11

Intercultural Communication

In this chapter, *Intercultural Communication,* we explore a variety of case studies related to healthcare communications. Conflicting worldviews and miscommunication are major challenges when professionals differ in cultural and linguistic background from the clients in their care. This chapter provides an opportunity to examine intercultural interactions in various practice settings, as well as exploring what it means to 'decolonize' practice. Health literacy as both an individual and organizational responsibility is discussed as an important element of cultural safety.

Chapter Objectives

After completing this chapter, you should be able to:

- demonstrate awareness of own language use
- describe some intercultural interactions that may influence practice and healthcare outcomes

P. B. Thompson and K. Taylor, *A Cultural Safety Approach to Health Psychology*, Sustainable Development Goals Series,
https://doi.org/10.1007/978-3-030-76849-2_11

- identify factors that facilitate or hinder communication between health professionals and patients who differ in cultural and linguistic backgrounds
- develop strategies to decolonize intercultural interactions
- define health literacy and identify strategies for enhancing health literacy in practice.

Intercultural or Cross-Cultural Interactions

As stated from the outset, all cultures and peoples are diverse and have diversity within. If we were all the same there would be no need to examine our interactions at all. However, in the healthcare and human services settings, the potential to misread, misinterpret, or miscommunicate leaves both practitioners and clients vulnerable to unintended negative consequences.

Cultural safety starts with *awareness* of difference. In doing so, we hopefully become aware of the commonalities between groups as well. For some, recognizing differences in the first place may be inhibited by being culturally blinkered—an inability to see beyond one's own cultural norms. This can get in the way of knowledge development and understandings needed to move to sensitivity and safety.

In this chapter, we provide examples of effective, and not so effective, ways of interacting. We strongly caution readers to recognize that not all communication can or should fit a neat stereotype. However, developing some language awareness can be a useful step in developing culturally safe communications.

Communication in Health and Human Services

An essential starting point for looking at any intercultural communication is to examine your own communication. Do you know how you communicate? What are your normal modes of asking questions, showing attention, or clarifying? What is polite and impolite in your own

primary language? If you are uncertain, think about it. If, for example, your primary language is English, start to pay attention to how English operates. English is spoken widely throughout the world and yet varies significantly across cultural groups. Encounters in health care or human services are often stressful for clients and when this is further aggravated by a language or communication difference between provider and client, the outcomes can range from frustrating to fatal.

In their now classic study, researchers Beckman and Frankel (1984) found when looking at communication in doctors' visits, only 23% of patients were able to finish their explanations and it only took 18 seconds, on average, for the doctor to interrupt. That is when a common language is spoken, so what happens when there is a language difference? It's not surprising when you look at the culture of the healthcare environment. It's often time-poor, resource-poor, and pressured but there is also an explanation that stems from how English is used.

English as a language does not handle silences well. It's a language that can be rapid and silence within spoken communication invites a response, but when someone is a speaker of another language, silences may mean something else. Silence created from the time needed for translating between languages, silence as a way of showing thoughtfulness about a question, or even silence as a way to show reluctance to answer a question are all ways to communicate something. The professional cultures of health and human services, however, is such that time is considered something we don't have enough of—'I haven't got time to wait'—yet getting communication wrong with patients could mean that more time is spent later with poor outcomes.

Frankel and Stein (1999) describe four habits—invest in the beginning, elicit the client's perspective, demonstrate empathy, and invest in the end—based on research evidence for improved outcomes in care. Although these have been designed for the medical or general practitioner, they may be useful for any health or human services professional to employ when working with any client. Commonly, there is the need for a polite introduction—checking that the participants are all safe in terms of the convenience of the interaction.

Invest in the beginning—listen to the reason the client is there. It is important to allow time for greetings and rapport building before

getting straight to the business. To believe that we do not have time for these simple processes is a false economy. What is saved by being so time efficient that you end up with wrong or poorer quality information exchange?

Let the client finish. Elicit the client's perspective—this is about asking the client what ***they*** think the problem is or what ***they*** think the solution might be. Clients have often thought about the problem before coming to see a professional and have already developed ideas about what the problem is and what might be the solution. This does not mean you have nothing to offer. They have after all, come to you for your expertise and assistance. It simply means you can also find out what the client's concerns are and deal with those concerns—such as fears of cancer or concerns about the adverse effects of medication. It allows for a richer picture to emerge. It is also an opportunity to validate the client's own worldview and belief system and offer service that is not at the expense of these aspects. Everyone is the expert of their own lives and their own experiences. Clients may well have talked to others and maybe even done some of their own research on their symptoms and experiences before coming to see you. The investment that they have made to understand what they are going through is valuable information that will help you provide more accurate as well as culturally safe service.

