Bad language in rural health advocacy

Ben Harris, Optometrists Association Victoria

Language is one of the key tools we use to communicate. If we want the wider community to engage in the issues of importance to rural health care we must communicate effectively—with each other and with the outside world. Language, and how we use it, is a key success factor for rural health advocacy.

If we want to promote rural health care generally, a particular program, or health care solutions for a specific community, we must be able to communicate effectively with those who can help us. However, rural health care is dominated by bad language. This bad language generally takes the form of EUA—excessive use of acronyms.

We are told to avoid academic language, simplify our messages and ensure greater clarity with the written word. These messages are vitally important in the rural health sector, as we work to advance the interests of our communities. The language of exclusion—initials, acronyms and abbreviations—places further unnecessary barriers in front of us communicating our goals, wishes and desires.

This paper looks at bad language (the language of exclusion), how power influences the use of language, provides examples of where bad language can be confusing, and provides a simple first step to avoid bad language.

Bad language—the language of exclusion

Acronyms, initialisations, nicknames, contractions and abbreviations can be wonderful tools for us to communicate quicker and easier. For people who speak the language and understand the code, we can talk quickly and accurately using this type of shorthand.

This type of bad language limits dialogue to people who know that language. Nearly every person we run into in course of a day’s work speaks at least part of our internal language, enough to get by. Daily interactions with staff, colleagues, members, other associations, academics and governments are full of shorthand—initials, acronyms, nicknames and abbreviated language—that speed up the process of communicating. Speeding up the language and communication flows among the in crowd has some clear benefits, but it comes at a high cost if you have a message that has trouble being heard.

The cost of shorthand language is that it is exclusionary. The language excludes those who are not working in the area every day, and it excludes those who cover a range of areas in their working day. The groups excluded with shorthand language include nearly everyone outside your organisation, to a greater or lesser degree.

How many times have you gone to a meeting with a group of people you don’t interact with regularly, and spent part of the meeting wondering what the hell people are talking about. This is particularly hard for some rural health advocates. If you don’t have ready access to people using shorthand languages—such as governments, it can be very difficult to work out.

The problems of not fully understanding the language of government is compounded if you are not strongly disciplined about avoiding exclusionary language yourself. If you are excluding some people through using language they don’t understand, the communication task becomes more difficult. As rural health advocates rarely have the time to spend learning each other’s languages, rural health issues can go unheard.
Language and power

The power of the rural health lobby is now significantly greater than it was ten to fifteen years ago. Over the last decade, rural health advocates have worked hard to gain credibility, through a strong combination of righteousness, illustrative examples and solid policy formulation. However, we need to do better.

Governments have inherent power. They are large, have coercive authority, and other organisations are forced to deal with them. This gives governments more ability to use whatever language they want, and to require others to learn their language.

This power allows governments to use shorthand language, at the cost of access to decision-making processes. There are a number of ways that disadvantaged groups lack access to the decision-making process, including cultural barriers, language barriers and physical barriers. All of these barriers relate to a difficulty communicating with governments, in particular, learning the language necessary to talk to governments.

Advocates who have barriers learning the languages of government have difficulty having their voices heard. Learning the language of governments—like learning any language—takes time and exposure. Rural health advocates have natural physical access barriers, as they do not live in capital cities. This lack of proximity and exposure can result in rural health advocates having language barriers to communicating with government.

If you don’t know the language that governments use, you certainly can’t afford to speak a foreign tongue as well—communication will become too hard.

Some rural health advocates are still prone to using their own shorthand language when talking to people outside their fields, including governments. This is not surprising, as rural health practitioners are generally recognised as being fairly busy people.

Saving time by using shorthand language can be seen as important in the day-to-day battles—but it’s important that such language does not cost us the war.

Examples and a test

Rural health is full of acronyms, initialisations, contractions and other languages of exclusion. Here are a few examples from the home page of www.ruralhealth.org.au—RAMUS, ARCPOH, AIHW, NSW, and APHCRi.

The links page from www.ruralhealth.org.au provides a very good example of EUA (excessive use of acronyms)—25 member organisations listed with six acronyms and 19 initialisations.

Any organisation that refers to itself with an initialisation or an acronym needs to consider if using the acronym/initialisation is worth it. Let’s take my organisation. We are the Optometrists Association Australia (Victorian Division) Inc. This name was commonly cut down to OAA, or OAA (Vic Div).

I have banned the use of “OAA” in our office. We need to present as the Optometrists Association Victoria. Our members prefer OAA, but our members also want us to increase public awareness, so using OAA in communication is disallowed.

Why this ban? All of our members know what OAA is, as do most of the people we deal with on a daily basis. But because we deal with them on a daily basis, these people cannot expand the organisation or take the profession forward. To grow, to improve members’ lives, and to improve the eye care of the community, we need people who don’t commonly deal with us to know us, understand us, and understand our issues. Using OAA means that some people will not understand us.

OAA can mean many things to many people. There is the Optometrists Association Australia, the Orthoptists Association of Australia, the Oceania Athletics Association, the Order of Apothecaries
Australia, the Order of Australia Association, the Office of Aboriginal Affairs, and a couple more all on the first two pages of Google in Australia. Internationally, there is the Ontario Association of Architects, the Obstetric Anaesthetists’ Association, and many more. Why confuse the issue when I can type a few more characters and ensure that people know I am representing optometrists?

To provide some more relevant examples, here’s a list from the first result from Google with some National Rural Health Alliance member bodies:

- ACHSE — the word for “road” in German
- AHA — Australian Hotels Association
- ANF — Australian Nudist Federation
- CAA — Community Aid Abroad
- RPA — Royal Prince Alfred hospital

A less silly example is RHS — which I think of as the regional health services, a federal government program for small communities within the RHS (regional health strategy). RHS also stands for regional health services, administrative areas in the South Australian health department. There is also a private company called RHS (Regional Health Solutions), the RHS (radiation health series) publications, the East Gippsland RHS (river health service) and the RHS (refugee health service). So if someone says to you that they work in the RHS in Port Augusta, what are they saying, and what are you hearing? Are you sure it’s the same thing?

Here’s a simple test — when you Google your organisation’s acronym, what comes up?

**The first simple step**

To get our messages through, people must understand us. With limited resources, our ability to advocate is constrained. We need to make every communication count. I am afraid that an ill-placed acronym or an unfamiliar initialisation will see the reader just give up on my communication and move on to the next thing in their in-tray.

The first simple step is to minimise the use of acronyms, contractions and initialisations.

A good dialogue will allow people to work together to come up with new solutions. A back and forth dialogue has the potential to improve rural health care as much as any public policy area.

Avoid the language of exclusion, and avoid EUA. Let’s cut out bad language in rural health advocacy.

**Presenter**

Ben Harris is the Executive Director of the Optometrists Association Victoria. An economist by training, he is also a Director of Andrology Australia. Ben has a history in health workforce, financing and public health. He is a long-term advocate for rural health, having been appointed rural health adviser to the Federal Health Minister from 1997 to 1999. He has also been involved in HIV, immunisation and legislation review. At the Optometrists Association Victoria since 2001, Ben has continued his work in rural health and health promotion. The association has nominated eye health public awareness as its key area in the current triennium. The association is also a Vision 2020 Australia partner, and a partner in the Vision Initiative Victoria. Ben is also a Friend of the National Rural Health Alliance.