Still lost in translation: language barriers in South African health care remain

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Introduction
Since the turn of the millennium, the global emphasis in health care has been shifting towards an increasingly patient-centred model that acknowledges patients’ autonomy, promotes their active participation in decisions concerning their own health, and strives to treat patients holistically. This approach, which has been shown to improve health outcomes, relies primarily on effective communication between healthcare providers and patients. In a multilingual society, a major barrier to effective communication arises when healthcare providers and their patients do not share the same first language. This review explores the impact of the language barrier on the effective rendering of healthcare services in South Africa, and to raise awareness that studies regarding language barriers within the South African healthcare sector are currently limited to isiXhosa in the context of English and Afrikaans, and has been conducted almost exclusively in the Western Cape. Research, therefore, needs to be extended to healthcare settings in the rest of the country, and needs to include all the languages and cultures protected under the South African Constitution. Moreover, there is an opportunity, and a need, for interdisciplinary collaboration between language practitioners and healthcare professionals to find viable solutions to communication challenges posed by linguo-cultural barriers within the multilingual South African population, in order to honour the right of every citizen to equitable health care.

Language legislation in the South African healthcare sector
The Constitution of South Africa (Act 108 of 1996) protects the rights of all citizens to access healthcare services (Section 27), as well as to participate in all aspects of life in the language of their choice (Section 6). The interlinked nature of these two basic human rights is emphasised in the National Health Act (Act 61 of 2003), which states that “[t]he healthcare provider must, where possible, inform the user ... in a language that the user understands and in a manner which takes into account the user’s level of literacy.” The National Patients’ Rights Charter reiterates this idea by providing that patients should have access to health care and health information, in a language that they understand. Legally, the importance of language in healthcare communication is thus well recognised in South Africa.

The importance of language in healthcare communication
Successful outcomes for patients with chronic diseases rely on the rapport between the patient and healthcare provider, the patient’s control of the dialogue, as well as the amount of information exchanged between the patient and healthcare provider, all of which require effective communication. Miscommunication due to the language barrier poses the threat of life-threatening misdiagnosis and mismanagement of disease. The inability to communicate with healthcare providers effectively adds to patients’ uncertainty and emotional stress, and dissatisfies with services, and often prevents them from seeking timely health care, resulting in complications of disease. Research in the United States, for example, showed that persons with limited English proficiency are less likely to have a regular source of primary care and are less likely to receive preventive care. In addition, when healthcare providers communicate the details of a diagnosis or treatment, but fail to communicate the seriousness of risk effectively, patients may not comply with instructions or elect not to have potentially lifesaving treatment.

Even in language-congruent situations, miscommunication commonly occurs in the healthcare sector, because healthcare professionals differ from their patients in terms of educational level and knowledge held regarding medical conditions. To complicate matters further, language can never be separated from culture. Whereas healthcare professionals are trained in the biomedical model of disease, their patients often hold very different culture-specific models to explain the origins of disease. Cultural competence is also necessary for developing rapport, understanding and respect between healthcare providers and patients. People from different cultural groups,
for example, describe pain and distress quite differently, while culturally specific terms, expressions or metaphors can cause misunderstandings. In particular disciplines such as mental health and nutrition, which rely heavily on communication and cultural competence for diagnosis and management, are particularly vulnerable to these linguo-cultural barriers.

The impact of the language barrier on healthcare provision in South Africa

In the South African healthcare system, consultations are generally conducted in patients’ second or third language. Levin found that in a large, urban paediatric hospital in Cape Town only 6% of medical interviews with the parents of patients were conducted in their first language (which was mostly isiXhosa). In this survey, parents cited language and cultural barriers, rather than structural and socioeconomic barriers, as the major barriers to their effective participation in the health care rendered to their children.

In a 180-bed hospital in the Amatole district in the Eastern Cape, which services the entire population of 262 000 people, most of whom are mother-tongue (often exclusively) isiXhosa speakers, difficulties identified by healthcare providers (who were mostly English speaking and did not understand isiXhosa) included the inability to ascertain the main complaint or obtain a coherent past medical history. These healthcare providers felt that the inability to understand isiXhosa had a negative impact on their ability to be empathetic, kind and approachable; to resolve psycho-social problems; and to give effective counselling and patient education.

Another survey, conducted in a Western Cape district hospital, found that language barriers interfered with work efficiency and the provision of holistic treatment, negatively influenced the attitudes of patients and staff towards each other, decreased the quality of, and satisfaction with care, and led to cross-cultural misunderstandings. The latter study also found that Xhosa patients were inclined to say that they understand what a healthcare provider had explained to them even when they did not, because they deem it disrespectful to ‘challenge’ the provider.

A recurring finding in the above-mentioned studies was that patients expressed shame and blamed themselves for not being able to communicate effectively with healthcare providers. This is inconsistent with the constitutional responsibility of the healthcare system to comply with the needs of the people it serves. Even though the impact of language barriers in multilingual societies on healthcare provision is recognised internationally, very little research has been done in this regard in South Africa. Moreover, to date, published studies have focused only on communication between isiXhosa, English and Afrikaans speakers, whilst the country has 11 official languages, as well as many more spoken by smaller language communities. Even from this limited evidence, however, the need to address the linguo-cultural barriers in health care is clear.

