PART 1

Communication Techniques for Assessment

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MODULE
1

COMMUNICATION SKILLS FOR ASSESSMENT

MODULE OVERVIEW

Clear communication provides the foundation for the patient assessment procedures from history taking to explaining assessment findings to the patient. Being able to communicate effectively—or participate in the exchange of information—is an essential skill for dental health care providers.

To a great extent, the patient's satisfaction with dental care is determined by the dental health care provider's ability and willingness to communicate and empathize with patient needs and expectations. Good communication during the assessment process sets the tone for quality care and loyal patients.

This module summarizes techniques for—as well as obstacles to—effective communication during the patient assessment process.

MODULE OUTLINE

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KEY TERMS

Communication • Personal filters • Verbal communication • Nonverbal communication • Stereotypes • Proxemics • Personal space • Territory • Low-contact cultures • High-contact cultures • Empathy • Diplomacy • Helping relationship • Paternalism • Patient-centered care • Finding the problem • Fixing the problem • Engagement • Education • Enlistment • Patient-centered communication • Closed questions • Open-ended questions • Electronic dental record • Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT) • Systematized Nomenclature of Dentistry (SNODENT)

OBJECTIVES

- Define communication and describe the communication process.
- Describe how ineffective communication hinders the provision of quality dental care.
- Describe the two major forms of communication and give examples of each.
- Discuss techniques that promote effective communication.
- Understand the role of effective communication in the provision of quality dental care.
- List and describe three ways in which people communicate nonverbally.
- Explain why appearance can often lead to incorrect assumptions about an individual.
- Identify the purpose of the patient–hygienist relationship.
- Discuss patients' rights as consumers of dental health care services.
- Define patient-centered care.
- Identify patient-centered communication techniques.
- Define bad news.
- During role-plays or in the clinical setting, demonstrate the SPIKES model communication strategy when sharing bad news with a patient.
- Describe how a nomenclature system, such as SNODENT, may improve communication between clinicians and different settings (offices).
- Develop improved clinical communication skills and the ability to role model those skills through simulated patient scenarios.

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SECTION 1 • The Communication Process

What Is Communication?

Communication is the exchange of information between individuals. The word "exchange" is essential to understanding the act of communicating. The process of communication is an ***exchange of information*** that moves back and forth between two people. A dental health care provider must be a successful communicator, both as a sender and receiver of information. Communication with a patient not only involves telling the person something (sending information) but also is about listening to the patient's response—receiving information—in return. The understanding of how to convey and interpret meaning is essential for effective communication. In the context of dental care, communication's primary function is to establish understanding between the patient and dental health care provider.

Ineffective Communication

There are always at least two parties involved in any communication. Communication blocks can occur when the clinician assumes that the patient knows what he or she is thinking (Fig. 1-1). (The patient **should know** that the health history is important, **shouldn't he**?) Box 1-1 shows examples of the impact of poor patient communication.

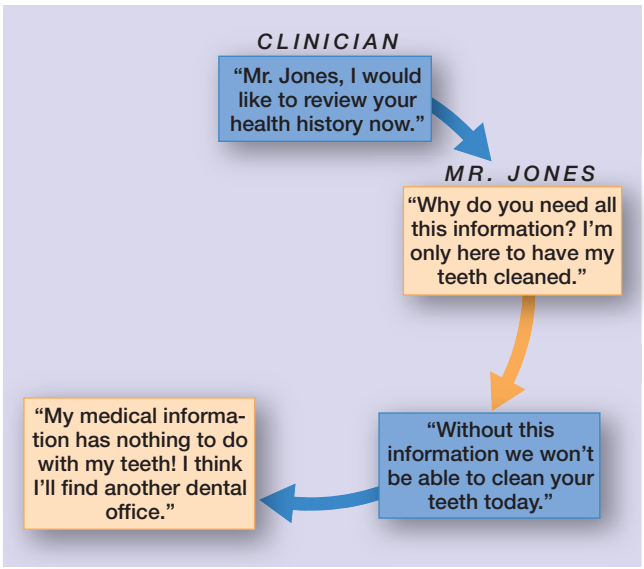

FIGURE 1-1 Ineffective flow of communication. The assumption that the patient knows what the clinician knows—such as why an accurate health history is important—presents a major roadblock to effective communication.

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BOX 1-1

The Impact of Poor Patient Communication

POOR COMMUNICATION

- Decreases the patient's confidence and trust in dental care
- Deters the patient from revealing important information
- Leads to the patient not seeking further care
- Leads to misunderstandings
- Leads to the misinterpretation of advice
- Underlies most patient complaints

These difficulties may lead to poor or suboptimal dental health for the patient.

Effective Communication

Being a good listener is key to interacting and responding to the patient in a manner that conveys empathy for as well as interest in his or her concerns. A successful communication begins by recognizing the patient's needs and concerns (Fig. 1-2). Box 1-2 shows examples of the benefits of effective communication.

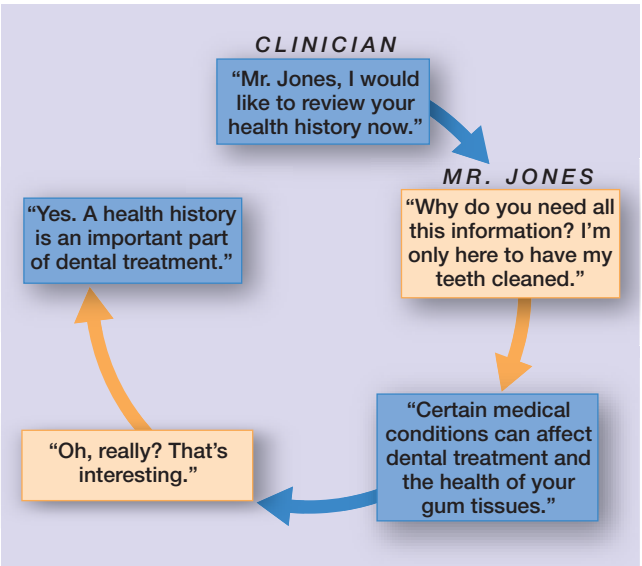

FIGURE 1-2 Effective flow of communication. Communication is most effective when the clinician uses words that the patient will understand and listens carefully to the patient's responses or questions.

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BOX 1-2

The Benefits of Good Patient Communication

GOOD COMMUNICATION

- Builds trust between the patient and health care provider
- May make it easier for the patient to disclose information
- Enhances patient satisfaction
- Allows the patient to participate more fully in health decision making
- Helps the patient to make better dental health decisions
- Leads to more realistic patient expectations

The benefits of good communication may contribute to better dental health for the patient.

Communication Filters

Each person involved in the act of communication interprets a message based on many factors such as his or her life experiences, age, gender, and cultural diversity. These factors act as **personal filters** that "distort" messages being sent and received (Fig. 1-3). ***For this reason, the message received may not be the message sent. Normal human biases or personalized filters create major barriers to effective communication.*** Communication is promoted by awareness that human beings have personalized filters that can impede accurate communication. Means of encouraging accurate communication include using a vocabulary that is easily understood by patients combined with an awareness of physical limitations, life experiences, and cultural differences.

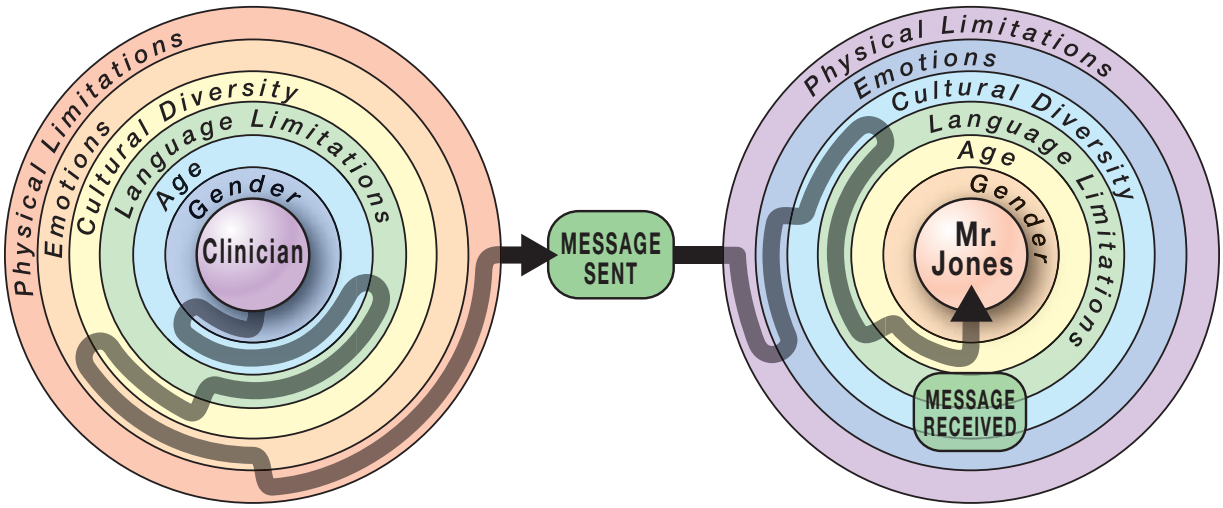

FIGURE 1-3 **Personal filters.** Each individual interprets a message based on his or her own filters such as life experiences, beliefs, physical limitations (e.g., hearing loss), and gender.

