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How to cite this thesis

Homoeopathy Master’s Students’ at the University of Johannesburg
Experiences of Language Barriers in the Delivery of Healthcare

A research dissertation presented to the
Faculty of Health Sciences, University of Johannesburg,
a partial fulfilment for a
Master’s Degree of Technology: Homoeopathy

By:

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DECLARATION

I declare that *Homoeopathy Master’s Students’ Experiences of Language Barriers in the Delivery of Healthcare at the University of Johannesburg* is my own work. This thesis was submitted to the University of Johannesburg, Faculty of Health Sciences as fulfilment of a *Magister Technologiae: Homoeopathy*. The study was ethically cleared by the Higher Degrees Committee (HDC-01-31-2018) and the Research Ethics Committee (REC-01-40-2018). This work has never been submitted to any other university for any other qualification purposes.
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Signature__________________________________ Print name_________________________
DEDICATION

I dedicate this work to my patients- past, present and future.
So much dedication, time and love went into this work and I hope that each and every one of you will feel that same dedication, time and love from me throughout our journeys together.
ACKNOWLEDGEMENTS

This work could not have been successfully completed without the amazing support system that I’ve had.
To Mom and Dad. Thank you for working hard to give me the amazing opportunity to earn this degree and for being an amazing support system. Thank you for shaping me into a person that I am proud to be. I hope that I make you proud every day.

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ABSTRACT

South Africa is a multilingual society and therefore the likelihood of healthcare professionals, including homoeopathy Master’s students, encountering language barriers with patients is high. Language barriers between healthcare professionals and patients have a negative influence on the healthcare that the patients receive. There is no training in the current syllabus for MTech Homoeopathy students at the University of Johannesburg that teaches an additional language nor one that teaches the students how to better handle encounters with patients where a language barrier exists between them.

The purpose of this study was to explore and describe the students’ experiences of language barriers in the delivery of healthcare, and to provide guidance towards overcoming language barriers in homoeopathic practice.

This study design was qualitative in nature with a phenomenological approach. Individual interviews were conducted with registered homoeopathy Master’s students from the University of Johannesburg and followed later by a focus group. The central question: “What has your experience been regarding language barriers between you and your patients at the UJ Homoeopathy clinics?” was asked and responses recorded and transcribed for later analysis.

Four themes emerged from participants’ experiences. Theme one described how language barriers create challenges in understanding between patients and participants. Theme two describes the intrapersonal and interpersonal effects that are associated with language barriers. Theme three describes language barriers’ influence on the various aspects of the healthcare process. Finally, theme four describes the mitigation of language barriers through various strategies as described by participants. Participants reported finding language barriers challenging which in turn result in negative effects on the various aspects of the healthcare process, as well as on the practitioner’s personal feelings and the patient-practitioner relationship. Participants also reported employing certain self-developed strategies in an attempt to mitigate the negative effect of the language barrier in the delivery of healthcare.

Recommendations were made for Homoeopathic students, the Homoeopathic syllabus, and for future researchers. Homoeopathic students should practice with an awareness of the role language barriers play in their practice and employ strategies to aid in the mitigation thereof. The
Homoeopathic syllabus should consider introducing a basic language course from the first year of study. Future researchers should consider using an interpreter’s assistance when interviewing subjects of differing first language and consider exploring further related avenues in terms of the role of language barriers and culture in practice, as well as different points of view.
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<table>
<thead>
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<th>Abbreviation</th>
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<tr>
<td>AHPCSA</td>
<td>Allied Health Professions Council of South Africa</td>
</tr>
<tr>
<td>HCP</td>
<td>Healthcare Provider</td>
</tr>
<tr>
<td>HDC</td>
<td>Higher Degrees Committee</td>
</tr>
<tr>
<td>HHC</td>
<td>Homoeopathy Health Centre</td>
</tr>
<tr>
<td>HP</td>
<td>Homoeopathic Practitioner</td>
</tr>
<tr>
<td>HSA</td>
<td>Homoeopathic Association of South Africa</td>
</tr>
<tr>
<td>IC</td>
<td>Informed Consent</td>
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<td>ICC</td>
<td>Intercultural Communication</td>
</tr>
<tr>
<td>MTech</td>
<td>Master of Technology</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Act</td>
</tr>
<tr>
<td>PCC</td>
<td>Patient-centred Communication</td>
</tr>
<tr>
<td>REC</td>
<td>Research Ethics Committee</td>
</tr>
<tr>
<td>SA</td>
<td>South Africa</td>
</tr>
<tr>
<td>UJ</td>
<td>University of Johannesburg</td>
</tr>
<tr>
<td>VF</td>
<td>Vital Force</td>
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CHAPTER 1
OVERVIEW AND RATIONALE

1.1 INTRODUCTION

When two or more people are unable to communicate due to a difference in language proficiency or languages spoken it is referred to as a ‘language barrier’. Language barriers between healthcare professionals and patients may have a negative influence on the healthcare that the patients receive (Parsons et al., 2014; Zendedel et al., 2016). Students at the Homoeopathy Health Centre at the University of Johannesburg encounter a variety of patients who may speak a language that isn’t known proficiently, or at all, by the student which may have an influence on the healthcare provided to these patients. Studies have been conducted both nationally and internationally in the field of healthcare regarding language barriers; however no studies have been done on the experience of language barriers amongst those who practice homoeopathic medicine (Paternotte et al., 2015; Ahmed et al., 2017; Deumert, 2010).

In Chapter 1 an overview of the study is provided, including contextualisation of the study, rationale, research problem and question, methodology, and ethical considerations. Important concepts relevant to this study are defined.

1.2 CONTEXTUALISING THE STUDY

1.2.1 South African Languages

There are 11 official South African languages used by 98% of the population- these are English, Afrikaans, isiNdebele, Sepedi, Sesotho, siSwati, Xitsonga, Setswana, Tshivenda, isiXhosa and isiZulu (South Africa, 1996). With South Africa’s population at approximately 56.6 million people, isiZulu is the most spoken first language (spoken by 23%) and in Gauteng (spoken by 14%). The country’s second most spoken language is isiXhosa (spoken by 17.64%), while English is second in Gauteng (spoken by 11%) (Statistics South Africa, 2012; SA National Department of Health, 2015; Statistics South Africa, 2017; Worldometers, 2018). Although South Africa is a multilingual country English is the preferred language of use in our healthcare system because of its prominence in public settings, economic environments, and primary and tertiary educational systems (Barnard, 2010; South African Institute of Race Relations, 2013).
Benjamin et al. (2016) states that a reality for South African society is that the majority of consultations, up to 80%, are not performed in the home language of the patient and has described the interplay of language and health as follows, “A monolingual health service in a multilingual society”.

1.2.2 Language Barriers in Healthcare
The pre-eminence position of English in this field is problematic as detailed and accurate communication and understanding during care management is vital (Paternotte et al., 2015). Parsons et al. (2014) and Zendedel et al. (2016) argue that language barriers and miscommunication have a negative effect on the healthcare process, including death. Patient-centred communication allows the practitioner and patient to make decisions regarding the patient’s health together however language barriers block this process from occurring (Paternotte et al., 2015).

Informed consent (IC) means that a patient understands information provided to them regarding the management and treatment of their case and can therefore make informed decisions about their health (Barit, 2017). Parsons et al. (2014) and Benjamin et al. (2016) acknowledge that IC, which is required to be established at any time during the care of the patient, may be negatively affected by language barriers because it cannot be assumed that a patient understands the concept of IC despite the use of an interpreter.

In South Africa, in terms of the National Health Act, 2003 (Act 61 of 2003), all healthcare personnel (inclusive of healthcare providers and healthcare workers) have duties to users of health services to ensure that their rights are upheld, as outlined in Chapter 2. Informed consent is defined in section 7 of this Act as being consent for a specified health service by a person with legal capacity to do so who has been informed of their health status, treatment options and their associated risks and consequences, as well as their right to refuse healthcare services and the implications thereof. Further, section 6 states that where it is possible, a healthcare provider needs to relay this information in a language and manner that the user understands (South Africa, 2003).

Effective communication results in patients feeling more comfortable, more understood, and results in higher rapport with their healthcare provider (HCP). Patients also rate their care of a higher quality if they were able to communicate effectively. This may occur even when the HCP
is unable to speak the patient’s language yet makes an effort to communicate in their language (Levin, 2006; Paternotte et al., 2015).

1.2.3 Interpreters in Healthcare

Healthcare providers (HCPs) are not experts in language and therefore interpreters may prove invaluable to the healthcare system by assisting communication between HCPs and patients by reporting what is being said in an exact and accurate way (Spencer, 2016). Interpreters are widely used in South Africa because of the language barriers faced due to the country’s multilingual nature.

Interpreters are not always qualified but merely able to speak the languages in question which may result in a person unrelated to a patient’s healthcare being involved in a patient’s case (referred to as ‘informal interpreters’) (Parsons et al., 2014; Zendedel et al., 2016). Some HCPs prefer to use the patient’s family members (even children) as informal interpreters as they are sometimes able to provide more insight into the patient’s condition and lifestyle (Benjamin et al., 2016). Informal interpreters, such as nurses, have been left feeling exploited by HCPs who ask them to help interpret over and above their own job responsibilities (Benjamin et al., 2016). There is an ethical and legal responsibility for the HCP to ensure that the fundamental right to privacy is upheld and confidentiality is respected at all times (Nell, 2006). Brink (2014) suggests that appropriate policies including a code of ethics for interpreters, confidentiality agreements, and insurance coverage for healthcare providers. However, in addition to the potential lack of formal training in informal interpreters, and the potential non-existence of policies, such as those suggested in Brink (2014), then questions of who is accountable for any breaches in contract are raised.

Interpretation may result in ineffective communication of context and deep understanding of a patient’s words (Benjamin et al., 2016; Zendedel et al., 2016). Furthermore, the HCP is completely reliant on the interpreter and has no way of knowing whether or not this information has been accurately communicated (Zendedel et al., 2016).

1.2.4 Impact of Multiculturalism in Healthcare

Culture is a pattern comprised of shared ideas, customs and behaviours in a particular group of people that influences their knowledge, attitudes and behaviours in life (Oxford Dictionary of English Online, 2010a; Paternotte et al., 2015).
South Africa is a multicultural country due to a rich history of European and African migration into South Africa and the merging of ideas and beliefs with the already established indigenous inhabitants (New World Encyclopaedia Contributors, 2016). Cultural competence, as a set of behaviours, considerations, and policies that govern effective communication amongst different cultures, is an important concept in multicultural South Africa (Ashkinazy, 2017). Cultural miscommunications in healthcare may result in negative consequences, including death (Paternotte et al., 2015; Matthews & Diab, 2016). Being aware of and understanding one’s own cultural identity (referred to as ‘cultural awareness’) as well as those around us is difficult as a patient’s culture is largely individual (Paternotte et al., 2015). For this reason, we must apply the concept of ‘cultural humility’ to learn about cultural beliefs and apply them to practice (Ashkinazy, 2017).

1.2.5 Homoeopathy in South Africa

Homoeopathy was first brought to South Africa in the 1820s by European missionaries and used by laymen at the time. In 1857 the first number of Homoeopaths arrived from the United Kingdom to set up practice in South Africa. Only in 1949 was the first homoeopathic Society of South Africa established by Homoeopath, Barbara McFarland. In 1951, Dr William Lilley arrived in South Africa and established the first formal homoeopathic training course. In the years to follow many other courses and institutes were established (Gower, 2013).

However, by 1982 all colleges were officially closed as a means to prepare for new regulation as set out by Act 63 of 1982. This Act allowed for the establishment of the Chiropractors, Homoeopaths and Allied Health Services Professions Council of South Africa which set up new statutory guidelines for education in Homoeopathy and required that homoeopathic practitioners register as such with the established council in order to practice legally. In 1987, the first course following these guidelines was officially offered at Technikon Natal in Durban, and five years later at Technikon Witwatersrand in Johannesburg in 1992. In the year 2000, the Chiropractors, Homoeopaths and Allied Health Services Professions Act became the Allied Health Professions Act, leading to the name change of the council to the Allied Health Professions Council of South Africa (AHPCSA) and expanding the number of professions it regulated. It remains compulsory for qualified homoeopathic practitioners (HP) to register as such with the AHPCSA in order to become a legally practicing Homoeopath in South Africa (Gower, 2013).

The homoeopathic practitioner’s scope of practice is extensive with subsequent registration with the AHPCSA allowing HPs to legally perform a medical consultation and medically diagnose
and treat any condition presented to them in practice. Homoeopathic practitioners may also compound and dispense medications within their scope as long as they have a Dispensing and Compounding Licence issued to them by the South African Department of Health (Gower, 2013).

The AHPCSA requires that a registering person has completed the full-time five-year Master’s degree in Homoeopathy from University of Johannesburg (UJ) or Durban University of Technology, or has an equivalent degree. The five-year MTech course offered is extensive and medico-scientific in nature (Gower, 2013; Homoeopathic Association of South Africa, 2016b). During their coursework, students are expected to learn and be tested on a wide variety of subjects, including the basic sciences, clinical and classical applications in homoeopathy, homoeopharmaceutics, and medical diagnostics. A more extensive description of the curriculum offered to students at the University of Johannesburg is highlighted in Table 1.1 (University of Johannesburg, n.d.)

<p>| Table 1.1: Homoeopathy Curriculum at UJ |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year</td>
<td>Anatomy and Physiology 1, Chemistry 1 (Theory and Practical modules), Physics 1 (Theory and Practical modules), Biology 1, Philosophy Principles and History 1, Social Studies</td>
</tr>
<tr>
<td>Second year</td>
<td>Immunology 2, Epidemiology 2, Biochemistry 2, Anatomy 2, Physiology 2, Medical Microbiology, Materia Medica 2</td>
</tr>
<tr>
<td>Third year</td>
<td>General Pathology 2, Systemic Pathology 3, Diagnostics 3, Psychopathology 2, Materia Medica 3, Auxiliary Therapeutics 3</td>
</tr>
<tr>
<td>Fourth year</td>
<td>First Aid level 3, Diagnostics 4, Clinical Homoeopathy 4, Homoeopharmaceutics 4, Materia Medica 4, Research Methods and Techniques: Homoeopathy</td>
</tr>
<tr>
<td>Fifth year</td>
<td>Clinical Homoeopathy 5, Materia Medica 5, Practice Management and Jurisprudence, Minor Dissertation and Research: Homoeopathy</td>
</tr>
</tbody>
</table>

1.3 RATIONALE

Healthcare workers encounter a diverse patient base, especially in a multi-lingual country as South Africa. Homoeopathic students are no exception and should be prepared in dealing with situations where a language barrier is encountered especially as detail is important to the
homoeopathic physician. Being equipped in this regard may be beneficial to both the homoeopathic physician and patient involved in the homoeopathic healthcare process.

1.4 PROBLEM STATEMENT AND RESEARCH QUESTION

While the five-year coursework prepares students to fulfil their scope as Homoeopaths, a note of significance for this research is that there is no formal training in African languages or cultures offered in any modules in any of the academic years despite the diverse demographic of patients visiting the Homoeopathy Health Centre at UJ (University of Johannesburg, n.d). Understanding the experiences of the students who encounter patients with language barriers may help provide some guidance as to whether students are left potentially unprepared in dealing with a diverse patient base.

Therefore, the research question must be, what are the experiences of the homoeopathic students at the UJ Homoeopathy Health Centres (HHC) regarding language barriers when encountering patients and how do they deal with them?

1.5 THE INTERVIEW QUESTION

An interview guide was established and used by the researcher in order to assist with consistency in interviews, as well as to allow the interview to proceed easily. The interview guide consisted of the central question “What has your experience been regarding language barriers between you and your patients at the UJ Homoeopathy clinics?” as well as a variety of sub-questions. These are further discussed in Chapter 2.

1.6 RESEARCH PURPOSE AND OBJECTIVES

1.6.1 Research Purpose

The purpose of this study was to explore and describe the experiences of homoeopathy Master’s students regarding language barriers in the delivery of healthcare, and to provide guidance towards overcoming language barriers in homoeopathic practice at the University of Johannesburg.
1.6.2 Research Objectives

- To explore Homoeopathy Master’s students’ experiences of language barriers in the delivery of healthcare by conducting individual interviews.
- To describe the participants’ experiences regarding language barriers in the delivery of healthcare at the University of Johannesburg.
- To provide guidance in overcoming language barriers in homoeopathic practice at the University of Johannesburg.

1.7 DEFINITIONS AND DESCRIPTIONS OF KEY CONCEPTS

Understanding the following key concepts is important as they are relevant for this study:

1.7.1 Language barrier
The Oxford Dictionary of English Online (2010f) describes a language barrier as follows: “A barrier to communication between people who are unable to speak a common language”.

In the context of this study, a language barrier constitutes any instance whereby the student cannot communicate with a patient due to differences in languages spoken, or differences in proficiencies of a common language.

1.7.2 UJ Homoeopathy health services
This concept is comprised of the three Homoeopathy training facilities where students from the University of Johannesburg conduct homoeopathic consultations with patients from the public. The concept was used with participants as a collective concept that included the Homoeopathy Health Centre situated on the UJ DFC campus, the Soweto satellite services, and the Ennerdale satellite services.

1.7.3 Delivery of Healthcare
In the context of this study, the delivery of healthcare refers to the conduction of the healthcare process by the homoeopathic student. This healthcare process involves conducting a consultation with the patient, performing relevant physical examinations, conduction of special investigations, arriving at a diagnosis, and selecting a prescription and treatment plan.
1.7.4 Interpreter (vs Translator)
An interpreter is a person who translates between two languages in an oral context; a translator is a person who translates between two languages in a written context (Refugee Health Technical Assistance Center, 2011).

Participants in this study often used the two interchangeably, but in all cases the concept of an interpreter, rather than a translator, was implied.

1.8 RESEARCH DESIGN AND METHOD

This research is a qualitative study with a phenomenological approach. A qualitative method was most appropriate because of the exploratory nature of the topic, allowing the researcher to collect data that helped gain insight into the students’ experiences on language barriers. The use of a phenomenological approach allowed for exploration into the experiences of participants regarding a particular phenomenon, in this case language barriers, resulting in a particular theory regarding that phenomenon (Bricki & Green, 2007; Fawole, 2014).

1.9 RESEARCH POPULATION AND SAMPLE

The participants for this research were recruited using a purposive sampling technique. The research population most suited to this study were students who were involved in delivering healthcare to patients at the UJ Homoeopathy Health Centre. The selected sample group consisted of students at the University of Johannesburg who registered as Homoeopathy Master’s Students in the years 2016, 2017, and 2018 as they have treated patients at the HHCs in recent times.

1.10 DATA COLLECTION

Individual interviews allowed for data to be collected from participants. The interviews were done in person at a location most convenient for the participant and were on average 30 minutes long. The interviews were recorded in order to be transcribed at a later stage. Data saturation was reached after 10 interviews were conducted.
1.11 DATA HANDLING AND ANALYSIS

The researcher chose to use Computer Assisted Qualitative Data Analysis Software in order to make the process of coding and organizing themes faster and more reliable and efficient. Qualitative software does not code the transcripts automatically but simply allows the data to be more organised and provides the researcher with tools that will aid them in reflection of the data as part of analysis (Saldana, 2009).

The following steps were followed in analysing the transcribed interviews:

STEP 1: The collected audio data was transcribed by the researcher herself in order to gain familiarity with the data.

STEP 2: First cycle coding of the transcripts was done in order to establish codes to segments of data.

STEP 3: Recoding of the transcripts was done in order to clean up chosen codes by deleting, merging, and renaming existing codes.

STEP 4: Second cycle coding commenced in order to reorganise codes into categories and thereafter overarching themes that are representative of the experiences of the participants.

STEP 5: The results from the analysis of this study were verified by an external analyst with appropriate experience in qualitative research. The rationale behind codes, categories and themes were analysed and verified (Appendix A) and feedback provided to the researcher for any relevant emendations.

STEP 6: The results were presented to a focus group and any relevant changes made before the final write up of the discussion of results.

Throughout the process the researcher wrote analytic memos documenting the process of coding as well as motivations for decisions regarding codes, categories, and themes.

1.12 TRUSTWORTHINESS

Trustworthiness is a concept used in qualitative research in order to ensure that the study is trustworthy and reliable. Trustworthiness is ensured through credibility, transferability, confirmability and dependability (DeMotts, 2018a). Trustworthiness is discussed further in Chapter 2.
1.13 ETHICAL CONSIDERATIONS

Ethical considerations considered in this study included autonomy, confidentiality and privacy, non-maleficence and beneficence, and justice. These are further described in Chapter 2.

1.14 CHAPTER ONE SUMMARY

In Chapter 1 an overview of the study is provided, including contextualisation of the study, rationale, research problem and question, methodology, and ethical considerations. Important concepts relevant to this study are defined. In Chapter 2, further detail is provided regarding methodological concepts and procedures, trustworthiness, and ethical considerations.
CHAPTER 2

METHODOLOGY

2.1 INTRODUCTION
In Chapter 2 the methodology of the study is discussed in detail. The study’s design, population and procedures are discussed, followed by ethical considerations.

