

Health Care Provider Accommodations for Patients With Communication Disorders

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Health care providers can experience increased difficulty communicating with adult patients during medical interactions when the patients have communication disorders. Meeting the communication needs of these patients can also create unique challenges for providers. The authors explore Communication Accommodation Theory (H. Giles, 1979) as a guide for helping providers learn to adapt, or accommodate, their communication style at the appropriate level (neither too much nor too little) when their patients have communication disorders. Using principles of Communication Accommodation Theory, this article navigates case examples of medical interactions involving 2 hypothetical patients, 1 with aphasia and 1 with dysarthria. We use these two patients to illustrate some appropriate accommodations for patients with aphasia or dysarthria. Suggested accommodations stem from the FRAME mnemonic for communicating with patients with communication disorders and are organized using SEGUE, a framework outlining specific steps in a typical medical interaction. This article may also serve as a resource for speech-language pathologists providing in-services to their health care colleagues on this topic and to support interprofessional practices. **Key words:** *aphasia, communication disorders, dysarthria, medical education, patient-provider communication*

A TALE OF TWO HEALTH CARE INTERACTIONS

Case example 1

Dr. Smith, an attending physician in the emergency room of a regional hospital, prepares to examine Mrs. Jones, a patient recently admitted with

pneumonia. It will be the first time they meet. Nurses have reported that, since being admitted, Mrs. Jones has communicated minimally, probably due to aphasia that resulted from a previous stroke. Mrs. Jones's daughter, who brought her to the hospital, just left to retrieve some of Mrs. Jones's clothes from her home. As Dr. Smith enters the room, Mrs. Jones turns toward her.

Dr. Smith introduces herself, and asks Mrs. Jones how she is feeling. Mrs. Jones nods her head slightly and continues to look at Dr. Smith. The doctor then asks, "Are you able to understand me?" Mrs. Jones looks confused, shakes her head slightly, and stares at the doctor. She attempts to say something to the doctor, but her words are a mixture of real words and apparent nonsense words. Dr. Smith cannot make sense of what Mrs. Jones is trying to say. While Dr. Smith continues the examination, Mrs. Jones again attempts to speak to her. Recognizing that Mrs. Jones' language output is not coherent, Dr. Smith smiles and nods at Mrs. Jones' communication attempts and does not address her further with any questions or comments. Mrs. Jones becomes frustrated.

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Case example 2

On a different floor of the hospital, Nurse Pryor, is working in the inpatient rehabilitation unit. He starts his shift by taking vital signs on one of his patients, Mr. Sharp, who was moved from acute care the day before. Mr. Sharp had fallen and fractured his left hip the previous week during an assisted transfer from bed to chair. Mr. Sharp also experiences advancing amyotrophic lateral sclerosis, and related to this, he developed severe dysarthria over the past 2 years. As a result, he currently uses a computerized speech-generating device as his primary method of communication. However, the nurse on the previous shift reported that the device has not been working properly since Mr. Sharp arrived. As Nurse Pryor enters the room and introduces himself, Mr. Sharp turns his head slowly toward him and nods. Nurse Pryor speaks to Mr. Sharp in an exaggerated slow, loud voice using short sentences. “I know your computer is broken” he says. “Your family is trying to fix it. I will talk slowly to you for now.” Mr. Sharp becomes agitated.

Interpreting the case examples

In the aforementioned scenarios, both health care providers engage in routine interactions with their patients. However, in both scenarios, the patients’ communication disorders complicate these routine tasks, resulting in communication breakdowns. Both providers sense that there are problems with communication in the encounters, but the frustrated and irritated reactions of their patients suggest that the providers’ actions were unhelpful. Dr. Smith likely helped too little. She assumed that Mrs. Jones could not communicate, ignored Mrs. Jones’ communication efforts, and continued the examination without adjusting her own communication style. Nurse Pryor, on the contrary, likely helped too much. He assumed that because Mr. Sharp had difficulty speaking, he also needed accommodations to comprehend the language of others, so the nurse spoke louder and slower, which was clearly annoying to Mr. Sharp. Because Nurse Pryor underestimated Mr. Sharp’s abilities, he simplified his own speech far more than his patient needed.

Emphasizing the need for a better way

A growing body of research documents situations such as those described previously. Adults with communication disorders report experiencing major challenges and frustrations during health care encounters because of communication barriers (Burns, Baylor, Dudgeon, Starks, & Yorkston, 2015; Hemsley, Balandin, & Togher, 2008; Morris, Dudgeon, & Yorkston, 2013). People with communication disorders face many barriers in health care, including the fast pace of medical appointments; unfamiliar people, locations, and terminology; complex conversations and documents; erroneous assumptions on the part of health care providers regarding their abilities; and a general lack of knowledge on the part of health care providers with regard to how to interact with this patient population (Fox & Pring, 2005; Kagan & LeBlanc, 2002; Law, Bunning, Byng, Farrelly, & Heyman, 2005; McCooey, Toffolo, & Code, 2000; O’Halloran, Hickson, & Worrall, 2008; Parr, Pound, & Hewitt, 2006). Likely related to these communication barriers, adults with communication disorders experience higher risk for adverse events in health care (Bartlett, Blais, Tamblyn, Clermont, & MacGibbon, 2008) and lower satisfaction with the health care services they receive (Hoffman et al., 2005). In the aforementioned scenarios, both Dr. Smith and Nurse Pryor, attempt to deliver the best care for their patients in challenging circumstances. However, even with the best of intentions, they helped too much, too little, or in the wrong way when communicating with their patients. What would be a better way?

This article explores Communication Accommodation Theory (CAT; Giles, 1979) as a guide for helping health care providers utilize appropriate accommodations to meet the communication needs of their patients with communication disorders during medical interactions. Extending the two aforementioned case examples, appropriate accommodations for these patients with aphasia and dysarthria are suggested and discussed. A secondary goal of the article is to provide a

resource for speech–language pathologists and other professionals who are preparing in-service trainings and other instruction to their health care colleagues on this topic.

CAT AS A GUIDE

Originally developed by Giles in the 1970s (Giles, 1979), CAT posits that individuals often adjust, or accommodate, their communication on the basis of assumptions about people with whom they are speaking and the context in which communication takes place (Giles & Ogay, 2007; Williams, 1999). According to CAT, the accommodations people make serve to improve the effectiveness of their communication (Ylance, 2008). Communication Accommodation Theory offers an explanation as to why the same individual may use different vocabulary, intonation, gestures, and other verbal and nonverbal accommodations when communicating with various listeners, based on characteristics such as age, gender, ethnicity, culture, and other characteristics (Baxter & Braithwaite, 2008; Bylund, Peterson, & Cameron, 2012). For example, while giving directions to someone on a noisy street, individuals may raise their voices or use accompanying gestures (e.g., pointing to a landmark down the street) to get a point across.

Communication accommodations occur routinely during medical interactions when patients do not have communication disorders. For example, physicians may describe the purpose of medications and potential side effects to their patients in lay language rather than in complex medical terminology to increase their understanding. Another example would be a bilingual nurse who converses with patients in their primary language to determine whether they are experiencing any pain or discomfort. In these examples, the health care providers accommodate their communication styles to find the “best fit” in meeting the communication needs of their individual patients.

