

INCLUSIVE COMMUNICATION IN HEALTHCARE: PERSPECTIVES OF PEOPLE WHO STUTTER AND PROFESSIONALS

Mirosław SKOREK

M.Sc. Eng, Doctoral School in University of Silesia in Katowice

e-mail: miroslaw.skorek@us.edu.pl

ORCID ID: 0009-0001-5873-1936

Justyna SUCHACKA

BA. University of Silesia in Katowice

e-mail: justyna.suchackaa@gmail.com

ORCID ID: 0009-0004-2259-7407

Abstract

Inclusive communication in healthcare is a significant dimension of contemporary social transformation, influencing the quality of relationships between patients and healthcare professionals and the level of equity in access to healthcare services. This study examines the mutual attitudes and communication practices of adults who stutter and healthcare professionals. The study is exploratory and draws on empirical material from 10 individual in-depth interviews conducted between December 2025 and February 2026. The sample selection was purposive and comprised two groups: adults who stutter and representatives of the medical community, including physicians of various specialties, a laboratory diagnostician, and a physiotherapist. Data analysis was conducted according to the principles of thematic analysis. The results indicate that communication relationships between the studied groups are shaped by a complex system of cognitive, emotional, and behavioural attitudes. Healthcare professionals often adopt an overly cautious approach, leading to simplified communication. At the same time, people who stutter report using a variety of adaptive strategies that allow them to function within the healthcare system, although this does not eliminate the experience of communication barriers or subtle forms of stigmatization. The analysis also reveals discrepancies in the assessment of communication competences

between the two sides and indicates insufficient preparation of medical personnel to work with patients with diverse communication needs. The results emphasize the importance of developing inclusive communication competences as part of the professionalization of medical education. Systematic training in this area can help strengthen patients' sense of empowerment and build more collaborative relationships in healthcare.

Keywords: inclusive communication, stuttering, healthcare, thematic analysis, qualitative research, stigmatization.

1. Introduction

Contemporary social transformations encompass processes such as globalization, increasing social mobility, the development of communication technologies, and the growing importance of diversity and inclusivity in public life. These changes also influence the way we perceive health, disability, and communication, shifting the emphasis from a biomedical approach to a more integrated one that incorporates social and cultural perspectives. In this context, reflection on the quality of relationships within the healthcare system, including communication with individuals who function in different linguistic patterns, such as those who stutter, is particularly important.

Stuttering is a multidimensional phenomenon whose significance extends far beyond the observable disruption of speech fluency. Diagnostic classifications such as ICD-11 and DSM-5 define it as a communication disorder involving repetitions, prolongations, and articulatory blocks (ICD-11, 2019). However, contemporary scientific approaches are increasingly moving away from a solely symptomatic understanding of this phenomenon, emphasizing its biopsychosocial nature and interpreting stuttering as a form of verbal neurodiversity (Weidner & St. Louis, 2023; Schneider, 2024). This approach allows us to capture the complexity of the experience of people who stutter, which includes not only articulation difficulties but also emotional, cognitive, and social components. The literature emphasizes the role of communication anxiety, avoidance strategies, and experiences of stigma and self-stigma (Manning & Beck, 2013; Bauszek & Węsierska, 2022). As Węsierska and Boroń (2018) note, in addition to primary symptoms, secondary reactions are also important – both behavioural and somatic – which can significantly disorganize the communication process and affect the functioning of the individual.

The healthcare system is a particularly important context for analysing communication experiences. Interpersonal communication is the foundation of the therapeutic relationship and a key factor in determining the quality of medical care. It is not limited to the transmission of diagnostic and therapeutic information

