

A regulatory framework for interpreting in health-care settings: Implications for equitable access to healthcare in Lesotho and the Western Cape, South Africa

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Executive summary

Interpreting is an essential support service in multilingual health systems where language diversity dictates a need to facilitate communication between healthcare providers and patients. However, this service is neither institutionalised nor regulated in Lesotho or in South Africa, resulting in haphazard interpreting practices often decided by healthcare providers or by management of a healthcare facility. The result of these practices is an imbalanced system in which some patients access health services in the language they understand best while others do not, and some obtain interpreting services while others do not. This policy brief presents a case for the formulation of policies that regulate interpreting services in healthcare facilities in both countries.

Introduction

The extent of language diversity in the Lesotho and South African health systems has resulted in reliance on interpreting services to facilitate communication between healthcare providers and patients. In Lesotho, language diversity is primarily due to the health system's heavy reliance on expatriate physicians (Cohen et al. 2009; Sobane 2012). In South Africa, it is due to the multilingual nature of the country's population, characterised by 11 official languages. Efforts to manage language diversity between doctors and patients are therefore crucial for both countries in order to minimise problems that could be caused by the language barrier, given the well-documented role played by effective communication in the achievement of positive healthcare outcomes. In South Africa particularly,

issues of language diversity have been illuminated by the passing of the Use of Official Languages Act (No. 12 of 2012), which states as one of its objectives:

to promote parity of esteem and equitable treatment of official languages of the Republic; and to facilitate equitable access to services and information of national government ...

(Use of Official Languages Act, 2012, Sections 2[b] and [c])

This Act, read together with the national Patients' Rights Charter (1999), which highlights the right of patients to obtain health information in a language they understand and to be involved in decision-making, reflects the need for the health system to act on the management of language diversity in clinical consultations, and therefore on the role of medical interpreting.

In other countries there have been attempts to explore alternative language-intervention resources, such as the use of multilingual literary resources in Barcelona (Moyer 2011) and online training manuals (Van de Poel & De Rycke 2011). However, these materials have been found to be marred by mistakes that compromise their user-friendliness and effectiveness. Interpreting has therefore continued to be the most commonly used form of language intervention in developed countries such as Germany (Bührig and Meyer 2004), as well as in African countries such as Nigeria (Ijadunola et al. 2007) and Malawi (Kamwendo 2008), in addition to Lesotho and South Africa.

In this policy brief, interpreting practices in the latter two healthcare systems are examined. The implications that they have for equitable access to healthcare, as legislated in the South African Constitution, and several policies, prioritised in the WHO Country

Cooperation Strategy 2008–2013 in Lesotho (WHO 2009), are reviewed.

An overview of interpreting practices in the absence of guidelines and regulatory policies

The practice in two Lesotho healthcare centres

This policy brief is drawn from a study conducted in Lesotho between 2010 and 2012. Data on Lesotho were collected from healthcare providers and patients in two HIV and AIDS care centres staffed by expatriate physicians. For ethical reasons the clinics will be referred to as Clinic A and Clinic B. These physicians, who originate from francophone countries, have limited competence in both English (the official language in Lesotho) and Sesotho (the main local language spoken by approximately 90% of the country's population). The physicians speak a range of languages, such as Kiswahili, Kinyarwanda, Lingala and French.

Using semi-structured interviews, focus group discussions and on-site ethnographic observations, data on the multilingual practices, resources employed and participants' experiences of such practices and resources were collected. The observations recorded the structural organisation of the care process in order to identify particular consultation points at which language intervention was needed.

A discussion on interpreting practice in Western Cape health centres is drawn from the articles of Drennan and Swartz (2002), Levin (2006), Williams and Bekker (2008), Deumert (2010) and Kilian et al. (2014), which trace more than a decade of these practices. The empirical data and literature were analysed through content analysis. Based on the analysis, policy recommendations for explicit national health policies incorporating interpreting services as a formal part

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of clinical consultations in multilingual health systems were formulated.

The findings show that due to a lack of regulatory policies, the two healthcare centres studied deal with interpreting in two different ways, based on resource availability, staff willingness and the physician's rating of whether there is a need for such services or not. In Clinic A, the common practice is that interpreting services are a standard component of the physician's consultation. English-to-Sesotho interpreting is provided for every patient, regardless of whether or not the patient is sufficiently proficient in English. Neither patients nor physicians are asked to choose whether they would like to make use of an interpreter. However, instances were observed where there was no interpreter available during the consultation, so the physicians had to either carry on without interpreting services or look for someone in the vicinity to interpret.