This theory also can be applied to making informed decisions about the different or ad-

ditional accommodations that may be needed for successful and appropriate communication during medical interactions involving patients with communication disorders. As illustrated in the two aforementioned case examples, health care providers may struggle with identifying and using the type and amount of communication accommodations that represent the “best fit” for these patients (Burns et al., 2015). This article provides information about how to do so.

Overaccommodation and underaccommodation

Problems with communication often occur when individuals make accommodations on the basis of inappropriate stereotypes or assumptions about their communication partners (Gallois, Ogay, & Giles, 2005). In this way, uninformed accommodations can “miss the mark.” During medical interactions with elderly patients, health care providers may speak louder than usual, assuming that the patients are experiencing hearing loss because of their age—even if this is not the case. This type of overaccommodation occurs when health care providers modify their communication style without thinking and without establishing whether such accommodations are needed by the patient (i.e., providing more help than is needed).

Conversely, underaccommodations can occur when individuals do not recognize the need for accommodations or do not know which accommodations may be helpful for individuals, and thus, they fail to change how they communicate when changes are necessary (i.e., offering insufficient help) (Worrall & Hickson, 2003; Ylance, 2008). For example, a health care provider asking a routine question such as, “How are you today?” to a patient with a known difficulty retrieving words (as is common with aphasia) serves as an underaccommodation if the patient struggles to answer this type of open-ended question. A better approach would be to find out how a patient best communicates (to avoid making inappropriate assumptions) and then

ask questions in a way he or she can actually answer.

As noted previously, over- or underaccommodation can occur for a variety of reasons, including a lack of awareness when accommodations are needed, lack of knowledge about particular communication disorders and which accommodations are most appropriate for them (Williams, 1999), or lack of knowledge about a particular patient's preferences. If health care providers, such as those in the two aforementioned case examples, do not understand the characteristics of a patient's communication disorder and have not asked about that patient's communication preferences, they may adjust their communication style in an inappropriate or offensive way. Such was the problem in these two case examples.

Choosing appropriate accommodations begins with recognizing one's biases and the possibility that preliminary assumptions may or may not be correct. For example, incorrectly assuming that patients with significant speech, language, or hearing disorders do not possess the cognitive capacity to engage in health care conversations and decisions might lead health care providers to overaccommodate these patients by speaking to their family members instead of the patients themselves. Similarly, health care providers may incorrectly assume that one set of communication accommodations will work with all patients, regardless of their respective communication disorder diagnoses. This could lead to inappropriate use of under- or overaccommodations. Successful accommodations require a two-way exchange, in which communication is brought to the forefront as a topic of concern, and all involved parties agree to signal communication breakdowns and to adjust accordingly when they occur.

In the cases of Mrs. Jones and Mr. Sharp, the patients indicated their frustration and irritation that the accommodations attempted by their providers were not appropriate. However, their communication disorders prevented them from effectively communicating which accommodations might be most appro-

priate, and the providers did not know how to "read" their patients' frustrations, nor consequently were unable to adjust their communication behaviors effectively. If the health care providers had raised the topic of wanting to be sure everyone understood each other, and if they had modeled different options and asked for input or preferences, and if they had not been afraid to signal communication breakdowns, the interaction may have been more effective.

COMMUNICATION TRAINING FOR HEALTH CARE PROVIDERS

Effective communication between patients and their health care providers is referred to as *patient-provider communication*. Effective patient-provider communication can contribute to positive health outcomes for patients and improved quality of health care experiences (Baile et al., 2000; Egnew, Mauksch, Greer, & Farber, 2004; Fallowfield et al., 2002; Hemsley & Balandin, 2014; Lipkin, 2010; Makary & Daniel, 2016; Thompson, Dorsey, Miller, & Parrott, 2003). Consequently, training programs in medicine and many other health care disciplines (e.g., nursing, rehabilitation professions) now include content related to improving patient-provider communication. Research suggests that receiving formalized instruction in patient-provider communication can improve communication during medical interactions between health care providers and their patients (Back et al., 2007; Bowyer et al., 2010; Losh et al., 2005; Tulsky, 2005).

A tale of two frameworks

Frameworks developed to represent key components of patient-provider communication can provide a structured way for health care trainees and practicing providers to learn how to communicate more effectively with their patients (Baile et al., 2000; Bowyer et al., 2010; Makoul, 2001). One common patient-provider communication framework, termed *SEGUE* uses the acronym to represent steps in a systematic process for organizing

communication during a typical medical encounter (Makoul, 2001). The steps are intended to apply to all patients in health care and are aimed at (a) seeking patients' viewpoints regarding history, symptoms, and preferences for care; (b) informing patients fully of diagnoses and treatment options; and (c) working together with patients to develop a plan of care that best meets their needs. The steps are described in this section that follows as they are typically implemented.

Then a second framework, called *FRAME*, is introduced. *FRAME* can be overlaid on the *SEGUE* model, which is already familiar to most health care providers, to serve as a tool for building awareness of risks of over- and underaccommodation associated with each of the *SEGUE* steps. Specific accommodations for people with aphasia and dysarthria using this *FRAME*work are described in greater detail in a later section of this article.

The SEGUE framework

Set the stage: The first step in the *SEGUE* process involves greeting the patient and setting the agenda for the interaction. Goals for this step include establishing rapport with the patient, getting a sense of the patient's concerns, and informing the patient of what to expect during the medical interaction. Providers are often taught to establish rapport with a brief social interaction before steering the conversation toward setting the agenda. To accomplish this, providers may ask patients about their interests, or engage in brief social "small talk" before they set an agenda for the encounter.

Elicit information: Providers typically need to obtain information from their patients during medical interactions (e.g., the patient's history, symptoms, questions, and concerns). This step of the *SEGUE* framework teaches providers to ask patients open-ended questions and give patients the opportunity to provide information without interruption and without the use of leading questions.

Give information: The goal for this step of the *SEGUE* process involves providers educating their patients, including explaining diagnoses and treatment options and the advan-

tages and disadvantages of each option. This information can quickly become complex and difficult to follow, even for patients who do not have communication disorders.

Understand the patient's perspective: This *SEGUE* step involves providers soliciting patients' perspectives on any presented information (e.g., diagnostic and treatment information). Providers may pose questions such as: "Do you understand this diagnosis? Do you have questions about your diagnosis? Are you in favor (or against) one of the treatment recommendations? If so, why? What concerns or fears do you have?" Providers learn to ask such common questions of their patients in an attempt to understand their patients' perspective and preferences before making decisions about their care.

End the encounter: During the final *SEGUE* step of a medical interaction, providers are taught to ensure that patients understand what has been discussed, that everyone agrees on the next steps (e.g., course of treatment, scheduling future appointments), and that no other pressing problems need to be discussed before the interaction ends. During this step, providers attempt to clear up any possible confusion or frustration that has arisen from communication breakdowns so that patients understand and agree to follow the plan of care.

"FRAME"ing conversations

Most patient-provider communication frameworks have an inherent limitation of assuming that patients are typical communicators. Communication skills training across health care disciplines rarely includes content and instruction for accommodating the communication needs of patients with significant speech, language, cognitive, or hearing impairments (Yorkston, Baylor, Burns, Morris, & McNalley, 2015). Lack of education regarding effective ways to communicate with these patients can create a potential gap, which can lead to subsequent communication breakdowns with these patients.