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Nonverbal Communication

There are two major forms of communication: verbal and nonverbal.[1–5] Dr. Albert Mehrabian, who pioneered the study of communication, found that only about 7% of the meaning of a message is communicated through verbal exchange (Fig. 1-4).[6] About 38% is communicated by the use of the voice and tone. About 55% comes through gestures, facial expression, posture, etc. Dr. Mehrabian's communication model is useful in illustrating the importance of considering factors other than words when trying to convey meaning (as the speaker) or interpret meaning (as the listener). Patients interpret meaning from what the clinician actually says, but they also infer meaning from the way in which the message is conveyed—that is, messages conveyed through voice, facial expression, and body cues. The understanding of how to convey and interpret meaning is essential for effective communication.

1. **Verbal communication** is the use of spoken, written, or sign language to exchange information between individuals. In the context of dental care, communication's primary function is to establish understanding between the patient and clinician.
2. **Nonverbal communication** is the transfer of information between persons without using spoken, written, or sign language (Box 1-3).
   - In nonverbal communication "wordless" messages are sent and received by means of facial expression, appearance, gaze, gestures, postures, tone of voice, hairstyle, grooming habits, and body positioning in space.
   - Each of us gives and responds to literally thousands of nonverbal messages daily in our personal and professional lives.
   - We all react to wordless nonverbal messages emotionally, often without consciously knowing why.

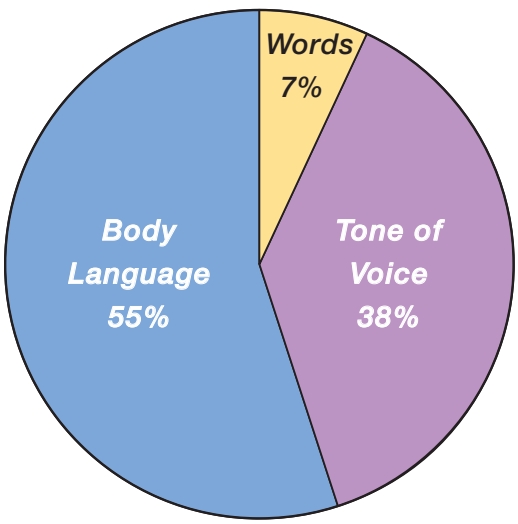

FIGURE 1-4 Nonverbal communication. Nonverbal communication is information that is communicated without using words.
- 7% of meaning is in spoken words
- 38% of meaning is paralinguistic (the way that words are said)
- 55% of meaning is in body language, such as facial expression

BOX 1-3

Nonverbal Communication

Nonverbal communication can include posture, facial expression, appearance, hairstyle, clothing, shaking hands, smiling, proximity to others, touch, color choice, and silence.

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First Impressions

1. **Unconscious First Impressions.** Although health care providers prefer to be judged on their knowledge, skills, and the care they provide to patients, other factors such as first impressions often influence patients' judgments about clinicians.
   - It seems unfair, but first impressions count (Fig. 1-5).
   - When a person walks into a room, others make subconscious decisions about him or her. Within about 60 seconds, others have judged the person's educational background, likeability, and level of success.
   - After about 5 minutes, conclusions have been drawn about the person's trustworthiness, reliability, intelligence, and friendliness.
   - Impressions are based on instinct and emotion, not on rational thought or careful investigation.
   - We all make associations between outward characteristics and the inner qualities we believe they reflect.
   - We filter everything we see and hear through our own experiences. We all have assumptions—**stereotypes**—regarding what it means to be short or tall, heavy or thin, clean or dirty, native or foreign, young or old, and male or female.
2. **Creating Positive First Impressions.** What can health care providers do to be in control of a patient's first impression of us?
   - Each clinician has to determine his or her objectives and make choices in dress and behavior that convey competence and caring.
   - First impressions can open the lines of communication and build trust.

Clinician A Clinician B

FIGURE 1-5 First impressions. If you were a patient, what message would these two clinicians be sending to you?

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Use of Space

1. **Proxemics** is the study of the distance an individual maintains from other persons and how this separation relates to environmental and cultural factors.
   - Every person has around him (or her) an invisible "personal zone of comfort" defined as personal space. We have all felt uneasiness in an elevator or airplane when the stranger on either side inadvertently touches us.
   - When our personal zone of comfort has been invaded, we feel uncomfortable and resentful. **Personal space**—or distance from other persons—is a powerful concept that we use in determining the meaning of messages conveyed by another person (Table 1-1).
   - For example, an angry person is perceived as less threatening if the person is not standing nearby. If an angry person is close, however, the individual's anger is perceived as more threatening.
   - Personal space is a subtle but powerful part of nonverbal communication that health care providers must understand in order to relate better to the patient in the dental setting.
   - ***Entering the personal or intimate zones of comfort is necessary in the dental health care setting and, if not carefully handled, may cause the patient to feel threatened or insecure.***

TABLE 1-1 PERSONAL SPACE

Territorial Zone	Body Space
Intimate	1–18 in (3–45 cm)
Personal	1.5–4 ft (0.5–1.2 m)
Social	4–12 ft (1.2–4 m)
Public	More than 12 ft (more than 4 m)

2. **Territory** is the space we consider as belonging to us.
   - The way that people handle space is largely determined by their culture.
   - Differences in culture can lead to different interpretations of personal space and touching. Misunderstandings can occur when low-contact cultures interact with high-contact cultures and either invade or avoid personal space and physical contact.
   - North Americans and Latin Americans, for example, have fundamentally different proxemic systems.
   - While North Americans usually remain at a distance from one another, Latin Americans stay very close to each other.
   - Remland and colleagues[7] reported that in their sample of seven nations, the British sample showed on average the greatest distance between persons in a conversation (15.40 in). Southern European countries such as Greece (13.86 in) and Italy (14.18 in) showed a closer distance between persons engaged in conversation.[7]
   - **Low-contact cultures** (North American, Northern European, Asian) favor the Social Zone for interaction and little, if any, physical contact. (Box 1-4 shows examples of low-contact and high-contact cultures.)
   - **High-contact cultures** (Mediterranean, Arab, Latin) prefer the Intimate and Personal Zones and much contact between people. In Saudi Arabia, persons engaged in conversation might be almost nose to nose with each other because their social space equates to a North American's intimate space.

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BOX 1-4

Low-Contact versus High-Contact Cultures

LOW-CONTACT CULTURES

Asian: China, Indonesia, Japan, Philippines, Thailand
Southern Asian: India and Pakistan
Northern European: Austria, England, Germany, the Netherlands, Norway, Scotland
North American: United States and Canada

HIGH-CONTACT CULTURES

Arab: Iraq, Kuwait, Saudi Arabia, Syria, United Arab Republic
Latin American: Bolivia, Cuba, Ecuador, El Salvador, Mexico, Paraguay, Peru, Puerto Rico, Venezuela
Southern European: France, Italy, Turkey

Touch as Nonverbal Communication

1. **The Importance of Touch.** Touching is perhaps the most powerful nonverbal communication tool.
   - We can communicate a wide variety of emotions through touching such as support, protection, anger, tenderness, or intimacy.
   - Touch is culturally determined. Each culture has a clear concept of what parts of the body one may not touch. Low-contact cultures—English, German, Scandinavian, Chinese, and Japanese—have little public touch. High-contact cultures—Latino, Middle-Eastern, and Jewish—accept frequent touches.
2. **Touch Is Universal.** Touch is perhaps the most universal of all forms of communication.
   - The comforting aspect of touch is significant in health care.
   - A comforting touch can say more than words (Fig. 1-6). A light pat on the shoulder or on the top of the hand is comforting and establishes a bond between the health care provider and patient.
3. **Touch Taxonomy.** Richard Heslin has developed a taxonomy that classifies touch (Box 1-5).
   - Heslin's five categories are functional/professional, social/polite, friendship/warmth, love/intimacy, and sexual arousal.[8]
   - ***Dental care involves being in close proximity to the patient—invading the patient's space—and touching the patient.***
   - A patient may be acutely aware of the clinician's touch, and some patients may question the appropriateness of touching.
   - Dental health care providers should recognize that the patient is entitled to know why and where he or she is to be touched.
   - Clinicians should respect, as much as possible, the patient's personal space.

