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Beyond ideal speech situations: adapting to communication asymmetries in healthcare

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Beyond Ideal Speech Situations: Adapting to Communication Asymmetries in Healthcare

Abstract

Inclusive, unconstrained and honest communication is widely advocated as beneficial and ethical. We critically explore this assumption by reflecting upon our research in acute care, informal care and public health. Using Habermas' ideals of dialogue to conceptualize ideal speech, we concur with observations that healthcare is often characterised by intractable exclusions and constraints. Rather than advocating implementing the ideals of dialogue, however, we examine how people adapt to these difficult and intransigent contexts. Non-ideal contexts, we find, sometimes call for non-ideal responses. Deception and furthering personal interests, and thus departing from the ideals of dialogue, can be adaptive responses.

Keywords

Communication, Habermas, Acute Care, Informal Care, Public Health, Dialogue

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Community health psychology is based on the insight that people and communities who experience health issues directly have important insights and resources for health-enhancing action. Dialogue within communities and between communities and stakeholders can strengthen these resources and produce effective contextual interventions. Such dialogue should be a form of “liberating action” for both local communities and powerful stakeholders (Freire, 1970: 139). But is open and unconstrained dialogue possible? Moreover, when it is not possible, what responses are appropriate?

The concept of dialogue is broad, with scholars variously emphasising ethical (Buber), literary (Bakhtin), and political (Freire) aspects. One commonality is the idea that genuine or transformative dialogue is inclusive, unconstrained and honest (Cooper et al., 2013). While it is often noted that healthcare contexts are asymmetrical, nonetheless, these ideals are often espoused in healthcare literature. Indeed, our initial aim was to better understand how to promote the ideals of dialogue in healthcare. In comparing our research, however, it was the violations of the ideals which proved most interesting. Without wishing to undermine situations where genuine dialogue is feasible, our reflection on the seemingly intractable asymmetries of status, ability and power in our research settings leads us to suggest that sometimes violating the ideals of dialogue can be a creative and adaptive response.

The Ideal Speech Situation in Healthcare Settings

There is a widespread assumption that healthcare contexts should be characterised by open and unconstrained communication. In acute care, there is emphasis on patients and junior healthcare staff speaking openly to senior health professionals, who are not always welcoming of critical engagement (Sexton et al., 2000). In long-term informal care relationships misunderstandings are common and open communication is advocated as a solution (Bowen et al., 2010; Yates et al., 2007). In public health, participatory strategies in which political and policy-making stakeholders engage in dialogue with marginalised communities are hoped to lead to health-enhancing social change (Jovchelovitch, 2007; Vaughan, 2011). However, the very persistence of these calls for open and unconstrained dialogue belies the constrained nature of communication in healthcare contexts (Greenhalgh et al., 2006).

To explore the transformative potentials of open and unconstrained speech in our respective research, we utilized Habermas’ (1981) conceptualization of the ideal speech situation because it is clearly defined and widely used. For Habermas (1981), dialogue in the ideal speech situation produces knowledge which is true and ethical. Ideas which can withstand open and unconstrained debate and argumentation are more likely to be effective and less likely to be disempowering. Habermas’ (2008: 50) recent revision identifies the following four “most important” aspects of such dialogue:

1. Inclusiveness: Anyone who can make a relevant contribution must be included

2. Equal rights: Everyone must have the same opportunity to speak
3. No deception: Participants must mean what they say
4. Absence of coercion: Raising issues and critiques must be unconstrained

These ideals ensure that the knowledge of each interest group is brought to the discussion, where it is debated from the standpoint of all stakeholders. While this is laudable in theory, it has been criticised as unrealistic and utopian in practice (see Calhoun, 1992). But these ideals are not intended to *describe* the world; rather, their very “counterfactual suggestiveness” is intended to mobilise *critique* (Scambler, 2001: 20). Habermas (2008: 50) acknowledges that their instantiation is rare and that they are not applicable to all communicative contexts. Whether he would view them as applicable to healthcare contexts is a moot point. Nevertheless, many researchers in healthcare contexts have advocated striving towards Habermas’ ideals explicitly (Teo, 1998) or towards more general conceptions of inclusive, unconstrained and honest dialogue (Bowen et al., 2010; Vaughan, 2011).

The following empirical case studies use Habermas’ ideals as a conceptual grid to analyse our own research in four healthcare contexts. Our aim is to consider the way in which these contexts are non-ideal, not because we are critiquing Habermas’ ideals, but because we agree with Habermas that the ideals will not always be applicable, and thus there is a need to consider the dynamics of dialogue beyond the ideals. Specifically, having identified how these contexts are non-ideal, our focus is on people’s local, adaptive and creative responses.

(1) Critical Care Team Meetings

Reader and his colleagues have shown how team meetings in critical care units raise distinct challenges for dialogue. Doctors (consultants, registrars, juniors) and nursing staff (senior and junior) must collaborate to make effective decisions on critically ill, often unconscious, patients. Consultants lead patient care; junior doctors and registrars are in a training role, and perform the majority of tasks; nursing staff monitor progress. The ideal of open communication with unconstrained exchange of information during decision-making and patient-monitoring is essential (Reader et al., 2007), yet, it is often not achieved.

