient Education and Counseling, 67*, 292-300.

Wood, M. L., (1991). Naming the illness: The power of words. *Family Medicine, 23*, 534-538.

Wright, N. (n.d.). Clear writing and plain language. *Plain Language.gov: Improving communication from the Federal Government to the public.* Retrieved August 26, 2008, from http://www.plainlanguage.gov/whatisPL/definitions/wright.cfm

Youdelman, M., & Perkins, J. (2005). Providing language services in small health care provider settings: Examples from the field. *Commonwealth Fund.* Retrieved October 17, 2006, from http://www.cmwf.org/usr_doc/810_Youdelman_providing_language_services.pdf

# Chapter 4
# Nonverbal Communication: The Eyes of Health Care

Learning Objectives For Chapter 4

After reading this chapter you should have:

1. Have been introduced to some basic concepts of nonverbal communication
2. A general understanding of the role of nonverbal communication in dentistry
3. Become more aware of incoming and outgoing nonverbal communication.

Hans was the most extraordinary horse of his day. By tapping his hoof, he could do simple and complex math, even fractions; he could count people in a crowd; he could answer questions using an alphabet coded to use his taps; he even appeared to be able to read! He was nicknamed "Clever Hans" and became famous, even outside his home in Germany in 1900. Of course, experts in several fields tried to disprove his abilities. All failed until 1911, when a researcher named Oskar Pfungst figured out what was happening. The secret was that Hans was unusually adept at reading nonverbal communication! When audience members knew the answer to a given problem, Hans could "read" their signals. They would tense up in anticipation of Hans' answer, then when the correct number of taps was reached, they would relax and move their heads upward slightly, as little as one-fifth of a millimeter, raise their eyebrows, or dilate their nostrils. Each of these subtle cues told Hans that it was time to stop tapping. Oskar Pfungst continued to study this phenomenon among human beings and eventually developed a concept called the "Clever Hans Effect," the notion that people can unknowingly send, receive, and be influenced by nonverbal messages. (Knapp & Hall, 1997; Pfungst, 1911, 1995).

## Introduction

We are all sensitive to the subtle and not-so-subtle nonverbal communication (NVC) that continually inundates us and that we intentionally or unintentionally use every day in practice. We assess patients' health by looking at their demeanor and energy level, skin color, eyes, facial expression, by listening to their voices, and attending to other clues. We can detect warmth or anger or impatience in a voice. We can gauge the sincerity of a smile. We attempt to detect fear or pain in body language, even when the patient denies its presence. This chapter will provide an overview of this interesting field. After defining the term and explaining its relevance to dental professionals, I will discuss some general knowledge and principles especially as they relate to health care, then give an overview of individual components of NVC and relate them to the dental field.

## Nonverbal Communication and Its Relation to Culture

What is ***nonverbal communication***? According to Harris and Sherblom (2002), it includes "all behaviors that are not consciously verbal and that are assigned meaning by one or both of the parties in a communication interaction" (p. 109). The interesting part of this definition is that only one person must assign meaning to a behavior for it to have significance. We can receive messages that another person may not have meant to send and, conversely, we can send unintended messages, as Oskar Pfungst declared with his Clever Hans Effect a century ago. Additionally, most scholars feel that verbal communication is commonly used to communicate facts while NVC is used mainly to express emotions, attitudes, and preferences (Mehrabian, 1972, 1981). Of course these are broad distinctions, the division is not exact, and there is an overlap between the two

modes. Mehrabian adds that nonverbal messages can also come from appearance and body adornments, color, odor, temperature, and inanimate objects or "environmental props" (p. 2) such as furniture and equipment. So we can see that this is an extensive and multifaceted area of study.

The field becomes even more complex when we factor in culture. Many misunderstandings can occur because of varying cultural rules of nonverbal communication. In most western cultures such as in North America a person who makes direct eye contact is considered forthright and trustworthy, whereas in many other cultures direct eye contact with someone who is not an equal is a sign of disrespect and even confrontation. In most cultures a smile sends a positive message but in some it can indicate embarrassment or other emotions. Due to these and many other differences, it is impossible to discuss nonverbal communication without acknowledging culture's influence, so you will find many cultural examples in this chapter.

## Why is NVC important in health care?

There are a several reasons why it is important for health providers to understand NVC. First, it is a major part of communication. Scholars differ as to exactly how much, but most agree that it is at least two thirds of our emotional and relational messages (Birdwhistell, 1970; Mehrabian, 1981). Mehrabian asserted that only 7% of emotional meaning is contained in the actual words we speak, 38% is vocal expression or *how* we say those words, and the majority, or 55%, is conveyed through facial expression. The amount also depends on the context. Obviously I could not write or even teach about nonverbal communication without words. The communication in a physiology class is

probably 95% verbal, while in an evolved personal relationship words can become almost unnecessary. Regardless of which scholar's ideas you accept, NVC includes a lot of information that can be sent, received, and misunderstood. In the rendering of health care, misunderstandings can impact wellbeing, so we aim to eliminate, or at least minimize them as much as possible. An understanding of NVC can assist us in doing that.

Second, both patients and professionals rely on NVC in the dental office to gain fast and reliable information, allay fear, and assure honesty. All of us can gain information quickly by watching each other's NVC before speaking. Patients will read an office's NVC from the moment they enter. They will notice the décor and cleanliness, how the staff treats patients and each other, how they speak on the phone, and so forth. Clinicians will use the patient's NVC to look for clues as to how the person is feeling that day, whether or not he will need extra care (and extra time), and to answer many other questions. Roger Ailes (1995) contends we can gain a first impression in only seven seconds. I disagree. I believe that dental personnel, especially those with some experience, can get surprisingly accurate first impressions almost instantly.

Many depend on nonverbal communication for reliable information. If a patient is embarrassed, or shy to the point that she cannot or does not want to ask a question, or if a question is asked and the answer is not understood, rather than requesting clarification the person may try to read the nonverbal messages. When patients feel that we are not honest with them, such as when they ask if something will hurt and we say it won't but then it does, they lose trust in our words and thus rely on our NVC to get what they perceive as the *truth*. If the patient seems distant, defensive, unclear, or incomplete in his

communication, does not speak English, or has hands and instruments in his mouth, then the practitioner turns to his NVC for needed information. At such times we watch their nonverbal messages to try to detect what we understand to be the *truth.*

Third, research supports the importance of nonverbal communication in business and dentistry, and of course dentistry is a business. I will report on some of that research in this chapter. For now, you may recall that Boswell (1997), the mystery dental patient who also surveyed and interviewed thousands of actual dental patients, listed 14 reasons why patients "graze" (p. 59) or go dental office shopping. None of those reasons relate to treatment. All of them relate to communication in general. Five reasons relate to nonverbal communication in particular: lack of listening; use of time especially when keeping someone waiting and not acknowledging their presence; appearance of the office; appearance and demeanor of the staff; and tension or lack of cohesiveness among the staff. These nonverbal cues make people so uncomfortable that they will leave an office just to get away from them, so it is important for dental personnel to understand the influence of nonverbal communication.

And finally the most important reason to study nonverbal communication is to enhance our ability to send and receive clear communication. Ralph Waldo Emerson wrote, "What you do speaks so loud that I cannot hear what you say." We need to begin to understand how such powerful messages are sent.

*Take time to think*: The next time you watch a movie, television show, or commercial, notice how much of acting depends upon nonverbal communication. You might even mute the sound to see how much of the messages you can understand without hearing words and vocal expression.

## Principles of Nonverbal Communication

In dentistry we learn the basics of biofilm, caries, and periodontal disease; there are also basic principles of nonverbal communication. First, this is a complex field that cannot be completely separated from verbal communication. "Ray Birdwhistell...reportedly said that studying nonverbal communication on its own is like studying noncardiac physiology" (Knapp & Hall, 1997, p. 11). Even so, we do study the various systems of the body separately to facilitate our learning. Likewise, there is much to be gained from devoting special attention to the individual components of nonverbal communication.

Nonverbal messages are not consistent among people. Just as we are unique in our use of language, so are we also unique in our use of NVC. I will make many generalizations in this chapter to help my readers understand the field, but remember that there is a range of possible outcomes for each generalization. Nonverbal styles will vary among people due to context, culture, personality, life experience, and other variables. The better you get to know someone, the more adept you will become at comprehending meaningful nonverbal messages from that individual.

Third, individuals are not equally able to understand nonverbal communication. Subordinate people are generally better at it than leaders, supervisors, and bosses, mainly because they have to be. Abused children are exquisitely able to read the slightest glimmer of anger on all adults' faces (Bower, 2002). Women tend to be better at reading NVC partly because they are more inclined to focus on emotional communication compared to men, partly because they are more likely to be employees than they are

employers (Tannen, 1990; Wood, 2002), as well as for the reasons stated in the previous paragraph. In my experience, however, employers who are sensitive to nonverbal messages make the best managers. So NVC abilities are valuable tools for everyone. Our aptitude in this area grows with experience in life and as health care providers.

When the verbal and nonverbal messages are inconsistent with each other, we tend to believe the nonverbal message. Herodotus wrote in the 5th century BCE, "Men trust their ears less than their eyes," and you know this from your own experience. If I tell you that I love the gift you just gave me but I wince as I say it, you will believe my facial expression over my actual words. If a patient tells you that he is "fine," but he continues to squirm and make ugly faces, then you will suspect that he is uncomfortable. In these cases the old saying, "Actions speak louder than words," is right on!

Verbal communication is always intentional and thus can be turned on and off; NVC is either intentional or unintentional and continuous. We choose when to start and stop speaking, but, as the Clever Hans Effect asserts, nonverbal messages can leak out whether we want them to or not. Verbal messages come through our words, a single channel. Nonverbal messages come through multiple channels including appearance, body language, facial expression, eye contact, vocal expression, touch, and the use of time, space, and silence. Isn't it amazing that we can take in these multiple messages and make sense of them most of the time?

Precisely because nonverbal messages are so complex and vary among individuals and cultures, and even though they are more trusted than words, they are more likely to be misunderstood compared to verbal messages. As a result, NVC can be both powerful

and limited: it is powerful because it makes up such a large proportion of communication, is continuous, and can come through numerous channels; it is limited because, compared to words, it is more likely to be misinterpreted.

We also must remember what nonverbal communication is *not*. Because NVC is so complex and can so easily be misinterpreted, it is not a foolproof way to understand people. Also, it should not be interpreted on its own. A person with folded arms may be defensive, as some body language texts claim, or she may be physically cold, or she may merely be most comfortable in that position. It is best to integrate the verbal message with the nonverbal messages to minimize the possibility of misunderstandings. "Read" nonverbal messages tentatively.

Now that we have defined nonverbal communication, discussed why it is an important area of study for health care providers, and listed some of its principles, we will move on to its various areas of study. These include: appearance of offices and practitioners; kinesics or body language including gesture; facial expression, smiling, and eye contact; paralanguage or vocal expression; chronemics or the use of time; proxemics and territoriality or the use of space; and haptics or the use of touch.[6] Even though I will emphasize NVC that passes between and among individuals, I will also include a brief discussion of office appearance.

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[6] Listening and the use of silence are also important components of nonverbal communication, so important that I will devote a full chapter to them in Section II.

## Areas of Nonverbal Communication Study

### *Appearance*

***Appearance*** communicates. We have all been taught in life and in school about the importance of personal appearance, especially in a work environment. We know that wardrobe and grooming choices, especially at first meeting, can impact credibility and either enhance or hinder the development of trust. We are "selling" health, so we must portray health and good grooming is a large part of that. Remember that Roger Ailes (1995) contends that we make or get a first impression in only seven seconds but that I disagree. I believe that an experienced dental hygienist can gain an immediate first impression, and many of our clients are just as fast at forming impressions of us.

*Take time to think*:
Name two or three people you met in the last few months. How quickly did you get an impression of each one? Name two or three people you know well. How accurate were your first impressions of those people? Now pay closer attention when you meet a new person and note the nonverbal cues you use to form first impressions.

One reason the issues of appearance and first impressions are important is because today's lifestyle is generally much more casual compared to a few years ago and we have many newcomers from different parts of the world in our country. Older people and many from other cultures tend to expect a higher level of formality in both speech and appearance, and they are only some of our clientele who may find it difficult to adjust to today's informal norm. An elderly gentleman was so shocked to find his attorney dressed in denim coveralls on "casual Friday" that he almost took his business elsewhere. Obviously we must also balance formality with practicality as we work in a physically demanding profession. We can be comfortable but still give a professional impression if

we aim for a neat, simple, and uncluttered look.

Office appearance also communicates, and that includes sounds and smells. Remember that Boswell (1997) named one reason that patients "graze" is due to the appearance of the office. People want to receive health care in a clean, uncluttered, efficient-looking, clean smelling, and relatively calm and quiet environment. We can become immune to the look and smell and sounds of our workplaces. I recall many times when I walked in the door from work and my husband would comment that I smelled like a dental office, but I was oblivious. We cannot completely eliminate the smells of necessary medicaments or the sounds of our equipment, but we can be sure that the light cover is free of splatter and that the counter is clear.

*Take time to think and talk*:
The next time you're at work take a moment to sit in the patient's chair and view your workplace from a different perspective. Then ask a friend or coworker to do the same and discuss your observations. You may be surprised at what you learn.

This is only a simple overview of this topic; there is much more to say about personal and office appearance, but I wanted only to draw attention to the topic here. Now I turn to the messages that we send by the way we use our voices.

### *Paralangauge*

How many times have we heard, "It's not what you said, it's how you said it?" This common expression refers to the nonverbal topic of ***paralanguage***. The paraverbal features of language include all sounds other than words as well as the rate, volume, and pitch of speech, pronunciation, accents, and other vocal qualities. All of these features add meaning and emotion to our spoken words and can also be meaningful on their own.

Mehrabian (1981) estimates that as much as 38 percent of the emotional meaning of a message is derived from such vocal cues. Some extra-language sounds can include *uh oh!* (oops), "*psst*! *ugh*! *uh uh* (no), *uh huh* (yes), *ah ah* (warning), *aha* (understanding), *phew*! *hmmm mmm*, and *tsk tsk*!" (Pennycook, 1985, p. 267). If a parent asks a teenager where he was the previous evening and the boy answers promptly, "At the library," that has one meaning. In another exchange, the boy uses the very same words, but hesitates for just a second before answering. The first answer is more credible than the second, even though the only difference between them is a one second delay. The classic example of paralanguage is sarcasm. Say the phrase: "You look wonderful today," both normally and sarcastically. The meaning is entirely different both times.

The research on the relationship between certain vocal signals and persuasion can be applied to dentistry. Burgoon, Burke, & Pfau (1990) found that a speaker's persuasiveness and credibility were enhanced by varied pitch, fluent and unhesitating speech, prompt response, and relatively louder and faster speech in comparison to the listeners. Obviously, there is a limit beyond which any of these characteristics might move from being persuasive to being annoying, so in order to be more believable we should be both verbally expressive and confident in our knowledge.

People depend on paralanguage cues to interpret meaning when receiving dental treatment because their caregivers are covered in long jackets, gloves, masks, glasses, and face shields. We can transmit a sense of concern, liking, authority, humor, and a hundred other positive and negative nuances of emotion, we can even "smile," by merely manipulating the rate, volume, pitch, and quality of our voices. The paralinguistic cues

that we send are modified by the way we move our bodies and manipulate our faces.

## *Kinesics*

When learning a foreign language, one of the most difficult skills to acquire is to understand a telephone conversation because we cannot see the other person. We depend a great deal on ***kinesics***, gestures and facial expressions, to complete the meaning of a person's words. This complex area of nonverbal communication, and its largest, includes the study of eye contact, facial expression, posture, arm and hand motions, and general body language.

A wink, a raised hand to indicate "stop," a shrug of the shoulders, and a studied stare all convey meaning both on their own and in conjunction with verbal messages. We signal how we see ourselves by how we hold our bodies. A slouch and a shuffle can indicate lack of confidence or a depressed mood, while an assured upright walk implies optimism or a positive self-image. Streek (1993) found that gestures generally forecast verbal communication, giving us a literal "heads up" so we are aware that a message is coming. They also enhance our verbal meaning by adding emphasis (pounding on the counter as you make a point) or clarity (indicating which way to go as you explain directions). "Clever Hans" was able to read minuscule head movements; humans can be even more discerning. In this section I will touch on the subjects of gesture and facial expression including smiling and eye contact.

### *Gesture*

***Gesture*** refers to the physical movement of all body parts except for facial expressions. We know that gestures can modify or clarify our words, but we must also

remember that these gestures are not culturally or semantically universal. When we want to encourage someone or show a positive response we may use our hands to make a "V" for victory, an "A-OK," or a thumbs up. All of these gestures are obscene in different parts of the world. In North America we pull our hand toward us to indicate, "come here," but the same gesture in the Philippines means "go away." A nod of the head can mean "yes" or "no," depending on where you are in the world. In many parts of the world it is extremely rude to point with a single finger. A shrug of the shoulders in western cultures means, "I don't care." The same gesture when used by New Zealand Maoris and native Fijians means "I don't know." In western cultures we stand when a respected person enters the room. In Fiji, Samoa, or Tonga, people sit down as a sign of respect (Singh, McKay, & Singh, 1998).

We can imagine the profound consequences if either the patient or the clinician misreads any of these gestures. There is a big difference between "I don't care" and "I don't know." There is a big difference between an encouraging thumbs up and an obscene gesture. When showing people to our operatories we should gesture with a whole hand rather than pointing with a single finger. If people take offense at our gestures, or we take offense at theirs, our relationships can be altered and trust can be lost. This does not mean we cannot use *any* gestures for fear of causing offense. It just means that we are more aware of the possibility of misinterpretation.

In dentistry we can use gestures to enhance our patient education efforts. Trout & Rosenfeld (1980) reported on the concept of ***congruence***. This is the mirroring of gestures that occurs when people are "in sync" and communicating well, indicating

rapport and cooperation. This phenomenon can be observed any place where you see people talking; they cross their legs or arms, tilt their heads, or lean forward in similar ways. This means that we can illustrate our interest in what our patients have to say by displaying congruence with their body language, and that we can recognize their meaning when they posture themselves congruently with us. It is an interesting experiment to try. Obviously we will be subtle when we consciously attempt to mirror another's body language. The importance of body language in health care goes beyond congruence.

Roter and her colleagues (2006), in a review of the literature on nonverbal expression of emotion in health care, found that physicians' emotionally expressive behaviors (including facial expressiveness, head nods, eye contact, and forward lean) generally produced patients who were more satisfied with their care, more likely to keep their appointments, and who functioned better. This was true for patients with a wide variety of diseases and conditions from heart disease to depression. It makes sense. Of course most people prefer and are more likely to respond to friendly and involved caregivers. But positive nonverbal behaviors can have an even more profound impact. Ambady et al. (2002) studied physical therapists (PTs) working with elderly patients during hospitalization and three months after going home. The researchers found that the patients of PTs who smiled, nodded, and frowned with concern (as opposed to frowning with disapproval) were less confused and depressed and more physically active when compared to the patients of PTs who did not smile or maintain eye contact. This leads us to other areas of kinesics.

*Take time to think and talk*: The next time you are in a public place see if you can detect the concept of *congruence* in action. Describe what you observe to a friend.

*Facial Expression*

We can create more than 7000 expressions with our 80 facial muscles, and we can show more than one emotion at a time. The seven main emotions that are expressed on the face are anger, sadness, concern, fear, surprise, contempt, and happiness. We can be simultaneously happy and surprised, sad and angry, happy and concerned and afraid, surprised and angry and concerned. There is no end to the combinations. Of the seven, only surprise is universal among cultures. What is called the "eyebrow flash" is such an instantaneous reaction that it is the most difficult to manipulate. Add to that the expression of feelings, of which *pain* is of particular importance in the dental office, and you can see how complicated this area of study can be.

Some research has shown that your facial expression can both influence and reflect your impressions and emotions. This concept is called the ***Facial Feedback Hypothesis***, which theorizes that if you smile while looking at something or someone, you are more likely to have a positive impression than you would if you frown. Adelman and Zajonc (1989) traced the history and development of this notion from research originally published as early as the 1850s and concluded that the evidence strongly supports the hypothesis. On the other hand, it has also been disproved at least in regards to the facial expression of pain. Prkachin (2005) found that either exaggerating or minimizing facial pain expression did not influence the degree of felt pain. Either way, it

is an interesting concept that can have implications in the dental office where, even thought we don't like to admit it, people do feel pain.

Pain is personal. Some people are scared silly when they see a mouth mirror and others actually ask us to be aggressive. One patient told me that forceful manipulation of mouth tissue felt like "scratching an itch," but that was one person in 26 years of practice. Recent research partially explains this phenomenon by demonstrating a genetic component to the experience of pain (Diatchenko, 2005). This study is especially significant to dental professionals because the researchers' subjects were suffering from temporomandibular (TMD) joint disorder. Most of us have treated people with chronic TMD and know how painful it can be. Diatchenko found that human beings carry one of three genes that are associated with low, moderate, or high pain sensitivity. People with the low pain sensitivity gene felt a decreased presence of myogenous temporomandibular joint disorder pain by as much by 2.3 times compared to people with the high pain sensitivity gene. The presence of a genetic connection helps explain the individual experience of pain but not its emotional expression.

Not surprisingly, culture can influence the nonverbal expression of pain. Fadiman (1997) described Hmong women in childbirth. Traditional Hmong women "labored in silence" (p. 3) because to cry out in pain might interfere with the birth and is considered shameful to the family and community. The same is true of men in many cultures where it is not masculine to react to all but the most extreme pain. We tell our athletes, even children, to "rub it up" or just deal with it. So the expression of pain is influenced by genetics, personality, and culture.

We know, or at least suspect, that some of our patients either over or understate the pain they actually feel and that sometimes pain, or fear of pain, can be expressed as anger or arrogance. So, as caring people, how do we know which is which and then how do we deal with it? Prkachin & Craig (1995) did some research on this topic and reached some conclusions that can help us understand it. First, people vary in their ability to "read" facial expressions of pain. No surprise there. Experience in general and with individuals can sensitize us to pain signals. Second, pain that is expressed facially is likely already pronounced. People tend to be more stoic than dramatic. The third and fourth conclusions follow from the first two: absence of pain expression does not necessarily mean an absence of pain so, as a result, observers tend to underrate facial expressions of pain.

We can see that it is important for us to know that in general people are more likely to tough it out rather than tell us that they are in pain. A dentist insisted that a dental hygienist routinely use local anesthetic for periodontal cleanings. The hygienist resisted until the dentist told him that patients were complaining about pain. The dentist's words reflect Prkachin & Craig's (1995) conclusions, "They won't *tell* you." But they will tell others and harbor negative feelings about you. So don't make assumptions about the presence or absence of pain based on ambiguous nonverbal communication. Confirm your suspicions by asking the patient directly. Now I turn to the opposite of pain expression—smiling.

*Smiling.*

We are in the business of improving smiles, a strong reason that we should understand the importance of smiling. "Service with a smile" is a common business motto. It is not surprising that people prefer to patronize businesses staffed by friendly people, but the subject of smiling is not as simple as it appears. Even though a smile expresses good feelings or happiness most of the time, it can also have other meanings. Leonardo Da Vinci's painting of the *Mona Lisa* is famous because of the lady's enigmatic smile. What emotion is behind it? Is she smiling because the artist asked her to smile, is she truly happy, is she smugly hiding some secret, or do rotten teeth embarrass her? We will likely never know. The same goes for a famous statue of Buddha. He smiles. Is it an expression of love, benevolence, happiness, or some other emotion? We can't ask, so we must draw our own conclusions based on nonverbal communication.