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FIGURE 1-6 The value of touch. Of the many techniques for enhancing communication, nothing says "I care about you and I want to help you" more effectively than a simple touch on a person's hand or shoulder.

BOX 1-5

Heslin's Categories of Touching Behavior

1. Functional/professional
2. Social/polite
3. Friendship/warmth
4. Love/intimacy
5. Sexual arousal

Empathy

Empathy—identifying with the feelings or thoughts of another person—is an essential factor in communicating with patients. Communication between the dental health care provider and the patient is more complicated than a normal conversation. For many patients, being in a dental office is a high-stress situation. Pain, worry, and waiting can make a patient anxious or irritable. Many problems can be prevented by keeping patients informed about waiting times, billing or insurance charges, and other office policies that might trigger angry emotions. **Diplomacy** is the art of treating people with tact and genuine concern. Courtesy is based on sensitivity to the needs and feelings of others. As a health care professional, it is important to be aware of what you say and how you say it. Patient complaints about dental care often revolve around a seemingly innocent comment made by a dental team member. The wrong words can affect a patient's perceptions of the care that he or she receives. Table 1-2 presents some common situations encountered in a dental office and analyzes both effective and ineffective responses.

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TABLE 1-2 FINDING THE RIGHT WORDS

Ineffective Response	Analysis	Effective Response	Analysis
Situation A. Mrs. Reman is a new patient. The health history form that she filled out in the reception area has many questions left blank, and many things are crossed out.			
Well, I can see that you had trouble filling this out. Here, why don't you start over with a new form?	Dismisses the patient's efforts to fill out the form; she may not understand all the questions and may need help.	*I know how difficult these forms are to fill out. Let's go over it together.*	Acknowledges the effort made by the patient and that the information is difficult to understand; provides assistance
Situation B. You notice Mr. Jones sitting alone in a treatment room. Two days ago, Mr. Jones learned that he has oral cancer. You can tell that he is very upset.			
Cheer up! I am sure that everything will be OK after you see the oral surgeon.	Insensitivity to the patient's feelings; provides false reassurance, you have no way of knowing the outcome of surgery	*I can't even begin to imagine how difficult this must be for you. How can I help?*	Demonstrates caring
Situation C. The woman approaching the reception desk is holding her cheek. She says that she is in a lot of pain and would like to see the dentist.			
You don't have an appointment, and there are three patients ahead of you. You will have to wait your turn.	Ignores the patient's pain; punishes her for not making an appointment before she was in pain	*I can see you are in pain. Please sit down for a moment and I will get a treatment room ready for you.*	Recognizes that a patient in pain should have priority over routine dental care
Situation D. Mr. Daniels has not visited a dental office for many years. It is obvious that he is very nervous.			
Just relax.	This may seem like a good response, but actually it does nothing to put the patient at ease.	*Tell me what is worrying you.*	Acknowledges the patient's concerns; elicits specific information about what is worrying the patient

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SECTION 2 • The Patient–Hygienist Relationship

Have you ever been in the patient role: feeling vulnerable, unsure, or frightened? A friendly smile or a question about how you are feeling can reassure and calm. As hygienists, the dental office becomes our "daily world," and we forget that it can be an unsettling place for a dental patient. Dental hygienists commonly have a high level of dental health and therefore have had mainly pleasant experiences in the dental office. Many patients, on the other hand, have had—or have a fear of—painful experiences with dental care. This section presents concepts that are effective for building successful relationships with patients.

The Nature of the Helping Relationship

1. **The Professional Helping Relationship.** The professional hygienist–patient relationship differs from that which occurs between friends (social relationships), colleagues (working relationships), or family members (kinship relationships).
   - There may be some similarities between interactions with family and friends, but one factor in particular differentiates helping relationships from social relationships. A **helping relationship** is a relationship that is established for the benefit of the patient, whereas kinship and friendship relationships are designed to meet mutual needs (i.e., needs of both friends in the relationship).
   - ***In particular, the hygienist–patient relationship is established to help the patient achieve and maintain optimal health.***
2. **Technical versus Interpersonal Skills**
   - Psychomotor skills—such as periodontal instrumentation—develop when an individual practices the skills over a long period of time. Since periodontal instrumentation cannot be learned overnight, of necessity, a great deal of time in the dental hygiene curriculum is spent on learning this psychomotor skill.
   - It is important that dental hygiene students understand that the amount of practice time devoted to instrumentation does not indicate that this procedure is "what the profession of dental hygiene is all about." Rather, the role of the dental hygienist is that of a patient advocate who assists patients in maintaining their dental health.
   - ***A research study at the University of Sydney confirms that patients value interpersonal skills as highly as they value technical skills and wanted to be treated like a "real person."***[9]
   - Interactions hygienists have with patients can be caring and helpful or unfeeling and even harmful.
   - As a dental hygiene student, stop to consider whether you focus your attention on a procedure—such as the head and neck exam—or on the patient as a person (Box 1-6).

BOX 1-6

How Do YOU See Your Role as a Dental Hygienist?

- A technician . . . as a "tooth-cleaning" technician.
- A patient advocate . . . as a dental health specialist and patient advocate whose primary focus is on preventing and treating dental disease to improve oral health, in support of the patient's overall health.

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Patients' Rights in the Helping Relationship

As the "consumers" of dental services, patients have the rights summarized in Box 1-7.

BOX 1-7 Patients' Rights in the Helping Relationship

- To expect a systematic and accurate assessment of their oral health status
- To be informed about their oral health status so that they clearly understand what the hygienist means
- To have all their questions answered
- To receive care from a dental hygienist who has current knowledge and is able to provide safe, efficient care that meets the standards of care
- To be treated courteously by a dental hygienist who shows genuine interest in them
- To trust that the confidentiality of any personal information will be respected
- To consent to or refuse any proposed treatment without jeopardizing their relationship with their dental hygienist
- To receive quality care

Paternalistic versus Patient-Centered Care

Traditionally, medical and dental health care has taken a paternalistic approach. The patient-centered approach is a relatively new care model, being only a few decades old.

1. **Traditional "Paternalistic Model of Care"**
   a. **Paternalism** is the belief that health decisions (e.g., whether to have periodontal surgery, appropriateness of a fixed bridge versus a dental implant) are best left in the hands of those providing the health care.[10]
   b. This traditional approach assumes that patients don't have the capacity to understand medical or dental care.
      1) It also assumes that the patient does not need to understand his or her own health care.
      2) In this traditional approach, the physician or dentist decides "what is best for the patient" and then carries out that treatment.
2. **Patient-Centered Health Care**
   a. **Patient-centered care** is defined as respecting and responding to patients' wants, needs, and preferences, so that the patient can make choices in his or her care that best fits his or her individual circumstances.[11] Such care is characterized by a positive patient–provider relationship, shared understanding, emotional support, trust, patient enablement, and informed choices.[12]
   b. A patient-centered approach to patient care recognizes that there are two experts present during the interaction between a health care provider and patient. Both the health care provider and the patient have rights and needs, and both have a role in decision making about care and implementation of treatment.
      1) One expert is the health care provider who has clinical knowledge.
      2) The second expert is the patient who brings experience, beliefs, and values to the dental treatment planning process.

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c. **A clinical example of traditional versus patient-centered models of care.** A clinical example of the traditional approach versus the patient-centered approach is the instance of a patient with periodontal pockets.