Interpreting in the South African healthcare sector

To address language barriers in the healthcare sector, interpreters, who are often bilingual relatives (often children) or non-medical staff, are routinely called upon. The use of family members, cleaners, administrative staff or other patients as interpreters raises important ethical dilemmas as it affects patient confidentiality. Furthermore, the lack of medical knowledge on the part of the interpreter seriously affects the accuracy of the message being conveyed.

Hussey found that, even where interpreting is rendered by other medical staff, doctors agreed that the efficiency and quality of communication depended on the interpreter. These doctors expressed frustration at the fact that junior nurses or student nurses were often not proficient in English, causing an additional language barrier between doctor and interpreter. According to the Emzantsi report, many isiXhosa interpreters in the Western Cape health sector, mostly nursing staff, do not always have adequate knowledge of English or Afrikaans, whereas some complain that they do not always understand the ‘deep rural isiXhosa spoken by some patients’.

Other problems cited by doctors include that interpreters are often not available, and that they sometimes impose their own views on consultations, make translation errors, and may fill in gaps with their own knowledge. Some healthcare providers feel that using an interpreter is time-consuming in already understaffed medical facilities where healthcare providers struggle to render services to all. Similarly, staff who are asked to perform this role in addition to their other duties, become frustrated.

Clearly a better approach would be to make use of trained interpreters. It has been noted in the international healthcare setting that, although the expense of hiring interpreters is an important consideration in resource-poor settings, the cost of not using interpreters may be even greater. To be able to interpret both denotatively and connotatively and to make appropriate use of context, interpreters in healthcare settings require more than linguistic competency. Drawing on the findings of the Emzantsi Report conducted in the Western Cape healthcare sector in 2003, Lesch emphasises that these interpreters need knowledge of medical terms, and even more importantly, they need to have empathy and be sensitive for the doctor–patient relationship; an awareness of the role of the interpreter in this relationship; and an ability to deal with patient’s socio-cultural perspectives of health problems.

Specialised interpreters could be delivered by the higher education system in South Africa, whilst the Departments of Health in the different provinces would have to create the infrastructure to accommodate and effectively deploy them. Even then, though, many logistical challenges may still hamper the availability of such a service in all the instances where it is needed on a daily basis. One solution is telephonic interpretation services, which are well established internationally in many political and financial arenas. Specialised medical telephonic interpretation services, rendered mostly by for-profit companies, are widely used in the United Stated, and are currently also available from a Cape Town-based company. Although this approach can alleviate some of the pressure, there are many instances in which telephonic interpretation cannot replace face-to-face interpreting, for example for hard-of-hearing patients, or where patient education includes visual components to name a few. Clearly, other solutions to the language barrier also need to be explored.

Acquisition of the relevant second language

Another approach to address the language barrier is for healthcare providers to learn the language of their patients. Being able to converse with patients in their first language builds respect, trust and report between healthcare providers and patients, while improving cross-cultural understanding, all of which are vital components of effective patient-centred health care. Although this may be quite
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Challenging within the demands of the busy primary healthcare sector or practice, Pfaff and Couper identified a number of South African doctors who had successfully acquired an African language, spoken by their patients, after they had started practising medicine, and provide practical guidelines in this regard. This approach is not without problems though, as some evidence suggest that miscommunication is more likely to occur when healthcare providers use an inadequately mastered second language.

Second to being able to actually converse in the patient’s first language, codeswitching may be a useful alternative. Codeswitching refers to a linguistic phenomenon where speakers change between two languages in a single sentence or conversation. Healthcare providers thus still conduct the consultation in the language they themselves are comfortable with, but learn some essential terms and phrases in the patient’s language that they use to enhance the communication. Yet, much room remains for misunderstandings, as evidenced by Levin, who noted that, in a Western Cape paediatric hospital setting, most isiXhosa words were not in the doctors’ vocabulary; some common English words were not in the parents’ (of the patients) vocabulary; and even words that were in the vocabulary of both groups were often understood differently by the two parties.

Overall, there is a need for linguists, as specialists in language acquisition, to provide guidance and assistance in this regard, as healthcare practitioners receive very little formal language training and many lack conviction that they could become proficient in a new language.

Conclusion

The language barrier continues to compromise a large proportion of the South African population’s quality of, and access to, healthcare services. Despite international recognition of the importance of appropriate communication in the rendering of healthcare services, research regarding the language barriers in the South African healthcare sector remains limited to isiXhosa in the context of English and Afrikaans, and has been conducted almost exclusively in the Western Cape. This highlights the dire need for research that covers the entire South African healthcare sector and represents all the languages and cultures protected under the South African Constitution. Moreover, it raises a call for interdisciplinary collaboration between language practitioners and healthcare professionals to find viable solutions to communication challenges posed by linguo-cultural barriers within the multicultural South African population, in order to honour the right of every citizen to equitable health care.

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