

Communicative challenges for paramedics: language and interpretation

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ABSTRACT:

The communicative relations that paramedics are involved in can be categorised as (1) direct face-to-face interaction and (2) interactive communication. (1) corresponds to interpretative communication. In direct interaction with patients and other health personnel paramedics can use a variety of perceptual beliefs to secure adequate interpretation of linguistic and non-linguistic behaviour. (2) corresponds to concept communication. In order to communicate in this sense a paramedic and his audience need to understand the language that is used in a sufficiently similar way, so that they associate the same concepts with the same expressions. Knowledge of the difference between interpretative and concept communication can be of great practical importance for paramedics. The reason is that an explicit awareness of the difference will help to understand how communication can fail and succeed in cases where communication is crucial.

KEY WORDS: interpretative communication, interactive communication, concept possession.

Background

The importance of communication for paramedics is often connected to paramedic-patient communication and, more specifically, to the importance of receiving vital information from patients (or friends or family of patients) about states patients are in (1, 2). In a typical case of paramedic-patient-interaction a patient utters sentences that express subjective states such as beliefs or feelings. The paramedic interprets these sentences within the context the patient is in. On the basis of the interpretation he forms he then makes decisions related to treatment and transport.

The fact that this is the paradigm communicative relation can make it easy to forget that there is another form of communication that paramedics are involved in which is important as well, namely communication between paramedics and other members of the health services. These relations include communication with medical doctors, contact persons in communication centres and other health personnel such as nurses working in hospitals.

In interaction with patients paramedics typically communicate with medical laymen, people who do not have much medical knowledge (3, 4). When communicating with other health personnel it is, on the other hand, possible for paramedics to convey and receive information on the basis of a common platform of professional knowledge. This, together with the fact that patients are commonly in states that influence their capacity to communicate efficiently, have the obvious consequence that it is often more difficult to secure accurate communication with patients than with other health personnel.

There is, however, another communicative distinction that does not fit clearly with the distinction between laymen and health personnel. This is the distinction between communication on the basis of interpretation and communication on the basis of a common language. Paramedic-patient-communication typically involves interpretation in the sense that a paramedic, in direct interaction with a patient, can use a variety of perceptual beliefs to improve interpretation of the patient's linguistic and non-linguistic behaviour. But paramedic-patient-communication involves more than face-to-face interpretation. A paramedic often receives via radio or telephone information from a patient or from friends or family of the patient. This information reaches the paramedic purely as speech; the paramedic is not able to observe the patient in the context the patient is in. Communication in this sense therefore presupposes that the paramedic and his audience share a language with the same conceptual content. They have to understand the language they use in a sufficiently similar way (5).

Similarly with communication between paramedics and other health personnel. Here the paradigm relation is communication via radio or telephone. In this process it is necessary that the parties understand the language they use in a sufficiently similar way. But sometimes paramedics interact directly with other health personnel, as when the members of a crew communicate with each other, or when they deliver a patient to a hospital. In these situations interpretative communication becomes crucial; in addition to speech it is possible to base interpretation on verbal and non-verbal behaviour as well as on observations of other aspects of the situation.

It is, therefore, incorrect to think of interpretative communication as equivalent to paramedic-patient communication and interactive communication as equivalent to communication between paramedics and other health personnel. The aim of this paper is to argue that it is, nevertheless, important for paramedics to distinguish between the two forms of communication. The reason, I will show, is that the communicative processes are fundamentally different. Furthermore, the essential differences correspond to different strategies for improving and securing communication in cases where communication is crucial.

Interpretative communication

Underlying the idea that interpretation is essential in direct interaction is a pragmatic theory of communication - how speech acts can be understood as intentional actions that express subjective states (6, 7). Within the pragmatic framework the main steps of the fundamental communication process are conceived of as follows: (i) Some speaker A has a subjective mental state that he wishes to convey to an audience B. The state can be purely qualitative such as the experience of pain, or it can have a propositional content such as a belief (the belief is true or false, the feeling is not). (ii) A expresses his state by uttering a sentence or by making some appropriate non-verbal action. (iii) B interprets A's behaviour in the light of the context they are in and in the light of the body of knowledge B already has. (iv) Communication from A to B happens if the state that B thinks that A intends B to understand that A has really is the state A intends B to understand that he has. (Communication from B to A happens the same way, except that the starting point is a subjective state B is in.)

