



References

1. Ley P. *Communication With Patients: Improving Satisfaction and Compliance*. London: Croom Helm, 1988.
2. Kleinman A. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press, 1980.
3. Ebden P, Carey OJ, Bhatt A, Harrison B. The bilingual consultation. *Lancet* 1988; **2**: 347.
4. Kay M. Lexemic change and semantic shift in disease names. *Cult Med Psychiatry* 1979; **3**: 73-94.
5. Mkoka S, Vaughan J, Wylie T, Yelland H, Jelsma J. The pitfalls of translation – a case study based on the translation of the EQ-5D into Xhosa. *S Afr Med J* 2003; **93**(4): 265-266.
6. Levin M. Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital, *S Afr Med J* 2006; **96**...(this issue).
7. Levin ME. The importance of language and culture in paediatric asthma care. *Curr Allergy Clin Immunol* 2005; **18**(1): 8-12.
8. Levin M. Discordant definitions of medical terminology and their impact on communication between English-speaking doctors and Xhosa-speaking parents at a paediatric hospital. PhD thesis, University of Cape Town, 2005.
9. Ngubane H. *Body and Mind in Zulu Medicine*. London: Academic Press, 1977.

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The effects of a language barrier in a South African district hospital

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Background. Communication between health workers and patients at Hottentots Holland Hospital (HHH) is hindered by staff and patients not speaking the same language. HHH is a district hospital in the Cape Town Metropolitan District of the Western Cape where staff mainly speak Afrikaans or English and a large number of patients mainly Xhosa.

Objectives. The study aimed to explore the effects of this language barrier on health workers and patients at HHH.

Design. Three focus group interviews were held with 21 members of staff and 5 in-depth patient interviews were conducted.

Results. The language barrier was found to interfere with

working efficiently, create uncertainty about the accuracy of interpretation, be enhanced by a lack of education or training, cause significant ethical dilemmas, negatively influence the attitudes of patients and staff towards each other, decrease the quality of and satisfaction with care, and cause cross-cultural misunderstandings.

Conclusion. The effects of the language barrier were considerable and persistent despite an official language policy in the province. The training and employment of professional interpreters as well as teaching of basic Xhosa to staff are recommended.

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Although South Africa is a country with eleven official languages, most health care workers can only speak one or two, and it is obvious how this can lead to major problems when it comes to providing good quality health care. Language barriers are associated with reduced patient satisfaction,¹ fewer return visits² and poorer adherence with medication such as antiretroviral therapy.^{1,3,4}

Errors occur frequently in interpretations provided by untrained nurse-interpreters⁵ and yet in South Africa interpretation is most often an *ad hoc* duty provided by nurses,

ancillary staff or even patients and relatives⁶ (and Lesch HM – unpublished data). Although the use of trained interpreters is associated with a higher quality of patient-physician communication, their non-availability implies that other factors, such as cost, preclude greater use of their services.⁷ In the absence of a bilingual physician or a professional interpreter clinical decision making tends to be more cautious and expensive.⁸ Specific training of primary care physicians can improve the perceived quality of communication from the perspective of patients who do not speak the local language.⁹

This study took place at Hottentots Holland Hospital (HHH), a district hospital situated 30 km from Cape Town. It serves a population who mainly speak English, Afrikaans or Xhosa. A significant number of patients can only speak Xhosa, and although most of the staff are fluent in Afrikaans or English, only a handful of personnel can speak Xhosa and there are no official interpreters.

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The aim of this study was to explore the effect of the language barrier on the health workers and patients at HHH, to explore ways in which any related problems that emerged could be addressed, and to make recommendations on how to address these problems.