1) In the traditional model, the dentist explains the condition and tells the patient why she needs periodontal surgery.
2) In the patient-centered model, the dentist explains the condition and the various treatment options (surgery or frequent professional periodontal instrumentation) and the expected outcomes of these options. Then the dentist and the patient discuss the patient's needs and preferences and come to a joint decision about the treatment plan. For example, even though periodontal surgery provides the best possible outcome, the patient may be unable to afford surgery and opt instead to come every 3 months for periodontal instrumentation.
3) Table 1-3 summarizes the differences between traditional and patient-centered care models.

TABLE 1-3 TRADITIONAL VERSUS PATIENT-CENTERED MODELS OF PATIENT CARE

Traditional Model	Patient-Centered Model
Patient is passive. *(Patient is quiet.)*	Patient's role is active. *(Patient asks questions.)*
Hygienist dominates the conversation. *(Hygienist does not offer options.)*	Hygienist collaborates with the patient. *(Hygienist offers options; discusses pros and cons.)*
Patient is the recipient of treatment. *(Patient passively accepts hygienist's preferred treatment recommendation and does not voice concerns.)*	Patient is a partner in treatment planning. *(Patient asks for information and considers options.)*
Care is disease-centered. *(Disease condition is the focus.)*	Care is quality-of-life-centered. *(Patient wants and needs are the focus.)*
Hygienist does most of the talking. *(Hygienist does not allow time for patient to voice concerns or ask questions.)*	Hygienist listens more and talks less. *(Hygienist allows time for the patient to voice concerns and for discussion.)*
Patient may or may not adhere to treatment plan. *(Treatment plan reflects the hygienist's preferences and dental health values.)*	Patient is more likely to adhere to treatment plan. *(Treatment accommodates the patient's culture, needs, and values.)*

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Integrating Communication and Therapeutic Tasks

Dental therapy involves two important tasks, or the "2Fs" of **finding the problem** (diagnosis) and **fixing the problem** (treatment). New and experienced clinicians, alike, often find it difficult to combine these "2Fs" with communication skills.

The E4 model for clinician–patient communication defines the critical communication tasks—the "4Es"—to engage, empathize, educate, and enlist the patient. The "4Es" are of equal importance to the therapeutic "2Fs" tasks for successful patient care. Derived from an extensive review of the literature on clinician–patient communication, the model has proved to be a useful tool for health care providers regardless of specialty, experience, or practice setting.[13–15] Figure 1-7 depicts the relationship between the "4Es" of communication with the "2Fs" of dental therapy.

Engagement establishes an interpersonal connection between the patient and clinician. **Empathy** demonstrates the hygienist's understanding of and concern about the patient's thoughts and feelings—the patient is seen, heard, and understood by the hygienist. **Education** delivers information to the patient—the patient learns something. **Enlistment** invites the patient to actively participate in decision making and acknowledges that the patient controls much of what can happen in his or her dental health care treatment plan.[16]

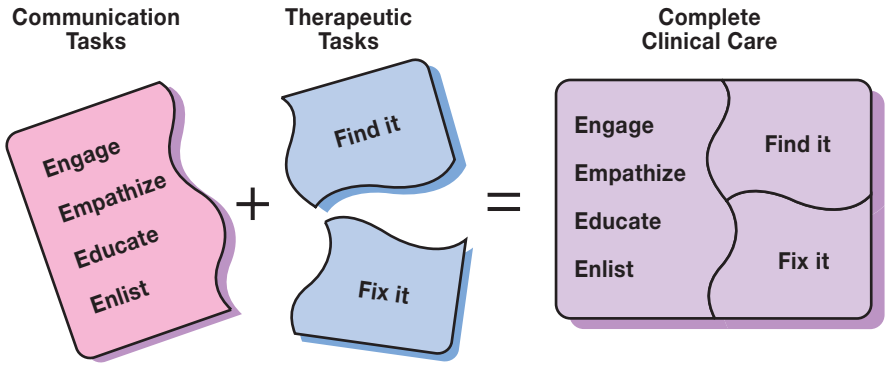

FIGURE 1-7 The E4 model for clinician–patient communication. The "4Es" define the communication tasks, combined with the traditionally taught therapeutic tasks, that are necessary for complete clinical care.

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SECTION 3 • Patient-Centered Communication

Patient-centered communication embraces three core attributes of "patient-centered care":

1. Consideration of patients' needs, perspectives, and individual experiences
2. Provision of opportunities for patients to participate in their care
3. Enhancement of the patient–clinician relationship[12]

Box 1-8 contains one example of a patient-centered conversation.

BOX 1-8 Patient-Centered Communication: An Example

Hygienist: "Good morning, Mrs. Jamison. It's nice to meet you. It must have been difficult driving here today with all this snow." (*small talk*)

Patient: "Yes, driving is dangerous. I left early for this appointment to make sure that I got here on time."

Hygienist: "Tell me why you decided to come to the dental office today." (*open-ended question*)

Patient: "Well, I have been seeing blood when I brush my teeth and I am wondering if this is a problem. And then I keep thinking about what my mother went through."

Hygienist: "Your mother? Can you tell me more about that?" (*facilitating question*)

Patient: "Well, my mother had terrible dental problems and had to see a periodontist and then she had to have surgery and it was very painful!"

Hygienist: "So, you are worried that the same thing might happen to you?" (*reflective listening*)

Patient: "Yes, that is it exactly."

Communication Tip: Note that the hygienist in this example refrains from immediately launching into an explanation of inflammation or periodontal disease. Instead, the hygienist concentrates on understanding the patient's concerns.

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Framework for Patient–Clinician Communication

Patient-centered communication is organized around six core functions of patient–clinician communication, as depicted in Figure 1-8.

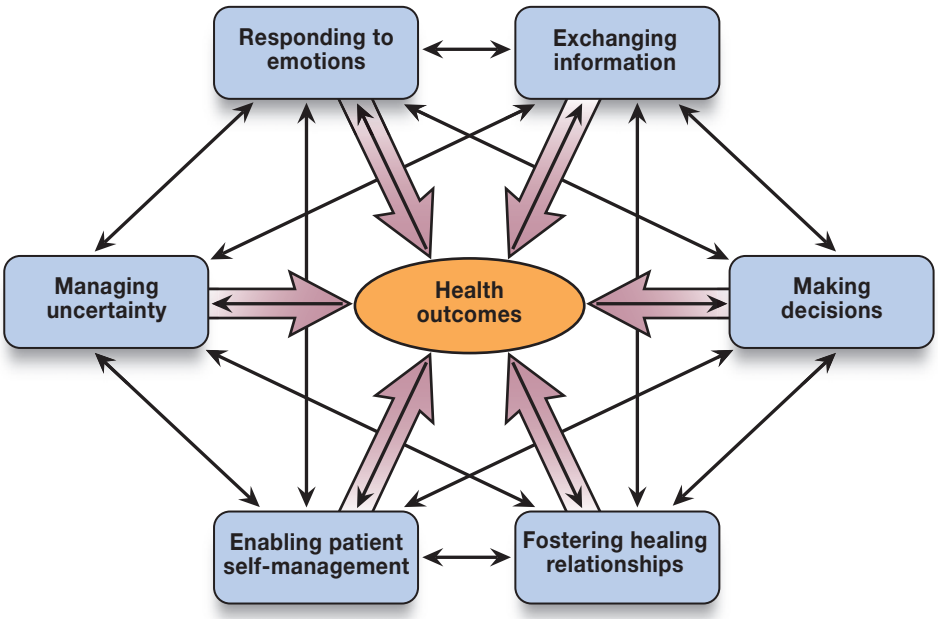

FIGURE 1-8 Core functions of patient–clinician communication. The diagram represents the six core functions of patient–clinician communication that interact to produce communication that can affect important dental health outcomes.

Patient-Centered Communication as a Key Clinical Skill

A number of national organizations acknowledge that communication is a key clinical skill for health care providers.[11,17] The increased interest in effective communication between health care providers and patients is motivated by the desire to provide the best possible care for patients. There is a growing recognition that the education and training of health care providers should focus on helping student clinicians acquire these skills.

Good communication is not "common sense"; rather, it is a set of skills and attitudes that need to be central to the practice of dental hygiene. The hygienist's ability to communicate clearly with compassion, to meet or even exceed the patient's expectations, is the essence of a helping relationship. Many patient complaints about dental care are not about how procedures are performed but about perceived lack of caring on the part of the dental staff. Table 1-4 is a self-assessment tool that explores the skills needed for effective communication and customer service.