but also encompasses building trust, reducing anxiety, and strengthening the patient's sense of security. In this sense, medical communication is relational and ethical in nature, and its quality directly influences the treatment process. For people who stutter, this situation becomes particularly complex. The need to precisely formulate statements under time and institutional pressure, as well as the asymmetry of the relationship between the patient and medical staff, can exacerbate communication difficulties. Research indicates that people who stutter may experience barriers in communicating information about their health, leading to frustration, tension, and a sense of being misunderstood (Iverach et al., 2009). An additional factor complicating these interactions are socially entrenched stereotypes about stuttering. People who stutter are sometimes perceived as less competent, insecure, or anxious, which – despite the lack of empirical support – influences how they are treated in various social contexts (Czubara, 2009; Boyle, 2018). Transferring these beliefs to the medical community can result in subtle forms of stigmatization, such as interrupting speech, rushing, or limiting the patient's communication space. From the perspective of the social model of disability, these difficulties are not solely the result of the individual characteristics of the person who stutters, but rather the result of interactions between the individual and the social environment. From this perspective, the quality of communication in healthcare depends largely on the interpersonal skills of medical personnel and their willingness to adapt their communication to the patient's needs (Costain et al., 2023). (Costain & Sønsterud, 2021). The attitudes of healthcare workers – including cognitive, emotional and behavioural components – may support the development of an inclusive relationship or, on the contrary, lead to the marginalization of the patient (Al-Shdifat et al., 2025).

Previous research indicates that attitudes toward stuttering are often inconsistent: declarative acceptance coexists with uncertainty, discomfort, or a lack of adequate communication skills. At the same time, the level of knowledge about stuttering among medical professionals can be limited, which further complicates the implementation of inclusive communication (Sønsterud & Wesierska, 2023; Weidner & St. Louis, 2023). Despite growing interest in the psychosocial aspects of stuttering, the experiences of people who stutter in the context of healthcare remain underexplored, particularly in Polish scientific literature. There is a lack of research that would thoroughly analyse the communication relationships between patients and healthcare professionals, considering the perspectives of both parties.

The aim of this article is to analyse inclusive communication in healthcare by reconstructing the experiences of people who stutter and medical professionals. Particular emphasis is placed on identifying communication barriers, analysing attitudes, and identifying the mechanisms that facilitate or hinder building a relationship based on mutual understanding. The topic addressed has not only cognitive but also practical significance. Understanding

the communication experiences of both parties can provide a foundation for developing interpersonal competencies among medical personnel and designing more inclusive communication standards within the healthcare system. In this sense, the article contributes to a broader stream of research on the humanization of medicine and strengthening patient empowerment.

2. Methodology

The subject of this research is the communication experiences and interpretations of interactions between people who stutter and healthcare professionals in the healthcare environment. The analysis focuses on the meanings participants assign to these experiences and the mechanisms that shape the quality of the communication relationship. The literature emphasizes that people who stutter may experience difficulty communicating their health needs, which can lead to stress, feelings of being misunderstood, and limited participation in the treatment process (Ceglarski et al., 2021/2023; Pakura et al., 2024). At the same time, it is the way medical staff communicate that largely determines the quality of the patient experience. The study was embedded in a qualitative paradigm, allowing for a deeper understanding of subjective experiences and the contextual conditions of the analysed phenomenon. According to Babby's classification (2002), The project is exploratory and descriptive in nature, with explanatory elements. The exploratory nature stems from the insufficient understanding of the issue in the Polish research context, while the descriptive component allows for a detailed reconstruction of the participants' experiences.

The main goal of this research is to explore the communication experiences of people who stutter and healthcare professionals in the context of their interactions within the healthcare system. Specific objectives include:

1. analysing the attitudes of healthcare professionals towards stuttering from a cognitive, emotional, and behavioural perspective (Kozielecki, 2000),
2. identifying mutual perceptions of communication competence,
3. identifying the communication strategies used by people who stutter,
4. exploring experiences of barriers, difficulties, and situations of stigmatization and discrimination.

The main research problem was formulated as follows: What are the experiences of people who stutter and medical professionals in their interactions in the healthcare environment? Specific problems relate to:

1. level of knowledge and beliefs about stuttering,
2. emotions accompanying communication interactions,
3. actual communication behaviours,
4. identification of barriers and coping strategies,
5. experiences of communication inclusion and exclusion.

The study employed a qualitative research method based on semi-structured individual interviews. This technique allowed for the acquisition of in-depth narrative data and the reconstruction of participants' experiences while maintaining the comparability of the information obtained. Interviews were conducted in two groups: individuals who stutter and medical professionals. This research design allowed for the juxtaposition of two complementary perspectives and the identification of any discrepancies between statements and experiences. Data analysis was qualitative in nature and involved the identification of recurring thematic categories, with particular emphasis on communication experiences, barriers, and manifestations of inclusivity.