Methodology

Qualitative methodology was used to explore the experience of staff and patients with the language barrier at HHH. Three focus group interviews (FGIs)¹⁰ were held with purposively sampled staff (Table I) and facilitated by the principal researcher. Five Xhosa-speaking patients were interviewed by an independent Xhosa-speaking research assistant using an unstructured questionnaire with open questions.¹¹ Interviews were audio-taped and transcribed, and the Xhosa interviews were translated into English. All the qualitative data were analysed using the framework method.¹²

Table I. Composition of focus group interviews (FGIs)

| FGI | Composition of FGI | Language of FGI |
|-----|--|-----------------|
| 1 | 6 junior doctors, Afrikaans-speaking, not proficient in Xhosa | Afrikaans |
| 2 | 8 experienced nurses, Afrikaans-speaking, not proficient in Xhosa | Afrikaans |
| 3 | 7 Xhosa-speaking staff (2 sisters, 3 cleaners, 1 clerk, 1 messenger) | English |

Results

The effects of a language barrier at HHH were described as follows.

Interference with working efficiently

The need to provide informal interpretation or to find an unofficial interpreter interfered with the efficient performance of the official duties of both parties concerned. In addition, the number of Xhosa-speaking nurses who could be asked to interpret was small relative to the number of patients who only spoke Xhosa:

We all have our tasks that we have to complete for the day. Because, if someone calls me to go and translate, it is not the matter. But the fact is that I have something to do – I will not always be there. That is why many people go away without knowing the reason why they came to hospital. (Xhosa-speaking clerk)

... 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't talk to this mother about her child that died. (Afrikaans-speaking doctor)

... we are very few, like the Africans. And lots of our patients here are mainly Africans. (Xhosa-speaking sister)

Causing uncertainty about the accuracy of interpretation

Even when someone was found to translate, the non-Xhosa-speaking staff aired their concern about what the translators told them:

And you also don't know what they say to each other. The patient gave a lot of words then the interpreter only say these few ... (Afrikaans-speaking nurse)

Being enhanced by a lack of training

It emerged clearly that Xhosa-speaking personnel who had a medical background were much more comfortable with having to translate than personnel without a medical background.

... we got different jobs ... he's a clerk and the other one is a cleaner and the other is a whatever. So, they don't know the medical terms. So, that makes really very difficult for them to translate. (Xhosa-speaking sister)

The non-Xhosa-speaking staff also repeatedly expressed that they wanted to learn Xhosa:

If they only had a little word every day. Today we learn this word and we all only speak this word ... we will be able to say a whole sentence full in a week's time. We will not be able to speak fluently, no, but we will at least be able to understand a little bit. (Afrikaans-speaking nurse)

It emerged that the educational level of the patient was felt to be a big stumbling block, especially in the case of older Xhosa people.

I feel bad [about the communication], because I am not well educated. I was born during those days when education was not important, the only thing which was very important was the livestock. To look after the cattle. (Elderly male Xhosa patient)

Causing ethical and medico-legal dilemmas

It was felt that the rights of both patients and staff were compromised, and that the autonomy of neither was respected.

... we are cleaners and then the others say their medical terms, which we don't know. Then we say 'No, I didn't understand the medical terms' – and then they will say that 'you don't do it for me, you do it for the patients'. And actually it is not right. Sometimes the nurses and doctors take other patients to translate and then when they see that the patient doesn't understand they would come and say 'come here' and when I come, the patient is already cross; the patient doesn't want to hear nothing. And then the patient and the doctor want you to – She is like forcing you to tell the person this and this and that. And I think – it's wrong. Because the patient has its right and I have my right also. Whenever a patient takes me to court, who will be there



for me, I don't have medical background. That is the problem. What I think, they must employ a translator, which have a background. (Xhosa-speaking cleaner)

Another concern aired was the issue of obtaining informed consent from patients for procedures.

