Fluency in the consulting room

THE analysis of communication is a complex topic that has been the subject of many disciplines, including philosophy, linguistics, and sociology. Within the sociology of health there has been an increase in the number of studies on the role of communication within the consultation process.[1] Two papers in this issue belong to this genre of research — they focus on communication between doctors and patients where the patients are not native speakers, and are a timely reminder of the increasing multicultural and multilingual nature of European societies and the challenge this poses to the provision of public health. Patients who do not have language skills to communicate with their GPs often rely on junior members of their family to act as interpreters. The study looking at bilingual young people's experience of interpreting in primary care by Free *et al*, shows that when problems arose in the health care encounters they were because of health care professionals' communication skills, the language skills of the young people acting as interpreters, and the nature of the health care problem.[2] Given that it is still uncommon to have regular trained interpreters available in surgeries where there is a large allophone population, the reliance on bilingual youth is inevitable and therefore it is important that healthcare professionals are aware of the special needs of junior family members acting as (untrained) interpreters. The need for greater training in communication skills for healthcare professionals is further endorsed in the study by Bischoff *et al*, which demonstrates that after healthcare professionals had undertaken special training programmes on how to work with interpreters, non-native speakers' experiences of healthcare encounters improved as a result.[3] Both of these papers recognise the importance of good communication for positive healthcare outcome and endorse what is now increasingly considered to be good practice in health care; i.e., the provision of interpretive and translation services. In addition, both studies point out that the effective use of an interpreter requires appropriate training for healthcare professionals, so that they know how to use interpreters. Thus, the use of interpreters is not something that is supplemental to healthcare provision but points to fundamental questions in the way in which healthcare professionals communicate with their patients. The problems of fluency in a language may be easy to detect when dealing with allophone patients. However, the problem of fluency cannot simply be reduced to a matter of language barriers. A person can be bilingual but still lack fluency in different aspects of his or her mother tongue. It may be useful to divide the question of language fluency into three levels: the technical, the ordinary, and the demotic (slang).[4]

A fluency in ordinary vernacular may prove difficult to translate into technical medical terminology, the situation in which most GP consultations take place.[5] When we say that someone is fluent, we normally refer to their competence in this type of linguistic exchange. This is the language of the educated, enculturated population. The absence of ordinary language fluency would of course complicate the normal consultation process, the difficulty being that it is not always immediately clear what degree of fluency in the vernacular would be necessary to make easy translations into medical terminology.[6] Fluency in slang is difficult to acquire through educational means, since its circulation and use are normally determined through informal contacts and mechanisms. Slang, however, can be very important in communication. Physicians may resort to slang or idioms (especially in dealing with subjects that are considered or maybe considered embarrassing, e.g. toilet functions). Those who are not native speakers are often likely to be at a disadvantage in the use of slang, since they are rarely part of the informal networks through which such terms are established and spread.

There is a tendency among many healthcare practitioners to assume that fluency in the native language is a reflection of being integrated into mainstream society and, conversely, the inability to speak English is seen as the sign of 'difficult' patients who have not made the effort to adapt to British society. There is no reason to assume that the intelligence or worth of patients corresponds to their ability to speak the 'official' language. This is particularly the case where other factors, such as the expert nature of much of the language, attempts to understand very subjective experiences, or using metaphors that do not have an exact or even close correspondence in the first language of a patient, might come into play for ethnic minorities.[7] For example, descriptions such as 'shooting pain' or 'splitting headache' used by a GP to understand a patient's symptoms may not be useful even to patients who feel they have a fairly good understanding of the 'official' language.[8] Measuring fluency within the context of GP consultations therefore cannot simply be a function of the general competence in the native tongue. The question of language competence and fluency within the context of the GP consultation requires a more specialised and more specific type of understanding.