In various Asian countries a smile can mean that a person is embarrassed, nervous, sad, angry, confused, apologetic, or appreciative (Dresser, 1996). Traditional Japanese people feel it is improper for a woman to show her teeth, such as when smiling broadly, which is why a Japanese woman will cover her open mouth and simultaneously tilt her head down or away. In many cultures it is improper for a man to smile at a woman or it is disrespectful to smile at a person who is not an intimate. A Swedish friend told me that one thing she did not like about living in the United States was that people always smiled at her in public and expected her to respond. She missed Sweden where "people leave you alone on the street." On the other hand, Remen (1997) told of her experience in Fiji, where it is considered extremely rude *not* to smile at everyone you meet in public.

The lesson when traveling can be to learn the local norm and follow it as best you can. In the United States, though, most people expect smiles from their health care providers.

When we give "service with a smile" our patrons will know if the friendliness is genuine. A fake smile involves only the mouth muscles; a sincere smile uses eye and other facial muscles and voices, too. Try this. Look in the mirror as you turn up the corners of your mouth to create a manufactured smile. Compare that expression to how you look as you smile sincerely when recalling a humorous memory. Now put on a mask and repeat the exercise. Can you detect the insincere smile when you are wearing a mask? This is important as we care for people because we usually cover our mouths with masks and shields, so an insincere smile will usually not be seen at all. A genuine smile, on the other hand, can also be seen in our eyes and forehead muscles and heard in our voices.

Gallegos and Trannel (2005) did some interesting research on facial expression. Participants in their study were able to identify famous faces significantly faster when the celebrities were smiling as opposed to when they wore neutral expressions. The researchers argued that their findings showed that facial expressiveness including smiling promotes attention and also aids memory and decision-making. So the implication is that if we smile at our patients they are more likely to remember what we tell them and make better decisions about their own care. The authors speculated that the reason for this could have to do with brain chemistry related to the amygdala. Whether these findings are due to chemistry or emotion, we must remember the important effect that our smiles, or the lack of them, can have on our patients.

*Web watch*: See if you can spot the fake smiles:
http://www.bbc.co.uk/science/humanbody/mind/surveys/smiles/index.shtml

*Eye contact.*

The eyes are another part of the face of particular importance in dentistry. This is mainly because they are virtually the only facial feature that patients can see when we are in full infection control gear that includes masks, glasses, and face shields. We use our eyes to regulate interactions. Making eye contact is the first step toward having a conversation with someone. If we don't want to talk we purposely avoid eye contact. In an elevator or on an airplane it can be considered a rude invasion of privacy to look at someone for more than a moment. The rules regarding who can look at whom and for how long in a given situation can be complicated, especially when we factor in culture.

In most western cultures, especially in North America and Europe, direct eye contact is considered a sign of honesty and a lack of it can indicate that a person is deceptive or shifty. However, in many Asian, Latin, and American Indian cultures it is disrespectful to maintain direct eye contact with someone who is not your equal, and looking away is a sign of deference or respect (Dresser, 1996). A dental hygienist who took one of my surveys wrote, "I find that with the Asian patients, I get minimal eye contact and feel that they are disengaged with me" (Adams, 2005, p. 30). I hope that person reads this so s/he will know that it is all right. Those people are showing respect according to their own rules of nonverbal communication.

In regards to health care, the way we use our eyes can also influence our patients. Remember that Ambady et al. (2002) included eye contact as one of the positive kinesic

behaviors that helped elderly patients to function better and be more active. King (2001) found that appropriate eye contact can be a factor in gaining cooperation and Ruusuvuori (2001) reported that lack of eye contact causes patients to feel that they are not being heard, even when practitioners actually are listening. We can see from the study of kinesics that we may be communicating more than we know by how we express ourselves with our faces and bodies. Now we move to another interesting area of nonverbal communication, the use of space.

### *Proxemics and Territoriality*

People, like animals, maintain and defend certain areas of space around themselves. ***Proxemics*** is the study of the interesting topics of ***territoriality***, or the claiming a fixed spot of land, and personal space, or the portable pocket of space that we carry with us. We send messages with the territories that we claim and the amount of personal space that we need.

At home we have rooms, beds, chairs, desks, closets, and other designated areas that "belong" to us. Most young people today have a presence online called "MySpace." When we are away from home we stake out temporary territories with our personal possessions. At the beach we put down our chairs and towels; in the movies we may leave a jacket on a chair; in a continuing education course we place a notebook, coffee cup, or handout on the table. In the office we feel more comfortable if we have our own territories and the accessories that go with them: *my* operatory, *my* chair, *my* instruments, *my* computer, etc. We also mark and personalize those items and woe be unto any who dare violate them. I recall seeing a label attached to a pen that read, "stolen from

operatory 4." On a more global level, the defense of territory can get ugly. If you think about it, many of the wars in the history of our world have resulted from disputes over territories and land.

In regards to patient care I think it is important for us to remember that in the dental office we are on our own turf and our patients are visitors. In sports it is called the home field advantage. In order to see us, patients not only have to travel, pay for our services, and face the possibility of enduring pain (at least in their own minds), but they also must leave the security of their own territories to do it. Furthermore, the intimidating turf that they enter is full of distinctive smells, fearsome sounds, and pointed tools. This "out of my element" feeling is just one more reason for people to be uncomfortable in a dental office.

Patients enter alien territory only to have their personal spaces violated as well. ***Personal space*** is defined as an "invisible, portable, and adjustable 'bubble,' which we maintain to protect ourselves from physical and emotional threats" (Stewart & Logan, 2006). Imagine yourself walking around inside this bubble of space. No one else can see it, but most people of the same culture understand the rules regarding it. This psychological barrier expands if you are not crowded, such as when you are the only person on the bench or in the reception area, and it contracts when others are present, especially within a limited space such as an elevator or airplane. Edward T. Hall (1966, 1982) studied this phenomenon and concluded that our personal spaces are comprised of four main zones.

***Intimate distance*** is the space from our skin to about 18 inches away. This area is reserved for those emotionally closest to us and we move away when others violate it. At this distance we can hug, cuddle, smell each other, and speak in low voices. In its extreme, trespassing in this space can result in a fight or a sexual harassment lawsuit. ***Personal distance*** is the space from 1.5 to about 4 feet from us. Most personal conversations occur at this distance, which can be as much as an arm's length apart. The outer limit is the point at which one person cannot touch another. ***Social distance***, measuring from four to eleven feet or so, can be found among casual co-workers or between strangers at parties. Conversations at this distance tend to revolve around neutral and impersonal topics. ***Public distance*** is from twelve feet out. This is usually found in more formal contexts and between people of different status, such as in the boss's office, a classroom, or a lecture hall. Of course these are not hard and fast rules. The amount of personal distance we require to feel comfortable is influenced by gender, age, relationships, personalities, context, and, not surprisingly, culture (Knapp & Hall, 1997).

Since the research to establish these categories was conducted in the Midwestern United States, these guidelines do not necessarily apply around the world. In Asian countries people tend toward larger distances, and in Latin and Arab countries they usually stand closer together compared to United States averages. Have you ever been in a conversation with someone from another country and felt that there was something wrong but you just couldn't put your finger on what it was? It might have been a personal space issue. If you could have stood back and watched you might have seen one person feel crowded and then move back. This created too great a distance for the other person

who then moved forward. This continued, back, forward, back, forward—argh!! Both are aggravated but they don't know why. People are not likely to change their perceptions of space, but life is easier if we understand the differences.

In dentistry we routinely "invade" our patients' most intimate personal spaces. We place people on their backs, a vulnerable position, and then, literally, get in their faces. We do have professional license to do this, otherwise we cannot do our jobs, but we are trespassing all the same. This intrusion is likely another factor that contributes to discomfort in the dental chair. As we get this close then we must touch people to care for them.

### *Haptics*

Remember that Boswell (1997) in her interviews of thousands of dental patients found repeatedly that patients want a combination of high touch and high tech. They want dental caregivers to be on the cutting edge in regards to technology and knowledge, but they also want to be recognized as individuals. In other words, they want the personal touch. ***Haptics*** is the study of touch as communication.

Touch is a powerful communicator. Montagu (1986), in his classic book on touch wrote: "Touch is the parent of our eyes, ears, nose, and mouth" (p. 3). Touch is mediated by the skin, our largest organ, so it is felt throughout the body and not limited to certain organs as the senses of sight, hearing, smell, and taste are. It is the first sense to develop at the beginning of life and one of the last to remain at the end of life. "Touching…is, above all, an act of communication" (p. 398). But what are we communicating?

Both the word and the act are loaded with meaning. As we have seen, dental

patients want the personal touch. We also refer to the human touch, the magic touch, the soft touch, the Midas touch, the velvet touch, and the healing touch. We can lose touch and then be out of touch, so AT&T ads encouraged us to "Reach out and touch someone." The word can also describe a particularly meaningful event. "Your note touched me." "I was so touched by the story." On the other hand, we apologize when we touch others by accident, an overly sensitive person is "touchy," one who is slightly crazy is "touched," and many kinds of touch can be physically and emotionally harmful.

Touch has been significant in health care throughout time. There were references to healing touch on an ancient Egyptian tomb dated 2200 BCE and Hippocrates is said to have encouraged all physicians to be adept at "rubbing" or massage (Mentgen, 2001). Animal and human infants who are not touched do not survive, and touch helps colicky babies to sleep better and premature babies to gain weight (Montagu, 1986). Touch deprivation can interfere with sleep, suppress the immune response, and even cause a person to become physically violent (Field, 2003). Massage therapy decreased the frequency and intensity of pain associated with TMD and increased mandibular range of motion (Eisensmith, 2007). Nurses' touch can help medical patients feel more calm and comfortable, can promote better relationships with their patients (Routasalo, 1999), and can modulate heart rate and rhythm, diastolic blood pressure, and anxiety (Bush, 2001). Touch has produced so many positive effects in health care that at least one author has called for touch/massage training for all nursing students (Bush).

Touch is important in dental care for two main reasons. First, touch can facilitate patient cooperation. Segrin (1993) compiled results from 13 studies that investigated the

relationship between touch and compliance.[7] In most cases a light touch on the upper arm or shoulder produced more compliance than no touch at all. Second, appropriate touch can communicate such positive feelings as friendship, reassurance, comfort, interest, concern, and care. Children aged 7-10 who were gently patted on the arm or upper shoulder were less nervous while being treated by a dentist and retained more positive feelings regarding their experiences afterward compared with children who were not touched (Greenbaum, Lumley, Turner, & Melamed, 1993).

The nursing literature refers to two main kinds of touch. Watson (1975) was the first to describe what she called *instrumental* and *expressive* touching. ***Instrumental touch*** is deliberate and task oriented whereas ***expressive touch*** is more spontaneous and related to emotions. The two kinds of touch are not mutually exclusive so they can be combined in a number of ways. This makes sense. Dental hygienists must touch people to care for them. It is the basis of our care. Roberts & Bucksey (2007) found that physical therapists spend 54% of their time touching their patients. If such a statistic were available for dental hygienists it would certainly be at least equal to or, more likely, higher than that. The same researchers concluded that it was not possible to determine if physical therapists' touch was instrumental or expressive and again there is a parallel. The job that we do is modified by the way that we do it. Our instrumental touch can be firm, gentle, tentative, rough, aggressive, brief, long, tolerable, intolerable, and so forth.

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[7] I do not like the word "compliance" because it implies that patients follow orders. I prefer the words "cooperation" or "participation" instead. I use the word "compliance" here because it is the term used by these particular researchers.

All of these kinds of touch communicate in a way that either helps or hinders relationship development and care of our patients.

Touch is not always positive or desirable. It is unwelcome when it has a sexual connotation, is perceived as negative or potentially harmful, invades the person's privacy, or is used as a form of dominance or control (Davidhizar & Gigar, 1997). A dental hygienist's touch could be misperceived as any of these. Touch can also be inappropriate in certain cultural groups especially in regards to sex or gender. In a review of the nursing literature regarding touch, Routasalo (1999) found that female nurses touched more, female patients were more accepting of touch, and the touch of male nurses was less accepted by either sex. Many cultures forbid a man to touch a woman who is not a relative, so the more traditional patients from Asian, Middle Eastern, and Latin cultures may insist on working only with a caregiver of the same sex as the patient (Chachkes & Christ, 1996). Additionally, in some Asian cultures it may be inappropriate to touch the head because it is believed that is where the soul resides (Lipson & Dibble, 2005).

The memory of how we touch can last a long time. I recall the first time I put my hands in another person's mouth when a classmate and I examined each other in dental hygiene school. My friend's touch was hesitant and a little rough, and I'm sure my touch felt the same to her. The instructor then demonstrated the correct procedure to my classmate in my mouth. I was struck by the contrast in an experienced versus an inexperienced touch. I vowed to develop the gentle yet firm and confident touch of our instructor.

Our job is made more difficult because we must touch some of the most sensitive

areas of the body. Watson (1975) found that it was all right to touch someone expressively on the shoulder or upper arm, but *not* the face. Nurses touch the neck, ears, and lips least often because they are such sensitive areas (Routasolo, 1999). Senior citizens were especially uncomfortable when nurses touched their faces (McCann & McKenna, 1992). I noticed this phenomenon when performing the extraoral cancer screening. If I neglected to inform the patient what I was about to do I heard about it immediately. "What are you *doing*?" I learned quickly the importance of describing what I was doing and why ahead of time. Otherwise, people would misunderstand and wonder what this touching of delicate areas had to do with cleaning teeth.

Even though the touch of all health professionals today is attenuated by the required use of gloves to comply with infection control standards, we can still use positive touch to help our patients. We employ affective touch outside of and even during our clinical care. We can shake hands, give a pat on the back or hand, or place a reassuring hand on a shoulder while we are ungloved. A handshake is almost expected. When looking for a dentist in a new city, a friend eliminated the first three candidates in part because they did not shake her hand. During treatment, we can ask an ungloved staff person, preferably one who the patient knows, to hold the hand of an apprehensive person. I have both held the hand of a person receiving treatment from colleagues, and asked other staff people to hold the hands of people who were in my care, and patients always responded positively.

Inasmuch as the appropriateness of who can touch whom under any given circumstance can vary among individuals and cultures, we must be sensitive to the

patient's reaction to our touch and back off at the slightest sign of disapproval. And we will discern that disapproval by "reading" the nonverbal communication. Finally, we must remember that patients are not the only ones "touched" by our care. "Physical touch, as tactile communication, is reciprocal...whom or what a person touches also touches the person" (Routasalo, 1999, p. 843). We must be aware of what we "say" to people with our touch because the effect certainly comes back to us.

*Take time to think and talk*:
Pay close attention to your touch the next time you care for a patient. If appropriate, ask the patient for his or her feedback.

## Conclusion

This chapter is only a brief introduction to the fundamentals, basic tenets, and various aspects of nonverbal communication. The dimensions of NVC combine to create complex messages. We can become better clinicians by training ourselves to be more aware of both the nonverbal messages sent to us by our patients, and those we send to them. We need to "listen" to the nonverbals. We can read as much from a person's posture, movement, expression, and demeanor, as we can from examining a mouth. These skills can serve us in all areas of life as well as at work.

We have now laid a foundation of knowledge about health, intercultural, verbal, and nonverbal communication. In Section II we will add to that base and build skills in interviewing, listening, patient education, persuasion, and understanding emotions in the dental office.

*Side Bar*

*Try This*: Another way we can often use gestures in dentistry is in patient education. I am grateful to my friend and colleague, Mary Sheehan, RDH, for teaching me a technique that was consistently effective in explaining the progress of periodontal disease. Hold your left forearm vertically and make a fist with your left hand, then wrap the fingers of your right hand around your left wrist. Your left fist represents a tooth, your left wrist and arm represent the root, and the fingers of your right hand represent the bone and soft tissue. Move the fingers of your right hand toward your elbow as you explain that gum disease causes the bone to move away from the teeth. Then open up those fingers and move them away from your left arm as you say that gum disease also causes the gums and the bone to separate from the teeth. These three-dimensional, nonverbal gestures, when combined with a verbal explanation, always elicited an "Ah-ha!" or an "I see!" reaction, which a spoken explanation or even a two-dimensional picture alone did not.

## Glossary for Chapter 4

*Appearance*: Personal grooming, wardrobe choices, and the look of our surroundings that send nonverbal messages

*Chronemics*: The study of the use of time as communication

*Congruence*: The mirroring of gestures that occurs when people are "in sync" and communicating well, indicating rapport and cooperation

*Expressive touch*: Spontaneous and related to emotion, compare to *instrumental touch*

*Facial Feedback Hypothesis*: A controversial theory that posits that if you smile while looking at something or someone, you are more likely to have a positive impression than you would if you frown

*Gesture*: A study of the physical movement of all body parts except for facial expressions

*Haptics*: The study of touch as communication

*Instrumental touch*: Deliberate and task oriented, compare to *Expressive touch*

*Intimate distance*: One of Edward T. Hall's four zones of personal space, the space from our skin to about 18 inches away

*Kinesics*: A complex area of nonverbal communication that includes the study of eye contact, facial expression, posture, arm and hand motions, and general body language

*Nonverbal communication*: "All behaviors that are not consciously verbal and that are assigned meaning by one or both of the parties in a communication interaction" (Harris & Sherblom, 2002, p. 109)

*Paralanguage*: The features of language that include all sounds other than words, such as pronunciation and accents as well as the rate, volume, and pitch of speech along with other vocal qualities

*Personal distance*: One of Edward T. Hall's four zones of personal space, the space from 1.5 to about 4 feet from us

*Personal space*: An "invisible, portable, and adjustable 'bubble,' which we maintain to protect ourselves from physical and emotional threats" (Stewart & Logan, 2006)

*Proxemics*: The study of the use of personal space and territory as communication

*Public distance*: One of Edward T. Hall's four zones of personal space, measuring twelve feet from our bodies to infinity

*Social distance*: One of Edward T. Hall's four zones of personal space, measuring from four to about eleven feet from our bodies

*Territoriality*: The claiming of certain fixed plots of land

## References for Chapter 4

Adams, T. S. (2005). *Oral culture: Intercultural communication competence among dental hygienists*. Unpublished manuscript, California State University at Sacramento.

Adelman, P. K. & Zajonc, R.B. (1989). Facial efference and the experience of emotion. *Annual Review of Psychology, 40*, 249-280.

Ailes, R., & Kraushar, J. (1995). *You are the message: Getting what you want by being who you are*. New York: Currency Doubleday.

Ambady, N., Koo, J., Rosenthal, R., & Winograd, C. H. (2002). Physical therapists' nonverbal communication predicts geriatric patients' health outcomes. *Psychology and Aging, 17.* 443-452.

Birdwhistell (1970). *Kinesics and context: Essays on body motion communication*. Philadelphia: University of Pennsylvania Press.

Boswell, S. (1997). *The mystery patient's guide to gaining and retaining patients.* Tulsa, OK: PennWell Publishing.

Bower, B. (June 22, 2002). Hostile intent: Abused kids face up to angry expressions. *Science News, 161,* p. 389.

Burgoon, J. K., Birk, T., & Pfau, M. (1990). Nonverbal behaviors, persuasion, and credibility. *Human Communication Research, 17,* 140-169.

Bush, E. (2001). The use of human touch to improve the well-being of older adults. *Journal of Holistic Nursing, 19*, 256-270.

Chachkes, E., & Christ, G. (1996). Cross cultural issues in patient education. *Patient Education and Counseling, 27*, 13-21.

Davidhizar, R., & Giger, J. N. (1997). When touch is *not* the best approach. *Journal of Clinical Nursing 6*, 203-206.

Diatchenko, L. et al. (2005). Genetic basis for individual variations in pain perception and the development of a chronic pain condition. *Human Molecular Genetics, 14*, 135-143.

Dresser, N. (1996). *Multicultural manners: New rules of etiquette for a changing society.* New York: John Wiley & Sons, Inc.

Eisensmith, L. P. (2007). Massage therapy decreases frequency and intensity of symptoms related to temporomandibular joint syndrome in one case study. *Journal of Bodywork and Movement Therapies, 11*, 223-230.

Fadiman, A. (1997). *The spirit catches you and you fall down.* New York, NY: The Noonday Press.

Field, T. (2003). *Touch.* Cambridge, MA: The MIT Press.

Gallegos, D R., & Tranel (2005). Positive facial affect facilitates the identification of famous faces. *Brain & Language, 93*, 338-348.

Greenbaum, P. E., Lumley, M. A., Turner, C., & Melamed, B. G. (1993). Dentist's reassuring touch: effects on children's behavior. *Pediatric Dentistry, 15*, 20-24.

Hall, E. T. (1959, 1990). *The silent language.* New York: Anchor Books.

Hall, E. T. (1966, 1982). *The hidden dimension.* New York: Anchor Books.

Harris, T. E., & Sherblom, J. C. (2002). *Small group and team communication* (2nd ed.). Boston, MA: Allyn & Bacon.

King, P. E. (2001). Automatic responses, target resistance, and the adaptation of compliance seeking requests. *Communication Monographs, 69*, 386-399.

Knapp, M. L., & Hall, J. A. (1997). *Nonverbal communication in human interaction.* (4th ed.). Orlando, FL: Harcourt Brace Jovanovich College Publishers.

Lipson, J. G., & Dibble, S. L. (Eds.) (2005). *Culture and nursing care: A pocket guide.* San Francisco: UCSF Nursing Press.

McCann, K., & McKenna, H. P. (1992). An examination of touch between nurses and elderly patients in a continuing care setting in Northern Ireland. *Journal of Advanced Nursing, 18(5)*, 838-846.

Mehrabian, A. (1972). *Nonverbal Communication.* Chicago, IL: Aldine-Atherton, Inc.

Mehrabian, A. (1981). *Silent messages* (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Mentgen, J. L. (2001). Healing touch. *Nursing Clinics of North America: Holistic Nursing Care, 36*, 143-157.

Montagu, A. (1986). *Touching: The human significance of the skin* (3rd ed.). New York: Harper & Row.

Pfungst, O. (1911, 1965). *Clever Hans (the horse of Mr. Von Osten): A contribution to experimental, animal and human psychology* (C. L. Rahn, Trans.; R. Rosenthal, Ed.). New York: Holt, Rinehart and Winston, Inc.

Prkachin, K. M. (2005). Effects of deliberate control on verbal and facial expressions of pain. *Pain, 114*, 328-338.

Prkachin, K. M., & Craig, K. D. (1995). Expressing pain: The communication and interpretation of facial pain signals. *Journal of Nonverbal Behavior 19,* 191-205.

Remen, R. N. (1997). *Kitchen table wisdom: Stories that heal.* New York: Berkley Publishing Group.

Roberts, L., & Bucksey, S. J. (2007). Communicating with patients: What happens in practice? *Physical Therapy, 87*, 586-594.

Roter, D. L., Frankel, R. M., Hall, J. A., & Sluyter, D. (2006). The expression of emotion through nonverbal behavior in medical visits: Mechanisms and outcomes. *JGIM: Journal of General Internal Medicine, 21(Suppl.)*, S28-S34.

Routasalo, P. (1999). Physical touch in nursing studies: A literature review. *Journal of Advanced Nursing, 30*, 843-850.

Ruusuvuori, J. (1990). Looking means listening: Coordinating displays of engagement in doctor patient interaction. *Social Science & Medicine, 52*, 1093-1108.

Segrin, C. (1993). The effects of nonverbal behavior on compliance gaining attempts. *Communication Studies, 44.* 169-187.

Singh, N. N., McKay, J. D., & Singh, A. N. (1998). Culture and mental health: Nonverbal communication. *Journal of Child and Family Studies, 7*, 403-409.