Because, many times, especially if some of them now has to go for operations, now the doctor explains to that person. The person agrees with everything. That doctor is not even out of the door yet – then they already do not know what is going on at all. (Afrikaans-speaking nurse)

Confidentiality was another area of concern raised. One of the doctors expressed herself as follows:

What is very bad for me, many times what happens here is if the patient cannot speak English, then we ask another mother or another patient to translate. And it is so bad for the confidentiality of that patient, because I have already many times before asked other mothers to do HIV counselling for me for a mother and her child about HIV. And it is so inappropriate and it is so unprofessional and it is so bad for the mother, because the mothers then all know what the test is about and why the patient is there. But what other options do you have? (Afrikaans-speaking doctor)

Negatively influencing the attitudes of patients and staff towards each other

There were preconceived negative attitudes towards Xhosa-speaking patients among the non-Xhosa-speaking staff because of the staff's prior experience with the patients. They felt the patients should try to learn English, and some believed that the patients sometimes deliberately did not understand what was said:

But many of the Xhosas, they do understand what you say to them. They pretend as if they do not know! Then they pretend to be stupid. (Afrikaans-speaking nurse)

These negative preconceived attitudes were also detected among the Xhosa patients.

... nowadays the doctors who speak English they don't care about us, they don't care how we feel. (Xhosa-speaking patient)

Decreasing the quality of patient care

Nurses and doctors shared their experiences of patients who were discharged without knowing their diagnoses, without knowing how to take their medication, and without knowing what to do with the letter they received on discharge. Because doctors and patients do not understand each other, many tests that have already been done are repeated unnecessarily. Concerns were even raised about patients dying because of the language barrier. One of the nurses shared her experience of a patient who responded incorrectly to his name and died after a drain was put into his normal chest.

It's a problem. He cannot tell the doctor for how long the child is sick, what the child drank or what medicine the child was given

or whatever. Lots of people have already died because they cannot understand or say what is the matter with them. (Afrikaans-speaking nurse)

It also emerged that the language barrier was compromising the practitioner-patient relationship, which is so important for good quality care:

But your quality of care also deteriorates. We are now on obstetrics. Now you get the primigravida that only speaks Xhosa, and you want to PV her. All she sees is, you want to put your fingers in somewhere – where you may not. She becomes more and more excited, screams more and more, crawls up the bed, you become more and more impatient with her, because the more you want to tell her 'I must feel how far you are dilated' in English, the more she thinks you are some sort of perverse animal. And in the end you are impatient, and you push her flat to try and PV her. It is very bad, because the patient is cross with you for the rest of the evening. (Afrikaans-speaking doctor)

The gathering of accurate information and genuine participation of the patient in decision making was hindered by the lack of proper interpretation, the need to struggle in a poorly understood second language, and unbalanced power dynamics in the practitioner-patient relationship.

Interviewee: *First of all I become afraid of the doctor and confused about the situation I'm in. In most cases I don't understand what he is saying. I don't feel right about it. I don't like what they are doing.*

Interviewer: *Why are you afraid?*

Interviewee: *It's because I would say yes to a thing which I was not supposed to say yes to.*

Interviewer: *So, you just say yes even if you don't understand?*

Interviewee: *Yes.*

Interviewer: *Why don't you want to say you don't understand?*

Interviewee: *Sometimes I'm a little bit confused, and I don't want to appear as stupid. I don't want to say no because I don't want him to leave me.* (Xhosa-speaking patient)

The Xhosa-speaking personnel also felt that the language barrier caused patient care to be of a poor standard.

The caring or what must be done won't be – won't go right because of misunderstanding something ... Because I remember one time, one of the patients in OPD had the STD and she was with her husband and the husband was chasing her, thinking she was getting the family planning. Then we have to explain to him that she is getting Bicillin 2.4 – maybe inside the room the doctor didn't explain to him what did he [give] the injection for. (Xhosa-speaking sister)

Decreasing satisfaction with care

None of the 5 patients reported having had a staff member to translate for them initially and either had family members or other patients interpreting who themselves were poor in



Afrikaans or English. Some of the patients were assisted by Xhosa-speaking sisters in the ward, but only after they were admitted to the hospital. Even if the nursing personnel could just speak a little bit of Xhosa the patients found it better than if they could speak none at all. The patients aired their frustration:

I wish there would be someone who can interpret for us. A Xhosa interpreter who is going to help us when the doctor is talking to you and he interpret what the doctor is saying. A person who is going to understand what we need.

Patients expressed themselves quite strongly, some saying that they are 'treated like coloureds, they expect us all to understand Afrikaans' and that the hospital is a 'dog hospital'.