Not all problems in the field of communication necessitate or can be resolved by the intervention of adequate interpreting and translation services. (There is also research that argues that language as a barrier to communication is diminishing problem among Asian patients in Leicester.)[9] Before a decision is made regarding the necessity or otherwise of interpreting and translation services, it would be more cost efficient if healthcare practitioners were aware of the types and the variety of forms that issues of fluency may take. A more rigorous understanding of fluency focuses attention away from the blanket requirement for interpreting and translation services to the provision of services that are much more closely targeted to the linguistic needs of the patients. By keeping in mind the distinct nature of skills involved in fluency (reading, writing, speaking, and understanding), healthcare practitioners may be more able to assess accurately the linguistic needs of their patients and thus reduce the possibility of miscommunication having adverse effects on healthcare outcomes. One can imagine a grid in which fluency in one type of language may not extend

to another, thus complicating issues of translation. This means that linguistic competence is a function of the different levels of fluency and that fluency itself depends on a certain cultural literacy, since language is embedded in cultures. Thus, the treatment of ethnic patients does not simply mean the provision of translation services (focusing on linguistic aspects of communication) but also some awareness by healthcare professionals of the way in which linguistic competence is embedded in cultural practices and beliefs.[10]

Fluency, then, cannot be easily reduced to competence in a dominant language; it has many dimensions that have potentially medical consequences.[11] Attempts to deal with the problem by simply providing interpreters or translation services neglects the nature of the difficulties involved, and it is only with careful and rigorous analysis of the way in which the multifaceted nature of fluency interacts with the consultation process that one can proceed with ameliorative measures. Fluency can often be a tangible and specific way of dealing with more complex and troubling issues arising out of cultural aspects of the patient–doctor encounter. The provision of interpreters is not the end process by which universal access to public heath services is provided to allophone minorities, but rather the beginning of the process by which the healthcare profession has to understand the way issues of cultural diversity impact upon its practices. The studies by Free *et al* and Bischoff *et al* contribute to what is a complex and important debate within healthcare service delivery.

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Language Line offers a comprehensive interpreting and translation service to organisations such as NHS Direct. For more details see their website at www.languageline.co.uk.

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Screening for domestic violence in general practice: a way forward?

INTERPERSONAL violence is a significant health problem with potentially serious physical and mental health sequelae. Recent focus is on the high incidence of domestic violence, including child, spousal, and elder abuse. Routine screening of women patients for physical abuse by male partners in primary health care settings is widely advocated internationally, including Britain,[1] New Zealand (NZ),[2] and the United States.[3]

General practice has evolved from a demand-led service of diagnosing and managing patients' presenting disorders, to one incorporating preventive medicine. Screening is secondary prevention: identifying pre-symptomatic patients who are at risk of developing a disorder and offering appropriate intervention. Since screening benefits the minority, with the possibility of harm to others, introduction of national screening programmes requires stringent assessment, to ensure that the benefits outweigh the risks and that screening is justified.

Advantages of screening

Potential harm from violent partners should not be under estimated. Serious partner abuse can result in psychological and social sequelae, physical morbidity, and occasionally death. While over 100 studies consistently find that men and women engage in physical aggression towards their partners in roughly similar frequencies throughout the western world, most research indicates that women are two to four times more likely than men to suffer significant injury and be fearful of their partner.[4]

Studies in emergency departments have found that

domestic violence is reported by 19% to 24% of females and 8.5% of males. Prevalence is likely to be significantly lower in GP populations.

Reducing domestic violence is a laudable aim, with potential public health gains for reducing both morbidity and mortality. Partner abuse affects not only couples, but also children and other family members. As well as direct health costs there are educational, employment, financial, judicial, and social service implications.

Disadvantages of screening

The World Health Organisation criteria, the *JAMA* Evidence-based Medicine Working Group recommendations, and the US Preventive Services Task Force give directives regarding screening on the basis of scientific effectiveness. These criteria are considered with respect to annual general practice screening for domestic violence of all women aged over 15 years, as advocated in NZ guidelines, and are set out below.[2]

Is it an important health problem?