Stewart, J., & Logan, C. (2006). Verbal and nonverbal dimensions of talk. In J. Stewart (Ed.). *Bridges not walls* (9th ed.). Boston: McGraw-Hill.

Streeck, J. (December 1993). Gesture as communication: Its coordination with gaze and speech. *Communication Monographs, 60*, 275-299.

Tannen, D. (1990, 2001). *You just don't understand: Woman and men in conversation.* New York: Quill.

Trout, D. L., & Rosenfeld, H. M. (1980). The effect of postural lean and body congruence on the judgment of psychotherapeutic rapport. *Journal of Nonverbal Behavior, 4*, 176-190.

Watson, W. H. (1975). The meanings of touch: Geriatric nursing. *Journal of Communication 25*, 104-112.

Wood, J. T. (2002). *Interpersonal Communication: Everyday encounters* (3rd ed.). Belmont, CA: Wadsworth/Thompson Learning.

# Chapter 5
# Listening: The Responsibility of Health Care

Learning Objectives For Chapter 5

After reading this chapter you should have:

1. Learned a definition of listening in health care
2. An understanding of the importance of listening in business, health care, and dentistry
3. Begun to comprehend why attentive listening is so difficult
4. An appreciation of the function of silence in communication
5. Acquired some strategies to improve your listening

The most difficult thing of all, to keep quiet and listen.
Aulus Gellius, 150 BCE

It is the province of knowledge to speak, and it is the privilege of wisdom to listen.
Oliver Wendell Holmes, 1858

Listen to the patient, he is telling you the diagnosis.
Sir William Osler, 1890

## Introduction

***Ausculation*** is a medical art of diagnosing illness by which physicians use stethoscopes to listen to such noises as blood rushing through the heart and vessels or breath flowing in and out of the lungs (Anderson, Anderson, & Glanze, 1998). Unfortunately, many health care professionals, including dental care providers, may not be listening to their patients' ***outer ausculation***, their words and nonverbal communication, with the same intensity, skill, or urgency. Yes, thoughtful listening is difficult, and has been so for a long time, as Aulus Gellius noted over 2,000 years ago. However, as Oliver Wendell Holmes wrote, it is truly a privilege to hear what patients have to tell us; they share some of the most intimate details of their lives. And, as Osler pointed out over 100 years ago, we can learn so much. We in the dental hygiene

profession surely have many responsibilities, but our ability and willingness to listen to our patients is fundamental to fulfilling all of them.

A four-year-old child was seeing a dentist for the first time. This was at a military facility so the dental office was in a hospital. The family members had a few other appointments before reporting to the dentist and at one point they were in a lab where Bunsen burners were flaming. Somehow, through the warped reasoning of a child, the girl got it into her head that the dentist was going to put the fire in her mouth, so when she finally sat in the dental chair she would not open up. The dentist's solution was to hold his hand over both her nose and mouth so that she couldn't breathe. She opened her mouth to breathe, he took his hand away for a moment, she closed her mouth, he put his hand over her face again, and they went back and forth a few times. He thought she was a bratty kid but she was actually terrified. She wanted her mother in the room to help her feel safe but the dentist would not allow it. I was that child. That experience is one of my earliest and most indelible memories and was so traumatic that I remember it sixty years later. I have thought many times after I became a dental hygienist that if the dentist had only asked me what the problem was, and listened to my answer, he could have easily allayed my irrational fear and saved me a lifetime of a bad memory.

We have seen so far in this book that verbal and nonverbal communication are critical components in the delivery of health care in both medicine and dentistry. I will show in this chapter that health care providers' ability to listen is just as essential. In medicine, "One of the most widespread and persistent complaints of patients today is that their physicians don't listen" (Coulehan et al., 2001, p. 221), and remember that Boswell

(1997) learned from her numerous focus groups that dental patients' number one complaint is that they are not listened to. Though there is a lack of specific, peer-reviewed, research on listening in dentistry, there are many studies from the medical literature that can be applied to us, and many in the dental literature that mention and strongly imply its importance. After defining *listening* and other terms, I will discuss its importance in business, health care, and dentistry, review the reasons why it is so difficult, discuss the role of *silence* in communication, and finally offer suggestions for how to improve listening skill.

## What Is Listening?

***Listening*** is more than just the physiological process of hearing. Most simply, listening means paying attention to a message. According to the International Listening Association, it is "the process of receiving, constructing meaning from, and responding to spoken and/or nonverbal messages" (Listening, 2005). The speaker and the listener are equally responsible for assuring that the message sent is the message received.

There are two main purposes to listening in health care. First, we listen to learn. In order to deliver evidence-based, standard of care treatment, we need an understanding of our patients' health histories, medications, personal insights, and preferences. We can get this information only by listening to them. If we miss a crucial fact, the patient's health could suffer and both the patient and the practitioner could lose time and money. Second, we listen to show ***empathy***. It is important that people know we understand their concerns and fears. "In clinical medicine, *empathy* is the ability to understand the patients situation, perspective, and feelings and to communicate that understanding to the patient"

(Coulehan et al., 2001, p. 221). Listening communicates empathy and everyone benefits when patients perceive their caregivers to be empathetic. Practitioners are able to reach more accurate diagnoses, patients are more cooperative with treatments and recommendations, and all are more satisfied with their relationships (Coulehan et al.).

I refer to listening in health care as ***attentive listening***. Is this term redundant? Doesn't listening assume attention? No, not always. People often pretend to listen or listen only half-heartedly, but that is not good enough in health care. So the purpose of this term is to point out that patient-centered caregivers who attempt to assure clear and complete communication must pay special *attention* as they *listen* to patients. That listening should be empathetic, respectful, nonjudgmental, and involved (Bavelas, Coates, & Johnson, 2000) and should attend to both verbal and nonverbal messages (DiMatteo, McBride, Shugars, & O'Neil, 1995; Lazare, Putnam, & Lipkin, 1995). So my definition of *attentive listening* is: the therapeutic, holistic, empathetic, collaborative, and continuous process of paying attention to, constructing meaning from, and responding to another person's verbal and nonverbal communication as an important component of patient-centered care. This importance extends to three aspects of dentistry: business, health care, and dental care.

## Importance of Listening in Business, and Dentistry is a Business

We are health care providers who are usually employed by others so may not always be concerned with the business aspects of care. But the bottom line is that an insolvent business is out of business, we are out of jobs and, most importantly, patients

are left out. So I want to take a brief look of some research into listening in leading American businesses and in the business of health care.

Researchers surveyed the training managers of 106 Fortune 500 companies, *Fortune Magazine's* annual listing of the 500 largest and most successful companies in the United States. They learned that managers in these top businesses considered poor listening to be a major problem that led to deficits in employee performance and productivity, and that the employees incorrectly thought that they listened well (Hunt & Cusella, 1983, p. 399). Eight years later, Wolvin & Coakley (1991) surveyed the training managers in 249 Fortune 500 companies. These managers reported that: listening is important to organizational success, both employees and management are deficient in listening skills and need training, and training improves employees' listening ability. As a result, more than half (59%) of the reporting corporations provide listening training to executives, managers, supervisors and/or employees, and a few require such training annually. At least one large medical care provider could have benefited from that knowledge.

Conemaugh Memorial Medical Center in Johnstown, Pennsylvania, was in trouble. Their patient satisfaction scores were in the 22$^{nd}$ percentile and they were losing $2 million a month. So they hired new consultants who surveyed their patients. They learned that patients wanted caregivers, office workers, and hospital administrators to be nice and to improve communication. Among other things, people wanted a say in deciding their own treatments, they wanted information, and they wanted their families to be included in discussions. They and their families wanted their concerns to be heard and

their questions answered. The changes were made and the hospital has now averaged $370,000 per month in the black for several years, their patient satisfaction scores range up to the 92nd percentile, and they have won many service awards. The administrators state that this success has occurred because "We've finally listened to the real experts" (Listening to patients..., 2002). They could have saved a lot of trouble if they had looked at the research on listening in health care.

## Importance of Listening in Health Care

Concern about listening in health care goes back at least as far as the 1950s. Balint (1957), a psychiatrist, included listening as a theme throughout his book, *The Doctor, His Patient, and The Illness*. He wrote, "If in doubt, do not hurry, but listen" (p. 275), advocated the kind of listening that "puts the patient at ease" (p. 121), and advised that, before giving advice the doctor "must learn to listen" (p. 134). Balint was a pioneer in this area and it took a while before reports in the medical literature caught up with him, but when they did, they confirmed his advice and expanded on it.

Researchers reported benefits for both patients and practitioners. They found that patients who were involved cooperatively in a therapeutic relationship, requiring listening by both participants, were more satisfied with their medical care compared to those patients who were not (Speedling & Rose, 1985), and that nurses considered listening to be a critical element in their interactions with patients, doctors, administrators, and each other (Worobey & Cummings, 1984). In the study that I first reported on in Chapter 1, women with severe, chronic, virtually untreatable pelvic pain reported significantly greater pain reduction when cared for by doctors who listened to their stories at their

initial appointments compared to women who were cared for by non-listening physicians (Selfe, Matthews, & Stones, 1998). Others found that patients perceive listening caregivers to be more competent and empathetic and prefer them to caregivers who do not listen (Arnold & Shirreffs, 1998). Lynn Kacperek (1997), a nurse in a surgical hospital, lost her voice due to a non-infectious laryngitis. She was surprised to realize that this temporary disability actually enhanced her capacity to relate to patients when she was forced to replace speech with listening, silence, facial expression, and touch. Klagsbrun (2001) showed that nurses' attentive listening helped patients focus and achieve such benefits as decreased stress and depression and controlled pain. And a number of researchers found that excellent communication skills, especially listening to patients, helped prevent malpractice suits (Brown, Stewart, & Ryan, 2003; Lefevre, Waters & Budetti, 2000; Lester & Smith, 1993; Levinson, Roter, Mullooly, Dull, & Frankel, 1997; Wyatt, 1991).

Listening is especially critical over the phone. Pettinari & Jessopp (2001) described how British nurses on call lines evaluated callers' needs with only paralinguistic, nonvisual cues. The nurses agreed that it was a disadvantage to not be able to see the callers and found it especially difficult to "comfort by silence" (p. 670), because silence on the phone could have many meanings that could be misinterpreted. They learned to pay particular attention to a patient's breathing, tone of voice, energy of voice, among other clues to evaluate callers. They also found that good questioning skills were imperative, such as learning to ask the same question in several different ways because the person may understand one way and not the others. They had developed

mini-tests that the patients could do at home either on their own or with help, such as taking a temperature and gauging how long they could speak if they were having an asthma attack. One nurse commented, "Your ears become your eyes" (p. 672). They concluded that it was also important to monitor their own paralinguistic cues to communicate caring and establish rapport and trust. "They won't ring back if you haven't got a good, warm, empathetic attitude towards them" (p. 673), which all health care providers should ideally have even when they can see their patients.

Other types of nonverbal communication were also found to be important. One physician who thought that she was "attentive and friendly" (Goldstein, 1998, p. A01) consented to being videotaped while consulting with patients. She was shocked to realize that she spent more time looking at the records than at the patients. Ironically, Ruusuvuori (2001) later studied what happened when physicians looked away from the *patient embodied*, meaning the actual person, to the *patient inscribed*, or the person's chart. Withdrawal of the physician's attention and lack of listening, or at least the *appearance* of a lack of attention and listening, caused patients to lose their thoughts and actually stop speaking at the exact moment the doctor turned away. As a result, patients in this study missed this key opportunity to share important information and usually never got back to it.

It was all about nonverbal communication, which you recall from Chapter 4 is believed more than verbal communication when the two messages contradict each other. Ruusuvuori (2001) found that two areas of NVC were most important, the direction in which the face points and the position of the lower part of the body (below the waist).

First, the caregiver's face should focus on the patient and not on the chart. Caregivers should look at the chart before seating the patient and then refer to it only briefly to confirm information or take quick notes during the appointment. Also, the whole body should face the patient. Being seated with legs facing a desk or counter, even if the upper body is turned toward the patient, is still seen as a lack of attention. In order to both listen and *appear* to listen, caregivers need to orient their bodies and faces fully toward their patients. However, the most famous research about listening in health care refers to *not* listening at all, or interrupting.

According to a frequently cited study by Beckman and Frankel (1984), "physicians interrupt their patients after a mean interval of 18 seconds into the opening statement" (p. 695). These interruptions caused a loss of information because patients, put in a passive role by being cut off, usually never finished their opening statements. In a follow-up study, Beckman and Frankel (1985) found that patients who were cut off were more likely to bring up issues during or at the end of appointments, when it usually required more time for physicians to backtrack to address them. Consequently, taking the time to listen at the beginning of the appointment may actually save time in the long run. Other researchers had already found that people who feel heard are more articulate and succinct, so take less time to convey their messages. People who do not feel heard are more likely to repeat themselves in several different ways in an effort to be understood (Kraut, Lewis, & Swezey, 1982), which of course takes more time. Marvel, Epstein, Flowers, and Beckman (1999) conducted research similar to Beckman and Frankel's

(1984) original study in which the mean interval of time before interruption had increased to 23.1 seconds, only a five-second improvement after 15 years.

In both the original Beckman and Frankel (1984) and the Marvel et al. (1999) studies, only about a quarter of the physicians listened long enough to allow patients to complete their opening statements before cutting them off, but those patients who were allowed to finish spoke for an average of only 32 seconds each. Marvel et al. concluded that, in addition to taking very little time, listening to the patients' main concerns at the beginning of visits improved both appointment efficiency and amount of information given, which fostered better diagnoses. In a similar vein, Swiss researchers studied patients with complicated medical histories. Physicians who had been trained in active listening for one hour were instructed to time patients' opening statements for up to five minutes. Patients talked an average of 92 seconds, but these patients were generally unhealthy so their average time may have been high compared to medical appointments for average patients (Langewitz et al., 2002).

We can see that the overall trend in physician-patient relationships has been to move away from the old paternalistic non-listening pattern and toward a patient-centered equality, or attention to the patient's "voice" (Roter et al., 1997, p. 354). Such egalitarianism includes an equal amount of talk and listening by both participants in caregiver-patient interactions. When we talk less, the assumption is that we listen more and in fact hear our patients' "voices." Roter et al. also found that appointment times for patient-centered visits in which patients were allowed to talk and were listened to attentively averaged only one to two minutes longer than the more traditional caregiver

dominated visits. It seems logical to conclude that this could save time in the long run by minimizing time-consuming mistakes. In that sense we might say that if we make time, we *make* time.

So, according to medical research that spans several decades, listening to patients actually takes little time, and may even save time overall, but accrues great benefits. A medical patient who feels heard experiences less pain, stress, and depression and more accurate and complete diagnoses, holds the listening caregiver in high esteem, and is less likely to sue that caregiver if mistakes are made. It seems logical to assume that dental patients would experience similar benefits from attentive listening by their caregivers. Though there is a lack of specific research in this area, both personal experiences and dental studies support this assumption.

## Importance of Listening in Dentistry

If listening is important in business and medicine, than it should also be important to us. The following incident made the point for me. An elderly woman arrived fifteen minutes late for her appointment. She also wanted to leave early, so when I asked her to update her health history, she merely scanned it and made no changes. I was almost ready to treat her when I heard her mutter under her breath something about not wanting to miss this appointment after all she had gone through to get to it. Though we were already running very late, I felt compelled to question her about that comment. She explained that she had to ask her son to take time off work to bring her. She couldn't drive because she had just been released from the hospital after having had a pacemaker implanted. Of course I had to tell her that, for her own well-being, we would need to reschedule her

appointment until we could consult with her cardiologist, which was the standard of care at the time. She was *not* happy. But I was so glad that I took a moment to listen; otherwise the consequences could have been serious.

*Take time to think and talk*:
Have you had or do you know of similar experiences in which taking the time to listen prevented problems, or lack of listening caused them? Have any of your colleagues had such experiences? What happened? Discuss what was done to create a positive result, and what could have been done or said to prevent bad outcomes.

Though Freeman (1999), writing in the *British Dental Journal*, declared that "Listening skills are perhaps the most important of all the verbal communication skills" (p. 241), I found no specific peer-reviewed research on the benefits of listening in dentistry. This should be a significant topic because, due to the fact that caries, periodontal disease, and other dental problems are collectively more common than most medical diseases, the average person is more likely to require dental care than medical care (Slavkin & Baum, 2000). Millions of Americans suffer from dental diseases "resulting in needless pain and suffering; difficulty in speaking, chewing, and swallowing; increased costs of care; loss of self-esteem; decreased economic productivity through lost work and school days; and, in extreme cases, death" (U.S. Department of Health and Human Services, 2000, p. 21-3). Additionally, as a practical matter, dental patients usually have their mouths full of fingers and instruments during treatment and are unable to speak, so listening to verbal communication when they can talk, and attending to nonverbal communication when they cannot talk, is just as important in dentistry as it is in medicine.

Some investigators have strongly implied that attentive listening in dentist-patient dyads benefits both patients and dentists. Kleinknecht, Klepac, and Alexander (1973) reported that eight students, ranging from junior high to college age, said that their dental fear developed because a dentist or staff member had slapped them. This was the epitome of *not* listening. I cannot help but wonder how these experiences might have affected those young people throughout their lives, and how might compassion and attentive listening when they were young have changed those subsequent experiences. Corah, O'Shea, and Bissell (1985) found that dental patients whose comments were heard and taken seriously and encouraged to ask questions, implying that the answers were listened to, were more satisfied than those who were not heard. Street (1989) concluded that dental patients preferred dentists who were communicatively involved, or listened, to dentists who were communicatively dominant, or did not listen.

In a key article, Newton (1995) took a broad view of communication in dentistry, outlining benefits to patients and dentists, models of patient-dentist interaction, components of the interaction, and guidelines for applying those components. The importance of listening by both parties to verbal and nonverbal communication was implicit throughout. Finally, Kulich, Berggren, and Hallberg (2003) found that patient-centered dentists, who had a "holistic perception and understanding of the patient" (p. 177) and who listened to both verbal and nonverbal communication, were most successful at treating dental phobics. Certainly treating phobic people is as stressful for dental caregivers as it is for patients, so listening and understanding should benefit both. I would love to see research that could help us learn the ways in which attentive listening

by dental practitioners may help patients overcome *odontophobia* (fear of dentistry) and other impediments to seeking care, obtain treatment, and thus improve their oral health, general health, and overall well being. We need to learn how to overcome the obstacles to listening in the dental office.

*Take time to listen and reflect*:
Practice listening. Choose one day in which you will try very hard to stifle your inclination to jump into a conversation before the other person has finished talking. Write down your observations about how this effort might have made a difference for you and the other people.

## Why Don't We Listen Better?

Many of us do not listen better simply because listening is tough. For one thing, human beings conversing in English speak about 125-180 words per minute, but are capable of hearing 400-700 words per minute, depending on the length, complexity, fluency, and organization of the message (Stiel, Barker, & Watson, 1984; Wolvin & Coakley, 1979). Steil et al. call this the ***thought-speed/speech-speech differential***. We tend to use that extra time to come up with a snappy response or let our minds wander rather than concentrating objectively on the message before us. One other physical reason why listening is so difficult is because when you listen deeply, your heart rate and respirations quicken and your blood pressure becomes elevated (Nichols, 1957). So listening well is a physical as well as an emotional workout.

Additionally, according to Stiel et al., we miss information because, rather than paying attention to the message:

- We focus on the speaker's delivery, allowing ourselves to become annoyed by a high-pitched voice, an accent, or a tendency to say "um."

- We concentrate on the speaker's appearance (How can he wear that hideous shirt? What was she thinking when she had her lip pierced?)
- We neglect to "listen between the lines," or focus on only the facts or only the emotion and then miss how the two combine to affect the whole message.
- We fake attention.
- We think of certain information as uninteresting so not worthy of our consideration.

In regards to that last point, after listening carefully to patients for a while you realize that virtually everyone has something interesting to say. You may have to search for it, but it is there. I used to wince when I saw the name of a particularly crotchety patient on my schedule. Nothing was ever right for him, no matter how hard I tried. One day we got into a conversation in which he revealed some of his history. He had survived the Battle of the Bulge, a bloody combat toward the end of World War II that resulted in 75,000 Americans being killed, wounded, or captured, and he had written a brief book about his experiences. I read his book and learned about WWII and about the human being within the cantankerous patient. Those insights changed my view and our relationship, and after that I always looked forward to his appointments. I came away from that experience with a valuable lesson on listening. Unfortunately, Stiel et al.'s list is only the beginning of listening impediments.

Wood (2002) listed both external barriers and internal barriers that make listening difficult. In today's complicated world, we are constantly bombarded with listening needs. Many of the messages that we receive are complex, difficult to process, and require deep attention, but external noises interfere. The radio, television, stereo, iPod, cell phone, teachers, bosses, coworkers, patients, friends, family, and others all vie for our listening attention. A dental office is a noisy place where the sounds of drills,

ultrasonic scalers, and even telephones can annoy everyone and so interfere with listening. But those interruptions may be relatively minor compared to some internal obstacles to listening.

Wood's (2002) internal distractions—preoccupation, prejudgment, distraction by certain words, lack of effort, and lack of understanding of various listening styles —are more difficult to avoid.

- We are preoccupied. It might be difficult to listen at work because our minds are elsewhere, perhaps sidetracked by thoughts of a sick child, the errands we have to do after work, or dreams of weekend plans.
- We prejudge the speaker's message. We've heard it all before, we know what's coming, so why waste energy listening this time?
- We allow ourselves to be distracted by certain words that push our emotional buttons. These may be political or social terms that make us see red, accusations such as "You never..." or "You shouldn't...," or challenges to our abilities or values such as, "I don't floss and never will, no matter what you say." After we hear such words we tend to focus on them alone and stop listening to anything else the person has to say. It is difficult, but we need to keep our ears and minds open so that we can learn the person's full intent. We may never agree with a particular person, but at least we can know that we heard her complete message before making judgments based on a few emotionally laden words.
- We simply don't try to listen. It takes a lot of effort to remain focused and involved and we may be tired, hungry, uncomfortable, coming down with something, or just feeling lazy. In a social situation we can beg off or ask to postpone a discussion. At work we just have to deal with it and do our best to ignore our own discomfort.
- We don't understand various rules of listening. This distraction is perhaps the most difficult to deal with because we do not always recognize it. In fact, if we haven't studied nonverbal communication, we may not even realize that different rules exist. For instance, in one-on-one conversations in the United States, it is polite to pay close attention and give frequent, though not constant, eye contact. In other cultures the norm is anything from no eye contact to continuous eye contact. In America, people feel that you are listening when they hear your ***backchannel responses***, when you say "uh-huh," "yes," "I see," "Oh?," and so on, whereas in Nepal these kinds of responses are considered impolite (Wood). Changes in these forms of nonverbal communication, though we may not consciously notice them, can interfere with listening.

So assumptions, distractions, and lack of effort can derail our listening intentions, but awareness can help us avoid these traps. Each patient deserves our undivided attention.

*Take time to think*:
Which words push your emotional buttons? After you identify a few of them, try not to let them interfere with your listening.

