Chapter 2

Communication, nursing and culture

Learning outcomes

At the end of this chapter, you should be able to:

✔ identify different types of communication
✔ discuss communication in nursing
✔ identify problems in health-care communication
✔ appreciate some cultural difference in communication

Introduction

This chapter explores the concept of communication among and between people, focusing on key aspects of verbal and non-verbal communication. In particular, cultural variations in communication patterns are explored, along with some potential implications for nursing practice.
What is communication?

We communicate all the time: in fact, we cannot *not* communicate. There is a common tendency to think of communication in terms of speech, conversation, written documents and so on. Or we think of non-verbal communication, which is about the ways in which we use *eye contact*, gestures, *touch* etc. However, we also communicate in numerous other ways, such as the clothes we wear, the symbols we adopt (e.g. the Christian who wears a cross around their neck, or the Buddhist who wears wrist threads), our accents and the use of speech. All of these things, and many more, help to convey messages to other people about who we are. In nursing, all of these aspects of communication come into play, but these aspects of communication may be ‘read’ differently by patients and nurses from other cultures. There is probably no such thing as ‘culture-free’ communication.

It will be useful to consider the cultural implications of both verbal and non-verbal aspects of communications, under the following headings:

- Communication hierarchies
- Saying hello and goodbye
- Please and thank you
- **Phatic communication**
- **Listening**, turn-taking and pacing
- **Proximity**
- Touch
- Eye contact
- **Volume and gesture**

**Communication hierarchies**

In the west, particularly in northern Europe and the USA, people work and communicate together in fairly informal ways. There is what may be called a ‘flattened hierarchy’ in many organisations. This is still not completely true in the health-care professions, where medical staff tend to view themselves as ‘senior’ in relation to nursing staff. However,
It is increasingly common to use first names, instead of titles and surnames ('Jane', as opposed to 'Dr Hartman') in working situations. Almost paradoxically, though, we should not assume that patients automatically want to be called by their first names, particularly if they are older or have held posts of seniority.

Given the relative lack of hierarchy in western society tends to mean that people can talk fairly freely between themselves, and patients are increasingly questioning and challenging health-care professionals. They are also becoming increasingly knowledgeable about the conditions from which they suffer, partly from television programmes, from reading, and to quite a large degree because of the amount of information available on the internet. Health professionals seem to have mixed views on this. Some see it as an empowering process for the patient, and others (perhaps rightly) are concerned about the status (and possibly the reliability) of the information available on the internet. Whatever the views held by individuals, it seems unlikely that the tide will turn back to a time in which Western patients meekly accepted advice from their doctors and nurses.

The other side to this 'knowledgeable patient' situation is that doctors and other health-care professionals are being increasingly influenced by the notion of evidence-based practice and patient-centred care. Evidence-based practice is concerned with health professionals identifying, through the research literature, the efficiency and effectiveness of particular treatment regimens (Gill, 2004). Clinical judgement is increasingly being supported by all the available research to provide the best possible line of treatment and care. At the same time, healthcare practice is increasingly being run along business lines and patients are, to a much greater extent, being viewed as 'customers' or 'clients', with the right to request or challenge the available treatment. The pull, in both directions, in the west, is thus towards a further flattening of the health-care hierarchy.

In the east, however, the notion of a highly structured social hierarchy is much in evidence. In Thailand, for example, no-one is equal to anyone else, and Thai people are adept at quickly identifying where they stand in relation to those with whom they come in contact. Even twins are not equal: the first born is 'senior' to the second born, and the second born
will defer to the elder twin. Seniority may be broadly identified in terms of age, education, job and salary. In health-care settings, patients listen to doctors and, to a lesser degree, nurses, and never challenge the advice they are given. They may also be nervous about asking doctors questions if they do not understand a particular plan of treatment, and it often falls to the nurse to act as intermediary or go-between, in the doctor-patient relationship. However, this takes some courage on the nurse’s part, as he or she may also be nervous of questioning the doctor.

In Eastern countries, too, professional titles are important and are often used, although in Thailand people are generally known by their first name with a title attached in front. Thus people may be called the equivalent of Dr John or Miss Jane. Even the Thai phonebook is printed in first-name order, rather than by surname.

