Dealing with the Disadvantaged

Communicating with patients with speech problems

JANET THRUSH

Explaining a problem to the doctor depends entirely on the ability to communicate. The person with a speech difficulty is at an obvious disadvantage at a consultation and anything the doctor can do to help will not only save him time in tortuous questioning, but will also save the patient great embarrassment. Speech problems may be divided into those affecting only expressive speech or talking and those involving language in all its forms. Talking may be impaired due to loss of voice, as in laryngectomy; defective articulation, as in Parkinson's disease; or lack of fluency, as in stammering. These patients have no difficulty in understanding and, unless there is an additional handicap, they can always communicate in writing. When language ability is impaired, however, both expression and comprehension of speech are affected, and writing and mime, being dependent on internal language, are unable to provide alternative means of communication. The following suggestions will help the doctor to get the best possible communication with patients with a speech problem and in a further article I will suggest ways to help those who have a language difficulty.

General points

(1) People with all types of speech problem speak better when they are relaxed. Concealing the pressures on your time and spending a few moments making the patient feel at ease save time later when the patient has to talk.

(2) Do not treat speech-handicapped people as if they were mentally deficient; they are not.

(3) People with defective speech are sometimes thought to be drunk or just fooling about, particularly on the telephone. If the receptionist is aware of this, she is less likely to be dismissive on the wrong occasion. If it is very difficult to understand what the patient is saying, it is best to say so tactfully and extract the necessary information by questions which can be answered with "Yes" or "No"—for example, it is no good asking "Can you come on Tuesday or Wednesday?" Each part of a question must be taken separately.

(4) Keep out extraneous noise by shutting doors and windows. Talking is very tiring for speech-handicapped people even without the need to compete with passing cars, and having to repeat usually launches the stammerer into a stammer.

Stammering

It is easy for the fluent speaker to underestimate the amount of courage it takes a severe stammerer to enter any situation where he is totally dependent on his speech. The doctor can help him by remembering the following suggestions.

(1) Maintain personal contact with the speaker even when he is blocking completely. There is no need for this to develop into a staring match, but refrain from shuffling papers, sorting out drawers, and generally making it clear that your attention is elsewhere.

(2) Do not finish sentences for the patient unless he is totally stuck and you are pretty sure you will get it right.

(3) Advice such as "Take a deep breath before you start," "Talk more slowly," is rarely helpful and often irritating.

(4) Some people find it so difficult to confess to having a stammer that they reappear in the surgery on several occasions, making up reasons for their attendance, before they can screw up courage to ask for help. It is difficult to deal with this, but if the doctor is aware that it occurs, the patient is less likely to leave the surgery with yet another bottle of cough medicine, when he really wanted a referral for speech therapy.

(5) Children passing through the normal non-fluency stage at the age of 3 or 4 are sometimes mislabelled stammerers and then live up to the label. Early referral to the speech therapist could avoid this by providing support and reassurance for the parents.

Dysarthria

Dysarthria is a difficulty in articulating or enunciating words. Comprehension is intact.

(1) Resist the temptation to pretend that you have understood when you have not; it rarely saves time in the long run and may be frustrating for the patient.

(2) Do not shout. (Just as people tend to raise their voices when talking to foreigners, they do so with the speech-impaired.)

(3) A reminder to slow down may help. (People with Parkinson's disease find this particularly difficult to remember.)

(4) Do not "talk down"; just because someone cannot speak properly does not mean that he cannot understand. Nursing and remedial staff sometimes need reminding of the irritation caused by the "how are we today?" approach.

(5) Pay attention when the patient is speaking; do not sort through notes etc.

(6) The effort of talking is very tiring. If possible, divide up the consultation by doing the physical examination in the middle.

(7) Ask the patient to write down salient points before a return visit if communication is very difficult; writing may be very time-consuming.

Voice disorders, including laryngectomy

(1) Anticipate when the patient needs to interrupt you and give him chance to do so. Dysphonic patients and those who have undergone laryngectomy often have difficulty in initiating speech, so it is difficult for them to butt in when someone else is talking.

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Br Med J (Clin Res Ed): first published as 10.1136/bmj.282.6266.802 on 7 March 1981. Downloaded from http://www.bmj.com/ on 5 April 2021 by guest. Protected by copyright.

(2) Use lip-reading; watching a patient's lips may give sufficient additional clues to enable you to understand.