The presence of communication disorders can potentially interfere with patient-provider communication at each step of

the SEGUE framework (Bartlett et al., 2008; Duggan, Bradshaw, Carroll, Rattigan, & Altman, 2009; Ziviani, Lennox, Allison, Lyons, & Del Mar, 2004). For example, providers attempting to *set the stage* may avoid initial conversations to establish rapport with patients with communication disorders if communication is difficult. Additionally, *eliciting information* from these patients through open-ended questions may not be effective for patients who are limited to providing one-to-two word responses. Another problem is that patients with auditory comprehension difficulties may fail to understand when providers *give information* about medical diagnoses or treatment options. These are just a few examples of how communication disorders may influence typical use of the SEGUE steps.

The outcome of over- or underaccommodation of communication needs is that patients with communication disorders may express frustration with being ignored or not being included in making medical decisions about their care. In a 2015 study by Burns and colleagues, individuals with aphasia participated in qualitative interviews exploring their experiences with communication during medical interactions. Participants with aphasia discussed their desire to retain an active role in participating in conversations and in making decisions about their health care, but being offered limited opportunities to do so during medical interactions (Burns et al., 2015). Physicians interviewed as part of the same study also reported experiencing frustration; they discussed wanting to provide quality care and good communication with their patients, but not knowing how to accomplish this in the presence of communication disorders. This diminished communication can result in a lack of connection between the provider and the patient and can negatively impact the patient-provider relationship (Baile et al., 2000; Kennedy Sheldon, 2005; Yorkston et al., 2015).

In response to this potential gap in training and the negative impact communica-

tion disorders can have on medical interactions, new patient-provider communication frameworks have been introduced to supply health care providers with the means to appropriately accommodate the communication needs of these patients (Cameron et al., 2015; Legg, Young, & Bryer, 2005; Saldert, Forsgren, & Hartelius, 2016; Simmons-Mackie et al., 2007; Sorin-Peters, McGilton, & Rochon, 2010; Welsh & Szabo, 2011). Burns and colleagues developed one such framework, which uses the acronym FRAME (Burns, Baylor, Morris, McNalley, & Yorkston, 2012; Yorkston et al., 2015). As outlined in Table 1, FRAME can serve as a mnemonic device for helping health care providers learn and remember basic principles to incorporate informed strategies into medical interactions to accommodate the communication needs of patients across a variety of communication disorders.

Strategies that make up FRAME include taking the time to learn how the patient best communicates before starting a medical interview or examination, being mindful that patients with communication disorders often need to communicate at a slower pace, being willing to try different communication strategies and modalities (e.g., writing, pointing to pictures, selecting messages on communication devices), and continuing to show respect for patients as individuals by engaging with him or her directly versus with their family member or caregiver (Burns et al., 2012). FRAME supplements (rather than replaces) existing patient-provider communication frameworks, such as the SEGUE. It includes accommodation strategies to assist health care providers with accomplishing the steps in a typical medical encounter when their patients have communication disorders.

“FRAME”ING ACCOMMODATIONS FOR PATIENTS WITH APHASIA AND DYSARTHRIA

Although the FRAME components outline some general communication strategies

Table 1. The FRAME mnemonic for accommodating communication disorders

	Key Principle	Example Strategies
F	Familiarize with how the patient communicates before starting medical interview	Find out whether patient already has a reliable and preferred communication method.
R	Reduce Rate: Slow down!	Pause between phrases, one idea at a time, allow more time for patient to respond.
A	Assist with communication: Actively help the patient with communication	Ask questions in a different way to help patient understand (e.g., multiple choice; yes/no).
M	Mix communication methods: Show, do not tell	Keep a small white board/pad of paper handy to write key words or draw. Use pictures, alphabet boards, gestures.
E	Engage the patient first: Respect each patient's abilities and autonomy	Communicate directly with the patient. Do not ignore patient and talk only to family/caregivers.

Note. Adapted from "Medical education: Preparing professionals to enhance communication access in healthcare settings," by K. Yorkston, C. Baylor, M. Burns, M. Morris, & T. McNalley, in S. Blackstone, D. Beukelman, & K. Yorkston (Eds.), *Patient-Provider Communication: Roles for Speech-Language Pathologists and Other Health Care Professionals* (p. 55), 2015, San Diego, CA: Plural Publishing, Inc. Copyright 2015 by Plural Publishing, Inc. Adapted with permission.

to use with patients across communication disorders, some disorders also require the use of specific strategies to accommodate patients' communication needs successfully. This section presents reviews how accommodations needs may differ for individuals with aphasia and dysarthria.

Communication disorders differ in their nature and characteristics both across and within conditions of neurogenic disorders that affect language, as aphasia does, and speech production, as dysarthria does. For example, patients with aphasia (such as Mrs. Jones) may have difficulty understanding questions asked by their health care providers or in finding words and formulating responses, whereas patients with dysarthria (such as Mr. Sharp) may easily understand their providers' questions but have difficulty with producing intelligible verbal responses. In addition, patients may exhibit differing degrees of severity of the same communication disorders. For example, Mrs. Jones' difficulties with word retrieval may be more severe than another patient with aphasia in the same hos-

pital who only occasionally struggles to find words when speaking. As another example, Mr. Sharp's level of motor speech impairment may require him to have access to an alternative for natural speech, whereas another patient with dysarthria might be intelligible if the pace is slowed and first-letter cues are used to augment the message.

Thus, whereas successful accommodations often can be based on general FRAME principles and strategies, the specific strategies used with each patient may differ depending on the strengths and weaknesses of the individual's unique communication abilities. Mrs. Jones may need her providers to slow down and use key word writing for key points to help her understand, whereas Mr. Sharp may be fine with providers speaking at a typical pace but may need to use an alphabet board to spell out words to produce an understandable response.

Table 2 summarizes characteristics of aphasia and dysarthria exhibited by our two example cases. This table admittedly oversimplifies the descriptions of these two

Table 2. Comparison of key communication characteristics for aphasia, as exhibited by Mrs. Jones, and dysarthria, as exhibited by Mr. Sharp, in the two example patient cases

	Mrs. Jones: Aphasia Due to Stroke^a	Mr. Sharp: Dysarthria Due to ALS^a
Definition of disorder	Language impairment affecting ability to encode and decode language to varying degrees	Motor speech impairment affecting strength, speed, timing, and coordination of speech muscles to varying degrees
Cognitive abilities (memory, problem-solving)	Intact (unless language is involved in the task)	Intact (unless affected separately)
Hearing acuity	Intact (unless affected separately)	Intact (unless affected separately)
Ability to understand what is said to them	Impaired to varying degrees	Intact (unless affected separately)
Ability to put thoughts into words and sentences	Impaired to varying degrees	Intact formulation; impaired execution
Ability to move speech muscles to produce sounds, words	Intact (unless affected separately)	Impaired to varying degrees
Ability to understand what they read	Impaired to varying degrees	Intact (unless affected separately)
Ability to hold a pen and control muscles for writing	Intact (unless affected by associated hemiplegia)	Not related to speech problems but might be impaired in ALS due to widespread motor impairment

Note. ALS = Amyotrophic Lateral Sclerosis.