Except among friends, in the east the normal practice is for senior people to speak first and for junior people to listen and answer questions asked of them. In this sense, eastern cultures often appear very ‘polite’ in comparison with their western counterparts.

Saying hello and goodbye

People in the UK say hello or hi very frequently during the course of the day, sometimes even extending to saying hello to a colleague each time they meet. In contrast, in a number of Asian cultures, neither hello nor goodbye is frequently used: it is acknowledged that you are there by your presence, and it is not felt necessary to say hello. Similarly, it is fairly obvious when you are leaving and it is not felt necessary to say goodbye. The term for both hello and goodbye, in Thai, is sawatdee, and it came into the language only in the 1930s. It is not used frequently among Thais themselves, but is sometimes used to greet foreigners. Departures in Asia can appear abrupt to those from the West, where, particularly in the UK, departures can be very prolonged. Consider the following situation:

**Friends have been to your house for a meal and begin to indicate that they will be leaving soon. This will often be heralded by a vague statement, such as ‘We must be**
Culture and nursing: a Thai nurse’s perspective

In Thailand there is a culture of respect towards people who are older than you. In general, the more senior you are, the more respectfully you will be received, particularly by older people. Even though you do something wrong, people are ready to forgive you because you are older, more senior, and have more experience. As an old person you are supported, not blamed.

In nursing practice, this culture of respect has been adopted in how nurses approach patients from different age groups. The interpersonal relationship can be initiated by how we relate to other people. Thus, you could show your respect to older patients by calling them ‘father’, ‘mother’, ‘grandmother’, ‘grandfather’, ‘uncle’ etc. This is more common than using a patient’s name. The more precise initial name you give needs to be related to your own age. For example, when you are around 20-30 years of age you may need to call patients who are 50 years old ‘father’ or ‘mother’.

Case Study

Contrast this with a meal in a Chinese house, where, as soon as the meal is finished, guests will usually get up and leave immediately. Similarly, in health-care settings Asian patients may not expect you to greet them, whereas UK patients may feel affronted if you do not say good morning or good afternoon when you come on duty, or visit them in their houses.
Most patients seem to feel happier when they see you are paying respect; they feel more comfortable in the situation and have a lot of self-esteem while being a patient.

However, this practice needs to be validated if you work in a big city, where they are more prone to westernisation and people are more individual. When you call a patient father or mother, he or she may reply that ‘I have only child’ or ‘I’m not your mother’: this means that you are not their child, and so you are not supposed to call them father or mother. The interpersonal relationship between patient and nurse in a big city is much more formal and quite distant. Money is power, too, if you are hired as a personal nurse for patients who are better off, to take care of them in their private hospital room. Basically, we do not mind if we provide whatever patients need when they cannot do it for themselves, but sometimes their family may view a personal nurse as a servant or housekeeper, who should provide extensive services to the patient’s family as well as their visitors. For example, they may expect the personal nurse to prepare drinks and snacks for the patient’s guests, or to turn the TV on and off as the patient or their family request. From time to time it has been brought into discussion in nursing meetings whether these are professional nursing jobs. It was concluded that nurses need to work strictly on their professional jobs and leave the rest to patients’ families or housekeepers. This response, of course, does not please the patient’s family, who has more of an expectation and has the attitude that they have already paid for a personal nurse, so they must work as a personal assistant too.

In conclusion, providing nursing care in Thailand involves not only the need to bring cultural influences into account, but also cultural changes are needed to keep nursing professional.

Please and thank you

As with hello and goodbye, the saying of please and thank you varies greatly from culture to culture. People in the UK tend to use these
words excessively. For example, a conversation in a local newsagent, involving a man buying a newspaper and the woman operating the till, might proceed thus:

‘Hi. Thanks.’ (Man places paper on the counter)
‘Thanks. That’s 80p please.’ (Assistant)
‘Thanks.’ (Man, searching for money and then giving the money to the assistant)
‘Thanks.’ (Assistant taking money)
‘Thanks.’ (Man receiving change)
‘Thank you.’ (assistant)
‘Thanks.’ (Man, leaving area)

This transaction involves seven ‘thank yous’ in order to buy a single newspaper. In South-east Asia, and probably in many other parts of the world, the transaction might have taken place in silence. The problem with growing up and living in a country where please and thank you are said so frequently is that people from that country tend to perceive those from other cultures, where the words are less frequently said (if at all), as rude. Nurses in the UK are likely to expect patients to thank them for carrying out a particular nursing task, but if the patient comes from another culture such a statement might be deemed unnecessary; it should not, however, be construed as rude.

