The Language Barrier: The overlooked challenge to equitable health care

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This chapter examines the effects of language barriers on the access of patients and communities to quality health care. It also looks at communication challenges experienced by health professionals that provide this care. Using a case study of a rural hospital, the chapter highlights some of the challenges posed by the language barrier and explores current methods that English-speaking health professionals at this hospital use to overcome these difficulties.

The case study findings indicate that the language barrier decreases work efficiency and the provision of holistic treatment. It makes communication time consuming, which increases frustration levels and decreases empathy, approachability and confidentiality. Current methods for overcoming problems include the use of untrained and ineffective interpreters – usually overworked nurses; linguistic codeswitching; and the use of a selection of key isiXhosa vocabulary. These methods have many drawbacks and are not suitable or sustainable.

Recommendations for improving communication include the promotion of a culture of multilingualism, which includes language education as a part of professional development and the employment of trained interpreters. For multilingualism to occur, more research needs to be conducted, and the political will to address this problem must be demonstrated. Overcoming the language barrier needs to be prioritised and commitment must be made to implementing strategies that provide a multilingual patient base with a multilingual healthcare service.
Introduction

Good communication has long been acknowledged as the cornerstone of the health professional-patient relationship and plays an important role in the quality of healthcare delivery. A lack of proficiency in a common language, however, decreases the quality of verbal communication between people. This lack of linguistic mutuality means that language becomes a limiting barrier – and, like any barrier, the language barrier impedes and obstructs effective communication.

In South Africa (SA) the language barrier continues to compromise a large proportion of the population’s quality of and access to healthcare services. This compromising of quality and access extends beyond the scope of the language barrier itself. It reflects and interlinking divisions in South African society forged by disparate educational access, divergent socio-cultural backgrounds and various historical legacies.

Health care in this country has many challenges to overcome. A lack of material and human resources, ineffective management of these resources, and the HIV epidemic are some of the complex and diverse challenges that SA is currently facing. The provision of a monolingual health service to a multilingual society is an additional and yet commonly overlooked challenge – especially in a country where diversity is not only constitutionally acknowledged but part of a public “rainbow nation” discourse. Using a case study of Madwaleni, a rural hospital in the Eastern Cape, this chapter highlights some of the challenges posed by the language barrier and explores current methods that English-speaking health professionals at this institution use to overcome these difficulties.

The effects of the language barrier on health care

The true depth of the impact of the language barrier is often disregarded by health practitioners, administrators and policy makers. The literature reviewed showed that the problem is widespread and not only limited to peripheral rural areas. In a 2006 study conducted by Levin of a large, urban paediatric hospital, a survey showed that only 6% of medical interviews were conducted (wholly or partly) in the patients’ home language. Patients are generally interviewed in a second or third language despite the fact that they prefer to be consulted in their own language. The Patients’ Rights Charter provides that patients have access to health care and the right to health information that includes the availability of health services and how best to use such services and that such information shall be in the language understood by the patient.4

This sentiment is echoed in the Bill of Rights, which states that: “everyone has the right to have access to health services”. The language barrier is simply that: a barrier to the accessing of health care. English remains the dominant language used officially and unofficially in healthcare services. According to the Constitution (Act 108 of 1996), though, SA has 11 official languages, with unofficially in healthcare services. According to the Constitution

“everyone has the right to have access to health services”. The language barrier is simply that: a barrier to the accessing of health care. English remains the dominant language used officially and unofficially in healthcare services. According to the Constitution (Act 108 of 1996), though, SA has 11 official languages, with each language having an equal standing in the eyes of the law. Furthermore, the Constitution states that:

recognising the historically diminished use and status of the indigenous languages of our people, the state must take practical and positive measures to elevate the status and advance the use of these languages.