^aCommunication characteristics for aphasia and dysarthria summarized in this table represent key distinctions between aphasia and dysarthria; although this table emphasizes the profiles exhibited by the two case examples, individual profiles of actual patients can vary widely.

common communication disorders, and the characteristics listed represent the specific communication strengths and weaknesses these patient case examples exhibit; however, the table highlights how patients with different communication disorders can demonstrate different communication abilities and characteristics, therefore, requiring different communication accommodations.

Using the cases of Mrs. Jones and Mr. Sharp as examples, the following section suggests ways for health care providers to accommodate the communication needs of patients with aphasia and dysarthria during a typical medical encounter. For each condition, each step in the SEGUE, both general FRAME communication strategies and disorder-specific strategies are suggested as appropriate. Typi-

cal over- and underaccommodations for these two common communication disorders also are discussed. Table 3 summarizes the steps of the SEGUE framework and provides examples of commonly used accommodations for patients with aphasia or dysarthria.

Accommodating patients with aphasia

Set the stage

Most patients with aphasia—except the most profoundly impaired—communicate using language to some degree. However, considerable variability exists in the extent to which they can understand and express themselves using language. When setting the stage with Mrs. Jones, Dr. Smith should first get a sense of how well Mrs. Jones understands and

Table 3. Suggested accommodations for aphasia and dysarthria using the SEGUE framework

Title of Step	Goals of Step	Accommodations for Aphasia	Accommodations for Dysarthria
S	Establish rapport with the patient Set the agenda	Take a few moments to learn how the patient best communicates. Does the patient have a communication device? Establish a reliable method for comprehension and expression Allow extra time for the patient to process information and speak	Take a few moments to learn how the patient best communicates. Does the patient have a communication device? Suggest the patient use writing or an alphabet board if the patient's speech is too difficult to understand
E	Obtain health information and concerns from the patient Allow the patient time to talk without interruption	Replace open-ended questions with multiple-choice or other simpler question formats if needed. Encourage patient to use gestures, pictures, writing/drawing to help convey information Verify that you understood the message correctly by summarizing key points	Allow extra time for the patient to speak Let the patient know if you did not understand something that was said Encourage patient to use writing, alphabet board, or other modalities if speech is difficult. Verify that you understood the message correctly by summarizing key points
G	Explain diagnoses Explain treatment options along with pros and cons	Slightly slow your rate of speech and take frequent pauses to allow processing time Supplement what you say with key word writing, diagrams, pictures, and gestures. Verify the patient's understanding and be prepared to repeat or try another way to convey information	Use key word writing, diagrams, and pictures so that the patient has reference material to point to when asking questions or conveying information. Although the patient should understand the conversation, checking frequently for questions and understanding can help the patient more easily ask questions in reference to the immediate topic

(continues)

Table 3. Suggested accommodations for aphasia and dysarthria using the SEGUE framework (Continued)

Title of Step	Goals of Step	Accommodations for Aphasia	Accommodations for Dysarthria
<p>U Understand the patient's perspective</p>	<p>Seek out and acknowledge the patient's preferences for treatment Be respectful of the patient's perspective</p>	<p>Use key word writing and gestures to supplement the patient's words and to help coconstruct the message Verify information intermittently to ensure obtaining the patient's perspective</p>	<p>Allow extra time for the patient to speak Suggest using writing implements or an alphabet board if the patient's speech is too difficult to understand Verify understanding of the patient's viewpoint</p>
<p>E End the encounter</p>	<p>Review the plan/next steps Check if the patient has any other concerns</p>	<p>Use verbal/written time markers (e.g., "First, we . . . , then, we . . . , finally, we . . .") to review what happened and next steps Provide simplified, "aphasia-friendly" written information for the patient to take home for instructions and education Recognize that all targeted tasks may not be completed in the session because of extra time required for communication. Plan for additional visits.</p>	<p>Allow extra time for patient to speak Provide written information for the patient to take home to help the patient in communicating with family about the medical visit Recognize that all targeted tasks may not be completed in the session because of extra time required for communication. Plan for additional visits.</p>

Note. SEGUE framework information adapted from "The SEGUE framework for teaching and assessing communication skills," by G. Makoul, 2001, *Patient Education and Counseling*, 45(1), pp. 32-33. Copyright 2001 by Elsevier.

expresses spoken language, as well as Mrs. Jones' preferred methods for communicating.

Dr. Smith should initially attempt to gauge Mrs. Jones' comprehension skills. At the point in the communication exchange where Dr. Smith realized that Mrs. Jones might not understand her, it was appropriate to ask, "Do you understand me?" At this point, however, Dr. Smith should have recognized that she would need to familiarize herself with Mrs. Jones' communication abilities before continuing the consultation. To demonstrate her respect, she could have used mixed methods, including gesture and slow, simple instructions, to indicate that she was going to ask some questions to check Mrs. Jones' understanding. To do this, Dr. Smith might then ask a series of simple yes/no questions to which the answer could be known (e.g., "Is your name Nancy?" "Is your birthday in May?"). Alternatively, she might provide an opportunity for Mrs. Jones to demonstrate her comprehension by following simple directions (e.g., "Would you show me how you write your name?"). Dr. Smith should also be careful to avoid using gestures when trying to judge language comprehension. For example, she should wait for Mrs. Jones to look for a pad and pencil in response to the question about writing her name and be careful not to offer writing materials prematurely. Dr. Smith also should avoid using orientation questions (e.g., "Are you in the hospital?") to evaluate Mrs. Jones's comprehension at this point, because her patient may comprehend the question but answer incorrectly if she is not oriented to place or time. Asking, "Can you understand me?" presents similar difficulties because Mrs. Jones could recognize it as a yes/no question and respond "yes," even though "no" would be more accurate (a common behavior with aphasia). The value in asking "Can you understand me?" is that it raises awareness in the room that comprehension might be a problem, and Dr. Smith is going to take that into consideration, but exploration should not stop there.

A brief evaluation of Mrs. Jones' comprehension could establish that she likely would benefit from Dr. Smith using accommodations

to help support her comprehension during a medical interaction. For example, Mrs. Jones' comprehension might improve if Dr. Smith paired her verbal communication with visual information such as gestures or other meaningful body language, pictures, and written key words and phrases. If Mrs. Jones does not understand the meaning of the spoken message, she may be able to use this added mixed-modality information as an accommodation to help with comprehension. Dr. Smith should also attempt to gather information about Mrs. Jones' preferences in the process of conducting this small evaluation of her communication skills and preferences.

In this case example, it should also be clear to Dr. Smith that Mrs. Jones is struggling to express herself. If Dr. Smith intersperses simple Wh-questions with yes/no questions (e.g., "Did you ever have any pets?" "What kind?"), it may be easier to judge whether questions were actually understood. By asking for verbal responses beyond "yes" and "no," it is also possible to observe the degree to which language expression may be affected as well as comprehension, indicating possible need for Dr. Smith to provide support in this area as well.

