Barriers to communication

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Outline
General barriers
Cue in case – The Downward Slope
General Practice example
Potential cultural barriers in communication
Use of interpreters

General barriers to effective communication

Barriers related to patient
• Speech difficulties
• Deafness
• Poor sight
• Poor cognitive skills
• Language
• Perceptions
• Prejudice
• Fear

Barriers related to health care professional
• Perceptions
• Prejudice
• Fear
• Poor understanding of needs of patients from different cultures
• Poor communication skills

Potential Consequences

• Patients not able to express expectations/preferences
• Insufficient information for accurate diagnosis
• Misunderstanding of diagnosis or treatment regimen
• Challenges to some basic ethical principles guiding doctor-patient relationship
  – Autonomy
  – Confidentiality
• ‘No-go’ areas – e.g. discussion of sensitive or embarrassing issues
• Low expectations for future care

Case 4 – The Downward Slope

Mr Ahmed

‘He came to Britain in 1988 and registered with a GP seven years later’ (lines 2,3)

When he visited his GP he was usually accompanied by his 14 year old daughter who interpreted for her father and the GP’ (line 4)

Tomorrow’s Doctors
(GMC 2003)

21. Graduates must know that some individuals use different methods of communication, for example, Deafblind manual and British Sign Language
22. Graduates must be able to do the following:
   a. communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds, or their disabilities
   b. communicate with individuals who cannot speak English, including working with interpreters

Culturally appropriate care – barriers to communication

• Responding to an individuals cultural as well as medical needs
• Simplistic notions of cultural differences
• Avoiding tokenism – in some cases cultural differences may be helpful
• Avoid concentrating on differences
At least she speaks some English': a consultation in general practice in the UK

Medical education, 1999, 33, 616-623

Diversity issues raised in this dysfunctional consultation might include

- Stereotyping of South Asian woman with 'psychosomatic' abdominal pain
- Lack of shared language causing mutual frustration for patient and doctor, and affecting diagnosis and care received
- Difficulties of access to health care & knowledge of appointment systems and the practicalities of doing so without speaking English
- Negotiating culturally sensitive issues and treating people as individuals - the doctor excuses himself from examining the patient despite her implicit permission to do so
- Assuming the patient can read a letter - she is unlikely to read English and may not be literate in her own language even if that material were available
- Discrimination and racism in failing to adequately follow up with appropriate interpreting help
- The considerable challenges of such consultations

Beliefs

- Stigma, usually mental illness.
- Referrals to psychiatrists or psychologists can be taken as an indication that a problem is severe and intractable in all cases.
- HIV/AIDS is even more stigmatised than in the UK.
- Somatisation because of mental health problems may not be seen as possible
- People aware that their traditional health beliefs are different from those accepted in the UK and will therefore be reluctant to admit to them

Expectations

- Appointment system
- Questions about personal life may be considered intrusive and inappropriate
- Many cultures have different ways of dealing with the social and psychological aspects of illness
- If certain care is expected, but not received because the health worker judges it unnecessary, it may be interpreted as discrimination.

Communication styles

- Greetings can assume a greater significance and feelings of discomfort at the start of a consultation can be a block to effective communication.
- May be used to providing a narrative to health workers rather than answering a list of questions.
- Hand gestures may be easily misinterpreted.
- There are the well known taboos about who can touch whom, and when and where.
- People may find the naming of body parts and organs shocking - it may be more usual for metaphors or indirect reference to be used.
General

- Check common understanding – doctor and patient
- Be explicit about communication issues if there appears to be a problem.
- Use simple, non-technical language unless it is appropriate.
- Make use of visual aids and written material in the client’s own language where possible

Definitions - interpreting

Establishing, either simultaneously or consecutively, oral or gestural communications between two or more speakers who are not speaking (or signing) the same language.

- Translating – source and target are written
- Interpreting – source and target are spoken
- Simultaneous – given while the source speaker is speaking
- Consecutive – interpretation is given after the source speech (or a segment of it) has finished
- A trained and officially accredited interpreter will endeavor to interpret not only elements of meaning, but also the intention and feelings of the original speaker.

Types of interpreting

- Spoken/sign language
- Bilingual health workers (preferred by patients)
- Trained interpreters
- Friends and relatives
- Untrained volunteers

Extent of communication problems for deaf patients (RNID survey, 2004)

- 53,500 severely/profoundly deaf people in UK
- 24% of deaf/hard of hearing patients missed an appointment due to poor communication
- Cost of missed appointments – £20 million a year
- 35% visiting hospital unclear about condition
- 70% of sign language users not provided with an interpreter for emergency admissions
- 62% of GPs and 27% not aware of interpreting services

Communicating with deaf patients

- Combination of signing, writing, speech and lip reading
- BSL interpreter present
- Visual signals to attract attention
- Regular voice volume and lip movement, maintain eye contact, don’t cover mouth
- Provide patient with writing materials
- Allow patient to have back to light, not you
- If signing, keep dominant arm free of IV etc

Interpreters

- Talk and listen to the client, not the interpreter
- Listening means giving your full attention to the client when they are speaking and looking out for non-verbal cues
- Always introduce yourself and (when appropriate) the interpreter to the client
- Make confidentiality explicit for the client and interpreter
- Remember that you have the responsibility for making the most of the consultation, not the interpreter
- Talk in short bursts – one question or statement at a time
### Interpreter services in the NHS
- Bookable in advance
- Lack of knowledge about language requirements
- Interpreters often booked for planned consultations
- More than doubles length of consultations

### Problems with interpreters
- Many problems faced in getting as far as a consultation (e.g. booking appointment, out of hours care, understanding of NHS)
- Comfortable raising sensitive issues?
- Distortion?
- Often only during office hours
- Poorly paid

### Use of family and friends
- Often only viable alternative
- Children – lack emotional and cognitive maturity
- Details of bodily function and dysfunction private
- Source of danger – misinterpreting information
- Source of stress for patient, family member and doctor
- Confidentiality issues

### Remote (telephone) interpreting
- Doctor phones telephone service
- Appropriate equipment (conference telephone)
- Can be reached immediately
- Interpreter misses all non-verbal communication
- Impractical during examination
- Patient confidence in confidentiality might be higher
- Often interpreters have little/no medical training
- Used in 15% of trusts – increasing rapidly
- 140 languages

### Summary
- Focusing on individual needs, taking account of culture and other attributes
- Consequences of communication difficulties
- Scope of services for sign and spoken language interpreting
- Benefits and drawbacks of different methods
- Seeking opportunities to observe consultations