The practical focus of healthcare reform emphasises structural, administrative and resource shortages. The importance of language, especially in doctor-patient communication, is ignored. According to Levin’s 2006 study, “language and cultural barriers were cited by more parents [of patients] as a major barrier to health care than structural and socioeconomic barriers”.2

While medical science does have an objective and examinable component, the importance of communication is irrefutable. In an article reporting on a 2010 study by Deumert, a doctor is cited as explaining:

I can put my stethoscope [on a chest] but I will be guided by what my patient has told me. If the patient, for instance, was talking, let’s say TB treatment, and she didn’t finish the treatment, I won’t hear it from the stethoscope.6

Along with the negative impact of the language barrier on health professionals shown by the case study findings described below, the consequences for patients can be devastating. According to Jacobs et al., people with a limited English proficiency are:

less likely to have a regular source of primary care and are less likely to receive preventive care. They also are less satisfied with the care that they do receive…, more likely to report overall problems with care… [and] may be at increased risk of experiencing medical errors.7

In an era of patient-centred care, patients continue to have a reduced ability to participate in decision making and dialogue, which results in a power shift in favour of the healthcare practitioner. The link between English proficiency and educational attainment in post-apartheid SA means that previously disadvantaged groups of people continue to be marginalised and to experience this power imbalance. In many cases, patients may even blame themselves for their own linguistic inability rather than hold health professionals accountable for the decreased quality of care.2

The inability to communicate can be a traumatic, fearful experience – one that eliminates empathy and humanity from the health services provided. Schlemmer and Mash in 2006 recorded this account from a health professional:

the other day a child died, and the mom stands there, and we literally sit and wait for half an hour for an interpreter, so that I can talk to this mother about her child that died.8

Studies have shown that miscommunication caused by the language barrier results in increased patient avoidance behaviour (which may result in later presentation of disease) and adds to the uncertainty and emotional stress experienced by patients.6,9 Miscommunication can result in increased errors (potentially life threatening) both in diagnosis and management. Thus patients experience decreased satisfaction with services and are less inclined to adhere to and comply with treatment and they also receive less health education.6,10

Language cannot be isolated from culture. Cultural competency by health practitioners is important and facilitates a greater respect from patients. For example, doctors need to understand that not questioning a doctor can be perceived as a sign of respect in some cultures even if the patient has not understood what the doctor has said.8 Consultations are the point of contact between two people
Doctors experienced a stark difference in treating English-speaking patients. They found that bonding between patient and doctor increased and that the doctor took more time to explain to the patient the disease, the prognosis and the treatment plans – which, undoubtedly, affects the quality of treatment.

In summary, the language barrier decreased work efficiency and the provision of holistic treatment; it increased frustration levels, was time consuming and decreased empathy and approachability. The experiences of these health professionals correlate with other health professionals’ experiences of the language barrier cited in other research and formed an almost singular collective experience of this language obstacle.

Methods of overcoming the language barrier at Madwaleni Hospital

One of the measures used to overcome the language barrier is a reliance on non-trained interpreters. The health professionals interviewed reported relying on interpreters, who were often professional staff, junior or student nurses, family members of the patients (often children) and auxiliary staff.

Typically, a communication barrier often exists between doctor and interpreter and between interpreter and patient. This perpetuates the metaphorical ‘broken telephone’ phenomenon that is reportedly common at Madwaleni. Doctors interviewed stated that a language barrier also exists between themselves and some nurses. One doctor recounted how he had asked a nurse to interpret “Is the patient having difficulty breathing?” The nurse had replied, “Yes, she is breathing.”

Doctors agreed that the efficiency and quality of communication depended on the interpreter. Junior nurses or student nurses often had acquired a less proficient use of English. Some interpreters filled in gaps with their own knowledge. One doctor suggested they could see more patients when they did not use an interpreter – which points to the time-consuming nature of translating.

Most health professionals interviewed felt that a simple question from them to a patient would lead to the nurse and patient having a five-minute-long conversation, with the only feedback from the nurse being either “yes” or “no”. Doctors felt that this led to a subversive disconnect between patient and doctor and some doctors reported writing on patient charts while the nurse and patient were talking.

The examples provided above illustrate the potential disadvantages of using interpreters. In addition, the health professionals acknowledged that the use of interpreters can make one lazy and prevent a faster acquisition of the language of the patients.

Interpreters do, however, serve as cultural mediators and can pick up on the semantic subtleties and underlying tones of patient discourse. At Madwaleni, it was reported that interpreters facilitate a greater reflection on culture-specific topics. Currently they are the best available communication method and for this reason are valuable.