During this step in the medical encounter, Dr. Smith needs to establish a reliable method of communication for Mrs. Jones to express herself. Appropriate accommodations for facilitating Mrs. Jones's expressive communication may include asking questions that require shorter responses or providing an array of choices from which Mrs. Jones can choose. One approach to facilitating improved communication during conversation in individuals with severe aphasia is the Written Choice Communication Strategy (Garrett, 1993). Written Choice involves communication partners providing written choices from which individuals with aphasia can choose when they are unable to verbalize a response to a question (Lasker, Hux, Garrett, Moncrief, & Eischeid, 1997). Although Mrs. Smith's aphasia is not severe, Dr. Smith could attempt to employ this technique in an effort to reduce the communication burden on her patient. Dr. Smith

should also encourage Mrs. Jones to point or use meaningful gestures when communicating if appropriate. Because Mrs. Jones' verbal expression in writing may be impacted similarly to her verbal expression when talking, writing may or may not be an option for her to use for communication. After asking her to write her name, which could be automatic, Dr. Smith might ask her to write the name of her favorite beverage. Any categorically appropriate response would be acceptable and could provide information about Mrs. Jones' verbal abilities in writing. If Mrs. Jones does not appear to comprehend the request, Dr. Smith could rephrase it as, "What is your favorite drink?" [Note that the key word comes last in these questions.] If that is still a problem, Dr. Smith could draw a cup of coffee and use a combination of words and gestures to convey "I like coffee. What do you like?" while handing the pen back to Mrs. Jones. This mini examination process involves starting at a level that requires language comprehension and expression skills in the absence of nonverbal supports to judge whether that is possible, then simplifying the verbal message, and later, introducing nonverbal supports in the form of pictures or gestures to identify the types of supports that may work best for Mrs. Jones.

Overaccommodation: Overaccommodation can be avoided by starting with higher language levels and only moving to simpler ones if the need is clear. In this example, if Mrs. Jones understands up to a few words at a time, Dr. Smith should avoid oversimplifying her messages to only a single word or switching from speaking to using only gestures or writing to communicate. Mrs. Jones might perceive this as condescending. Furthermore, if Mrs. Jones answers multiple-choice questions consistently and the doctor asks only yes/no questions, the inefficiency of that method can begin to frustrate the patient. Finally, Dr. Smith should avoid talking in an exaggeratedly slow rate or using a patronizing "baby talk" tone of voice, both of which can be condescending and would likely offend Mrs. Jones. It is possible to use somewhat slower speech, with clear phrasing and uncomplicated syn-

tax, while maintaining a conversational, adult tone.

Underaccommodation: Underaccommodating someone with aphasia may involve sole reliance on using verbal communication without checking for the patient's comprehension. If Mrs. Jones struggles to understand Dr. Smith's questions, the doctor needs to recognize that a brief assessment should be conducted to decide whether accommodations are needed. If Dr. Smith continues to speak at a normal rate without slowing her own rate of speech or allowing Mrs. Jones sufficient time to respond, she would be underaccommodating her patient's communication needs. Similarly, Mrs. Jones may quickly become frustrated if she struggles to express herself verbally and Dr. Jones provides no other method to communicate responses to questions.

Elicit information

Mrs. Jones likely will struggle to answer open-ended questions often asked during this SEGUE step of a typical medical interactions (e.g., "How can I help you today?"). Dr. Smith appeared to recognize that communication with Mrs. Jones could be a problem, but she did not appear to know how to structure her questions differently to accommodate her patient's communication needs so that she could elicit the information she needed. Asking yes/no and multiple-choice questions may allow Mrs. Jones to more readily respond. Dr. Smith should also consider co-constructing answers to assist Mrs. Jones in responding. Co-construction involves communication partners actively helping scaffold the responses by individuals with aphasia (Hersh, 2015). Communication partners can often employ a multimodal approach (i.e., supplementing verbal communication with other nonverbal methods) as part of co-construction of a message. For example, instead of asking, "How can I help you today?" and waiting for the patient to answer, Dr. Smith may instead use a strategy such as the Written Choice Communication Strategy and ask the question while writing down a few simple options from which Mrs. Jones can choose. These choices may include

a few common responses such as “in pain,” “have a question,” and “need something.” It should also include a null option in case Mrs. Jones is unsure how her doctor can help her (e.g., “not sure”). Dr. Smith should also verify that she has correctly understood Mrs. Jones by repeating or rephrasing her patient’s answers, giving Mrs. Jones the opportunity to confirm that the doctor correctly understood or to signal a communication breakdown.

Overaccommodation: Oversimplification of language can leave patients feeling as if their intellectual abilities are not recognized. As previously stated, Dr. Smith should not confine Mrs. Jones to answering yes/no questions if her patient can provide more extensive answers, or if she needs multiple-choice questions to respond without guessing. In this regard, it is important to keep in mind that different forms of aphasia are associated with different patterns of language comprehension and expression. One person with aphasia can have relative strength in comprehension but extremely limited expression, in which case yes/no questions may be particularly helpful, whereas another person may sound fluent but have difficulty making sense and difficulty comprehending even seemingly simple questions, in which case, yes/no questions may not be helpful, and yet another person with aphasia could have exaggerated difficulty retrieving words but could comprehend language with minor difficulty. This individual might benefit most from multiple-choice questions that could prompt the missing words.

Using too many different communication strategies simultaneously with one individual, however, can also have the effect of overaccommodation. In this case example, Dr. Smith might explore whether it helps Mrs. Jones to pair verbal information with one type of visual cue (e.g., gestures) before attempting others. To avoid overaccommodating Mrs. Jones’ communication and confusing her, Dr. Smith could introduce one type of support and seek information about Mrs. Jones’ preferences, perhaps by observing her facial expressions or asking for feedback, before introducing others. The point would be to

avoid overwhelming Mrs. Jones with simultaneous strategies (e.g., written key words, pictures, drawings) without assessing first whether each is necessary and preferred. Family members or other communication partners present who know Mrs. Jones may also be helpful in providing information on which communication strategies may work best, or cues the patient may be demonstrating (e.g., facial expressions or other body language) that indicate that she is overwhelmed or confused.

Underaccommodation: Continuing to ask only open-ended questions without any necessary communication supports in place represents a common underaccommodation for this step in the SEGUE framework. Mrs. Jones needs to understand Dr. Smith’s questions and have a way to successfully answer them for communication to be effective. In addition, Dr. Smith needs to realize that patients with aphasia require supplemental time to communicate. If Dr. Smith were to maintain a typical pace of conversation (which often indirectly imposes a time pressure for responding) or were to interrupt Mrs. Jones, Dr. Smith would be demonstrating other forms of underaccommodation.

Give information

In the case example, a brief assessment indicates that Mrs. Jones’ aphasia is likely to impact her ability to understand much of the information Dr. Smith wants to impart regarding her pneumonia diagnosis and potential treatment options. Successful accommodations for giving information may include Dr. Smith segmenting or “chunking” information she provides into short, concrete phrases or sentences; presenting information slowly to allow time for Mrs. Jones to process; and presenting the information in more than one modality. For example, Dr. Smith might first say, “Mrs. Jones, you have pneumonia” while also writing down the word “pneumonia” and showing it to her patient. She then might list a few of Mrs. Jones’ symptoms, writing each one down as she says them. When discussing treatment recommendations, Dr. Smith might

say, “Here are some choices for treating your pneumonia” while writing the phrase “treatment choices” and then writing a few options below it. Other appropriate accommodations for this SEGUE step may include Dr. Smith providing pictures to illustrate her talking points as she discusses them, or simply drawing them on a white board. Dr. Smith should also check intermittently that Mrs. Jones is understanding the diagnostic and treatment information presented and inquire whether she has any questions about this information.