Empathy is about showing compassion. We can reflect on various 'clues' from the client to indicate how they are feeling. Sometimes, unfortunately, empathy can be more easily provided to those of a similar cultural background to the practitioner. Those of a different cultural background may receive less empathy without the practitioner being conscious of possible differing responses. This is another important reason to engage in critical reflective practice.

The Influence of Accents on Communications

Who reading this book does not have an accent? So, think about what the following statement implies: *'I had trouble understanding him because he spoke with an accent'.*

- Reflect on the above statement. What assumptions have been made?
- Who is positioned as 'normal' and who is 'different'?
- Who has the perceived deficit?

There are some significant differences across the U.S. in terms of accents or dialects, even among those who speak only English. In some regions, accents or dialects are so distinct as to potentially lead to misunderstandings. English-speaking professionals' lack of familiarity with specific pronunciations can lead to great frustration, on both sides, as well as shame and avoidance of certain situations. The consequences of these can range from an amusing encounter to something far more serious.

Remember the discussions around identity and the importance of our names. For many speakers of languages other than English, it's not uncommon that names are changed by health, or education professionals who might be unfamiliar and unskilled in pronouncing certain names: 'Oh, that's a hard one, I think I'll just call you Betty– is that OK with you?' Have you or anyone you know had to change your name or had it changed by someone who could not pronounce it properly?

- What message does this give the client about how you perceive them?
- How is this potentially a colonizing act?
- What would be the culturally safe approach to your difficulty with pronouncing someone's name?

The issue of frustration and embarrassment in trying to make oneself understood is a major issue for some people. In the U.S. today, there is an expectation that most people will or should speak English and therefore have no real problem with communication in a healthcare setting. However, this is a serious underestimation of what many authors believe to be a major barrier to safe and effective health care (Osborne, 2018).

The lack of awareness of potential communication barriers can often result in clients being labelled 'non-compliant', 'non-communicative', 'non-responsive', or not interested in their own health. This labeling

locates responsibility for outcomes on the clients. It is rarely acknowledged that the healthcare services need to examine their own responsibility for communication failures. How likely is it, for example, for a note in a client file to read something like this?

'*Note: Ineffective client history obtained due to poor cross-cultural communication skills of staff. Further staff education required.*'

Website and Reading

Explore the PBS website, '*Do you speak American*?' https://www.pbs.org/speak/ for information on dialects and language in the U.S. See the section *American Varieties* under the section *From Sea to Shining Sea* where you will find information on African American English, Cajun, Chicano English, Pittsburghese, and more. https://www.pbs.org/speak/seatosea/americanvarieties/.

You might also like to read this article for more about dialects in the U.S. and to explore a map of dialects across the country: Wilson, R. (2013, December 2). What dialect do you speak? A map of American English. *The Washington Post*. https://www.washingtonpost.com/blogs/govbeat/wp/2013/12/02/what-dialect-to-do-you-speak-a-map-of-american-english/.

The Fluency Corp provides some useful communication tips on their website relating to American English dialects: https://fluencycorp.com/american-english-dialects/.

Think about the requirements of 'informed consent' for many medical procedures. When working with patients whose first language is not English, if put to the test of what constitutes informed consent, there would be many examples that would fail the standard. How can you be certain that a client has truly understood what they are consenting to, what the procedures are, and what the risks are? Even when someone's first language is English, this is often difficult to determine. The social elements of obtaining consent, often in rushed circumstances, are less than ideal.

Communication challenges with linguistically diverse clients have also been identified as a major stressor for staff, who often feel unprepared and experience a sense of 'hopelessness'. Of greatest concern is the idea that preventable morbidity and mortality result from something that should be more easily facilitated these days. So why has communication been so neglected as an issue of consequence?

What can be done in practice? Without creating a tick-box approach, there are aspects of communication patterns worth examining in relation to English structures and patterns. More precisely, there are elements of English language that professionals can be made aware of in order to recognize where potential communication barriers might occur. Cultural safety starts with an awareness of one's own culture and the potential differences between the practitioner and the consumer. Below in Table 11.1 is a brief introduction to 'language awareness' that focuses on key elements of communication.

While it would be nice if everyone followed such prescribed ways of interacting, the variables that individuals bring to an encounter are extensive, which is why such a checklist is offered with caution. These are just a few aspects that you might encounter, where English could be creating expectations of understanding that are not there.