While domestic violence causes considerable psychological and physical harm, and occasional fatality, it has far less impact on population morbidity and mortality than many biomedical conditions. In NZ an average of ten women and three men are murdered by their partners each year.[5] Six hundred women are expected to die annually from diabetes mellitus,[6] compared with ten from domestic violence.

Is there a clear definition?

Inter-spousal abuse is a continuum, with 'partner abuse' defined as physical or sexual violence, psychological/emotional abuse, or threat of violence occurring between current and former intimate partners. Psychological abuse involves behaviour causing anguish or fear, including intimidation, harassment, property damage, threats of physical, sexual, or psychological abuse, and attacks on individuals' self-esteem and social competence, causing increased social isolation.[7] Examples include shouting at a partner, insulting them or their family, controlling what they do, or limiting their spending of family income.[8] This broad definition clearly will result in a high identified incidence of partner violence. While door-slamming or voice-raising may be undesirable actions, a 'cut-off' point of what constitutes 'serious' abuse needs determination. Existing screening questions largely focus on physical or sexual abuse, but also include possible emotional abuse. A clear definition of the condition to be screened for is currently unavailable.

Is there a suitable test?

For a national screening programme to be introduced, evidence should be available that the proposed screening tool can accurately detect the condition (test sensitivity and specificity should be known), measured against a 'gold standard' diagnostic test. While numerous screening tools exist, none have been validated in the general practice setting and most are too lengthy for routine use.

Is the test acceptable to the population?

A recent systematic review of acceptability of screening women for domestic violence in healthcare settings found that most studies were methodologically flawed.[9] Only four studies met the review inclusion criteria. In these studies, 15% to 57% of women found routine screening unacceptable. Similarly, studies indicate that most general practitioners (GPs) and other primary health care workers (48% to 66%) do not favour domestic violence screening.

Are there benefits in screening?

The potential benefits of screening are earlier detection of partner abuse and application of appropriate interventions to prevent the ongoing abuse, and hence reduction in the incidence of subsequent psychological sequelae, physical morbidity, and deaths. Currently, there is no evidence to indicate that routine annual domestic violence screening of adult women will alter morbidity or mortality levels. One emergency department study found protocol introduction initially increased case identification, but this change was not sustained on annual follow-up. Routine screening by GPs is likely to have very modest gains with respect to case identification. Ensuring that GPs sustain their screening behaviour will require considerable ongoing training, prompts, and other encouragement, including possible contractual obligation.

Does screening cause harm?

The potential harm of screening women has not been researched.[9,10] Some patients may find questioning about partner abuse upsetting or offensive. This could negatively affect the doctor–patient relationship. Screening all women will not detect all cases, difficulties in definition aside. Some will choose not to talk to their GP about their relationship with their partner (false-negatives). A validation study of the Partner Violence Screen found 10% false-negative and 13% false-positive rates.[11] Labelling a woman who discloses that sometimes her partner makes her feel 'no good' or 'worthless' as a 'victim of domestic violence', and labelling her partner as a criminal, might inflate their marital conflict into a more major problem than it is in reality. This may adversely effect how the woman views her relationship and her partner's behaviour.

Are there high-risk populations?

The benefits of screening are greater for people at higher risk for the condition. While women from all social strata are equally likely to be violent, partner abuse is more likely to be perpetrated by men from low socioeconomic and socially deprived backgrounds. Associated factors are poverty, low education, unemployment, other interpersonal violence, mental illness, conviction for violent crime, drug abuse, and a background of family adversity.[12,13] Men in intact marriages are less likely to engage in violence generally. Young women leaving school, cohabiting and having babies early, have an increased risk of being abused. Most people have little exposure to violence or threats, but for a small percentage of the population violent events are almost commonplace.[14]

Does earlier intervention work?

