Section 1
Care, Compassion and Communication

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CHAPTER 1

An Introduction to Communication

Palo Almond and Jackie Yardley

Introduction

There is an abundance of literature on communication which is seen as central to quality health care services and is identified as an essential skill (NMC 2007b); and yet the skills of communication remain lacking within the health care professions and every year complaints in the National Health Service (NHS) continue to be focused on misunderstanding based on poor communication (Pincock 2004).

Not all problems are communication problems, however; a skilled communicator can facilitate meaning and understanding in a given situation bringing clarity to an issue that otherwise would escalate out of control. Part of the difficulty lies in the fact that we communicate all the time and for most this is an activity that is valued and almost everyone agrees is important; but this chapter is asking you to consider your communication skills as if for the first time and reflect on where change would enable you to employ the principles and process of a skilled communicator.

This chapter is divided into three sections. The first section focuses on some of the policy imperatives that require nurses to ensure that they have the knowledge and skills to communicate with all people whatever their age, gender, disability, sexual orientation or ethnicity might be. The second section places communication skills centre stage within health care and therapeutic settings and explores what it means to communicate. Finally, the third section explores some of the evidence base currently influencing communication and delivery of health care.

The specific learning outcomes addressed in this chapter link with the Nursing and Midwifery Council’s (NMC 2007b) Essential Skills Clusters, and are identified below.
Learning outcomes

By the end of this chapter you will be able to do the following:

- Identify the term health inequality and recognise how communication is an important factor in accessing health care.
- Describe the importance of policy and how it aims to reduce health inequalities.
- Establish different theoretical perspectives increasing your understanding of communication.
- Identify the key principles of effective communication so that appropriate communication strategies can be employed.
- Examine the importance of self-awareness and how attitudes, beliefs and values can create barriers to effective communication.
- Explain how effective communication can enhance practice.
- Use a case study approach to explore evidence-based, ethically and culturally sensitive communication practice.

Inequalities in Health: Provision and Access to Health Care

Many sectors of society are at risk of having poor health due to difficulties in access to health care or because health care does not meet the specific needs of all groups in mind. It is beyond the scope of this chapter to appraise all barriers to health care faced by service users including ethnic minority populations residing in the United Kingdom. Instead, this chapter focuses on a specific barrier that many patients face, that is effective two-way communication. Robinson (2002) appraised 134 studies related to communication and provides evidence of the part that communication plays in creating barriers to providing quality health care or accessing health care by patients who do not have English as their first language. However, it needs to be stated at the outset that not all patients experience difficulties in communication and not all minority ethnic patients are not fluent in communicating in written or oral English. Indeed, many patients are very satisfied with the care they receive. In this chapter, the term patient is used instead of the more cumbersome ‘patients or clients’. It is accepted that either of the two terms can be applied in most health care settings. The focal point of this chapter is on access issues relating to communication with minority ethnic patients, when the ethnicity of the patient is different to that of the nurse. The final section discusses some of the barriers to effective communication that may cause inequality in access and how these might be avoided.

The Black Report (Townsend & Davidson 1982) and The Health Divide (Whitehead 1988)

Both these studies found marked differences in the health of certain sections of the UK population. The researchers theorised that these differences were preventable by addressing the provision and delivery of health services and other public services. Such changes would increase access by those who need health and social
services. Governments of that time appeared not to have taken any policy actions to address these reported health inequalities. Their ideology emphasised less Government control over people’s health, and greater responsibility by individuals for their own health (Baggott 2000; Ham 2004). Ten years later, Acheson (1998) found that the gap between the health of the well off and the less well off was as wide or wider. An analysis of policy in the last 10 years suggests a more positive attitude to the need to reduce and prevent health inequalities.