Institutional status, lines of responsibility and differential expertise thwart the ideal that each has equal opportunity to speak. The consultant's overall responsibility, expertise and seniority inhibit junior doctors and nurses from communicating openly (Reader et al., 2007). Thus treatment decisions and practices might be carried out with incomplete information (Reader et al., 2011). Junior team members can believe that consultants do not value their contributions (even when the opposite is true). Furthermore, nursing staff can feel excluded by opaque medical discourse and junior doctors fear embarrassing themselves (through asking a ‘silly’ question) or the consultant (through contradicting them). In each case, the second ideal (equal rights to speak), is violated through asymmetries of status.

Although interventions (e.g. daily goal sheets) have been developed to overcome communication barriers (Pronovost et al., 2003), asymmetries in status and expertise are deep-set. To work around these seemingly intractable asymmetries, critical care teams sometimes engage in a degree of deception in their communication (Reader et al., 2011).

For example, to build the confidence of trainee doctors, consultants allow them to lead patient decision-making. However, consultants report subtly leading or ‘scaffolding’ the decision-making process, so that while the trainee appears to have decision-making power, the decision matches the consultant’s own assessment (Reader et al., 2011). Thereby, consultants can ensure the ‘right’ choice is made for the patient, and that the trainee is shown respect and not undermined. Interestingly, trainee doctors report using a similar tactic to influence consultants’ decision-making. When trainees disagree with a consultant’s decision, they describe attempting to influence decision-making through having the consultant explain (i.e. teach) the logic underlying their decision. This avoids directly challenging the consultant. In both cases, junior and senior medics adapt to unequal rights to speak rather than ‘fixing’ the situation (e.g., removing status). However, whilst this further violates the ideals (no deception), it is not strategically advancing personal interests. Rather, it is aimed at ensuring high-quality patient care.

(2) Informal Care for People with Aphasia

Gillespie and colleagues have examined the dynamics of dialogue in studies of people with aphasia and their main informal carers (Gillespie et al., 2010). Aphasia is a communication difficulty, often caused by stroke or trauma, which affects speaking, understanding, reading and/or writing. People with aphasia often find everyday activities difficult and thus supportive care relationships are central to successful adaptation (Hinckley, 2006).

Although carers typically recognise the right of people with aphasia to speak, it is often difficult to include them in conversations (Croteau and Le Dorze, 2006). Thus the disability (and communication partner’s limited capacity to support communication) results in exclusion (violating the ideal of inclusiveness). Interestingly, the concept of the ideal speech situation does not, in this instance, serve a useful critical function. Both parties would prefer an inclusive dialogue.

How do care givers and receivers adapt to this non-ideal situation? Beyond using assistive technologies, people with aphasia often receive day-to-day help from an informal carer (usually a family member). Research has revealed a wide range of misunderstandings between informal care givers and receivers in both aphasia and other disabilities (Gillespie et al., 2010). For example, it is common for care receivers to underestimate the effort and distress of the main carer. While some researchers have advocated open communication to resolve these misunderstandings (e.g., Yeates et al., 2007), closer analysis suggests that these so-called misunderstandings are far from accidental. Many informal carers try to conceal the burden of care, because communicating this burden to the care-receiver would increase distress (Power, 2008). Thus a deliberate violation of the third ideal (no deception) appears as an adaptive response to a seemingly intractable disability. Deception here is not malevolent, seeking to distort outcomes to advance selfish interests. Rather, the deception is perpetrated to protect the confidence and positive identity of the person with the disability. This violation is not a pathology of communication, but a carefully crafted adaptive response to a difficult situation.

(3) ‘Community Conversations’ in Rural South Africa

Research by Campbell and colleagues with a community in South Africa with high levels of HIV/AIDS found stigma, AIDS-denial and disempowerment (Campbell et al., 2007). A lack of perceived agency was limiting positive responses by the community and undermining the impact of a group of stalwart women volunteers to provide home-based care (Campbell et al., 2009). The researchers decided to use a series of community conversations to (1) feed research back to the local community, (2) create a discussion about potential community responses, and (3) enhance people's sense of agency by emphasising local strengths and cultivating ownership over the problem. The workshops aimed to instantiate the ideals of inclusiveness (ensuring previously excluded community members participated) and equal rights (between researchers and the researched).

The first problem encountered was that some key actors (men, traditional leaders, and traditional healers) refused to engage in the dialogues. They were physically present (being forced to attend by the chief) but uncommitted; sitting in silence they undermined inclusiveness. Because they were gatekeepers to hard-to-reach groups the research team did not challenge their non-participation. This complicity, a violation of the ideal of unconstrained dialogue, was deemed better than causing offence which might result in a walk-out and thus even less participation. The subsequent project evaluation suggested that this short-term complicity led to greater inclusion over the long-term through creating common purpose and trust.