The other ‘automatic’ word for many UK people is ‘sorry’. If two people bump into each other, it does not matter who was at fault, as both are likely to say ‘sorry’. And many people will say ‘sorry’ when such an apology is not required at all (e.g. ‘I’m sorry, but do you have a book on pain care, please?’) Again, such automatic responses are not the case in many cultures. Indeed, in Thailand the overuse of please, thank you and sorry is deemed not only to be unnecessary, but even slightly rude itself. If you are working with people from countries that do not use these words very much (or if you are visiting or working in those countries), you would do well to cut down on their usage. For further details about UK manners and customs, see Fox (2005).

This leads to the phrase that often comes up in cultural debates: the idea that ‘When in Rome, do as the Romans do’. We sometimes expect that a) people will know the culture they visit, and b) will live their lives according to the norms of that culture. The problems here should be
immediately obvious. First, the visitor to another culture cannot be expected to know all about the culture in ‘Rome’. Second, we are socialised into our own culture at a very early point in our lives, and breaking our own norms may be very difficult. Just try, for example, not to say sorry next time someone bumps into you, or not to say thank you when buying something from a shop. Although it is to be hoped that everyone visiting a particular country will do some homework and know a little about the culture they are visiting, it would take years, if not a lifetime, to understand the complexities of other people’s cultural behaviour.

True ‘cultural enlightenment’ may therefore not be obtainable. Perhaps the best that can be achieved is a state of cultural awareness (i.e. aware that others may have different beliefs, views and practices from our own) and cultural respect (i.e. respect for those beliefs, even if they are incongruent with our own). This process should, of course, be a two-way street: that is, whereas we may feel we should respect others, it is only fair that they should also respect us.

Phatic communication

Phatic communication is an everyday feature of interaction. First used by the anthropologist Malinowski (1922, 1923) – although he used the phrase ‘phatic communion’ – the term is used to refer to ‘language used in free, aimless, social intercourse’ (Malinowski, 1922). Brown and Levinson (1987) observed that, for such talk, ‘the subject of talk is not as important as the fact of carrying on a conversation that is amply loaded with . . . markers of emotional agreement’. The Hutchinson Encyclopaedia (2000) defines phatic communication as: ‘denoting speech as a means of sharing feelings or establishing sociability, rather than for the communication of information and ideas’. We might think of phatic communication as ordinary chat, or ‘small talk’.

Examples of phatic communication are scattered throughout most conversations. Most greetings and acknowledgements are phatic. An example of a phatic exchange is as follows:

‘Hi. How are you getting on?’
‘I’m OK thanks. How about you?’
‘Yes, fine, thanks.’
‘Good. I’m not doing so badly.’
Note that, in such an exchange, the point is not to establish the health status of the other person but simply to acknowledge their presence and to establish rapport, and that ‘we are friends’. In this way, phatic communication can be compared and contrasted with information requesting and receiving. In the phatic exchange, the content of the conversation is not important: the point is to establish or re-establish social relationships.

The degree of phatic communication used in any culture probably varies. Sometimes, phatic communication is almost completely devoid of content or formal meaning. Consider, for example, the use of language by young people. It is not uncommon, at present, for younger people to insert the word ‘like’ into their conversation in a way that has little formal meaning. An example of such use, in a phatic sense, would be the following statement: ‘I mean, I was like “wow”.’

The statement has little formal content but is used, perhaps, to indicate a certain emotional tone to the listener. Also, a language style that includes the fairly random use of the word ‘like’ may be adopted by younger people to exclude older people. In this sense, the phatic communication becomes almost a private language, or a means of indicating solidarity between people of the same age. It may also be the language of songs, poetry and ‘rapping’.