**Government Health Policy and Legislation**

Analysis of policy suggests that some formal steps have been attempted to reduce health inequalities in the United Kingdom. *Saving Lives: Our Healthier Nation* (Department of Health (DH) 1998) set out,

... to improve the health of the worst off in society at a faster rate than the rest of the population. (DH 1998, p. 1)

This reflects a willingness to accept that inequalities do exist, and that Government action needs to be taken. Consequently, the Government set targets to reduce inequalities in *The NHS Plan* (DH 2000). The Government noted causative structural factors and particular populations most at risk of poorer health:

The social and economic determinants of health remain important factors. Poverty, ethnic origin, and low educational achievement are all potentially significant issues. The determinants of health give rise to inequalities in health between different socio-economic and ethnic groups. (*The NHS Improvement Plan: A Plan for Investment, a Plan for Reform*, DH 2004a, p. 43)

This policy emphasised that people experiencing social and economic adversity and minority ethnic populations have less good health than other sectors of the population and that this situation is avoidable and needs addressing. The *National Service Framework for Children, Young People, and Maternity Services* (DH 2004b) also emphasises that the needs of people, who may have difficulties in accessing health services should be met by tailoring services that best meet their requirements. The predecessor to *The NHS Improvement Plan: A Plan for Investment, a Plan for Reform* (DH 2004a), *The NHS Plan* (DH 2000), was the very first UK policy to set targets for the reduction of health inequalities.

Chapter 3 of the *Equality Act* (2006) discusses equality and human rights and diversity. The main purpose of the Act is to set out the powers of the new Commission for Equality and Human Rights. Nevertheless, the Act raises awareness of the points made earlier that difference, that is ethnic diversity, should be acknowledged and not ignored. This builds on the 2000 *Race Relations (Amendment) Act* which set out the statutory responsibilities of health and local authorities to examine discriminatory practices and promote equality. Health services have a duty to provide culturally sensitive services (*Race Relations Amendment Act* 2000) (Activity 1.1).
Policy Guiding Health Care Practice

The Government have clearly been aware that health inequalities can arise from poorly trained staff who are not competent and do not provide appropriate and accessible care. Consequently, the Government have taken action and set benchmarks for best health care practice, in the form of *Essence of Care* (DH 2001). It recommends that nurses and other health and social care professionals need to consider,

> Patients and or carers’ individual needs or special needs including ethnicity, religion, culture, language, age, physical, sensory, developmental and psychological requirements. (DH 2001, p. 12)

A specific benchmark has been set for communication between health professionals and between the health professional and the patient. For instance, it states that

> patients and carers experience effective communication, sensitive to their individual needs and preferences, that promotes high quality care for the patient. (DH NHS Modernisation Agency 2003, p. 1)

Additionally, the *Essential Skills Clusters for Pre-Registration Nursing Programmes* (NMC 2007b) includes a key requirement of all newly registered nurses to have the ability to treat patients with dignity and respect them as individuals. The *Care, Compassion, and Communication* skills cluster requires nurses to respect diversity, be culturally competent, be non-discriminatory and not to harass or exploit patients. Nurses should be able to demonstrate an understanding of how culture, religion, spiritual beliefs, gender and sexuality can impact on illness and disability (NMC 2007b, p. 5). Nurses are therefore required to promote care that is sensitive to patient differences. Cultural competent practice can be defined as,

> A requirement of a practitioner to have culturally relevant knowledge, skills, and attitudes when working with diverse populations. To have an attitude of respect and openness to learn and provide effective health care which takes account of people’s cultural beliefs, needs and behaviours. (Almond 2008, p. 229)

Effective communication is also reliant on the nurse working in partnership with patients. Almond and Cowley (2008) provide a skills typology for working in partnership with patients and clients. It is founded on egalitarian and ethical principles. To work in this way the nurse requires a moral framework, to help her practice ethically and sensitively. Such a framework involves developing an understanding that all patients have a right to good quality health care, all patients
should be enabled to access the care provided and that barriers are removed for patients to access health care. These barriers are not concerned with geographical or physical barriers but are more often related to difficulties in communication (Gerrish et al. 1996).