It is important to be aware of all of these internal distractions, but the fifth one relates especially to diverse people because they generally feel even less heard in health settings compared to majority people. Shi (1999) found qualitative as well as physical barriers to care for minority patients, including a lack of listening by health care providers, when compared to the experiences of white patients. Patients representing some of the main minority groups in the United States (especially American Indian, Hispanic, and African-American) participated in focus groups where they discussed the barriers to caring for diverse people. Almost all agreed that a significant problem with communication was, "doctors don't really listen" (Shapiro, Hollingshead, & Morrison, 2002, p. 754). It is a particular challenge to listen well when speaking through an interpreter, even though such times require heightened attentiveness. Riffaat Mamdani, a Canadian nurse in the Public Health Service, acknowledged the frustration caused by the extra time required when relying on an interpreter, but also noted "You can't know everything, so you have to be sensitive. And in order to be sensitive, you really have to be listening" (Mackay, 2003, p. 599). These and other barriers interfere with listening in a health setting, but before I offer some ideas to enhance your listening, I want to mention the role of a topic related to listening, ***silence*** in communication.

## Silence

"Silence communicates" (deVito, 2001, p. 207).

"No response is a response" (Stiel, Barker, & Watson, 1983).

Silence is an important component of communication that is most often associated with listening. It can have a positive or a negative connotation, depending on the context and the individuals involved. It can indicate shyness, stress, defiance, annoyance, secrecy, hesitation, lack of confidence, knowledge, lack of knowledge, agreement, disagreement, and more (deVito, 1989; Pennycook, 1985). A pause in a conversation can give a person time to digest what was heard and then consider a response or it can be an indication of an awkward situation or lack of understanding. In the United States, silence can be used as punishment. The "silent treatment" in an interpersonal relationship is a refusal to communicate in response to some perceived wrongdoing. "Silencing" in military academies and excommunication (or "no communication") from religious groups mean that a person is completely ostracized (deVito, 2001) and this is considered the most extreme punishment in those institutions.

Silence has different meanings in different cultures. An American who wishes to withdraw from a conversation will usually leave; a British person will usually go silent. To the Japanese, silence is a complex part of their language, a "great virtue" (Pennycook, 1985, p. 268), and is often preferred to speech. They have an ***emoticon*** for silence: ('_'), indicating a need to show it even in written communication. An American professor who spoke excellent Japanese listened in on business negotiations in that language, but concluded that the outcome was the opposite of the actual decision. He had understood

the words that were spoken but he had not understood the silences. In this case the use of silence was a way to disagree without causing any participant to lose face (Pennycook). Among the Apache, silence is commonly used in times of uncertainty or when there is a power differential such as when meeting strangers, courting, and comforting people who are ill or have had a great loss (Basso, 1990; Braithwaite, 1990). In the Osage tribe, a person who answers a question too quickly, that is, without a silent pause before answering, is thought to have given too little thought to the response (Wieder & Pratt, 1990).

The use of silence can play multiple roles within and among cultures, so never assume that you understand the implication of a patient's silence. Perhaps it has deep meaning, or perhaps the person is just daydreaming or listening for your next remark. Now that we have looked at the importance of listening in various contexts, especially in health care, and discussed the barriers to listening and the role of silence in communication, we are ready to discover some techniques to help us listen better. There is always room for improvement.

## How Can We Listen Better?

The combination of Chinese characters that stand for "to listen" have five parts: ear, ten, eyes, undivided attention, and heart. The derived meaning is that "The ear is worth ten eyes," and "The heart listens with undivided attention" (Suzuki, 2005). This gives us clues about how to listen well. Ralph G. Nichols, a rhetorical scholar, was a listening pioneer whose classic article, "Listening Is a Ten-Part Skill" first appeared in *Nation's Business* in July 1957. This article has been repeated, reworded, reinterpreted,

and expanded upon by many scholars and others through the years. I am basing the following summary on that original article along with various updates and interpretations and some of the research reported in this chapter, and I am organizing it according to the parts of the Chinese characters for listening. Throughout this chapter I have acknowledged that listening is difficult. However, just like any skill, it can be learned and gets easier with practice. These ideas should help with that practice.

How to listen well:

- Listen with your ears to words, facts, and paralanguage:
  - *Maintain your focus and composure*. Do not allow emotionally charged words to distract you from the real message.
  - *Differentiate ideas from the entire message*. Focus on the main ideas and try to separate them from arguments, evidence, and emotions.
  - *Practice*. Take every listening opportunity to challenge yourself. Listen to different types of recorded books and also attend lectures, dental continuing education, and a variety of other presentations that cover topics that will challenge you to improve your listening skill. You can begin by hearing a listening skills seminar titled, "Listening First Aid: An Empathic Approach," offered by the University of California. Though related to interpersonal rather than health care listening, there is still much to learn that could be applied to health settings. Download it from: http://www.cnr.berkeley.edu/ucce50/ag-labor/7article/article40.htm
  - *Take a few notes, but don't overdo it*. Writing down a few key points while you are listening to a patient may show your desire to get the facts straight, but remember to maintain your main focus on the person and not on the chart.
  - *Listen for problems with vocal strength, tone of voice, breathing, etc*. These may be signs of health issues (Pettinari & Jessopp, 2001).
  - *Take advantage of the thought-speed/speech-speech differential* (Steil et al. 1983). That is the extra thinking time we have because we can hear so much faster than most people can speak. Focus on the message and try to mentally organize it in a way that will make it memorable, think of questions that can clarify points, or simply learn from what the person has to say.

- Listen with your eyes to nonverbal communication:
  - *Judge the message and not the delivery skill*. This is difficult because it contradicts our natural instinct to believe the nonverbal message over the

verbal message, but remember that just because a person may be awkward or inept at communication does not mean that her message is insignificant.
    - *Show your interest.* Use backchannel responses, eye contact, facial expression, and body posture to indicate your sincere interest. People who feel heard are more articulate and succinct so may take less time to explain their thoughts (Kraut, Lewis, & Swezey, 1982).
    - *Use silence to your advantage.* After asking for questions, wait a few extra seconds before assuming the person has none. This is called "wait time" (Kougl, 1997), and allows the person to process your message before answering.

- Listen with your heart to show compassion:
    - *Find value in every message.* Everyone has something important to tell us because each person is the best expert on himself or herself.
    - *Be respectful and empathetic.* A study of over 1400 calls to a suicide hotline showed that counselors who communicated these two characteristics to callers were the most successful at getting them to allow contact at the end of the call (Mishara et al., 2007).

- And finally:
    - *Work at listening.* It is certainly difficult to listen well, so give it the energy it deserves and do not allow yourself to be distracted by physical or psychological noise. If you try to fake it, you will be discovered sooner or later and then lose credibility and trust, which are so difficult to retrieve.
    - *Listen at work.* Challenge yourself to give each patient a full two minutes to complete an opening statement. This does not include your social time, but begins after you ask, "What can I do for you today?" or "Do you have any questions or problems?"

*Explore some more*:
Find the reprint of Dr. Nichols' original 1957 article, "Listening Is a Ten-Part Skill," on the International Listening Association website, where you can also hear, "Ten Bad Listening Habits," his humorous 40-minute speech from the 1960s. Dr. Nichols' ideas are still timely and apply remarkably well to health care. These resources are available at: http://www.listen.org/Templates/nichols_ten_part_skills.htm

## Conclusion

Dental hygienists are busy. Our days are long, our schedules are tight, and our work is physically and emotionally demanding. So even when our intentions are good we may not always listen as well as we should. I hope that the information in this chapter

reminds you of the importance of attentive listening and also offers help to do it better. Listening is inherently a two-way process, but since most patients have not necessarily had any kind of communication or listening training, the majority of the responsibility to make sure that the message sent is the message received falls on us. Patients have unique insights into their own health that we may not always understand. Idler and Kasl (1991) found that elderly people who perceived their health to be poor were up to six times more likely to die than those who perceived their health to be excellent, *even in the absence of analogous physiological indicators*. At the other end of the age spectrum, even a four-year-old child had important information and insight for her dentist, if only he had taken a moment to listen. You never know where the next critical piece of information will come from unless you open your ears to all possibilities. We need to listen before we try to do anything else for our patients, which is why I put this chapter at the beginning of the Applications section of this book. Next, we need to understand some principles of persuasion and know how to interview. These are the topics of the next two chapters.

## Glossary for Chapter 5

*Attentive listening*: The therapeutic, holistic, empathetic, collaborative, and continuous process of paying attention to, constructing meaning from, and responding to another person's verbal and nonverbal communication as an important component of patient-centered care. See: *Listening.*

*Ausculation*: The medical art of diagnosing illness by which physicians use stethoscopes to listen to such noises as blood rushing through the heart and vessels or breath flowing in and out of the lungs (Anderson, Anderson, & Glanze, 1998).

*Backchannel responses*: Brief verbal and nonverbal remarks, such as "uh-huh," "yes," "I see," "interesting," "tell me more," and "Oh?" They indicate that a listener is listening and encourage a speaker to continue speaking.

*Emoticon*: Symbol used in written communication, especially electronic communication, to indicate emotional content. The most famous is the smiley face: ☺

*Empathy*: "The ability to understand the patients situation, perspective, and feelings and to communicate that understanding to the patient" (Coulehan et al., 2001, p. 221).

*Listening*: According to the International Listening Association (Listening, 2005), it is "the process of receiving, constructing meaning from, and responding to spoken and/or nonverbal messages." See: *Attentive listening.*

*Outer ausculation*: Listening to people's words and nonverbal communication.

*Silence*: The often ambiguous pauses in communication that can indicate shyness, stress, defiance, annoyance, secrecy, hesitation, lack of confidence, knowledge, lack of knowledge, agreement, disagreement, and more, depending on the context and the individuals involved in the interaction (deVito, 1989; Pennycook, 1985).

*Thought-speed/speech-speech differential*: Human beings conversing in English speak about 125-180 words per minute, but are capable of hearing 400-700 words per minute, depending on the length, complexity, fluency, and organization of the message (Stiel, et al., 1984; Wolvin & Coakley, 1979). This is what Steil et al. call the difference between the two.

## References for Chapter 5

Anderson, K. N., Anderson, L. E., & Glanze, W. D. (Eds.). (1998). *Mosby's medical, nursing, and allied health dictionary* (5th ed.). St. Louis: Mosby.

Arnold, W. E., & Shirreffs, J. H. (1998). Patient perceptions of patient-physician communication with allopathic and naturopathic physicians. *International Journal of Listening, 12*, 1-11.

Balint, M. (1957). *The doctor, his patient and the illness*. NY: International Universities Press, Inc.

Basso, K. H. (1990). "To give up on words": Silence in Western Apache culture. In: Donal Carbaugh (Ed.), *Cultural communication and intercultural contact* (pp. 303-320). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Bavelas, J. B., Coates, L, & Johnson, T. (2000). Listeners as co-narrators. *Journal of Personality and Social Psychology, 79*, 941-952.

Beckman, H. B., & Frankel, R. M. (1984). The effect of physician behavior on the collection of data. *Annals of Internal Medicine, 101*, 692-696.

Beckman, H. B., & Frankel, R. M. (1985). Soliciting the patient's complete agenda: A relationship to the distribution of concerns. *Clinical Research, 33*, 714A.

Boswell, S. (1997). *The mystery patient's guide to gaining and retaining patients.* Tulsa, OK: PennWell Publishing.

Braithwaite, K. H. (1990). Communicative silence: A cross-cultural study of Basso's hypothesis. In: Donal Carbaugh (Ed.), *Cultural communication and intercultural contact* (pp. 321-327). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Brown, J. D., Stewart, M., & Ryan, B. L. (2003). Outcomes of a patient-provider interaction. In T. L. Thompson, A. M. Dorsey, K I. Miller, & R. Parrott. (Eds.). *Handbook of health communication* (pp. 141-161). Mahwah, NJ: Lawrence Erlbaum Associates.

Corah, N. L., O'Shea, R. M., & Bissell, G. D. (1985). The dentist-patient relationship: Perceptions by patients of dentist behavior in relation to satisfaction and anxiety. *Journal of the American Dental Association, 111*, 443-446.

Coulehan, J. L., Platt, F. W., Egener, B., Frankel, R., Lin, C.-T., Lown, B., et al. (2001). Let me see if I have this right...": Words that help build empathy. *Annals of Internal Medicine, 135*, 221-227.

DeVito, J. A. (1989). Silence and paralanguage as communication. *Et Cetera, 46(2)*, 153-157. Silence along with the volume, rate, and pitch of our spoken words communicate.

DeVito, J. A. (2001). *The interpersonal communication book* (9th ed.). New York: Longman.

DiMatteo, M. R., McBride, C. A., Shugars, D. A., & O'Neil, E. H. (1995). Public attitudes toward dentists: A U.S. household survey. *Journal of the American Dental Association, 126*, 1563-1570.

Di Salvo, V. S., Larsen, J. K., & Backus, D. K. (1986). The health care communicator: An identification of skills and problems. *Communication Education*, 35(3), 231-242.

Freeman, R. (1999). Communicating effectively: Some practical suggestions. *British Dental Journal, 187*, 240-244.

Goldstein, A. (1998, October 3). Classes in bedside manners: Healing doctor-patient relations. *The Washington Post*, A01.

Hunt, G. T., & Cusella, L. P. (1983). A field study of listening needs in organizations. *Communication Education, 32*, 393-401.

Idler, E. L., & Kasl, S. (1991). Health perceptions and survival: Do global evaluations of health status really predict mortality? *Journal of Gerontology, 46*, 555-565.

Kacperek, L. (1997). Non-verbal communication: The importance of listening. *British Journal of Nursing (BJN), 6(5)*, 275-279.

Klagsbrun, J. (2001). Listening and focusing: Holistic health care tools for nurses. *Nursing Clinics of North America, 36*, 115-129.

Kleinknecht, R. A., Klepac, R. K., & Alexander, L. D. (1973). Origins and characteristics of fear of dentistry. *Journal of the American Dental Association, 86*, 842-848.

Kougl, K. (1997). *Communicating in the classroom.* Prospect Heights, IL: Waveland Press, Inc.

Kraut, R. E., Lewis, S. H., & Swezey, L. W. (1982). Listener responsiveness and the coordination of conversation. *Journal of Personality and Social Psychology, 43*. 718-731.

Kulich, K. R., Berggren, U., Hakeberg, M., & Gustafsson, J.-E. (2001). Factor structure of the dental beliefs survey in a dental phobic population. *European Journal of Oral Science, 109*, 235-240.

Langewitz, W., Denz, M., Keller, A., Kiss, A., Rüttimann, S., & Wössmer, B. (2002). Spontaneous talking time at start of consultation in outpatient clinic: Cohort study. *British Medical Journal, 325*, 682-683.

Lazare, A., Putnam, S. M., & Lipkin, M., Jr. (1995). Three functions of the medical interview. In M. Lipkin, Jr., S. M. Putnam, & A. Lazare. (Eds.). *The medical interview: Clinical care, education, and research* (pp. 3-19). NY: Springer-Verlag.

Lefevre, F. V., Waters, T. M., & Budetti, P. P. (2000). A survey of physician training programs in risk management and communication skills for malpractice prevention. *Journal of Law, Medicine & Ethics, 28*, 258-266.

Lester, G. W. & Smith, S. G (1993). Listening and talking to patients: A remedy for malpractice suits. *The Western Journal of Medicine, 158*, 268-272.

Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician Patient Communication: The relationship with malpractice claims among primary care physicians and surgeons. *Journal of the American Medical Association, 277*, 553-559.

Listening. (2005). *International Listening Association*. Retrieved July 30, 2008, from: http://www.listen.org

Listening to patients improves bottom line (2002). *Modern Healthcare, 32(51)*, 26-27.

Mackay, B. (2003). Changing face of Canada is changing the face of medicine. *CMAJ: Canadian Medical Association Journal, 168(5)*, 599.

Marvel, M. K., Epstein, R. M., Flowers, K., & Beckman, H. B. (1999). Soliciting the patient's agenda: Have we improved? Journal of the American Medical Association, 281(3), 283-287.

Newton, J. T. (1995). Dentist/patient communication: A review. *Dental Update, 22*, 118-22.

Nichols, R. G. (1957). Listening is a 10-part skill. *Nation's Business, 45(7)*, 56.

Pennycook, A. (1985). Actions speak louder than words: Paralanguage, communication, and education. *TESOL Quarterly, 19*, 259-282.

Pettinari, C. J., & Jessopp, L. (2001). "Your ears become your eyes": Managing the absence of visibility in NHS Direct. *Journal of Advanced Nursing, 36*, 668-675.

Roter, D. L., Stewart, M., Putnam, S. M., Lipkin, M., Stiles, W., Inui, T. S. (1997). Communication patterns of primary care physicians. *Journal of the American Medical Association, 277*, 350-356.

Ruusuvuori, J. (1990). Looking means listening: Coordinating displays of engagement in doctor patient interaction. *Social Science & Medicine, 52*, 1090-1108.

Selfe, S. A., Matthews, Z., & Stones, R. W. (1998). Factors influencing outcomes in consultations for chronic pelvic pain. *Journal of Women's Health, 7*, 1041-1048.

Shapiro, J., Hollingshead, J., & Morrison, E. H. (2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education, 36.* 749-459.

Shi, L. (1999). Experience of primary care by racial and ethnic groups in the United States. *Medical Care, 37,* 1068-1077.

Singh, N. N., McKay, J. D., & Singh, A. N. (1998). Culture and mental health: Nonverbal communication. *Journal of Child and Family Studies, 7(4),* 403-409.

Slavkin, H. C., & Baum, B. J. (2000). Relationship of dental and oral pathology to systemic illness. *Journal of the American Medical Association, 284,* 1215-1217.

Speedling, E. J., & Rose, D. N. (1985). Building an effective doctor-patient relationship: From patient satisfaction to patient participation. *Social Science & Medicine, 21(2),* 115-120.

Stiel, L. K., Barker, L. L., & Watson, K. W. (1983). *Effective listening: Key to your success.* Reading, MA: Addison-Wesley Publishing Company.

Street, R. L., Jr. (1989). Patients satisfaction with dentists' communicative style. *Health Communication, 1,* 137-154.

Summers, L. C. (2002). Mutual timing: An essential component of provider-patient communication. *Journal of the American Academy of Nurse Practitioners, 14(1),* 19-25.

Suzuki, C. (2005). The art of Zen listening. *The Listening Professional, 4(1),* 14-15.

U. S. Department of Health and Human Services (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.). Washington, DC: U. S. Government Printing Office.

Wieder, D. L., & Pratt, S. (1990). On being a recognizable Indian among Indians. In: Donal Carbaugh (Ed.), *Cultural communication and intercultural contact* (pp. 45-64). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Wolvin, A. D, & Coakley, C. G. (1979). *Listening instruction.* Urbana, IL: ERIC, Clearinghouse on Reading and Communication Skills.

Wolvin, A. D., & Coakley, C. G. (1991). A survey of the status of listening training in some Fortune 500 corporations. *Communication Education, v 40,* 152-164.

Wood, J. T. (2002). *Interpersonal Communication: Everyday encounters* (3rd ed.). Belmont, CA: Wadsworth, Thompson Learning.

Worobey, J. L., & Cummings, H. W. (1984, Fall). Communication effectiveness of nurses in four relational settings. *Journal of Applied Communication Research, 12(2)*, 128-141.

Wyatt, N. (1991). Physican-patient relationships: What do doctors say? *Health Communication, 3(3)*, 157-174.

# Chapter 6
# Persuasion: The Challenge of Health Care

Learning Objectives For Chapter 6

After reading this chapter you should have:

1. Acquired insight into persuasion's place in the delivery of dental care
2. Considered the ethics of persuasion
3. Reviewed the basics of the Transtheoretical, or Stages of Change, Model
4. Learned about various views on persuasion, including invitational persuasion, classic rhetoric, and narrative
5. Thought about the relevance of Maslow's Hierarchy of Needs when caring for a diverse clientele
6. Added to your repertoire of persuasive strategies

People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the minds of others.
Blaise Pascal, scientist & philosopher, 1623-1662

Would you persuade, speak of interest, not of reason.
Benjamin Franklin, 1734

One of the best ways to persuade others is with your ears—by listening to them.
Dean Rusk, United States Secretary of State, 1961

## Introduction

We, as dental hygienists, rely a great deal on the ability to be persuasive. It is what we do, though we often refer to ***persuasion*** euphemistically as *motivation*, *incentive*, *influence*, *reasoning*, or *encouragement*. We try to persuade our patients to share their health information, improve their health practices, accept treatment, or see specialists; to convince our bosses to purchase the best equipment and supplies, send us to a wonderful continuing education course, change patient care protocol based on what we learned at the last wonderful continuing education course, or give us a raise; to encourage the receptionist to stop squeezing in extra patients; to convince our coworkers that the prima donna stereotype is untrue and that we do everything for a reason; to argue

with sales reps to give us the best deals; or to influence our dental hygiene friends to try particular products or instruments. That list is far from complete and doesn't even touch on all the persuading we do in our personal lives.

Coincidentally, scholars and teachers in the Communication Studies field also rely a great deal on the ability to be persuasive. It is a large part of what they do and is taught in classes on public speaking, argumentation, persuasion, debate, rhetoric, and many others. *Persuasion* is also referred to as *rhetoric*. ***Rhetoric*** is not the empty words that are implied when we say, "Oh, that's just a bunch of rhetoric." It is, as Aristotle defined it in the 4th century BCE, "The available means of persuasion" (Larson, 2001, p. 8). It is, as Stoner and Perkins (2005) defined it in the 21st century CE, "messages that rely on verbal and nonverbal symbols that more or less intentionally influence social attitudes, values, beliefs, and actions" (p. 6). Every part of that definition is significant. Both our words and our actions can be persuasive, we may or may not intend to be persuasive, and persuasion can influence both what people think and what they do.

Persuasion is also important in our society. It is the foundation of business, advertising, politics, entertainment, the media, philanthropy, religion, family relations, and health care. Everywhere we turn we are asked to buy this product, access this service, vote for this candidate, see this movie, visit this website, donate to this cause, believe this philosophy, raise our children a certain way, get a flu shot, or floss our teeth. As health care providers, we are both persuaders and persuadees, if you will. We attempt to influence others, but cannot help being influenced by others as well. Persuasion/rhetoric is a fact of life throughout our lives so it is important to acquire a fundamental

understanding of it. In this chapter we will consider the ethics of trying to persuade people to change their minds or their behavior, look at a major stages of change model and different views of how to be persuasive, reconsider a classic health care notion, and then summarize some successful persuasive strategies.

## Ethics of Persuasion

Persuasion can be powerful, especially when we apply all the knowledge and techniques at our disposal, so it is important to consider the ethics involved. ***Ethics*** refers to "principles of right action" (Sproule, 1997). In this case, it refers specifically to following the "right action" when trying to persuade patients. Informing patients is part of our responsibility as patient-centered health care providers who follow the guidelines of ***Informed Consent***[8] and ***Evidence Based Decision Making***[9] (EBDM), but the act of informing can also be persuasive. When I met an employer dentist's wife for the first time, she told me, "My husband says that you can really 'sell' dentistry." She thought she was giving me a compliment, but I was horrified. That was not my intention at all. I intended to objectively inform people of their options, I was not necessarily trying to be persuasive. It sounded to me as if she thought I was coercing or manipulating people into accepting treatment. I worked hard to develop relationships with my patients and I now realize more clearly that information coming from a respected source at an opportune

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[8] For more information about informed consent, access the American Medical Association website at http://www.ama-assn.org/ama/pub/category/4608.html

[9] For more information about Evidence Based Decision Making, refer to Clancy & Cronin (2005), with special attention to the paragraph titled "Shared decision making." This article is available online at http://content.healthaffairs.org/cgi/content/full/24/1/151

time can be enormously influential. The wife's comment caused me to take a closer look at what I was saying and to aim for more balance in my discussions.

