Developing Communication Techniques for Working with Persons with Limited Literacy Skills

1.5 Contact Hours

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Developing Communication Techniques for Working with Persons with Limited Literacy Skills

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Objectives:

The learner will be able to:

1. Identify the value placed on patients' healthcare literacy and learn how rapport-building and Universal Design for Learning can be used to facilitate patient understanding in healthcare settings
2. Demonstrate and explain physical and verbal mirroring techniques and how they relate to working with persons with limited literacy
3. Recognize assessments of medical literacy
4. Model the use of the Socratic Method for gathering information from persons with limited literacy

Before you entered the healthcare profession, you went to school to learn the fundamentals of reading, writing and arithmetic. You built a foundation of skills that helped you get where you are today. However, many times, you need to deal with patients whose education is not as complete as your own. In increasing numbers, patients with limited literacy skills are entering healthcare facilities for treatment. Some may not have received much, if any, formal education, while others may be highly literate in other languages, but lack strong communication skills in English. "Literacy skills predict an individual's health status more strongly than age, income, employment status, education level and racial or ethnic group" (Faguy,142). This fact underscores the importance of learning how to work with persons with limited literacy on the job. Even when a patient's limited English literacy is a barrier, there are common teaching methods that can be used to facilitate communication between you and your patients. This essay will introduce you to several considerations for working persons with limited literacy skills, while continuing to provide premium care.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states in standard PF.4 that all health care facilities must provide patient education that is "understandable to the patient and family in terms of cultural and religious variables, language, age abilities and resources" (Faguy, 142). This may seem like a tall order, but the idea of providing informational access to the largest number of people is not a new concept. The principles of Universal Design were first acknowledged in the 1970s by the field of architecture in consideration of the accessibility needs of persons with disabilities. Since that time, Universal Design has expanded to consider how educational content can be made accessible to a larger audience of learners. This resulted in the development of Universal Design for Learning, or UDL, which includes the needs of persons with disabilities, and those with limited literacy skills.

According to the Center for Applied Special Technology (CAST), UDL principles involve consideration in three major learning domains:

- *Multiple means of representation* - Giving learners various ways of acquiring information and knowledge by presenting patient materials in a variety of formats including visually, verbally, and in writing.
- *Multiple means of expression*- Providing patients with alternatives for demonstrating what they know by encouraging speaking, writing, or demonstrating through use of gesture to communicate relevant information
- *Multiple means of engagement*- Accessing patients' needs and interests, by providing appropriate challenges to engage them in both verbal and non-verbal dialogue

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Recent neurological studies confirm descriptions of three distinguishable, yet connected networks in the brain. Each of these networks serves a different function. One recognizes patterns, another generates patterns, and the third determines priorities. PET scans show that everyone has a different distribution of these networks in their cortex. Some people have larger regions devoted to recognizing patterns, others in generating strategies, and still others in focusing on priorities. These differences appear to be reflected by different types of learning styles. Each person's learning style is the expression of their different strengths and weaknesses when coming across and attempting to understand new information. (CAST, http://udl.cast.org/udl/)

As you probably realized in completing your healthcare training, all individuals do not learn in the same way. While many of us can learn from a variety of instructional methods, each of us has one or two methods that are usually more effective, helping to make learning an easier and more enjoyable task. Think back on your own education, was it easier for you to read about a healthcare concept, hear about the concept, see it demonstrated, or practice it for yourself?

What I hear I forget…

What I see I remember…

What I do I understand.

-*Confucius*, 551-479 B.C.

Confucius, the great Chinese philosopher, may have stated it best when he said the above quote. It is easiest to comprehend new information when we are actively engaged in the learning process. This is usually a combination of activities, including reading, hearing, seeing, and performing. The challenge for you as a healthcare professional is in

discovering what constitutes active engagement for each of your patients. What constitutes active engagement for one person is not necessarily the same for the next. Therefore, it is important to engage patients and learn more about their preferred learning style. By taking time at the beginning to learn more about what involves active engagement with your patients, especially patients with limited literacy skills, you will benefit from clearer communication of their issues and concerns, and ultimately save yourself time and unecessary frustration.