Overaccommodation: Dr. Smith could overaccommodate by oversimplifying the diagnostic and treatment information she provides. People often need context to understand information. Simplifying information to the extent that context is removed may leave patients confused. For example, if Dr. Smith were to provide only single words, such as “pneumonia” or “inhaler,” Mrs. Jones might not realize that one is a diagnosis and the other a treatment option. On the contrary, pairing verbal communication with too many nonverbal strategies might overaccommodate what Mrs. Jones actually needs to understand this information.

Underaccommodation: Failing to slow down and simplify her language could result in Dr. Smith underaccommodating her patient’s aphasia. Similarly, if Dr. Smith were to fail to accompany her verbal explanations of the diagnosis or treatment options with another modality of communication (e.g., written list or pictures of the options), Mrs. Jones might be unable to comprehend this important information.

Understand the patient’s perspective

During this step in the SEGUE process, Dr. Smith should ensure that Mrs. Jones has the accommodations she needs to provide her perspective and ask questions about presented information. Dr. Smith needs first to verify that Mrs. Jones has understood any information presented to her. Dr. Smith also needs to ensure that she has understood Mrs. Jones’ perspective and answered any questions asked in response to this information.

Dr. Smith can do this using the accommodations for Mrs. Jones’ comprehension and expression identified during previous steps in the SEGUE process. In addition, Dr. Smith needs to realize that communication may be effortful and slow for her patient with aphasia. Consequently, Mrs. Jones may choose not to persist in getting the exact nuance of her message conveyed because it is too tiring, difficult, or takes too much time. She also may not ask questions for these same reasons. Dr. Smith needs to continue to assist her patient with both constructing responses and asking questions to ensure obtaining Mrs. Jones’ full and accurate perspectives.

Overaccommodation: Dr. Smith should avoid interrupting her patient and “jumping-in” too soon to help Mrs. Jones communicate, which are forms of overaccommodation. As Mrs. Jones attempts to communicate, Dr. Smith should allow extra time as part of her assessment of what Mrs. Jones can communicate on her own. If Dr. Smith only allows Mrs. Jones the opportunity to provide a one-word answer at a time (e.g., consistently asking only yes/no questions), the doctor could interfere with her patient’s autonomy to provide her perspective. Similarly, if Dr. Smith encourages Mrs. Jones to pair her verbal communication with a strategy that allows for too narrow of a response (e.g., providing only two choices on a topic in which there are many more available options) or pairing too many strategies at once, the doctor also could limit the autonomy of her patient’s communication through overaccommodation.

Underaccommodation: If Dr. Smith were to fail to provide other options besides verbal communication for Mrs. Jones to express herself after identifying limitations in verbal communication during assessment, this would be a form of underaccommodation. As another example, if Dr. Smith were not to check in periodically to verify the accuracy of Mrs. Jones’ responses to questions, she might not be obtaining the patient’s true perspective or decision about treatment options. The result can be decisions about care that Mrs. Jones did not actually intend or want.

End the encounter

When ending the encounter, Dr. Smith should continue using multimodal communication strategies that are individualized for Mrs. Jones (e.g., pairing verbal with visual communication). Such supports can be used while reviewing information discussed during the medical encounter and for agreeing on next steps (e.g., selected treatment options). Dr. Smith should also provide Mrs. Jones with a simple written summary so that the information covered in the medical session can be reviewed and shared with anyone involved in her care.

Although written summaries of medical visits continue to become commonplace in health care, patients with aphasia may struggle to understand this information. They may also struggle to understand instructions written on medicine bottles, patient education booklets, insurance forms, and other medical documents. Dr. Smith should consider simplifying this type of medical information to make it “aphasia-friendly” for Mrs. Jones so that she can better understand it. Increased comprehension of this medical information can decrease Mrs. Jones’s chances of making errors in following through with treatment (e.g., taking too much or too little medication). Guidelines are available to make written materials “aphasia-friendly” (Berarducci, Cooper, & Giles, 2007; Rose, Worrall, & McKenna, 2003; Worrall et al., 2005). These guidelines include making written sentences short and concrete, adding simple pictures to illustrate what is written, and keeping pages uncluttered.

Overaccommodation: Dr. Smith can overaccommodate Mrs. Jones’ communication needs by oversimplifying her verbal communication or using too many multimodal communication strategies at one time. Overaccommodation may also involve providing oversimplified written information, which is insufficient and consequently less meaningful. In addition, the visual presentation of information is important. Photographs or drawings used should accurately represent the concepts being communicated. Pictures

that are cartoonish or childish in nature may be offensive to adults with aphasia.

Underaccommodation: If Dr. Smith were to summarize the medical encounter orally without any accommodations for Mrs. Jones’ impaired comprehension, that would constitute underaccommodation, particularly if it occurred after learning about Mrs. Jones’ comprehension difficulties. In addition, Dr. Smith would be underaccommodating Mrs. Jones’ aphasia if she were to fail to provide a modified written summary of the medical encounter to improve her patient’s understanding of this important information.

Accommodating patients with dysarthria

Set the stage

Dysarthria is associated with a different set of needs from aphasia. In the case of motor speech disorders, problems arise from speech production and speech intelligibility issues rather than from problems with language comprehension and expression (Hanson & Fager, 2017). Mr. Sharp’s progression of amyotrophic lateral sclerosis has resulted in a significant dysarthria, which limits his speaking. In addition, changes in fine motor skills have resulted in impaired ability to use written communication. However, his language skills and cognition remain intact.

When setting the stage for patient-provider communication, Nurse Pryor needs to ensure that he can understand Mr. Sharp’s speech, or if not, that Mr. Sharp has another way to express himself. Thus, as with Mrs. Jones, an appropriate patient accommodation for this step in the SEGUE process would be taking a few minutes for Nurse Pryor to explain that he would like to learn how Mr. Sharp communicates best, as well as his communication preferences to be sure that they are communicating effectively. This could include verifying that it is acceptable to Mr. Sharp if Nurse Pryor is honest about occasions when he is uncertain what Mr. Sharp said.

Because Mr. Sharp’s speech is difficult to understand, he typically uses a digitized

augmentative and alternative communication device with which he composes messages to create computer-generated speech. When patients use such strategies and technological supports, providers should invite and encourage their use during the interaction. However, because Mr. Sharp's device is not functioning properly, Nurse Pryor should make other materials and methods available for his patient to express himself. Because Mr. Sharp's motor abilities interfere with his ability to write without his device, Nurse Pryor can ask him to point instead to make choices from a written list of options or from a picture or letter board. For example, Mr. Sharp might prefer to spell what he is trying to say by pointing to letters on an alphabet board or by pointing to the first letter of each word as he attempts to say it to make the word more intelligible. Encouraging Mr. Sharp to gesture as appropriate may also augment the clarity of his communication. Once Nurse Pryor has established a reliable method of communication for his patient, he needs to let Mr. Sharp know the reason for this medical interaction (e.g., to record Mr. Sharp's vitals).