(3) Encourage the use of the laryngeal vibrator if the patient has one; patients are sometimes self-conscious about using vibrators in unfamiliar surroundings.

Children

If the child is old enough to be attending the surgery alone then the preceding points will apply, and if he is accompanied by an adult the problem of communication will be circumvented, but a few points are worth making.

(1) Talk to the child wherever possible; because he does not speak clearly does not mean that he does not understand.

(2) The presence of a few toys and a relaxed approach will, with the speech-handicapped as with the normal child, prevent an examination turning into a tussle and future visits to the doctor becoming a cause of nightmares.

(3) Do not feel that a child should not be referred for speech therapy because he is too young or he has no speech at all.

Letter from . . . Chicago

Reading aloud

GEORGE DUNEA

At the beginning of a new presidency we may well reflect on Plato's view that the human race will enjoy no respite from evil until its leaders "become genuine and adequate philosophers, and political power and philosophy are brought together." Yet we may at least enjoy the comforting thought that most of the effective leaders of the past, many of whom have conferred great benefits on humanity, were far from being intellectuals. Few of these successful men of action would have understood the raptures of the literary critic who, in a recent review on Jane Austen, extolled the pleasures of reading aloud as a peaceful enriching way of establishing an atmosphere of intimacy between the author and his readers, with frequent pauses for discussion—"especially on the many nights when there is nothing on TV." And I was vicariously reminded of the rather unkind and undoubtedly apochryphal anecdote about a head of state who after his heart attack was confined to complete bed rest, as was the fashion of the times, while the doctors hovered anxiously over his ailing myocardium, periodically tranquilising the populace with reassuring press releases. After a few days, the time of maximal danger having passed, the patient asked to see the newspapers. The doctors, however, denied his request, fearing he might become too tired from moving his lips.

Achiever facilitator

For those who find the written word less of a challenge, however, Jane Austen remains an ever-present source of delight. Not that the liberated twentieth-century woman would readily agree with the observation that, "a woman, especially if she have the misfortune of knowing anything, should conceal it as well as she can." For, unlike the earlier Hanoverian and Regency ladies, the modern executive woman is so busy pursuing her career that she would be well served by having a "wife" in the home. Unfortunately, as Maryanne Vandervelde points out, only 20% of husbands are of the "non-achiever facilitator" kind, who would do the housework, take care of the children, plan their lives around their successful wives, and readily move if their successful better half had an opportunity of promotion in another city. Leaving out the "non-achiever obstructionists," who amount to less than 5% of husbands, we find that most men, over half, conform to the traditional "achiever obstructionist" pattern; and that less than one-quarter belong to that ideal type, the "achiever facilitator," who helps and encourages his wife, shares the household responsibilities, and is not threatened by her success. Some ambitious women, of course, retain the option of never marrying, getting divorced, or having no children.

But returning to the achiever facilitator who reads aloud with his wife, we find that this blissful couple devoured all of Trollope during one summer and all of Miss Austen during the next. A reference to Sanditon, the fragment finished by Another Lady, from Australia, reminded me of the formidable Lady Denham, who at the age of 70 was still opposed to taking physic and had never consulted a doctor. She was determined that no member of that particular tribe should ever set foot in her beloved seaside resort, for, "it would only be encouraging our servants and the poor to fancy themselves ill"; and even her dear Sir Harry might have stayed alive had he not put himself in the hands of a doctor: "Ten fees, one after another, did the man take who sent him out of this world. I beseech you . . . no doctors here."

Crisis of excess

Echoing Lady Denham's view, some 200 years later, are those alarmed by the predicted surplus of doctors in the US, especially as each new doctor generated an additional $300 000 in expenses to an already overinflated annual medical bill of $256 billion. Yet what in the 'sixties was deemed to be a crisis of access is rapidly becoming a crisis of excess; so that an estimated deficit of 50 000 doctors in the late 'sixties could turn into a projected surplus of as many as 130 000 by the year 2000, with one doctor for 200 people. Already the number of doctors has grown from 320 000 in 1970 to 440 000 last year, with a predicted "inexorable" increment to almost 600 000 by the end of this decade. And, while some shortages may persist in unpopular areas, the overall projection is one of too many doctors engaging in cut-throat competition for patients, with an increased focus on the financial aspects of medicine, practising perhaps at a higher cost per patient visit, with more laboratory tests, more

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