



Overcoming language barriers

Patients experience significant barriers to accessing quality medical care. Foremost among these are socioeconomic, structural and cultural/linguistic barriers. Studies also focus on the potential implications of alternative explanations for disease. In the African setting these alternative explanatory models are often regarded as a cause for decreased assessment of severity,¹ late presentation,^{2,3} non-adherence to medical treatment⁴ and the use of potentially dangerous traditional remedies.^{5,6}

Three articles in this issue address language and cultural barriers in two settings in the public health service in the Western Cape. Schlemmer and Mash⁷ describe the effects of language barriers on staff and patients at a district hospital. In concert with research from Chris Hani Baragwanath Hospital,^{8,9} they found that significant barriers exist between Xhosa-speaking patients and non-Xhosa-speaking staff. They document that language issues interfere with working efficiently, create uncertainty about the accuracy of interpretation, and negatively influence the attitudes of patients and staff towards each other. In addition, patient interviews document decreased quality of and satisfaction with care and cross-cultural misunderstandings. In Levin's study,¹⁰ language and cultural barriers were cited by more parents as a major barrier to health care than structural and socioeconomic barriers. Parents did not have access to same-language practitioners or interpreters, and experienced difficulties with understanding the doctors, making themselves understood and asking questions. Parents were dissatisfied with communication between themselves and their doctors, tending to blame their own linguistic limitation rather than those of the doctors. In his second article,¹¹ Levin shows that Xhosa-speaking parents experience difficulty in understanding medical terminology used by doctors and documents differences in the use of medical terminology by Xhosa-speaking patients and English-speaking doctors. He focuses on discordant definitions of terminology due to culture-specific explanatory models of disease held by patients.

Interpreters in medical settings

Levin found that interpreters were rarely used in the acute admissions ward of Red Cross War Memorial Children's Hospital, and that parents uniformly desired interpreters to be present. Schlemmer, however, found that most medical and nursing staff have concerns about the accuracy of translation. Saohatse's research^{8,9} at Chris Hani Baragwanath Hospital also showed significant interpreter errors and resentment of nursing staff at being asked to provide interpretation in addition to their nursing duties. Untrained interpreters may lack sufficient language skills and frequently commit errors that may result in serious distortions of meaning and adversely affect

care. Five basic interpreter errors were classified by Vasquez,¹² viz. omission, addition, condensation, substitution and role exchange. Omission is when the interpreter completely or partially deletes a message sent by the speaker. Addition is the tendency to include information not expressed by the speaker. The tendency to simplify or explain is referred to as condensation and the tendency to replace concepts as substitution. Role exchange occurs when the interpreter takes over the interaction and replaces the interviewer's questions with the interpreter's own, thus assuming the role of interviewer. Besides the errors untrained interpreters make, the use of strangers for interpretation raises the question of ensuring patient confidentiality and may undermine the patient's confidence in the doctor and the system. Use of family members or strangers from the waiting room may make patients feel inhibited, embarrassed or angry.

Not only do interpreters need to be well trained, doctors should be encouraged to use interpreters more regularly and become skilled in their use. Levin¹³ noted that most doctors experience difficulty in the use of interpreters, but tend to ascribe blame to the interpreter, rather than looking for sources of miscommunication in the triad of doctor, patient and interpreter.

Claire Penn¹⁴ has analysed interpreted medical interviews in South Africa, and elucidated techniques that serve as facilitators of good communication, and those factors that deter communication. Major factors that influence the success of interpreting in such contexts are the power relations between participants, clinicians' and interpreters' expertise in engaging in mediated interviews, and interpreters' medical field knowledge. Strategies that may improve communication are equal and active roles of the interpreter, familiarity and co-operation between the interpreter and practitioner, and the use of techniques for good communication such as the elimination of jargon, repetition, paraphrasing and tolerating silence.

Cultural training in health care

A common thread in the articles is stressing the provision of culturally similar health practitioners and improving the training of all health practitioners. Teaching points should include the rationale for learning about culture in health care as well as practical tools for productive cross-cultural clinical encounters.

In South Africa these issues are being afforded increasing importance by medical educators. At my alma mater, the University of Cape Town, the demographics of first-year medical students has changed substantially over the years since I graduated in 1994 (Fig. 1). The proportion of white students has decreased from over 60% to just under 35% in this time period. In addition, the curriculum now includes courses with a focus on communication with patients whose language



(English, Afrikaans or Xhosa) and culture are different from students' own. This includes not only language skills but also an awareness of the contribution of cultural background to the doctor's and patient's concept of health and illness and to the doctor-patient relationship. These skills will serve young doctors in great stead and should help to close the communication gap between them and their patients.