The second problem encountered was how to foster community agency given the asymmetry in expertise and status between the local community and the research team. Transmitting alien biomedical information about HIV/AIDS would have risked undermining local agency to respond. The team decided not to challenge misconceptions about HIV/AIDS, believing it to be more important that the community felt respected and had ownership of AIDS-related knowledge than that they had technically accurate information. Thus the research team adapted to the asymmetries of knowledge and status by positioning the community as knowledgeable, even when they saw gaps in their knowledge. They perpetuated this deception in the interest of advancing community empowerment in a context where truthfully 'correcting misconceptions' might have appeared rational, but may have further undermined community confidence and empowerment (Campbell et al., 2012).

(4) Sex Workers and Powerful Stakeholders in India

Cornish and colleagues have examined how sex workers' HIV prevention organisations in India have managed their relations with the police, politicians, journalists, government officials and funding agencies (Cornish et al., 2010; Cornish et al., 2012). The 'rational' goal that these organisations seek is a safer environment for sex workers. Through engagement with stakeholders, they seek to reduce violent police raids, secure politicians' support for health camps, and obtain supportive media coverage.

While it may be argued that dialogue among such groups could lead to perspective-taking and co-operation, in the competitive context of the red light area, where disadvantaged and stigmatised men and women struggle for survival, communication is typically strategic and political rather than pursuing the ideals of dialogue. Pimps and madams wish to maximise their profits. Local men's clubs seek to establish political sway over the area. Often, such

groups' priorities are opposed to sex workers' interests in safer sex and empowerment. These divergent interests constrain what can be said and heard, undermining the ideal of no coercion.

To mobilise support in this competitive context, sex workers' organisations often treat like with like, politicking with powerful stakeholders, persuading them to help the sex workers, not because it will lead to health and empowerment, but because the powerful groups themselves stand to gain. By 'exchanging favours', sex workers negotiate these stakeholders' support by incentivising their co-operation, usually creating an unspoken bargain or debt to be repaid. Instead of addressing common concerns, then, they meet the private interests of others in return for meeting sex workers' interests. For example, sex workers can offer the police information on criminal activities in the red light area in exchange for reducing arrests of sex workers (Cornish et al., 2010). Or they may offer politicians 'chief guest' status, a stage, and a potential 'vote bank' in return for symbolic and practical support (e.g. allowing construction of a clinic). Instead of trying to remove the vested interests which constrain dialogue, these organisations are adapting to these seemingly immutable power asymmetries by *furthering* the interests of powerful groups in a tit-for-tat exchange of favours.

Conclusion: Adaptive responses to non-ideal speech situations

The literature recognises that ideal speech situations are rare (Calhoun, 1992; Greenhalgh et al., 2006; Habermas, 2008; Marková and Foppa, 1991). However, the ideals of dialogue are not intended to describe communication. Rather, they are intended to provide goals to strive towards and future possibilities which enable critique of the present. Habermas (1981, 2008) has consistently emphasised that these ideals are only applicable *in some contexts*. Accordingly, we conclude by reflecting on the extent to which the ideals of dialogue are applicable, as ideals, in our four case studies.

Our healthcare contexts are beyond the ideals of dialogue in three ways. First, the constraints of status, disability, disempowerment and personal interests evident in our case studies are ingrained into the environment and it would be naïve to call for their removal. Second, utilising the critical potential of the ideals would entail criticising junior doctors who feign ignorance to educate the consultant (case study 1), caregivers who conceal the burden of care (case study 2), researchers who avoid pedantry to foster confidence (case study 3) and sex workers who further the interests of powerful stakeholders to obtain a favour (case study 4). As these are adaptations to non-ideal contexts, critique would appear misplaced as the motivations behind deception are well-intended and aimed to overcome other immediate problems. Third, dialogue in these healthcare contexts is not simply 'truth-seeking.' People are also managing identities, and sometimes, identities are protected or even bolstered by a degree of deception. But this is not to further the interests of self (i.e., strategic action), rather, it is other-directed, aiming to redress an intransigent asymmetry. The key point is that these deceptions are not meant to create personal advantage. On the contrary, they are often meant to reduce it, striving towards mutuality where none is possible.

We are not advocating that the ideals of dialogue be abandoned; there are doubtless cases where we should pursue the ideals. But, as we hope to have demonstrated, there are also contexts where they are not applicable. Specifically we argue that the ideals of dialogue should not be over-extended, thus blinding us to alternative ways of dealing with manifestly non-ideal contexts. Interventions based on the principles of open and unconstrained dialogue often fail (e.g. Kelly and van Vlaenderen, 1996). Looking beyond the ideal speech situation entails recognising that social life is often (but not always) characterised by immutable asymmetries. It also means recognising how people are adapting to these constraints. Before judging an act of deception or a self-imposed constraint on dialogue against decontextualized ideals, we should examine how it fits into its own particular context as a potentially reasonable response to a non-ideal situation.

Statement on authors' interests

No conflicting interests

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