The study sample consisted of 10 individuals and was purposefully selected to include two key perspectives: those of people who stutter (n=5) and those of medical and healthcare professionals (n=5). The group of people who stutter was dominated by young people aged 22–24 (n=3), while the remaining participants were aged 35–44 (n=1) and 45–55 (n=1). The participants were diverse in terms of education and professional experience, including both students (e.g. speech therapy, medicine, graphic design) and those professionally active in various fields (e.g., entrepreneurship, catering, care work). The subgroup of medical professionals varied significantly in age and length of service. It included individuals at an early stage of their careers (resident physicians), specialists with several or a dozen years of experience (e.g. laboratory diagnosticians, physiotherapists), and those with many years of professional practice (dentists, family physicians with managerial positions). In this group, alongside age, the key differentiating factor was seniority, which reflected the level of professional experience. This sample structure enabled analysis of the phenomenon from the perspective of both patients and healthcare practitioners, as well as capturing differences resulting from age, experience, and professional context.

The study was conducted in accordance with the ethical principles of social research. Participants were informed of the purpose of the study, its voluntary nature, and the right to withdraw at any stage. Anonymity and confidentiality of the collected data were guaranteed. Due to the sensitivity of the subject matter – including the possibility of disclosing experiences of stigmatization – particular emphasis was placed on creating a safe environment for discussion, enabling the free expression of opinions and experiences.

3. Results and discussion

3.1. Level of knowledge and beliefs about stuttering

Analysis of the research findings reveals a complex picture of knowledge and beliefs about stuttering within the medical community. The most important finding is the existence of a significant gap between academic biological knowledge and practical communication skills, leading to numerous misunderstandings and stigmatization of patients who stutter.

Medical professionals' knowledge of stuttering is typically fragmented and based on a biomedical model. Physicians perceive stuttering primarily through a neurological lens, often associating it with acute events such as stroke or brain injury, rather than understanding it as a chronic speech disorder or a form of neurodiversity. The lack of systematic education on this topic is explicitly articulated by respondents, as evidenced by the quote from a medical student: "When I checked the syllabus, there was nothing about clinical speech therapy throughout my entire studies, so nothing will come of it. We learn about aphasia, stroke, but there's not a word about how to talk to a patient who simply has a different speech fluency". As a result, medical staff often feel unprepared for contact with a person who stutters, which generates discomfort on both sides. Knowledge, if it is supplemented, usually comes from informal sources such as social media, not from the curriculum. The prevailing perception among medical staff is that stuttering is a "challenge" requiring increased cognitive effort. Physicians and other healthcare professionals often profess empathy, but their actual behaviour can be paternalistic. Staff often harbour the mistaken belief that finishing a patient's sentences or suggesting words facilitates communication, while patients perceive this as infantilization and a denial of autonomy. This discrepancy between intention and perception is perfectly illustrated by a statement from one doctor: "Well, unfortunately I give you a hint, I give you a hint, I finish your sentence, it seems to me that I make it easier". This behaviour stems from the time pressure that is ubiquitous in the healthcare system. In an environment where doctors see dozens of patients daily, stuttering can be perceived as a "time cost" leading to increased stress for the physician. A study participant working in primary care admitted: "It requires more effort from me, which makes me more tired after such a visit".

In their beliefs about medical personnel, people who stutter (PWS) often emphasize the feeling of being judged as intellectually inferior. The most painful experience for patients is when medical personnel equate their speech (stuttering) with cognitive competence. Patients often encounter questions that suggest their stuttering is a symptom of a sudden illness, forcing them to play the role of educator in situations where they themselves need medical help. One participant recalls: "I'm wondering if you've been stuttering since you fainted, or have you been stuttering at all? It's like I have to suddenly explain my whole story when

I'm feeling down and just need help, not a lecture on speech therapy". This leads to self-stigmatization and patients employing sophisticated masking strategies to avoid the "medical gaze" that pathologizes their speech. Some patients note that disfluency can be interpreted as weakness, which provokes authoritarian behaviour from staff: "For example, you often come across a doctor who is rude and boorish. That is, if he notices a weakness in my conversation, such as a stutter, he will exploit it viciously, he will start talking to me in his own way". Research indicates that the level of knowledge and beliefs about stuttering in the healthcare system is closely linked to the lack of standards of practice. Stuttering is "invisible" in the system – it does not fit into standard disability categories, which means these patients "get lost" in medical structures, not receiving necessary communication support, such as extended appointment times or alternative registration methods.