Overaccommodation: Because Mr. Sharp's language and cognition skills are intact, Nurse Pryor should avoid oversimplifying communication with his patient. For example, limiting questions to yes/no when Mr. Sharp is cognitively and linguistically capable of communicating more in-depth information would likely frustrate the patient and be viewed as patronizing. Mr. Sharp's communication difficulties lie in his verbal expression, not his comprehension. If he has access to supported communication options that he is physically able to navigate, Mr. Sharp should be able to communicate answers to Nurse Pryor's questions, including much more complex responses than yes and no.

Underaccommodation: Mr. Sharp likely needs extra time to communicate effectively whether he chooses to use his natural speech, perhaps augmented by pointing to first letters on an alphabet board, his speech-generating device, or other spelling methods. In any case, Nurse Pryor needs to allow his patient

supplemental time both to answer questions and communicate information. If Mr. Sharp is rushed, or even perceives being rushed (e.g., if Nurse Pryor continues to communicate at a typical pace of conversation), he may be less successful with communication during the interaction.

Elicit information

When eliciting information from Mr. Sharp, Nurse Pryor again needs to recognize that although his patient cannot produce intelligible speech, this impairment does not affect his ability to comprehend others' messages or to formulate independent thoughts into language. Nurse Pryor needs to ensure that Mr. Sharp has a successful and efficient means to respond to questions, but motor speech disorders, unless part of more extensive problems, do not interfere with comprehension. The best accommodation for Mr. Sharp likely would be to figure out what is wrong with and to repair his speech-generating augmentative and alternative communication device so that he can use it. For example, the problem could be as simple as charging the battery. Until then, when Mr. Sharp attempts to speak, Nurse Pryor should allow him extra time to respond. If nurse Pryor does not understand what his patient says, or perhaps understands only part of the message, he should let Mr. Sharp know, so an attempt can be made to repeat what was not understood, assuming they have agreed on this strategy.

Nurse Pryor also should explore alternate ways for Mr. Sharp to express himself, who may be able to convey his own preferences. For example, Mr. Sharp may prefer to use an alphabet board for spelling messages to be able to produce unique messages even though they take longer. If Mr. Sharp's diminished motor skills do not allow him to use nonverbal pointing to access written communication, Nurse Pryor might need to instead implement a simple partner-assisted scanning strategy. Partner-assisted scanning involves the communication partner systematically pointing or verbalizing various choices available to the individual with the communication

disorder who is watching and provides a signal (e.g., movement, vocalization) when the correct choice is identified (Costello, Patak, & Pritchard, 2010). For example, Nurse Pryor may systematically point to letters on the alphabet board and instruct Mr. Sharp to watch and vocalize when the correct letter has been identified. Once received, Nurse Pryor's verification of Mr. Sharp's message is critical. Nurse Pryor should repeat or write down what he understands of Mr. Sharp's verbal message as it is generated so that Mr. Sharp can confirm the message or signal misunderstandings.

Overaccommodation: Nurse Pryor needs to provide an opportunity for Mr. Sharp to communicate at the level of complexity that matches his capabilities. Restricting Mr. Sharp's communication to answering only yes/no questions instead of options that allow him to communicate more specific and detailed information, such as selecting from a list of written choices or using partner-assisted scanning techniques to spell words to generate messages, can quickly result in overaccommodating the patient's communication needs. Offering Mr. Sharp access to other means for producing original verbal messages, but which do not require him to speak, can allow him more freedom and autonomy to communicate on a specific topic without having to wait for Nurse Pryor to ask the right yes/no question.

Underaccommodation: Providers often fail to verify the information patients with dysarthria provide when their speech is difficult to understand. When nurse Pryor does not understand something that Mr. Sharp communicates (verbal or nonverbal), either pretending to understand or failing to verify the information would be an underaccommodation. This type of underaccommodation can be common when providers are communicating with patients with dysarthria and can cause significant communication breakdowns. It may also frustrate the patient. Nurse Pryor should raise this concern explicitly when setting the stage with Mr. Sharp, both to ensure that he understands what Mr. Sharp is trying to communicate, no matter what form

that communication takes, and that he and Mr. Sharp agree on what nurse Pryor should do if he is unsure about understanding a message.

Give information

Unlike patients with aphasia, such as Mrs. Jones, Mr. Sharp's dysarthria does not preclude him from understanding information conveyed by his health care provider. Assuming that Mr. Sharp exhibits no other communication disorders (e.g., a co-occurring cognitive-communication disorder or a hearing impairment), few accommodations should be needed when nurse Pryor provides this verbal information to his patient. Even so, patients may be challenged to grasp information in medical consultations whether or not they have communication disorders. Some common strategies that may help support any patient's comprehension during this step in the SEGUE process include writing down key words or using related pictures or drawings that relate to the content information. Providers also should frequently check whether patients understand the information being presented or whether they have questions. Nurse Pryor should be prepared to support Mr. Sharp with previously discussed accommodations should the patient have any questions or decide to comment on this information.

Overaccommodation: Common overaccommodations stem from assumptions that, because patients with dysarthria have difficulty speaking, they likely cannot hear or understand information presented to them either. Consequently, providers may speak loudly or with overly slowed and simplified speech. Such overaccommodations are not necessary and can be demeaning to patients. Nurse Pryor should ensure that he speaks to Mr. Sharp using a typical volume and avoiding oversimplification or exaggeration of the information presented.

Underaccommodation: Knowing that Mr. Sharp struggles to produce speech, nurse Pryor should anticipate that his patient likely will have difficulty asking questions about

presented information. Underaccommodations for patients with dysarthria during this step in the SEGUE process may include failure to support patients when they try to clarify information or ask questions. Although Mr. Sharp likely does not need supports to understand the information Nurse Pryor presents, it may be supported by written and other visual information about the topic so that two of them can jointly reference the material as an aid for asking questions and sharing information.

Understand the patient's perspective

During this step of the SEGUE process, providers should ensure that they understand their patients' answers to medical questions as well as their perspective about medical information that has been presented. When patients have communication disorders, this step also reminds providers to check that they understand their patients' perspectives on preferred methods of communication. Although the medical visit in this case example focuses primarily on recording the patient's vital signs, Nurse Pryor may also inquire about other aspects of Mr. Sharp's well-being, such as his current pain level. Whether or not Mr. Sharp indicates he currently is in pain, Nurse Pryor should verify this information to provide appropriate medical services (e.g., administer pain medication). If Nurse Pryor misunderstands his patient's communication, he may inadvertently provide pain medications when they are not needed, or fail to provide medications when the patient needs them. One way Nurse Pryor can ensure that he understands his patient is to support Mr. Sharp's verbal communication with the same supportive strategies that were identified as methods Mr. Sharp prefers during the medical interaction (e.g., written choices, pictures, alphabet board). Nurse Pryor also should allow extra time for his patient to formulate responses to questions.

Overaccommodation: Nurse Pryor needs to avoid responding too soon and guessing information while his patient actively attempts to communicate. Providing more help than

Mr. Sharp requires or prefers for expressing his opinions and answering questions is a common overaccommodation when interacting with patients with dysarthria. In addition, having Mr. Sharp change to using alternative methods of verbal communication when his speech is somewhat intelligible may also be overaccommodating his needs. Instead, providing augmented methods as needed to supplement Mr. Sharp's speech to augment its intelligibility would be an appropriate level of accommodation.