Limited English Proficiency (LEP)

Dettenmeier (2014) defines a person with Limited English Proficiency (LEP) as an 'individual whose primary language isn't English and who has a limited ability to read, write, speak, and understand English'. While this sounds like a deficit, it should be remembered that speaking your first language is not a limitation and effective communication in healthcare and human services is a human right. Surveys indicate that about 80% of people in the U.S. speak only English at home. However, 20% speak mainly languages other than English and many speak multiple languages. Of the 20% of those who speak a language other than English at home, a significant proportion don't speak English well and some not at all. These ratios are expected to increase in the future with changes to patterns of migration.

Table 11.1 Elements of healthcare communications in the U.S

Question formats	To indicate a question in English, there is often a raised intonation at the end. 'Do you have any children?' (the voice tone rises on children.) Not all languages do this and may sound like a statement when conversing in English as a second or other language 'I need to bring my children?' can in fact be a question without the obvious rise
Use of medical jargon	Use of technical language or jargon is often considered professional and used for specificity within practice. It indicates knowledge and expertise. However, when used in communications with patients, it becomes a barrier for conversing with lay people and particularly LEP clients. Use of jargon without awareness or regard can also be used to enhance the power of the users and exclude others. A decolonizing approach is one which limits or makes sure to explain medical terminology so the client is well-informed This can be done by linking technical words to commonly used words or terms E.g.: So, do you have any problems with *diabetes*, sugar sickness? Have you ever been tested for sugar or what we sometimes call *glucose* in your blood?

Model appropriate English	There is a distinction between plain English and over-simplifying that also needs to consider the age and responsibility of the client Substandard English doesn't help understanding yet this is something English speakers often do when they are talking with someone of a different language background. You may need to slow down a little, and use plain language, but your English should remain standard
The use of silence	In the U.S, when using English, questions bring an expectation of a prompt answer. For some other language speakers, questions, even seemingly routine ones, require careful consideration as a matter of good manners, which is demonstrated by lengthy pauses. Such pauses can be disconcerting to people whose first language is English. They may interpret silence as a failure to understand or as resistance to answering, or even dishonesty. Apart from a politeness, pauses may also reflect the time taken to process information into the person's first language and then relay the answer back in English. Try not to interrupt and allow adequate time for responses

(continued)

Table 11.1 (continued)

The use of abstract concepts	Healthcare often involves the use of abstract concepts that are difficult to translate, for example 'anxiety', 'depression', or even 'pain'. Ask instead what the point of the concept is and what needs to be done about it. For example, instead of asking someone how much pain they are in, ask them, 'What would you like for your pain?' English also uses metaphors or similes to explain abstract concepts which can be confusing for speakers of a different language. You can't assume that an example you use with an English speaker will be interpreted in the same way for speakers of other languages
Body language	English speakers use body language less consciously than some other language speakers, who incorporate gestures and facial expressions into the communication. Interpretation of facial gestures and non-verbal responses can be culturally specific Many cultures use non-verbal communication to convey information. When asking a question, health staff may 'miss' the non-verbal answer that was given by the client. Eye contact is also a feature of English communications in the U.S. that shows interest and honesty, whereas some cultures avoid eye contact at times, to show respect depending on who is speaking and what the topic is about

Reluctance to make a decision or 'yes' response	In English, to say yes to something implies and agreement. Some cultural communication styles use concurrence: that is, to agree with the person, and then continue on with no expectation of agreement. It can be impolite to contradict or confront, so agreement does not necessarily oblige one to do something, even if they have said they would For example, you might have asked someone to wait for something and they reply yes, but then you notice later, they have left. This can be frustrating in a healthcare setting. A helpful strategy might be to ask a little more, about how waiting might impact: "Do you need to be somewhere else, -is someone able to watch your children while you're here?' This might help gain more confidence about the response or indicate an issue requiring further attention

When professionals are not provided with the skills and resources for working with clients who have Limited English Proficiency, this puts both clients and professionals at risk of miscommunications, especially when healthcare and human services environments are almost exclusively limited to only English. A background of language difference between provider and client can result in shorter consultations, less access to preventative health services, poor medication and treatment compliance, medical errors, and more. Remember that with a cultural safety approach, the onus for communication is on the providers and the systems in which they work.