In conclusion, the analysis shows that improving the quality of medical contact with a person who stutters does not require advanced technologies, but above all, a shift in the paradigm of awareness. It is necessary to move from a remedial model of "treating speech impairments" to a more personalized encounter with the patient, which requires incorporating elements of functional speech therapy and empathy training into medical staff training programs. Research shows that patients are willing to accept even gaps in a doctor's substantive knowledge, provided they are met with a calm and patient attitude.

3.2. Emotions accompanying interactions and actual communication behaviour

The research findings allow us to reconstruct the complex emotional and behavioural landscape that accompanies interactions between people who stutter and medical personnel. This relationship, rooted in an asymmetry of power and knowledge, becomes a field of friction between professional standards, individual affective reactions, and systemic pressure. The emotions accompanying interactions in a doctor's office are bilateral and often create a so-called "stress loop". For medical personnel, contact with a patient who stutters involves intense emotional labour. On the one hand, physicians declare a willingness to help and empathize, but on the other, they experience the tension resulting from the need to maintain professionalism in conditions of difficult communication. One doctor points to a specific type of mental burden: "[I feel] tension and a little stress related to wanting the visit to go well". Patients (PWS), on the other hand, bring a baggage of anticipatory anxiety and shame into the office, which is intensified by the awareness of the system's time constraints. The most hurtful element of the interaction for them is the "medical gaze" which pathologizes their speech and casts doubt on their intellectual abilities. Staff emotions, such as embarrassment or irritation, are accurately interpreted by patients through their microfacial

expressions, which creates a barrier of exclusion. A respondent who stutters describes this experience as humiliating: “She made a strange face, as if I was some kind of retarded person, she didn't tell me anything, but I can see when someone makes their different faces... a bit of disgust on their face”. An interesting emotional thread among the staff is the emerging sense of guilt stemming from an imbalance in the pace of conversation. One medic notes that time asymmetry in communication can be a source of moral discomfort for the medic: “I felt guilty that it took me significantly less time to respond than my interlocutor”.

In the behavioural sphere, research indicates the dominance of two opposing models: a paternalistic desire by staff to “improve” communication and advanced adaptive strategies developed by patients. Medical staff often succumb to the impulse to “close sentences” or interrupt, which they mistakenly interpret as help. Such paternalistic behaviours are, in fact, a form of communication abuse that infantilizes the adult patient. However, some conscious staff attempt to “bypass” the system to allocate necessary time for the patient without generating delays in the waiting line. One doctor describes a creative strategy for managing appointment time: “I send such a person for an ECG, for example [...] and return to the conversation”.

People who stutter, however, are not passive victims of the system. Their communication behaviours are often sophisticated systems for managing the social situation, aimed at regaining agency and protecting their dignity. These strategies include, among other things, managing the volume of their voice to force a specific response from the interlocutor, which will give the patient time to express the message more fluently. The stuttering respondent reveals the technique of „defensive automation”: “I know that if it's a sentence, it'll be difficult for me. I always say it unclearly or quietly so the person can't hear. Then they ask, ‘Excuse me?’ and I say it again, this time slower and usually more fluently”.

Research emphasizes that both negative emotions and inappropriate staff behaviour (e.g. rudeness or rushing) are not solely the result of individual physician characteristics but are a product of a flawed system. Time pressure, noise in facilities, and a lack of privacy are factors that exacerbate patient speech disfluencies and staff frustration. Burnout among physicians appears to be a key barrier to empathy – in conditions of overload, staff reduce patients to a “parameter” or “glitch”, ignoring their communication needs. The lack of procedures for patients with stuttering makes them a “borderline group” that gets lost in the system, forced to cope using their own, often exhausting, psychological resources.

Research analysis of medical interactions demonstrates that the emotions and behaviours of both parties are closely intertwined. Improving the quality of this relationship requires not only medical education in functional speech therapy, but above all, structural change – introducing solutions such as online

registration, which alleviate the patient's anxiety about the first telephone contact. The key to success is "unconditional time" and an attitude of acceptance, which allows the patient to be disfluent in a safe, professional atmosphere. Research shows that a physician's genuine calm and patience are often more important to the patient than their technical proficiency in making a diagnosis.