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TABLE 1-4 SELF-ASSESSMENT TOOL: COMMUNICATION SKILLS

Directions: Complete this assessment as a quick check of your skills. Rate yourself from 4 (very skilled) to 1 (not skilled).

1. I feel good about my communication skills.	4	3	2	1
2. I greet patients, families, and staff (instructors and peers) with a smile.	4	3	2	1
3. I make eye contact.	4	3	2	1
4. I take a moment to calm myself before meeting a patient.	4	3	2	1
5. I dress professionally and pay attention to my grooming.	4	3	2	1
6. I learn patient names and inquire if my pronunciations are correct.	4	3	2	1
7. I introduce myself and wear my name tag.	4	3	2	1
8. I explain procedures clearly, using everyday words (not dental terminology).	4	3	2	1
9. I encourage patients to ask questions.	4	3	2	1
10. I take responsibility for finding answers to patient questions.	4	3	2	1
11. I listen, knowing it is OK to be quiet and not have all the answers.	4	3	2	1
12. I apologize for delays (making the patient wait for me).	4	3	2	1
13. I encourage patients to take an active role in care decisions.	4	3	2	1
14. I respect patients' confidentiality.	4	3	2	1
15. I encourage feedback about my work.	4	3	2	1
16. If I don't understand, I seek clarification.	4	3	2	1
17. I thank a colleague (peer) who helps me.	4	3	2	1
18. I offer to help colleagues.	4	3	2	1
19. I am learning to deal with multiple demands on my time.	4	3	2	1
20. I understand that I am still learning that it is impossible to be perfect.	4	3	2	1

Scoring: Add the numbers that you have selected. Remember that this is a self-assessment and that feedback from your instructor, peers, and patients adds more information.
64–80, High awareness of necessary skills.
63–40, Average awareness of skill. Review your lower scores and select areas for growth.
20–39, Low awareness of skills. Pay more attention to the development of communication and interpersonal skills.

Patient-Centered Communication Techniques

Surveys conclude that patients strongly desire a patient-centered communication approach.[18,19] During patient assessment, being patient-centered consists of making a conscious effort to understand the patient's concerns and beliefs.[16] Table 1-5 presents a set of practical and evidence-based suggestions to help improve the quality of the hygienist–patient relationship during the patient assessment process.[16,20–23]

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TABLE 1-5 SUMMARY OF PATIENT-CENTERED COMMUNICATION TECHNIQUES

Technique	Description
Preparing for the appointment	• The dental office environment is full of distractions, including noisy equipment sounds from other treatment rooms, movements and conversations of other team members, computers and cell phones, and even the hygienist's own thoughts about issues related or unrelated to patient care. • Before meeting the patient, the hygienist should take a moment to review the patient's chart and make conscious decision to focus on the patient he or she is about to meet.[24]
Greeting the patient	• In a dental setting, as in most other human interactions, first impressions count. Meeting and greeting a patient is the first step in the dental care process. • Greet the patient appropriately. If this is the first time that you are meeting an adult patient, greet him or her by last name and title (Mr., Mrs., Ms., Dr., etc.). Greet anyone accompanying the patient in a similar manner. Ask how to pronounce unfamiliar names. • After the initial greeting, it is fine to ask if the patient prefers to be addressed by his or her first or last name. Make a note of the patient's preference in the patient chart. • Introduce yourself. Escort the patient to the treatment room. • Use touch sparingly. Many people are not comfortable with strangers hugging, patting, or touching them. • Several studies indicate that patient satisfaction is increased when there is a brief period of informal conversation.[25,26] An example of small talk is "Have you been enjoying this beautiful weather?" • Small talk is a way that the health care provider can connect with the patient as "a person."[25]
Reducing distance	• Diminishing the physical space between the patient and hygienist • Sitting at the same level as the patient and making eye contact conveys the health care provider's compassion and interest in the patient's welfare.[27] • An exception to this suggestion occurs when the patient's culture may view direct eye contact as inappropriate. Koreans, Filipinos, certain Asian cultures, and Native Americans may find direct eye contact offensive.[28] Be guided by the patient's behavior; if he or she avoids eye contact, do likewise. • Standing and looking down at the patient creates a negative impression and emphasizes the dominant role of the health care provider in the relationship.[29]

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TABLE 1-5 SUMMARY OF PATIENT-CENTERED COMMUNICATION TECHNIQUES (Continued)

Technique	Description
Monitoring body language	• Be aware of your own nonverbal behaviors. For example, glancing at your watch might convey that you are rushed. Use reassuring gestures, such as nodding your head, to encourage the patient to keep talking. • Be alert for nonverbal clues that indicate the patient is uncomfortable or anxious. Some of these are fidgeting, rapid breathing, shakiness of hands, eyes wandering around the treatment room, or actual wringing of hands.
Engaging the patient and gathering information	• Seek to understand the patient's reasons for coming to the dental office. Questions such as "How are you today?" or "What brings you here today?" provide a means to start the conversation. • Ask open-ended questions that allow the patient to determine the direction that the conversation will take.
Listening	• Allow the patient to talk. The biggest challenge on the part of the health care provider is to take the time to listen—really listen—to the patient's concerns and not to interrupt the patient. The most effective dental hygienists are those who have developed good listening skills. • Listening is a nonverbal way to communicate the hygienist's interest in and acceptance of the patient. • Statements such as "Tell me more about that" or "That must be a worry" are helpful in encouraging patients to provide information. • Pay attention to what is being said; do not worry about what you are going to say next. Avoid interrupting the patient. Focus on the patient who is telling you something that is important to him or her. • Use facial expressions and body language to confirm that you are listening to what the patient is saying. Make eye contact, lean forward, and nod your head at key points. • Offer confirmation that you hear what is being said. An "um-hmm," "go on," or "I see" may be all that is required.
Remaining silent	• Silence, also, is a very effective tool. A brief pause in conversation allows the patient time to think and prepare for what to discuss next.[30]
Gently and respectfully steering the conversation	• Many hygienists worry that asking the patient to talk about his or her concerns will take too much time and allow the patient to ramble on about information that is not helpful. • If the patient seems to be "rambling," an effective way to steer the conversation in a more organized direction is to tactfully ask the patient "Would it be OK if I interrupt you to ask some specific questions about what you are telling me?"

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TABLE 1-5 SUMMARY OF PATIENT-CENTERED COMMUNICATION TECHNIQUES (Continued)

Technique	Description
Restating and seeking clarification	• Restating—the act of restating what the hygienist heard the patient say—greatly facilitates accurate communication between the health care provider and the patient. Restating is not simply repeating what the patient has just said. For example, if the patient says, "I am here today because of these brown stains on my teeth," the hygienist might restate by saying, "So what you are saying is that you are most concerned about the appearance of your smile? Is that correct?" • Restating allows the hygienist to verify the patient's concerns and provides an opportunity for the patient to make corrections. This process reassures the patient that the health care provider understands his or her concerns or needs. • Use confirmation to ensure that both the clinician and patient are on the same track and to clear up misconceptions. • Clarify information. Ask a question, if you want to clarify the patient's statement. Patient: "This is too much for me to handle." Clinician: "What is it that worries you the most?" (Clinician gives the patient an opportunity to explain the statement.)
Validating	• Validate the patient's feelings (e.g., "Many people feel the same way you are feeling in this situation. It is understandable."). • Acknowledge and praise the patient for things he or she is already doing (e.g., "I can see that you are making every effort to care for your dental health.").
Collaborating	• Acknowledge that for care to be effective, the patient and clinician must work together. • Treat every patient as though he or she is the only expert on the problem—you are only a collaborator in producing solutions and/or providing advice regarding the problem. • Interact with the patient as a peer; avoid a condescending approach. • Avoid being defensive; state information clearly without a confrontational tone. • Understand and respect patients' values, beliefs, and expectations (e.g., "So what you are saying is that you want to have a healthy mouth, but that you are concerned about the cost of periodontal surgery. Is that correct?").