2.2 RESEARCH DESIGN

2.2.1 Qualitative Design
Qualitative methods are employed when the research phenomenon under scrutiny involves understanding of subjective experiences of the participants (Bricki & Green, 2007). Qualitative research methods may be inductive, which means that concepts and ideas emerge by exploring and analysing the data collected. Emphasis is placed on understanding the subjective context of the participants’ experiences and understanding their perspectives. The researcher is often considered a ‘research tool’ in qualitative studies as the analysis depends largely on their own understanding and interpretation of the data (Morgan, 2014). In this study, a qualitative research design was utilised as it was most appropriate for understanding the participants’ subjective experiences of the phenomenon under investigation, i.e. students’ experiences of language barriers in the delivery of healthcare.

2.2.2 Phenomenological Approach
A phenomenological approach allows for exploration into the experiences of multiple participants regarding a particular phenomenon. The aim of a phenomenological approach is to condense what multiple participants are experiencing into a describable concept (Creswell, 2007). In this study a phenomenological approach was most appropriate to formulate a well-rounded description of the experiences of languages barriers in the delivery of healthcare by homoeopathic Master’s students, the particular phenomenon under investigation. Creswell (2007) describes “psychological phenomenology”, a sub-type of the phenomenological approach, which describes the importance of the description of the participants’ experiences rather than the researcher’s own interpretations thereof.
2.3 RESEARCH POPULATION AND SAMPLE

2.3.1 Purposive sampling
Purposive sampling is a type of sampling whereby the sample group selected for the study is done so in a non-randomised way because it is likely to be the most representative in regards to the study topic (Lavrakas, 2008). In this study the researcher employed this purposive technique by using their own judgement to select the sample group for the particular study. Purposive sampling allows the researcher to select the most appropriate sample group that will provide the necessary answers to the research questions in regards to a particular phenomenon (Laerd Disseration, 2012). The type of purposive sampling technique suggested by Creswell (2007) as the most appropriate technique for phenomenological studies is criterion sampling. Criterion sampling involves choosing participants based on predetermined criteria. These particular participants will provide the richest data about the phenomenon under investigation. The population of potential participants selected by the researcher to take part in this research study have been selected due to the exposure to the phenomenon in recent and current years and therefore will provide rich and current information regarding their experiences (Cohen & Crabtree, 2006; Creswell, 2007).

2.3.2 Sample
Participants included all registered homoeopathic Master’s degree students at UJ who registered as a Master's student in the years 2016 to 2018. Participants were selected according to predetermined criteria relevant to the phenomenon under investigation. This type of criterion purposive sampling was most appropriate for this study because the sample group was chosen based on their characteristics and the study’s aim, in this case, Homoeopathy Master’s students’ experiences were to be explored, and so Homoeopathy Master’s students formed the sample group (Crossman, 2018). Homoeopathy Master’s students of 2016 to 2018 have treated patients at the UJ HHC and the Soweto and Ennerdale Homoeopathy satellite services in recent years and could therefore provide the most relevant information for the study. Sample size was determined by data saturation which was after 10 interviews. The interviews were followed by a focus group consisting of 6 voluntary participants. These participants were also Homoeopathy Master’s students at the university pf Johannesburg. Only one of the 6 was previously interviewed.
2.3.3 Inclusion criteria
Participants were included in this study if they were registered Homoeopathy Master’s students at the University of Johannesburg in the years 2016 to 2018, and if they willingly volunteered to participate in the study.

2.4 RESEARCH METHOD AND PROCEDURE

After clearance was obtained from the Higher Degrees Committee (HDC) and the Research Ethics Committee (REC), the Head of the Homoeopathy Department and the Head Clinician at the HHC were contacted requesting permission to interview students of the years 2016 to 2018 (Appendix B). Thereafter it was requested that emails to invite students to participate be sent on the researcher’s behalf by the head clinician (Appendix C). This email included details of the study, estimated length of the interviews, and contact details of the researcher. Once a student agreed to be a participant an appointment was made for the interview to take place at a time and place that was at the participant’s convenience.

The interview began with a greeting and an explanation of the study. A hard copy of the information sheet (Appendix D) was discussed with the participant who read it and had the opportunity to ask any questions regarding the study. The participant signed the information sheet and consent forms provided which granted permission to conduct the interview and use the information obtained (Appendix E). A recording device was used with consent of the participant to record the interview (Appendix F) so that the researcher was able to type a transcript at a later time. The interviews were on average 30 minutes long depending on the amount of information provided by the participant.

A focus group consisting of 6 students was then conducted in English on the UJ campus after analysis of the data was completed and themes compiled. Focus group participants were presented with an information sheet (Appendix G) and consent form to take part and be audio taped (Appendix H). The purpose of this focus group was to validate findings that arose from the analysis and to provide richness of the data with insights that were not expressed in individual interviews. Any new information was appropriately added and any differences and ambiguities were accounted for in the discussion of the final results.
2.5 DATA COLLECTION

Individual interviews were used allowing the researcher to gain insight into the personal experiences of the students while eliminating the risk of missing data due to participants being intimidated initially by large focus groups. Interviews allowed participants to feel comfortable and unrestricted in sharing their experiences, whilst still obtaining answers to certain questions required by the researcher for enough appropriate data to be obtained.

As mentioned in Chapter 1, an interview guide was used by the researcher. This guide consisted of a central question and sub-questions.

The central question for the individual interviews was:

What has your experience been regarding language barriers between you and your patients at the UJ Homoeopathy clinics?

Due to the exploratory nature of this research the type of central question was exploratory in order to explore the nature of the phenomenon—i.e. language barriers. As recommended by Creswell (2007), the central question was followed by sub-questions to further aid the researcher in collecting data. The sub-questions explored sub-topics related to the central question (Creswell, 2007).

The sub-questions for the interview consisted of:

• Do you think language barriers affect your patient in any way?
• How do you think language barriers make the patient feel?
• Do you think this language barriers affects your delivery of healthcare as a doctor?
• How do language barriers make you, as the doctor, feel?
• What do you do when you encounter these language barriers?
• What do you think would help remedy the situation?
• Have you ever used an interpreter before? What was the experience like?
• Do you think culture has a role to play in creating barriers between you and your patients?

A pilot study was conducted with one student to ensure that the proposed research question and sub-questions flowed well and were easy to understand and answer. Issues that arose from the pilot study interview in terms of interview skills and questioning were accounted for and
corrected in order to make the study more reliable. The results from the pilot study were purely to improve reliability of interviews and are not included in the final analysis.

The interviews were conducted in English and at a private location that was convenient for the participants. A brief demographic profile for each participant was taken by the participant filling out an additional demographic profile table (Appendix I). This table included age, race, home language, other languages spoken, and to what personal perceived proficiency they are able to speak these additional languages, using a key set out by the researcher.

Before starting the interview the researcher explained the study to participants, the structure of the interview, and explained a few central concepts vital to the understanding of certain questions in the interview (discussed in Chapter 1). Thereafter, participants were asked a central question: What has your experience been regarding language barriers between you and your patients at the UJ Homoeopathy clinics? The researcher asked the participants to answer questions in as much detail as possible and used probing and sub-questions in order to elicit more data rich information. These sub-questions were asked in order to provide guidance to the participants in order to obtain more data rich information regarding various aspects of the topic.

During the interview main themes were written down by the researcher and statements made by the participant were probed, verified, and clarified. Field notes were taken after interviews relating to the setting of the interview, the participant’s manner, the interview process and critical reflection of the interview (Phillippi & Lauderdale, 2018). This allowed the researcher to identify any issues during the process and improve questioning to become a more effective interviewer.

The interview ended by asking if the participant had anything else they wanted to share regarding the research question in order to ensure that the participant felt unrestricted and had ample opportunity to share all relevant experiences. The researcher then thanked the participant, provided contact details, and answered any other questions they may have had. A total of 10 interviews were conducted as determined by the point of data saturation.

Data saturation is reached when a researcher can no longer obtain any new information or ideas from the interviews and therefore no further coding during the analysis stage would be possible. By using relevant sub-questions the researcher was able to facilitate reaching data saturation.
within the sample group. Reaching data saturation increases the validity of a study (Fusch & Ness, 2015).

A focus group allowed participants to provide commentary and clarification of resulting themes, categories and codes. This allowed richness of data by providing deeper insight into the experiences collected. This focus group session was voluntary and was recorded.

2.6 DATA HANDLING AND ANALYSIS

The audio-recorded data was transcribed by the researcher after each interview. The data was recorded into an MS Word document and saved in a format that did not allow identification of the participant. Safety of the data was ensure by storing the MS Word documents on a password protected device. Once all transcriptions were complete the researcher compared the transcripts to the audio-recordings to ensure that all transcripts were recorded accurately. An example of a transcript is provided (Appendix J). Any unintelligible audio-data was amended as far as possible and any other relevant corrections were made. The researcher then went through each transcript checking for spelling and grammatical errors and that all names of mentioned people and places were redacted. This process of editing by the researcher allowed them to become more acquainted with the particulars in each transcript and allowed familiarity with emerging themes.

The researcher chose to use Computer Assisted Qualitative Data Analysis Software in order to make the process of coding and organizing themes faster and more reliable and efficient. Qualitative software does not code the transcripts automatically but simply allows the data to be more organised and provides the researcher with tools that will aid them in reflection of the data as part of analysis (Saldana, 2009). The particular software chosen by the researcher was Atlas.ti (version 8) as a 3-day intensive training course on this software was offered by a certified trainer by University of Johannesburg.

After transferring the transcript data from MS Word into the Atlas.ti program, the process of first cycle coding began. First cycle coding is the initial process of coding whereby the researcher assigns labels, known as codes, to segments of data. The researcher employed an open-coding sentence-by-sentence method. Segments of data were labelled and new codes created until there were no new codes being added (Benaquisto, 2008). Various coding methods were employed to code the data as outlined by Saldana (2009) which included grammatical methods such as
attribute coding; and elemental methods such as descriptive and in-vivo coding. Throughout the process, the researcher ensured that codes were appropriately named and assigned. Recoding took place and codes that were found to be redundant were deleted, codes that described the same ideas were merged, and codes that could have been named more appropriately were renamed throughout the process (Saldana, 2009). During the coding and recoding process the researcher wrote analytic memos documenting the coding process and motivation for code names. Memo writing plays an important role in qualitative research in that it allows the researcher to critically reflect on the qualitative process, and choices made, and aids them in coming to conclusions about the data (Saldana, 2009). The researcher in this study chose to record personal experiences of the coding process, as well as reflection and motivation of code names (Saldana, 2009). This ensured a level of transparency and increases trustworthiness in the study.

Once initial coding was performed, a second-cycle coding process commenced. The purpose of second cycle coding is to organise the codes created during the first cycle coding process into categories and themes thus producing final results that are representative of the data. A focused coding method was used whereby overarching categories were created by grouping codes that were similar in theme. From these categories larger themes were produced (Saldana, 2009). For this second cycle process as well, the researcher recorded motivations for categories and themes chosen in the form of an analytic memo.

The findings produced from the researcher’s coding were presented to the research supervisor for verification and any changes in codes were made.

Finally, these findings were presented to a focus group for commentary and clarification. Any new information was appropriately added and any differences and ambiguities were accounted for in the discussion of the final results. All data will be destroyed 2 years after the publication of this dissertation.

2.7 TRUSTWORTHINESS

Trustworthiness is a concept used in qualitative research in order to ensure that the study is trustworthy and reliable. Trustworthiness is ensured through credibility, transferability, confirmability and dependability (DeMotts, 2018a).
2.7.1 Credibility

Credibility is a method of establishing truthfulness and accuracy of the data collected and interpreted therefore establishing plausibility of the participants’ views (Korstjens & Moser, 2018; DeMotts, 2018b). Shenton (2004) outlines multiple methods of ensuring credibility in studies which include use of recognized qualitative research methods, triangulation, iterative questioning, encouraging honesty from participants, debriefing sessions, peer scrutiny, member checks, and reflective commentary.

Triangulation is one method for establishing credibility in qualitative research studies. Triangulation requires a researcher to explore multiple methods to ensure a well-rounded understanding of the topic being investigated. Methods triangulation is a type of triangulation method which involves using various methods of collecting data in order to ensure that results are consistent. Analyst triangulation is another type of triangulation whereby an external analyst is involved in analysing the data separately to the researcher so as to eliminate the risk of the researcher missing important aspects (DeMotts, 2018b).

Iterative questioning is a type of questioning done by the researcher where concepts previously mentioned by the participant are returned to and fleshed out through further questioning or re-questioning (Shenton, 2004).

In this study credibility was ensured in the following ways:

• Individual interviews were recorded with two devices in order to ensure maximal clarity of data for accurate transcription.
• The process of transcription was conducted by the researcher herself therefore ensuring familiarity with the subject material. The process was careful and recorded as accurately as possible with continuous verification and review after completion.
• The researcher did extensive research into the conduction of qualitative research methods and as a result made use of well-established and recognised methods of conducting qualitative research.
• The researcher used methods triangulation which involved conducting individual interviews and conducting a focus group in order to collect and verify data for this study. Supporting data in the form of an extensive literature control with thick description of the phenomenon being investigated provided further verification of data collected. These triangulation methods ensure accuracy and eliminate any ambiguity.
• Tactics were used during the interviews in order to encourage open and honest answers from participants. This was done by explaining to participants beforehand the purpose of the research and what is expected of them during the interview. Participants were assured that the researcher wanted their honest opinion in as much detail as possible and that no answer would be seen as correct or incorrect. At the end of each interview the researcher asked if the participant had any other views or information that they would like to share regarding the phenomenon under investigation. This allowed the participant to feel unrestricted and encouraged additional information.

• Iterative questioning was employed by the researcher during interviews by taking notes during the interview and revisiting concepts brought up by the participant in order to probe more deeply and to clarify any ambiguity or contradiction.

• Meetings with superiors allowed the researcher to make better informed decisions regarding the qualitative research process and proceed with confidence.

• Emerging results from the data analysis process were verified.

• Peer scrutiny by colleagues and superiors was influential in the researcher’s process and decision making throughout the study.

• The researcher was sure to record memos documenting decision their own critical reflection throughout the data collection and analysis processes. This contributed to a concept known as ‘progressive subjectivity’ whereby the researcher was able to monitor and add an element of transparency to the study (Shenton, 2004).

• The researcher attended an introductory training session and thereafter a 2 day intensive training workshop in the Atlas.ti 8 software which ensured the most appropriate and correct use of the program for analysis.

• Member checks in the form of focus groups were conducted in order to verify emergent themes and patterns.

2.7.2 Transferability
Transferability refers to how easily the findings of the research can be applied, or transferred, to other settings or contexts (Korstjens & Moser, 2018). Transferability in this study is facilitated by using a purposive sampling method. The participants were selected by the researcher as these individuals fit specific criteria that would allow the researcher to obtain the richest and most up-to-date information (Anney, 2014).
2.7.3 Confirmability
Confirmability is a method of ensuring trustworthiness by ensuring that the researcher’s views do not impose themselves on the research findings and that the findings are purely based on the participants’ views. An audit trail is one technique used to ensure confirmability. It involves careful documentation of the data collection and analysis process. Reflexivity is another technique employed in establishing confirmability by reflecting on personal ideas and preconceptions and understanding how these influence research decisions (Korstjens & Moser, 2018; DeMotts, 2018c). In this study field notes which included a section for critical reflection was conducted, and memos were written during the coding process of data analysis. These field notes and memos allowed for the identification of common topics, improvement of techniques, and rationale for choices made during the coding process. Bracketing is a process whereby the researcher recognises and then puts aside his own preconceptions, perceptions, theories, and assumptions regarding a particular topic so as to allow open-mindedness and non-bias when dealing with participants’ responses (Tufford & Newman, 2010). In this case bracketing was done in the form of memo writing so as to allow reflection and avoid the researcher’s interpretations and personal beliefs about the phenomenon contaminating the true essence of what the participant is describing.

2.7.4 Dependability
Dependability is a method of establishing trustworthiness that involves making sure that other researchers can replicate the study and arrive at similar conclusions (DeMotts, 2018d). In this study dependability is ensured through detailed documentation of methodology employed by the researcher. Dependability is also ensured in this study by making use of various overlapping methods of data confirmation and collection, i.e. conducting a pilot study, conducting individual interviews, as well as conducting a focus group.

2.8 ETHICAL CONSIDERATIONS

2.8.1 Autonomy
Respect for the participants in this study and for their informed decisions was upheld. Informed consent means that a person understands information provided to them and can therefore make informed decisions about the particular situation (Barit, 2017). Importance was placed on the participants understanding of the purpose of the interview and how the information which they provide will be used. The procedure of the interview process was explained to participants before the interview commenced. They were given a participant information sheet to read through and
sign in order to facilitate understanding of the study’s nature and purpose. The participant signed letters of consent which were also explained to the participants before the interview commenced. These consent forms included consent to be interviewed and for information to be used by the researcher (Appendix E), and consent for the interview to be recorded (Appendix F).

2.8.2 Confidentiality and Privacy
Participants were interviewed in a private room. Participants were assured that their confidentiality will be upheld at all times and all information provided will be kept anonymous. This was done by assigning each participant a number in order to identify the different transcripts after the researcher has reviewed the transcript. The focus group was conducted in a private room. Participants of the focus group were kept anonymous throughout the session as no names were mentioned.

The information collected was used to generate general themes, patterns, and ideas, and if any quotes were used in final data analysis the participant remained unidentifiable. The transcripts were saved on a device which was password protected and was further saved to a secure cloud dedicated to this research, access to which was also password protected. Only the researcher knew the passwords and therefore was the only person with access to this information. This ensured the safety and privacy of the information obtained. All data will be destroyed 2 years after the publication of this dissertation.

2.8.3 Beneficence
The concept of beneficence in research involves outweighing the risks with benefit (Townsend et al., 2010). The only possible risk to this study was emotional distress in the case of negative experiences experienced by the participant. However, participants were made aware that their experiences on this topic would be used to possibly open doors to further research in the field and encourage ways of helping students to better deal with language barriers.

2.8.4 Non-maleficence
The concept of non-maleficence in research involves not doing any harm to the participant (Townsend et al., 2010). In the context of this study the researcher was required to probe into the experiences of the willing participant which carried the risk of possible emotional distress in the case of negative experiences. In the case that emotional distress was experienced, the researcher was prepared to avoid probing further so as to not cause any undue harm to the participant. None
of the participants experienced any harm emotionally or physically during any stage of this study.

2.8.5 Justice
Justice involves treating participants equally, respectfully, the way they deserve (Townsend et al., 2010). All participants in this study were treated equally and respectfully. The participants were seen at times and locations that were at their convenience. Participants’ ideas and answers were respected. All participants have access to the results of this study. Participants were permitted to withdraw from the study at any point without repercussion.

2.9 CHAPTER TWO SUMMARY

In Chapter 2 methodology and ethical considerations were discussed. In Chapter 3 results from data analysis are presented and discussed.
CHAPTER 3
RESULTS AND DISCUSSION

3.1 INTRODUCTION

In Chapter 3 the resultant themes and categories that emerged from data analysis are presented and discussed. A literature control follows highlighting the influence of language barriers general in healthcare, as well as language barriers in Homoeopathy-specific healthcare.

In this chapter the sample group is referred to interchangeably as students and participants. The term participant is referred to when referencing the participant’s experiences in the context of the study. The term student is used when referring to the participant’s daily role as a registered Master’s student who is involved in treating patients at the UJ HHC and its associated satellite services.

3.2 DATA COLLECTION

Thirty-seven participants consisting of registered homoeopathic Master’s degree students at UJ who registered as a Master’s student in the years 2016 to 2018 were included in the potential sample. These students have experience in treating patients from diverse backgrounds at the UJ HHC and Soweto and Ennerdale Homoeopathy satellite services.

Participants only included students from the University of Johannesburg. A request to the head clinician to send an invitation to participate in the study via email was made. Students were to contact the researcher if they were interested. The researcher also approached potential participants in person to invite them to participate in the study. Once a participant agreed to be a part of the study, an information sheet was provided to them (Appendix D) along with consent forms (Appendix E and Appendix F).

The researcher interviewed a total of 10 individuals. Data saturation was reached at the point where the researcher felt that no new ideas were arising and each interview was providing the same overall experience of the phenomenon under scrutiny. All 10 interviews were used for analysis. All of the participants fell within the inclusion criteria and no participants who agreed
to be a part of the study were excluded. Participants who fell within the appropriate criteria formed part of a 6-person focus group discussion. The purpose of the focus group was to provide feedback on the results of the data analysis that were presented to them so that the researcher could verify results and gain clarification into the themes presented as well as to provide richness of the data with insights that were not expressed in individual interviews.

3.3 DEMOGRAPHICS

There were 10 participants interviewed for this study. This comprised of 2 males and 8 females. Of those females 5 reported that their spoken home language is English, and 3 females spoke English as an additional language. Of the 2 males, neither reported English as their spoken home language but both spoke English as an additional language. As a whole, this means that 50% of the sample speaks English as their first language, and 50% speaks English only as an additional language. This is represented in figure 3.1 below:

*Figure 3.1: First Language vs Additional Language Split*

This is in contrast to the fact that in Gauteng- the province in which the study was conducted- isiZulu is the most spoken language, while English is the second most spoken language (Statistics South Africa, 2012).