3.3. Identified barriers and coping strategies

Analysis of the collected research material allows for the formulation of conclusions regarding the profound, often structural barriers faced by people who stutter (PSW) in the healthcare system, as well as the creative, though sometimes exhausting, coping strategies developed by both parties. The medical environment, dominated by the paradigm of efficiency and speed, becomes an exclusionary space for patients with speech disfluencies, where barriers are not merely personal in nature but are an inherent feature of work organization.

The most serious barrier identified in the research is the institutional invisibility of people who stutter. These patients constitute the so-called "borderline group" – their difficulties do not fit into standard disability categories, which means the system does not provide any procedural facilities for them. This barrier manifests itself already at the "entry threshold" stage, i.e. registration. The necessity of telephone contact, lacking visual support and the ability to control the pace, is an almost insurmountable barrier for many PWS. This is confirmed from a medical perspective, where one doctor notes: "The biggest challenges they may face are at the stage of registration by phone". This phenomenon leads to secondary exclusion – patients cancel appointments or accept delays, opting for text communication, which is often not prioritized in the medical system. Another significant barrier is the technocratization of the medical visit. Modern physicians, forced to operate IT systems in a short timeframe (often 5–15 minutes per patient), inadvertently become oppressive for people who stutter. The mere sight of a physician focused on a monitor rather than on the patient drastically increases anticipatory anxiety. One person who stutters describes this tension from a unique perspective „inside" the system, as a medical student: "Very often I just feel pressure, time pressure, because I know that, for example, the doctor has 5 minutes for the patient, or 10, 15. And then I think: God, he has to type so many things into the computer, and I'm standing here and I can't get a word out". In response to these barriers, patients develop complex systems for managing the social situation that go beyond simple speech therapy techniques. One of the most interesting strategies is the use of gestures as a "competence anchor". In the medical world, where fluency is often mistakenly associated with intelligence, PWS use body language to "regain" the image of a competent and professional person. One person who stutters explains: "I really enjoy gesturing because it makes me feel more at home, more competent, and it simply makes people take

me more seriously. It gives me the freedom to communicate not just with my mouth, but with my whole body”. It is a form of psycholinguistic relief of the speech apparatus, allowing the transfer of communicative energy to other channels, which in the patient's eyes is supposed to eliminate the negative perception of his stuttering.

Despite attempts at adaptation, research reveals a painful lack of open discussion about the very nature of communication difficulties in the office. Medical staff rarely ask about their preferred way of conducting a conversation, forcing patients to constantly conceal their problem or struggle with it alone. This gap stems from a lack of procedural knowledge – doctors don't know whether it's permissible to ask about stuttering, which results in either ignoring it or inappropriate paternalism (e.g. prompting words). One stutterer accurately diagnoses this condition: “I have never met anyone who delved deeper into this topic or asked me how they could behave”.

The identified barriers are dynamic in nature – patient anxiety about lack of time meets staff frustration resulting from overload, causing discomfort for both parties. Coping strategies, while functional, are often temporary (e.g. bypassing telephone registration via text message). The key conclusion is that improving the quality of care does not require a technological revolution, but the introduction of inclusive procedures, such as online registration for all patients and systemic consent for extended appointment times if necessary. Interpretation of the results indicates that stuttering in medicine is a test of whether the system is open to diversity, not only physical but also communicative.

3.4. Experiences of communication inclusion and exclusion.

The analysis of the research results allows for the formulation of conclusions regarding the experience of communication inclusion and exclusion, which in the medical context do not result solely from the characteristics of individual interlocutors, but are the result of human attitudes and the rigid framework of the healthcare system.

The communication exclusion of people who stutter in the healthcare system rarely takes the form of overt hostility. It most often manifests as structural invisibility, stemming from the fact that stuttering doesn't fit into standard, bureaucratic definitions of disability. This leads to a situation in which the communication needs of this group are systematically ignored, which one of the physicians managing the facility describes as the “disappearance” of patients in procedures: “This group, just like us, is dying in the system”. This exclusion is exacerbated by burnout and performance pressure, where the patient ceases to be a subject and becomes a “parameter” to be checked. In conditions of staff overload, any communicative discrepancy that prolongs the interview process can become a source of aggression or ignorance. One healthcare representative diagnoses this, pointing to the real risk of emotional harm to the patient: „Yes, if

you come across an unaware or burned-out healthcare professional, they may be harmed by harsh treatment". In this model, a patient with stuttering experiences exclusion through having to do the speaking for them or through infantilization, which builds up a feeling of being less intellectually competent.