Think about what we ask people to do. Yes, we have the knowledge. We know that if that area of decalcification is not treated it will almost certainly become decay. We know that if periodontal disease is not treated it will almost certainly result in tooth loss or worse. Tell the patient, give them all their options and the pros and cons of each and then let them make their own decisions. We want people to have the ideal treatment, but at the same time we do not necessarily understand all of the financial, physical, psychological, philosophical, cultural, or other barriers that stand between that person and the treatment that you think is best. What we consider to be an irrational choice may, in fact, be quite rational from the patient's point of view (Donovan & Blake, 1992). That does not mean that we withhold our knowledge or opinions, just that we are clear and forthright about our biases. When patients asked, "What would you do in my situation?" I always began my answer by telling them to remember that I was, "very tooth-oriented." So what we do should focus more on giving people choices rather than persuading them to accept particular options.

## Invitational Persuasion: The Importance of Choice

I believe that the theme of persuasion in the dental office should be *choice*. We should not approach persuasion as a battle in which the goal is conquest (Foss & Griffin, 1995). When operating from the conquest point of view, we try to convert people to our way of thinking. Instead, I ask you to consider what Foss and Griffin (1995) call "invitational rhetoric" (p. 15), and what I will call ***invitational persuasion***. This

alternative view of persuasion is based on the idea that in a free society one person cannot ultimately force someone else to change. The only person who can change you is you. Foss and Griffin, quoting Gearhart, define this concept as, "the creation of a milieu in which those who are ready to be persuaded may persuade themselves, may choose to hear or choose to learn" (p. 20). In this scenario, the intent to persuade is still present, but instead of imposing a belief or behavior on another, the persuader makes it possible for the other person to choose that action *when and if s/he wishes*. The key concept here is *choice*. People will change when they are ready to do so and no sooner.

In invitational persuasion, the metaphor is one of sharing and caring rather than one of winning. Foss and Griffin (1995) suggest two ways to enact this view. First, model the change you advocate. We can't expect people to take care of their health if the person encouraging them to do so obviously does not take care of hers. Our words and our nonverbal communication are coordinated and credible when we model the behavior we promote. Second, provide information. A person will never change if he does not have a knowledge base that first informs him of the option to change and then supports him in his efforts to change. It is our job to provide the information needed to institute healthy life changes; the patients take that information and do with it what they will when they can. So, one ethical way to use invitational persuasion is to help people move toward the goals that they themselves chose. The Transtheoretical model describes how that change happens.

*Take time to think and talk*:
With one or two friends, discuss your answers to these questions:

- Have you had experiences at work or in your personal life when you used invitational persuasion?
- What happened?

## Transtheoretical Model

Before looking at the fundamentals of classic persuasion, it is important to understand how people change their minds or change their behaviors. The ***Transtheoretical Model*** (***TTM***), also known as the "stages of change," describes the phases that people go through as they attempt to eliminate unwanted behaviors and/or acquire new positive ones. It originated with research by DiClemente and Prochaska on smokers and addiction in the early to mid 1980s (Purdie & McCrindle, 2002), and has since been applied to multiple diverse areas of health care. It has helped modify behavior in "smoking cessation, exercise, low fat diet, radon testing, alcohol abuse, weight control, condom use for HIV protection, organizational change, use of sunscreens to prevent skin cancer, drug abuse, medical compliance, mammography screening, and stress management" (Velicer et al., 1998, ¶ 4). Regarding TTM (also known as Stages of Change, or SOC), Rimer and Kreuter (2006) say, "Although there are other stage models, none have achieved the level of dissemination of SOC" (p. S186).

Thus TTM has been used extensively in health care to encourage people who want to stop unwanted behaviors and/or begin new desirable behaviors. That is exactly what we in dentistry want people to do. It is an especially appropriate topic in this book because it has been applied to an oral health campaign (Tillis et al., 2003) and has been mentioned as a valuable oral health behavior model in both the *Journal of Dental*

*Hygiene* (Holliser & Anema, 2004) and the ADHA's magazine, *Access* (Long, 2006). I also chose it because it has been used in multicultural contexts (Etter, Perneger, & Ronchi, 1997; Frankish, Lovato, & Shannon, 1999).

TTM predicts that a person will typically change behaviors in a progression of five stages (Prochaska & DiClemente, 1983) and TTM identifies ten major factors that can influence the process (Prochaska, DiClemente, & Norcross, 1992; Purdie & McCrindle, 2002). The five stages of change are: *Precontemplation*, *contemplation*, *preparation*, *action*, and *maintenance*. According to TTM, a person's response to your health message is influenced by the stage she happens to be in when she hears it. Keep in mind that people do not always move neatly through the stages. They can repeat stages numerous times, get stuck indefinitely in one stage, and even overlap some stages, so it is not always easy to determine exactly where in the process a person may be. However, if we can understand in general how human beings change, we can then apply the most appropriate persuasive strategies and encouragement to help them move forward toward their desired goals.

The five *stages of change* are (Prochaska & DiClemente, 1983; Prochaska et al., 1992; Velicer et al., 1998):

- P*recontemplation*: A person has no intention to change within the foreseeable future, usually defined as the next six months, and, due to being uninformed, underinformed, or uninterested in the topic, is not attending to her risky behavior. The person is uninterested in the personal, social, societal, or environmental consequences of the behavior and is not likely to listen to your message about it.
- C*ontemplation*: The individual is aware of the positive and negative reasons to change and intends to begin the change process within six months. A smoker who wishes to quit begins to think, "I need to do something about this, but I can't do it

right now." He may be open to looking at a brochure or accepting a "Take Charge" or "Take Control" card with information on how to get help.[10]

- *Preparation*: The person has decided to begin the change process within one month and may already have taken some preliminary actions for up to a year. *A person in this stage is most inclined to act on a health message* so is most likely to accept your offers of information and other help.
- A*ction*: This stage occurs when the person begins and continues with the positive health behavior change for about six months. Someone in this stage is really into the change and might be telling you and others how to do it.
- M*aintenance*: The person sustains the positive behavior change and becomes increasingly confident and less likely to relapse to an old negative behavior thus *regressing* to a less-advanced stage. As time in the maintenance stage passes, *self-efficacy*, or the person's feeling of confidence in his ability to resist regression, increases, and *temptation*, or an attraction to the old negative behavior, decreases. The change is solidly established and is spoken about in the past tense. Stewart, Wolfe, Maeder, & Hartz (1996) found that self-efficacy is a particularly important factor in changing oral hygiene behavior. Dental hygienists can bolster self-efficacy with words of encouragement.

There are also 10 *processes of change*, or activities that contribute to forward movement through the stages. These are divided into experiential (thought) and behavioral (action) processes (Frankish et al., 1999; Velicer et al., 1998). After defining each process, I have added some suggestions for how to communicate encouragement and support for someone who is trying to quit smoking. These suggestions can be adapted to any effort to improve health behavior. The five experiential (thought) processes that have the greatest influence in the early stages of change are:

- *Consciousness raising*, or enhancing awareness and beginning to acquire information. Be prepared to talk about the experience of quitting, how other people have done it, and the pros and cons of different approaches, and dispense or refer to other resources.
- *Dramatic relief*, or the increase of a person's emotional reaction to the health messages. Share stories of how quitting smoking has positively impacted the lives

[10] The "Take Charge" card is available from the California Dental Hygienists Association (www.cdha.org) and the "Take Control" card can be obtained from the American Dental Hygienists Association (www.adha.org).

of people you know (keeping identities confidential, of course); discuss the health benefits of quitting.

- *Environmental reevaluation*, or realizing the impact of the negative behavior on the environment. Make patient aware of how smoking affects those around him.
- *Social liberation*, or becoming aware of the ways that society supports the behavior change. Mention the positive changes that quitters enjoy, such as lower health insurance premiums or not having to leave a restaurant to smoke.
- *Self-reevaluation*, or assessing personal feelings about the problem, increasing disappointment in oneself for continuing the negative behavior and/or for not adopting a new positive behavior. Acknowledge that quitting is a difficult process and reassure the patient that you have information and support whenever it is requested.

The five behavioral (action) processes also include some thought elements and are more likely to appear during the latter stages of change. They are:

- *Stimulus control*, or altering an environment to support the change. Suggest ways that the person can adjust his house or car to help him stick with quitting. For instance, remove all ash trays, write encouraging notes to himself and leave them around, buy a new easy chair that does not smell of smoke, etc.
- *Helping relationship*, or accepting support from caring and sympathetic others. Allow family and friends to offer words of encouragement and praise. Some people have difficulty accepting compliments.
- *Counter-conditioning*, or substituting positive stimuli to perform the new behavior for negative stimuli that might prompt the old behavior. Suggest that when he feels like smoking, chew some xylitol gum or have a piece of hard sugarless candy instead.
- *Reinforcement management*, or rewarding oneself or accepting rewards from others for maintaining the positive behavior. Allow others to give him small gifts for his efforts and celebrate with him. They could take him out to lunch at a special place or purchase that CD he has been wanting. Or he could treat himself. Maybe the office could give him a free cleaning when he has quit for a specified period of time, six months to a year or so.
- *Self liberation*, or self-commitment to and belief in ones ability to maintain the new behavior. Remind her how far she has come and continue to congratulate her.

*Take time to think and talk and plan*:
Talk about what you would say, or have said, to people who want to improve their oral health or quit smoking. Ask a dental hygiene colleague to help you write down ideas for people who:

- Are adamant that they will not change.
- Are beginning to think about changing.
- Are in the process of changing but finding it difficult.
- Have changed and are maintaining.

TTM might apply to a person trying to quit smoking, as illustrated here, or improve her eating habits, or lose weight, or take better care of his teeth, or implement any number of health-improving behaviors. The main point to remember is that the person initiates the process of change at her or his convenience. Our job is to support the effort. We can turn a person completely off by mentioning a touchy subject prematurely. The topic usually comes up while reviewing the health history, at which time you can let the patient know that you have resources to help if s/he should request them. Then leave it at that. Above all, don't preach! That would be in opposition to the concept of invitational persuasion. It is challenging to institute major life changes, so the effort deserves our positive reinforcement and patience.

The Transtheoretical Model is strong because it matches the person's stage of change with the communication intervention appropriate for it (Purdie & McCrindle, 2002). It is important in health because it reminds us that many factors are involved in behavior change; the mere acquisition of information alone, while important and a necessary first step, is seldom enough on its own to stimulate that change (du Pré, 2000). People need to decide when they are ready to use that information. Dental hygienists, because we work almost exclusively in one-on-one contexts and see people as frequently

as every 2-3 months, are privileged to establish close relationships with many patients. Thus we are in prime positions to assess stages of change and apply appropriate communication strategies to help people initiate and sustain the process, and then maintain the positive outcomes (Hollister & Anema, 2004). So, even though TTM has been used mostly in public health campaigns, it can also support face-to-face patient-centered care and individualized patient education, which are hallmarks of dental hygiene practice. It gives us another way to support our patients.

Now that we have an idea of how change happens, we can look at some persuasive principles. It is important, I believe, in the persuasion chapter in a communication handbook, to include a brief summary of varying ideas about persuasion. We have already learned about invitational persuasion, which can be supported by considering the rhetoric of ancient Greece and Rome and the timeless rhetoric of storytelling.

## Classic Rhetoric

Some of the earliest rhetorical strategies ever documented go back as far as Greece in the 4th century BCE. The fundamentals of classic persuasion are summarized in the ***three modes of proof***, generally attributed to Aristotle (Larson, 2001; Stoner & Perkins, 2005). He outlined three basic sources of persuasion, the validity of the *evidence*, the *credibility* of the speaker, and the *emotion* of the audience. *Evidence* refers to the examples, statistics, reasoning, stories, and other information that you bring to your arguments. The *evidence* part of evidence-based decision-making refers to findings from scientific studies combined with your own knowledge and experience and the patient's

needs and preferences in a given situation. Good evidence is persuasive and creates interest in the topic (Dodd, 2004). We reason using evidence every day. "Your gums are red and they bleed easily and there is a layer of biofilm on the surfaces between your back teeth. We know that if this condition continues, your gum disease will get worse and I am concerned that you could lose some teeth. We've talked about flossing before, but I have learned some new ways to clean between your teeth. Would you like to hear about them?" Our credibility is enhanced when it is clear that we have extensive knowledge about a topic (Dodd).

*Credibility* refers to your personal integrity and trustworthiness. If you are not credible, then even the most compelling evidence can be weakened. Dental hygienists have a certain amount of inherent persuasiveness just by being the professional, and this is enhanced as patients come to trust us over time. They sense and then come to know whether or not we are honest, caring, well informed, and motivated by good will. I was honored by a patient who said he would follow my recommendations simply because everything I had told him over the years had been the truth. However, that statement also reminded me of the huge responsibility that we take on as health care providers as well as the ethical issues involved in persuasion.

Finally, we need to pay attention to the patient's *emotions*, or the significance and relevance of an argument to a particular individual. Human feelings can be powerful motivators, especially when related to such an important issue as health. Patients need to see that our information relates to them. They want to know, "what's in it for me?" People are much more likely to learn and change if the arguments resonate with them

(Weiss, 2000). We have much emotional ammunition to use, including the current developing knowledge about the relationship between general and dental health and people's concerns about appearance, function, and pain, and we need to apply judgment as we use it.

A good argument balances evidence, credibility, and emotion. If we give too much evidence, especially scientific data, people's eyes begin to glaze over and they tune us out. But our credibility will wear thin over time if we depend on it alone without adding evidence and relevance, and emotional appeals can also be overused. So, thanks to Aristotle, we know the main ways that people are persuaded. Remember that the metaphor for invitational rhetoric is one of sharing rather than conquering. Simply offer what you have and give it when it is wanted, or, even better, wait for people to ask for it. As Blaise Pascal wrote in the 15th century, "People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the minds of others." One particularly effective way to get people's attention and start them thinking of how a problem might relate to them is through stories.

## Narration

Everyone enjoys a good story. We like to tell stories and we like to hear them. Most of us began by hearing stories told or read to us as young children, and have continued to be interested in true and fictitious tales in magazines, books, movies, television, and other media. Even a single picture can tell a story and, as the saying goes, is worth a thousand words. Walter Fisher (1989) proposed and developed narrative

theory, in which he called human beings "homo narrans," story-telling animals. It seems a natural thing for us to do.

Stories can be informational, inspirational, or entertaining, and as such, can also be persuasive. Look at television ads. They manage to squeeze a sales message into a story that lasts 30 seconds or less. Man is unhappy, man buys fabulous new car, man gets gorgeous girlfriend because he has the new car. College student is bogged down, college student buys the latest computer, college student suddenly loves college and makes straight As. Woman has no boyfriend, woman whitens her teeth, woman is popular beyond her wildest dreams. These kinds of ads sell cars, computers, and tooth whiteners because people identify with the characters' problems and hope that the solutions will work for them, too.

Our patients like to tell stories, too, and Borkan, Miller, and Reis (1992) advocate taking the time to listen to them. This kind of attention gives context to patients' issues and simultaneously helps us perceive symptoms and other information that can offer insight into the patient's health situation, such as hearing the strength of a person's voice and "listening between the lines" of a patient's symptoms. Listening to patients' stories "leads towards patient mastery, implies caring and support, maximizing the perceived and objective relief of sickness and may be the basis of the placebo effect. Just agreeing with the patient on the 'story line' can improve outcomes" (p. 128).

We see this idea confirmed by the success of self-help or support groups. People who have endured life crises meet together to discuss their experiences. You wouldn't think that telling a sad story and listening to others tell their sad stories would help people

feel better, but it does (Humphreys, 1997). That is because people identify with the stories, benefit from seeing others cope, cope better themselves, and finally complete the cycle by helping others cope. The whole purpose of these groups is communication. People meet to tell and hear stories, which relieves stress, which in turn has positive measurable physiological effects (Reissman, 1987). So maybe that is part of the reason that humans find stories so compelling.

I always noticed that the stories I told patients seemed to be more persuasive than any statistics or other information. I could tell them about the latest data from a study that I had read or learned about in a class, but the stories about others who had tried the new product or technique seemed much more convincing, and that observation was confirmed by research. People who are poorly motivated to change health practices, compared to those who are more highly motivated, are more likely to change after hearing a story than after hearing statistics (Braverman, 2008).

However, telling stories can work for or against us in the dental office. My most successful story in 26 years of practice was about two elderly relatives who had lost most of their teeth in their mid forties due to gum disease, a process that was not understood in the 1950s. Telling that story inspired more people to care for themselves than almost any other single strategy I ever employed, including sharing the most astounding facts and statistics. On the other hand, when people hesitated to have certain treatments such as root canals or wisdom tooth extractions, no matter how much we explained that each case is individual and that each body reacts to procedures in its own way, people were always convinced that they would have the same horrible reaction to a given procedure as a

friend whose (possibly exaggerated) story they had heard. People believed their friends' stories more than they believed the knowledge and experience of professionals. That is the power of narration.

## Persuasion and Diversity

In regards to working with diverse patients, all of what has already been mentioned applies. Use a patient-centered approach. Watch your nonverbal communication, especially in relation to touch, vocal volume, and eye contact. If language difference is a problem, use handouts in the patient's language and visual aids wherever possible. In general, apply the information from the rest of this book. There is, however, one other icon of American values that may need reconsideration and reinterpretation when recognizing diversity.

Take another look at the priorities of Maslow's Hierarchy of Needs. Abraham Maslow was a psychologist who developed a prioritized list of five human needs and placed them in a triangle with the most basic at the bottom, the widest part, and the most esthetic needs at the narrowest top. Physiological needs, the fundamental requirements of human existence such as food and water, are at the base. The need for safety is second and the needs for love, affection, and belongingness are third. The fourth level addresses the needs for esteem and self-esteem, and finally, at the top of the pyramid, sits the need for self-actualization, or the ability to use one's creativity and spontaneity to find personal fulfillment (Delaune & Ladner, 2002). Hospital nurses often use this system to try to gauge what is best for their patients (Harvath, 2008).

The Maslow model emphasizes the importance of individuality at the top of the pyramid, and downplays the importance of relationships by placing that need in the middle, just above the need for safety. Since relationships are key in collectivist cultures, the ordering of the concepts may not always seem appropriate to diverse people (Hanley & Abell, 2002). So, reconsider how relevant *self*-esteem and *self*-actualization may be to people who value and emphasize the group over the individual as you work with diverse patients and attempt to be persuasive.

In sum, our job is not to get the patient to *comply* with our advice. I dislike the word, *compliance*, because it connotes coercion or manipulation. To me, it does not fit in a patient-centered approach to care. I feel that our job is: to listen first and foremost; to inform completely based on each individual's needs; to collaborate with the patient to choose the best option for that individual; and finally to provide the chosen treatment as well as we are able. To that end, rather than *compliance*, I suggest the words *collaboration*, *cooperation*, *involvement*, or *participation*. If we subscribe to the concepts of patient-centered care, then we form partnerships with our patients, collaborate with them, and help them participate in their own care to the extent that they can and wish to do so. As those relationships evolve, our patients come to trust us and we have a responsibility to honor that trust and not take unfair advantage of it.

So use your persuasive abilities with care and consideration for the patient's best interests. People have a right to choice; that is the basic premise of informed consent and a fundamental part of EBDM. Once patients have all the information, and they are deemed able to understand that information, then they get to choose. If they choose not to

have treatment, then so be it. They have made informed decisions based on sound, complete, and current information and those decisions should be respected. That doesn't mean we can't continue to gently inform and discuss, especially when new information becomes available. "It's your decision. It's my responsibility to be sure that you make an informed decision." I said that almost every day of practice, and I still believe it. Always consider the ethics of how you use your considerable persuasive power.

## What Works?

So, what actually *is* persuasive in a health interaction? What really works? Below I have synthesized the successful persuasive strategies from throughout this chapter and this book. You may use many of these methods already, but I hope this list gives you a few new ideas, too. The literature is vast, so this list is by no means complete, but I believe that it is representative. Some suggestions work better than others, but all of the ideas below have worked in various situations, so choose what seems appropriate in a given situation. Also refer to the suggestions in Chapter 3, Table 3-1 because communicating well is also persuasive, and remember that using multiple methods is often more successful (Scrimshaw, 2002).

- Create relationships with patients.
  - Foster trust and likeability.
  - Demonstrate that you are knowledgeable.
- Listen.
  - Be mindful of your nonverbal behavior; use selected touch and varied vocal pitch.
  - Give positive feedback.
- Individualize information & recommendations.
  - Practice evidence-based care.
  - Acknowledge that the patient's own knowledge and experience are valuable.

  - Be knowledgeable of and sensitive to the patient's cultural beliefs and practices.
  - Be aware of the patient's practical barriers and try to work around them (work schedules, child care, transportation issues, etc.)
- Give as much information as the patient wants.
  - Give choices as much as possible.
  - Spend time; don't expect to effect change too quickly.
  - Work on only one or two skills at a time. Do not overwhelm.
  - Dispense written information and individualize it.
  - Use demonstrations.
  - Use Teach Back and Show Me methods. Ask the person to repeat instructions or demonstrate the procedure that you taught.

Asadoorian, 2007; Bartholome, 2004; Beckman, Markakis, Suchman, & Frankel, 1994; Burgoon et al., 1987; DiMatteo, 1994; Kagawa-Singer & Kassim-Lakha, 2003; Kreuter & McClure, 2004; McKee et al., 2006; O'Keefe et al., 2007; Reutter & Ford, 1997; Roter, 2002; Scarbecz, 2007; Vivian & Wilcox, 2000.

*Take time to think and talk*:
Gather several dental hygiene colleagues together and discuss this list. Do these strategies work for you? What works best? Also, as you review the list, discuss how each method relates to the concepts of patient-centeredness, Informed Consent, Evidence-Based Decision Making, and invitational persuasion. Then write down other ideas.

## Conclusion

My job as a dental hygienist involved a great deal of persuasion. I worked hard to try to motivate people to clean between their teeth, in some cases to even brush their teeth, to accept the treatment they needed, to see a specialist, and on and on. In the early years, I was frustrated when I felt unsuccessful, because I put all the responsibility on myself. Finally, the light dawned. My responsibility was to model and inform and do my best to stay current. I was not there to elicit "compliance." I realized that it is ultimately the patient's responsibility to accept and act upon my information, or not. I had discovered invitational persuasion, though I did not have a term for it at that time. I began to relax and sleep better at night, and simultaneously became better at my job. There is no

more gratifying feeling than that of being able to help someone achieve a higher level of health, but it is a cooperative effort, not the full responsibility of the caregiver, as discussed in the principles of patient-centered care in Chapter 1.

This chapter has both reviewed some principles that you may have learned previously and, I hope, introduced some new ones. Now that you have a foundational appreciation of health, intercultural, verbal, and nonverbal communication, and also understand the importance of listening and the place of persuasion in dental hygiene practice, it is time to turn to how to use communication principles to acquire patient information in the interview.

# Glossary for Chapter 6

*Ethics*: "Principles of right action" (Sproule, 1997), or, choosing to do the right thing in a given situation.

*Persuasion*: The act of trying to change another person's ideas or behavior.

*Rhetoric*: According to Aristotle, "The available means of persuasion" (Larson, 2001, p. 8). The classic term for persuasion.

*Three modes of proof*: Aristotle outlined three basic sources of persuasion, the validity of the *evidence*, the *credibility* of the speaker, and the *emotion* of the audience (Stoner & Perkins, 2005).

*Transtheoretical Model* (*TTM*): Also known as the "stages of change," describes the phases that people go through as they attempt to eliminate unwanted behaviors and/or acquire new positive ones.

# References for Chapter 6

Asadoorian, J. (2007). Strategies for incorporating antimicrobial mouthrinses into daily oral care. *Journal of Dental Hygiene, 81*(5), 1-7.

Bartholome, P. T. (2004). Rethinking persuasion. *The Listening Professional, 3(1)*, 12,19.