Contrary to what happens in Clinic A, in Clinic B interpreting is carried out only on the physician's demand. A consultation proceeds without an interpreter up to a point where the physician senses a misunderstanding or communication breakdown, upon which an interpreter is called for. Interpreting in these two clinics is conducted by the following categories of workers:

- lay interpreters employed from the local community. These are high school graduates with bilingual competence in Sesotho and English, and no formal training in either interpreting or medicine (only found in Clinic A);
- administrative personnel, who have no training in interpreting or medicine;
- bilingual nurses, who have had no prior training in interpreting; and
- counsellors, who have had prior training as HIV and AIDS counsellors but not in interpreting.

The choice of which staff member to use in these cases depends on who is available at the time, and who is willing when the physician calls for help.

Interpreting practices in some healthcare centres in the Western Cape

The non-standardised, non-professional and often ad hoc interpreting practices observed in healthcare centres in Lesotho are not very different from those observed in some of the healthcare centres in the Western Cape province in South Africa. Five studies that were carried out in different healthcare institutions in the Western Cape (Drennan and Swartz 2002; Levin 2006; Williams and Bekker 2008; Deumert 2010; Kilian et al. 2014) report on the existence of a language barrier between healthcare providers, who are largely Afrikaans- and English-speaking, and patients, who are mainly isiXhosa-speakers.

Williams and Bekker (2008) show that, despite the existence of section 6 of the Constitution (Act No. 108 of 1996) aimed at promoting multilingualism at the national Department of Health level, and a provincial language policy that recognises the equal status of English, Afrikaans and isiXhosa in healthcare services (De Vries 2003), there is still no adequate provision of trained interpreters to mediate between healthcare personnel and their patients. As a result, all these studies report that, in practice, interpreting in these healthcare centres is not formal, but is done on an ad hoc and haphazard basis (Kilian et al. 2014). With no guidelines on the use of interpreters, an array of bilingual staff such as nurses, cleaners, security guards, healthcare workers and household aides are called in to interpret. In some cases, where bilingual staff are unavailable, family members and other patients are called on to interpret.

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These differential approaches to language discordance, characteristic of most healthcare institutions in Lesotho and South Africa, raise questions about the extent to which access to healthcare is equitable when some patients have access to interpreting services while others do not.

Challenges presented by interpreting practices

Research on language in healthcare (Drennan and Swartz 2002; Deumert 2010) shows that when interpreting practices are neither regulated nor professionalised, they pose challenges to both healthcare providers and patients. The most significant challenge is dissatisfaction among bilingual workers, who are often called on to interpret. The feeling of being overworked was reported among nurses in the Lentegeur psychiatric hospital in the Western Cape (Drennan 1999: 11). According to Drennan (1999: 9), this hospital caters for a large patient base in several townships around the Mitchells Plain and Khayelitsha area; care is segmented into a rehabilitation centre for mentally handicapped patients, and care for acute and chronic psychiatric illnesses. In reporting their experiences, Xhosa-speaking nurses in this hospital showed that they feel overworked because they perform many roles, including carrying out ward rounds, interpreting and social work duties such as accompanying the patient home and interviewing relatives (Drennan 1999: 9). More dissatisfaction is reported in Deumert (2010: 54–57), where staff reported feelings of helplessness, frustration, low morale and job dissatisfaction. Their source of dissatisfaction was shown mainly to emanate from the lack of interpreters in hospital structures, leaving them with an obligation to do both their work and the interpreting task.

Similarly, in the two clinics studied in Lesotho, staff dissatisfaction was evident among 80% of the nurses who participated in the study (Sobane 2012). Their perception of interpreting is viewed as an additional and uncompensated workload for them. Of the 80% who are dissatisfied, 71% declared that they sometimes refuse to interpret because it is not part of their job (Sobane 2012). Their refusal

usually leaves the physician with no other option but to carry on with the consultation without an interpreter.

The quality of interpreting is also problematic in these scenarios. While there is a general consensus on the need for interpreters in language-discordant settings, Deumert (2010) observes that the quality of unprofessional interpreting can be poor, which seriously affects healthcare outcomes such as history-taking, diagnosis, patient education and informed consent. Dressler and Pils (2009) found one of the main problems in unprofessional interpreting to be the fact that these interpreters are untrained. Their interpretation is usually therefore flawed, given that such interpreters are not aware of the institutional implications of certain linguistic constructions.