This overview provides the policy drivers for nurses’ communication practice. It is argued that if health inequalities are to be prevented, nurses need to develop and practice communication skills that do not exclude patients and prevent them from getting the care they have a right to. The chapter now presents some of the general theories of communication, but it may be helpful to undertake Activity 1.2 before reading further.

What is Communication?

Communication is a process of interaction, meaning and understanding, in other words a message is passed from one individual to the intended individual and/or group of people and will be received or not, interpreted or not, understood and/or misunderstood. The message can also act as a trigger creating a positive or negative response which in turn can affect the responding message and behaviour of the individual and/or group. Consider also in this process that other factors influence the message and response of any given individual that when you enter these factors into the context of the situation you begin to understand the complexities of communication.

Communication is used for a range of reasons with social interaction as one of the main reasons; however, it can be used for power, control, manipulation and management and each of these concepts are studies on their own. The issue of power is an important area as though paternalism (i.e. where the professional makes the decision for the patient) is said to have declined. Lupton (2003) argues that this is not the case and our approach could be described as tokenistic.

Almost any field in the domain of communication with its underlying theoretical underpinnings can bring a different understanding and different perspectives to the communication process.

A critical social perspective (Robb et al. 2004) considers issues of power, gender, inequalities and race as influential in the communication process. This understanding raises issues within the health care setting, for example do health care professionals engage in collaboration with service users or are there still power imbalances? If someone has English as their second language do professionals become impatient and shorten the consultation as it presents difficulties for them?

A psychodynamic perspective (Woolfe & Dryden 1997) would argue that the communication process can be influenced by the unconscious; in other words, past
events may influence our perspective and understanding of any given event. If a service user had experienced in the past poor care within the health care setting and perceived the staff as hostile, a further admission would affect the communication covertly as the patient without realising may act defensively (as a way of protecting themselves) and the professional would respond accordingly without realising the negative effect this would have on the ensuing conversation.

When you examine a behaviourist perspective (Rungapadiachy 2001), it would be argued that as a result of experience behaviour changes and a positive and/ or negative reinforcer would increase/decrease the behaviour. This perspective is not so much interested in the why of the situation but how patterns of behaviour are learnt and maintained. If you smile at someone and he or she smiles back you are more likely to engage with that person on a regular basis than someone who ignores or frowns at you. It could be that learnt communication skills elicit a positive response and so are repeated and become the norm. This form of training is popular in many settings not just in the health care domain.

A humanistic perspective (Woolfe & Dryden 1997) or ‘person-centred’ approach emphasises the importance of the individual and his or her beliefs in self. The individual’s values and beliefs can influence how the individual responds to a situation. Obviously this applies to service user and professional equally. Rogers’s (1957) core conditions for effective interpersonal relationships will be discussed later in this chapter. The essence of a ‘person-centred’ approach can be found in the counselling domain and many of the key skills used in communication education have been applied to communication skills. Accepting a patient, for example, without judgement is one of the core conditions of a Rogerian perspective. This is not as easy as it sounds because the patient admitted for heart surgery has continued to smoke could easily provoke feelings of judgement and affect the communication process (Activity 1.3).

**Key Communication Principles**

Rogers (1957) provides some sound principles for effective communication that by accepting a person as unique and individual, accepting the individual without judgement and unconditional positive regard with empathy and with genuineness it can create a platform for rapport and effective communication. These principles, however, require closer examination if they are to be linked to clinical practice.

Each of us constructs our experiences in different ways and we store those memories in our minds and make sense of our reality by calling on those experiences. Each

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### Activity 1.3

Read again the four different perspectives and explore one of them in more depth specifically linking your findings to the communication process and record 2–4 key points that have increased your understanding of that perspective. Reflect on the impact of your findings and how it will influence your own communication skills.
of us will choose to filter an experience by acknowledging parts and ignoring other aspects of the incident. So two people could be in the same accident and one will remember one part of the story in a calm way and the other person will recount a much more dramatic picture and become very emotional. Rogers (1957) is highlighting the individuality of each person and the communication process needs to acknowledge that what you understand and what the service user understands may be completely different based on differing experiences and stored memories.