While many health and human services have tried implementing services for people for whom their primary language is not English, these are not consistently available in all areas. Dettenmeier (2014) advises that there are certain documents that must be translated according to Health and Human Services guidelines. These documents are vital to patients' healthcare and include: consent and complaint forms, documents that must be provided by law, notices about emergency preparedness and risk communications notices of eligibility for benefits, and notices about no-cost language assistance.

Providing culturally safe care requires services and professionals to find resources and strategies to help them communicate most effectively with clients, and it is important that these resources be critiqued to ensure their safety as well as effectiveness. It's a positive thing to learn some phrases for simple instructions in a different language, but it is also limited, and may still lead to misunderstanding and error. Using graphics or pictures is similarly limited and needs to be checked for their interpretation, but of course, these can be helpful communication aids. What is not helpful is speaking a substandard form of English, or childlike English (as opposed to plain, simple English) or raising the volume of your voice when speaking with clients.

Let us preface this by saying once again that people's life experiences need to be thoughtfully considered and we need to be careful not to act on stereotyped notions. The use of broken or substandard English by English-speaking professionals does not enhance understanding and can be demeaning. But there may be times when simplifying English is necessary to facilitate understanding. Be mindful of the experience of the

recipient of care. If you are not sure if your communication is understood, ask the client or family or support people with them to repeat what it is they have understood. In addition, it may help to explain why you are asking with something like, 'Could you tell me what I just said so I can be sure that I've explained everything properly?' This brief rationale shifts the responsibility to the practitioner who needs to make sure that their communication is effective, rather than placing the responsibility on the client.

With anyone of a linguistically different background, you cannot simply check understanding by asking yes/no questions. A plain English approach (not simple or childlike English) will facilitate greater understanding between yourself and clients of most backgrounds. Similarly, the use of technical jargon may be another barrier to understanding for many clients.

Scenario

'A nine-year old Vietnamese girl died from a reaction to the drug Reglan. Her parents primarily spoke Vietnamese, yet no competent interpreter was used throughout the child's encounters with the medical system. Instead, records show the patient and her 16-year-old brother served as interpreters. In the subsequent lawsuit, an expert witness who was a professional interpreter testified that "the parents were not able to adequately understand and address [the patient's] medical needs—the failure of the doctor and the facility to provide a professional medical interpreter was a substantial factor in causing [patient]'s death"' (Health IT Outcomes, 2014).

- What are the laws around providing access to interpreters for LEP patients?
- What are the key elements of informed consent?
- Discuss the ethical issues in using family as interpreters?
- What strategies are helpful when using an interpreter?
- What cultural safety principles should be applied in scenarios like this?

Think of a situation where you have had difficulty communicating. Perhaps you travelled to a country where the primary language was not

your first language. Maybe you can recall a situation of trying to understand a different professional area and not understanding what they were talking about—perhaps trying to understand an economist or geologist, when economics or geology was not your area of knowledge or familiarity.

- What was your experience? What communication skills did you rely on? These may have included nonverbal cues which themselves may not be universally understood.

Think about an experience of needing to communicate with a client whose first language was not English.

- How effective was your communication?
- What do you expect of clients when they come for a healthcare encounter?
- What do you expect of clients who may not speak English as their first language?
- What do you do or use to assist communications?
- How aware are you of the issues affecting communication for some Americans?

Scenario

'A first responder in Florida misinterpreted a single Spanish word, *intoxicado*, to mean "intoxicated" rather than its intended meaning of "feeling sick to the stomach, or nauseated." This led to a delay in diagnosis, which resulted in a potentially preventable case of quadriplegia, and ultimately, a $71 million malpractice settlement' (Graves, 2015).

Critical Thinking

- Without knowing all the aspects of the above case, reflect on how such a situation may have arisen.
- What actions might have changed such an outcome?
- What policies and procedures might be developed to ensure such a tragedy never occurs again?

Working with Interpreters

It is surprising how often professionals will fail to engage an interpreter when these services are available, especially in an area as critical as healthcare communications. Sometimes clients themselves will resist involving interpreters for a range of reasons. But sometimes, professionals believe that they either don't have the time or that they communicate 'well enough' or the client understands 'well enough'. What do you think of this standard for healthcare communications? Medical interpreting specifically is a specialized skill and when health professionals upskill themselves to work effectively with interpreters, this can only lead to better outcomes for clients. What is the role of health professionals for whom their primary language is not English? There may be many health and human services professionals who can speak languages other than English, but they are not necessarily trained for medical interpreting work and to do so may compromise the cultural safety of an encounter. What responsibility does healthcare and human services have for preparing all staff for culturally safe communication?