It seems possible that there is sometimes a ‘private language’ at work in certain forms of mental illness. Certain types of psychotic state are sometimes characterised by unusual use of language. However, it is perhaps important to distinguish between the ‘modern’ or ‘popular’ use of language as used by young people, and the evidence of some cognitive or emotional disturbance displayed by people with problems in living.

Phatic communication is important. Without it, and with only informative communication taking place between two people, conversations would be stark affairs. Consider, for example, the following exchange:

‘Do you want to talk?’
‘Yes.’
‘When?’
‘Later.’
‘Where?’
‘In private.’

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This, more normally, is ‘padded’ with a little phatic communication, perhaps as follows:

‘Do you want to talk about how you are feeling, at all?’
‘Yes, I do, I think . . .’
‘When is the best time for you to sit down and talk, do you think?’
‘Not at the moment, thanks. I want to be quiet for a bit. Later on this afternoon?’
‘Where would you feel most comfortable talking?’
‘In private, I think. In your office, perhaps?’

Much of the above exchange is redundant, as far as understanding and the passing on of information are concerned. However, we are social animals and do not communicate simply to pass on information, but also to develop relationships.

Question for reflection

Next time you have a conversation with a friend, colleague or patient, carefully consider how much of the conversation is ‘padded out’. What purpose do you think this serves for both parties?

Phatic communication can be helpful in making patients feel comfortable and ‘thought about’, but it can also be carried on too long. Sometimes, the lack of content of a conversation stops the patient being able to express specifically what they need to say. Nurses might therefore wish to consider pacing their conversations with patients, so that, after a few phatic comments the conversation can be steered towards the essence. For example:

‘How are you feeling today?’
‘Not so bad, thanks.’
‘You look better than when I saw you last night.’
‘Thanks.’
‘Do you still have much pain?’
‘I still feel very sore around my stomach . . .’
‘Have you had any medication for it recently?’
‘No, I don’t like to ask.’
‘I will see what you are due or can have.’
‘Thank you very much.’

Listening, turn-taking and pacing

In the west, perhaps, particularly in the UK and USA, people tend to pay great attention to listening to one another. Listening is particularly emphasised in counselling, psychotherapy and interpersonal skills training. Being able to listen really well to another person is seen as a great asset. Similarly, and linked to this, is that the same people ‘turn take’ in conversations. If two people are talking to each other, one will allow the other to finish speaking before offering their own point of view. Further, conversations in the UK and USA are fairly evenly ‘paced’. That is to say, they are fairly continuous and are carried on at a regular speed until the conversation ceases. The end of a conversation is clearly marked by both parties saying ‘goodbye’ or its equivalent.

In the east, none of these rules necessarily applies. In Thailand, conversations between groups of friends are notable by their low volume (people do not shout to be heard) and the fact that, often, many people will be talking at the same time. This may be due to the cultural factors of content and process. In the west it is usually felt important to understand everything that is said: this leads to the listening and turn—taking, described above. There is usually a logical flow to the conversations. This can be described as an emphasis on content. Such discussions often lead to arguments and debates about certain issues. This is not to suggest that they are necessarily hostile, but that, as ‘equals’, western people often choose to challenge what their friends and colleagues say. In the east, the accent is often on process: it matters, perhaps more than is the case in the west, that everyone is taking part in what is going on. Harmony and agreement are sought where possible, and challenges and debates are not the norm: ‘junior’ people will necessarily give way to more senior members of the group.

The idea of pacing in conversations tends to reflect similar issues. Conversations and discussions in the west tend towards a linear style of progression: a point is raised, it is discussed, and a means of ‘closure’ is worked towards. Out of this initial discussion, other issues may be raised and
worked through in a similar manner. In the east, however, a conversation or discussion may cover many topics and meander in a way that is not immediately recognisable in the west. This is a roundabout style of communication which can often be noted in Thai speech patterns. The first author has noted that when interviewing Thai students and teachers in research projects, their answers to questions may, indeed, be very roundabout. An answer can start with a ‘no’ and end with a ‘yes’. For example:

Researcher: Do you believe in ghosts and spirits?
Respondent: I don’t, but older people do and those who live in northern Thailand. It is an old fashioned idea. Sometimes I believe it a little, and I respect ghosts and they scare me. Yes, I do believe in them.