Accepting someone without judgement is a very difficult concept to consider. Each of us holds our own beliefs and values and if, for instance, fairness is a strong value and you believe everyone deserves the right to equal treatment, a patient who has received preferential treatment and/or has not been given the required care can affect the way you respond to the decision-maker. You may find yourself behaving in a slightly hostile manner, ignoring the person and/or making decisions about their code of ethics. Without realising it at some level the judgements we make can create barriers in the communication process.

Accepting someone with unconditional positive regard in a genuine way requires empathy and understanding. It is argued that only parents can claim unconditional positive regard for their children, and yet it is possible to accept a person without compromising your own beliefs and values by separating out the individual behaviour from the individual self. Unless you can own your own judgements it will be virtually impossible to be totally congruent in accepting another with empathy and unconditional positive regard. Some examples may be the patient who continues overeating whilst waiting for hip surgery; the patient who has been violent to his partner and is waiting to go into rehabilitation for a drug-related problem; the single mother who is on benefits and is failing to look after her young children.

Questioning is another key principle regarding communication. It is important to ask yourself as to what is the purpose of this conversation; if I hold this conversation what effect will this have on the other person. What do I need to say or do? Be clear of the focus and of the effects. So many communication failures could have been avoided if only some thought and planning had taken place prior to the conversation.

Questions can be leading (Burnard 1996) and full of assumption; we assume that we know what people are thinking, feeling and planning without even asking them. We ask questions that are value-laden, that is we make judgements: ‘you don’t do that do you?’ Confrontation can be very useful as long as a sledgehammer approach is not used; however, going round the houses is not very useful either. Some areas of health care require a more confrontational approach; however, this can still be attained with respect for the service user.

Self-awareness

Understanding yourself and your response to situations can lead to improved communication skills. The barriers to effective communication are often generated by the individuals’ own response to the situation in hand.

- Feeling uncomfortable with the situation: Sometimes we can find ourselves in situations that leave us feeling uneasy, and conversations may be shortened
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and/or ended so that we can make an escape. Providing that there is not a sense of danger, the reason for these feelings can generate from past experiences. If, for example, when you were a child you had an unpleasant experience whilst in hospital the situation you find yourself in may be acting as a trigger. Reflective practice can help in these situations by asking yourself the following questions: Is this more about me and my past experiences? Do I need clinical supervision to put things into perspective?

- **Personal issues:** If stress and anxiety are related to personal issues, our response to any given situation can be affected by the feelings and behaviours associated with stress. Being stressed can cause us to be irritated, curt and sarcastic, sullen and even voiceless if we cannot tolerate things any longer. Understandably, this will affect the communication process, and recognising our tolerance levels is important and developing strategies to manage stress levels is both important in the workplace as well as in a more social context.

- **Feeling out of control:** When in a new situation you can easily find yourself feeling out of control; for example, you may have been asked to admit a patient and you have difficulty understanding the patient, and the more you ask for clarification the more you cannot understand. The feelings of being out of control will affect the interaction – you may need to cut short the procedure and seek someone else to continue or acknowledge to yourself that you are doing the best you can and complete as much of the process as is possible and report your difficulties to another colleague. As soon as you stop blaming yourself and recognise the situation as a challenge and that it is not about you being out of control, with all the accompanying negative self-beliefs this can generate, the sooner you will begin to feel more in control of the situation.

Self-awareness is the key to understanding the reason why some interactions are successful and why others are not. Realising how much our past experience can affect us and how certain triggers can generate a response that surprises us is a process that can take a long time. Concepts from the counselling domain can bring some understanding and this only reflects a simplistic macro overview, but it is worth considering when exploring the communication process. Issues of transference and counter-transference (Dryden 1989) bring understanding as to why some interactions fail.

Certain thoughts, feelings and actions can be transferred from patient to professional health carer; for example, maybe you remind the patient of a next-door neighbour who has caused them problems, and they treat you as if you are the neighbour, and this leaves you asking yourself why is this patient so hostile? Equally the counter-transference will be you behaving towards someone as if the patient is the individual in question. You will be aware of how often someone will say: ‘She reminds me of my Nan/mother’ and respond accordingly.