Of the 5 participants who listed English as an additional language 4 reported their English proficiency as being above average, or fluent by using the perceived proficiency score chart provided. Only 1 participant rated their proficiency as average, or conversational. No participants rated their perceived proficiency of English as poor, only knowing a few words.
Of the 5 participants who listed English as a first language only 2 listed isiZulu as an additional language. Both of these participants rated their perceived proficiency of isiZulu as poor, only being able to speak a few words. This is represented in figure 3.2 below:

![Figure 3.2: Perceived Proficiency Split by First and Additional Language](image)

### 3.4 DATA ANALYSIS

Phenomenological qualitative research aims to explore experiences of participants regarding a particular phenomenon under scrutiny (Creswell, 2007). The researcher interviewed and transcribed the interviews herself. The researcher then coded and recoded all 10 of the transcripts using qualitative analysis software called Atlas.ti version 8. This software allowed the researcher to organise and analyse the data in the most efficient way possible.

Once all transcripts were coded and re-coded to the researcher’s satisfaction, codes were organised into categories. These categories allowed the researcher to conceptualise appropriate themes that were representative of the collective experiences of the participants. Memos were recorded by the researcher outlining motivations for all decisions made throughout the process and included memos for code names, category names, theme names, and for revisions and corrections made. These memos, transcripts and any other relevant documentation were provided to an external analyst with appropriate experience in qualitative research to verify the process used by the researcher and provide input where applicable.

With this input the researcher was able to finalise the most appropriate themes for presentation to a focus group, and discussion of results. The focus group was able to provide the researcher with
verification of the resultant themes, which allowed the researcher to present an accurate representation of experiences in the discussion of results.

3.5 PRESENTATION OF RESULTS

From the results of data analysis themes emerged in the following logical flow:

1. Students find language barriers challenging to deal with as they lead to a lack of understanding between the practitioner and the patient.
2. Students experience negative feelings as a result of these language barriers. Negative effects are also noted regarding the relationship between the patient and the student.
3. Various aspects of the healthcare process are negatively influenced by the presence of language barriers. However, it is the experience of some participants that patients still benefit from their homoeopathic treatment despite language barriers.
4. Students employ certain strategies to try and mitigate the negative effect of language barriers on their healthcare process.

The emergent themes and categories with associated subcategories are represented in Table 3.1, as follows:

Table 3.1: Themes, Categories, and Subcategories

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories and Subcategories</th>
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<tbody>
<tr>
<td>3.5.1</td>
<td></td>
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<tr>
<td>Theme one: Language barriers create challenges in understanding</td>
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The themes and their associated categories and subcategories are discussed in detail below. The associated code number and transcript number will follow each quotation used.

3.5.1 Theme one: Language barriers create challenges in understanding
Participants described understanding patients when there is a language barrier present between them as challenging:

“It has been challenging” (code 5.1)

“...communication’s been tricky” (code 5.7)

“...think it makes it difficult. It’s challenging” (code 5.2)

3.5.1.1 Challenge in understanding the patient
Language barriers result in difficulty for the student in understanding what the patient is trying to communicate or express:
“She told me that she was fainting. So I took a case as though she was fainting, and then I saw her collapse and it wasn’t a syncope, it was a seizure. And then I thought, okay we’ve kind of gotten the wrong story here” (code 20.3)

“Because it was very obvious in a sense that we were speaking of two completely different things” (code 20.10)

“And the way that they use words would be different to the way that I would use words. So understanding, or trying to understand what they mean by using that word in such a way, is also sometimes difficult” (code 20.4)

Due to the challenge in understanding the patient, the student may lose details and record inaccurate information which could be detrimental to the rest of the healthcare process:

“I felt that sometimes perhaps I didn’t understand the detail, so the detail got a little bit lost” (code 49.3)

“There’s always that little glitch where you’re trying to get the finest of details but the language is coming in the way” (code 20.9)

3.5.1.2 Challenge for the patient in understanding the HCP

Communication is an important part of the student’s job as they need to elicit information from patients by asking questions, as well as to explain aspects of a patient’s health and health maintenance to them. Participants expressed the opinion that language barriers cause an inefficient delivery of questions and information to the patient and contribute to difficulties for the patient in understanding the student:

“…sometimes they might not understand my question” (code 21.2)

“Because, for example, there’s certain questions that we ask them and the way we deliver it, they don’t really understand it” (code 21.1)

“So you’re trying to coax them and move them and they’re not quite sure what you’re doing and why you’re doing it. And you can’t explain that because you know that they won’t understand anyway” (code 5.4)
3.5.1.3 Understanding children with language barriers

Participants expressed that challenges associated with working with children are unique, as they were uncertain as to whether difficulty understanding children of different languages was due to language barriers or limitations of being a child, or both. Children often have limited vocabulary and are too young to understand what is required of them. The participants speculate that many of the children come to the clinics for attention instead of treatment for an illness.

Ennerdale satellite service is situated in a primary school where the majority of patients treated by the homoeopathic students are children.

“With the kids, at Ennerdale I don’t think the language barriers are too bad, I don’t know if sometimes the symptoms are made up or they just don’t understand” (code 6.5)

“It can be a language barrier because English isn’t their first language and of course now they have to explain themselves in a language that’s not their first with their limited vocabulary on top of that, so that’s also another language barrier” (code 6.3)

“You’ll ask them what colour is the snot coming from their nose, I mean the mucus but we use snot for kids, but if “You’ve got a runny nose, what’s the colour of the stuff coming out?”, and they’ll say funny things like purple. I don’t know if that’s just a kid or if that’s a language barrier” (code 6.5).

3.5.2 Theme two: Intrapersonal and interpersonal effects associated with language barriers

Language barriers result in the student experiencing negative emotions during their interaction with the patient. Further to this, the relationship between the student and patient is also negatively affected as a good relationship and rapport relies on good communication.

3.5.2.1 Experience feelings of frustration

Many of the participants described feeling frustrated when encountering a language barrier during their interaction with a patient:

“It’s very frustrating. I get frustrated” (code 13.2)

“I would feel genuinely frustrated. I would feel very very frustrated” (code 13.7)
“I become frustrated about it, which is also a negative affection” (code 13.10)

3.5.2.2 Experience feelings of inadequacy

Many of the participants had feelings that were rooted in inadequacy. “Inadequacy” describes the state of not possessing the quality or ability required in dealing with a situation (Oxford Dictionary of English Online, 2010d). The participants felt that they were not good enough or were not doing as much as they could for their patients because of the language barriers between them:

“I could be serving my patient better” (code 12.7)

“You feel like you’re not doing enough” (code 12.8)

3.5.2.3 Experience feelings of insecurity and uncertainty

“Insecurity” is a term that refers to a lack of confidence in oneself and “uncertainty” is a term that refers to a lack of surety (Oxford Dictionary of English Online, 2010e; Oxford Dictionary of English Online, 2010g). Many of the participants described feelings where they did not know whether or not they were doing the right thing, and they were not sure of how to proceed in the presence of the language barrier:

“By then I get so lost and I don’t know what to do” (code 15.6)

“And anxious, I suppose, because what am I not getting from this patient that I should be getting. Yes, I’d be feeling insecure that I might be missing stuff” (code 15.7)

“And I panic that I’m not always certain that I’m getting the exact information that I’m requiring” (code 15.9)

3.5.2.4 Compromised rapport

A patient’s comfort, respect for the patient in all instances, professionalism and care for a patient were aspects that participants felt to be an important aspect of the healthcare interaction. Participants felt that if they were able to communicate without the barrier of language, these concepts could be more easily attainable, but that professionalism should remain despite the language barriers with the associated negative feelings:
“You can actually comfort that patient and say ‘no don’t worry, we’re going to work through this. We’re going to find a way’” (code 50.3)

“Just because you can’t understand someone doesn’t mean you shouldn’t still be trying your best to make sure they’re getting the best care. It does make it certainly difficult, that’s why it’s a barrier, it makes it more difficult, but I think if we take on the attitude to just write them off just because we don’t understand them then I don’t think we are fulfilling our duties” (code 72.3)

Participants valued care, professionalism, respect and open communication with patients as it improves the relationship between a patient and the student resulting in a good rapport. Participants felt that language barriers negatively affect rapport between themselves and their patients:

“Because it’s like this constant gap, it’s not like a conversation where you can actually get to know the person and understand them, understand the whole of the person. It makes it quite difficult” (code 74.2)

“…how you’re relating to the patient. I think every aspect of your patient-doctor relationship is affected by not being able to communicate effectively” (code 74.7)

“You might see them again, but they might not want to see you because you didn’t build that relationship with them because you can’t talk to them properly” (code 74.8)

3.5.3 Theme three: Language barriers’ influence on the various aspects of the healthcare process

The healthcare process consists of many aspects that are aimed at eliciting an adequate amount of relevant information that will help the student to diagnose, treat, and manage a patient’s case in the most appropriate way possible. Language barriers influence the various aspects of this process in a variety of ways, as described by participants.

3.5.3.1 Difficulty obtaining accurate information for effective healthcare delivery

Information obtained from the various aspects of the healthcare process is vital to how the case management will proceed:
“the better information we gather from the patient the more accurately we can treat, prescribe, examine, etcetera, the better chance we have at getting good results” (code 67.3)

“...for the diagnosis, the remedy, the treatment, the examination I think across the board it would affect how we treat” (code 67.9)

However, language barriers cause a breakdown of the process in various ways by making obtaining accurate and detailed information difficult, according to participants:

“it’s painting your case in a way that might not be as accurate as if you were able to speak the language” (code 20.7)

“So, I think it sort of disables your process because you aren’t able to gain as much detail as you would need” (code 49.4)

“But often, or at times, you can’t probe a patient because you can see that they don’t understand your initial question. So how can you go into more depth?” (code 53.4)

Many participants described that they would suggest answers to patients in order to help the case proceed. This results in inaccuracy as the information is not spontaneous and from the patient’s own experience, which is highly important in homoeopathic case taking:

“If you’ve painted it in a particular way that didn’t come directly from the patient, it could change the way that you interpret the case going forward” (code 95.7)

“Or I worry that I’m leading them on with maybe trying to give them examples for them to better understand but then take those examples as that is their picture and then they use them” (code 95.5)

“It’s like I’m leading them to Materia Medica. It’s like already I’m repertorizing the case without even taking it” (code 95.6)
a. Consultation

The consultation is the part of the healthcare process whereby the student elicits as much information from the patient about the main complaint. In this case, the students are conducting a homoeopathic consultation which is heavily reliant on details of the patient’s subjective experience of the disease. Obtaining information in the consultation is made more complicated by language barriers as patients find it difficult to express their symptoms and students find it difficult to elicit the correct information:

“I take disease as an object and symptoms are an image. So it’s a mirror image of an object. So if I can’t have such symptoms I’d lose the case already” (code 65.6)

“Homoeopathic consult is so personal, even the five-minute consult, where you sit and it’s a conversation, and depending on the skill of the person conducting the interview is how much information you’re getting out” (code 65.7)

“Because you would never be able to know exactly what’s the essence of the symptom that they are experiencing. And that’s important in homoeopathics. You should know exactly what they are experiencing” (code 65.7)

b. Physical examination

The conduction of a good physical examination depends on clear instruction to the patient, an explanation of what they can expect, and then receiving information both subjective- from what the patient tells the student, as well as objective- from what the student observes in the patient. Participants report that language barriers cause difficulty in explaining the process and getting accurate information from the patient:

“...or a neuro exam where you have to ask a patient to follow through with instructions, it becomes difficult if they’re not sure what they need to do, and perhaps you’re not getting the correct readings because they’re not really following through with instruction, it’s really difficult to make sure that everything runs as systemically, or as fluidly as you want it to” (code 70.3)

“Well, I would be like, ‘We’re going to test blood pressure now’ and the woman would undress herself, and that’s not the case...” (code 70.10)
Students are able to fall back on the objective information that they pick up from careful observation of the patient instead of the subjective information received from talking to the patient, but participants felt that it was not always the most reliable way to obtain information:

“It’s difficult to ride an entire diagnosis or an entire treatment plan based on that because, again, what might cause one person to wince is not going to cause another to wince. And so that is all so relative, right? So then it does become, I would say, a little bit inaccurate” (code 94.3)

“If I can’t elicit subjective information from them, I can barely prescribe” (code 94.7)

c. Diagnosis
The diagnosis is highly dependent on the information received from a patient. Without information, participants feel that they are not able to perform the correct physical examinations, conduct the correct special investigations, and ultimately arrive at an accurate diagnosis. While participants felt that they may be able to get a reasonable working diagnosis, language barriers cause an information breakdown and therefore have an effect on the subsequent accurate diagnosis:

“I think it ends up affecting your method of diagnosis because if you were to be completely indulged in the patient, or into it with no language barriers, you would have a set pathway in your mind on how to make an accurate diagnosis or accurate assessment” (code 66.10)

“It’s more difficult for me to come up with a diagnosis” (code 66.3)

d. Homoeopathic prescription
The homoeopathic prescription is based on the details described by the patient about their experience with the complaint or illness. These details help the student to differentiate between remedies and choose, most ideally, one specific remedy most suited to the patient. Language barriers make obtaining these details difficult and therefore have a negative influence on the subsequent homoeopathic remedy prescription, according to participants:

“We need that specification, that specific symptom for us to get to the right remedy” (code 68.1)
“Sometimes you always think that maybe if this was answered differently it could have turned toward a different remedy than the one that I’m giving” (code 68.1)

“It makes it a little bit, I think, trickier, to try and find a specific perfect remedy” (code 68.2)

“If you don’t get the right information it’s always hard to get the right remedy” (code 68.8)

e. Treatment plan and patient outcomes
Homoeopaths take on a holistic approach to treating patients in that they will look at all aspects of a patient and consider mental, emotional, and physical health; how lifestyle may be influencing the patient’s wellbeing; and generally look at all aspects of a patient’s life that may be preventing health (Homoeopathic Association of South Africa, 2016a). This is especially important as the patient cannot get better if obstacles to cure are not removed, if lifestyle changes are not made, and, in some cases, if appropriate conventional intervention is not sought out. The only way for a student to know what treatment plan to propose to a patient is based on information received from the patient. Just the same, patients need to understand what is being proposed to them that will allow them to regain their healthy state.

Language barriers make it difficult for a HCP to formulate the most appropriate plan for a patient. Language barriers also make it difficult for a HCP to explain to a patient in a way that they will understand what is required of them. This treatment plan directly affects the subsequent outcomes of a patient’s health:

“That has sort of a ripple effect on to how their treatment plan will come about and what kind of care they get, even how they respond to treatment, because obviously the better information we gather from the patient the more accurately we can treat, prescribe, examine, etcetera, the better chance we have at getting good results” (code 69.3)

“And then it’s also quite difficult to try and make lifestyle changes or give advice” (code 71.4)
“...they wouldn’t get the best treatment that they could in that circumstance, because of my lack of understanding” (code 69.4)

3.5.3.2 Implementation of homoeopathic philosophy

Homoeopaths are governed by fundamental homoeopathic philosophies. These philosophies are described by Dr Samuel Hahnemann, the founder of Homoeopathy, in his book the Organon of Medicine. The philosophies described include individualisation, the concept that each and every patient is an individual who requires their own remedy to restore health; holism, the concept that health is not simply about disease but about all aspects of an individual’s life; like cures like, the principle of using substances to cure disease that would cause disease in a healthy individual (Hahnemann, 2011). Participants discussed how language barriers negatively affect the implementation of these philosophies in practice:

“I do think that in that way it sort of compromises our philosophy and what we strive to offer” (code 18.3)

a. Individualisation

Individualisation is an important concept in homoeopathic philosophy. Its importance is described in aphorism 82 and 83 of the Organon (Hahnemann, 2011). The homoeopathic practitioner ensures individualisation of their homoeopathic treatment by taking a full homoeopathic detailed case from the patient and prescribing homoeopathic remedies that match the symptoms the patient presented with. This means that because patients present with different complaints and experience these complaints in individual ways, remedies will be personalised for the individual patient (Hahnemann, 2011).

Participants in this study described how language barriers negatively influence the obtaining of subjective information that is so vital in understanding an individual’s experience with their disease. This means that remedy choice becomes less individualized as there is a lack of guiding symptoms to help the homoeopathic practitioner choose the individualised remedy as treatment:

“...one of our philosophies is this individualised treatment, and if the patient doesn’t feel that they can express themselves as an individual and everything they say is being filtered through a translator, I don’t think that’s really fair on the patient...” (code 18.3)

“I want to keep it like that and to individualise the case again” (code 18.6)
“Because you know with Homoeopathy we need that specification” (code 18.1)

### 3.5.3.3 Disruption of the case taking

During a case taking, the student and patient play different roles throughout the process and the delicate interplay of these roles is what allows the consultation to run smoothly and successfully. When confronted by language barriers the case flow and nature of the consultation is disrupted because the student has to take on a different role and shift their focus to what is really important. The case becomes uncomfortable and disjointed:

> “It’s that awkward, with the lack of fluent communication verbally, comes that awkwardness throughout the rest of the case” (code 4.4)

#### a. Power dynamics

Participants noted that the power dynamic between the patient and student play a role in how the case unfolds. Participants felt that the nature of a practitioner-patient relationship already causes the patient to feel as though they are inferior to the practitioner from the beginning, which does not lend well to the free expression that homoeopathic practitioners require:

> “We were these great big learned people coming in to help these poor people. Which is an awful dialogue but there is truth in it. And even if I go and see a doctor, most of us, there’s a reverence for this person who knows more. You’re coming to them for help, so immediately you’re sort of on the back foot” (code 63.7)

To further this, when confronted by a language barrier the patient feels even further detached from the student, which again negatively influences the free expression of information required by the student:

> “There is a well-established power dynamic between a doctor and a patient, and now the patient’s even further on the back foot because they can’t communicate” (code 63.7)

Because of this skewed power dynamic combined with language barriers patients are too intimidated to attempt to express to the student what they need and often don’t elaborate or correct the student when it’s necessary. They also don’t ask the student questions, believing that the student will act in their best interest:
“So they always just see it as ‘the doctor will do whatever the doctor needs to do for me to get better’” (code 63.8)

“It’s that set belief that the doctor is right and will do what’s best for you” (code 63.4)

b. Consultation duration
Homoeopathic consultations are longer than the average conventional consultation because of the amount of detail required by the student regarding all aspects of the patient’s health and general wellbeing. Participants felt that language barriers negatively affects the time taken to conduct a homoeopathic consultation making it longer as so much time is spent trying to ensure that both the patient and the student are expressing themselves appropriately:

“The problem with the language comes in more, I suppose, with the time aspect of things. It takes you longer to get the information you need” (code 96.9)

“I spent almost 20 minutes asking almost the same question” (code 96.6)

However, participants of the focus group noted that this may not always be the case and that consultation duration may in fact be shorter as language barriers result in difficulties obtaining information from the patient. This means that with no communication to guide the case the consultation will prematurely end.

c. Shift in mental focus
Participants described the effect that being confronted with language barriers has on their mental focus in a case. In some cases the participants felt that because of a language barrier too much of their focus is spent on obtaining information about a particular aspect of the case which can mean that the rest of the case falls by the wayside. This means that the case would not be complete and subsequent management of the case would be affected:

“It can become disruptive to the case taking process because you’re focused on this one question when you might be missing the full picture for what the patient’s really going through” (code 97.3)
“You’re concentrating so hard just on the basics of communication, there’s so much else that you’re losing in it” (code 99.7)

Other participants described the difficulty in maintaining mental focus when confronted with language barriers. The distraction that the language barrier causes doesn’t allow the practitioner to really immerse themselves into the case and obtain the necessary information for management:

“And I actually feel like that, it shouldn’t make you negative, but it does, where you actually lose interest in what the patient is saying. They are speaking and you actually lose concentration due to that language barrier” (code 99.10)

“I don’t want to say that you’re distracted, but you’re having to think of a whole lot more than if you were able to just sit across the table from someone and they’re just reaming off rubrics” (code 99.7)

“My mind definitely does definitely dwell from the patient, which is terrible. Because as soon as my mind dwells it’s not effective patient care. And that does happen a lot. Well, not a lot but if there is a language barrier that is what happens” (code 99.10)

3.5.3.4 Ethical dilemmas
The terms “ethical” and “dilemma” are appropriately used here as “ethical” means being ‘governed by moral laws’ and dilemmas refers to ‘difficult situations where difficult choices need to be made’ (Oxford Dictionary of English Online, 2010c; Oxford Dictionary of English Online, 2010b). Participants find themselves in difficult situations when confronted by language barriers whereby a choice needs to be made in the best interest of the patient.

a. Informed consent
Informed consent is an incredibly important concept that any health worker needs to uphold. Patients must be informed about all relevant aspects of their personal health in a way that they can understand so that they may make informed decisions regarding how to proceed. In the case of language barriers it is difficult to explain to a patient what is happening with them, and to definitively ensure that understanding once it has been explained is extremely difficult (Barit, 2017). This raises questions about the validity of the patient’s consent in certain scenarios.
Participants in this study identified that informed consent is a tricky concept to uphold when trying to help a patient with a language barrier:

“Well because you’re not able to explain to your patient what you’re going to and when you’re going to do it, why you’re going to do it, what you’re expecting or anticipating, and to check with them if that’s okay. And to know that they fully comprehend what you’re saying and to expect…” (code 16.4)

“And you’re not getting that informed consent- full-on informed consent” (code 16.4)

Despite this, participants expressed that they still try to inform patients and get their consent to proceed with management of their case, as it is so necessary. However, participants suspect that patients sometimes give their consent even though they may not understand what they are consenting to. Reasons for this, according to participants, may include the aforementioned power dynamics and that trust that the patient has in the doctor that he/she will do what is required to make them healthy again:

“Oh, with the issues of consent also. It’s actually quite, having to explain to them, but they don’t really understand what you’re saying, but they consent to it anyway” (code 16.8)

“Yes, so they’ll let you do what you need to do, trusting that you’ll do what you need to do” (code 63.4)

“It’s that set belief that the doctor is right and will do what’s best for you” (code 63.4)

3.5.3.5 Benefit to patients despite language barriers

Despite the definite influence that language barriers has on the various important aspects of the healthcare process, participants felt that patients still benefit from the treatment they are provided:

“But I do think that at the end of the day we do still provide as best service as we can, and I still think that the patients do benefit regardless of the… there is some benefit despite those language barriers” 2.3
“I still think with how we’ve been trained we get pretty close to extracting the needed information so that we can get to a remedy at the end of the day” 2.5

“And I think being in the caring profession, and especially being Homoeopaths, we’ve been quite equipped to read our patients and understand them” 2.9

3.5.4 Theme four: The mitigation of language barriers through various strategies

The term “mitigation” refers to the action of reducing the severity, seriousness, or painfulness of something” (Oxford Dictionary of English Online, 2010h). Participants employ various strategies to try and help them to mitigate the effect that language barriers may have on their process and aid in better communication with their patients. These include using interpreters, acquiring the language, and various other strategies to be discussed further. While language acquisition is not something the participants in this study have attempted, it is suggested by the participants as a strategy that would aid in the mitigation of language barriers.