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Acute surgical pain in an elderly patient from South-east Asia

I work as a staff nurse on a general surgical ward in a district general hospital in south Wales, UK. For almost a year I have worked with a qualified nursing colleague who was recruited by the hospital directly from South-east Asia. Several months ago his parents came to stay with him and his wife for 2 weeks, before paying a visit to his other brother (also a registered nurse) in the USA. However, a few days before they were due to leave the UK, his mother developed severe abdominal pain and was admitted to our ward with appendicitis. She was taken to theatre that evening for an appendectomy, and returned to the ward in the early hours of the morning.

My colleague Jeff* (*a pseudonym) was not allowed to work on the ward while his mother was an in-patient. The first morning, I cared for Jeff’s mother. While walking around the ward to assess the patients under my care, I spoke with her and asked her if she had any pain. She responded, ‘No, I am fine’, to which I replied, ‘Well if you do have any pain, please let me know and I can give you some painkillers, if you think you need them’. I then left her and spent
some time with the other patients, but when I later left the bed area to answer the phone, I saw her holding her abdomen and grimacing.

I made my way to her bed and asked her how she was feeling. She again replied ‘Fine’, although her body language suggested otherwise. I therefore commented that I thought she looked uncomfortable and asked her if she was now experiencing any pain. However, she again replied, ‘No, I’m fine’, but because of her behaviour I was not convinced and felt that she probably was experiencing some discomfort. I then looked at her drug chart and discovered that she had not had any analgesia for over 6 hours, but obviously I did not want to keep asking her the same question over and over again.

I therefore took a different approach and sat at the side of her bed and started to talk about how she felt in general. We quickly struck up a conversation about how she was feeling, and soon established a rapport. At this point, I gently asked her if she was uncomfortable, to which she finally admitted that she was ‘quite uncomfortable’. When I asked her why she had not told me sooner, she replied that she did not want to bother me. I immediately arranged some analgesia for her and emphasised the importance of her telling me if she was experiencing any discomfort in the future.

I didn’t think any more about the incident until Jeff arrived on the ward later in the day with his wife and father to visit his mother. We spoke together and I explained how his mother was doing, and I briefly mentioned the incident to him. I felt that, as with many patients, especially the elderly, it was probably due to the fact that she just didn’t want to ‘trouble me’. However, Jeff explained to me that this ‘roundabout’ form of communication (particularly the apparent switching from no to yes (or vice versa) and back again) is found in many cultures, especially those in South-east Asia, but is almost never seen in northern Europe, the USA or the UK.

On reflection, I suppose that this particular incident is, perhaps, an important issue in cross-cultural nursing. However, I was unaware of this type of behaviour and probably would never have found out
Direct and indirect communication

Cultures vary in the degree to which their members communicate directly or indirectly. In the USA and the UK it is fairly common for people to express their views and preferences quite directly (as in, ‘Yes, I like that’, or ‘No, I don’t like that’). In many cultures, however, communication is much less direct (for example in South-east Asia) and opinions are rarely expressed so as to avoid offending the other person.

Speaking indirectly and not expressing strong opinions is a way of increasing social cohesion. What is more important is what the group thinks, rather than what ‘I’ think. Another example of this everyday directness and indirectness can be observed by comparing and contrasting UK and Thai people looking around the shops. The UK person will tend to turn to his or her companion and say about something in a shop window: ‘That is beautiful’, or ‘That is so ugly’. A Thai person, however, is more likely simply to point to something in a shop window and make no comment. Usually, interestingly, their ‘opinion’ is often conveyed, perhaps by a smile or by a smirk, but an outright comment on what is being looked at is rarer.