Another aspect of self-awareness is the boundaries we set on an interaction, and if there are issues of low self-esteem, a need to be liked, self-loathing, our conversations may be guided for a need to meet that concept of self. For example, you may be over-friendly in a professional setting and without those boundaries in place your need to be liked will be greater than your professional conversation.
Communication and Practice

When you first engage with a patient there are some core underlying principles that will enable this process. These same principles can be applied to relatives and other professionals. It is essential that you establish rapport and most of this will be achieved through the use of body language, facial expression, where you position yourself and touch. We are capable of picking up messages from body language – if someone is angry, depressed, grieving or happy, language is not required, and if you add facial expression the message is enhanced; yet, so many people are not aware of these messages. If you are in a strange town what makes you stop and ask someone for directions?

If you are approaching a patient, scan for those messages, and if the patient looks anxious, approach with empathy. Be aware of where you stand or sit, and if at all possible be at the same height as the patient as it can be very intimidating for the patient if you tower over them. Space is also an important consideration; often, we stand too close and may even touch the patient’s arm as a means of comfort, but for some patients this action is intrusive, and this requires you to reflect on the question of touch and who is the touch for; is it to make ‘us’ feel better or is it for the patient’s benefit? The question itself can make individuals defensive and state that of course it is for the patient. There are times when touch is appropriate but not all the time and not for all patients. When you observe facial and body language and act accordingly you will find that rapport will increase, as the message you give the patient is one of engagement. Watch how many times people carry on with other activities barely glancing at the receiver of their greeting and/or information.

Always introduce yourself and explain all procedures, and when giving information ask the patients to explain what they think you have said, as it is often then that you discover that your explanation has not been understood. For some patients a conversation and a leaflet can help the process of understanding. For others, time and room for questions are required for comprehension. Yet others need the information in small chunks and others need time to think, find out more for themselves. If you accept the concept of being individual then it follows that information requires many approaches.

It is also important to listen to the tone of the voice, as it gives you many messages. When someone is sad you can hear the sadness in the voice, and equally if someone is happy this will also be conveyed through the tone of the voice. This can be important in telephone work as there are no visual clues. A patient can be telling you one thing, and the tone of the voice gives a different message. Equally, if you are able to recognise this, so can the patient, and if you feel irritated and/or cross with the patient, they will be able to recognise this in the tone of your voice.

One of the most difficult aspects of good communication is the ability not only to listen but to hear. We can let people know that we are engaging in the conversation by the use of minimal prompts (Burnard 1996). We may nod our head or use para-language, for example ‘mm’; however, the use of para-phrasing and summarising can let the person know that they have been heard, and it can also be an opportunity to clarify your own understanding. Following the told story, select the
perceived key aspects and repeat it back to the person: ‘So Mary you have been feeling unwell for 3 months and you say you are scared that there is something seriously wrong with you.’ At this stage make sure you do not put any of your own interpretation as you may be completely right but also very wrong. Ask the individuals to express their feelings and accept their response; if Mary has told you she went to the doctors and she said it was nothing it would be easy to say, ‘I bet you are angry with her’ when this emotion has not entered Mary’s head. This process of listening, hearing, feedback and asking more questions creates a forum for effective communication.

The use of open-ended questions can also generate a greater understanding of the issues being explored. As a principle, if you put who, what, when, where and how at the beginning of a sentence you will generate an open-ended question, and you can use ‘why’; however, this can sound very judgemental and needs to be used with caution. The open-ended question, for example, can change the response you receive (see Table 1.1).

There are times when it is necessary to use closed questions, for example, when gathering personal details like name and address. With practice the use of open-ended questions will become a more natural way forward to improving communication skills.