Confidentiality is another concern within health and human service communications. However, in respect of culturally preferred ways of operating, it may be that the client wishes to have family or other support people with them who are entitled and expected to be involved in information exchanges. The important thing is not to assume these entitlements exist and to check with the client about who they wish to include in communications.

Singleton and Krause (2009) offer some insights into intercultural healthcare communications:

> Even when an interpreter is used to facilitate understanding, or when a patient for whom English is a second language appears to have competent speaking and listening skills in English, cultural issues may still interfere with the effectiveness of communication between the patient and a healthcare provider. For example, many cultures emphasize showing politeness and deference toward healthcare providers who are perceived as authority figures. High context cultures have a preference for indirect, non-confrontational styles of communication; a cultural preference for

conflict avoidance can lead patients to say what they believe the healthcare provider wants them to say, or voice agreement or understanding whether or not they actually agree or understand. Asking questions and self-advocating in high context cultures might not be acceptable. Sometimes culture even influences which healthcare provider(s) a patient or family member will listen to and/or speak with. For example, there may be a preference for listening to a doctor over a nurse, or a male over a female. These cultural preferences can influence a patient's listening and speaking practices in clinical encounters. (Singleton & Krause, 2009)

Activity
Look up high context and low context cultures. Where do you position yourself in terms of these descriptions?

Check your local area or your workplace for interpreter services. How easy are these to find? Have you worked with interpreters? What culturally safe considerations might be useful in working with an interpreter?

Health Literacy

Health literacy has received less attention than it perhaps should as it contributes to health inequalities. Some 60% of all Americans, regardless of their primary language, experience poor health literacy at times, affecting medication adherence, compliance with medical instructions, and treatment outcomes. Not only is there potential for misunderstandings due to cross-cultural communication, but the way individuals and groups conceptualize and use health information influences the exchange of health information. Research suggests that there is a strong link between health and literacy, with literacy skills able to predict health status more strongly than age, income, employment status, educational level, and racial or ethnic group. Although literacy is implicit, health literacy is more than simply the ability to read and write. Low health

literacy is more likely (but not exclusively) to occur in those with low general literacy, the elderly, those with impaired eyesight, hearing, and mental alertness, some ethnic and cultural groups, as well as those on a low-income level.

Low health literacy affects the ability to follow instructions, provide informed consent, take medications, understand disease-related information, learn about disease prevention and self-management, and understand their rights. It affects access and uptake of care and increases the chances of dying of chronic and communicable diseases as well as the costs of health care. As health literacy is about a conceptual understanding, it is important that as practitioners you make sure you are using the same 'language', that is, that you have the same picture in your head as the client. This applies even when people share the same cultural background. Where there is a cultural difference, it is even more critical that you ensure a common understanding before proceeding with any other information exchange.

For example, to ask a client how many cups of coffee, wine, beer, soft drink they might have in a day requires an understanding of how that drink is consumed. For the authors, a cup of coffee may be something around 250 ml or 8 oz. For others, depending on their circumstances, the 'cup' may be a 'grande' holding about 500 mls or 16 oz. So, is it a cup of coffee… or a *cup* of coffee? Are you a 'social drinker or a *social* drinker'? What can help the exchange, if there is any uncertainty, is to have actual examples handy of each sized drinking cup. Here are some suggestions for improving the health literacy of your clients:

- Review written materials—check readability. Most word processing programs have a readability tool under the grammar and spelling check. Look at the reading age and ask yourself if the resource could be stated more plainly. Writing something in a plain way will be more accessible to a wider audience than something written at a college level.
- Use age-appropriate resources—try not to offer adults information that is normally targeted at children, such as pediatric pain tools, unless these have been validated for specific groups.
- Use or develop culturally appropriate, 'local' resources where possible. Without reinventing the wheel, it is helpful to show a resource from

elsewhere to key advisors and then work with them to develop a local resource that will help with engagement and interpretation.
- Lift the standard of expectation—plain English does not have to be simple or childlike English.
- Find a relatable concept from within patients' worldview or experience.
- Use the professional language in tandem with plain/local terms. Talking about diabetes, for example, it is helpful to link the common or lay terminology from the local context, to say something like: 'So tell me about your sugar problems, your *diabetes* …'
- Use graphics, symbols, drawings, illustrations rather than cartoons depending upon the intended audience. Photo-shopped images are a good way of using real pictures and transforming them into graphics. (Check symbols for interpretation because graphics that may represent a tree in some regions may look nothing like a tree in the clients' cultural context.)
- Never assume strong health literacy based on general literacy or educational level.
- Look for signs of low English literacy, such as clients who may avoid reading information in front of you, saying things like they have 'left their glasses at home' and will take the form home to do later.
- Ensure an environment of trust and safety.
- Communicate without jargon.
- Give clients a chance to tell their story without interruption.
- Limit the number of new concepts introduced (three per visit). (Adapted from Harvard T.H. Chan School of Public Health, 2019).