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TABLE 1-5 SUMMARY OF PATIENT-CENTERED COMMUNICATION TECHNIQUES (Continued)

Technique	Description
Assessing the patient's needs and wants	• To assess a patient's wants and needs, the health care provider asks questions about the patient's concerns, priorities, and values. The health care provider should listen attentively to the patient's answers and ask follow-up questions if the answers need clarification. • For example, a patient might say that she wants to have "everything possible" done to treat her periodontal disease. The astute clinician, however, will realize that "everything possible" could have a number of different meanings (surgery versus everything but surgery, willingness to engage in fastidious daily self-care versus having the dental team "fix this for me without my having to do much at home"). • Take time to truly figure out what the patient needs and wants.
Focusing	• Asking questions to help the patient develop or expand on a value, need, or concern (e.g., "Can you tell me more about that?")
Providing information	• Seek to understand the patient's informational needs. • Communication should be uncomplicated, specific, use some repetition, avoid the use of dental terminology, and check for patient understanding. • When it comes to important points that you need to convey to the patient, keep it simple and leave nothing to doubt. • Overly directive communication (e.g., "You need periodontal surgery.") and teaching (e.g., "Let me explain the periodontal disease process to you.") appear to have negative consequences on the communication process.[19,31]
Enabling the patient	• Near the end of the assessment procedures, the hygienist should make sure that all of the patient's concerns have been elicited.[32,33] This can be accomplished by asking "What other questions do you have for me today?" • This approach is a useful way to prevent patients from feeling rushed and is a positive way to help to conclude the assessment procedures.
Summarizing	• Statement of the main areas discussed before and during the assessment appointment (e.g., "So your main concern today is the raised area that you found here in your mouth. Secondly, you are worried about this black spot on your tooth. Are those all your concerns? Did I miss anything?")

Confirming satisfaction	• Bring an assessment appointment to a close with confirmed satisfaction with the patient feeling that all needs, concerns, or questions have been addressed (or will be at future appointments).
	• The hygienist's willingness to do this shows the patient two very important things:
	  ◦ That the hygienist cares about getting it right
	  ◦ That the patient is the one who determines what "right" is

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Techniques that Hinder Communication

In contrast to communication techniques that facilitate the hygienist–patient relationship, there are certain communication habits that hinder this relationship. Such habits include asking irrelevant personal questions, stating personal opinions, or showing disapproval. Table 1-6 summarizes communication techniques that hinder the hygienist–patient relationship.

TABLE 1-6 SUMMARY OF TECHNIQUES THAT HINDER HYGIENIST–PATIENT COMMUNICATION

Technique	Description/Outcome
Not listening	• Not trying to understand the patient's values, needs, or concerns • Places the hygienist's needs above those of the patient (i.e., keeping on schedule, completing a procedure)
Failing to probe	• Not obtaining complete information from patient by rushing the patient, following standard forms (e.g., health history form) too closely, or inadequate data collection during the assessment process • Generates inadequate information with which to make treatment decisions/recommendations; leads to lack of individualization of patient care
Asking irrelevant personal questions	• Asking personal questions that are not related to patient care • Prying • Makes the patient feel uncomfortable and distrusting of the hygienist
Parroting	• Repeating patient's exact words (like a parrot) • Indicates that the hygienist really is not listening or is not a competent communicator
Showing disapproval	• Belittling the patient's feelings • Being judgmental; for example, disapproval of the patient's lifestyle or self-care habits • Implies that the hygienist "knows best" or is superior in some way to the patient • Disagreeing or opposing the patient's ideas • Implies that patient is "wrong" (e.g., "I know that you believe that since your parents lost all their teeth, that you will, too. But, this is just not the case.")
Challenging	• Demanding proof from the patient (e.g., "You say that you stopped smoking, but I wonder if that is really true.")
Giving advice	• Telling the patient what to do; stating personal opinions to the patient about what the hygienist thinks should be done (e.g., "You really should see a periodontist.") • Conveys that patient's feelings or preferences are not important

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TABLE 1-6 SUMMARY OF TECHNIQUES THAT HINDER HYGIENIST–PATIENT COMMUNICATION (Continued)

Technique	Description/Outcome
Making stereotyped or patronizing responses	• Use of trite, meaningless verbal phrases (e.g., "Don't worry, everything will be OK. We refer lots of patients to an oral surgeon" or "Well, that idea is not a good one . . . ") • Implies that the patients concerns or feelings are not valid or important • Implies that the hygienist–patient relationship is not equal; the hygienist is in a superior position
Changing topics	• Changing the subject away from the patient's concerns to one that fits the hygienist's agenda (e.g., "OK, but right now, let's concentrate on the medicines that you take . . . ") • Communicates that the hygienist is in control of deciding what will be discussed; may result in topics of importance to the patient not being discussed
Interpreting	• Telling the patient the meaning of his or her experience (e.g., "Well, it is obvious to me that you smoke because you are worried that you will gain weight if you stop.")
Probing	• Persistent questioning of the patient (e.g., "You still have not told me why you will not floss daily.")
Reassuring	• Indicating there is no reason for anxiety or worries (e.g., "Don't worry about having a root canal. It will be fine.")
Testing	• Appraising the patient's degree of insight or knowledge (e.g., "What do you know about diabetes and how it may impact your dental health?")
Using denial	• Refusing to admit that a problem exists (e.g., "I know that you are concerned that dental x-rays may be harmful, but really, they are not dangerous at all!")

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Questioning Skills

Questioning skills are particularly important during the health history portion of the assessment process to gather complete and accurate information from the patient. Tips for effective questioning are summarized in Box 1-9.

BOX 1-9 Tips for Effective Questioning

1. **General Tips for Gathering Information**
   - Use language that is understandable to the patient. Avoid medical/dental terminology if the patient does not have a medical or dental background. Most people have difficulty understanding the words used in health care. For example, rather than asking if the patient has ever experienced vertigo, ask if she felt dizzy.
   - Ask one question at a time. Keep questions brief and simple and give the patient plenty of time to answer.
   - Avoid leading questions. Avoid putting words in the patient's mouth.
   - Avoid interrupting the patient. If you need to ask a follow-up question, wait until the patient has completed his or her thought. Let the patient do the talking.
   - All questions should be asked in a positive way. Avoid accusing language in your questions (e.g., Why don't you floss every day?).
2. **Use of Closed Questions**
   Closed questions can be answered with a yes or no or a one- or two-word response and do not provide an opportunity for the patient to elaborate. Closed questions limit the development of rapport between the clinician and the patient. Use closed questions primarily to obtain facts and zero in on specific information. Examples of closed questions include:
   - *Are you allergic to latex?*
   - *How* frequent *are your seizures?*
   - *Did you check your blood sugar levels this morning?*
3. **Use of Open-Ended Questions**
   Open-ended questions require more than a one-word response and allow the patient to express ideas, feelings, and opinions. This type of questioning helps the clinician gather more information than can be obtained with closed questions. Open-ended questions facilitate good clinician–patient rapport because they show that the clinician is interested in what the patient has to say. Examples of such questions include:
   - *What happens to you if you are exposed to latex?*
   - *What things can trigger your seizures?*
   - *What were your blood sugar levels this morning?*
4. **Exploring Details with Open-Ended Questions**
   Focused, open-ended questions define a content area for the response but pose the question in a manner that cannot be answered in a simple word.
   - *Please describe the pain that you are feeling.*
   - *Please start from the beginning and tell me how this began and how it has progressed.*
   - *Do cold temperatures like an ice-cold drink cause the pain?*
   - *Which of your family members have diabetes?*

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Communication Tasks during Patient Assessment

When performing assessment procedures, the dental health care provider should remember to communicate with the patient. It is easy for the clinician to concentrate so completely on the steps involved in a procedure that he or she forgets to explain the procedure to the patient or forgets to keep the patient involved in what is happening.

Communication tasks during the patient assessment process include giving information to the patient, explaining a procedure to the patient, seeking the patient's cooperation, providing encouragement to the patient, reassuring the patient, and giving feedback to the patient. Box 1-10 shows a sample dialogue for communication during blood pressure assessment.