Another method of overcoming the language barrier is codeswitching. Codeswitching is a linguistic phenomenon where speakers change between two languages in a single sentence or conversation. Doctors and rehabilitation staff have picked up some essential words that allow them to practise some independence in the absence of the ad hoc interpreters. While this is a drop in
the linguistic ocean, it provides some direct communication with the patient that allows for bonding and trust to develop between patient and doctor. It also allows for more rapid communication and is a practical tool for transferring instructions quickly.

Common phrases used include “buya date” (date of return), “you must go there ngomso (tomorrow)” and “kubuhlungu?” (is there pain?) or “uxolo” (sorry). “Hamba to the ifestile ngoku” is a common phrase that indicates that patients must go to the “window” – which is the pharmacy. Most English-speaking health professionals at Madwaleni know a fair number of anatomical words – for example: “indlebele” (ears), “intloko” (head) and “amadolo” (knees). They have also mastered some action command verbs: “goba”, “lula”, “vala”, “vula”, “phefumla”. Doctors were observed to call out into the waiting room of the outpatient department “olungileyo” (next) or “omnye” (one) to signal that the next patient must enter. Additionally, most doctors changed their accents when speaking to patients and used simple English in the hope of transferring meaning.

Towards future solutions

Kaplan, Greenfield and Ware in a 1989 assessment of the effects of physician-patient interactions on the outcomes of chronic disease noted three aspects of communication that had a critical link with patients’ health outcomes: the amount of information exchanged between the patient and physician, the rapport between the patient and physician and, lastly, the patient’s control of the dialogue. Speaking and understanding the language of the patient allow for this and can be developed through effective translation and/or increasing the bilingual workforce. Additionally cultural competence is necessary for providing appropriate care in the language of the patient and developing rapport, understanding and respect.

Effective translation and interpretation

The five main models of interpreting are:10

➢ approximate-interpreting model – ad hoc interpretation from anyone available that can speak the language;
➢ tele-active model – using telephones or computerised interpretation devices;
➢ bilingual worker model – hiring of clinicians that have language skills;
➢ volunteer interpreter pool model – hiring interpreters and translators on an as-needed basis; and
➢ staff interpreter model – formally trained interpreters that are part of the clinical staff.

The staff interpreter model involves employing dedicated trained interpreters. This tackles the problem of the 11 official languages and varieties of cultures that exist in contemporary SA. Some doctors at Madwaleni preferred the idea of medically trained interpreters – which would give the interpreter background knowledge. Others preferred the idea of an interpreter with no medical knowledge – which would mean that the interpreter would repeat exactly what the doctor said.

Language translation is complex and translation is necessary as bilingualism does not always equal or result in effective translation. To convey the true meaning and the nuances of a language, the interpreter may not always translate the language directly. Additionally, certain words may not be easy to translate into another language as Swartz illustrates.13

A Xhosa-speaking psychologist translated the word “sad” as khatazekile. On back translation by two senior students of African languages, khatazekile was translated as “worried”. Sadness and worry have, from a psychiatric point of view, very different implications for diagnosis and treatment.

A 2010 study found that the use of professionally trained medical interpreters improved “communication (e.g. errors and comprehension), utilisation [of health services], clinical outcomes, and satisfaction with care for both Low-English proficiency (LEP) patients and health care practitioners.”12 Interpreters may increase the reception of preventive services, physician visits and adherence, which increase patient access to primary care.7

An interpreter inevitably becomes an intermediary in the doctor-patient relationship and this can have a negative impact on the communication between the doctor and patient.7 Interpreting staff may be frequently unavailable or may insert their own values and views into the conversation.3 In some cases interpreters have been shown to make many errors in translating and this affects patient care. Nurses particularly have been shown to be inaccurate interpreters.2,14 Training nurses to be interpreters and equipping them with the skills to translate may be a useful strategy for professionalising language mediation in the South African context – but the issue is complex, as nurses are already overworked and health facilities understaffed.

The use of family members (often small children), cleaners, administrative staff, other patients or any ad hoc bilingual person is not ideal. It affects patients’ confidentiality.8 These interpreters are unlikely to understand medical terminology, may struggle to break bad news to patients and translate and interpret sensitive issues and may have conflicting agendas or priorities.15 Neither are they counsellors and are not accountable legally for any mistakes or breaches of confidentiality.