Low health literacy, cultural barriers, and limited English proficiency have been coined the 'triple threat' to effective health communication by The Joint Commission (Schyve, 2007). Health literacy, both conceptually and in practice, has often been siloed from interventions designed to overcome cultural and linguistic barriers (Singleton & Krause, 2009).

Health literacy is not dependent upon written literacy, even though there can be an association. A person who has limited English literacy may have strong health literacy, just as a person with strong English literacy can possess limited health literacy. For example, talking to clients

about restricting their fluid intake relies on a shared picture of what fluid is exactly. A client may tell you that they have not had more fluid, just some orange juice. In the intercultural domain, this potential for mismatched ideas is greater. A key principle of cultural safety is to talk with and to the client. Developing health literacy can only enhance the intercultural information exchange.

Website

An excellent resource for learning more about health literacy can be found at: www.healthliteracy.com.

Health literacy expert, Helen Osborne, publishes a monthly newsletter with tips and strategies for enhancing health literacy both at an individual level and organizationally. She also authored a text, Health Literacy A to Z (2018). Helen has kindly offered readers of this book access to her podcasts, websites, newsletters, including the option to rent or buy digital copies of her textbook. https://redshelf.com/book/1152309/health-literacy-from-a-to-z-2nd-edition-updated-2018-1152309-9781947937130-helen-osborne-medotrl.

Helen's materials often include information for intercultural health literacy as well as for those who speak English as their primary language.

Activity

Health information given to patients today usually aims to provide plain English explanations. However, the average health information sheet or brochure is presented at a Year 12 reading age. Examine the text below. Even with a readability score of Grade 6, which words and phrases might be difficult for speakers of other languages to read and interpret? Can this be made even plainer without 'dumbing down' the information?

> Asthma has been on the rise all over the world. We need to take action to help people control their asthma. We also need to learn how to prevent asthma. Asthma is a disease of the lungs that cannot be cured. Diseases like asthma that are with us for a long time are called chronic diseases. Asthma, like many chronic diseases, cannot be cured but can be controlled. To understand asthma,

> we first have to know some things about our breathing. The airways that move air through our lungs look like an upside down tree. When we breathe in, air flows into our nose and mouth, down our windpipe (trachea), through the air tubes (bronchi) and smaller airways, and into the air sacs (alveoli).
>
> When people have asthma, the airways swell. This swelling causes the airways to become narrow. Also, when people have asthma, mucus builds up in the airways. This swelling (chronic inflammation) and the mucus build-up that goes along with it get in the way of breathing. Medicines can make a difference. (Rudd, et al, 2004).

Try writing your own information sheet. Most word processing programs allow you to check readability levels of written materials by selecting this tool within spelling and grammar check options. Test a few patient information sheets for their readability and, if they are above a 10th-grade level, think about how the information could be made more accessible to readers with a range of reading levels.

How will you know this is appropriate?

Who would you involve in developing the materials?

What elements of culturally safe practice are important to remember when working with clients with different languages and literacy backgrounds than yourself?

Making It Local

Look at the latest policies related to language access in healthcare or human services in your state and nationally. What are the current priorities for health and well-being and how have these been determined? To do this: Go to the following federal government website www.health.gov. Next, go to the relevant state health department site. Search for and download the latest health policy directions or strategies.

Search for any information about language or communication in healthcare and if there is any information about a Patient Bill of Rights. What information can you find?

- Reflect on how these directions fit with the key issues you have been reading about so far in the topic.
- Reflect on what you have noticed either in your own experience in health services or in the context of clinical placements.

- Can you find such a document for your own community?

Conclusion

The content covered in this chapter is offered only as a prompt for what might influence interactions in healthcare settings. It should not be taken as applying to every encounter. The important thing in a cultural safety approach is to find out from the client or from other appropriate resources what the client's unique and specific needs might be. Cultural safety does not offer a checklist of responses. While the aspects discussed in this chapter point to some areas in which culture impacts on interactions; it is important not to see these as prescriptive. Awareness of differences is only a first step along the cultural safety continuum. Acknowledging the right to difference is therefore key to culturally safe communications.

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