Fortunately, a lot of your interaction with patients involves face-to-face communication. As a result, the opportunity to read non-verbal cues can help to interpret information that may not be clear from verbal communication. Neurolinguistic programming (NLP) has been shown to help healthcare professionals build rapport with patients. Rapport is crucial to developing unguarded non-verbal communication between patient and professional. The practice of NLP is the result of a group of medical professional's study of language, tone of voice and body language used by therapists in establishing rapport and effecting change in their patients.

The key to NLP, as it relates to body language, is the concept of physical mirroring. Physical mirroring should not be confused with imitation. The important distinction between mirroring and imitation is that mirroring is the counterpart to a patient's body language, whereas imitation is the exact duplication of body language. For example, when a patient crosses their arms in a tight and anxious manner, mirroring that body language would involve crossing arms casually, in a more loose and relaxed manner. This action should follow the patient's action by a comfortable time delay. The result is to unconsciously put the patient at ease, which encourages open dialogue and facilitates greater kinesthetic awareness by the patient. Kinesthetics, is the body's perception of its orientation in space resulting from stimuli within the body. For example, if a patient is experiencing symptoms (headaches) that are conducive to certain body postures (cradling the forehead), they are more likely to repeat physical patterns (continuing to cradle the forehead), regardless of your physical mirroring. However, if they are using body language to express anxiety or fear, physical mirroring may help ease these emotions and they will be more likely to respond by adapting their kinesthetic awareness as they feel more comfortable in the situation. This change of posture may allow the patient to respond more accurately to underlying physical symptoms (for example, swollen lymph nodes).

Similarly, verbal mirroring can be used to engage patients' auditory learning. Verbal mirroring is used to develop rapport and verify information by repeating the patient's last few words and using a questioning inflection to give the patient a chance to reflect on their comments, and perhaps provide additional information. This action helps the patient to clarify what they have just said, and correct themselves when their words do no match their intentions. The following dialogue gives an example of how verbal mirroring can be used to gain potentially relevant information that might otherwise have been neglected.

Nurse: "Do you have any medical problems?"

Patient: "No, I'm fine."

Nurse: "So, you've been in fine health, (pause) and you haven't had any recent visits to the doctor?"

Patient: "I was to the doctor's last winter for a flu shot."

Nurse: "So, you got a flu shot last winter?"

Patient: "Yes"

Nurse: "And that was the last time you saw a doctor?"

Patient. "Yes, I got a flu shot, *and* I got the flu, but I didn't see to the doctor again."

Here, verbal mirroring helped this nurse gather more information from an initially reluctant patient. Without using this strategy, our nurse may have walked away thinking the patient was in 'fine' health prior to this visit. However, verbal mirroring, like its physical counterpart, may not always yield greater detail or new information. What is does provide is the chance to ease tensions over communication difficulties and helps access two very powerful learning styles that may ultimately help engage you in more relaxed and meaningful dialogue.

There are other more concrete estimates of patient aptitude for meeting the communication challenges of a healthcare setting. The Rapid Estimate of Adult Literacy in Medicine (REALM) was developed by a group of physicians at Louisiana State University Medical College. REALM, as it is called recognizes that a patient's education level does not always reflect their literacy level. Specifically, the REALM looks at patients' ability to pronounce some of the most common medical terms.

The short version of the REALM consists of 66 words in 3 columns, ranging from the least to the most difficult. The following is a sample of the words included on this list. Patients are given the list and asked to read the words out loud. If a word is unfamiliar, they are encouraged to make an attempt at pronouncing the word, or simply say 'blank' and continue. The assessment is intended to only take a few minutes, and the results are then easily converted to a grade level range. 0-18 correct answers equals a grade level range of third grade or below; 19-44 correct answers equals a fourth to sixth grade level; 45-60 correct answers equals a seventh to eighth grade level; and 61-66 correct answers equals a grade level of ninth grade and above. The REALM does not check for any type of reading comprehension, but is "accepted as [a] useful predictor[s] of general reading ability" (Faguy, 143). Obviously, the REALM is not a useful resource in every situation. However, it may serve as a reliable resource when dealing with patients who are required to provide informed consent. Using an instrument shown to have strong concurrent validity with standardized reading tests may be a good way to judge whether documents used for patient education meet JCAHO's stated standards.