Before a routine screening programme is introduced, there should be strong evidence that earlier intervention is effective. Good quality evidence is not available currently regarding effective interventions to prevent or manage partner abuse. No randomised controlled trials have been conducted to test the effectiveness of interventions. A recent systematic review found a lack of suitably designed research on the benefits of interventions for either women or men.[10] Comparative studies, mostly conducted in emergency departments and antenatal clinics, use referral rate to outside agencies as a primary outcome measure. This gives no information about women's resultant outcomes; for example, their quality of life or mental health status.[9] No studies have been published assessing potential harms of treatment.[10]

Cost-effectiveness?

A 1994 report from NZ estimated the economic cost of family violence as $1.2 billion, based on an assumed prevalence of 14% - one in seven women and one in seven children being victims of family violence.[15] While this figure is commonly quoted in government and other publications,[16] critical analysis indicates severe methodological study flaws, including faulty assumptions about prevalence and potential overestimates on many parameters used in the calculations.[17] Although $1.2 billion is a gross overestimate, there are clearly considerable costs to society, both human and financial, from partner violence. If screening significantly increases earlier case detection and effective interventions can be applied, then decreased healthcare, law enforcement, and judiciary costs would be expected, as well as reduced human suffering. Most screening is not usually cost-saving but it is considered worthwhile spending a certain amount to gain one quality-adjusted life-year. However, with no studies of effectiveness, cost-effectiveness cannot be assessed.

Recommendations

Inter-partner violence, especially against women by male partners and ex-partners, is a serious public health problem. Reducing this would effect public health gains. However, current evidence does not support routine screening, a conclusion supported by a recent systematic review.[9] Nevertheless, the degree of public and professional concern does demand some action and further research in this area is required. Possible avenues to address domestic violence screening include:

- *Establishment of a meaningful definition.* The majority of minor partner abuse episodes will not progress to incidents with serious physical or psychological sequelae. The aim of screening is early detection of a condition, so that preventive or early intervention heathcare measures can be applied. We should therefore determine that we are screening for a partner abuse history that is likely to escalate to more serious outcomes, should intervention not occur. Screening criteria should be selected to detect the serious end of the spectrum.
- *Develop a validated screening tool.* Before introducing screening, a validated GP tool that is acceptable to patients is required.
- *Targeted screening.* An alternative to routine screening is to screen only high-risk groups (background of family adversity; early school leaving and juvenile aggression; poverty and unemployment; cohabitation or motherhood at an early age; drug abuse or alcohol abuse; mental illness; criminal convictions; patients with injuries suspicious of abuse), to increase detection and reduce false-positives. While some may object to this process of screening, an improved detection rate may justify it.
- *Development of effective early interventions.* Most current interventions offer support to women to help them leave their partners and provide programmes for violent men. One study demonstrated that the majority of women who reported physical abuse by their partners wanted it to stop, but most did not want to separate.[18] Furthermore, living on their own does not necessarily reduce women's risk of violence. Solo mothers and women living alone are at greater risk of assault than those living in intact families.[19] Evidence suggests that many women who leave extremely violent relationships subsequently form new relationships with equally violent partners. Some evidence indicates that community-based early partner abuse intervention, using behavioural/cognitive techniques to teach couples communication, negotiation, and conflict resolution skills, results in sustained improvement in measures of couples' consensus, satisfaction, affection, cohesion, and use of reasoning to resolve conflicts in their relationships.[20] Research should be supported for randomised controlled trials of appropriate interventions, from prevention through early intervention to management of crisis situation.

It is not realistic for GPs to screen patients for domestic violence until there is (a) an effective and acceptable test that identifies those who would benefit from intervention; (b) GPs have training in effective skills, to care for patients experiencing or participating in partner abuse; and (c) there are agencies and programmes to which they can refer their patients that are shown to provide effective management with measurable positive outcomes.

Whether or not screening is introduced, GPs should be encouraged to learn about partner abuse and consider this possibility in patients presenting with physical injuries, psychological disturbance, or social dysfunction.

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