Beckman, H., Markakis, K., Suchman, A., & Frankel, R. (1994). Getting the most from a 20 minute visit. *The American Journal of Gastroenterology, 89*, 662-664.

Borkan, J. M., Miller, W. L., & Reis, S. (1992). Medicine as storytelling. *Family Practice, 9*, 127-129.

Braverman, J. (2008). Testimonials versus informational persuasive messages: The moderating effect of delivery mode and personal involvement. *Communication Research, 35*, 666-694.

Burgoon, J. K., Pfau, M., Parrott, R., Birk, T., Coker, R., & Burgoon, M. (1987). Relational communication, satisfaction, compliance-gaining strategies, and compliance in communication between physicians and patients. *Communication Monographs, 54*, 307-324.

Clancy, C. M., & Cronin, K. (2006). Evidence-based decision making: Global evidence, local decisions. *Health Affairs, 24*, 151-162. doi: 10.1377/hlthaff.24.1.151

Delaune, S. C., & Ladner, P. K. (2002). *Fundamentals of nursing: Standards & practice* (2nd ed.). Clinton Park, NY: Delmar, Thompson Learning.

DiMatteo, M. R. (1994). Enhancing patient adherence to medical recommendations. *Journal of the American Medical Association, 271*, 79, 83.

Dodd, C. H. (2004). *Managing business and professional communication.* Boston: Pearson, Allyn & Bacon.

Donovan, J. L., & Blake, D. R. (1992). Patient non-compliance: Deviance or reasoned decision-making? *Social Science & Medicine, 34*, 507-513.

du Pré, A. (2000). *Communicating about health: Current issues and perspectives*. Mountain View, CA: Mayfield Publishing Company.

Etter, J.-F., Perneger, T. V., & Ronchi, A. (1997). Distributions of smokers by stage: International comparison and association with smoking prevalence. *Preventive Medicine, 26*, 580-585.

Fisher, W. R. (1989). Clarifying the narrative paradigm. *Communication Monographs, 56*, 55-58.

Foss, S. K., & Griffin, C. L. (1995). Beyond persuasion: A proposal for an invitational rhetoric. *Communication Monographs, 62*, 2-18.

Frankish, C. J., Lovato. C. Y., & Shannon, W. J. (1999). Models, theories, and principles of health promotion with multicultural populations. In D. J. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 41-72). Thousand Oaks, CA: Sage Publications.

Hanley, S. J., & Abell, S. C. (2002). Maslow and relatedness: Creating an interpersonal model of self-actualization. *Journal of Humanistic Psychology, 42(4)*, 37-57. doi: 10.1177/002216702237123

Hollister, M. C., & Anema, M. G. (2004). Health behavior models and oral health: A review. *Journal of Dental Hygiene, 78(3)*, 1-8.

Humphreys, K. (1997). Individual and social benefits of mutual aid self-help groups. *Social Policy, 27*(3), 12-20.

Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine, 78*, 577-587.

Kreuter, M. W., & McClure, S. M. (2004). The role of culture in health communication. *Annual Review of Public Health, 25*, 439-455. doi: 10.1146/annurev.pubhealth.25.101802.123000

Larson, C. U. (2001). *Persuasion: Reception and responsibility* (9th ed.). Belmont, CA: Wadsworth/Thompson Learning.

Long, R. H. (2006). Patient-based behavior change. *Access, 20*(8). 32-38.

McKee, S. A. (2004), O'Malley, S., Steward, W. T., Neveu, S., Land, M., & Salovey, P. (2004). How to word effective messages about smoking and oral health: Emphasize the benefits of quitting. *Journal of Dental Education, 68*, 569-573.

O'Keefe, D. J., & Jensen, J. D. (2007). The relative persuasiveness of gain-framed and loss framed messaged for encouraging disease prevention behaviors: A meta-analytic review. *Journal of Health Communication, 12*, 623-644. doi: 10.1080/10810730701615198

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrated model of change. *Journal of Consulting and Clinical Psychology, 51*, 390-395.

Prochaska, J. O. & DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

Purdie, N. & McCrindle, A. (2002). Self-regulation, self-efficacy and health behavior change in older adults. *Educational Gerontology, 28*, 379-400.

Reissman, F. (1997). Ten self-help principles. [Electronic version]. *Social Policy, 27*(3), 6-12.

Reutter, L, & Ford, J. S. (1997). Enhancing client competence: Melding professional and client knowledge in public health nursing practice. *Public Health Nursing, 14*, 143-150. doi: 10.1111/j.1525-1446.1997.tb00285.x

Rimer, B. K., & Kreuter, M. W. (2006). Advancing tailored health communication: A persuasion and message effects perspective. *Journal of Communication, 56(Supp.)*, S184-S201.

Roter, D. (2002). Three blind men and an elephant: Reflections on meeting the challenges of patient diversity in primary care practice. *Family Medicine, 34*, 390-393.

Scarbecz, M. (2007). Using the DISC system to motivate dental patients. *Journal of the American Dental Association, 138*, 381-385.

Scrimshaw, S. C. (2002). Chair's preface. In: Committee on Communication for Behavior Change in the 21st Century: Improving the health of diverse populations; Board on Neuroscience and Behavioral Health; Institute of Medicine of the National Academies, *Speaking of health: Assessing health communication strategies for diverse populations* (pp. xi-iv). Washington, D.C.: The National Academies Press.

Sproule, J. M. (1997). *Speechmaking: Rhetorical competence in a postmodern world* (2nd ed.). Madison, WI: Brown & Benchmark Publishers.

Stewart, J. E., Wolfe, G. R., Maeder, L., & Hartz, G. W. (1996). Changes in dental knowledge and self-efficacy scores following interventions to change oral hygiene behavior. *Patient Education and Counseling, 27*, 269-277. doi: 10.1016/0738-3991(95)00843-8

Stoner, M., & Perkins, S. (2005). *Making sense of messages: A critical apprenticeship in rhetorical criticism.* Boston: Houghton Mifflin Company.

Sypher, B. D., Russo, T. C., & Hane, A. C. (2002). The development of persuasive abilities in college students [Online exclusive]. *American Communication Journal, 5*. Retrieved September 24, 2008, from http://acjournal.org/holdings/vol5/iss3/special/sypher.pdf

Velicer, W. F., Prochaska, J. O., Fava, J. L., Norman, G. J., & Redding, C. A. (1998). Detailed overview of the transtheoretical model. Retrieved November 28, 2006, from http://www.uri.edu/research/cprc/TTM/detailedoverview.htm

Vivian, B. G., & Wilcox, J. R. (2000). Compliance communication in home health care: A mutually reciprocal process. *Qualitative Health Research, 10*, 103-116. doi: 10.1177/104973200129118273

Weiss, R. P. (2000). Brain-based learning. *Training & Development, 54(7)*, 20-25.

# Chapter 7
# Interviewing: The Art of Health Care

Learning Objectives For Chapter 7

After reading this chapter you should have:

1. Begun to understand why interviewing skill is important in health care
2. Learned the three purposes of a health interview
3. Gained insight into how to accomplish the purposes of a health interview
4. Acquired strategies for working with difficult patients in interviews

A sense of curiosity is nature's original school of education.
Smiley Blanton

Patience is also a form of action.
Auguste Rodin

When people talk, listen completely. Most people never listen.
Ernest Hemingway

## Introduction

You've listened to the patient's opening statement and learned her main concerns. Now it is your turn to ask questions, that is, to interview the patient. A dental hygienist conducts thousands of patient interviews throughout a career, yet few of us ever receive instruction on how to interview patients effectively, a skill that is critical to optimum practice. We need to know what medications people are taking, including over the counter, herbal, and even illegal preparations, and we need to know their health habits and history so we can treat them safely. The information derived from the medical patient interview is a powerful clinical and diagnostic tool that, on its own, yields as much as three quarters of medical diagnoses (Cole & Bird, 2000; Peterson, Holbrook, VonHales, Smith, & Staker, 1992). Only 12% of those diagnoses are derived from the physical examination and 11% from medical tests (Peterson et al.). The percentages may not be

exactly the same for dentistry, but the interview does provide a significant portion of the information that we use to develop our dental hygiene diagnoses and treatment plans. So, even though we have an array of technologies at our disposal, talk and interaction are fundamental to optimum practice and to helping obtain the best and most complete information about each individual.

By ***interview***, I refer to the part of the appointment in which we clarify answers from the health history and other paperwork and then learn what we can about the patient as a person and about his concerns, needs, and expectations for the particular appointment. In a strict sense, of course, you are "interviewing" the patient throughout the visit, from the initial greeting to the completion of treatment, but this chapter focuses on the information gathering part of the session.

Patient-centeredness should be an important part of interviewing, just as it is throughout care, but it has not always been so. I noted in Chapter 3 that, as recently as the 1960s, the patient interview was called an "interrogation" (Weston, 2001); for most of the latter half of the 20th century health providers referred to "taking" a medical history (Wearne, 2005); but in the early 21st century Haidet and Paterniti (2003) encouraged "building" a cooperative history. The "cooperative" part of this definition means that both the caregiver's and the patient's perspectives and knowledge combine to help render optimum treatment. The philosophy of building together to achieve better health for the patient is aligned with patient-centered care, informed consent, evidence-based decision-making, and the view of care that I have promoted throughout this book. We will look at why the interview is an important part of an appointment, the three purposes of patient

interviews, the skills we need to build cooperative patient health histories, the interview agenda, the role of culture, the time an interview might take, and how to work with difficult people.

## Importance of Health Interviewing Skill

Dental hygienists must be competent interviewers, for professional and practical reasons. We are required to compile information but we also need it to provide competent care. As of this writing, The American Dental Education Association had last revised their "Competencies for Entry into the Profession of Dental Hygiene" in 2003, and these were published in the *Journal of Dental Education* in 2004. Dental hygienists must be able to "Determine a dental hygiene diagnosis," and "Collaborate with the patient/client, and/or other health professionals, to formulate a comprehensive dental hygiene care plan that is patient/client-centered and based on current scientific evidence" (American Dental Education Association, p. 747). The information needed to accomplish these goals is gathered during patient interviews. All primary health care providers should be competent communicators and interviewers, but unfortunately many are not.

Research that spans more than 30 years indicates that, without training, medical students' ability to interview patients declines drastically as they progress through medical school. In two early studies, students began medical school with good interpersonal skills, but by the fourth year their communication with patients was "terrible" (Helfer, 1970; Helfer & Ealy, 1972, p. 559). At a medical school in Canada, the interviewing skills that medical students learned in their first year declined progressively as they moved through their programs, and as their skills worsened, *their confidence*

*increased* (Craig, 1992). In the early 1990s, the medical school curriculum at the University of Connecticut School of Medicine emphasized interviewing. For the first two years of the four-year program, the students spent ½ day per week in a course devoted to physical examinations, communication skills, and developing medical histories. Students' skills increased initially, but then diminished after they finished that course and as they progressed through the last two years of the program (Pfeiffer, Madray, Ardolino, & Willms, 1998).

All of these researchers postulated a similar reason for the drop in interviewing skill. They thought that it was related to an intense acculturation into the medical field that focused on scientific as opposed to interpersonal skills. Scientific knowledge and technical skill are certainly important; I would not want to see a physician who did not have them. But all the knowledge and skill in the world are useless if you cannot communicate well with the people who need your care. Since the University of Connecticut study was conducted in the early 1990s, the school has instituted a course that lasts throughout the four years of medical school and preliminary evaluations of the new program suggested that it was making a positive difference (Pfeiffer et al., 1998).

As a result of this and other research, communication became one of six required competencies identified by the Accreditation Council on Graduate Medical Education in 2003, and is thus included on the Medical Board Examination that all graduating medical students must pass in order to become licensed medical doctors (Shirmer et al., 2005). Additionally, the American Medical Association and the Accreditation Council for Graduate Medical Education require medical education programs to produce physicians

who display "sensitivity to patients of diverse backgrounds" (Accreditation Council for Graduate Medical Education, Section *V*, Part D, Line 5). The effects of these policies are in question. Eighty-seven percent of medical schools now include cultural competence training in three or fewer courses (Champaneria & Axtell, 2004) and, as of 2003, 51% of residency programs offered physicians cultural competence training (Weissman et al., 2005). At least one medical school is committed to communication training for their students. The University of California at Davis Medical School requires instruction and practice in interviewing skill throughout the four years of their program. Their "Doctoring" course includes issues of cultural competency, death and dying, sexual histories, and many other critical topics (M. M. von Friederichs-Fitzwater, personal communication, November 10, 2008).

I found several related studies in dentistry. One group of researchers surveyed 40 out of the 64 dental schools in Canada and the United States regarding the type and amount of interpersonal communication training that their dental students received (the remaining 24 schools were contacted but either declined to participate or did not send enough information to qualify for the study). The two courses most frequently taught were communication (88% of the schools) and interviewing (75%), though the scope of the courses was generally "quite narrow" (Yoshida, Milgrom, & Coldwell, 2002, p. 1284) and most omitted both interpersonal communication and culture. The researchers called for an expanded communication curriculum that increases in complexity throughout the dental school programs. Other dental research studied the outcomes of one of those courses.

The findings from two similar studies conducted a few years apart by the same lead researcher were almost identical. Third-year dental students at Nova Southeastern University College of Dental Medicine took a 35-hour communication course and then were followed for one school term. The students' initial interviewing skills were rated at the low end of average, but by the end of the semester they were rated as strong (Hottel & Hardigan, 2005; Hottel & Hiller, 2001). That was not all. "Students with improved interviewing skills have *increased clinical skills and tend to be more productive*" (Hottel & Hiler, italics added), and also displayed empathic abilities by being sensitive to diversity, paying attention to nonverbal communication, keeping appropriate eye contact, noticing patient discomfort, and trying to help lessen patient anxiety. So these researchers concluded that communication ability, specifically interviewing and listening skills, predict empathy, clinical proficiency, and productivity as well. Unfortunately, the researchers did not follow the students past the end of the semester, and, if we extrapolate from the medical student research, it is likely that the benefits of the communication training faded if it was not reinforced. This conclusion seems to be confirmed by concurrently published research in which the authors reported a steep and significant decline in empathy and the ability to relate to patients in untrained dental students as they progressed through dental school (Sherman & Cramer, 2005).

I found only one account of similar research that included dental hygiene students, though it was reported online and not in a peer-reviewed publication. Lanning (2005) reported on a communication skills training program that was piloted with second year dental students and third year dental hygiene students at Virginia Commonwealth

University. This program added 9 curricular hours of lecture, role-playing, and simulated patient interactions. Students had previously received only two hours of lecture instruction regarding communication. Though they learned many skills, students most often commented about those relating to how to motivate patients, improve verbal and nonverbal communication, decrease their use of medical jargon, and confirm their own and patient understanding. Students and instructors both found the training helpful and, as a result, it was being expanded to 15 curricular hours that would become a permanent part of the school's dental and dental hygiene programs.

Additionally, I noticed one interesting finding from the Sherman and Cramer (2005) study that could apply to dental hygienists. Female dental students scored significantly higher on the empathy scale compared to male students. The authors postulated that women in general may be more adept at being empathetic and communicating empathy to patients, and they suggested this as a topic for future research. Earlier research had also noted that female medical students were more empathetic than their male counterparts (Hojat et al., 2002). Since the majority of dental hygienists are female (we need only look around at any of our gatherings to confirm that), we may have an advantage when it comes to empathy. Even if this is so, we still need to learn how to interview, and the good news within all the research reported above is that training helps improve interviewing skill. The information in this chapter is only a beginning. I hope you are also able to benefit from hands-on clinical communication practice with feedback from qualified instructors to help fulfill everyone's expectations of health interviews.

## Who Wants What?

We as clinicians want to help people achieve better health, and, in order to realize that goal, we need to acquire complete information. We hope that patient interactions will be pleasant, productive, efficient, and as stress-free as possible. In regards to communication, patients desire much the same, but more. They prefer an open, reciprocal, and affiliative interview style as opposed to a controlling style (DiMatteo, Hays, & Prince, 1986; Larivaara, Kiuttu, & Taanila, 2001; Speedling & Rose, 1985). They want caregivers to be positive, friendly, attentive, respectful, empathetic, and communicatively competent (Bertakis, Roter, & Putnam, 1991; Hall, Roter, & Katz, 1988). This is what some authors refer to as "high touch," a capable, personalized, sensitive kind of care (Boswell, 1997; Fromoyer & Fromoyer, 2002). They want information, but we don't always give them as much as they want and they don't always let us know when they want more (Schouten, Hoogstraten, & Eijkman, 2003). Some patients want to make their own decisions based on full information from caregivers; others want the healthcare provider to make the decisions while taking their opinions into account (Delgado et al., 2007). In other words, they want patient-centered care.

When we tend to what patients want, then we get what we want. Satisfied people are more likely to understand and remember what we say and to follow our recommendations (Hall et al., 1988), which ultimately result in improved health. A bonus benefit for us is that patients who achieve optimum outcomes are less likely to sue us for malpractice (Lester & Smith, 1992). But we cannot be all things to all people all the time. The patient list of "wants" is a tall bill to fill. Part of the problem is that we aren't trained,

but fortunately, training helps us learn how to achieve the purposes of patient interviews (Frymoyer & Frymoyer, 2002; Haidet & Paterniti, 2003).

## Three Purposes of Health Interviews

We want to accomplish three main goals in health interviews: build relationships, assess patients' health problems, and then offer information and suggestions to help patients manage their health problems, *in that order* (Cole & Bird, 2000; Froymoyer & Frymoyer, 2002). We cannot expect people to share their most sensitive health information until we get to know each other at least a little and begin to establish trust, and we cannot recommend care until we have complete information. However, as with all developing relationships, the parts can overlap and will not always be clear-cut, and each function is ongoing and may or may not be accomplished within one interview. In rare cases with well-established and healthy patients, we may not significantly address any of these purposes at a particular appointment. Part of being patient-centered is choosing goals for each encounter based upon the patient's needs at the time. This chapter focuses on the second goal, assessment.

The relationship-building goal, which is more prominent in earlier patient meetings, requires the application of at least five skills (Cole & Bird, 2000), all of which have been addressed in this book. First, be aware of and understand both your own and the patient's *nonverbal communication* (Chapter 4), which includes attention to cultural issues (Chapter 2). Second and third, show *empathy* and *respect* by understanding and accepting the patient's point of view. Remember from Chapter 5 (Listening) that caregiver empathy for patients contributes to more accurate diagnoses, better cooperation

with treatments, and increased satisfaction for both patient and clinician (Coulehan et al., 2001). Empathetic statements could include: "It must be very difficult to enjoy life and take care of your responsibilities when you are in so much pain," and "I want to be sure I understand your concern." Fourth, make statements of *personal support* such as "I want to help," or "Let me know what I can do to help" (Cole & Bird, p. 19). Use the information from Chapter 3 (Verbal Communication) to help assure that the message sent is the message received. Finally, create *partnerships* by involving patients in their own care. Health goals should be mutually agreeable; people are more likely to follow recommendations that are based on shared priorities and that come from a trusted source. Enhance your credibility and trustworthiness by modeling the behaviors that you advocate and by sharing up-to-date knowledge (Chapter 6).

After establishing a relationship, we then assess the patient's condition. First and foremost, *listen.* Remember that dental patients' number one complaint is that we don't listen to them (Boswell, 1997). Give each patient at least two continuous minutes to make an opening statement. Much of the information that you might need will be offered voluntarily if the patient can speak without interruption. The patient's opening statement combined with the written answers on the health history form (which should have been reviewed before seating the patient) usually give a rounded picture of the current situation, but you can fill in the information gaps through skillful *questioning.* The third goal, helping the patient manage his health issues through education, negotiation, and motivation (Cole & Bird, 2000), is a huge subject for another text. The main focus of this

chapter is to learn how to accomplish the second goal of the health interview, evaluate the patient's current condition.

## Skills for Building a Health History

Since both the caregiver's and the patient's views are important, the patient interview should be a conversation rather than a simple question and answer session. Develop three important skills for "building" a cooperative history: sensitive questioning, mental multitasking, and use of verbal and nonverbal devices (Haidet & Paterniti's, 2003). First, ask questions mindfully, that is, with a self-awareness of the words you use and how you phrase your questions. This includes using "focused but still open-ended" (p. 1137) questions that stay on topic, but are also open and flexible enough to allow the patient to bring up other relevant topics. "What is going on with your health?" "What are your concerns today?" Avoid questions that are too vague, such as "How are you doing?" or "What's happening?" (M. M. von Friederichs-Fitzwater, personal communication, November 10, 2008). Second, use "organizational multitasking" (p. 1138), or apply the patient's answers to dental hygiene diagnosis and practice. This process has also been described as "listening at multiple levels" (Lipkin, Frankel, Beckman, Charon, & Fein, 1995, p. 75). You pay attention to the patient at the same time you are mentally putting all the pieces together.

Finally, use verbal and nonverbal conversational devices other than questions to clarify and follow up on both the new threads of information that the patient introduces and your own tentative conclusions. Ask for clarification or elaboration and/or paraphrase what the patient has said. You might include statements such as "Tell me some more

about..."; "Let me be sure that I understood what you said..."; "Did I leave anything out?"; "And then what happened?"; and "What else?" Some nonverbal devices include backchannel responses, silence and pauses, eye contact, head nods, facial expression, body position, and time management. We apply these three skills as we progress through the interview.

## Agenda for the Health Interview

What, exactly, are we trying to accomplish in an interview? Of course the details will vary with the patient and the appointment, but Stoeckle and Billings (1987) took a rounded view of interview goals. "In our diverse culture (it is hoped that) the patient's perspectives—concerns, requests, attributions, cultural beliefs, explanatory models, and self-treatment—are all recognized and, of course, responded to, while that older clinical advice to attend to feelings, relationships, and personality attributes is not forgotten" (p. 126). All parts of the interview are important.

### *Beginning and Ending*

The way a patient interview ends is related to the way it begins. Careful interviewing in the beginning and middle of appointments contributes to a smooth and efficient closing. It is wrong to assume that a patient will share her most worrisome symptoms right away. She may start off with a relatively minor and unrelated concern to sort of test how that is received or to wait until she feels comfortable discussing a more private matter. A doctor could have made a diagnosis, planned the treatment, ordered tests, written prescriptions, and referred to specialists, only to have to redo all of it when the patient reveals an alarming and complicating symptom at the end of the appointment

(Garafanga & Britten, 2003; White, Levinson, & Roter , 1994). This type of revelation has been called "Oh, by the way," (Barker, O'Connell, & Platt, 2005) or a "doorknob disclosure" (du Pré, 2000, p. 58), that is revealed as the doctor literally has her hand on the doorknob as she is leaving the room. This problem can be minimized when we elicit complete information at the beginning and in the middle of interviews, which includes clarifying patients' beliefs, understanding, emotions, and psychosocial issues. In order to achieve all that, we must first establish a trusting relationship.

*Take time to think and talk*:
Can you think of a time when a "doorknob disclosure" derailed your schedule? Ask a colleague the same question and then discuss how you might have prevented these incidents.