1. **Giving Information**
   Example: *We do this to make sure that your temperature, pulse, respiration, and blood pressure are OK before starting any treatment.* Other ways of phrasing this include:
   - *This is . . .*
   - *I need to . . .*
   - *This is important because . . .*
2. **Explaining a Procedure**
   Example: *I am going to wrap this cuff around your arm and pump some air into it so that I can read your blood pressure.* Other ways of phrasing this include:
   - *I just want to . . .*
   - *Now I would like to . . .*
   - *Now I am going to . . .*
3. **Seeking Cooperation from the Patient**
   Example: *Could you roll up your sleeve?* Other ways of phrasing this include:
   - *I would like you to . . .*
   - *If you would just . . .*
   - *Would you please . . .*
4. **Offering Encouragement**
   Example: *Yes, that is fine.* Other ways of phrasing this include:
   - *That's good.*
   - *Well done.*
5. **Offering Reassurance**
   Example: *Don't worry; you will only feel the pressure of the cuff around your arm.* Other ways of phrasing this include:
   - *It won't take long.*
   - *This might feel a bit strange at first.*
   - *Have you had your blood pressure taken before?*
6. **Giving Feedback**
   Example: *Your readings are quite normal.* Other ways of phrasing this include:
   - *Everything is OK.*
   - *Your blood pressure is a bit high, so I'll let Dr. King know what your readings are.*

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BOX 1-10

Sample Dialogue: Communication Tasks during Blood Pressure Assessment

Clinician: *Now, Mrs. Tanner, I need to take your blood pressure. We do this to make sure that your blood pressure readings are normal before beginning any dental treatment.* [giving information to the patient]

Patient: *Oh . . . I see. I have been taking blood pressure pills; my doctor says that it is important to keep my blood pressure under control.*

Clinician: *I am going to wrap this cuff around your arm and pump some air into it so that I can read your blood pressure.* [explaining the procedure to the patient] *Could you please roll up your sleeve a bit?* [seeking cooperation from the patient]

Patient: *Yes.* (rolls up sleeve) *Is this far enough?*

Clinician: *Yes, that's just fine.* (attaches the cuff and begins inflating the cuff) [giving feedback]

Patient: *It feels a bit funny.*

Clinician: *Yes, it does feel funny, but don't worry. I am almost done pumping up the cuff. Then, I will start releasing the air, and you will feel less pressure against your arm.* [offering reassurance to the patient]

Patient: *Is my blood pressure OK?*

Clinician: *Yes. It is quite normal. Your readings today are 110 over 70.* [giving feedback to the patient]

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SECTION 4 • The Impact of Electronic Records on Communication

Integrating Computerized Records and Patient-Centered Communication

An **electronic dental record** refers to a computerized system for maintaining patient health information in an electronic, digital format. Electronic dental records are used as a substitute for the traditional paper medical record; material is easier to access and update. Computerized patient records are almost a universal feature in today's dental office. Electronic dental records let dental health care providers easily access information about their patients. Many hygienists, however, find that the computer screens distract from the clinician–patient relationship.

Experts report that a lack of eye contact is the biggest problem with having to input information into a computer. Eye contact establishes trust with patients. A lack of eye contact also prevents the hygienist from being able to read body language and cues from patients.

Several authors have proposed a patient-centered model for the interaction among the clinician, the patient, and the computer.[34,35] Box 1-11 summarizes guidelines, nicknamed POISED, designed to help health care providers communicate effectively with patients while recording data electronically.

BOX 1-11

Tips for Effective Use of Computerized Records

P **Prepare:** Review the electronic record before seeing the patient.

O **Orient:** Briefly explain how the computer will be used during the visit.

I **Information Gathering:**
- Start with your patient's concerns.
- Look at your patient. Make sure your full attention is in listening to the patient.
- As much as possible, indicate your full attention by taking your hands off of the keyboard and facing the patient.
- At various points in the information gathering, explain to the patient that you will pause the conversation to enter information in the chart.
- Enter data to show patient's concerns are being taken seriously.

S **Share:** Tell your patient what you are doing as you do it.

E **Educate:**
- Point to the computer screen; highlight discussed data.
- When possible, display data, such as the patient's blood pressure or probing depths over time.

D **Debrief:** Make sure the patient understands what you said.

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Improved Communication with Standardized Nomenclature

With the advent of computerized, electronic records, the medical and dental communities foresaw a need for a standardized nomenclature in patient records. The **Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT)** is a comprehensive clinical nomenclature of medical terminology. In 1999, the Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT) was created by the merger and restructuring of clinical terminologies developed by the College of American Pathologists and the National Health Service of the United Kingdom. As of April 2007, SNOMED CT is owned, maintained, and distributed by the International Health Terminology Standards Development Organization, a not-for-profit association in Denmark, in order to promote international adoption and use of SNOMED CT. SNOMED is a multinational and multilingual terminology that can manage different languages and dialects.

The American Dental Association developed the **Systematized Nomenclature of Dentistry (SNODENT)**, a system of descriptive dental codes for use in electronic dental records. SNODENT is a comprehensive nomenclature that contains codes for identifying not only diseases and diagnoses but also anatomy, dental and medical conditions, morphology, risk behaviors (e.g., smoking), and social factors that may affect dental health or treatment. SNODENT is distributed by the American Dental Association as a set of downloadable files.

SNODENT-enabled electronic dental records benefit individuals and evidence-based dental health care by:

- Providing standardized terms for describing dental disease
- Enabling information to be recorded consistently during office visits and among different settings and locations
- Allowing detailed information to be recorded by different people, in different locations, and to be combined into the patient record
- Enabling analysis of patient care services and outcomes
- Enabling the exchange of clinical details between different systems and devices, such as electronic sharing of detailed patient information between the general dental practice and a periodontal practice
- Allowing identification of patients who need follow-up for specific conditions and improved coordination of care
- Enabling a platform-independent, language-independent, cross-cultural oral health record with precise, highly detailed recording of all oral health information
- Enabling terminology to be updated in collaboration with oral health subject matter experts to represent current oral health knowledge

More Information on SNODENT

The SNODENT User Guide may be downloaded at http://www.ada.org.

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SECTION 5 • Difficult Conversations with Patients

Communication in a Difficult Patient Encounter

Communication skills are particularly important when dealing with angry patients, disappointed patients, or patients with unrealistic expectations. Anger may be a patient's way to express anxiety (about his or her oral health or a treatment procedure) or dissatisfaction with the care that he or she is receiving.[36] In such situations, the health care provider's first instinct often is to provide additional information about the patient's dental condition or a treatment procedure. Often, a more helpful approach is to acknowledge the emotion that the patient appears to be feeling and explore its causes—before explaining. Helpful skills in these situations include:

- If a patient is angry, acknowledge this feeling and explore its causes before attempting to explain or defend your position.
- If the patient is disappointed, say something like "I wish things were different."
- Box 1-12 provides an example of a communication with a disappointed patient.

BOX 1-12

Example of Communication with a Disappointed Patient

Patient: "I left my old dentist and came here today because nothing is working for me. My old dentist keeps prescribing antibiotics for me. But as soon as I am done taking the medicine, my gums start bleeding again and feel 'itchy.' I have taken antibiotics several times over the past year, and they just don't seem to be working for me. I am very frustrated!"

Hygienist: "So what you are saying is that the antibiotics don't fix the problem. Sounds like you are disappointed." [repeating what you heard and naming the emotion]

Patient: "Yes, I thought the antibiotics would get rid of the bleeding."

Hygienist: "I wish that I could tell you that antibiotics cure gum disease, but they do not. Would it be OK if I explain how gum disease works and then we can discuss where we go from here?" [validating the patient's feeling of disappointment and asking permission before explaining]

Sharing Bad News

Unfortunately, the dental team sometimes has to convey bad news to patients. Examples include telling a patient that he or she has a cancerous lesion, periodontitis, or many teeth that need restorations. Although the dentist usually tells the patient about his or her treatment needs, the hygienist often is asked to clarify the information after the dentist leaves the treatment room.

Difficult conversations with patients are necessary and, when done well, can actually empower patients and help them plan for the future. Sharing bad news with a patient covers several general considerations, including the environment in which the bad news is shared, the components of bad news including emotions, and following up with the patient once the bad news has been shared.

The **SPIKES** mnemonic is a six-step model for sharing bad news with a patient.[37] Table 1-7 summarizes this six-step model for communicating bad news. It is important to realize that even though this is a six-step linear model, the steps may overlap to some degree when having a conversation about bad news.

