Has He Eaten Salt: Communication Difficulties in Health

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Abstract:

The communication gap can lead to lack of trust, poor diagnoses and ineffectual treatment. Using research in allied fields of applied linguistics and intercultural communication this article demonstrates the problem of considering patients as deficient in their language resources and suggests the use of arts-based methods for bridging the communication gap in minority and Aboriginal community settings.

Communication questions and how they relate to known social determinants of health such as cultural competence and racism are highlighted in this issue. This ground is well covered in the literature, not just in health but more broadly. Less attention has, until recently, been focused on questions of language, intercultural communication and the utility of arts-based approaches in health communication. Amery[1] highlights the language element:

"Our refusal to take Aboriginal languages seriously not only results directly in less than optimal medical outcomes, but also results in mistrust and disengagement with the health sector and non-compliance with treatment regimens"

Language is the medium through which life-saving, or life-giving, remedies are communicated. Where there is miscommunication, either through inaccuracies of written or oral translation, or inability to understand the wide range of possibilities which any utterance will afford, then no matter how valid the scientific research, diagnosis or management plan, the outcome can be failure.

An example may be drawn from the title of this editorial. 'Édu dzea?' in the West African language, Ewe, means 'has he eaten salt.' It is an idiomatic expression which has the metaphorical meaning 'does s/he understand?' In a context such as Ghana where English is the language of public transaction, the phrase, particularly in health care settings, can lead to misunderstandings.

It is worth contextualizing these aspects of communication through the debates in my own field of languages and intercultural studies. Over the past two decades there has been a move away from the concept of the 'native speaker' and towards the 'intercultural speaker'[2]. An intercultural speaker is someone capable of communicating between languages and cultures. Native speakers are not necessarily good translators. The concept change is important as it prevents the use of deficit models to describe participants in communicative situations meaning that one language can no longer be the 'dominant' language in a particular interaction. In the health setting this may not only avoid discrimination against a non-English or English Creole speaker but could also prevent the all too common interpreter-patient ancillary conversations, which in themselves can be obstructive[3]

Commonly used phrases which perpetuate deficit models, such as ‘language barrier’, ‘good English’ or ‘poor English’ are in common use across most non-linguistic disciplines and in most non-language based teaching situations. Such normative phrases make applied linguists cringe and subtly continue to disadvantage minority groups, further increasing their vulnerabilities. Frimberger[4] demonstrates how those interpolated into positions of language deficit are in fact competent speakers of many languages and enable intercultural encounters to be ones of considerable ‘language plenty’ and communicative resourcefulness. The majority of the world’s societies do not operate in monolingual deficit models but work multilingually with ease. The argument that Australia is a monolingual country is empirically false. Practising with multilingual resource is a key pillar of Lo Bianco’s Australian policy work.[5] Arts-based methods extend the communicative and symbolic resources to assist health communication. Canagarajah’s model of translingual practice[6] also offers resourcing beyond the straight-jacketing of a belief that the national language is a) singular and b) can be the only resource for communication.

Our qualitative, educational research in intercultural communication with refugees and asylum-seekers in Glasgow has investigated responses of primary health care providers, refugee and asylum seeking patients and translators, offering a further example of the kinds of pictogram work advocated by Amery in this issue. Working with Freirean[7] and Boalian[8] models of pedagogy, which move away from deficit models, we have made training films (Appendix 1), which dramatise the difficulties any intercultural encounter which works between languages can engender. In using the materials patients, professional care-givers and translators all recognize concepts, situations, alienations and frustrations so that they can develop communicative and care-giving strategies which can empower everyone. Dynamics in one-to-one encounters differ from group contexts, but power differentials remain in need of circumvention, and here arts methods are also helpful in improving dynamics.

This arts-based, practice-based research is not produced according to the kinds of quantitative measures of evidence which are required in clinical trials but, like the use of pictograms of the kidney cited in this issue[1], it has been effective in medical teaching and interpreter training sessions, helping to increase understanding of the problems of reduction of trust and increased vulnerability. It is here that we find enacted a practice which sustains the rationale for using different artistic media, beyond text or spoken word, to expand the range of forms available for understanding and interpreting medical communication. Health professionals can learn methods which can be successful even when it is not feasible to have an interpreter present.

The form communication takes matters. Giving leaflets to middle-class professional women about their care works well, because invariably they trust text-based literacy. When communication is more challenging, use of forms, which engage the whole person, such as drama, dance and film, have a stronger salience. They expand the range of communication possibilities and also reduce the arbitrary relationship identified in deficit models. Using visual or kinesthetic representations of the body to communicate about the body directly, rather than through deficit-model-based or abstracted linguistic signs, reduces the communication gap.[9].

Innovative engagement with the arts community will create new approaches to expand existing communication resources for Indigenous Australians, will continue ‘bridging of the communication gap’ in Aboriginal and minority language encounters in Australia, and will enliven diagnostic settings with greater trust.

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Appendix 1

Film Resources: http://www.gla.ac.uk/research/az/gramnet/research/trainingmodel/resources/

These film resources have been adopted by health boards in Scotland and by the health-care and public sector workers Union, UNITE, in the U.K. They are freely available for training in any multilingual context and have also been adapted and re-made by social service agencies concerned with translation in, for example, the foster-care system.