These differential approaches to language discordance, characteristic of most healthcare institutions in Lesotho and South Africa, raise questions about the extent to which access to healthcare is equitable when some patients have access to interpreting services while others do not. The fact that patients do not decide whether or not they need interpreting also casts obvious concerns on the patient-centredness of these consultations. All these factors add to the already well-documented concerns about the quality of interpreting, given that even among speakers with the same language, doctor–patient communication can be fraught and fragile. Such concerns are exacerbated when the interpreter has no specialised background in medical care or medical terminology.

Implications for equitable access to healthcare

Promoting equitable access to healthcare has been an objective of the South African national health system

since 1994 and has also been a priority of the Lesotho Ministry of Health and Social Welfare since 2000. In South Africa, in order to realise this objective, several policies, plans and guidelines were drawn up and implemented to address factors that act as barriers to access to quality healthcare, with the aim of improving the healthcare system. Examples of such policies include the Patients' Rights Charter (1999), Policy on Quality in Health Care for South Africa (2007) and the Policy on Language Services (2011). While the Policy on Quality in Health Care for South Africa focused on addressing socio-economic barriers to healthcare access, the other two policies specifically emphasise access to health services in the language that users 'know and understand best'. In Lesotho, equitable access to healthcare is emphasised in the National HIV and AIDS Strategic Plan (2006–2011).

Language diversity, however, compromises these efforts to achieve equity as some patients are fortunate to be seen by physicians who speak their language while others are not. For example, Levin (2006) established that, at the time of his study at the Red Cross War Memorial Children's Hospital in the Western Cape, only 6% of medical interviews were conducted partly or wholly in the patient's home language. Of the remaining 94% of interviews, where no Xhosa was spoken by medical staff, 21% were conducted with the aid of an interpreter (formal or ad hoc); in 79% of interviews, no interpreter was used. Parents experienced difficulties in understanding the doctors (64%), making themselves understood (54%) and asking questions (38%). Moreover, 69% of parents were dissatisfied with communication between themselves and their doctors, and 45% were concerned about the negative effects of poor communication on themselves or their children.

These results reflect an imbalance in access to services where the majority of patients are disadvantaged as they are deprived of the ability and opportunity to (i) explain their problems in a language they can use best, (ii) understand the physician's diagnosis and (iii) comprehend the proposed treatment. While nothing can be done about the extent of language diversity, some level of equitability would have been achieved by providing these patients with professional interpreting services, a sentiment shared by De Vries (2003).

For patients in language-discordant consultations, a further inequality occurs as a result of some patients receiving interpreting services (even though such interpreters are untrained) while others do not. Although the quality of interpreting in these cases has been questioned, the value of the interpreting service in language-discordant provider–patient consultations cannot be underestimated. The service provides the kind of language intervention that at least keeps the conversation going. Patients in these interpreter-mediated consultations are better off than those in situations where the physician struggles as a result of minimal shared linguistic resources.

Conclusion

The two healthcare systems have demonstrated an awareness of the need to improve equitable access to healthcare. However, the failure of available policies in addressing the domain of language intervention in provider–patient consultations leaves a loophole that perpetuates inequalities in accessing healthcare. It is argued that inequalities in access to healthcare can be addressed by improving the linguistic accessibility of national healthcare centres.

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Recommendations

Given the current non-regulation of interpreting practices and the challenges this presents, the following recommendations for the formulation of policies are proposed:

1. Ensure, as a long-term intervention, the availability of medical training and induction programmes in the two healthcare systems, incorporating local languages as part of the curriculum. Ensure that placement of doctors recognises their competence in such local language training.
2. Establish medical interpreting as a recognised profession in national health services. Interpreters should be certified and remunerated accordingly as health service staff. This should be carried out as an immediate intervention.
3. Conduct provincial- (district-) level needs assessment surveys to determine the linguistic profiles of patients and the estimated number of interpreters needed in each area.
4. Facilitate in-service training of government health personnel in the local languages(s) in order to increase the number of personnel proficient in the language of users and patients.
5. Advise higher education institutions to offer study courses and programmes in medical interpreting to create a cadre of skilled personnel for this function. This should be done by the Department of Higher Education and Training in South Africa and the Ministry of Education in Lesotho.
6. Make interpreters a standard component of clinical consultations at the healthcare-facility level. There should be an explicit policy that governs this to guide healthcare-centre management.

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