Related to this is the amount that is spoken. North American and British people tend to feel a need to talk, and will often extract every last detail out of a description or a discussion. South-east Asian people, however, will often be much quieter and feel the need to talk only when there is ‘something to say’. Part of this, too, may relate to Buddhist tradition, in which to be quiet and thoughtful of others are important values.

about it, unless I’d experienced it first hand. What it did make me realise, though, was the importance of using a range of communication skills, especially when caring for those from a different culture. It really made me think about how, as nurses, we should communicate with patients in order to acquire important information from them. I am now aware that good communication is not just about talking, or even listening: it’s also about observing and assessing the situation, so that you use the most appropriate approach and skills (verbal and non-verbal) in that situation.
Compliments

Cultures vary in the ways in which they treat or give compliments. In UK culture it is common to belittle a compliment once it is given. It is not unusual for the hearer to dismiss the compliment with a phrase such as ‘not really’, whereas in other cultures it is not uncommon for compliments to be returned. Valdes (1986) gives the following example of a conversation between two Iranian friends:

‘Your shoes are nice’.
‘It is your eyes which can see them that are nice.’

As a rule, Thai people seem to enjoy paying each other, and other people, compliments.

Answering questions

In a UK or North American context, people expect others to answer questions clearly and unambiguously. In some cultures, however, it is considered rude to say ‘no’ as an answer to a question. The Japanese ‘no’, for example, if given at all, will be given with a sigh, indicating the speaker’s reluctance to use it. The Chinese ‘no’ is more likely to be worded as ‘That may be difficult’, to avoid the problem (Varner and Beamer, 1995).

Similarly, in some cultures giving very direct answers to questions, if those questions are posed by persons of senior status, is frowned upon. Again, ‘no’ answers are often given only very reluctantly. Further, students may worry about offering a ‘challenging’ response to a teacher’s question in class. Someone from a South-east Asian background is likely to be loath to force a teacher to question his own statements, as to do so would mean loss of face on the part of both the student and the teacher. This goes some way to meet the criticism, often heard in UK nursing colleges, that ‘overseas students won’t criticise or debate issues in class’.

Similarities in communication

Despite cultural differences, there are some behaviours and ways of communicating that seem to be universal. Almost all cultures appreciate politeness and respect between communicators (Brown and Levinson, 1987).
Most languages have an equivalent of ‘hello’ as a form of greeting, and have rules about the freedom with which people can use forms of other people’s names. Using given names is usually the prerogative of friends and seniors (however, in Thailand, for example, given names are used routinely but may be prefaced by a title: ‘Mr David’, or ‘Professor Sarah’).

In most cultural groups it is appreciated if the visitor or foreigner attempts to use the local language. British and North American people have probably become lazy about learning other languages because of the seeming universality of the use of English. If the visitor moves out of large cities and into rural environments, however, it quickly becomes clear that English is not so ‘universally’ spoken.

The process of learning cultural differences – in both communication and more generally – is not always without pain and a certain sense of loss. The ‘enculturation process’ (a process of cultural adaptation) can also involve a loss of one’s own sense of culture, as Hoffman (1989) so graphically illustrates in this description by a Polish student living in England:

*My mother says I’m becoming English. This hurts me, because I know she means I’m becoming cold. I’m no colder than I’ve ever been, but I’m learning to be less demonstrative. I learn this from a teacher who, after contemplating the gesticulations with which I help myself describe the digestive system of a frog, tells me to ‘sit on my hands and then try talking’. I learn my new reserve from people who take a step back when we talk because I’m standing too close, crowding them. Cultural distances are different. I learn in a sociology class, but I know it already . . . (Hoffman, 1989)*

Although the examples in this book, which have been used to highlight some of the cultural differences in communication, have often been drawn from what traditionally have been called ‘east’ and ‘west’, it is not particularly helpful or accurate to think in these terms, especially as most societies, including the UK, are now multicultural. Therefore, most nurses are likely to come into contact with patients from other societies or cultures, who may, on occasion or in certain circumstances, communicate differently.
Although differences between cultures are often most noticeable between those physically distanced from each other, this need not be the case: the French, for example, usually shake hands on meeting friends; British people tend not to do so with the same frequency.

**Proximity**

Proximity refers to the distance we maintain when we stand or sit in relation to each other when we talk. There are considerable cultural variations in this. For example, people in Latin countries, such as Spain and Italy, tend to stand closer together than do people from the UK. It is even possible to experiment with proximity. Next time you are talking to a friend, take half a step towards them. You will probably find that your friend takes a small step backwards, in order to find their 'comfort zone'. It is possible to move people considerable distances by gradually moving towards them as you converse.