3.5.4.1 Use of interpreters

Participants had extensive experience with using interpreters during their clinic experiences. Some participants seemed unable to separate the concept of language barriers and interpreters, as when the central question “what has your experience been with language barriers?” was proposed, often participants would almost immediately speak about how interpreters have made the language barrier easier to handle:

“If there wasn’t a translator we’d be stuck” (code 26.10)

“…they can be very beneficial” (code 26.3)

However, some participants expressed feelings of frustration when using translators.

“Sometimes I find that really frustrating” (code 26.7)

“It was just like, well this was a bit frustrating” (code 26.2)

Despite the frustrations experienced when using an interpreter, participants still felt that an interpreter is an essential part of communicating with patients with language barriers:
“But it can be super beneficial especially for patients who do not speak English at all, even broken English. Then of course, a translator is absolutely essential that you have them there” (code 26.3)

“If you didn’t have a translator you wouldn’t be able to help the patient that’s sitting in front of you. But it will never be as effective without a translator” (code 26.10)

a. The types of interpreters
All participants have used informal interpreters in their experiences at the UJ HHC and satellite services. In the context of this study, informal interpreters are those who interpret between the student and the patient but are not involved in the patient’s health and who have not signed formal agreements to interpret for the consultation. In this context, the informal interpreter may be another student, the available tutor, school teacher, or a family member who can speak both the patient’s and the student’s language:

“Sometimes from the school. Or sometimes it’ll be one of the students who have come with us who is willing to translate between us. Or teachers from the school” (code 32.4)

“In Soweto also, I think the interpreter, when I’ve been there, there’s only been one lady who was working there and she was doing the filing. And also, she’s busy with other things, it’s not really her sole responsibility to come and interpret” (code 32.5)

Some participants feel that because the informal interpreters are not always primarily present for the purpose of interpreting, it may make the process a little more unprofessional. However, most of the participants feel that despite the informal nature of the interpreter, having the assistance is “better than nothing” (code 32.3) and that they are helpful:

“They’re there to do another job and they come in to interpret where they can, but because they stressed to do their other job, it’s not really going as professionally as it could” (code 32.5)

“I think it still has its value and it still has its place” (code 32.3)

“Sometimes the student translator is helpful. I think they are helpful. So I feel, there is a need, especially for more” (code 32.8)
In fact, some participants feel that having a member of the community or a family member helps the patient to feel more comfortable and understood at a deeper level:

“It makes the situation more comfortable for them to be able to have an interpreter there of their culture and of their community. That I can understand” (code 32.5)

Participants also expressed that the use of family members and colleagues as interpreters was beneficial as the interpreter then felt the same desire to help the patient as there is an invested interest for both parties in getting the patient back to health.

“I'd like to think that a fellow student would be aiming for the best interest of the patient as any one of us would respond to our own patient. If I asked a fellow student to help me they would come in with the same respect or desire for the patient’s health. Yes, so I’d like to believe that we’re all on the same page” (code 33.3)

“If it's a family member there's an investment there because they really want the best for the patient because they’re related and they care for them” (code 33.7)

However, in the case of a family interpreter, this invested interest may rather become a conflict of interest and have negative implications for the patient. This was pointed out by members of the focus group with one participant saying “just because it’s a family member doesn’t mean that they have the patient’s best interest”.

Some participants have had experience in using formal interpreters as well. In the context of this study, formal interpreters are those who are employed to interpret for a student and patient and who have signed necessary agreements- but who have not necessarily formally been trained in interpretation. The participants have mixed feelings about whether a formal interpreter would be better than using an informal interpreter. Some feel that it would be best to have a formal interpreter:

“What I basically mean by that is to have someone who this is their primary job to do. So that only allows them to be really good at it as opposed to having a family member or the person who just happens to be available to help out or that type of thing” (code 30.3)
“And they know how important it is to deliver word for word for what the other person said, I assume” (code 30.1)

Some participants have no problems with using an informal interpreter instead of a formal interpreter:

“Sometimes the student translator is helpful. I think they are helpful. So I feel, there is a need, especially for more” (code 32.8)

“I think that whatever has been happening so far has worked. I don’t have any problems” (code 32.9)

Despite the mixed feelings regarding formal and informal interpreters, participants rather put emphasis on having an interpreter who is invested in a patient’s health, whether they are formal or not:

“I almost feel like if there’s no investment from someone you’re going to be getting fairly random info back, that’s not going to be particularly valuable” (code 33.7)

“I suppose the interpreter has to have the best interest of the patient” (code 33.3)

“There has to be some kind of investment from the person interpreting” (code 33.7)

b. Mistrust towards interpreters

Participants expressed mistrust towards the interpreters. Participants felt that they could not be sure that what the interpreter is telling the patients is correct, and they could not be sure that what the interpreter is relaying to them is correct:

“I don’t know if they’re giving what I’m asking in full or if they’re giving what the patient’s stating in full” (code 36.5)

“I suppose I couldn’t trust what she was saying” (code 36.7)

“How am I certain that they are actually saying everything?” (code 36.8)
This complete reliance on the interpreter makes the student feel vulnerable and mistrustful, as the power shifts in the interpreter’s favour:

“So I feel like especially with the interpreters, they can just choose to ignore something that the patient says” (code 36.1)

“I would just sit here and I don’t know what [redacted] is asking her. I don’t know if [redacted] is asking it the way that I would want to ask it. And if she’s leaving out something that I would have wanted to ask” (code 36.2)

“So you on the other end are giving all the information and be as accurate as possible, you don’t know if there’s follow through with that” (code 36.3)

“...they will only tell you what they think is important” (code 34.4)

One of the most commonly cited explanations by participants for this mistrust is that the participants have experienced disparity in the time it takes for the patient to relay information to the interpreter and the time it takes for the interpreter to relay that information back to the practitioner:

“Or the patient will say in their language and then [the translator] will say “oh, no, it’s fine” but there was a good 30-seconds of conversation” (code 34.2)

“You can ask such a long question and they say maybe two words, not a sentence” (code 34.5)

“The translator would have a 5-minute discussion with the patient and only answer you with a one-liner” (code 34.10)

c. Effect on obtaining information

While the primary role of an interpreter is to assist in the communication between patients and practitioners, participants sometimes felt that this communication still fell flat. Students are completely reliant on the interpreter to correctly relay information between the them and the patient. Participants felt that sometimes the interpreter does not relay the correct information resulting in inaccuracy of the information received:
“The problem is, languages, I don’t know, it’s very, you know, there are ways to ask things, and sometimes I ask them something and then they give me something else” (code 31.8)

“Things get lost in translation” (code 31.10)

“You can’t necessarily verify that they’re getting everything spot on” (code 31.3)

Possible reasons for this were varied, but ranged from suggestions of interpreter tiredness to limitations of the interpreter understanding of the other language:

“...I had a translator who only knew “needles” as a description for pain. So let’s say that for 10 patients that I saw for the day, 7 of them had a needle pain. Which is a very peculiar symptom to actually have” (code 31.4)

“I think because we see patients one after the other, the interpreters start to get tired, so maybe they’re also not giving you the full story at the end of the day, or pre-empting what you’re going to ask because they’re used to how you ask questions” (code 31.5)

Participants felt that not only would some information possibly be inaccurate, but sometimes details would be lost in the translation process altogether:

“Even with a translator it becomes a problem because you need to get the fine detail which you don’t often get clarification on” (code 34.9)

“You could be losing vital information” (code 34.3)

These ideas may be confirmed by one of the participants who has acted as an interpreter herself saying:

“And I did tell the student what the patient said, but it was like a diluted version because I couldn’t say what they really said” (code 34.8) and “I’ve had points where I have to translate something and I don’t really say it properly” (code 31.8).
For these reasons, participants emphasised the importance of having a “clued-up” interpreter who understands how the homoeopathic processes is conducted and what information is required. This means that the interpreter will ask the student’s questions appropriately, and that they are interpreting the patient’s answers back in the most exact way—keeping in line with homoeopathic philosophies. This would be to the benefit of both the student and the patient:

“Preferably someone who understands the philosophy of what we do, someone who is maybe familiar with some terminology, just so that at the end of the day the patient still feels like they’re getting information from somebody who is knowledgeable and who is giving them sincere and well indicated advice and treatment” (code 23.3)

“Even if you take an informal translator and train them to understand the Homoeopathic case taking procedure what we’re looking for, what information is available, or what information is important, to understand the process” (code 23.4)

“If you can have someone who understands all of that, I think the quality of information that you extract is going to be better” (code 23.7)

Participants felt the most comfortable with having other Homoeopathy students interpret for them and their patient as they are invested in the health of the patient, they are familiar with homoeopathic philosophy and understand what answers are required from the questions:

“Because they know the terminology much better. Obviously because they are Homoeopaths so they know Homoeopathic language, they understand the case better, they can actually bring that essence of the case over to the patient to explain it better” (code 23.10)

“With students, like Homoeopathic students, it’s more reliable because they know how important we need the symptoms” (code 23.1)

d. Effects on the nature of the case

Participants felt that although communication is easier with the help of an interpreter, it has a negative effect on certain aspects of the nature of the case. Because the student and patient have to speak through another party, the case taking process becomes time-consuming:
“Obviously it’s a little bit more time-consuming” (code 38.3)

“It’s such a long and tedious process to get an answer” (code 38.10)

The flow of the process also becomes disrupted and disjointed as the patient and the student are constantly communicating through a middle-man:

“It also becomes difficult because it’s almost like the conversation becomes disjointed. Almost like your flow of questions doesn’t seem to flow as easily” (code 29.3)

Due to the constant need to go back and forth with an extra participant means that the student and patient don’t connect to each other. This lack of connection between the student and patient can in turn affect the rapport between student and patient:

“...this is my patient, so I’m supposed to build a relationship with this patient but now, everything is going through somebody else, you have a middle man. So you might not be able to form a relationship” (code 35.10)

“Like I said the relationship first matters with the patient because now it feels as though you are treating this other person” (code 35.8)

“I think that relates to what I was saying earlier about now because the interpreter’s there you’re losing something here between the patient and the doctor” (code 35.7)

e. Ethical dilemmas in interpreter use

The students need to make decisions regarding the best course of action for a patient who they can’t communicate with. Although the use of a third party may pose ethical challenges the student needs to decide how best to proceed in the best interest of the patient. One such ethical challenge is that of confidentiality. Maintaining confidentiality of a patient’s medical information is a right of every patient. By bringing in an interpreter, especially one who has not signed any legal documents ensuring that the information they learn will be kept confidential, students directly infringe this right. This is a concern highlighted by participants:

“...it's a little bit unethical because I don’t think that they’re signing anything to say that they are not going to be telling anybody what they’re hearing in the consult” (code 24.5)
Another ethical challenge posed is that of privacy. Patients have the right to privacy and do not need to have anyone that they are uncomfortable with or do not know involved in their personal medical stories. When a student brings in an interpreter, the patient’s right to privacy may be infringed as they need to disclose personal and private information to someone they perhaps do not want to:

“I also think it kind of invades their privacy as well. Because now they need to relay this private information, not only to the doctor, but to the translator as well” (code 37.10)

“It’s a matter of privacy. Especially with some people, some patients don’t want to be touched. So if you can’t explain to them why you need to touch them, they’re going to feel very... I wouldn’t say molested or harassed, but something like that. To that effect. Where this person is touching me, and I don’t know why they’re doing it” (code 37.8)

These ethical dilemmas pose challenging situations for the students as it is their sole purpose to help the patient and the language difference is creating a barrier to this. The student needs to decide whether or not infringing these rights is in the best interest of the patient.

3.5.4.2 Language acquisition and responsibility to acquire a language

While participants are not actively attempting to acquire language in order to assist their communication with patients, participants felt that if they were able to acquire the language of the patients it would eliminate much of the language barrier present:

“It would help us in these situations. Maybe we could spread our services out more. It would benefit us in [external clinic] that we’ve just started engaging in. It would help our patients more” (code 43.5)

“Because that will give us at least something to go with so that when we face society we are effective to them” (code 43.6)

“I think it would definitely be beneficial for us to learn the language because it makes the process, it just makes it easier” (code 44.2)
Participants felt that even if they were able to say a few basic phrases, it would have a positive effect on the rest of the case, especially in terms of making the patient comfortable and building rapport:

“If it were basic greeting skills, “How are you”, maybe just like a few words, also so that the patient feels comfortable with you and it helps to build that relationship and rapport” (code 43.3)

“If you have the basics, you know, again the patient will feel eager to have a relationship with you, because you’ve taken an interest in them and their language” (code 64.8)

“I think you gain a better rapport with the patient if you’re able to greet them in their language, or say please and thank you. You know, the basics” (code 64.9)

The language that the majority of the participants felt would be the most beneficial language to learn is isiZulu. This is due to the fact that it is the most encountered by the participants in the Johannesburg clinics, and it also has the added benefit of being the easiest to learn and can be understood by a variety of other-South African language speakers:

“Zulu would have been the best one, especially for Joburg” (code 42.7)

“It’s mostly Zulu. Zulu or Tswana. Because I know most people will understand you if you speak Zulu or Tswana” (code 42.8)

“I think Zulu maybe. Because it’s the easiest” (code 42.2)

Most participants approved of the idea of having a language course added to the university syllabus:

“I think it would be good for all of us to learn the language to be honest” (code 43.9)

“I think that it will be so helping to have training course in all languages, it will be nice. It will help all of us actually” (code 43.6)
“It would be valuable full stop” (code 43.7)

Other participants felt that despite the benefit that language acquisition would have on their delivery of healthcare, having a language course added to the current university syllabus would “be challenging to have it as part of the course material” (code 43.3). Reasons for this include a lack of motivation to learn language amongst all the other demanding subjects already part of the syllabus; a lack of time; difficulty as an adult to acquire new language; and the difficulty with deciding on which language to learn:

“I came here to study Homoeopathy, I didn’t come here to study a language” (code 46.1)

“It would be lovely to say we should all go out and learn new languages but who really has the time, and sometimes even the skill and the talent, to do that” (code 46.3)

“In light of how the course is structured and how the workload can become quite a lot. I don’t think that many people would take to it, or at least give it that time and attention that it might even warrant because of that” (code 46.3)

“Also, there are 11 of the African languages, which one are you going to choose? And then if we’re going to do an African language are we going to do Afrikaans as well?” (code 46.4)

Despite the fact that the participants were not actively learning the languages of the patients they encounter, and despite the fact that they could foresee problems with a language course being implemented into the syllabus, the majority do feel that it is their responsibility to learn the languages in order to best help their patients:

“Choosing the profession that we’ve chosen, in our country with the many different languages, it is definitely a responsibility of ours to learn more of the language so that we can communicate better. Especially being put into situations like satellite clinics” (code 78.5)

“It’s my responsibility I think. To my perspective it’s my responsibility. Because I’m a health practitioner and my target is everyone” (code 78.6)
“I think it’s the doctor’s responsibility. You take an oath to help and heal, so you need to do your utmost” (code 78.8)

“I think the responsibility lies with the doctor. Because we are in a profession where we are willing to help the community. So we’ll be going to patients, and it’s not likely that there’s so many patients out there, I just can’t see how they’ll come to you and speak your language, you know. I just feel that the responsibility does lie with the doctor” (code 78.10)

3.5.4.3 Various other strategies employed

Besides using an interpreter and learning the language, students employ a variety of other strategies during consultation with a patient in order to try and mitigate the language barrier, aid in improving communication, and elicit necessary information despite the presence of the language barrier.

a. Adapt questioning

Participants often expressed that they would try to adapt their words and questioning to match the understanding of the patient in front of them. This would involve asking the question in a variety of different ways in the hopes that the patient may understand one of the questions posed to them:

“I just try to find a better way to try to deliver what I want to, to tell them what I want to tell them, or to get them to tell me what I want to know” (code 82.1)

“And then I just try my best to work the questions to make it easier for them to answer” (code 82.5)

“And then obviously, having said that, I do try to rectify it and try different routes to explain the question and what I want from the patient” (code 82.10)

This also includes using terms that the practitioner knows the patient is familiar with in their own context, such as “high blood” when referring to “high blood pressure”, or “sugar” when referring to “diabetes”.
Adapting the questioning by using descriptions and a point of reference that the student feels the patient would understand further aims to enhance a patient's understanding:

“Like, for example, giving them description of pain. Just so that they better understand what I’m trying to say. ‘Does it feel like a gunshot or is it a stabbing pain or does it feel like a bee sting?’” (code 87.5)

b. Simplification of language
Using simple language and basic terms and phrases is another way that participants try to ensure that the patient will understand what they are asking or saying.

“I try not to get too convoluted... Small, short sentences” (code 93.3)

“I do my best to keep my language as simple as possible” (code 93.4)

“Just trying to make them maybe easier for a person who is maybe not proficient in English to understand. So, simple questions, smaller words to describe something that they may more better understand” (code 93.5)

c. Checking the patient’s understanding
Participants who were acutely aware of the language barrier between themselves and the patients report that they try to ensure that the patient is keeping up with all the information during the consultation. While not directly mitigating the language barrier, checking in with a patient would ensure that the student could go back and try and employ other strategies to maximize understanding for this patient should they report that they do not understand. It also gives the student a chance to ensure that they understand the information received from the patient correctly:

“Wait for them to respond so that you know you haven’t lost them, you’re on the same page with them- I think that’s really important” (code 84.3)

“I’ll often check in with the patient, ‘Does that make sense? Do you understand? Are you sure?’” (code 84.4)

“I double check everything” (code 84.9)
d. Code switching
It is common for people to pick up on certain words and phrases in different languages, especially when exposed to them all the time such as in multilingual South Africa. Participants report that they will use words or phrases that they know in the patient’s language to try and get the concept across to the patient. This is called “code switching”.

