The language of communication

Speaking to a person in their own language provides an opportunity to place that person at their ease, an essential requirement in medicine, and makes retrieving information from that person easier.

An article in this edition discusses the conversion of an English uterovaginal pelvic organ prolapse questionnaire into the language of Afrikaans. This South African (SA) language is based on European Dutch brought by settlers in a migration from Europe in the 17th century. It is closer to modern Flemish, spoken in Belgium. Afrikaans is the first language of approximately 13% of the SA population.

SA has 11 official languages. Zulu (or more correctly isiZulu) is the first language of 22% of the population. Several languages are spoken by only 5%. English is the first language of only 9%. There is clearly a great need to translate questionnaires into many languages and this is acknowledged by the article. Any person in SA wishing to perform research translates questionnaires into the predominant languages of that region. This facility in language should really be for everyday usage and not just for writing papers or for giving validity to academic research.

The problem of language is a worldwide phenomenon. It affects all populations and medical professionals from the Amazon to the Hindu Kush, from Timbuktu to Kamchatka and into the Pacific.

India has 22 official languages, though dialects would multiply this number even further. These include Hindi in the north, Bengali in the east, Tamil in the south, and Gujarati in the west. Any Indian would see this as an insulting oversimplification. Hindi is the language of government and films with the international language of family conflict. Hindi is spoken by 40% of India's population; English is spoken with ease by 9%.

Any large or populous area suffers from the same problem. The Beijing language of Mandarin may be spoken theoretically by over 900 million of China's 1.2 billlion people. But China is divided into at least 56 different ethnic groups. The number of spoken languages is large, including the Turkic languages in the west incorporated into China by several thousand years of migration along western trade routes.

Communicating in medicine in India, China, South America, Africa, or the Middle East may require many university-trained doctors to speak and investigate medical problems via interpreters. This must limit the accuracy and reliability of information. In English there is a children's game (broken telephone) in which each child whispers a message to a neighbour, and as it passes down a line of children a very different message emerges. Although in a medical interaction where language is an issue this process is limited to the message of one interpreter, the same problem can occur.

It is not just the actual accuracy of medical information that may be lost in translation, but also its completeness. Much of medicine lies in the detail. We have all sat next to a patient who communicates with an interpreter at some length, with a series of sentences exchanged, to be told simply on inquiring that 'the pain has gone.' Accuracy and completeness of information are important, not just in acquiring information for the detective element of medicine, but also in the information and reassurance that is given by the doctor to the patient. Reassurance is an important element of medicine. This can be lost by an interpreter. As language skill of the doctor improves this can become very clear, as reassurance given to the patient in several sentences is omitted and is translated by an interpreter as, 'you can get your pills from the pharmacy.'

Communicating through an interpreter may also limit the privacy of the moment, which must inhibit disclosure of information thought to be sensitive by the patient; this encompasses almost everything that might pertain to obstetrics or gynaecology. The patient may not experience loss of trust in the interpreter, but it is possible that sensitive information such as urine leakage may not be volunteered if a patient does not see the interpreter as sensitive or sympathetic.

Ethnic diversity breeds confusion if a dominant centralised training system requires centralised language usage. Even when a common language is used by the doctor and patient, misinformation and miscommunication can prevail.

A dominant language, such as Mandarin, English, or Hindi, may engender a dominant pattern of behaviour from the doctor when talking to patients of diverse ethnic backgrounds for whom the preferred medical language is a second, third or fourth language. Doctors may often be better educated than their patients (though not necessarily clearer thinking). A tendency to dictate in a doctor-patient interaction rather than to listen easily emerges. A British training film attempted to emphasise this point by showing a senior doctor celebrating communication skills on a large ward round as the patient repeatedly replies, 'Yes, doctor.' When the ward round is completed the tea lady approaches, offering to pour tea or coffee from the trolley. 'Yes, doctor,' replies the patient, who clearly has not been part of the previous ward round conversation.

The doctor-patient interaction may easily benefit the doctor more than the patient. Doctors may satisfy themselves that communication has been good even when it has not. Much depends on the attitude and humility of the doctor and much depends on language. As we pass through a world where technology and machinery replace the fundamentals of medical investigation, where notes contain phrases such as 'not sonographically or clinically appendicitis', basic skills are being lost. The use of language, the use of another language, and in a common language the careful choice of routine words where complex words have no place are at the core of maintaining this process of medicine, the ability to investigate and the ability to heal.

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