



Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital

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Background. Disease is closely linked to the social context in which we live. Difficulty with communication, cultural incompatibility between patients and health care providers and socioeconomic obstacles are important barriers to quality care when doctors and patients come from different backgrounds and speak different languages. Red Cross War Memorial Children's Hospital (RCH) is a paediatric teaching hospital in Cape Town where staff members communicate mainly in English or Afrikaans, while many patients speak Xhosa as their first language.

Objectives. The study aimed to identify barriers to optimal care for Xhosa-speaking parents of patients at RCH. The contribution of language difficulties was assessed as a possible barrier to health care for this group.

Design. A questionnaire was developed and administered to 53 Xhosa-speaking parents of children admitted to the short-stay ward at RCH. The questionnaire examined parents' perceptions of barriers to their children's care, using open-ended questions, closed-ended questions and selection from lists.

Results. Parents experienced significant structural and socioeconomic barriers to access of health care for their children. 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, as only 6% of medical interviews were conducted partly or wholly in the patient's home language. Of the 94% of interviews where no Xhosa was spoken by medical staff, 21% were conducted with the aid of an interpreter (formal or *ad hoc*) and in 79% no interpreter was used. Parents experienced difficulties with understanding the doctors (64%), making themselves understood (54%) and asking questions (38%). Sixty-nine per cent of parents were dissatisfied with communication between themselves and their doctors and 45% were concerned about negative effects of poor communication on them or their children. Parents tended to blame their own linguistic limitation rather than those of the doctors.

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Many studies have consistently shown that where language barriers exist there is patient dissatisfaction,¹⁻⁴ with many patients rating this as the least satisfactory aspect of their care.

A study by Flores *et al.*⁵ in the USA demonstrates that Spanish-speaking Latino parents find difficulty in communication the single greatest barrier to health care for their children. Twenty-six per cent of parents cited this problem, 15% saying that it was a barrier that nurses and doctors did not speak Spanish, and 11% citing a lack of interpreters. Other barriers included financial issues (20%) and long waiting times at the doctor's office (15%). Causes for parents not bringing their child in were identified as finances (34%), transportation (21%), excessive waiting time (17%) and lack of cultural understanding by staff (11%). Where language barriers exist, parents' perceptions are that adverse health consequences including the prescription of inappropriate medication occur.⁶

Language difficulty results in reduced patient understanding of diagnoses, medication and follow-up³ and non-adherence to medical advice in adult⁴ and paediatric settings.⁷ In addition, the language barriers are directly associated with reduced quality of care. A review of 21 studies from 1983 to 1993 by Stewart *et al.*⁸ showed reduction in emotional health, symptom resolution, function, physiological measures and pain control. A recent study showed that interpreter errors were a common occurrence in a paediatric outpatient department and resulted in clinically significant adverse consequences.⁶

In South Africa, where we have 11 different official languages, discrepancy between the language spoken between patients and doctors is extremely common. The overwhelming majority of health professionals, with the exception of nurses, cannot speak any of the indigenous African languages.⁹

Crawford¹⁰ documented problems at all stages of contact with the health service with particular focus on structural barriers to health care, the roles of nurses as interpreters, incompatible concepts of illness and differing or overlapping lexical relations between Xhosa and English words. Incorrect pronunciation of Xhosa names in the waiting room led to delays and patient anxiety, nurses were unwilling to interpret and lay translators were mostly used with subsequent errors in translation.



At Chris Hani Baragwanath Hospital, language problems are common due to lack of interpreters and inability of most doctors to speak an African language. In a survey by Saohatse¹¹ in 1998, nurses and *ad hoc* interpreters were most often used for translation and poor quality care resulted, including inappropriate discharge leading to patient distress, medical consequences and non-compliance with medication as well as anger from doctors and resentment from nurses. A follow-up in 1999 documented a lack of mutual understanding leading to misdiagnosis.¹² Forty per cent of nurses said they were not willing to help doctors with interpreting and 35% of patients said nurses did not want to speak African languages other than their own.

Red Cross War Memorial Children's Hospital (RCH) is a paediatric teaching hospital in Cape Town, South Africa. The majority of doctors are first-language English speaking, followed by Afrikaans and a minority of Xhosa speakers. In a review of a year's admissions in 2004,¹³ approximately 40 - 50% of patients admitted spoke Xhosa as a mother tongue; 25 - 30% spoke Afrikaans and 20 - 30% spoke English. Only two interpreters are available and this service is confined to office hours. This study aimed to identify barriers to optimal care for Xhosa-speaking parents of patients at RCH. The contribution of language difficulties was assessed as a possible barrier to health care for this group.