“It was a way in which to overcome. I still didn’t understand a word of Tswana but just by throwing in a couple of phrases here and there, they caught on immediately” (code 85.7)

“And with me there is a few words that I know in Zulu so it’s not really much of a challenge because even if I can’t get it in English, I’ll think about Zulu, and if I know it in Zulu I’ll ask them. I find that helps me a lot” (code 85.1)

e. Visual strategies
Participants reported using a variety of different visual strategies to help them explain concepts to patients and to try and understand what patients are saying. Demonstration and the use of gestures help students to elicit some information from patients:

“You can’t give them instructions on how to do something verbally, so you’d have to show them” (code 86.7)

“I must still indicate to them “Okay I’m going to touch you now”, let them see my hands [holding hands up], then move slowly” (code 86.3)

“You can point nicely to certain areas; you can show is it a hard pressure or a soft pressure” (code 88.5)

Students use observation and visual cues to try and elicit information from participants:

“When you’re doing a physical exam notice facial expressions- are they wincing” (code 90.3)

“Also, you can pick up a lot of things by mannerisms and facial expressions” (code 90.5)
f. Patience with patients
Participants found that when they did not rush the patient and gave them enough time to try and relay information to the student, they were able to obtain more information than if they had rushed the patient. They also found that they needed to give the patient a time to try and understand everything they are being told and asked:

“Wait for them to respond so that you know you haven’t lost them” (code 91.3)

“When you give the patient enough time they find the words amazingly well” (code 91.7)

g. Abandon/change the question and/or refer the patient
Participants exasperated by trying to ask questions or provide information to patients would abandon that line of questioning and continue with a new line of questioning:

“If they really still don’t [understand] then I usually abandon the question and move on to something else” (code 81.8)

“I leave it out” (code 81.1)

When participants feel that they are not going to be able to assist this patient to the best of their ability due to the presence of the language barrier they would refer to a more appropriate practitioner:

“I will have to explain to them that If I can’t speak someone’s language I’m not enough for them. It’s either then I have to say that I can’t help you, then I will have to make referrals or something like that” (code 92.6)

“...you have to be really sharp about referring people, and going “I can’t actually serve you” and you need to then be referring to other places” (code 82.7)
h. Additional points

During individual interviews participants mentioned a few topics that are important aspects of miscommunication between patients and their healthcare providers. Each will be briefly discussed below:

- Culture

Culture and language are two concepts that are often difficult to separate, as an individual’s first language is often determined by the culture they have been brought up in. Culture may influence the delivery of healthcare as it determines the way that an individual should approach another individual.

Participants in this study recognised the role that culture may play in their interactions with patients and what role culture plays in a patient’s lifestyle. However, opinions on whether or not culture influences the delivery of healthcare were varied and remains to be investigated:

“I think it’s really important to try and stay open minded about people’s backgrounds and where they come from, and a lot of cases it might be very different to your own” (code 7.3)

“Culture is how we relate to everything around us. And language is just one iteration of that culture” (code 7.7)

- Issues outside of language that influence communication

Communication is not only reliant on the language that we speak, but also other factors that influence how this language is understood. In this study, participants mentioned issues such as medical literacy, accents, and race assumptions play a role in mutual understanding. Should a patient not have the same medical knowledge and literacy as the HCP who then speaks in medical terms, the understanding is going to be impaired despite the fact that they may be speaking the same language. Accents may cause difficulty in understanding another individual despite speaking the same language. Lastly, people often assume that an individual can speak a particular language based on the colour of their skin. These race assumptions lead to misunderstandings due to incorrect language assumptions:

“at times it’s also difficult to understand their accent” (code 1.4)
“I don’t know if you know the saying that says some stuff can only be said in African language” (code 41.1)

All of these issues outside of language can influence communication and understanding and the influence of these on delivery of healthcare remain to be investigated.

• Resultant patients’ feelings
Participants in this study described their assumptions of the emotional response of patients when encountered by language barriers with the healthcare provider. These included fear, hopelessness, insecurity, uncertainty, and guilt. These negative emotions may influence the healthcare consultation process and remains to be investigated.

“They’ll probably lose hope in me because they won’t really be able to help me because we can’t really communicate” (code 54.1)

“I think it makes them feel frustrated” (code 56.10)

3.6 LITERATURE CONTROL

3.6.1 Multilingualism in South Africa
There are 11 official South African languages used by 98% of the population- these are English, Afrikaans, isiNdebele, Sepedi, Sesotho, siSwati, Xitsonga, Setswana, Tshivenda, isiXhosa and isiZulu (South Africa, 1996). With South Africa’s population at approximately 56.6 million people, isiZulu is the most spoken first language in the country (spoken by 23%) and in Gauteng (spoken by 14%). The country’s second most spoken language is isiXhosa (spoken by 17.64%), while English is second in Gauteng (spoken by 11%) (Statistics South Africa, 2012; SA National Department of Health, 2015; Statistics South Africa, 2017; Worldometers, 2018).

Although South Africa (SA) is a multilingual country English is the dominating language of use in public settings, economic environments, primary and tertiary educational systems, as well as in our healthcare system (Barnard, 2010; Deumert, 2010; South African Institute of Race Relations, 2013). Aside from the 11 official South African languages, there are hundreds of other languages without official status. This means that not only are South Africans confronted with language barriers on a regular basis, but immigrants who speak various other languages are also affected by language barriers in South Africa (Hunter-Adams and Rother, 2017).
Participants reported that they encounter patients that speak different languages to them and therefore their communications with patients can sometimes be challenging. Fifty percent of participants in this study spoke English as a first language, the other fifty percent spoke a variety of first languages, including Afrikaans, isiZulu, French, Portuguese and Xhosa.

3.6.2 Impact of Language Barriers in Healthcare

Participants in this study expressed how language barriers have a significant influence on various aspects of healthcare, including aspects of the healthcare process, interpersonal and intrapersonal experiences, time implications, and ethical considerations. They also express how effective communication would result in positive consequences.

Benjamin et al (2016) states that a reality for South African society is that majority of consultations, up to 80%, are not performed in the home language of the patient and has described the interplay of language and health as follows, “A monolingual health service in a multilingual society”. The pre-eminent position of English in this field is problematic as detailed and accurate communication between patients and practitioners is vital (Paternotte et al., 2015). Successful health outcomes are dependent on successful communication between the healthcare provider (HCP) and patient (Van den Berg, 2016). Language barriers have been shown in many studies to have an effect on a multitude of aspects in healthcare including patient satisfaction, adherence to advice and medication, diagnosis, costs, mortality, and HCP-patient relationships (Lukoschek et al., 2003; Levin, 2006; Deumert, 2010; Levin, 2011; Taylor et al., 2013; Parsons et al., 2014; Ahmed et al., 2017; Ashkinazy, 2017; Li et al., 2017).

Language involves words with underlying complex meanings and concepts that are used differently by patients and HCPs in different contexts (Lukoschek et al., 2003). This makes it challenging for patients to express appropriately what they are experiencing, which in turn makes it challenging for an HCP to understand and use the information to manage the patient appropriately (Ahmed et al., 2017; Li et al., 2017).

These disparities in the use of language by different people results in an HCP perceiving the process of helping a patient to be risky even the patients are of adequate language proficiency in a second language (Parsons et al., 2014). Having said this, some participants in a study by Govender et al (2017) suggested that language barriers allow an improved relationship with
patients as it forced them to attempt to learn the patient’s language and forced them to work together with the patient to find a common ground to work from.

3.6.2.1 Healthcare Process
The healthcare process involves a patient explaining their experience of their situation to the HCP, the HCP must understand and elicit appropriate information from the patient, and thereafter formulate and explain a management plan which would include possible further investigation, treatment, and advice. Should efficient communication be lost, this process of obtaining necessary information is directly affected (Deumert, 2010; McCarthy et al., 2013; Ahmed et al., 2017; Li et al., 2017).

Participants in this study expressed these same opinions stating that language barriers make it difficult to obtain accurate information in order to deliver effective healthcare. This difficulty is experienced throughout the healthcare process including not the consultation, the physical examination, diagnosis, prescription, and the forming of a treatment plan.

According to HCPs it is extremely challenging to make a diagnosis without a good medical case history, although not impossible. In the case of a language barrier, the HCP would need to rely on the objective physical examination in order to diagnose- which is not as reliable (Deumert, 2010). Misdiagnosis may occur which could lead to mismanagement of the patient, inappropriate and/or unnecessary costly treatment and investigations to attempt to establish a diagnosis, and unnecessary prolonged suffering and distress for the patient (Schlemmer & Mash, 2006; Van den Berg, 2016; Li et al., 2017). Sobane and Anthonissen (2013) demonstrate the danger of miscommunication with a descriptive account from an HCP whereby a discrepancy was detected in a HCP’s prescription that may have been caused by miscommunication, which could have resulted in serious side effects for a paediatric patient.

Even in patients without language barriers medication and lifestyle advice adherence is an issue, therefore in the case of language barriers adherence and compliance is more severely affected (Taylor et al., 2013; Ahmed et al., 2017). This non-adherence may lead to patients’ conditions worsening, and in more serious events patients’ mortality. One HCP described in Deumert (2010) the dangerous effects that overdose due to miscommunication and poor counselling have on a patient.
Another risk is the refusal of treatments by patients and/or family members if HCPs are unable to communicate how serious the patient’s condition is and how necessary, and possibly life-saving, that treatment would be (Van den Berg, 2016).

3.6.2.2 Patient Experiences of Language Barriers

Patients who feel that they are misunderstood by HCPs have shown to be frustrated and dissatisfied with the care they are receiving which affects their compliance with the HCPs treatment (Van den Berg, 2016; Ahmed et al., 2017). These patients also are more likely to withhold information which could be vital in their management and less likely to return for follow-ups (Schlemmer & Mash, 2006; Engelbrecht et al., 2008; Hunter-Adams & Rother, 2017).

In this study, participants described what they assumed would be the emotional response of a patient encountering a language barrier. This included feelings of fear, frustration, insecurity and uncertainty, and guilt. Participants also reported how challenging language barriers make forming treatment plans and how they may complicate patient outcomes.

Patients who cannot understand their HCP tend to not ask questions when they do not understand, this leads to adverse effects on their personal health. For example, if patients do not understand the warning signs of a specific ailment they may exhibit avoidance behaviour whereby they avoid seeking care until later stages in their diseases. Patients who are not able to communicate effectively with HCPs are less likely than those who are able to communicate effectively with HCPs to seek preventative care. This increases the risk for permanent damage and mortality and reduces the chances that an HCP may be able to help resolve issues (Lukoschek et al., 2003; Deumert 2010; Van den Berg, 2016).

When patients have a limited understanding of their health and the HCPs proposed management of their case it has a direct effect on the personal decision-making process and patients tend to let HCPs make the decisions for them (Lukoschek et al., 2003).
3.6.2.3 HCP Experiences of Language Barriers

Participants described the intrapersonal effects that language barriers have on their own experiences of their patient encounters. The participants reported that they often felt frustrated by the language barrier. They also experienced a loss of confidence, resulting in feelings of inadequacy, uncertainty, and insecurity in their own ability to help treat the patient appropriately.

Other studies confirm that HCPs themselves experience the effects of language barriers and feel the frustrations of not being able to help patients as effectively as they would hope to. When encountering a language barrier HCPs tend to take on a more medical and direct approach to communicating with the patients and give more direct advice in order to keep the process as short and simple as possible. By doing this, HCPs are unintentionally excluding the patients from being a part of their own healthcare (Bank et al., 2016; Ahmed et al., 2017). Healthcare providers who perceive that their patient may not understand tend to withhold information and make decisions for the patient, which is in direct conflict with the requirement of obtaining informed consent and the concept of patient-centeredness (Ahmed et al., 2017).

Schyve (2007) suggested that HCPs tend to underestimate language barriers between themselves and patients, as often patients overestimate their own language abilities and consider themselves able to speak the HCP’s language. These language barriers, unfortunately, only become evident later in the healthcare process, such as in a follow-up consultation (Schyve, 2007; Sobane & Anthonissen, 2013). Conversely, Lukoschek et al (2003) suggested that HCPs tend to overestimate language abilities of patients and therefore overestimate how much patients comprehend when providing health information.

An HCP in a study conducted by Russell et al., (2015) described how confidence in personal ability to assess a patient’s understanding is affected, and described it as overwhelming when they are unable to meet patients’ needs due to a language barrier. Paternotte et al (2015) showed that HCPs found it challenging to relate to patients due to a perceived incompetence in communication skills which would severely affect the doctor-patient relationship. HCPs found that not only was it difficult to communicate concepts effectively, but it was challenging to communicate the intricacies of language that are so important when dealing with patients, such as empathy (Paternotte et al., 2016).

Healthcare-colleague relationships also suffer where ineffective communication is experienced between colleagues. It is not only challenging to communicate to each other about the health of a
mutual patient, but interpersonal relationships are affected, resulting in staff members feeling frustrated, isolated, and burnt-out (Skjeggestad et al., 2017). Staff morale and job satisfaction is negatively impacted by the inability to communicate (Deumert, 2010). This concept is reiterated in a study by Skjeggestad et al (2017) whereby HCPs expressed how language barriers cause a severe lack of confidence in their medical abilities resulting in HCPs leaving their jobs. Sometimes healthcare providers who are able to communicate with patients feel that they are expected to, or need to, compensate for their colleagues limited language proficiencies by trying to resolve any misunderstandings that may have occurred. This may result in feelings of frustration and colleagues feeling as though they are being exploited (Engelbrecht et al., 2008; Skjeggestad et al., 2017).

Despite evidence that lack of effective communication would significantly impact health outcomes negatively, some HCPs in Russell et al (2015) felt that while good communication is important, lack thereof would not impact the medical care provided by them to their patients.

3.6.2.4 Time and Cost Implications
Healthcare providers perceive that attempting to communicate with patients of another language is extremely time-consuming as more effort is needed to elicit necessary information (Taylor et al., 2013; Ahmed et al., 2017). However in contrast to this, other studies have shown that in fact, consultation times are shorter with patients of limited language proficiency due to a lack of information and physicians being less likely to make efforts to elicit further information. This is in direct conflict with findings that patients feel more comfortable when HCPs make an effort to ensure that the patient has understood by asking questions and paraphrasing the patient’s responses (Parsons et al., 2014; Paternotte et al., 2015; Ahmed et al., 2017). These contrasting ideas are both reported in this study by participants. Some felt that it was either longer, due to the time taken to understand the patient and to ensure the patient understands them, and some felt it was shorter, due to the significant lack of communication.

Costs incurred by individuals and the government are substantially higher than necessary as more time needs to be spent on patients due to the delayed entry into care, longer time is taken to make a diagnosis, and tests and medications ordered are unnecessary and/or inappropriate and costly (Hunter-Adams & Rother, 2017).
3.6.2.5 Language and Cultural Stereotyping

Participants in this study recognised that culture may play a role in their interactions with patients, and that language and culture often go hand-in-hand. Both HCPs and patients are guilty of putting one another into certain generalized categories based on preconceived ideas of language and culture (Ahmed et al., 2017). Healthcare providers may learn of a patients’ language and associate that patient with preconceived ideas of a culture and subsequently treat the patient in a certain way without considering the individual who has come seeking healthcare. HCPs in Deumert (2010) reported “boxing” their patients when they see names from another language on the patient list and would leave those patients for last because they expected that the consultations with those patients would be longer and more challenging.

In Engelbrecht et al. (2008) ‘language of colour’ was a prominent theme which described how patients judged what languages HCPs could speak solely based on the colour of their skin. An HCP from this study, who could speak an African language, described how patients would withhold information from her even when she spoke to them in their language and would rather give their information to a HCP of the same colour because they assumed that she would not understand. That being said, patients in Paternotte et al. (2015) placed more importance on HCPs being able to speak their language than being the same ethnicity as themselves. Patients also found it to be more comfortable for them when HCPs could speak at least some of their language, a finding that was reiterated in another study which found that being able to speak even a few words improved the doctor-patient relationship (Schlemmer & Mash, 2006; Paternotte et al., 2015).

Patients fear that HCPs will make assumptions about their intellect if they ask questions about their health when they do not understand. This results in patients making a decision to simply ‘say yes’ to whatever the HCP recommends as they are confused about the process and afraid of the HCP, and are afraid that the HCP will abandon their care (Levin, 2006; Schlemmer & Mash, 2006; Deumert, 2010). On the other hand, HCPs have expressed a fear of insulting patients by probing when they perceive that the patient cannot understand what they are saying (Deumert, 2010).

Healthcare providers tend to gauge a patients’ language proficiency by observing cues whilst communicating, such as facial expression, and asking open-ended questions in order to elicit a response from the patient that will allow the HCP to determine how much the patient understands. When a physician perceives that a patient may not comprehend health information
that they provide, they also tend to make the assumption that these patients will be incapable of making their own decisions (Lukoschek et al., 2003).

3.6.2.6 Result of Language Barrier Resolution

Participants in this study felt that when communication between themselves and their patients was lacking it negatively influences interpersonal and intrapersonal experiences. This leads us to conclude that when communication is effective, the participants feel that it has a positive effect on their healthcare delivery.

Levin (2011) demonstrated this by conducting an interventional study to determine if intervention whereby language skills are taught to HCPs would improve HCP-patient communication and patient satisfaction. This study demonstrated benefits for both patients and HCPs. Patients felt that they were able to better understand explanation and instruction given to them by HCPs and felt that HCPs were more empathetic towards them. HCPs also felt that they were able to better understand and communicate with patients. This lead to the experience of better HCP-patient relationships and less frustration (Levin, 2011).

Effective communication results in patients feeling more comfortable, more understood, and results in higher rapport with their HCP. Patients also rate their care of a higher quality if they were able to communicate effectively. This may occur even when the HCP is unable to speak the patient’s language yet makes an effort to communicate in their language (Levin, 2006; Paternotte et al., 2015).

Effective communication also leads to better trust in the HCP, better understanding of conditions and therefore better treatment adherence and self-care (Sobane & Anthonissen, 2013; Ashkinazy, 2017). It also improves patient satisfaction and patient-centeredness (Li et al., 2017). Psychosomatic effects were also reported whereby patients who perceived that their HCP’s language proficiency was good in their language reported experiencing less physical pain (Itzhak et al., 2017).

3.6.2.7 Patient-centred Communication

Participants in this study described how language barriers have a negative effect on the relationship and rapport between themselves and their patients. These effects result in a patient who is not only uncomfortable to sharing experiences with the practitioner, but causes the patient
to feel that the power dynamic has shifted in the HCPs favour. This unwillingness to share and feeling of inferiority does not allow the patient to be a part of the process.

Communication is considered effective if the communication is experienced as a dialogue between the HCP and patient, and if both parties understand what the process entails and the intended outcome (Schyve, 2007). Hibbard and Greene (2013) differentiates between compliance, which is when the patient follows the advice of the HCP, and patient engagement, which are strategies employed the HCP to increase patient activation and improve patient’s health-seeking behaviours. Patient-centred communication (PCC) is an approach which allows for effective communication in the healthcare setting. It allows for the HCP and patient to discuss and make decisions regarding the patient’s health together (Paternotte et al., 2015). Patient-centred communication is about treating the patient the way that they want to be treated and understanding that there is no one better to consult about a patient’s health than the patient themselves (Lukoschek et al., 2003; Ashkinazy, 2017).

Gorman et al (2018) speaks of the six functions of PCC in the context of cancer care, however these functions are transferrable into principles of PCC in general healthcare. Patient-centred communication is intended to establish a relationship between the HCP and the patient and their family. Having a solid relationship among participants allows for the establishment of an effective exchange of information between the HCP and the patient. The patient feels more comfortable discussing important aspects of their health, their concerns and are able to ask the practitioner questions when they do not understand. When the relationship between practitioner and patient is strong patients feel more comfortable expressing feelings, such as uncertainty, during the healthcare process. PCC establishes the validation of patients’ feelings by causing the practitioner to take on a more tolerant, understanding and empathetic stance. This will allow the practitioner to appropriately console and counsel the patient when it is required and allows the patient to feel acknowledged and understood (Gorman et al., 2018).

Allowing patients to be a part of the decision-making process in regards to their own health encourages and enables patients to self-manage their care. Patient activation involves the patient being willing to take responsibility for making decisions in managing their own healthcare and allows the HCP to formulate management plans that match the patient’s values (Hibbard & Greene, 2013; Gorman et al., 2018). The more highly active a patient is, the better the health outcomes have proven to be. Studies investigated by Hibbard and Greene (2013) have shown that high patient activation is associated with better adherence to treatment, more positive
experiences and higher quality of dialogue with HCPs, better understanding of their conditions, more confidence in asking questions and eliciting desired information, and even evidence of improved measurable health biometrics, such as blood pressure and cholesterol ranges. Evidently PCC is an important and necessary aspect of communication in healthcare.

Language barriers literally block this process of PCC from occurring as miscommunication and frustrations make discussion and sharing of decisions extremely challenging (Paternotte et al., 2015; Ahmed et al., 2017). As previously mentioned, when language barriers are involved, HCPs have changed their approach to the patient to a direct and medical approach which results in less input from patients which results in HCPs making decisions for the patients directly infringing on a patient’s autonomy (Deumert, 2010; Bank et al., 2016; Van den Berg, 2016; Ahmed et al., 2017). Interestingly, HCPs in Lukoschek et al (2003) who regarded their communication towards patients as highly effective had a higher number of patients who did not understand what was explained to them by the HCP (Lukoschek et al., 2003).

### 3.6.2.8 Informed Consent

Informed consent means that a patient understands information provided to them regarding the management and treatment of their case and can therefore make informed decisions about their health (Barit, 2017). Participants in this study were able to recognise the complexity that language barriers create in obtaining informed consent from their patients. A patient’s autonomy is an important part of ethical medical practice today with healthcare professionals being seen as facilitators who aid the patients in making their own decisions regarding their health. It is for this reason that the establishment of IC is necessary. Patients need to be given appropriate information about their healthcare, including treatment and procedures that will be pertinent in influencing the decision for giving permission to proceed with the treatment/procedure plan. In this way, IC and PCC go hand in hand allowing the patient an opportunity to make decisions regarding their own healthcare, whilst allowing practitioners to do their jobs ethically and legally (Barit, 2017).