**Research: Communicating with Non-fluent-English-speaking Patients**

Having presented some of the general theories of communication, the chapter now moves on to discuss some specific communication issues that have been reported. Gerrish (2001) reported that nurses found patients who could not speak English to be one of their greatest challenges. The United Kingdom is increasingly becoming a richer and more socially and culturally diverse society. Health professionals are therefore required to be conversant with the communication needs of patients who may not have been born in the United Kingdom and who may not have English as their first language. This does not mean that nurses need to speak multiple languages. What it does mean is that nurses need to be cognisant of the diversity of the population they serve.

Box 1.1 shows how a research study discovered issues relating to communication (Almond 2008).
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BOX 1.1

A study of equity issues within health visiting postnatal depression policy and practice (Almond 2008)

A qualitative case-study approach was used to study one PCT’s health visiting postnatal depression service. Health visitors (HVs) were observed doing 21 home visits to antenatal and postnatal women. Post-observation interviews were conducted with 16 HVs. Nine Bengali women and 12 English women were interviewed. Additionally, 10 interviews were conducted with health visiting managers and other personnel involved in the health visiting postnatal depression service. In total, 51 interviews were conducted. The data were analysed using Ritchie and Spencer’s (1994) Framework Analysis method.

The study found HVs had access to interpreters provided by a local authority. They could arrange to have an interpreter when they were visiting postnatal women in the home or when they saw them in the health clinic. The Primary Care Trust (PCT) had not placed any limits on how often HVs could use interpreters and indeed a local policy had clearly stated that the service needed to be equal and equitable. However, Almond (1998) found that HVs thought using interpreters was a costly resource. It took a lot of effort to arrange for an interpreter to accompany the HV on a home visit, and the visit itself was also more time consuming and challenging. Therefore, busy HVs were more inclined to use an adult member of the family as an interpreter. Yet, even when a professional interpreter was used, HVs lacked confidence in their ability to interpret accurately. The paradox is that resources were available but HVs were disinclined to use them. These findings echo those reported by Gerrish (2001), who reported inequalities in the care provided by district nurses to Asian patients. She too reported limited use of professional interpreters, and the disadvantages that Asian patients experienced because of poor communication between them and the nurse. She goes onto argue that district nurses need to acknowledge their responsibility to provide equitable services to all their patients irrespective of ethnicity and languages spoken. Equity can be defined as,

Equity involves conscious and deliberate efforts to ensure and monitor whether appropriate services are provided and are accessible to those who stand to benefit the most from their uptake. This may involve making decisions that result in unequal distribution for some. Yet the standard and quality of services should be the same for all regardless of class, position race, disability, age, or gender. (Adapted from Almond 2002, p. 604)

Another barrier to effective communication was not related to the quality of the interpretation. The Bengali women said they did not want interpreters from the local community to be used. This was because they knew of instances where the interpreter had broken confidentiality and told other women about things she had been told at a home visit. So whilst the PCT had in essence attempted to overcome potential communication barriers, the actual resources provided were not culturally sensitive.
Activity 1.4

Read the case study below.

A case study of communication with a woman whose first language is not English.

Kishmiro is a young mother, who has been admitted to hospital for surgery. She arrived in England three years ago when she married her UK-born husband, Dharam. The nurse approached Kishmiro to carry out an assessment of her health. Whilst Kishmiro can speak English she does not speak it well. The nurse finds it very difficult to communicate with Kishmiro. She is not convinced that she has been able to carry out an accurate assessment. She tells Kishmiro that she would like her husband to interpret for her.

Read the following literature and then discuss the methods or resources the HV could use to communicate effectively.


The HVs explained that they did not feel culturally competent and were therefore reluctant to do more than the minimum on visits to Bengali women. The immediate solution to these difficulties is HVs and indeed other nurses who lack cultural competence need training to give them the skills and knowledge to effectively communicate with their patients. Health professionals need translated literature so that patients can learn about their condition and treatment. It should not be assumed that people from low-income countries cannot read or write in their own language (Activity 1.4).