Those in dominant positions may overestimate the degree to which they can stand close to a person in a more subservient position. Thus ‘the boss’ may stand closer to an employee than is comfortable for the latter. Similarly, nurses (who, by the nature of their jobs, are in a dominant position) may stand too close to patients. For the patient who is in bed, too, the nurse may get too close. It is important to consider proximity, to be aware of it, and to allow the other person to find their own comfort zone when you are chatting. A useful device for nurses who meet patients in outpatients or clinics is to invite them to ‘pull your chair over’, which will allow them to set a comfortable distance. Note that even this suggestion has cultural implications. In Thailand, for example, sliding a chair across the ground is considered rude.

**Touch**

Cultures vary in the degree to which they use touch as a form of communication. Many Latin countries are ‘high touch’ countries, where it is normal to be able to touch the other person during a conversation, particularly when reassuring someone. In most western countries, an initial, albeit formal, greeting is the handshake. In Islamic countries,
the opposite of these is true: informal touch is rare and touch between the sexes is usually forbidden. It is not acceptable, in most Islamic countries, for example, for a man to shake hands with women. However, this rule is not universal. In the Islamic sultanate of Brunei, it is reasonably common for men to be able to shake hands with women. In Thailand, the handshake is common, but not as common between Thais as the wai: a prayer-like gesture of the hands. The wai is offered by the junior person to the more senior, and it is not unusual to wai people for services rendered. For example, it would be considered odd to return a waiter’s wai as he thanks you for eating at his restaurant.

The wai has many other meanings beyond that of a greeting, and is used in countries other than Thailand. It can also be used to indicate that ‘I am sorry’. It is not uncommon to see a Thai driver apologising to another with a wai when the first mentioned has broken one of the rules of the road. This is interesting, given that many Thai drivers break most of the rules of the road.

In some countries the head is considered a sacred part of the body and the feet are considered dirty. It is therefore considered a great rudeness to touch the head of another, or to point with the feet or touch someone else with the feet. Again, these rules apply in Thailand. However, those in certain professions, such as nursing, are (very practically) allowed to break these taboos and can touch the head or the feet without apology. Other health-care professionals, such as doctors and masseurs, are also freed from this rule.

**Eye contact**

The degree to which eye contact is maintained or initiated varies from country to country and from culture to culture. In the west, and, perhaps particularly in the USA, it is not uncommon for two people talking to one another to maintain fairly constant eye contact. However, in the east, the more senior person in a pair is allowed to make eye contact with the more junior, but the more junior will often frequently look down as a mark of respect. In the east, it is usually rare to make continuous eye contact.
In most parts of the world, eye contact is made at the beginning of an utterance, and as the person continues to say what he or she is saying, they look away. However, for a reason I have never been able to identify, in the Caribbean this rule is reversed. The person looks away as he or she starts an utterance and looks towards the person as he or she continues the conversation.

**Volume and gesture**

People in different countries vary in the volume at which they pitch their speech. Perhaps the ‘loudest’ people in the world are those from Latin countries and those from the USA. British people can talk loudly but often adopt moderate volume levels. Many people in South-east Asia talk very quietly, and this can be a problem for nurses working with or caring for people from this part of the world. As well as trying to understand English spoken with a broad accent, the UK nurse may have problems hearing what is being said. Again, hierarchy comes into play here. A junior person from South-east Asia will often talk more quietly than a more senior person, out of due respect.

Use of gesture as a means of communicating varies considerably from culture to culture. Compare, for example, Italian and Thai use of hand and arm gestures. Italians often use hand gestures to a very large degree while conversing, and, because of the volume of their conversation, it is possible to think that they are arguing. Conversely, when Thais talk they use very little hand movement: ‘talking’ is conversation, as it were. Similarly, in formal settings in the UK, few hand movements are made. Until recently, television newsreaders and reporters used very little hand movement.

**Conclusion**

This chapter has explored the concept of communication, including the intricacies and subtle nuances associated with communication in a cultural context and the potential impact these issues can have on nursing practice.
Suggested reading