Informed Consent must be given voluntarily by the patient himself, who is capable of consenting. The harms and risks must be acknowledged, understood, and accepted (Barit, 2017). This directs attention to the concept of understanding, a vital requirement of IC. A person cannot give their consent if they have not fully understood what is involved. This points to a serious issue in language barriers between HCPs and patients, in that HCPs cannot be fully confident that the patient understands all the facts presented to him in order to consent to the continuation
of treatment (Parsons et al., 2014). Doyal (2001) goes as far as to suggest that the concept of IC is somewhat of an illusion due to the extreme difficulty in determining that patients understand and remember information provided to them by HCPs. A South African study reported that while 72.5% of HCPs felt that the information they gave in order to inform patients of various aspects of their health was satisfactory, language barriers was listed by 87.5% of HCPs as a major challenge in obtaining informed consent (Chima, 2013).

The concept of autonomy and IC is highly regarded both by the Constitution of South Africa and health legislation. Section 12(2)(b) of the constitution highlights the right to physical and psychological integrity which includes the right to security and control of their own bodies (Constitution of South Africa, 1996). Patients have to be able to take control of, and consent to, what is happening to them as an individual, and anything that may interfere with their individual integrity must be consented to (Barit, 2017). Essentially patients have the right to decide what happens to them both physically and psychologically. If an HCP proceeds with treatment without having provided the patient with sufficient information regarding their health to allow them to make decisions and obtained consent to treat, they may be charged with assault and/or medical negligence (Doyal, 2001; Barit, 2017).

Despite the legal implications for the practitioner not obtaining IC, there are possible implications that directly impact the patient’s health and safety. Among these is the missed opportunity for the patient to be involved in their healthcare, resulting in low-activated patients. Low-activated patients have been shown to be more likely to delay necessary medical care and have unsatisfied medical needs which could result in disastrous consequences, including death (Hibbard & Greene, 2013).

Language barriers cause patients to give consent without fully understanding what they are giving consent for because they trust the HCP to make the correct decisions and they are afraid to say ‘no’ in case the HCP abandons their care (Levin, 2006; Deumert, 2010; Schlemmer & Mash, 2006). This results in patients suffering physically and psychologically due to the unknown implications that result in undesired consequences that they were not aware of and did not consent to, as well as patients developing a mistrust and fear towards HCPs (Lukoschek et al., 2003; Hunter-Adams & Rother, 2017). Some HCPs have indicated that some patients expect them to make the health decisions on the patients behalf, however, this should still be an informed choice made by the patient (Doyal, 2001; Zendedel et al., 2016).
Another challenge for IC in language barriers is lack of terminology for translation. When translating between languages there are not always appropriate ways to explain concepts exactly the same in both languages, which results in words and possibly concepts being changed. This results in difficulties determining what has been explained to the patient and if the patient is fully aware of what they are consenting to (Engelbrecht et al., 2008).

Obtaining IC is so ethically vital that HCPs should make every effort to obtain IC from the patient even in the case of a language barrier (Doyal, 2001). Obtaining IC from a patient with a language barrier, even with the use of an interpreter, can be challenging due to a lack of terminology and complete reliance on the interpreter. One cannot assume that patient truly understands the information relayed to them (Parsons et al., 2014). In terms of using family interpreters it can be risky because of the involvement of personal feelings and differing values resulting in the possibility that certain information has been omitted and/or changed (Parsons et al., 2014). Family interpreters have reported that they leave final decisions up to the patient unless asked for their input. However, some HCPs suspect that the interpreter has more influence on the patient’s decisions than is realised in the way that they direct the interview (Zendedel et al., 2016).

3.6.3 Strategies Employed for Language Barrier Mitigation

3.6.3.1 Interpreters in Healthcare

Participants spoke extensively about their experiences of the use of interpreters in situations where language barriers are encountered. The various roles of their interpreters were described—these interpreters include students, tutors, and family members. Despite the benefit that interpreters have, participants did report difficulties in interpreter use, such as the complete reliance that the HCP has on the interpreter to interpret correctly. Participants also raised ideas of ethical consideration in interpreter use—of particular concern was issues of privacy. The interpreters that most participants reported encountering were informal interpreters with no formal training.

Healthcare providers are not experts in language and therefore interpreters may prove invaluable to the healthcare system by assisting communication between HCPs and patients by reporting what is being said in an exact and accurate way (Spencer, 2016). Interpreters are widely used in SA because of the language barriers faced due to the country’s multilingual nature. South Africa is also largely multicultural and so interpreters are also referred to as ‘cultural brokers’ as they
are expected to mediate between the HCP’s culture and the patient’s culture, as well as balance ideas from their own culture and stereotypes (Engelbrecht et al., 2008; Zendedel et al., 2016).

A professional, or formal, interpreter is one who is trained and able to communicate medical concepts to patients using the correct terminology whilst understanding the ethical and moral implications involved in health (McCarthy et al., 2013). HCPs appreciate the objective approach that professional interpreters are able to provide to the consultation, providing the practitioner with the relevant information they need to know to treat the patient (McCarthy et al., 2013).

While studies have shown that professional interpretation in medical situations is most effective, the costs for a low-income, low-resource country like South Africa is too high and therefore informal interpreters are used more frequently (Benjamin et al., 2016). Informal interpreters are not always qualified but merely able to speak the languages in question which may result in a person unrelated to a patient’s healthcare being involved in a patient’s case (Parsons et al., 2014; Zendedel et al., 2016). Informal interpreters are more cost-effective and are able to identify with the patient socially and culturally. Some HCPs prefer to use family members (even children) as informal interpreters as they are sometimes able to provide more insight into the patient’s condition and lifestyle (Benjamin et al., 2016).

Informal interpreters are not limited to family members but include other staff members such as nurses, cleaners and security guards, and even other patients (Deumert, 2010). These individuals have been left feeling exploited by HCPs who ask them to help interpret over and above their own job responsibilities, particularly nurses (Benjamin et al., 2016).

Reasons HCPs do not use professional interpretation services include cost issues, availability issues, and the time it takes to commit the interpreter to the consultation (Ahmed et al., 2017). In fact, most HCPs don’t use interpretation services despite their necessity due to the costs involved (Li et al., 2017). Healthcare providers have also questioned the reliability and trustworthiness of both the professional and informal interpreters (Ahmed et al., 2017). Healthcare providers feel that sometimes the use of an interpreter causes the consultation to be more challenging and time consuming (Paternotte et al., 2016). Having said this, if interpreters are not used in the case of an encounter with a language barrier care would be impeded (Sobane & Anthonissen, 2013).
a. Role of the Interpreter

Interpreters have multiple roles and have likened their title to that of “health communicators” instead of “interpreters” due to the fact that the role of the interpreter is not limited to simply translating a consultation, but extends to health education, medication education, and mediating concepts between languages and cultures, and in the case of family-interpreters caregiving after the fact (Deumert, 2010; Zendedel et al., 2016). Healthcare providers recognise these additional roles as added benefits especially to using family interpreters, where the family member would be able to be involved in all aspects of the patients’ healthcare continuing after they leave the hospital (Hilder et al., 2017).

While these additional roles add benefit to the healthcare process, the actual role of the interpreter is sometimes confusing as it is not always clearly defined, with interpreters in some instances performing administrative duties, policy translation among other duties (Engelbrecht et al., 2008; Sobane & Anthonissen, 2013). The blurred roles and high expectations on informal interpreters by both the HCP and the patient to communicate effectively may result in conflict and feeling of exploitation for the interpreter (Engelbrecht et al., 2008). These conflicts are highlighted by nurses in Levin (2006) who were unwilling to help HCPs translate and were unwilling to speak to patients in a language different to their own.

In terms of patients understanding the interpreter’s role, there are some disparities where in some cases patients have discussed with the interpreter their opinion about what they feel the patient should do in their current situation (Taylor et al., 2013). Expectations of the HCP and patient may also put the interpreter into compromising situations where they are expected to withhold information from the patient or from the HCP, further causing distress and conflict (Benjamin et al., 2016).

b. Use of Interpreters

Using informal interpreters is more cost-effective and allows patients to feel more comfortable in because of higher levels of trust, which leads to increased patient satisfaction (Deumert, 2010; Ahmed et al., 2017). Informal interpreters tend to take on the role of patient advocate which patients desire and appreciate (Deumert, 2010; Benjamin et al., 2016). Having said this, professional interpreter use has been extensively linked to greater accuracy in consultations and better health outcomes (Deumert, 2010). Patients trust family interpreters more because they perceive that they will be loyal to the patient; conversely HCPs doubt the family interpreter’s
ability to remain honest, neutral and objective, as well as the ability to effectively communicate medical concepts (Zendedel et al., 2016).

Unfortunately use of informal interpreters raises questions of the accuracy of the quality of interpreting, which when compromised may lead to misdiagnosis, issues of informed consent, and diminish effective patient health education (Engelbrecht et al., 2008; Deumert, 2010; Hunter-Adams & Rother, 2017). This is an issue as HCPs, in a situation of language barriers, are completely reliant on the interpreter.

While HCPs using interpreters are not able to understand the words spoken, they are able to pick up discrepancies in the translation process by noting the consultation length and the appropriateness of the responses from the patients in regards to the questions asked by the interpreter (Deumert, 2010). They have also reported an instinctive feeling that the interpretation has not been accurate (Zendedel et al., 2016). It is, however, unlikely that HCPs would be able to detect when omissions and additions are made to the questions and answers, over-simplifications of explanations, and substitutions of content by the interpreter occurs (Engelbrecht et al., 2008; Ahmed et al., 2017).

The most common errors according to Li et al (2017) were omissions and errors in direct translation (Li et al., 2017). Interpreters in Zendedel et al (2016) have admitted to omitting information because they feel it is irrelevant to the case, and feel that they effectively correct any errors that occur during the consultation (Zendedel et al., 2016). Interpreters have also reported to summarising patients words when relaying the information to the HCP (Zendedel et al., 2016).

Informal interpreters are not trained to handle difficult and distressing situations encountered in medical consultations which may cause the interpreter significant emotional distress (Benjamin et al., 2016; Li et al., 2017). Informal interpreters are also not trained in the intricacies of sharing distressing situations with the patients as HCPs are, such as in imparting bad news about a family member or prognosis (Deumert, 2010). Interpreters tend to minimize the seriousness of situations and HCPs worry that they will omit vital information all together (Zendedel et al., 2016; Ahmed et al., 2017).

Family interpreters are easily able to shift the balance of power in consultations in the patients’ favour, which may result in the HCP feeling as if they lack control of the consultation. HCPs try
to mitigate these feelings by involving the patient more by looking directly at them or verifying the answers with them after the interpreter has answered (Zendedel et al., 2016).

c. Use of Children as Interpreters
Due to the immense need for timely communication with patients, HCPs often resort to using children as informal interpreters (Russell et al., 2015). It is unfair to lay the mature responsibility of interpretation of medical consultations onto a child (Li et al., 2017). The use of children as interpreters may result in undue emotional distress, disrupted family dynamics, as well as other issues such as a higher risk of miscommunication and therefore misdiagnosis and mistreatment (Russell et al., 2015; Li et al., 2017).

Children may learn of child-inappropriate content such as financial status, sensitive medical or psychological information of the patient, and distressing news that puts an undue burden on the child. However, this practice is controversial with some claiming that interpretation would enhance the child’s cognitive abilities and also provides the added benefits of additional insight into the patient and prolonged care after leaving the hospital (Russell et al., 2015).

d. Difficulties Encountered in Interpreter Use
Words and concepts are not always able to translate into the exact same meaning in another language which makes accurate translation and interpretation extremely difficult (Engelbrecht et al., 2008; Benjamin et al., 2016). It is important to keep in mind that there may be language barriers between the interpreter and the HCP. Sometimes among patients and interpreters of similar languages there are differences in dialects and backgrounds, which still results in some communication barrier between the interpreter and patient (Van den Berg, 2016; Li et al., 2017). An HCP in Deumert (2010) likened it to a case of “broken telephone” in that the message relayed to the interpreter by the HCP may not be the same message relayed to the patient, and vice versa.

e. Ethical Considerations in Interpreter Use
The use of informal interpreters raises a number of issues including ethical issues of confidentiality, privacy, responsibility (Benjamin et al., 2016). While staff in Deumert (2010) reportedly recognise and understand the ethical implications that the use of informal interpreters may have, they express frustration in that there is no other option but to help the patient the best that they can and therefore make use of informal interpreters.
Healthcare providers in McCarthy *et al* (2013) and Hilder *et al* (2017) reiterated how in some circumstances the use of adult informal interpreters is not only a necessity but also appropriate. There is an ethical and legal responsibility for the HCP to ensure that the fundamental right to privacy is upheld and confidentiality is respected at all times (Nell, 2006). However, despite the use of any signed confidentiality agreements there is no formal responsibility for informal interpreters to uphold these agreements which brings into question whether the HCP or the interpreter would be held accountable for any breaches in confidentiality.

Patients and HCPs have trust in family interpreters that they would not break confidentiality by disclosing personal information (Zendedel *et al*., 2016). However, participants in a study conducted by Hunter-Adam and Rother (2017), particularly women, reported to feeling more vulnerable and dependent when the use of an interpreter is required, leading to feelings that the use of interpreters violates patients’ privacy (Hunter-Adams & Rother, 2017).

Because of the aforementioned possibility of ineffective communication of context and deep understanding of a patient’s words the HCP has no way of knowing whether or not the necessary information has been accurately communicated to the patient which raises ethical concerns of informed consent (Benjamin *et al*., 2016; Zendedel *et al*., 2016).

**f. Training of Interpreters in South Africa**

In South Africa, certification for conference and simultaneous interpreting is available through the South African Translators’ Institute but there is no specific programme for community and/or health interpreting despite the vast literature motivating the desire and need for interpretation in community settings (Benjamin *et al*., 2016). Furthermore, there are no guidelines and/or systems in place outlining the use of interpreters in South Africa (Deumert, 2010; Hunter-Adams & Rother, 2017).
3.6.3.2 Other Strategies

Participants reported using a multitude of strategies to try and mitigate the language barrier between themselves and their patients. Besides interpreter use, these include learning the language, and smaller strategies such as adaptation of questioning, slowing down and simplifying language, and using visual aid such as gestures to help enhance understanding. In other studies, other strategies that mirror those reported by participants and have been suggested and attempted as well in order to make communication more effective and mitigate the effects of ineffective communication.

Some studies such as Deumert (2010), Levin (2011), and Van den Berg (2016) propose that HCPs learn a new language, which is a solution that HCPs have expressed interest in. This would completely eliminate the issue of ineffective communication with patients; however it is challenging and time-consuming to master a new language and inadequate language acquisition itself would still lead to miscommunication issues.

Although Levin (2011) showed positive results in communication between HCPs and patients after HCPs learned the patients’ language, communication between HCPs and interpreters was less effective after the intervention possibly due to increased detection of errors during the consultation. Taylor et al (2013) suggests encouraging and empowering patients to learn how to speak English so that they can communicate with HCPs, however, just as patients, HCPs speak a wide variety of languages.

The possible use of interpretation services over the telephone has been proposed. This would eliminate issues of availability and time lost in trying to organise the presence of an interpreter. However, issues such as patients who are hard-of-hearing may find it difficult to consult in this way, the intricacies of body language and facial expression are important to conveying messages to one another and lost over the phone, and some patients may find it uncomfortable (Van den Berg, 2016; Ahmed et al., 2017).

Healthcare providers emphasised the importance of non-verbal communication, such as gestures, e.g. pointing to the location of the pain, and facial expressions. However, often patient experiences are too complex to explain without words, especially in the case of psychiatric complaints (McCarthy et al., 2013; Sobane & Anthonissen, 2013; Li et al., 2017).
Continuously checking if the patient understands by asking the patient to repeat in their own words, or demonstrating understanding and answering open-questions is proposed a strategy that is more effective when used by interpreters (Lukoschek et al., 2003; Sobane & Anthonissen, 2013; Parsons et al., 2014; Bank et al., 2016; Li et al., 2017).

Visual aids such as drawings may help physicians explain the location and description of the problem, but it doesn’t seem to help the HCP understand what the patient is experiencing (Lukoschek et al., 2003; Sobane & Anthonissen, 2013).

Printed materials in the language of patients in the form of booklets, pamphlets and posters in order to provide patients with certain medical information would bridge the gap between information and language barriers. However, this approach highlights another significant challenge faced in South Africa—illiteracy. Printed materials may not answer all patients’ questions, and the cost of printing is high (Sobane & Anthonissen, 2013).

Other strategies include code-switching, which is when the HCP uses a few keywords from the patients’ language to communicate, and providing a supportive and empathetic atmosphere for the patient to encourage the patient to clarify when they do not understand (Lukoschek et al., 2003; Benjamin et al., 2016).

3.6.4 Impact of Multiculturalism in Healthcare

Culture is a pattern comprised of shared ideas, customs and behaviours in a particular group of people that influences their knowledge, attitudes and behaviours in life (Oxford Dictionary of English Online, 2010a; Paternotte et al., 2015). Because patients have varying backgrounds, ethnicities, languages and cultures, many HCPs feel incompetent in their ability to communicate with these patients (Paternotte et al., 2015).

Language is at the core of culture, and therefore one cannot speak of language without speaking of culture (Engelbrecht et al., 2008; Parsons et al., 2014; Van den Berg, 2016). Thus, difficulty understanding one’s language would also result in difficulty understanding one’s culture (Govender et al., 2017). However learning a language does not mean that one has learned what there is about a particular culture. Different cultures may use different languages, or dialects of that language (Schyve, 2007). Different cultures employ different meanings to words spoken, and many have certain expressions and cultural metaphors unique to their culture which may not translate easily into a different culture’s language (Engelbrecht et al., 2008; Ahmed et al., 2017).
Differences in the delivery and reception of concepts and phrases, by both HCP and patient, is also influenced by culture (Schyve, 2007; McCarthy et al., 2013; Taylor et al., 2013). While participants in Paternotte et al (2016) considered cultural barriers as significant, they did not feel that they were as important as language barriers.

Cultural differences may account for some of the barriers to obtaining effective healthcare in South Africa due to its cultural history and resultant rich diversity of cultures (Levin, 2006; Almutairi, 2015). Intercultural-communication (ICC) simply refers to the communication between two parties of different cultures, in this case, between an HCP and patient of different cultures (Bank et al., 2016). Intercultural-communication is a patient-centred approach whereby the HCP is acknowledging the individual patients wished in line with their culture (Bank et al., 2016). Understanding what a patient’s expectations of the outcomes of the consultation is also important so as to ensure that the patient gets what they need and is satisfied with their care (Paternotte et al., 2015; Bank et al., 2016).

Understanding the role a patient’s culture plays in their lives allows practitioners to improve their communication with patients regarding various aspects of the healthcare process, for example giving appropriate support to the family when a patient has died (Russell et al., 2015). An important concept in multicultural South Africa is that of ‘cultural competence’, whereby professionals and organisations are governed by a set of behaviours, considerations, and policies that allow effective communication amongst different cultures to occur (Levin, 2011; Ashkinazy, 2017; Govender et al., 2017). Being aware of and understanding one’s own cultural identity, referred to as ‘cultural awareness’, as well as those around us is difficult as cultures are diverse, changing, and largely individual (Paternotte et al., 2015; Ahmed et al., 2017; Govender et al., 2017). When an HCP lacks cultural awareness effective communication with patients of varying cultures is negatively influenced (Ahmed et al., 2017). It is for this reason that HCPs must commit themselves to learning about cultural beliefs and applying these beliefs to practice. This is referred to as ‘cultural humility’ (Ashkinazy, 2017).

Understanding cultures doesn’t make an HCP culturally competent, but rather cultural competence comes from the ability to adapt to the varying cultural situations encountered (Paternotte et al., 2015). It has been suggested that training HCPs about different cultures may increase the risk of stereotyping and a counter-suggestion is to instead train HCPs in how to appropriately handle the different cultural situations encountered (Paternotte et al. 2016). Results
from Almutairi (2015) showed that HCPs display a lack of knowledge of their Muslim patients’ practices and beliefs, such as disallowed foods and ideas about breastfeeding (Almutairi, 2015).

3.6.4.1 Results of Cultural Miscommunication

Cultural differences in beliefs, values, ideas and practices may result in barriers in effective communication (Parsons et al., 2014; Li et al., 2017). Cultural miscommunications in healthcare may result in negative consequences, including lower quality care, patient dissatisfaction, and even death (Almutairi, 2015; Paternotte et al., 2015; Russell et al., 2015; Bank et al., 2016; Matthews and Diab, 2016). Patients often have differing explanations for the origins of disease that are strongly influenced by cultural models, which may make diagnosis and treatment challenging (Van den Berg, 2016).

Cultures may, for example, have differing ideas of power dynamics in a consultation and therefore be less likely to ask questions to HCPs regarding their health concerns (Li et al., 2017). Power dynamics are affected by culture in that great respect is placed on that of the HCPs position resulting in miscommunication due to patients’ beliefs that they are in no position to question the HCP and respond only when spoken to. This is common in non-Western cultures (Schlemmer & Mash, 2006; Ahmed et al., 2017; Li et al., 2017).