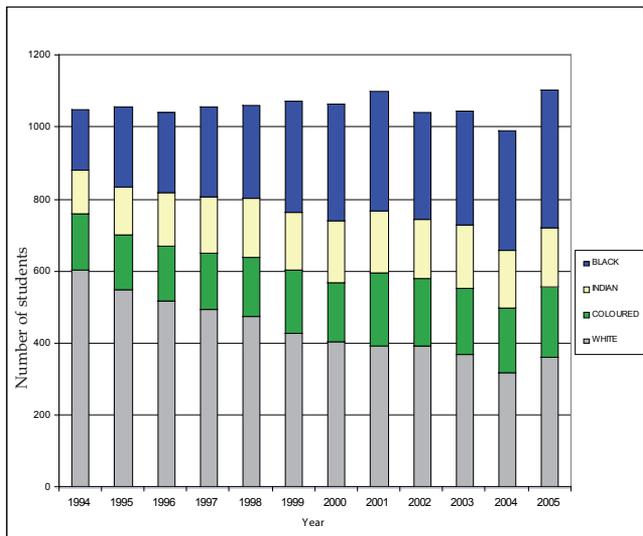


Fig. 1. University of Cape Town MB ChB population statistics, 1994 - 2005.

The responsibility for the patient's health lies with the doctor. It is therefore as important to practise good communication as good medicine, since failure of the first can lead to failure of the second. For medical practitioners who are grappling with communication between themselves and patients whose language and culture are different from their own, the articles in this edition provide some insight into the complexity of the problem and suggest some solutions. The provision of more interpreters and attention to their effective use is one solution. In addition, doctors must be aware that medical jargon will not be equivalently understood by most laypeople, and where the patient's language differs from their own the differences

in definitions will be more pronounced and will apply to more terminology. The world-views of doctors and patients are affected by their cultures, and where they are different, communication may become more difficult. Excellent South African texts that address this issue are the *Oxford Handbook of Family Medicine*¹⁵ and Ellis's¹⁶ *Learning Language and Culture in the Medical Consultation*.

M E Levin

School of Child and Adolescent Health
Red Cross War Memorial Children's Hospital
Rondebosch
Cape Town

Corresponding author: M E Levin (mlevin@ich.uct.ac.za)

1. Muhe L. Mothers' perceptions of signs and symptoms of acute respiratory infections in their children and their assessment of severity in an urban community of Ethiopia. *Ann Trop Paediatr* 1996; **16**(2): 129-135.
2. Pilkington H, Mayombo J, Aubouy N, Deloron P. Malaria, from natural to supernatural: a qualitative study of mothers' reactions to fever (Dienga, Gabon). *J Epidemiol Community Health* 2004; **58**(10): 826-830.
3. Winch PJ, Makemba AM, Kamazima SR, et al. Local terminology for febrile illnesses in Bagamoyo District, Tanzania and its impact on the design of a community-based malaria control programme. *Soc Sci Med* 1996; **42**(7): 1057-1067.
4. Kauchali S, Rollins N, Bland R, Van den Broeck J; Child Health Group. Maternal perceptions of acute respiratory infections in children under 5 in rural South Africa. *Trop Med Int Health* 2004; **9**(5): 644-650.
5. Ajaiyeoba EO, Oladepo O, Fawole OI, et al. Cultural categorization of febrile illnesses in correlation with herbal remedies used for treatment in Southwestern Nigeria. *J Ethnopharmacol* 2003; **85**(2-3): 179-185.
6. Iyun BF, Tomson G. Acute respiratory infections - mothers' perceptions of etiology and treatment in south-western Nigeria. *Soc Sci Med* 1996; **42**(3): 437-445.
7. Schlemmer A, Mash B. The effects of a language barrier in a South African district hospital. *S Afr Med J* 2006; **96**: 1084-1087 (this issue).
8. Saohatse MC. Communication problems in multilingual speech communities. *S Afr J Afr Lang* 1998; **18**(4): 111-117.
9. Saohatse MC. Solving communication problems in medical institutions. *S Afr J Afr Lang* 2000; **20**(1): 95-102.
10. Levin ME. Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *S Afr Med J* 2006; **96**: 1076-1079 (this issue).
11. Levin ME. Different use of medical terminology and culture-specific models of disease affecting communication between doctors and patients at a South African paediatric teaching hospital. *S Afr Med J* 2006; **96**: 1080-1084 (this issue).
12. Vasquez C. The problem with interpreters: Communicating with Spanish speaking patients. *Hospital and Community Psychiatry* 1991; **42**(2): 163-165.
13. 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.
14. Friedland D, Penn C. Conversation analysis as a technique for exploring the dynamics of a mediated interview. *Int J Lang Comm Dis* 2003; **38**(1): 95-111.
15. Mash B, ed. *Handbook of Family Medicine*. Cape Town: Oxford University Press Southern Africa, 2000.
16. Ellis C. *Learning Language and Culture in the Medical Consultation*. Parktown: Sue McGuinness, 1999.