A counterweight to these exclusionary mechanisms is communicative inclusion, which in the study material rests on two pillars: sensory awareness and acceptance of the patient's pace. This inclusion begins when the physician consciously relinquishes dominance in the conversation and gives the patient space to complete their thoughts. Such an attitude is not merely "politeness", but a recognition of the patient's fundamental right to subjectivity, as one of the physicians emphatically articulates: "Everyone deserves to be able to express their thoughts at their own pace". For medical staff, however, inclusion comes at a specific cost – increased cognitive effort. Inclusive contact requires the physician to be fully present "here and now", abandoning unnecessary multitasking (e.g. typing on a computer) and intensive information processing, which the healthcare professional describes as the need for heightened vigilance: "You have to concentrate hard to understand what the interlocutor has to say". A particularly moving theme of inclusion is so-called reactive empathy. Interviews feature a physiotherapist who builds an inclusive relationship with a patient based on her own past experiences, when she herself began stuttering at a moment that surprised her. Her approach is a conscious protest against the communicative humiliation she herself experienced: "It was a humiliating experience, generating deep shame".

These research shows that inclusion in the Polish healthcare system is currently incidental and depends on the physician's individual resources – their patience, work ethic, and personal history. Exclusion, however, is systemic, rooted in the lack of alternative registration channels and the lack of speech therapy education for staff.

In conclusion, the experience of inclusion for a person who stutters is primarily an encounter with a physician who can manage their own embarrassment and "endure the silence" of a speech block. Real change, however, would require a shift from individual acts of empathy toward a systemic normalization of disfluencies, with every medical facility offering multi-channel communication (SMS, email) and procedures that allow for extended appointments without stigmatizing the patient as "difficult". Inclusion, in this sense, means "allowing one to be disfluent" in a safe and professional office atmosphere.

Concluding remarks

This analysis summarizes research whose primary goal was to explore the communication experiences of people who stutter and medical professionals in

the context of their interactions within the healthcare system. To achieve these specific objectives, a multidimensional analysis of medical staff attitudes toward stuttering was conducted, based on the classification of cognitive, emotional, and behavioural components. A key focus of the work was identifying the mutual perception of communication competences, which allowed for the identification of discrepancies in the assessment of the quality of medical visits. The research also allowed for the identification of various communication strategies used by people who stutter to cope with difficult diagnostic situations. The study is complemented by an exploration of experiences of barriers and situations of stigmatization and discrimination, shedding light on the realities of functioning of patients with stuttering within medical structures.

Research findings demonstrate that medical interaction in the context of stuttering is a complex phenomenon, in which biological factors intertwine with systemic barriers and individual psychological reactions on both sides. Medical staff's attitudes toward stuttering are characterized by significant inconsistency, resulting from a clash between professional ideals, a lack of systemic knowledge, and organizational pressures. The cognitive dimension of these attitudes is primarily based on the dominant biomedical model. Many medical professionals perceive stuttering as an acute symptom of neurological pathology, leading to erroneous clinical interpretations, particularly in emergency situations. Academic knowledge among medical staff in this area is highly fragmented and is typically limited to the theoretical foundations of neuroanatomy, completely ignoring the psychosocial and functional dimensions of communication with a patient with special needs. Medical staff perceive contact with a person who stutters as a challenge requiring increased cognitive effort and concentration, which is sometimes interpreted as an organizational burden. At the same time, a shift in awareness is noticeable among some staff members, who – often through informal sources – are beginning to perceive stuttering through the lens of neurodiversity, not just trauma or a deficit. The emotional dimension reveals a profound dualism. On the one hand, physicians declare empathy and compassion, while on the other, they admit to feeling embarrassed, tense, and afraid of making a communication error. An interesting phenomenon is the sense of guilt resulting from the temporal asymmetry of the conversation – physicians feel uncomfortable that their responses are significantly shorter than the patient's. In conditions of burnout and systemic overload, these initially neutral emotions can transform into irritation or emotional coldness, which patients accurately interpret from the staff's micro-facial expressions. The behavioural dimension manifests itself in specific interaction management strategies. The most common, though negatively assessed by patients, behaviour is communicative paternalism, manifested in closing sentences and interrupting to expedite the interview. On the other hand, mindful clinicians implement supportive behaviours such as maintaining engaged eye contact, refraining from working on a computer while listening to a patient, and modifying the environment to provide more privacy and quiet. Some

clinicians use creative „workarounds“, intentionally extending the visit or breaking it into stages to reduce communication pressure.