When communication fails the problem is typically step (iii) (8, 9). When we communicate we normally take people at their words, we assume that they express beliefs that correspond to the words they use (5). For instance, when a person utters the sentence 'I am in pain' we normally assume that he expresses the belief that he is in pain. But sometimes we depart from literal interpretation, and we do this when the context is such that we think that there are good reasons for doing so. Examples are cases where a patient's body language is such that there is good reason for doubting that he is sincere. In other contexts it can be overwhelmingly difficult to understand what belief a patient expresses. This is typically the case when paramedics encounter immigrants who do not master the standard language in the linguistic community. In such contexts gestures, interpreters and knowledge of the meaning of alternative languages can be of great help.

In order to explain how different properties of a context can help to facilitate interpretation theorists have often appealed to the idea of a holistic perspective, the idea that all aspects of a person's context are, in principle, relevant for interpretation. The consequence of this is that language-in-use plays merely a limited part in the interpretation process. Non-verbal behaviour and other aspects of the context become equally important.

Below I will discuss in more detail how awareness of the nature of interpretative communication is crucial for paramedics. Before I do that interpretative communication should be distinguished from another form of communication.

Concept communication

When communicating interactively via radio or telephone a paramedic is not able to observe his audience. Steps (i), (ii) and (iv) of the above pragmatic communication process remain the same, but step (iii) becomes different. All that that is accessible to the paramedic is the language that is used. The obvious consequence is that the paramedic has to assume that he and the audience understand the words that are used in a sufficiently similar way.

But what, exactly, is a sufficiently similar understanding? A member of the health services and a patient will very seldom use a word in exactly the same way (10). So, if we think of sameness of language in terms of sameness of use, then we have to accept the uncomfortable conclusion that paramedics and patients very seldom communicate. This problem is especially acute in connection with medical terms, terms that patients often have a partial or even incorrect understanding of.

In recent years theorists have attempted to solve this problem of securing communication between persons who use a term in different ways by thinking of sameness of language in terms of sameness of concepts instead of sameness of use (5, 11). The concept that a person associates with a word is what he means when he utters the word; it is the conceptually content of his words (12). If a paramedic means *arthritis* by 'arthritis' and if his audience means the same, then they communicate when they use the word 'arthritis' in the sense that they both express the same concept *arthritis* by the word 'arthritis'.

The reason why this theory of concept possession escapes the problem of securing communication despite different usage is that it is assumed that a minimal understanding of a word can be sufficient for possessing the concept that the word literally expresses (e.g. the word 'arthritis' literally expresses *arthritis*). This means that two persons who use a term in different ways might still express the same concept - and thereby communicate in this sense - if their use is such that they both have a minimal or better understanding of the term they use. Since two persons often use a term such that they have a minimal or better understanding, this condition for communication is often met in real life. But it is not always met and this, I want to argue, is a point that paramedics should be aware of.

Applications

The difference between interpretative and concept communication is, in a nutshell, this: when interpretative communication is important the paramedic needs to have a holistic view on the whole situation in order to secure and sometimes improve interpretation. During concept

communication the much more narrow focus has to be exclusively on the language that is used, since there is nothing else for the paramedic to focus on. Several important implications follow:

- (1) In direct face-to-face encounters with patients and other health personnel a paramedic's hypotheses about the subjective states of his audience should be tested against the context as a whole.

A situation witnessed by the author of this article can serve as an illustration. A crew was sent to a patient who experienced severe pain in his chest. The patient was obviously nervous about his condition and anxious to know what the underlying cause was. The crew informed him that they were going to use an electrocardiograph. They thought, apparently, that this information would contribute to calm the patient down in the sense that it would bring the case closer to a diagnosis. The patient's behaviour suggested that they were wrong. It was reasonably clear that the patient had no idea whatsoever of what an electrocardiograph was. He did not have the minimal understanding necessary for possessing the concept *electrocardiograph* and was therefore not even able to form the thought that the paramedics were going to use an electrocardiograph.