Methodology

An 'access barrier' questionnaire, based on that used by Flores *et al.*,⁵ was devised to elicit concerns about access to hospital, service within the hospital and experiences around caregivers' communication issues. The questionnaire was administered by Xhosa-speaking research assistants with no relation to the hospital. The subjects were a convenience sample of 53 Xhosa-speaking parents whose children had been admitted to the short-stay ward suffering from various illnesses. Informed consent was taken from parents. The survey documented parents' demographic data, language of the previous medical interview, the duration of the interview and the presence of an interpreter. Open questions were asked about the single greatest obstacle to getting health care for their child, problems with accessing care for their child, any problems with communication, effects of any problems with communication and any possible solutions to these problems. Parents were asked to select the single greatest obstacle to getting quality health care for their children from a preformed list. Yes/no questions were posed about the presence or absence of socioeconomic, structural, cultural and language barriers to patients receiving quality health care.

Results

Of the 53 subjects selected, 49 were prepared to respond. The mean age was 31.5 years. (median 30, range 16 - 53). Caregivers had passed a mean of 9.6 years of education

(grade 9) (median 10, range 0 - 17). When asked, on open questioning, to name the single greatest barrier to access to good care for their children, 63% cited lack of money. When asked to select from a preformed list (see Table I), difficulty paying medical costs was cited most often (14 respondents), yet when added up overall, communication problems were cited by more parents (25 respondents) than structural and socioeconomic concerns (24 respondents). This indicates that language issues are closely followed by socioeconomic issues as major access barriers to good care for Xhosa parents.

The duration of the preceding interview with the doctor was not measured, but caregivers were asked to estimate the time the doctor had spent speaking with them. Caregivers claimed that doctors spent an average of 16 minutes explaining their child's illness to them (median and mode 10 minutes). Four caregivers claimed doctors had spent no time explaining to them, and 4 that doctors had spoken to them for an hour.

In parents' prior discussion with a doctor, the language of communication had been English in 92%, Xhosa in 4%, English and Xhosa in 2% and Afrikaans in 2%. Only 6% of medical interviews had been conducted partly or wholly in the patient's home language. Of the 94% of interviews where no Xhosa was spoken by medical staff, 21% were conducted with the aid of an interpreter (formal or *ad hoc*) and in 79% no interpreter was used.

The respondents answered questions about the nature of their communication with their doctor. Only 15 (31%) of caregivers said they were satisfied with the amount and nature of the communication with the doctor. Thirty-four (69%) were dissatisfied or had experienced problems. The most common cited problem (64%) was failure to understand English, especially specific words or medical terminology. Fifty-four per cent of parents experienced problems making themselves understood to the doctor, and 38% felt unable to ask questions.

Twenty-two (45%) of caregivers were concerned about negative effects of poor communication on them or their children. Fourteen parents (28%) believed poor communication

Table I. Single greatest barrier to access to good care for children (from preformed list)

Structural and socioeconomic concerns	
Difficulty paying medical costs	14
Long waiting time for the doctor	6
Difficulty arranging transportation	3
Difficulty taking time off work	1
Inconvenient doctors' working hours	1
Total structural and socioeconomic	24
Communication problems	
Doctors and staff who don't speak Xhosa	8
Difficulty understanding explanations of the child's illness	6
Rude or discourteous doctors or nurses	6
Lack of interpreters	5
Total communication	25



could have a direct effect on their child's health. Six (12%) parents believed poor communication could adversely affect their understanding of the disease and the medication use. Negative consequences of poor communication (on open questioning) are listed in Table II.

On open questioning, 11 caregivers (22%) said there had been a specific adverse effect on their child from doctors or other staff not speaking Xhosa. These comprised direct adverse effects on their children's health. Most commonly cited adverse effects are set out in Table III.

Themes

The difficulties that parents expressed with language can be divided into three main themes. Language difficulties were seen as a significant barrier to attaining good quality care for their children. Poor communication had adverse effects on parents and their children. The use of medical terminology is a significant barrier to parents' understanding of doctors. Some illustrative quotations from interviews follow:

Language difficulties are a significant barrier to health care for Xhosa-speaking parents

Parents were dissatisfied with the inadequacy of communication between themselves and their doctors, tending to blame their own linguistic limitation rather than that of the doctors. Parents experienced difficulties in understanding English, asking questions and responding to doctors' questions.

... they don't speak Xhosa.

Q: Not even a little bit?

A: No, they don't.

Q: How then do you solve this problem?