*Establishing Trust*

Trust evolves over time, but we need information right away. So we need to make good first impressions, especially with new patients. First impressions can establish a sort of instant credibility and trustworthiness that can then be confirmed and reconfirmed over time. We usually have an advantage at the beginning simply because we are the professionals, but our actions and inactions can erode those early perceptions. We must pay attention to personal appearance, the appearance of our work areas, and our verbal and nonverbal communication, as Boswell (1997) learned from interviewing and surveying thousands of dental patients. Swedish visiting nurses listed the qualities and behaviors of caregivers that help patients develop trust, and these included respect, sensitivity, humility, attentiveness (listening), broad knowledge, the ability to educate well, and calm demeanor (Eriksson & Nilsson, 2008). Before arriving at the interview

portion of an appointment, you probably share some social time with the patient. This "small talk" isn't small at all; it is critical to establishing trustworthiness and building relationships. When relationship issues are not attended to, especially if the patient disagrees with the clinician's views, the result may be that patients drop out of care in various ways. They may fail to follow directions, fill prescriptions, take medications, or return for continuing care (Platt et al., 2001), which all lead to poor outcomes. When trust is established, we can begin questioning.

*Questioning*

After attending to first impressions, then we get down to the business of "building" a patient history. We have the completed health history form as a beginning, but there are always questions about illnesses, medications, limitations, aches, pains, and fears. "What problem did you have with previous dental treatment?" "How long have your gums been bleeding?" "What causes the bleeding and what makes it better?" "I see you took Phen-Fen. When and for how long? Has your physician checked you to make sure you don't have any heart damage from it and are you cleared to receive dental treatment?" "Has anyone ever shown you different ways to clean between your teeth?" and "We haven't seen you here for a while. What happened?" When we do not allow patients to communicate their individual concerns, we may not acquire the necessary data, patients are less likely to cooperate with treatment recommendations, and, as a result, outcomes can be negatively impacted (Platt et al., 2001). We can encourage complete answers by our use of nonverbal communication and language.

*Nonverbal communication.*

Remain aware of your nonverbal communication during this exchange. Use appropriate touch, eye contact, facial expression, head nod, slight forward body lean, and verbal expression. Sit at the same level as your patient with your head and full body facing her. After you ask a question, listen to the answer, showing "respectful attention" (Platt et al., 2001 p. 1132) by using encouraging and empathetic backchannel responses in an open and nonjudgmental manner (Thompson, 1986). A caregiver's most important qualities in their interactions with patients are *curiosity* and *patience*, and these qualities are communicated via both nonverbal and verbal channels (Platt et al.). Verbal communication in the interview part of the appointment involves mostly asking questions.

*Verbal communication.*

We need to ask more than just "Tell me about yourself." We need to make it our business to understand: (1) some personal information about the patient's life and lifestyle, (2) the patient's desires, values, and fears, (3) how the illness impacts the patient's life, (4) how the patient perceives the illness, and (4) the patient's ideas about the cause and expected course of the illness (Platt et al., 2001). To gather this information, perhaps the most significant question you can ask is, "What is the most important thing that we can do for you?" (Frymoyer & Frymoyer, 2002, p. 98). The answer to this question can offer insight into the patient's values and priorities. One question you might want to steer away from is, "What do you think the problem is?" because it can elicit a response such as, "I don't know, that's why I came to see you"

(Lang, Floyd, Beine, & Buck, 2002, p. 326). If you get this kind of answer, then you can counter with, "We find that patients have important insights that can often help us determine the cause." An alternative statement could be, "I'd like to know your perspective." You will be asking more such questions at the beginning of a relationship with a new patient. The longer you know someone, the less you need to ask.

*Open versus closed questions.*

Ask open-ended rather than ***closed questions***. ***Open-ended questions*** invite the patient to expand the response rather than answering only "yes" or "no." For instance, perhaps you noted on the health history that a patient is an ex-smoker. Instead of asking, "When did you quit?" ask, "How were you able to quit?" The first question can be answered simply with a date and the patient may or may not choose to elaborate, but the second question *requires* elaboration. This provides an opportunity to gather more information, congratulate the patient, and work on building the relationship at the same time. Or, perhaps you noticed that a patient is allergic to Penicillin. Instead of asking "Does it cause a rash or do you have trouble breathing?" ask, "What kind of reaction do you have to Penicillin?" The first question is not only closed, it is also leading. Perhaps she has a reaction that is entirely different from the two choices provided but she may reply with one of the them because she thinks those are her only choices, or she doesn't want to go into it, or for other reasons that we may not understand. You would choose to ask the second question so that the answer will be given in the patient's own words without prompting. Obviously every question does not need to be open-ended, especially follow-up questions when all you want or need is a simple brief answer.

*Avoiding jargon.*

When asking questions, use understandable language and avoid jargon. We do try, but some words are so natural that they just jump out of our mouths. Even everyday sayings can be confusing to some people. A friend who was just learning English was in a group of friends when someone asked, "What's up?" and she looked up. Think of how our dental jargon and colloquial expressions might sound to a child, a low literacy person, someone with limited English proficiency, or anyone from a different generation. As a sixty-something person, I often do not understand the teen and twenty-something lingo—and they don't always understand me. If the meaning of "What's up?" can fool some people, imagine the confusion that these words from dental health histories can cause: *acute*, *edema*, *ligament*, *metastasis*, *angina pectoris*, *arthrosclerosis*, *HIPAA*, and *ulcer*. And then imagine how these words from every-day dental office conversation might sound to a lay person: *amalgam*, *maxilla*, *mandible*, *pontic*, *bridge*, *abutment*, *apicoectomy*, *mesial*, *distal*, *occlusal*, *lingual*, *cone cut*, *debridement*, *frenum*, *contact*, *restoration*, *endo*, *torus*, *apical*, *cusp*, and *dentition*. We don't have to give up our dental language, it helps us communicate clearly with each other, but we do need to be aware that it can puzzle our patients, so reword and rephrase as needed, especially when caring for diverse people.

*Explore some more*:
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http://www.bracesinfo.com/glossary.html

## Cultural Issues in Interviewing

Your questioning and your "reading" of nonverbal cues can be more challenging when you don't share a culture with the patient (see Chapter 2). In many situations, it is clear that the thick layer of biofilm probably caused or at least contributed to the decay and periodontal problems. But sometimes the cause is less obvious and more complex. Either way, it is important to elicit the patient's view. In their classic article about the role of culture in the health interview, Kleinman, Eisenberg, and Good (1978) suggested eight questions, better known as "Kleinman's Questions," that can help clarify diverse patients' views. Remember the Hmong man's opinion of what causes decay. "A very small bug with a big red head gets into the tooth and can only be killed by pulling the tooth out and crushing it and throwing it in the fire" (Moch, Long, Jones, Shadick, & Solheim, 1999, p. 240). If this person were to sit in your chair, you would never know that this is his belief until you ask. Even though they evolved out of the needs of diverse people, these questions can be applied to all patients, because anyone can have a different view of disease.

The questions that Kleinman et al. (1978) suggested are:

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

I reorganized these questions into a past, present, and future framework to help you remember them. For the past, remember etiology; for the present, remember symptoms and fears; for the future remember course, severity, duration, treatment, and outcome (see table). It is unlikely that you will need to ask all of these questions because, given the chance, many patients will naturally share much of this information, and many goals, values, beliefs, and attitudes are likewise embedded in other comments and accessible to the perceptive interviewer. If we keep these categories in mind, and asks questions to fill in the gaps, then our and the patient's hypotheses can combine to create what Platt and Platt (2003) called "a work of art" (p. 1131).

Table 7-1: Kleinmen's Questions redefined

| **Dimension** | **Questions Regarding Patient's View** |
|---|---|
| Past | Etiology |
| Present | Symptoms and Fears |
| Future/Expected | Course, Severity, Duration, Treatment, and Outcomes |

## Time

It takes time to create a work of art, but the reality of scheduled patient care is that you cannot let the conversation go on forever. So it is up to you draw the interaction to a close when you feel that the patient has explained herself fully and that you have the information that you need. Of course the amount of time needed for an interview will

vary with the individual and the circumstances surrounding each appointment, but with practice, it should be reasonable (Platt et al., 2001). Two conditions are associated with increased patient participation in the interview: longer relationship with the particular person and the addition of just two minutes to the average appointment time (Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995). That would add an extra 16 minutes to an 8-patient day, but it may actually save time in the long run because the less patients are interrupted as they try to explain their views, the less time the interview takes (Levinson, Gorawara-Bhat, & Lamb, 2000; Menz & Al-Roubaie, 2008), the more satisfied people are (Emmanuel & Emmanuel, 1992; Stewart, 1984), and the more likely they are to participate in their own care (Adolfsson, Starrin, Smide, & Wikblad, 2008; Kaplan et al.). That is a big payoff for a two-minute investment of time.

In spite of all the research that I have presented here, remember that, though most people want patient-centered care and they want to share information and be understood (Levinson et al., 2000), some do not. In a survey of 2750 Americans, researchers found that people who were female, relatively more educated, healthier, and 45 years of age or younger preferred to have more of a say in medical decision making, and African-American and Hispanic respondents preferred to leave the decision-making up to the doctor (Levinson, Kao, Kuby, & Thisted, 2005). Other researchers found that the elderly and the very ill prefer caregivers to make the decisions (Little et al., 2001).

There are also different views of what it means to be "involved." Peek et al. (2008) conducted in-depth interviews and focus groups with African-American patients with diabetes. Almost all patients wanted to be included in the decision-making process,

but most defined that as just *feeling* that they had choices, even if they did not want to actually *make* a choice, preferring to leave that up to the doctor. Part of the reason for this attitude was that some patients "were so unaccustomed to having more than one treatment plan described, that the concept of multiple, acceptable treatments was new and confusing" (p. 454). One patient said, "I prefer that the doctor and I decide together...When he prescribes what he prescribes, I'm all for it. I want to have a say in things, but I go along with what he tells me" (p. 455). Though not all felt that way. "There are doctors out there that will listen to you and tell you what's going on right then and there, but then some doctors don't know what they are doing...You are not going to know what's wrong with me unless I tell you," and "God has given us this strength to speak up, to tell people what we think...the positives and the negatives. You just can't sit here like a dummy and listen to [the doctor] say 'Take this' and 'Take that." You have to question them..." (p. 455). So we have come full circle back to people who want to be involved in decision-making.

Patient preferences cannot be predicted based on race or culture or even on knowledge of what a person previously preferred. We need to question and apply the principles of patient-centeredness at each appointment to clarify the patient's current wants and needs. There are, however, some people who never seem to be satisfied.

## Interviewing Difficult People

The most infamous patient in one office was a middle-aged woman with a sour disposition, a sharp tongue, and no kind word for anyone. I'll call her Alice (not her real name). The sight of Alice's name on a schedule put everyone on edge. In five or six years

of treating her I don't believe I ever saw her smile. She snapped at receptionists, assistants, hygienists, and financial office staff for every mild or imagined error, but oozed honey when she spoke with the dentists. The first time I met Alice she questioned why she should update her health history. I said that we needed current information so that we could treat her safely. She replied, "You just don't want to be sued." I tried to answer calmly and without sarcasm, "You're right. I don't want to be sued. And the best way to avoid it is to get your complete health information before I treat you." She grudgingly scribbled something on her form, though I was never sure that it was correct or complete. We eventually came to a sort of truce, but she always put up at least a little fuss when asked to revise her health history. Sartre wrote, "Hell is other people," and I believe that Alice must have been one of the people he was talking about. The doctors ultimately dismissed her from the practice because she was such a difficult person, though they said it more diplomatically in the letter. I never understood why it took so long.

We all deal with difficult patients. By "difficult," I do not refer to people with complicated medical histories and treatment plans or those with true physical, mental, and emotional limitations. While people with these problems can be challenging to care for in different ways, the individuals themselves can be wonderful, the kind of people that make you want to do all you can and then feel badly when you've exhausted your options. Even more, most are aware that they are making your workday harder and appreciate your efforts on their behalf, and some even apologize for their limitations. It is tough to care for them, but I try to remember that it is much tougher to *be* them. I do not

refer to these people when I say "difficult," instead I am talking about the rude, demanding, pain-in-the-neck kind of people like Alice who don't care how insufferable they are, and may even revel in their obnoxiousness. Alice seemed to take pleasure in being nasty.

The best way to cope with such people is to give them the opposite of what they give you. Two researchers call it being "nice in an exaggerated way" (Steinmetz & Tabenkin, 2001, p. 498); I call it "killing them with kindness," and it works almost every time. Mr. X arrives late for his appointment and is upset about his bill, or Mrs. Y had a fight with her teenager and couldn't find a parking place, and they unload it all on you. Most of the time you are not the problem, you just happen to be the first sounding board they encounter. You get nowhere with being defensive or argumentative. Listen, be empathetic, don't judge, be patient and tolerant, use appropriate humor if you can, and let them blow off steam. Maintain this attitude throughout the treatment as well. Many people come around and by the end of the appointment actually apologize for their outbursts. This approach even worked with Alice, though it took longer and she *never* apologized. Alice's son later told me that she actually liked me, though she never let me in on that little secret. My goal with her was never to be liked, it was just to do the best I could in a difficult situation, and "killing her with kindness" was a successful strategy.

There is one other difficult situation that people often ask about. What about the non-stop talker? Again, this is not the person who has something important to say and just needs a little more time to say it. This is the person who rambles, "My tooth started hurting last Thursday…or was it Friday…no, it must have been Tuesday because that was

the day the dog got sick, et cetera, et cetera, et cetera..." This chatty kind of person also feels the need to tell you every detail of every minute of their vacation, or workday, or trip to the grocery store. Most of these people mean well, some are lonely and some just have poor communication skills. Listen politely for as long as you can, then use an "empathetic bridge" (Barker et al., 2005, p. 769), a tactful statement that reveals understanding but also gently gets the conversation and the appointment back on track. "I'm really enjoying our conversation, but I have to get to work," or "I know you wanted me to anesthetize that touchy tooth today, so we need to get going in order to have time for that." It is also helpful to add nonverbal signals such as standing up and putting on your infection control gear as you continue to listen. Most people understand and then you can proceed with the appointment.

*Take time to think and talk*:
What are your favorite strategies for dealing with nasty people and incessant talkers? Gather some dental hygiene friends and share your ideas.

## Conclusion

In healthcare encounters, both providers and patients attempt to establish rapport and trust and to judge each other as to many qualities, including ability, knowledge, experience, compatibility, honesty, integrity, friendliness, compassion, patience, and humor. Whether the relationship is new or established, the interview sets the tone for both the particular meeting and subsequent interactions and provides the opportunity to render or receive optimum care. Information is exchanged, understanding should be achieved, and crucial decisions are often made. However, such exchanges can be unfulfilling. Patients often feel unheard and clinicians often feel rushed. Fortunately, training can help

us become better communicators and interviewers, enhancements that foster efficiency for providers and better clinical outcomes for patients. In this chapter we have touched on various aspects of health interviews, including the goals we want to accomplish and the skills and knowledge needed to reach those goals. Communication is the vehicle that transports information through understanding to decision-making. I hope that this chapter and this book have helped you enhance your communication skills.

## Glossary for Chapter 7

*Closed questions*: Questions that elicit only brief, one-word answers such as "yes" or "no," and often suggest the answer within the question. Example: "Are you more concerned about the gum disease or the decay?" See: *Open-ended questions.*

*Interview/Interviewing*: The part of a health care appointment when the clinician questions the patient to both clarify information on the health history and understand the patient's desires, concerns, needs, and expectations in order to arrive at a diagnosis.

*Open-ended questions*: Questions that encourage full answers and usually elicit more information compared to a brief reply such as only "yes" or "no." Example: "What is your most significant concern about your dental health?" See: *Closed questions.*

# References for Chapter 7

The Accreditation Council for Graduate Medical Education (July 1, 2004). *General competencies: Minimal program requirement language.* Retrieved October 25, 2005, from http://www.acgme.org/acWebsite/irc/irc_compIntro.asp

Adolfsson, E. T., Starrin, B., Smide, B., & Wikblad, K. (2008). Type 2 diabetic patients experiences in two different educational approaches—A qualitative study. *International Journal of Nursing Studies, 45*, 986-994.

American Dental Education Association (2004). Competencies for entry into the profession of dental hygiene (as approved by the 2003 House of Delegates). *Journal of Dental Education, 68*, 745-749.

Barker, L. H., O'Connell, D., & Platt, F. W. (2005). "What else?" Setting the agenda for the clinical interview. *Annals of Internal Medicine, 143*, 766-770.

Bertakis, K. D., Roter, D., & Putnam, S. M. (1991). The relationship of physician medical interview style to patient satisfaction. *Journal of Family Practice, 32*, 175-181.

Boswell, S. (1997). *The mystery patient's guide to gaining and retaining patients.* Tulsa, OK: PennWell Publishing.

Champaneria, M. C., & Axtell, S. (2004). Cultural competence training in US medical schools. *Journal of the American Medical Association, 291*, 2142.

Cole, D. J., & Bird, J. (2000). *The medical interview: The three-function approach* (2nd ed.). St. Louis: Mosby.

Coulehan, J. L., Platt, F. W., Egener, B., Frankel, R., Lin, C.-T., Lown, B., et al. (2001). "Let me see if I have this right...": Words that help build empathy. *Annals of Internal Medicine, 135*, 221-227.

Craig, J. L. (1992). Retention of interviewing skills learned by first-year medical students: A longitudinal study. *Medical Education, 26*, 267-281.

Delgado, A., López-Fernández, L. A., de Dios Luna, J., Gil, N., Jiménez, M., & Puga, A. (2007). Patient expectations are not always the same. *Journal of Epidemiology and Community Health, 62*, 427-434.

DiMatteo, M. R., Hays, R. D., & Prince, L. M. (1986). Relationship of physicians' nonverbal communication skill to patient satisfaction, appointment noncompliance, and physician workload. *Health Psychology, 5*, 581-594.

du Pré, A. (2000). *Communicating about health: Current issues and perspectives*. Mountain View, CA: Mayfield Publishing Company.

Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association, 267*, 2221-2226.

Eriksson, I., & Nilsson, K. (2008). Preconditions needed for establishing a trusting relationship during health counseling—an interview study. *Journal of Clinical Nursing, 17*, 2352-2359. doi: 10.1111/j.1365-2702.207.02265.x

Frymoyer, J. W., & Frymoyer, N. P. (2002). Physician-patient communication: A lost art? *Journal of the American Academy of Orthopaedic Surgeons, 10*, 95-105.

Garafanga, J., & Britten, N. (2003). "Fire away": The opening sequence in general practice consultations. *Family Practice, 20*, 242-247.

Haidet, P., & Paterniti, D. A. (2003). "Building" a history rather than "taking" one: A perspective on information sharing during the medical interview. *Archives of Internal Medicine, 163*, 1134-1139.

Hall, J. A., Roter, D. L., & Katz, N. R. (1988). Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care, 26*, 657-75.

Helfer, R. E. (1970). An objective comparison of the pediatric interviewing skills of freshman and senior medical students. *Pediatrics, 45*, 623-627.

Helfer, R. E., & Ealy, K. F. (1972). Observations of pediatric interviewing skills: A longitudinal and cross-sectional study. *American Journal of Diseases of Children, 123*, 556-560.

Hojat, M., Gonnella, J. S., Mangione, S., Nasca, T. J., Veloski, J. J., Erdmann, J. B., Callahan, C. A., & Magee, M. (2002). Empathy in medical students as related to academic performance, clinical competence and gender. *Medical Education, 36*, 522-527.

Hottel, T. L., & Hardigan, P. C. (2005). Improvement in the interpersonal cmmunication skills of dental students. *Journal of Dental Education, 69*, 281-284.

Hottel, T. L., & Hiler, C. L. (2001). The effects of patient management training on the interpersonal communication and clinical skills of third-year dental students. *Journal of Psychotherapy in Independent Practice, 2*, 73-79.

Kaplan, S. H., Gandek, B., Greenfield, S., Rogers, W., & Ware, J. E. (1995). Patient and visit characteristics related to physicians' participatory decision-making style: Results from the medical outcomes study. *Medical Care, 33*, 1176-1187.

Kleinman, A., Eisenberg, L, & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88*, 251-258.

Larivaara, P., Kiuttu, J., & Taanila, A. (2001). The patient-centered interview: The key to biopsychosocial diagnosis and treatment. *Scandinavian Journal of Primary Health Care,19*, 8-13.

Lang, F., Floyd, M. R., Beine, K. L. B., & Buck, P. (2002). Sequenced questioning to elicit the patient's perspective on illness: Effects on information disclosure, patient satisfaction, and time expenditure. *Family Medicine, 34*, 325-330.

Lanning, S. K. (2005). Communication skill development for dental and dental hygiene students. *Virginia Commonwealth University Center for Teaching Excellence*. Retrieved October 25, 2008, from http://www.vcu.edu/cte/programs/small_grants/2005/communication_skill_development.htm

Lester, G. W. & Smith, S. G (1993). Listening and talking to patients: A remedy for malpractice suits. *The Western Journal of Medicine, 158*, 268-272.

Levinson, W., Gorawara-Bhat, R., & Lamb, J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *Journal of the American Medical Association, 277*, 553-559.

Levinson, W., Kao, A., Kuby, A., & Thisted, R. A. (2005). Not all patients want to participate in decision making: A national study of public preferences. *Journal of General Internal Medicine, 20*, 531-535. doi: 10.1111/j.1525-1497.2005.0088.x

Lipkin, M. Jr., Frankel, R. M., Beckman, H. B., Charon, R., & Fein, O. (1995). Performing the interview. In M. Lipkin, Jr., S. M. Putnam, & A. Lazare (Eds.), *The medical interview: Clinical care, education and research* (pp. 65-82). NY: Springer-Verlag.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M. et al. (2001). Preferences of patients for patient centred approach to consultation in primary care: Observational study. *British Medical Journal, 322*, 1-7.

Menz, F., & Al-Roubaie, A. (2008). Interruptions, status and gender in medical interviews: The harder you brake, the longer it takes. *Discourse & Society, 19*, 645-666.

Moch, S. D., Long, G. L., Jones, J. W., Shadick, K., & Solheim, K. (1999). Faculty and student cross-cultural learning through teaching health promotion in the community. *Journal of Nursing Education, 38*, pp. 238-240.

Peek, M. E., Quinn, M. T., Gorawara-Bhat, R., Odoms-Young, A., Wilson, S. C., & Chin, M. H. (2008). How is shared decision-making defined among African-Americans with diabetes? *Patient Education and Counseling, 72*, 450-458.

Peterson, M. C., Holbrook, J. H., Von Hales, D., Smith, N. L., & Staker, L. V. (1992). Contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. *Western Journal of Medicine, 156*, 163-165.

Pfeiffer, C., Madray, H., Ardolino, A., & Willms, J. (1998). The rise and fall of students' skill in obtaining a medical history. *Medical Education, 32*, 283-288.

Platt, F. W., Gaspar, D. L., Coulehan, J. L., Fox, L., Adler, A. J., Weston, W. W., et al. (2001). "Tell me about yourself": The patient-centered interview. *Annals of Internal Medicine, 134*, 1079-1085.

Platt, F. W., & Platt, C. M. (2003). Two collaborating artists produce a work of art. *Archives of Internal Medicine, 163*, 1131-1132.

Schouten, B. C., Hoogstraten, J., & Eijkman, M. A. J. (2003). Patient participation during dental consultations: The influence of patients' characteristics and dentists' behavior. *Community Dentistry and Oral Epidemiology, 31*, 368-377.

Sherman, J. J., & Cramer, A. (2005). Measurement of changes in empathy during dental school. *Journal of Dental Education, 69*, 338-345.

Shirmer, J. M., Mauksch, L., Lang, F., Marvel, M. K., Zoppi, K., Epstein, R. M., Brock, D., & Pryzbyinski, M. (2005). Assessing communication competence: A review of current tools. *Family Medicine, 37*, 184-192.

Speedling, E. J., & Rose, D. N. (1985). Building an effective doctor-patient relationship: From patient satisfaction to patient participation. *Social Science & Medicine, 21*, 115-120.