The cost of hiring interpreters is an important consideration but the cost of not using interpreters may be even greater.7 Interpreter services have been shown to lower costs by decreasing the use of diagnostic testing or reducing post-emergency department visits.16 The short-term cost may increase as primary and preventive medicine increases in use – but over the long term this could see a possible reduction in cost, morbidity and mortality. The cost may also be overestimated. In recommendations to a study conducted in 2008, Deumert estimated that “200 interpreters would be sufficient to cover all the 34 public hospitals in the Western Cape”.6

Ultimately no single model exists that would provide the best method of translation for low-resource settings such as those found in SA.

Developing a culture of multilingualism – the bilingual worker model

The ideal is for the health service to employ health professionals who are already culturally and linguistically capable. Health professionals who would be proficient in the language of their patients should be identified and recruited. The already short-staffed nature of the health service prevents this but language-sensitive posting should be looked into.1
If mother-tongue speakers are not available, health professionals must learn to speak the language of the majority of their patients. The Faculty of Health Sciences at the University of Cape Town is attempting to achieve this by transforming its health sciences undergraduate curriculum:

The curriculum design principles of inclusiveness, participation and social responsiveness mirror the primary healthcare (PHC) approach. Furthermore, a client/patient-centred approach that strengthens inclusivity and participation has been given impetus with the integration of two of the indigenous languages [isiXhosa and Afrikaans], most frequently spoken in the Western Cape, and cultural competences into all curricula.\(^\text{17}\)

The diversity of languages in SA may dictate that specific competency in every language cannot be prepared for in tertiary institutions. Competence in the language of future patients could, however, become a form of professional development or part of in-service training. In Schlemmer and Mash’s 2006 study, health professionals were shown to consider this:

As the doctors and nurses in this study requested, they should also be offered training in basic isiXhosa. Although language acquisition as an adult is not easy the idea is not to become bilingual in isiXhosa, but rather to create sufficient basic understanding of medical isiXhosa and respect for the other’s culture.\(^\text{8}\)

Additionally, as a starting point, medical institutions could provide short word lists, which include salutations and medical vocabulary.\(^\text{2}\) While language acquisition is a difficult and complex process, greetings and pronunciation of patients’ names should be seen as absolute necessities. At Madwaleni, self-taught vocabulary allowed for independence from interpreters and increased direct interaction with the patient. But this was felt to be no substitution for proper communication. This finding confirms the findings of other research. For example, a doctor interviewed in the Deumert 2010 study explained how rudimentary communication contradicts the “essentials” of medical practice emphasised during training:

A lot of the time a patient arrives, they are breathing heavily, so you think that it’s probably a respiratory problem, or a cardiac problem, and you want to ask them are they coughing, and you know the word is kotshelwana in isiXhosa, but more than that, you can’t really get. You want to ask, are you coughing? Is it productive? Is it painful when you cough? Is blood mixed in, in the cough? You know, there is a problem, I mean, every professor of medicine will tell you three-quarters of your diagnosis comes from the history. And that is verbal.\(^\text{8}\)

While many doctors do show an interest in learning the language of their patients, the argument against health professionals’ learning of language is centred on the time-consuming nature of language acquisition over and above an already stressful workload. Additionally, doctors at Madwaleni explained that there were no role models or examples of people who had learned isiXhosa at that hospital and that the status quo of using nurses as interpreters was an easy habit to slip into. This may not be the global norm. For example renowned scholars Antia and Bertin noted in their 2004 Nigerian study: “irrespective of their home language, [practitioners] quickly acquired the languages of their patients.”\(^\text{11}\)

A counter argument to the need for developing multilingual practitioners may be that patients can learn English – or acquire enough English to get by in a hospital setting. English as the lingua franca is viewed as a cost-effective and simple response to SA’s cultural and linguistic diversity and takes away the responsibility for learning a new language from health providers.\(^\text{9}\) Cultural and linguistic marginalisation, with an emphasis on English and Afrikaans as the languages of operation, echoes pre-1994 experiences and can damage cultural diversity as a hegemonic Western culture assumes dominance. This will inevitably – as in fact it already does – marginalise those who may not be able to acquire English easily: older patients and people with low socio-economic circumstances or poor inter-cultural and linguistic exposure (characteristic of rural areas).