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TABLE 1-7 SPIKES MODEL FOR DELIVERING BAD NEWS

Six Steps	Concepts
Setting	• Provide privacy. As much as possible, try to assure that there will not be interruptions while speaking with the patient, such as closing the door to the treatment room, turning off cell phones. • Create a comfortable environment. Present yourself in a calm manner. Sit at eye level with the patient. Sit down and listen. • Maintain a welcoming ("shame-free") environment—whatever emotion the patient may exhibit is OK.
Perception	• Get a sense of the patient's state of mind as well as what facts the patient knows. • Don't assume that you know the patient's concerns. Ask the patient what he or she wants to know. Explore the patient's ideas about the problem (thoughts, worries, expectations) and take the patient's input seriously. "I'm hoping to discuss the proposed treatment. But, first, could you tell me what you want to talk with me about—so we can be sure to address that?" • Try to understand how the problem affects the patient's life.
Invitation	• Invite the patient to talk by asking open-ended questions. • Ask, "What other questions do you have?" • **LISTEN. Listening is the most important skill during a difficult conversation. If the clinician is doing most of the talking, he or she is talking too much! Difficult conversations are about encouraging the patient to explore what is going on and what he or she wants.**
Knowledge	• Explain the problem (such as periodontitis) in plain, everyday language; avoid dental terminology. Use language that the patient will understand. • Give information in small chunks. Avoid the temptation to tell patient the information all at once. • Ask-Tell-Ask Patient (Ask): "I don't understand what a periodontist does." Clinician: "Would it help if I give you an overview?" Patient: "That would be great." Clinician (Tell): "A periodontist is a dentist who specializes in . . . " Clinician (Ask): "Does that answer your questions?" • Pause for 10 seconds so the patient has time to absorb what was said and to respond to it. • Ask, "What other questions do you have?" Reassess until you feel confident that the patient understands the proposed treatment and any treatment options. • Wait for a response from the patient. This is hard to do. Frequently, we just want to do or say something, anything. Just wait!

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TABLE 1-7 SPIKES MODEL FOR DELIVERING BAD NEWS (Continued)

Six Steps	Concepts
	• Verify that your message has been received. You may want to say something like "I can see that this news has had a big impact on you. Tell me what you think it means." • If the patient does not correctly say back what you have told him or her, it is up to you to say it in another way. • Seek a partnership with the patient; agree on the nature of the problem, on the priorities, and on the goals of treatment. Clarify the respective roles of the dental health team and the patient.
Emotions	• Be prepared for the patient's emotional response. Common emotions in a sharing bad news situation may be fear, shock, sadness, and denial. • Clinician: "I can see this news is upsetting you." Patient: "I guess that I get really scared when I hear the word 'surgery'!" Clinician: "You sound worried. I can understand how you would feel that way. What worries you most?"
Strategy and Summary	• Strive for an enhanced relationship. Be approachable, show genuine caring, share decision making, and be respectful.

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SECTION 6 • The Human Element

Patient assessment procedures provide critical information for planning dental hygiene care. These complex procedures require practice and experience to master and methodical attention to detail to perform. Most textbook space—as well as classroom and laboratory time—tends to be devoted to the technical aspects, the steps that comprise the patient assessment procedures. Yet, the nonprocedural human element of the assessment process is equally critical to the success of the assessment process. The **Human Element** section of each module reflects the struggles, fears, and triumphs of the students, clinicians, and patients who engage in the assessment process. In addition, this section may include a fictitious patient scenario that addresses communication and treatment challenges frequently faced by dental hygienists.

Through the Eyes of a Patient

REMEMBER PATIENTS ARE PEOPLE

I know that, as a student, you come into clinic today thinking about what you will accomplish during this appointment. Perhaps you wonder if you will remember to do all of the steps and if you will do them correctly. I am sure that you are worried about your clinic requirements and the instructor's comments about your performance today.

As the patient, I, too, come to this appointment with some needs and concerns. I am not simply a 60 year-old woman with bleeding gums who only has 20 teeth in her mouth. I wish that you would take a moment to consider what is important to me. Most of my needs are simple things that you can do each time that I have an appointment:

- Do not keep me waiting.
- Ask me what I think.
- Really listen to me.
- Do not dismiss or ignore my concerns.
- Talk to me, not at me.
- Keep me informed about what you are doing.
- Do not treat me like a clinical requirement; treat me like a person.
- Do not tell me what I need to do without telling me why it is important and how to do it.
- Respect my privacy; do not talk about me to your classmates.
- Remember who I used to be. I was not always a 60 year-old woman; I used to be a young, enthusiastic research chemist.
- Let me know that you care about me.

Mrs. G, dental patient,
South Florida Community College

Used with permission and excerpted from a letter to the students of the Dental Hygiene Program, South Florida Community College.

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PATIENT PARTICIPATION IN CARE DECISIONS

Directions: Think about the last time you were a patient or client (of a physician, nurse, dentist, or attorney). How much did this professional engage you in mutual problem solving? What did this professional do to make you feel included (or excluded) in the planning?

- In what ways did the professional make you feel that your opinions are important?
- In what ways could this professional have included you more in the decision-making process?
- How do your feelings differ when you are included and when the professional takes over and does not consult you?

Compare your experiences with those of your classmates. What has this discussion taught you about mutual problem solving?

Patient Advocacy

YOUR BELIEFS ABOUT HEALTH AND THE PATIENT–HYGIENIST RELATIONSHIP

Directions: The following questions are designed to help you think about yourself as a patient advocate. These questions are challenging because they focus on your values about being a helper. To begin, answer the questions on your own. Later, discuss your responses with your classmates. You and your peers will learn a lot from each other.

- What does *health* mean to you?
- Do you think that dental health is a right or a privilege?
- To what extent do you believe individuals are *responsible* for the development of their own dental health problems?
- What can you do, as a dental hygienist, to increase the likelihood that patients will take better care of their dental health?
- What degree of independence are you comfortable with allowing your patients to make decisions about their own dental treatment?
- What is it you like most about helping patients?

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Communication Scenario

THE BUSY PATIENT

You are a dental hygienist who is employed in a general dental practice with a patient base that includes a number of important individuals in the community. You see that Ms. Murphy, a local bank president, is scheduled for her 3-month maintenance appointment with you at 4:00 p.m.

At her last visit, she arrived 15 minutes late due to a "very important meeting that ran late," and stated that she had to be out in 30 minutes for her next engagement across town. Ms. Murphy also constantly interrupted the appointment by using her cell phone for both incoming and outgoing calls. You found her self-care (plaque biofilm control) to be poor, and she presented with a number of areas of toothbrush abrasion that you wanted to address with her during your self-care instruction, but you simply ran out of time. When you attempted to start the conversation, she abruptly stood up stating that she had "more important things to do than talk about the way I brush my teeth." She also refused to return until her next scheduled 3-month appointment. You relay this information to the dentist in the office, who agreed that she was a difficult patient, but encourages you to address her self-care needs at her next appointment.

Discussion Points:

1. How can you best establish rapport with Ms. Murphy?
2. How can good communication benefit Ms. Murphy?
3. What nonverbal communication techniques could be used with Ms. Murphy during her dental hygiene appointment?
4. What kinds of questions would most effectively engage Ms. Murphy in her treatment planning?
5. How can you relay to Ms. Murphy that you are empathetic of her busy schedule yet want her to value and appreciate the importance of effective self-care at home?

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SECTION 7 • Skill Check

Skill Checklist: Communications Role-Play

Student: _____ Evaluator: _____

Date: _____

ROLES:

- **Student 1** = Plays the role of the patient.
- **Student 2** = Plays the role of the clinician.

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

DIRECTIONS FOR EVALUATOR: Use **Column E**. Indicate **S** (satisfactory) or **U** (unsatisfactory). In the optional grade percentage calculation, each **S** equals 1 point, each **U** equals 0 point.

CRITERIA:	S	E
Uses appropriate nonverbal behavior such as maintaining eye contact, sitting at the same level as the patient, nodding head when listening to patient, etc.		
Interacts with the patient as a peer and avoids a condescending approach. Collaborates with the patient and provides advice.		
Communicates using common, everyday words. Avoids dental terminology.		
Listens attentively to the patient's comments. Respects the patient's point of view.		
Listens attentively to the patient's questions. Encourages patient questions. Clarifies for understanding, when necessary.		
Answers the patient's questions fully and accurately.		
Checks for understanding by the patient. Clarifies information.		
OPTIONAL GRADE PERCENTAGE CALCULATION		
Using the **E** column, assign a point value of 1 for each **S** and 0 for each **U**. Total the sum of the "**S**"s and divide by the total points possible to calculate a percentage grade.		

NOTE TO COURSE INSTRUCTOR: A collection of role-play scenarios—for use with the Communications Skill Checks—can be downloaded from the Navigate 2 Advantage Access site.

ABOUT THE SKILL CHECK PAGES: The Skill Check pages in the book are designed so that the forms can be removed from the book without loss of text content. They can be torn out and used for role-plays and exercises. If desired, they can be collected and retained for course grade determination.

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