Robinson’s (2002) review of studies involving interpreters concluded that trained interpreters can increase access to care but organisational barriers to their use need to be removed. The organisational barriers in Almond’s (2008) study were the difficulties that HVs encountered in planning and organising visits with interpreters and the lack of an infrastructure to enable HVs to use interpreters from another city.

Ledger (2002) examined issues relating to bi-lingual student nurses and student midwives acting as interpreters in hospitals where they were receiving their training. She argues that this is an unsafe practice and can leave students vulnerable to being involved in discussions beyond their abilities. Nevertheless, the communication difficulties did lead to some innovative projects involving students and hospital staff developing multilingual and multicultural advocacy and communication resources. Randhawa et al. (2003) investigated the role of communication in providing culturally competent palliative care services in the United Kingdom. Their
findings suggest that care is hindered by ineffective communication between health care staff and non-English service users. They also discuss the ethics and challenges of using family members as interpreters but found that link workers who were often used as interpreters lacked the skills to be involved in highly sensitive and emotional interactions between the staff and terminally ill patients.

Communication with Non-fluent-English-speaking Patients: Removing the Barriers

The application of communication theory here centres on communication with non-fluent-English-speaking patients. Theory without implementation remains no more than ethereal knowledge. Theory has to be used if it is to make a contribution to evidence-based practice and practice that is inclusive and culturally sensitive. As argued earlier communication is the main medium through which nurses and patients engage with one another. It is the means by which information is passed between both parties.

The following suggestions are provided as a starting point for communicating sensitively and effectively with patients who may not speak English or have limited ability in speaking and understanding English. They have been distilled principally from the authors’ own experience of communicating with diverse communities and research involving participants who did have English as their first language (Box 1.2).

**BOX 1.2**

Overcoming language communication barriers in encounters with patients who do not have English as their primary language: 12 steps to more culturally competent practice

1. The patients’ name can be an indicator that they may not speak English. When possible, contact previous health care givers to find out as much about the patients’ spoken language, command of English, health beliefs and attitudes, dietary preferences and social circumstances. Find out which language they prefer to communicate in. Offer and gently encourage the use of a professional trained interpreter if the patients’ or their own interpreter’s English is not fluent. Check that you are pronouncing their name correctly.

2. When speaking keep the voice level moderate but speak slowly and clearly looking at the patient.

3. Keep sentences short and simple. Avoid using British idiom (for example, it’s raining cats and dogs; I could eat a horse; my head’s splitting). Avoid using nursing or medical jargon and technical language.

4. Be patient and allow time for the patients to form their sentence; remember that depending on the situation they or their interpreter will be translating what you are saying into their own language, then translating their response from their own language into English.

5. Use culturally sensitive and appropriate literature to communicate with patients.

6. Be guided by the patient’s body language as to how formal or informal you need to be in addressing the patient. Take care with proximity, that is, the distance between you and the patient. This also includes eye contact and physical touch. A professional touching a patient’s shoulder to show empathy, warmth and understanding is acceptable in most cultures. Do not assume if the patient is smiling or nodding that they fully understand what you have said. Ask for clarification.

(Continued)
Conclusion

This chapter has explored the complex yet crucial essential skill of communication. By reviewing current health policy and the principles of communication skills, it has offered the reader a taste of this challenging area in terms of the client and patient groups you will encounter. The final section of the chapter captures some of the evidence base that is emerging on how nurses can play an active role in influencing communication and delivery of health care across a broad spectrum of people.

References


BOX 1.2 Continued

7. Respect the patients’ wish to have a relative with them during the nursing encounter.
8. Respect as far as possible the patients’ privacy in respect to physical examination and sharing information.
9. Respect the patients’ wish to be attended to by a male or female nurse.
10. Find out what the patients believe about their condition or illness as their beliefs may be contrary to the nurses own or professional beliefs. Explore sensitively and non-judgementally the patients’ background, religion, dietary preferences and social arrangements.
11. Find out more about the culture of your patients and how best to nurse them by reading and talking to other health professionals who may have experience to share with you.
12. Use an interpreter who is not from the same community or town (in this country and their country of origin).
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