The National Health Act (Act 61 of 2003)\(^\text{18}\) puts the responsibility on the healthcare provider to provide multilingual health care but does not point to the methods that can accomplish this:

The healthcare provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user’s level of literacy.\(^\text{18}\)

This does not mean that patients should not take control of their own health. Patient empowerment and education must occur in institutions.

The language barrier is not new. Historically, this problem has always existed, but health professionals stayed much longer at one hospital – especially in the rural context. Increasing staff retention at hospitals, in itself, logically promotes the long-term acquisition of the language/s of that region. At the time the case study was conducted at the end of 2011 most health professionals at Madwaleni had been there for not more than one or two years. With the re-engineering of the health system long-term employment at one institution may be the single most sustainable method of eradicating the language barrier between doctor and patient.

Cultural competence

The “explanatory model approach” is an effective starting point for addressing a patient’s personal and cultural experience of illness. Using this framework, as outlined by Kleinman and Benson allows one to gain a better understanding of a patient’s experience of health.\(^\text{17}\) The framework also takes into consideration the pressures and time constraints of the modern hospital environment.

It involves the practitioner asking the patient:

➢ what do you most fear about this condition? and
➢ what do you believe is the cause of this problem?
➢ what course do you expect it to take?
➢ how serious is it?
➢ what do you think this problem does inside your body?
➢ how does it affect your body and your mind?
➢ what do you most fear about this condition? and
➢ what do you most fear about the treatment?

➢ what do you call this problem?
➢ what do you most fear about this condition?
Policy implications and recommendations

Primary health care re-engineering is centred on health promotion, prevention and community involvement, none of which can occur without an acknowledgement of the multilingual nature of South African society. Promotion and prevention cannot begin to succeed if there is no dialogue. The institutional and structural silencing of patients’ and communities’ non-English voices prevents community involvement.

The Core Standards 19 – a framework created by the Department of Health, for the assessment of health establishments – make no mention of the language barrier or even acknowledges it as a challenge to service-delivery quality. The Negotiated Service Delivery Agreement (NSDA), an intersectoral government agreement aimed at “a long and healthy life for all South Africans”, describes ways to increase patient care and satisfaction – but it too does not mention language. This ultimately demonstrates a lack of recognition or interest in the importance of language.

The Patients’ Rights Charter 4 and the National Health Act (Act 61 of 2003) mention that services must be in a language that is understandable but this mere mention is perfunctory rather than enforced and prioritised in policy. A policy-implementation gap still exists and this is partially related to the fact that no mention is made of the strategies needed to overcome the language barrier in health services.

A directed and focused policy needs to be developed that engages with appropriate methods of overcoming the language barrier. For this to occur, first, combating the language barrier needs to be prioritised. The data discussed in this chapter point to the validity of this prioritisation. Second, more research needs to be conducted in the South African context to develop evidence-informed effective solutions. Third, increased awareness and discourse around the language problem must be cultivated. Last, these solutions or interventions need to be communicated to stakeholders and all involved should understand the need for these interventions.

Conclusion

The Bill of Rights provides that “everyone has the right to have access to health services” and states that the language barrier is simply that: a barrier to the accessing of health care. Provision of services in a patient’s own language is an integral part of the quality of care and “getting language right” has been shown to result in positive outcomes for all stakeholders – patients, doctors and administrators. However, the problem needs to be prioritised and commitment to implementation strategies must occur.

The answer to overcoming the language barrier in hospitals in SA may be a combination of all the strategies discussed in this chapter and some may be more applicable in certain districts than in others. The data are compelling and the importance of doctor-patient communication cannot be ignored. Yet there are perceived undercurrents of chronic resistance, lack of interest and claims of irrelevance. The solution to addressing the communication barrier begins with an acknowledgment of its existence and strong political will to address the problem at all levels. In the overhauling of the healthcare system, now is the time to provide a multilingual society with multilingual healthcare.

Acknowledgements

Thank you to the health professionals interviewed and the community of Madwaleni. Thank you to those who reviewed this paper (in alphabetical order): Amber Myers, Claire Tucker, Dr Cynthia Le Grange, Professor Gregory Hussey, Dr Nayna Manga, Dr Sharon Groenmeyer and Terry Mwesigwa.
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