Despite the risk of miscommunication, HCPs ignorance of a patient’s culture may result in the patient feeling uncomfortable and/or offended by the HCP’s action. This may further cause a barrier between the HCP and patient and may result in dissatisfaction with care and negative outcomes (Li et al., 2017).

Examples of different cultural practices in South Africa include the use of ‘Sangomas’, or traditional healers (which much of the population makes use of), tying a rope around the belly for protection (which patients find unacceptable should an HCP want to cut it, even when it’s too tight), and issues of who is most appropriate to discuss decisions and disturbing news with first (Schlemmer & Mash, 2006; Taylor et al., 2013; Zendedel et al., 2016).

Healthcare providers must display cultural awareness in order to show respect and understanding of their patient in order to improve the healthcare outcomes (Paternotte et al., 2015; Bank et al., 2016). For example, ensuring that the prescription proposed by the HCP is acceptable and possible for the patient would display cultural awareness and humility (Bank et al., 2016). The HCP and patient have differing views of the world and health in line with their cultures, so when
the two parties are able to bridge this gap it results in improved diagnoses, improved adherence to and less misuse of treatment, less complications and improved patient satisfaction (Engelbrecht et al., 2008; Almutairi, 2015).

3.6.5 Decolonisation
Decolonisation is a call to appreciate the relevance of African ideas, concepts, behaviours, lifestyles and cultures in African context and continuously build on improving and integrating our knowledge. Decolonisation involves a complex concept of attempting to undo the effects of imposed power of a colonial past. A colonial influence affects not only the land but the minds, thoughts, and behaviours of the populations within it. Decolonisation can be viewed as an important process for a country to undertake in order for its population to gain back their sense of independence and rightful autonomous stance, while acknowledging that colonisation is already entwined within the lives of the majority of the people in that country. Wolff (2016) argues that colonial influences need not be used as instruments of oppression but rather to our advantage. In SA integrating the concept of speaking English and another widely spoken official language would allow for deeper and more meaningful encounters in everyday life as well as in a healthcare setting. This would empower both the HCP and the patient in order to give and receive the best possible healthcare (Illing & Sloan, 2016; Le Grange, 2016; Petersen & De Beer, 2016; Wolff, 2016).

3.6.6 Homoeopathy
Participants took their opinions a step further by describing the effects that language barriers have not only in aspects of the healthcare process, but also the effects that language barriers have in the various aspects of the healthcare process in a homoeopathic context. Participants described how language barriers affect the complexities of homoeopathic healthcare delivery in terms of taking a case history, performing physical examinations, and the unique treatment and management of a case.

Homoeopathy is a therapeutic system of medicine which is governed by the principle *similia similibus curentur*, or *like cures like*. This principle encompasses the idea that a substance that would cause certain symptoms in a healthy individual would cure those symptoms in diluted form in an unhealthy individual. The word Homoeopathy itself comes from the Greek words ‘homeos’ and ‘pathos’, meaning ‘similar suffering’. This principle was suggested by a few influential physicians of their time, including Paracelsus, referred to as “the Luther of Medicine” who suggested that any poisons in the body would be cured by a poison that is similar if the
dosage was correct (Borzelleca, 2000). Dr Samuel Hahnemann reignited the Law of Similars in the 1790s when he experimented with this idea and found it to be true. This discovery would set the stage for Hahnemann’s life long investigation into Homoeopathy, curing with similar substances (De Schepper, 2001; Homoeopathic Association of South Africa, 2016a).

Hahnemann also suggested the revolutionary idea that the mind and the body cannot be separated, that is, a person, the whole, is greater than the sum of its parts. Homoeopathy approaches this idea by treating holistically, taking into consideration the patient’s lifestyle, as well as the physical, mental, and emotional aspects of the patient’s wellbeing for the treatment and management of the case. This individualisation is an approach that is unique and allows the Homoeopathic Practitioner (HP) to treat individuals on all levels of wellbeing in order to cure and annihilate disease (European Committee for Homeopathy, ca. 2017).

The Vital Force (VF) is the animating energy that gives a physical body animated life, this idea is called Vitalism. The VF is the self-sustaining energy that maintains harmony and balance, or homeostasis, in the body. In Homoeopathy it is believed that a deranged VF is the reason a person would fall ill and thus the source of symptoms. Homoeopathic remedies work on the same energetic and dynamic levels as the VF to stimulate the VF into orchestrating a ‘healing cascade’ that will allow it to cure the disease (Bell et al., 2004; Hahnemann, 2011).

3.6.6.1 Homoeopathy in South Africa
As discussed in Chapter 1, Homoeopathy was first brought to South Africa in the 1820s by European missionaries. Despite its turbulent past Homoeopathy is an established part of the primary healthcare system in South Africa today. All qualified HPs must register with the AHPCSA in order to legally practice as a homoeopathic doctor in South Africa (Gower, 2013).

The AHPCSA requires that a registering person has completed the full-time five-year Master’s degree in Homoeopathy from University of Johannesburg or Durban University of Technology, or has an equivalent degree. The five-year M Tech course offered is extensive and medico-scientific in nature (Gower, 2013; Homoeopathic Association of South Africa, 2016b). During their coursework, students are expected to learn and be tested on a wide variety of subjects, including the basic sciences, clinical and classical applications in Homoeopathy, Homoeopharmaceutics, and medical diagnostics. A more extensive description of the curriculum offered to students at the University of Johannesburg is highlighted in Table 1.1 (University of Johannesburg, n.d.)
While the five-year coursework prepares students to fulfil their scope as Homoeopaths, a note of significance for this research is that there is no formal training in African languages or cultures offered in any modules in any of the academic years despite the diverse demographic of patients visiting the Homoeopathy Health Training Centre at UJ.

### 3.6.7 Homoeopathic Consultation Process

A Homoeopathic consultation in South Africa is medical at its core and involves a case history, physical examination, further examination (special investigation), treatment and management of the case (De Schepper, 2001).

#### 3.6.7.1 Case History

Participants described how obtaining the intricacies required by a homoeopath during the case history is made more difficult by language barriers. Case history is the first part of the consultation and can be up to approximately one hour long. It involves asking questions regarding the main complaint and relevant family, personal and past medical history that will allow the practitioner to think of a preliminary diagnosis and possible differential diagnoses. It will also allow the practitioner to manage the case in terms of prognosis, lifestyle and dietary advice, and special investigation. Patients will then be asked questions that elicit more information about who they are as an individual, which include energy levels, mental and emotional states of mind and appetite. These questions keep in line with the individualistic element unique to Homoeopathy and allows the Homoeopathic practitioner to holistically match a remedy to the mental, emotional and physical aspects of a patient (De Schepper, 2001).

Some literature has suggested that the Homoeopathic consultation may play a major role in positive therapeutic outcomes for patients (Eyles et al., 2012; Johannes et al., 2013; Levy et al., 2014). This may be due to the fact that Homoeopaths tend to conduct consultations in such a manner that aligns with what patients place in high regard- such as empathy, individualisation and the ability to express their concerns in-depth.

Central to the success of these consultations is effective communication between the HP and the patient. A Homoeopathic consultation relies heavily on a patients experience and accurate description of the complaint. It is the HPs job to understand the complexities and deeper meaning of a patient’s narrative. Accuracy is inherent to the consultation and should there be a diminished proficiency of communication between HP and patient then difficulty would arise in
the establishment of accurate and expressive information from the patient to be used throughout the Homoeopathic consultation process (Eyles et al., 2012).

As previously explained IC is a vital concept to be established at any point during the medical process so that the patient is able to make informed decisions about their health. Just as in all medical processes IC is also required to be established in the Homoeopathic consultation, which is also medical in nature. And just as in any medical process, if a patient is unable to understand the concept of informed consent negative medical and legal implications may result (Lukoschek et al., 2003).

3.6.7.2 Physical Examination

A physical examination is performed after necessary information has been obtained from the patient during the case history. This includes taking a patient’s vital signs, i.e. blood pressure, pulse, respiratory rate, and temperature, and thereafter performing any other physical clinical examinations that may be relevant to the patient’s presenting complaint. The findings are recorded and results may contribute to diagnosis and differential diagnosis, and/or warrant further investigation (Bickley et al., 2013).

While observation is a major part of physical examination much of the physical examination is guided by verbal and non-verbal responses from the patients (Boodman, 2014; Henderson, 2014). Homoeopathic practitioners need to be able to understand what a patient is experiencing while the physical examinations are being performed. Often, the HP will ask a patient to let them know when something is painful, for example, during palpation of the abdomen. The patient needs to be able to articulately express any experience, such as discomfort, at any point of the physical examination process and answer the practitioner’s questions accurately. If the patient is unable to communicate to the practitioner what they are experiencing the HCP may overlook, misinterpret, or completely miss an important and valuable symptom (Verghese & Ioannidis, 2017).

The HP needs to be able to explain to the patient what is required of them during the physical examination, and give appropriate instruction to allow for the most accurate results. If communication is lacking and the patient does not understand what is required of them physical examination may become extremely difficult and frustrating and possibly yield little useful information (Verghese & Ioannidis, 2017).
3.6.7.3 Treatment and Management

According to participants, language barriers make obtaining vital information difficult and how the lack of detail obtained leads to difficulties in choosing remedies and explaining to the patient how to administer the remedies. Taking into account the information and findings from the case taking and physical examination, the HP will then choose an appropriate treatment and management plan for the patient. This may include any medication within the Homoeopathic scope, dietary and lifestyle advice, special investigations and referrals- which participants in this study felt was made more difficult by language barriers.

‘Docere’ is a Latin word that means ‘to teach’ and is the origin of the word ‘doctor’ It is a healthcare physician’s, or medical doctor’s, major role to educate the patient on their condition and how to manage their condition through lifestyle and dietary changes, for example (Kinnear, 2005). In complementary and alternative therapies, such as in Homoeopathy, emphasis is placed on empowering the patient to take control of their own bodies and conditions in order for a well-orchestrated healing plan to be made both by the HP and patient together- which is an important part of true healing. The patient needs to understand what their responsibility is in the healing process and take action with the education and guidance of their HCP (Willis & Rayner, 2013).

Patient-centred healthcare is important to help the patient make informed decisions regarding their own health; however barriers in communication inhibit patients from feeling confident in making decisions about their health (Paternotte et al., 2015; Lukoschek et al., 2003).

Instructions for medication use is vital and when a patient does not comprehend these instructions negative effects may be noted, including adherence issues, unwanted side effects (Paternotte et al., 2015; Matthews and Diab, 2016; Lukoschek et al., 2003). The expectations of healthcare providers regarding the process of healing must be understood by patients so that they are empowered with the knowledge of what they should expect and recognise any deviations from this course to avoid dire consequences. Clear communication in this regard is especially important in Homoeopathy because of the aforementioned emphasis on the individual, who heals in their own unique way (De Schepper, 2001).

3.6.8 Related Research

Systematic reviews conducted by Paternotte et al. (2015) and Ahmed et al. (2017) concluded that language barriers proved challenging to both patients and HCPs and recommend that effective solutions in training HCPs in effective communication is needed. Two other studies in
which individual interviews were conducted on HCPs showed that HCPs need greater support and education in handling language barriers as they felt their lack of skill showed incompetence and an inability to accurately judge if information collected under these circumstances was sufficient (Parsons et al., 2014; Skjeggestad et al., 2017).

A South African study showed by use of questionnaires, individual interviews, and observation, that HCPs are unsatisfied with the language barriers they encounter and wish to learn their patients’ languages. The study further suggests the implementation of professional interpreter services in South African hospitals to negate the language barriers experienced and the subsequent effects (Deumert, 2010).

Another South African study showed that language barriers in healthcare may result in misunderstandings during case management as well as legal and ethical implications when making use of informal interpreters. This study suggests implementation of professional interpreter services and for language courses relevant to the particular region to be implemented for HCPs (Engelbrecht et al., 2008).

3.7 BRACKETING, REFLEXIVITY AND OBSERVATIONS

The term “bracketing” refers to the method employed by qualitative researchers whereby the researcher’s own experiences, ideas and opinions are suspended before and during the qualitative investigation. The purpose of this is to avoid contamination of data and results with the researchers own opinions in order to produce a true representation of the phenomenon under investigation (Creswell, 2007; Chan et al., 2013).

I am a Homoeopathy student at the University of Johannesburg and had seen patients for half a year when the idea for the topic came about. It came out of my own frustrations of seeing patients and not being able to communicate with them effectively. This experience was mentioned in passing by some of my colleagues and that made me realize that this may be a bigger problem than I had realised. A respected lecturer once made the comment regarding a language course that “change must come from the students”. With that I decided to turn this topic into a research study to see if that change truly is something the students would want.

Due to the qualitative and phenomenological nature of this study I needed to bracket my own experiences with language barriers and my ideas of how it has affected my delivery of healthcare
in order to get a true and honest representation of how the majority of students felt. The importance of this was highlighted to me in my pilot study where I found it difficult to keep my opinions to myself and would often verbally or visually, with nods and affirmations, agree with the participant. I realized upon critical reflection from that pilot interview that I would need to make a conscious effort to put my own experiences aside and take in fully what the participant had to say. I kept this in mind for the remainder of my study and constantly worked to improve my interview skills throughout the interview process by critically reflecting on and evaluating my own performance after each interview.

During the interviews participants were encouraged to speak openly and freely about their experiences. Although I did find myself agreeing with participants with nods and affirmations, I tried to be equally as enthusiastic when the participant expressed opinions I was not familiar with. I believe that my efforts were successful as I gained a lot of rich information from the participants, some that I had not even considered before and some that I may not have agreed with.

During the coding process I was able to look at lines of data objectively and code most appropriately without my own opinions clouding the coding process. During analysis I was able to look at what the participants had said without imposing my own ideas onto the data. This objectivity was further enhanced by an external analyst who was able to verify the motifs of various decisions made during the process as being appropriate (Appendix A). Further to this, a focus group of 6 participants was conducted and the results confirmed as being most representative of the experiences.

While I am passionate about this topic I feel that every effort was made to be as objective and as fair-minded possible and that my enthusiasm and excitement did not influence the outcomes of the study.

For the most part, participants were more than willing to partake in my study and showed a keenness to talk about experiences they have had. Some participants expressed that they felt nervous that they would not be able to answer my questions and felt nervous about being recorded, but after gentle encouragement and further explanation of my process the participants all relaxed and embraced being interviewed.
3.8 CHAPTER THREE SUMMARY

In Chapter 3, the themes, categories and subcategories that emerged from data analysis were presented and discussed. A literature control followed highlighting the influence of language barriers general in healthcare, as well as language barriers in Homoeopathy-specific healthcare. In Chapter 4, the researcher will present suggested guidelines in dealing with the language barrier, recommendations, limitations and conclusions to the study.
CHAPTER 4
CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In Chapter 4 the researcher’s conclusions are presented. Limitations of the study are identified and recommendations for future studies as well as homoeopathy students and the homoeopathic syllabus are suggested.

4.2 CONCLUSIONS

South Africa is a multi-lingual society therefore it is highly likely that healthcare providers will encounter patients who speak a different language to them at varying proficiencies. Homoeopathy students at the University of Johannesburg are no exception to this and encounter patients with a variety of different languages and proficiencies. There is no language component to the syllabus in any of the homoeopathic students’ five years of study. Effectively handling the language barriers encountered provides benefit to the practitioner and the patient in terms of a more effective healthcare encounter. Understanding the experiences of the homoeopathy students in terms of language barrier and its influence on healthcare delivery enables us to understand the extent of this influence and provide guidance in more effectively handling language barriers in practice. The purpose of this study was to explore and describe experiences of language barriers in the delivery of healthcare by homoeopathy students, and to provide guidance towards overcoming language barriers in homoeopathic practice.

The objectives of the study were as follows:

- Objective 1: To explore participants’ experiences of language barriers in the delivery of healthcare by conducting individual interviews.
- Objective 2: To describe the experiences collected in order to compile themes that are representative of the experiences of the complete sample group.
- Objective 3: To provide guidance in overcoming language barriers in homoeopathic practice.

Each objective is discussed below.
4.2.1 Objective 1: Explore participants’ experiences of language barriers in the delivery of healthcare by conducting individual interviews.

This was achieved by conducting a study that was qualitative in design with a phenomenological approach. A phenomenological approach was most appropriate as it allowed for exploration into the experiences of multiple participants regarding a particular phenomenon and condensing what multiple participants were experiencing into a describable concept. Individual interviews were conducted which allowed the researcher to gather information regarding each participant’s experience of the phenomenon under scrutiny, namely language barriers in the delivery of healthcare.

4.2.2 Objective 2: To describe the experiences collected in order to compile themes that are representative of the experiences of the complete sample group.

This was achieved through extensive analysis of the data and is discussed in detail in Chapter 2. The researcher analysed lines of data from transcripts thereafter coding, categorising, and finally producing four overarching themes that are representative of the experiences of the complete sample group. The themes were presented to a focus group and were verified as being representative of their experiences. The process and themes were further verified by an external analyst. These themes are discussed in detail in Chapter 3.

Students find language barriers challenging resulting in negative effects on the various aspects of the healthcare process, as well as on the practitioner’s personal feelings and the patient-practitioner relationship. Students employ certain strategies in an attempt to mitigate the negative effect of the language barrier in the delivery of healthcare.

• **Theme 1: Language barriers create challenges in understanding**
Theme one describes how homoeopathy students described language barriers between themselves and patients as challenging. This challenge is both in terms of the practitioner understanding the patient, and the patient understanding the practitioner. Participants gave special mention to the challenges they face when encountering children with a language barrier present.

• **Theme 2: Intrapersonal and interpersonal effects associated with language barriers**
Language barriers result in the students experiencing negative feelings which include frustration, feelings of inadequacy, as well as feelings of insecurity and uncertainty. The relationship
between the practitioner and the patient, the rapport, is also compromised as there is limited opportunity for the parties to effectively connect and establish a sound relationship.

• **Theme 3: Language barriers’ influence on the various aspects of the healthcare process**

The healthcare process consists of many components which include, the consultation, performing physical examination, formulating a diagnosis, prescribing a homoeopathic prescription, formulating a treatment plan and assessing patient outcomes. Language barriers make obtaining information difficult. This information is critical to each step of the healthcare process and dictates the progression of the case. Overall, language barriers make it challenging to move through each component effectively and with confidence.

An important component of homoeopathic treatment is the implementation of homoeopathic philosophy. Homoeopaths follow the philosophies set out by Dr Samuel Hahnemann in the Organon of Medicine (Hahnemann, 2011). One of these philosophies is the concept of individualisation. Individualisation involves treating a patient based on their own experiences of their disease. Language barriers make it challenging to obtain this individualised information and therefore implementation of the philosophy is compromised.

A medical consultation is a delicate interplay between the practitioner and the patient and it is what allows the consultation to run smoothly and successfully. Language barriers result in disruption of this smooth and successful process. Language barriers result in the various reasons cited for this disruption, such as a skewed shift in power dynamics, an effect on the timing of a case, and the practitioner’s focus during the consultation.

Language barriers also result in ethical dilemmas for the practitioner. The practitioner is forced to make decisions for the best interest of the patient that may be in direct conflict with medical ethics. One such ethical concept is that of informed consent. Language barriers cause difficulty in ensuring that the patient is well-enough informed to give their consent. The practitioner has to decide on behalf of the patient whether or not to proceed.

Despite language barriers encountered by the participants, they still felt that their patients benefited from the treatment they provide.
• **Theme 4: The mitigation of language barriers through various strategies**

Participants described the various strategies that are employed by them in order to mitigate the effects of the language barriers they encounter. The use of interpreters was extensively discussed in terms of their usefulness and effects that they themselves may have on a consultation. Overall, participants felt that interpreters were useful and helped mitigate language barriers successfully most of the time. Participants felt that language acquisition would be beneficial to healthcare delivery and despite some potential issues, introduction of a language course should be considered. Other strategies were also discussed including adaptation of questions, simplification of language, frequent “check-ins” with the patient, code switching, visual observations, patience, abandoning questioning and referral.

**4.2.3 Objective 3: To make suggestions based on the emergent data that would provide guidance in overcoming language barriers in homoeopathic practice.**

The first step to overcoming language barriers is being aware of their existence and the influence that they have on the delivery of healthcare. This influence is clearly stated in the discussion of results in Chapter 3. This objective is further achieved and is discussed below in recommendations of this chapter, Chapter 4, whereby suggestion is provided under recommendations for homoeopathy students and recommendations for homoeopathic syllabus. Homoeopathy students would be able to read the results that emerged under theme 4 “The mitigation of language barriers through various strategies” and apply those strategies in overcoming a language barrier when it is encountered in their consults. However, overcoming language barriers goes further than being aware of their existence and applying tried and tested strategies that would help mitigate their effect. The most effective way of mitigating language barriers is to learn the language itself. While this may prove difficult it is suggested that the Department of Homoeopathy consider introducing a basic language course into the syllabus at the first level of study so that students will be able to apply their language skills in practice with the patients they encounter.