Another approach to working with patients with limited literacy skills is to employ the Socratic Method. This method is an inquiry process, first used in the examination of moral concepts by the philosopher Plato. The method typically involves two people, with one leading the discussion and the other accepting or rejecting certain assumptions. Socratic dialogue can happen at any time when two people try to answer a question on a given topic. Starting from the concrete, you begin asking questions relating to real examples. In the case of a nurse needing to know more about a patient's symptoms, instead of asking, "Where does it hurt?", try asking something that identifies a specific region of the body that appears to be the source of the patient's pain. Reading the patient's body language, you might ask, "Does your stomach hurt?" Accompanying this question with a physical gesture focusing on the stomach can help the patient identify unknown vocabulary. Once the general physical location of the pain is identified, using your clinical skills will help to narrow down your questions and provide more specific details about the patient condition.

For example, you may need to ask if it is a dull or sharp pain, and whether it is constant or intermittent. When asking about the quality of the pain, it is best to present the person with limited literacy a select number of choices to use in responding. For example, when asking, "Is your pain dull or sharp?", it can be useful to consider using gesture to help the patient distinguish different meanings between unknown words. A gesture that conveys the meaning of "sharp" could be demonstrated by running an extended finger over an area of the patient's skin, such as the palm of the hand. The opposite, dull, could be conveyed by grasping the patient in the same location and applying light pressure.

You may use closed questioning to ask about the consistency of pain. Using the same technique, you can convey the idea of intermittent pain by grasping the patient's skin and applying light pressure, resting for several seconds, and then repeating the gentle pressure. If the patient's reported pain is sharp, you can try using the extended finger and running it over the skin, stopping and repeating several seconds later. Try to maintain eye contact with the patient during the intervening seconds between each gesture. This will encourage the patient's awareness of the break in the sensation. This is an important distinction, so that when you apply constant pressure, the patient understands the difference between the two gestures. During constant pressure, try to avoid eye contact with the patient to reinforce the sensation of the applied pressure. You should maintain this 'constant' pressure for an extended period, equal to or greater than the duration of your intermittent gesture. These gestures can be repeated for the patient to pick up on the distinction you are making between different gestures.

Note that when using gestures where you are touching a patient, it is critical that you follow the same safety precautions that you would when performing any procedure that requires direct patient contact. This gestural method of acquiring information from a patient is a good way to gather subjective information about that patient's reported condition. The Socratic Method works best when incorporated with opprotunities to engage different learning styles. By utilizing both kinesthetic and verbal cues with patients, you activate multiple opportunities for patient comprehension. It is equally important that you be receptive to a variety of responses. A patient's response to

questions about the type or consistency of their pain may not be reported verbally, but could be demonstrated kinesthetically or otherwise. It is valuable to remember that our own literacy is dependent not just on our ability to communicate information, but also on our ability to receive information from a variety of expressions.

References

Center for Applied Special Technology <http://www.cast.org/research/udl/index.html> Retrieved on May 3rd, 2006.

Chew, D., Bradley, K., Boyko, E. Brief Questions to Identify Patients With Inadequate Health Literacy. Family Medicine. 2004 September; 36(8): 588-594.

Clabby, J., O'Connor, R. Teaching Learners to Use Mirroring: Rapport Lessons From Neurolinguistic Programming. Family Medicine. 2004 September; 36(8): 541-543.

Faguy, K. Health Literacy. Radiologic Technology. 2004 Nov-Dec; 76(2): 139-146.

Guhde, JA. English-as-a-Second Language (ESL) Nursing Students: Strategies for Building Verbal and Written Language Skills. Journal of Cultural Diversity. 2003 Winter; 10(4): 113-7.

Guttman, MS. Increasing the Linguistic Competence of the Nurse with Limited English Proficiency. Journal of Continuing Education in Nursing. 2004 Nov-Dec; 35(6): 264-9.

Hong, OS. Limited English Proficiency Workers: Health and Safety Education. AAOHN Journal. 2001 January; 49(1): 21-6.

Malu, K. Six Active Learning-based Teaching Tips: Promoting Success for ESL Nursing Students. Nurse Educator. 2001 Sept-Oct; 26(5): 204-8.