As (1) states, an important strategy for improving communication is to use non-verbal behaviour or other aspects of a situation as a source for interpretation of thoughts or feelings that are not literally expressed in language, as the crew in the above example should have done. (In the above example the context clearly suggested that the patient did not form the thought that the paramedics assumed that he did.) Another strategy is to actually do something about a patient's understanding in order to improve communication. A second important implication is therefore this:

- (2) By making sure that patients have a minimal understanding of the terms they use paramedics can give patients information (and receive information) on the basis of a platform of a shared language (they possess the same concepts).

In most cases paramedics can make sure that patients have a minimal understanding by being explicit about common dictionary definitions of the term in question (1). In the case of 'electrocardiograph' it would have been sufficient to state that the word refers to an instrument for recording the changes of electrical potential occurring during the heartbeat (13). By internalising this explication the patient would have the minimal understanding sufficient for possessing the same concept as the paramedic, namely the concept *electrocardiograph*.

Another example is 'heart attack'. Although it is common to associate this word with some condition related to the heart, most people do not have very precise ideas about what this

condition is. When communication is important paramedics can secure that patients possess the concept *heart attack* by stating that the term refers to an acute episode of heart disease due to insufficient blood supply to the heart muscle (13).

At this stage some might claim that it is part of the professional competence of paramedics to have implicit knowledge of how communication can be secured. This claim is reasonable, but there are also paramedics whose competence is mainly based on practical experience. It is reasonable to assume that this group benefits from a more theoretical understanding of how communication can be improved. Furthermore, in a hectic work situation implicit knowledge may sometimes fail to reach the surface in the sense that it does not influence action. By having an explicit conceptual knowledge of the difference between interpretative and concept communication, the probability for this knowledge to influence practice is significantly improved. A third implication illustrates this last point even more clearly:

- (3) Having the same language in the sense of expressing the same concepts is not sufficient for communication

In an important range of cases of paramedic-patient-interaction the problem is not that the paramedic and the patient do not have a common language. The problem is that contextual factors complicate efficient communication. Such factors can include lack of attention, failure to systematise information in the way it should be systematised and failure to understand that the patient's perspective on himself and the situation is radically different from the paramedic's perspective (1, 8, 9). The fact that no cases of paramedic-patient-interaction are identical also suggests that paramedics should be careful about using general interpretation rules of the kind 'Patients of type T in context C has the belief that B if they utter sentence S'. A patient who fits the rest of the description might nevertheless not believe that B.

This point is also important in connection with interactive communication. The fact that a message has been sent out, together with the fact that the audience possesses the concepts expressed, does not necessarily mean that communication has succeeded. There may be factors of the kind mentioned that disturb the process such that the audience does not form the thought that has been transmitted. A final point is even easier to forget:

- (4) As a guiding rule, paramedics should seek to use theoretical words when communicating with other health personnel and ordinary words when communicating with patients.

The obvious reason is that patients are normally laymen. In order to be able to communicate with patients paramedics need to use words laymen can understand. When communicating with other health-personnel the situation is different: in this relationship a theoretical vocabulary with a fairly strict and

precise meaning is available (4, 10). As long as the other health personnel have internalised this meaning, then the word constitutes a very convenient precise tool. An interesting consequence of this is that it is normally easier to secure communication with other health personnel than with patients. Theoretical terms, once they have been learned, are more precise than many everyday terms that are used to talk about subjective states (consider 'pain', 'feverish', 'headache' and 'nausea').

In addition to the implications I have focused on others could be formulated, but that would fall outside the limits of this article. Furthermore, I believe that paramedics themselves should connect the difference between interpretative and concept communication to their professional practice. My aim has been to present a fundamental philosophical distinction between two forms of communication that should motivate reflection. Paramedics are the best to judge how the distinction apply in real life and how explicit awareness of the difference can be important in their daily encounters with patients and other health-personnel.

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