Underaccommodation: Expecting Mr. Sharp to use only natural speech communication to answer questions and provide information when Nurse Pryor knows he struggles to produce intelligible speech would be an underaccommodation. If Nurse Pryor attempts to have a typically paced conversation, that could impose an implied time pressure on Mr. Sharp to respond and keep up with the conversation. That would be an example of underaccommodating the communication needs of the patient.

End the encounter

Before ending medical interactions, providers should ensure that their patients understand what has been communicated during the interaction and have no further questions or topics to discuss. Nurse Pryor should continue to use established strategies to support Mr. Sharp's verbal communication when checking for his patient's understanding and supporting his patient's ability to ask any remaining questions. Written or other visual information and materials used during the medical interaction (e.g., a written summary of his current vitals) should be provided and given to Mr. Sharp. Having these materials can assist Mr. Sharp in recalling what has been discussed, as well as communicating this information with family and others involved in his care (e.g., staff from his assisted living facility), especially if his dysarthria interferes with relaying this information using natural speech.

Overaccommodation: Overaccommodation during this step in the SEGUE process

might include providing simplified information or materials when the patient does not need or want them. To avoid overaccommodating Mr. Sharp, Nurse Pryor should offer a choice of typical and simplified versions of this information and invite him to choose. Offering a choice can show respect for the patient's autonomy in deciding how to access and use this medical information.

Underaccommodation: Failing to provide any written information or materials to Mr. Sharp would likely underaccommodate his communication needs. If these materials are not provided, Mr. Sharp may struggle to communicate important medical information discussed during this interaction with family members or others involved in his care.

INCLUDING FAMILIES AND CARERS IN MEDICAL INTERACTIONS

This article has focused primarily on how health care providers can accommodate the communication needs of their patients with the communication disorders as if they were alone. In most situations, however, family members or other carers are present in medical consultations. Research confirms that they often are actively involved in medical interactions involving patients with communication disorders (Burns et al., 2015; Karnieli-Miller, Werner, Neufeld-Kroszynski, & Eidelman, 2012). The resulting dynamic can present unique communication challenges for health care providers. On one hand, family members typically know the patients well and can serve as a valuable resource to providers by relaying information too difficult for the patient to communicate. On the other hand, the presence of family members can increase the likelihood of providers focusing on communicating with them, to the exclusion of the patient (Burns et al., 2015; Hemsley & Balandin, 2004; Laidsaar-Powell et al., 2013).

Providers can navigate situations in which others are involved in several ways. In any case, providers should address patients first and ask permission to include family members or other carers in the conversation. Providers

should also have patients verify any information presented by family members and vigilantly check whether patients have anything to add to the conversation. Providers should also ask family members to facilitate communication with the patients rather than answering themselves. Family members often can provide examples of strategies that work to improve the patients' comprehension and expression abilities. Family members may also assist with augmentative and alternative communication devices by advanced programming of relevant vocabulary, adding pictures to a communication notebook, or helping document the medical interaction by taking written notes or recording the provider's verbal explanations. Providers need to be cautious not to overaccommodate the patients' communication needs by interacting solely with family members, excluding the patients from the conversation, but they also need to avoid underaccommodating the patients' communication needs by excluding family members from the conversation when they could provide valuable communication support.

RESOURCES FOR ACCOMMODATING PATIENTS WITH COMMUNICATION DISORDERS

The suggested accommodations presented in this article provide some initial ideas for health care providers. They should not be viewed as an exhaustive list of strategies to use with patients with communication disorders. Providers should focus on tailoring the accommodations they choose to the individual characteristics and preferences of their patients with communication disorders. Several resources exist that can assist providers in selecting and implementing appropriate accommodations for their patients.

Speech-language pathologists can assist providers in selecting and implementing appropriate accommodations when interacting with patients with communication disorders and their families. These professionals receive training in aphasia and dysarthria, as well as

understanding the impact communication disorders can have on medical interactions. They also learn how to accommodate communication breakdowns between providers and their patients and many specialize in preparing patients with communication disorders and their family members to navigate future medical encounters. Interprofessional practice is a movement that encourages professionals with diverse preparation to reach out to their speech-language pathology colleagues for consultation and referral regarding how best to communicate with patients who have communication disorders (Blackstone, 2015). Speech-language pathologists can help identify and demonstrate appropriate strategies that providers can use to accommodate the communication needs of individual patients with communication disorders.

Practical online and text resources also have emerged to assist professionals in selecting and implementing appropriate accommodations for patients with communication disorders. One Web site, www.patientprovidercommunication.org, summarizes current research on accommodating the needs of patients with communication disorders and provides ideas for accommodating different communication disorders, as well as printable resource materials for implementing these accommodations. Blackstone, Beukeman, and Yorkston (2015) also published *Patient Provider Communication: Roles of Speech-Language Pathologists and Other Health Care Professionals*, a text that provides suggestions for accommodations to be implemented across medical settings for these patients.

Implementing communication accommodations and strategies may be simpler than it may seem, and it typically requires few resource materials. Most materials that are required are inexpensive, readily accessible, and portable. These materials could be easily stocked in patient examination rooms, such as paper, pens and markers, dry erase boards, and pictures. Alphabet boards should also be available. They can be printed quite easily from online sources or they could be created

in moments using a pen and a piece of paper. Providers can also create picture boards relevant to their medical practice or specialty by downloading and compiling images, laminating the pages to have picture references readily available for use with patients. The key is having these resources nearby and readily available during medical interactions. Office staff often can assist providers in readying these materials. Student volunteers could also be engaged in developing support materials for consultation rooms as a meaningful and instructional activity.

SUMMARY

Health care providers often struggle to communicate effectively with patients with communication disorders, such as aphasia and dysarthria. Providers need to learn to identify and implement appropriate accommodations to meet the communication needs of these patients and avoid communication breakdowns. Selection of appropriate accommodations can help providers share information and obtain the information necessary to provide quality health care for their patients with communication disorders. When selecting appropriate accommodations, providers need to check the assumptions they make about the communication abilities of these patients that typically influence their interactions. Providers should not assume that patients with speech, language, or hearing impairments cannot provide health-related information or participate in discussions about their health care. With appropriate accommodations, many of these patients are quite capable, and highly motivated, to engage in these discussions and generally in medical interactions. However, while some strategies can provide general accommodations across communication disorders, as discussed here related to FRAME, accommodations should always be individualized on the basis of the communication needs of each patient.

Importantly, providers should know that sometimes accommodations do not work, no matter how appropriate they seem or

how many different strategies have been attempted. Some patients exhibit communication disorders so severe that they cannot participate enough in medical interactions to provide clear information or take full responsibility for making decisions about their health care. This, however, does not absolve health care providers from needing to explore accommodations to continue including their patients with communication disorders in conversations about their care.

When asked about the challenges health care providers face with communication during medical interactions involving patients with communication disorders, patients and

their families were quick to express their understanding for how difficult it can be to learn the unique communication needs of individual patients (Burns et al., 2015). What these patients and their families seek from their health care providers is awareness when patients are struggling to communicate, willingness to explore accommodations for their communication disorders, and showing respect for the person beyond the disorder. Even if specific communication accommodation strategies fail, patients and families greatly appreciate the respect that providers show to patients when they make genuine attempts to make communication work.

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