Identifying the mutual perception of competence reveals a significant gap in the sense of preparedness for dialogue. Medical personnel largely assess their competence in communicating with people who stutter as insufficient. The lack of appropriate training during their studies leaves doctors and nurses feeling helpless in the face of patient speech blocks, which they often mask with a retreat into routine or excessive technical professionalism. Medical professionals perceive patients who stutter as requiring “special treatment” in terms of time, but they rarely identify specific supportive techniques they could use. The patient perspective is critical of medical professionals' soft skills. People who stutter often feel that their disfluency is equated with a lack of intellectual competence or emotional instability. Patients note that medical personnel often fail to control their own discomfort, which manifests itself in avoiding eye contact or infantilizing the adult patient (e.g. by directing questions to the accompanying person). At the same time, patients highly value authenticity, calmness and patience, indicating that the „human character“ of the doctor is more important to them than his procedural efficiency.

People who stutter are not passive participants in medical interactions; they develop advanced adaptive strategies that respond to systemic barriers, such as:

1. information management: patients often selectively convey information, forgoing details to avoid prolonging the appointment and exposing themselves to further speech blocks. This can paradoxically lead to a decrease in the quality of diagnosis,
2. alternative channels: a very powerful strategy is the pursuit of written communication. Patients readily use pre-prepared symptom lists, pre-appointment forms, or text messages, which allow them to convey information precisely without the emotional burden of speaking,
3. interaction manipulation: some patients use the technique of deliberately speaking quietly or indistinctly to force a request for repetition. This gives them a natural excuse to rephrase their thoughts, often more fluently,
4. competency anchors: a strategy for image-building involves intense gesticulation and attention to body language. This is intended to counteract the negative stereotype of weakness and demonstrate self-confidence and professionalism, regardless of stuttering,
5. humour: used as a tension-relieving tool and an icebreaker in relationships with staff, although it carries the risk of being perceived as less than serious.

The experiences of people who stutter in the healthcare system are marked by both structural barriers and interpersonal stigma. Systemic barriers include, above all, a drastic time deficit and the necessity of contacting people by phone for registration. For many people who stutter, the telephone constitutes a psychological barrier, forcing them to forgo care or rely on third parties. The lack of privacy in medical facilities and the noise further exacerbate the fear of being misunderstood and the reluctance to visit. These people are a “structurally invisible” group – they are not entitled to any accommodations because stuttering does not fit into standard disability categories. Stigma and discrimination rarely take the form of open hostility; they are more often manifested through microaggressions. The most common situations include:

1. medicalization and pathologization: treating stuttering as a symptom of a mental or intellectual illness, which leads to the patient's agency being undermined.
2. infantilization: treating adult patients like children, addressing them by their first name without permission, or ignoring their statements.
3. “helping” paternalism: forcing patients to finish their sentences, which is perceived as a denial of dignity and autonomy.
4. patient triage: informally avoiding admitting people with communication “differences” due to staff impatience.
5. inappropriate advice: providing humiliating, pseudo-specialized advice (e.g. “speak slower”, “breathe”) or suggesting invasive procedures unrelated to the etiology of stuttering.

Based on the research results, improving the quality of care for patients who stutter requires the implementation of the following actions:

1. Multi-channel accessibility: introducing a standard online registration and SMS/email contact options to eliminate the telephone barrier.
2. Acceptance of written forms: officially encouraging patients to use notes and symptom lists, which should be treated as a full-fledged element of the medical interview.
3. The principle of “unconditional time”: educating staff on active waiting and refraining from interruptions, which reduces stress during the visit.
4. Reforming medical education: incorporating functional speech therapy elements, empathy training, and microfacial expression management training into the syllabus.
5. Training for support staff: providing educational support to registration staff, who play a key role in the patient's experience of healthcare.

6. Normalizing stuttering: shifting from a remedial model to a supportive model, in which stuttering is recognized as a natural speech variant that does not impact a person's value and competence.

Building an inclusive healthcare system does not require expensive technologies, but above all a profound change in attitudes and giving the stuttering patient the right to be fully themselves in the safe atmosphere of the office.

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