Steinmetz, D., & Tabenkin, H. (2001). The "difficult patient" as perceived by family physicians. *Family Practice, 18*, 495-500.

Stewart, M. (1984). What is a successful doctor-patient interview? A study of interactions and outcomes. *Social Science and Medicine, 19*, 167-175.

Stoeckle, J. D., & Billings, A. (1987). The history of history-taking: The medical interview. *Journal of General Internal Medicine, 2*, 119-127.

Thompson, T. L. (1986). *Communication for health professionals: A relational perspective.* Lanham: University Press of America.

Wearne, S. M. (2005). Taking histories—theft by clinicians. British Medical Journal, 330, 1421. doi: 10.1136/bmj.330.7505.1421

Weissman, J. S., Betancourt, J., Campbell, E. G., Park, E. R., Kim, M., Clarridge, B., Blumenthal, D., Lee, K. C., & Maina, A. W. (2005). Resident physicians' preparedness to provide cross-cultural care. *Journal of the American Medical Association, 294*, 1058-1067.

Weston, W. W. (2001). Informed and shared decision-making: The crux of patient centred care. *Canadian Medical Association Journal, 165*, 438-439.

White, J., Levinson, W., & Roter, D. (1994). "Oh, by the way...": The closing moments of the medical visit. *Journal of General Internal Medicine, 9*, 24-28.

Yoshida, T., Milgrom, P., & Coldwell, S. (2002). How do U.S. and Canadian dental schools teach interpersonal communication skills? *Journal of Dental Education, 66*, 1281-1288.

# REFERENCES

Abrahamsson, K. H., Berggren, U., Hallberg, L., & Carlsson, S. G. (2002). Dental phobic patients' view of dental anxiety and experiences in dental care: A qualitative study. *Scandanavian Journal of Caring Sciences, 16*, 188-196.

The Accreditation Council for Graduate Medical Education (July 1, 2004). *General competencies: Minimal program requirement language*. Retrieved October 25, 2005, from http://www.acgme.org/acWebsite/irc/irc_compIntro.asp

Adams, T. S. (2003). Becoming cultured. *RDH: The national magazine for dental hygienists, 23*(8), 40, 42, 44, 46, & 48.

Adams, T. S. (2005). *Oral culture: Intercultural communication competence among dental hygienists*. Unpublished manuscript, California State University at Sacramento.

Aikens, J. E., Bingham, R., & Piette, J. D. (2005). Patient-provider communication and self-care behavior among type 2 diabetes patients. *The Diabetes Educator, 31*, 681-690.

American Dental Association Commission on Dental Accreditation (1998a). *Accreditation standards for dental education programs*. Retrieved October 26, 2005, from http://www.ada.org

American Dental Association Commission on Dental Accreditation (1998b). *Accreditation standards for dental hygiene education programs*. Retrieved October 26, 2005, from http://www.ada.org

The American Dental Hygienists' Association: ADHA (2006a). Retrieved August 30, 2006, from the American Dental Hygienists' Association Web site: http://www.adha.org/

The American Dental Hygienists' Association: ADHA (2006b). Retrieved August 30, 2006, from the American Dental Hygienists' Association Web site: http://www.adha.org/annualsession/index.html

Armas, G. C. (2003, October 9). Tongues besides English rise in use. *Las Vegas Review Journal*, p. 7A.

Avruch, K. & Black. P. (1993). Conflict resolution in intercultural settings: Problems and prospects. In: D. Sandole and H. van der Merwe (Eds.), *Conflict resolution theory and practice: Integration and application*. Manchester, UK, Manchester University Press.

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine, 78*, 560-569.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*, 499-505.

Brophy, J. (Ed.) (2002). *Advances in research on teaching. Volume 9: Social constructivist teaching: Affordances and constraints*. New York: Elsevier Science.

Brown, J. D., Stewart, M., & Ryan, B. L. (2003). Outcomes of a patient-provider interaction. In T. L. Thompson, A. M. Dorsey, K I. Miller, & R. Parrott (Eds.), *Handbook of health communication* (pp. 141-161). Mahwah, NJ: Lawrence Erlbaum Associates.

Carbaugh, D. (2005). *Cultures in conversation.* Mahwah, NJ: Lawrence Erlbaum Associates.

Chachkes, E., & Christ, G. (1996). Cross cultural issues in patient education. *Patient Education and Counseling, 27*, 13-21.

Chambers, D. W., & Abrams, R. G. (1992). *Dental communication.* Sonoma, CA: Ohana Group.

Champaneria, M. C., & Axtell, S. (2004). Cultural competence training in US medical schools. *Journal of the American Medical Association, 291*, 2142.

Cheng, H.-I. (2004). Being ill in a foreign land: International students' perceptions of and experiences with university health service. *Kaleidoscope: A Graduate Journal of Qualitative Communication Research*, 3, 70-92.

Clark, D. (May, 2000). Learning domains or Bloom's taxonomy. Retrieved December 3, 2004, from http://www.nwlink.com/~donclark/hrd/bloom.html

Collier, M. J. (2000). Understanding cultural identities in intercultural communication: A ten step inventory. In L. A. Samovar & R. E. Porter, *Intercultural communication: A reader* (9th ed., pp. 16-33). Belmont, CA: Wadsworth Publishing Company.

Committee on Pediatric Workforce (2004). Ensuring culturally effective pediatric care: Implications for education and health policy. *Pediatrics*, 114(6), 1677-1685. Retrieved October 23, 2005, from http://www.pediatrics.org/cgi/content/full/114/6/1677

Connolly, I. M., Darby, M. L., Tolle-Watts, L., & Thomson-Lakey, E. (2000). The cultural adaptability of health sciences faculty. *Journal of Dental Hygiene, 74(2)*, 102-109.

Crandall, S. J., George, G., Marion, G. S., & Davis, S. (2003). Applying theory to the design of cultural competency training for medical students: A case study. *Academic Medicine, 78*, 588-594.

Daniel, S. J., & Harfst, S. A. (Eds., 2003). *Mosby's dental hygiene: Concepts, cases, and competencies*. St. Louis: Mosby.

Darby, M. L., & Walsh, M. M. (2003). *Dental hygiene theory and practice (2nd ed.)*. St. Louis, MO: Saunders.

De Jongh, A., & Stouthard, M. E. A. (1993). Anxiety about dental hygienist treatment. *Community Dental and Oral Epidemiology, 21*, 91-95.

Denoba, D. L., Bragdon, J. L., Epstein. L. G., Garthright, K., & Goldman, T. M. (1998). Reducing health disparities through cultural competence. *Journal of Health Education, 29(5 Suppl.)*, S47-S58.

Dhir, I., Tishk, M. N., Tira, D. E., & Holt, L. A. (2002). Ethnic and racial minority students in U.S. Entry-level dental hygiene programs: A national survey. *The Journal of Dental Hygiene, 76*, 193-201.

Dunning, D. G., & Lange, B. M. (1993). "Direction" in male and female dental students' interaction with patients: A confirmation of similarities. *Health Communication, 5*, 129-136.

du Pré, A. (2000). *Communicating about health: Current issues and perspectives.* Mountain View, CA: Mayfield Publishing Company.

Elkind, D. (2004). The problem with constructivism. *The Educational Forum, 68*, 306 12.

Epstein, R. M., Franks, P., Shields, C. G., Meldrum, S. C., Miller, K. N., Campbell, T. L., & Fiscella, K. (2005). Patient-centered communication and diagnostic testing. *Annals of Family Medicine, 3*, 415-421.

Etter, J.-F., Perneger, T. V., & Ronchi, A. (1997). Distributions of smokers by stage: International comparison and association with smoking prevalence. *Preventive Medicine, 26(4)*, 580-585.

Felder, R. M., & Brent, R. (1996). Navigating the bumpy road to student-centered instruction. *College Teaching, 44*, 43-47.

Fitch, P. (2004). Cultural competence and dental hygiene care delivery: Integrating cultural care into the dental hygiene process of care. *The Journal of Dental Hygiene, 78*, 11-21.

Flores, G., Abreu, M., & Tomany-Korman, S. C., (2005). Limited English proficiency, primary language at home, and disparities in children's health care: How language barriers are measured matters. *Public Health Reports, 120*(4), 418-430.

Fox, K. (2005). Learning about patient's cultures from experts. *ADA News Today.* Retrieved October 13, 2005, from www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=1419

Frankish, C. J., Lovato. C. Y., & Shannon, W. J. (1999). Models, theories, and principles of health promotion with multicultural populations. In D. J. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 41-72). Thousand Oaks, CA: Sage Publications.

Garcia, R. I. (2005). Addressing oral health disparities in diverse populations. *Journal of the American Dental Association, 136*, 1210, 1212.

Gardenswartz, L, & Rowe, A. (1998). *Managing diversity in health care.* San Francisco: Jossey Bass.

Gardner, H. (2004). *Changing minds: The art and science of changing our own and other people's minds.* Boston: Harvard Business School Press.

Gaston, M. A. (2004). Responding to diversity. *The Journal of Dental Hygiene, 78(1)*, 3 -4.

Geboy, M. J. (1985). *Communication and behavior management in dentistry.* Baltimore: Williams & Wilkins.

Gibson, S., & Zhong, M. (2005). Intercultural communication competence in the healthcare context. *International Journal of Intercultural Relations, 29*, 621-634.

Giger, J. N., & Davidhizar, R. E. (1999). *Transcultural nursing: Assessment & intervention* (3rd ed.). St. Louis: Mosby.

Gordon, H. S., Street, R. L., Jr., Sharf, B. F., Kelly, P. A., & Souchek, J. (2006). Racial differences in trust and lung cancer patients' perceptions of physician communication. *Journal of Clinical Oncology, 24*, 904-909.

Granello, D. H. (2000). Encouraging the cognitive development of supervisees: Using Bloom's taxonomy in supervision. [Electronic version]. *Counselor Education & Supervision, 40*, 31-47.

Granello, D. H. (2001). Promoting cognitive complexity in graduate written work: Using Bloom's taxonomy as a pedagogical tool to improve literature reviews. *Counselor Education & Supervision, 40*, 292-307.

Guay, A. H. (2004). Access to dental care: The triad of essential factors in access-to-care programs. *Journal of the American Dental Association, 135*, 779-785.

Hall, E. T. (1959; 1990). *The silent language*. New York: Anchor Books.

Hall, E. T. (2000). Context and meaning. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural communication: A reader* (9th ed., pp. 34-43). Belmont, CA: Wadsworth Publishing Company.

Hall, E. T., & Hall, M. R. (2002). Key concepts: Underlying structures of culture. In J. N. Martin, T. K. Nakayama, & L. A. Flores (Eds.), *Readings in intercultural communication: Experiences and contexts* (2nd ed., pp. 165-172). Boston: McGraw Hill.

Hausfather, S. J. (1996). Vygotsky and schooling: Creating a social context for learning. *Action in Teacher Education, 18*, 1-10.

Headache Study Group of the University of Western Ontario (1986). Predictors of outcome in headache patients presenting to family physicians: A one year prospective study. *Headache, 26*, 285-294.

Henson, K. T. (2003). Foundations for learner-centered education: A knowledge base. *Education, 124(1)*. 5-16.

Herselman, S. (1996). Some problems in health communication in a multicultural clinical setting: A South African experience. *Health Communication, 8*, 153-170.

Hofstede, G. (1997). *Cultures and organizations: The software of the mind.* New York: McGraw-Hill.

Hollister, M. C., & Anema, M. G. (2004). Health behavior models and oral health: A review. *Journal of Dental Hygiene, 78*, 1-8.

Howard, C. J. (1997). International student enrollment in US dental hygiene schools. *Journal of Dental Hygiene, 71*, 112-116.

Huff, R. M., & Kline, M. V. (1999). Health promotion in the context of culture. In D. J. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 3-22). Thousand Oaks, CA: Sage Publications.

Iran-Nejad, A. (1995). Constructivism as a substitute for memorization in learning: Meaning is created by learner. *Education, 116(1)*, 16-33.

Jenko, M., & Moffitt, S. R. (2006). Transcultural nursing principles. *Journal of Hospice and Palliative Nursing, 8(3)*, 172-180.

Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine, 78*, 577-587.

Kalkwarf, K. L. (1995). Creating multicultural dental schools and the responsibility of leadership. *Journal of Dental Education, 59*, 1107-1110.

Klyukanov, I. E. (2005). *Principles of intercultural communication.* Boston: Pearson.

Kougl, K. (1997). *Communicating in the classroom.* Prospect Heights, IL: Waveland Press.

Kreps, G. L., Bonaguro, E. W., & Query, Jr., J. L. (1998). The history and development of the field of health communication. In L. D. Jackson & B. K. Duffy (Eds.), *Health communication research: A guide to developments and directions* (pp. 1-15), Westport, CT: Greenwood Press.

Kreps, G. L., & Thornton, B. C. (1992). *Health communication theory & practice* (2nd ed.). Prospect Heights, IL: Waveland Press, Inc.

Kroll, L, & LaBoskey, V. K. (1996). Practicing what we preach: Constructivism in a teacher education program. *Action in Teacher Education, 18*, 63-72.

Lapinski, M, K., & Witte, K. (1998). Health communication campaigns. In L. D. Jackson & B. K. Duffy (Eds.), *Health communication research: A guide to developments and directions* (pp. 139-161), Westport, CT: Greenwood Press.

Lefevre, F. V., Waters, T. M., & Budetti, P. P. (2000). A survey of physician training programs in risk management and communication skills for malpractice prevention. *Journal of Law, Medicine & Ethics, 28(3)*, 258-266.

Leeds-Hurwitz, W. (1990). Notes in the history of intercultural communication: The Foreign Service Institute and the mandate for intercultural training. *Quarterly Journal of Speech*, 76, 262-281.

Leininger, M. (1978). *Transcultural nursing: Concepts, theories, and practices*. New York: John Wiley & Sons.

Lester, G. W. & Smith, S. G (1993). Listening and talking to patients: A remedy for malpractice suits? [Electronic version]. *The Western Journal of Medicine, 158*, 268-272.

Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician Patient Communication: The relationship with malpractice claims among primary care physicians and surgeons. *Journal of the American Medical Association, 277*, 553-559.

Littlejohn, S. W. (2002). *Theories of human communication* (7th ed.). Belmont, CA: Wadsworth.

Long, R. H. (2006). Patient-based behavior change. *Access, 20*(8). 32-38.

Luckman, J. & Nobles, S. T. (2000). *Transcultural communication in health care*. Albany, NY: Delmar.

Lukes, S. M., & Miller, F. Y. (2002). Oral health issues among migrant farmworkers. *Journal of Dental Hygiene, 76*, 134-140.

Lustig, M. W., & Koester, J. (1999). *Intercultural competence: Interpersonal communication across cultures* (3rd ed.). New York: Longman.

Magee, K. W., Darby, M. L., Connolly, I. M., & Thomson, E. (2004). Cultural adaptability of dental hygiene students in the United States: A pilot study. *The Journal of Dental Hygiene, 78*, 22-29.

McCroskey, L. L., Richmond, V. P., & McCroskey, J. C. (2002). The scholarship of teaching and learning: Contributions from the discipline of communication. *Communication Education, 54*, 383-391.

McKane, S. U. (1995). Reactions. *Journal of Dental Education, 59*, 1119-1122.

Mellor, A. C., & Milgrom, P. (1995). Dentists' attitudes toward frustrating patient visits: Relationship to satisfaction and malpractice complaints. *Community Dentistry and Oral Epidemiology, 23*, 15-19.

Meltzer, L. (1999). The dental hygienist's role in patient home-care motivation. *Access, Special Supplement Issue*, 1-12.

Mercado Galvis, D. L. (1995). Clinical contexts for diversity and intercultural competence. *Journal of Dental Education, 59*, 1103-1106.

Milgrom, P., Fiset, L., Getz, T., & Conrad, D. (1993). Dental malpractice experience: A closed claim study. *Medical Care, 31*, 749-756.

Milgrom, P., Garcia, R. I., Ismail, A., Katz, R. V., & Weintraub, J. A. (2004). Improving America's access to care: The National Institute of Dental and Craniofacial Research addresses oral health disparities. *Journal of the American Dental Association, 135*, 1389-1396.

Moch, S. D., Long, G. L., Jones, J. W., Shadick, K., & Solheim, K. (1999). Faculty and student cross-cultural learning through teaching health promotion in the community. *Journal of Nursing Education, 38*, pp. 238-240.

Morales, L. S., Cunningham, W. E., Brown, J. A., Liu, H., & Hays, R. D. (1999). Are Latinos less satisfied with communication by health care providers? *JGIM: Journal of General Internal Medicine, 14(7)*, 409-417.

Morey, D. P., & Leung, J. J. (1993). The multicultural knowledge of registered dental hygienists: A pilot study. *Journal of Dental Hygiene, 67(4)*, 180-185.

Nápoles-Springer, A. M., Santoyo, J., Houston, K., Pérez-Stable, E. J., & Stewart, A. L. (2005). Patients' perceptions of cultural factors affecting the quality of their medical encounters. *Health Expectations, 8*, 4-17.

Newton, J. T. (1995). Dentist/patient communication: A review. *Dental Update, 22*, 118 122.

Noble, T. (2004). Integrating the revised Bloom's taxonomy with multiple intelligences: A planning tool for curriculum differentiation. *Teachers* (sic) *College Record, 106*, 193-211.

Northouse, L. L., & Northouse, P. G. (1998). *Health communication: Strategies for health professionals*. Stamford, CT: Appleton & Lange.

Panitz, E.T. (2005). *Collaborative versus cooperative learning—A comparison of the two concepts which will help us understand the underlying nature of interactive learning*. Retrieved January 25, 2005, from http://home.capecod.net/%7Etpanitz/tedsarticles/coopdefinition.htm

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrated model of change. *Journal of Consulting and Clinical Psychology, 51*, 390-395.

Prochaska, J. O. & DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

Purdie, N. & McCrindle, A. (2002). Self-regulation, self-efficacy and health behavior change in older adults. *Educational Gerontology, 28*, 379-400.

Rao, N. (2003). "Half-truths" in Argentina, Brazil, and India: An intercultural analysis of physician-patient communication. In L. A. Samovar, & R. E. Porter (Eds.), *Intercultural communication: A reader* (10th ed., pp. 309-319). Belmont, CA: Wadsworth.

Rogers, E. M. (2000). Introduction. *Journal of Health Communication, 5*(Suppl.). 1-3.

Rogers, E. M., Hart, W. B., & Miike, Y. (2002). Edward T. Hall and the history of intercultural communication: The United States and Japan. *Keio Communication Review*, 24, 3-26. Retrieved May 8, 2006, from http://www.mediacom.keio.ac.ip/publication/pdf2002/review24/2/pdf

Roter, D. L., & Hall, J. A. (1993). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits.* Westport, CT: Auburn House.

Samovar, L. A., & Porter, R. E. (2003). *Communication between cultures* (5th ed.). Belmont, CA: Wadsworth.

Sensky, T. (1996). Eliciting lay beliefs across cultures: Principles and methodology. *British Journal of Cancer, 74(Suppl. XXXIX)*, S63-S65.

Shannon, S. (2003). Educational objectives for CME programmes. *The Lancet, 361*, 1308.

Shapiro, J., Hollingshead, J., & Morrison, E. H. (2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education, 36*. 749-459.

Sherman, J. J., & Cramer, A. (2005). Measurement of changes in empathy during dental school. *Journal of Dental Education, 69(3)*, 338-345.

Shirmer, J. M., Mauksch, L., Lang, F., Marvel, M. K., Zoppi, K., Epstein, R. M., Brock, D., & Pryzbyinski, M. (2005). Assessing communication competence: A review of current tools. *Family Medicine, 37*, 184-192.

Smedley, B. D., Stith, A. Y., & Nelson, A. R., 2003 (Eds.). Executive summary of *Unequal treatment: What healthcare providers need to know about racial and ethnic disparities in healthcare*. Retrieved October 23, 2005, from http://www.nap.edu/catalog/10260.html Washington, DC: The National Academies Press.

Smith, T. A., & Heaton, L. J. (2003). Fear of dental care: Are we making any progress? *Journal of the American Dental Association, 13*, 1101-1108.

Spector, R. E. (2000). *Cultural diversity in health and illness* (5th ed.). Upper Saddle River, NJ: Prentice Hall Health.

Sprague, J. (1992). Critical perspectives on teacher empowerment. *Communication Education, 41*, 181-203.

Staton, A. Q. (1989). The interface of communication and instruction: Conceptual considerations and programmatic manifestations. *Communication Education, 38*, 364-371.

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal, 152*, 1423-1433.

Storti, C. (1999). *Figuring foreigners out: A practical guide*. Boston: Intercultural Press.

Sumner, W. G. (1906). *Folkways*. Boston: Ginn and Company.

Teets, S. T., & Starnes, B. A. (1996). Foxfire: Constructivism for teachers and learners. *Action in Teacher Education, 18*, 31-39.

Thompson, D. (2000). *First-ever Surgeon General's report on oral health finds profound disparities in nations' population* (News Release). Retrieved October 23, 2005, from http://www.surgeongeneral.gov/news/pressreleases/pr_oral_2000.htm

Thompson, T. L. (1984). The invisible helping hand: The roles of communication in the health and social service professions. *Communication Quarterly, 32*, 148-163.

Tilliss, T. S. I., Stach, D. J., Cross-Poline, G. N., Annan, S. D., Astroth, D. B., & Wolfe, P. (2003). The transtheoretical model applied to an oral self-care behavioral change: Development and testing of instruments for stages of change and decisional balance. *Journal of Dental Hygiene, 77*. 16-25.

Ulrey, K. L., & Amason, P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Communication, 13*, 449-463.

U.S. Department of Health and Human Services (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health (2000). *Oral health in America: A report of the Surgeon General: Executive summary*. Rockville, MD: Author. Retrieved June 17, 2005, from http://www.nidcr.nih.gov/AboutNIDCR/SurgeonGeneral/

U.S. Department of Health and Human Services, Office of Minority Health (2001). *National standards for culturally and linguistically appropriate services in health care: Executive summary*. Rockville, MD: Author. Retrieved October 23, 2005, from www.omhrc.gov/assets/pdf/checked/executive.pdf

Vázquez, L., & Swan, J. H. (2003). Access and attitudes toward oral health care among Hispanics in Wichita, Kansas. *The Journal of Dental Hygiene, 77*, 85-96.

Velicer, W. F., Prochaska, J. O., Fava, J. L., Norman, G. J., & Redding, C. A. (1998). Detailed overview of the transtheoretical model. Retrieved November 28, 2006, from http://www.uri.edu/research/cprc/TTM/detailedoverview.htm

Vermette, P., Foote, C., Bird, C., Mesibov, D., Harris-Ewing, S., & Battaglia, C. (2001). Understanding constructivism(s): A primer for parents and school board members. *Education, 122*, 87-93.

Voelker, R. (1995). Speaking the languages of medicine and culture. *Journal of the American Medical Association, 273*, 1639-1641.

Weissman, J. S., Betancourt, J., Campbell, E. G., Park, E. R., Kim, M., Clarridge, B., Blumenthal, D., Lee, K. C., & Maina, A. W. (2005). Resident physicians' preparedness to provide cross-cultural care. *Journal of the American Medical Association, 294*, 1058-1067.

West, R., & Turner, L H. (2004). *Introducing communication theory: Analysis and application* (2nd ed.). Boston: McGraw-Hill.

Wiles, C. B., & Ryan, W. J. (1982). *Communication for dental auxiliaries*. Reston, VA: Reston Publishing Company, Inc.

Wyatt, N. (1991). Physician-patient relationships: What do doctors say? *Health Communication, 3*, 157-174.