

“Has he eaten salt?": communication difficulties in health care

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Using arts-based methods may extend communicative and symbolic resources to bridge the Indigenous health communication gap



Communication and how it relates to known social determinants of health such as cultural competence and racism is highlighted in this issue of the *MJA*. This ground is well covered in the literature, not only regarding health but also 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 highlights the language element:

A refusal to take Aboriginal languages seriously not only results directly in less than optimal medical outcomes, but also in mistrust and disengagement with the health sector and non-compliance with treatment regimens.¹

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 contextualising 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 common interpreter–patient

ancillary conversations, which in themselves may be exclusive or misconstrued by the caregiver.³

Commonly used phrases which perpetuate deficit models, such as “language barrier”, “good English” or “poor English”, are in frequent use across most non-linguistic disciplines and in most non-language-based teaching situations. Such normative phrases are problematical for applied linguists because of the subtle ways in which they continue to disadvantage minority groups, further increasing their vulnerabilities. Frimberger⁴ demonstrates how people who are interpolated into positions of language deficit are in fact competent speakers of many languages, which enables their 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 resources is a pillar of Australia’s national language policy.⁵ Canagarajah’s model of translanguaging practice⁶ also offers resourcing beyond the limiting belief that a national language is singular and the only resource for communication.

The use of arts-based methods can extend communicative and symbolic resources to assist health communication. The form that 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 that 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 kinaesthetic representations of the body to communicate about the body directly, rather than through deficit model-based or abstracted linguistic signs, reduces the communication gap.⁷

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 further examples of the use of pictograms advocated by Amery in this issue of the *MJA*.¹ Working with pedagogical models^{8,9} that move beyond deficit approaches, we have made training films which dramatise the difficulties that any intercultural encounter between languages can engender (<http://www.gla.ac.uk/research/az/gramnet/research/trainingmodel/resources>). In using the materials, patients, professional caregivers and translators all recognise concepts, situations, alienations and frustrations so that they can develop communicative and caregiving strategies that can empower everyone. Dynamics in one-to-one encounters differ from group contexts, but power differentials remain in need of creative circumvention for trust to be established, and here arts-based 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 discussed by Amery,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 that 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 may be successful even when it is not feasible to have an interpreter present.

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

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