Causing cross-cultural misunderstandings

Participants could not talk about their experience with the language barrier without also talking about the influence of culture. The non-Xhosa-speaking staff commented, among other things, about the influence of the sangoma and how some mothers keep on giving the 'sangoma's poison' in hospital despite the fact that they have been told about the dangers. One also commented:

And lots of them tie some of that ropes and things around them so tight, especially if they have oedema then it is so tight, now you want to cut it off ... then they get angry. (Afrikaans-speaking nurse)

A young female patient said that she does not ask questions when she is seen by the doctor because 'I do respect them'. Respect implies not querying anything the doctor says, and in turn the doctor mistakenly believes that the patient understands him or her, is satisfied and does not have any questions.

Discussion

This study has demonstrated how a language barrier in a typical district hospital can lead to significant problems for both staff and patients. It is likely that similar problems are being encountered in other South African district hospitals where staff and patients do not share the same language and no professional interpretation is available. Of particular concern is the erosion of the patient's rights to confidentiality and informed consent and the reduction in quality of care.

Despite the existence of a new language policy in the Western Cape that recommends the establishment of professional interpreters in hospitals¹³ little has changed over

the last 10 years (Lesch HM – unpublished data). The cost of employing professional interpreters has been determined¹³ and may be a barrier to implementation, but will be offset by improved quality of care and utilisation of resources.^{7,8} Further research may be needed to plan for the introduction of interpreters. (Lesch HM – unpublished data).

Although interpreters are necessary, their effective use is also an issue.¹⁴ The need to inform and educate medical personnel and students as well as the patients on the use of interpreters is very important. Courses in communication skills should be offered to staff, and patients should be informed about their rights and the implications thereof.

As the doctors and nurses in this study requested, they should also be offered training in basic Xhosa. Although language acquisition as an adult is not easy⁶ the idea is not to become bilingual in Xhosa, but rather to create sufficient basic understanding of medical Xhosa and respect for the other's culture.¹⁵

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References

1. David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban hispanic community. *Mt Sinai J Med* 1998; **65**: 393-397.
2. Pitkin K, Baker DW. Limited English proficiency and Latinos' use of physician services. *Med Care Res* 2000; **57**: 76-91.
3. Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. *Med Care* 1988; **26**: 1119-1128.
4. Orrel C, Bangsberg DR, Badri M, Wood R. Adherence is not a barrier to successful antiretroviral therapy in South Africa. *AIDS* 2003; **17**: 1369-1375.
5. Elderkin-Thompson V, Silver RC, Waitzkin H. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Soc Sci Med* 2001; **52**: 1343-1358.
6. Wood B. Interpreters in medical consultations – a literature review. *SA Family Practice* 1993; **14**: 347-353.
7. Hornberger J, Itakura H, Wilson SR. Bridging language and cultural barriers between physicians and patients. *Public Health Reports* 1997; **112**: 410-417.
8. Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department. *Arch Pediatr Adolesc Med* 2002; **156**: 1108-1113.
9. Bischoff A, Perneger TV, Bovier PA, Loutan L, Stalder H. Improving communication between physicians and patients who speak a foreign language. *Br J Gen Pract* 2003; **53**: 541-546.
10. Wood ML. Focus group interview in family practice research. *Can Fam Physician* 1992; **38**: 2821-2827.
11. Armstrong D, Grace J. *Research Methods and Audit for General Practice*. New York: Oxford University Press, 2003: 62.
12. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R, eds. *Analysing Qualitative Data*. London: Routledge, 1993: 173-194.
13. Cole P, Lawrence L, Nyubuse N, Goddenet J. *Costing the Western Cape Language Policy*. Cape Town: Emzantsi Associates, 2003.
14. Burbano O'Leary SC, Federico S, Hampers LC. The truth about language barriers: One residency program's experience. *Pediatrics* 2003; **111** (5): e569-e573.
15. Ellis C. *Learning Language & Culture in the Medical Consultation*. Parktown North: Sue McGuinness Communications, South Africa, 1999: 2.

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