A: I do try, as much as I know that what I'm saying is incomplete in order for him to understand. I basically summarise what I say, unlike if I were to speak in my own language. The information is therefore not complete as it would have been in Xhosa, in order for him to be able to understand.

Q: You understand everything he says?

A: Yes, I do but I'm unable to speak.

Q: What do you do when you have to answer?

A: I often answer whatever question he's asking.

Q: In isiXhosa or English?

A: In English, though doubting that I answered well.

Q: What effects can that have on the child?

A: It may happen that I said the wrong thing ... that I didn't answer what he was asking but what I thought he was.

I do have problems, sometimes when I want to ask or explain something to him and it becomes difficult because I don't have much English vocabulary ... when I want to ask ... about the problem and that becomes a problem because I wouldn't know what to do. I think each and every doctor should have an interpreter who would explain what the person is saying because when you speak the doctor writes and maybe he is not writing what you are saying because he is not going to show you anyway.

Poor communication has negative effects on parents and their children

Parents expressed difficulty with understanding diagnosis and treatment and a fear that this may lead to errors with their

Table II. Number (and %) of problems cited by respondents as possible negative consequences of poor communication (on open questioning)

Problem cited by respondent	Number	%
Poor health care	6	12
The child not getting better or getting worse	6	12
Being unable to understand what the treatment is or how to use medication	4	8
Being given the wrong treatment	2	4
Not being able to understand the cause of the illness	2	4
The doctor getting the wrong history	1	2
Getting cross	1	2
The child getting anxious	1	2

Table III. Number (and %) of specific negative outcomes experienced by respondents as consequences of poor communication (on open questioning)

Negative outcomes	Number	%
Incorrect or inappropriate medicines were given	4	8
The child was misdiagnosed	3	6
I did not understand the doctor's explanations and gave the wrong medicines	2	4
The child received poor medical care	2	4



adherence to instructions or medication. They would like interpreters to be present at all interviews or doctors to speak Xhosa to improve communication.

When the child is not going to be admitted one can have a problem because one won't know how to treat the child, things like that. It's you the parent that has problems because you don't know what the child needs. Another thing is when one is with the child in hospital ... whenever people ask what's wrong with the child one doesn't know.

Q: When you think about this problem, when you think about it, do you think that can put the child at a risk? Do you think that could endanger the way in which the child is treated by the doctor?

A: It can endanger the child because when the child gets the prescription from a doctor who speaks English talking to someone who does not understand English, she [the caregiver] may give the child the incorrect measurement which could be more than what the doctor prescribed because of the misunderstanding. In that way you endanger the child's life and that is why it is important to have somebody who will help with Xhosa because not all of us went to school.

Medical terminology is a significant barrier to parents' understanding of doctors

Difficulties with terminology were clearly expressed by subjects who stated that English words 'can mean different things' and that when the doctor is quizzed further 'he is often not able to explain'.

I'm able to understand him in some parts, in some I don't.

Q: What do you do when you don't understand him?

A: I keep quiet, I'm uneasy to ask because I don't know his language.

Q: Do you sometimes have difficulty understanding some English words?

A: Yes, I sometimes do.

Q: Sisi, in your own thinking what made you misunderstand him the first time he gave you the pumps?

A: The way he explained to me, made me misunderstand him. He used medical terms.

Q: Oh, medical terms. But you didn't ask him to explain fully.

A: I didn't ask and I felt so stupid. It created a problem, because, I think that when the doctor gives you instructions he expects you to apply them. But, when he checks up the child and discovers that you did not apply them as he instructed then he gets angry. So we should follow instructions.

Sometimes, English words may mean four different things, I think they mean this but then they mean something else. I'm not that well educated.

Selected recommendations

Interpreters should be made more widely available, and doctors should be educated how best to utilise their services. Doctors should learn basic greetings and questions in African languages. Courses held at hospitals may increase the language skills of doctors, allowing greeting, limited communication for diagnosis and systems review, and expose doctors to cultural issues that may make them more sensitive to their patients. Medical institutions should consider publishing small word-lists for doctors with greetings and systemic enquiry, and recommend local texts, such as the book by Kirsch, Skorge and Matsiliza,¹⁴ which more fully cover medical communication. A short medical Zulu dictionary is available online at <http://www.jwolfe.clara.net/WebPages/ZuluDict.htm>

Conclusion

Language barriers cause significant difficulties for Xhosa-speaking parents of children at Red Cross War Memorial Children's Hospital. 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 that of the doctors.

The increased provision and use of interpreters could alleviate these barriers. Doctors should be encouraged to learn greetings and basic communication in indigenous languages.

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