**4.3 LIMITATIONS**

The purpose of this study was to explore and describe experiences of language barriers in the delivery of healthcare by homoeopathic practitioners, and provide guidance towards overcoming language barriers in homoeopathic practice. This was achieved though certain limitations to the study were encountered and identified.
The researcher was required to conduct individual interviews until data saturation was reached. The researcher was inexperienced in this regard, and therefore interviews may have been better conducted if the researcher was better experienced. The researcher conducted a pilot interview and from that was able to learn and adjust her interview technique. The researcher also performed a critical reflection of the interview process after each interview therefore continually improving her interview skills. Despite this limitation rich information was collected from participants and data saturation was reached.

The researcher was required to analyse data making use of coding, categorisation, and identifying representative themes. The researcher was inexperienced in this regard and codes and resultant categories and themes are based on the researcher’s interpretation of the data. However, the researcher attended an introductory training session and a two-day intensive training session on Atlas.ti 8 use which further enhanced her qualitative research skills. The researcher kept analytic memos throughout the process in order to motivate and explain coding, categorisation, and theme decisions with the purpose of remaining transparent. The researcher also sought verification of analysis by an experienced qualitative researcher who was able to confirm data saturation and verify accuracy of the process. Therefore, despite this limitation the researcher is confident that the results are an accurate representation of the experiences described by participants.

The researcher conducted individual interviews in English. However, fifty percent of the sample spoke English only as an additional language. This posed some difficulties in conducting the interview as some of the participants in this category did not always accurately understand the questions posed to them and did not always answer the questions in a way that demonstrated understanding of the questions. The interviewer attempted to overcome this by being patient with the participants, adapting the questions by making them simpler and asking them in a variety of different ways, and always ensuring that questioning not be rigid so as to allow adequate opportunity for the participant to express their opinions fully.

4.4 RECOMMENDATIONS

4.4.1 Recommendations for Homoeopathy Students
Homoeopathy students should be aware of the role that language barriers play in the various aspects of the delivery of healthcare and the healthcare process. Students should strive to obtain the most accurate information possible from their patients in order to provide effective healthcare
despite the language barriers they encounter. There are many strategies tried by the participants that are highlighted in this study that other homoeopathy students can employ to mitigate the language barrier. It is recommended that students practice with mindfulness of the language barrier and employ the various techniques in order to allow them to gain the most from their healthcare encounters.

4.4.2 Recommendations for Homoeopathic Syllabus
Language barriers clearly influence the healthcare that is delivered to patients. The most powerful way of mitigating language barriers is through language acquisition. While some participants expressed valid concerns of introducing a language course to the syllabus, one hundred percent of participants felt that basic language acquisition would be beneficial to their practice. It is recommended that the Department of Homoeopathy seriously consider the possibility of introducing a basic language course into the syllabus. This course should cover the basics of select languages, such as isiZulu, and be introduced from the first year of study.

4.4.3 Recommendations for Future Researchers
The language barrier posed some difficulty between the researcher and the participant. Therefore it is recommended that future researchers employ the help of an interpreter to assist during the interview process.

It is also recommended that future researchers consider the following topics that lend well to this topic:
• The students’ experiences of religion in the delivery of healthcare
• The students’ experiences of cultural barriers in the delivery of healthcare
• The students’ experiences of language-related barriers in the delivery of healthcare

4.5 CHAPTER FOUR SUMMARY
In Chapter 4 the researcher’s conclusions were presented. Limitations of the study were identified and recommendations for future studies as well as homoeopathy students and the homoeopathic syllabus were suggested.
REFERENCES


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APPENDIX A

Data Analysis Verification Certificate

QUALITATIVE DATA ANALYSES

CERTIFICATE OF VERIFICATION

For

Lorna Blackwell
Mtech: Homeopathy

For the study

Homeopathy Masters’ students at the University of Johannesburg experience of language barriers in the delivery of healthcare

This is to certify that

Dr EM Solomon has analysed the data from 10 interviews and confirms that there is consensus with the codes and themes as presented by Lorna Blackwell. Data saturation was achieved as evidenced by repeated themes.

The data forwarded for analysis was void of any identifying information and therefore no ethical considerations were violated as the result of the verification process

Dr E.M. Solomon (DTrch Hom. UJ)
5th September 2018
Dear Dr Tsele-Tebakang / Dr Razlog

I am doing a research study on the experiences of language barriers in healthcare provided to patients by Homoeopathy Master’s students. The students in the clinics see many patients with varying languages and language proficiencies. My goal is to explore the experiences on language barriers of the Homoeopathy students in contact with the patients.

I would like to request your permission to interview all registered Homoeopathy Master’s students of the years 2016 to 2018.

[For Dr Tsele-Tebakang] If permission is granted, please would you email the relevant potential participants on my behalf.

Kindest regards
Lorna Blackwell

I hereby give permission to the abovementioned student to interview all Homoeopathy Master’s students of years 2016-2018

___________________ Head Clinician (UJ) Dr Tsele-Tebakang
Signature

___________________ Head of Department (UJ) Dr Razlog
Signature
Dear [Name of Potential Participant],

My name is Lorna Blackwell. I WOULD LIKE TO INVITE YOU TO PARTICIPATE in a research study on the experiences of language barriers in healthcare provided to your patients.

I am interviewing all registered Homoeopathy Master’s students of the years 2016 to 2018. I have chosen you because I think you will be able to give valuable insight into your experiences of working with patients of different languages and cultures.

If you would like to participate please contact me using the contact details below so that we can set up an appointment at your convenience for your interview.

Cell: 083 437 7468
Email: Lornab.homeo@gmail.com

Kindest regards,
Lorna Blackwell
Good Day

My name is Lorna Blackwell. I WOULD LIKE TO INVITE YOU TO PARTICIPATE in a research study on your experiences on language barriers in the healthcare you provide to your patients.

Before you decide on whether to participate, I would like to explain to you why the research is being done and what it will involve for you. I will go through the information sheet with you and answer any questions you have. This should take about 10 minutes. The study is part of a research project being completed as a requirement for a partial Master’s Degree in Homoeopathy through the University of Johannesburg.

THE PURPOSE OF THIS STUDY is to explore the experiences of language barriers in the healthcare that Homoeopathy students at the University of Johannesburg provide to their patients.

Below, I have compiled a set of questions and answers that I believe will assist you in understanding the relevant details of participation in this research study. Please read through these. If you have any further questions I will be happy to answer them for you.

Participant initials:__________
DO I HAVE TO TAKE PART? No, you don’t have to. It is up to you to decide to participate in the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form.

WHAT EXACTLY WILL I BE EXPECTED TO DO IF I AGREE TO PARTICIPATE? Once you have consented to an audio-recorded interview with me, you will be expected to have one interview, answering my research question regarding your experiences truthfully. The interview will last between 30 minutes and 1 hour depending on how much information you provide.

WHAT WILL HAPPEN IF I WANT TO WITHDRAW FROM THE STUDY? If you decide to participate, you are free to withdraw your consent at any time without giving a reason and without any consequences. If you wish to withdraw your consent, you must inform me as soon as possible.

IF I CHOOSE TO PARTICIPATE, WILL THERE BE ANY EXPENSES FOR ME, OR PAYMENT DUE TO ME: You will not be paid to participate in this study and you will not bear any expenses.

RISKS INVOLVED IN PARTICIPATION: There are no anticipated risks involved with your participation in this study.

WILL MY PARTICIPATION IN THIS STUDY BE KEPT CONFIDENTIAL? Yes. Transcripts and recordings will be given a unique code in place of your name. All data and back-ups thereof will be kept in password protected folders and/or locked away as applicable. Only I or my research supervisor will be authorised to use and/or disclose your anonymised information in connection with this research study. Any other person wishing to work with your anonymised information as part of the research process (e.g. an independent data coder) will be required to sign a confidentiality agreement before being allowed to do so.

WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY? The results will be written into a research report that will be assessed. In some cases, results may also be published in a scientific journal. In either case, you will not be identifiable in any documents, reports or publications. You will be given access to the study results if you would like to see
them, by contacting me. All data will be destroyed after 2 years after the study has been published.

**WHO IS ORGANISING AND FUNDING THE STUDY?** The study is being organised by me, under the guidance of my research supervisor at the Department of Homoeopathy in the University of Johannesburg. The study is funded by the Supervisor-linked bursary from the University of Johannesburg.

**WHO HAS REVIEWED AND APPROVED THIS STUDY?** Before this study was allowed to start, it was reviewed in order to protect your interests. This review was done first by the Department of Homoeopathy, and then secondly by the Faculty of Health Sciences Research Ethics Committee at the University of Johannesburg. In all cases, the study was approved.

**WHAT IF THERE IS A PROBLEM?** If you have any concerns or complaints about this research study, its procedures or risks and benefits, you should ask me. You may contact me at any time if you feel you have any concerns about being a part of this study. My contact details are:

Lorna Blackwell  
083 437 7468  
Lornab.homeo@gmail.com

You may also contact my research supervisor:  
Dr Reshma Patel  
rpatel@uj.ac.za  
011 559 6780

If you feel that any questions or complaints regarding your participation in this study have not been dealt with adequately, you may contact the Chairperson of the Faculty of Health Sciences Research Ethics Committee at the University of Johannesburg:

Professor Chris Stein  
Tel: 011 559-6686  
Email: cstein@uj.ac.za

Participant initials:__________
FURTHER INFORMATION AND CONTACT DETAILS: Should you wish to have more specific information about this research project information, have any questions, concerns or complaints about this research study, its procedures, risks and benefits, you should communicate with me using any of the contact details given above.

Researcher:

Lorna Blackwell
<Signature>

Participant:

____________________
<Signature>
APPENDIX E
Consent to interview and information use

DEPARTMENT OF HOMOEOPATHY
RESEARCH CONSENT FORM

Homoeopathy Master’s Students’ at the University of Johannesburg Experiences of
Language Barriers in the Delivery of Healthcare

Please initial each box below:

☐ I confirm that I have read and understand the information sheet dated 20/03/2018 for
the above study. I have had the opportunity to consider the information, ask questions
and have had these answered satisfactorily.

☐ I understand that my participation is voluntary and that I am free to withdraw from
this study at any time without giving any reason and without any consequences to me.

☐ I agree to take part in the above study.

☐ I agree to allow the information from my interview to be used in the research study.

_______________________       ___________________________________  ________________
Name of Participant        Signature of Participant     Date

_______________________      ___________________________________ ________________
Name of Researcher       Signature of Researcher   Date
APPENDIX F
Consent to be recorded

DEPARTMENT OF HOMOEOPATHY

RESEARCH CONSENT FORM FOR INTERVIEWS TO BE AUDIO-TAPED

Homoeopathy Master’s Students’ at the University of Johannesburg Experiences of Language Barriers in the Delivery of Healthcare

Please initial each box below:

☐ I hereby give consent for my interview, conducted as part of the above study, to be audio-taped.

☐ I understand that my personal details and identifying data will be changed in order to protect my identity. The audio tapes used for recording my interview will be destroyed 2 years after publication of the research.

☐ I have read this consent form and have been given the opportunity to ask questions.

________________________________________  ___________________________________  ________________
Name of Participant        Signature of Participant     Date

________________________________________  ___________________________________ ________________
Name of Researcher       Signature of Researcher   Date
DEPARTMENT OF HOMOEOPATHY
RESEARCH STUDY INFORMATION SHEET
Homoeopathy Master’s Students’ at the University of Johannesburg Experiences of Language Barriers in the Delivery of Healthcare

Good Day

My name is Lorna Blackwell. I would like to invite you to participate in a research study on your experiences of language barriers in the healthcare you provide to your patients.

Before you decide on whether to participate, I would like to explain to you why the research is being done and what it will involve for you. I will go through the information sheet with you and answer any questions you have. This should take about 10 minutes. The study is part of a research project being completed as a requirement for a partial Master’s Degree in Homoeopathy through the University of Johannesburg.

THE PURPOSE OF THIS STUDY is to explore the experiences of language barriers in the healthcare that Homoeopathy students at the University of Johannesburg provide to their patients.

Below, I have compiled a set of questions and answers that I believe will assist you in understanding the relevant details of participation in this research study. Please read through these. If you have any further questions I will be happy to answer them for you.

Participant initials: __________
DO I HAVE TO TAKE PART? No, you don’t have to. It is up to you to decide to participate in the study. I will describe the study and go through this information sheet. If you agree to take part, I will then ask you to sign a consent form.

WHAT EXACTLY WILL I BE EXPECTED TO DO IF I AGREE TO PARTICIPATE? You will be a participant in a focus group whereby results from the study will be presented to you and opened up for discussion. You will be encouraged to give your opinion freely and honestly.

WHAT WILL HAPPEN IF I WANT TO WITHDRAW FROM THE STUDY? If you decide to participate, you are free to withdraw your consent at any time without giving a reason and without any consequences. If you wish to withdraw your consent, you must inform me as soon as possible.

IF I CHOOSE TO PARTICIPATE, WILL THERE BE ANY EXPENSES FOR ME, OR PAYMENT DUE TO ME: You will not be paid to participate in this study and you will not bear any expenses.

RISKS INVOLVED IN PARTICIPATION: There are no anticipated risks involved with your participation in this study.

WILL MY PARTICIPATION IN THIS STUDY BE KEPT CONFIDENTIAL? Yes. Transcripts and recordings will be given a unique code in place of your name. All data and back-ups thereof will be kept in password protected folders and/or locked away as applicable. Only I or my research supervisor will be authorised to use and/or disclose your anonymised information in connection with this research study. Any other person wishing to work with you anonymised information as part of the research process (e.g. an independent data coder) will be required to sign a confidentiality agreement before being allowed to do so.

WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY? The results will be written into a research report that will be assessed. In some cases, results may also be published in a scientific journal. In either case, you will not be identifiable in any documents, reports or publications. You will be given access to the study results if you would like to see them, by contacting me. All data will be destroyed after 2 years after the study has been published.

Participant initials:__________
WHO IS ORGANISING AND FUNDING THE STUDY? The study is being organised by me, under the guidance of my research supervisor at the Department of Homoeopathy in the University of Johannesburg. The study is funded by the Supervisor-linked bursary from the University of Johannesburg.

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Lorna Blackwell
083 437 7468
Lornab.homeo@gmail.com

You may also contact my research supervisor:
Dr Reshma Patel
rpatel@uj.ac.za
011 559 6780

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Professor Chris Stein
Tel: 011 559-6686. Email: cstein@uj.ac.za

Participant initials:__________
FURTHER INFORMATION AND CONTACT DETAILS: Should you wish to have more specific information about this research project information, have any questions, concerns or complaints about this research study, its procedures, risks and benefits, you should communicate with me using any of the contact details given above.

Researcher:

Lorna Blackwell
<Signature>

Participant:

______________
<Signature>

UNIVERSITY OF JOHANNESBURG
APPENDIX H
Consent to focus group participation and permission to have the interaction audio taped

DEPARTMENT OF HOMOEOPATHY
FOCUS GROUP CONSENT FORM

Homoeopathy Master’s Students’ at the University of Johannesburg Experiences of Language Barriers in the Delivery of Healthcare

☐ I agree to participate in a focus group whereby results of the above study will be presented to the group and opened for discussion.

☐ I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐ I understand that my participation is voluntary and I am free to withdraw from this study at any time without giving any reason, without consequence to me.

☐ I am aware that my identity will remain anonymous and my personal opinions will not be identified or linked to my personal details.

☐ I agree to have the interaction audio taped.

☐ I understand that I may have access to the results of this study on request.

__________________________________  ___________________________  _____________
Name of Participant        Signature of Participant     Date

__________________________________  ___________________________  __________________
Name of Researcher       Signature of Researcher   Date
APPENDIX I
Demographic Profile

Homoeopathy Master’s Students’ at the University of Johannesburg Experiences of Language Barriers in the Delivery of Healthcare

Please fill out the following table:

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<th>Other languages</th>
<th>Proficiency</th>
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Opinion of proficiency of other languages

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<th>1 Average (Conversational)</th>
<th>2 Above average (Fluent)</th>
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APPENDIX J

Example Transcript

Researcher: What has your experience been regarding language barriers between you and your patients at the UJ Homoeopathy clinics?

Participant: So for the most part, it’s been alright. We obviously do find difficult situations at times where there is a language barrier. We try our best to work around it. I, when given the opportunity, like at Soweto and so on, sometimes you have the opportunity to have a translator—they can be very beneficial. Obviously that’s not always an option. It certainly makes it more difficult to get the relevant information out of the patient, and obviously that has sort of a ripple effect on how their treatment plan will come about and what kind of care they get, even how they respond to treatment, because obviously the better information we gather from the patient the more accurately we can treat, prescribe, examine, etcetera, the better chance we have at getting good results. So there’s certainly some hurdles there. But I do think that at the end of the day we do still provide as best service as we can, and I still think that the patients do benefit regardless of the… there is some benefit despite those language barriers.

R: So a few things that you mentioned that we’ll go into a little bit of detail with then. So, you said you need that relevant information because you said it has an effect on the treatment plan and all of that kind of thing. Why do you need that information? What effect does it have on that treatment plan?

P: So, for instance, if I can’t gather all the necessary information, if I ask a patient about modalities for example, what makes it better, what makes it worse, and they don’t really understand what I mean when I say what makes it better, what makes it worse, it’s more difficult for me to come up with a diagnosis, it’s more difficult for me to decide on the best remedy, the best treatment plan for them, and I’ve also noticed it’s also really difficult when you’re doing a physical exam and you’ll ask them to, something so simple, like when you take their blood pressure and they keep their arm elevated and you say “It’s fine you can relax your arm” and you feel like there is still this resistance and they want to hold it up for you and you’re like, “It’s really okay you can relax”, simple things like that. If you’re doing a musculoskeletal exam and you want to check muscle resistance and things like that, then it becomes difficult because… Or a neuro exam where you have to ask a patient to follow through with instructions, it becomes difficult if they’re not sure what they need to do, and perhaps you’re not getting the correct readings because they’re not really following through with instruction, it’s really difficult to make sure that everything runs as systemically, or as fluidly as you want it to. So yes, there again is a little bit of that hiccup.
R: So you said it makes it really difficult. Does it make it impossible for you to treat and do all those things?

P: Like I said, I think despite the hurdle of language barriers I still think that patients benefit from visiting our facilities and being treated. Is it as precise as it might be if we could understand each other one hundred percent? Perhaps not. But I still do think that benefit just something as simple as someone taking the time to listen and to examine, and for them to feel like someone’s actually taking the time to care. And based on even limited information that we get we do try our best to give them the best possible remedies. And then of course with follow up it becomes a little bit easier to see how the patient’s responding and perhaps if you’ve missed the mark a little bit you can re-evaluate. And perhaps then if you know that language is a big problem, arrange to get the translator in, depending on where you are.

R: Alright, so then you mentioned translators. Have you used a translator before?

P: Yes.

R: Okay and what was your experience like?

P: Obviously it’s a little bit more time-consuming. It also becomes difficult because it’s almost like the conversation becomes disjointed. Almost like your flow of questions doesn’t seem to flow as easily. So maybe you might miss something out or whatever because you are so infatuated on getting this one tiny piece of information that maybe you missed the full picture. But it can be super beneficial especially for patients who do not speak English at all, even broken English. Then of course, a translator is absolutely essential that you have them there.

R: When you have had a translator, who translates for you? Who has been the translator?

P: I’ve had one of the fellow students who could speak the patient’s language. And then I’ve also had someone assist at one of our satellite clinics who was also quite hands-on with assisting in patient-student translation.

R: So that assistant, were they a professional translator?

P: Oh no I wouldn’t say they’re a professional translator. Probably more like a colloquial language I suppose.

R: So not someone who is related to this patient’s healthcare?

P: No. Sometimes you’ll also get a family member who might come join in a consultation. That I’ve also had before, where the patient maybe is not one hundred percent comfortable speaking English, because that’s basically how we take our cases, then of course they would also not be a professional translator. They would just be there lending a hand.

R: So when we talk about family members and we talk about assistants…

[interruption]
R: So, we were busy talking about who translates for you, you spoke about students, family members and the assistant at the satellite clinic. So when we talk about the assistant and family members, those kinds of people, we refer to them as informal interpreters.

P: Okay.

R: How do you feel about the informal interpreters interpreting for you and a patient?

P: I think there’s certainly a lot that’s lost… Yes, I think there is still loss of information. Maybe not so much going from the patient to the doctor, or to the student, because in those settings we usually use normal conversation. But perhaps going in the other direction there could be a misunderstanding. If the informal interpreter doesn’t really understand what the student is saying and understand why the patient’s getting certain advice and being told to do certain things, they’re just as best they can passing on the information, the patient isn’t really given the opportunity to really fully understand the status of their health perhaps, or understand why they need to make lifestyle changes, or why they need to take this medicine or stop doing something. So I think we tend to gather information, as the student, we gather information in quite an informal way. So maybe in that way there is less lost. But what goes from the student to the patient, perhaps there might be a bit of a misunderstanding or less opportunity to fully understand their state of health. So yes, there might be a little bit of a glitch there using an informal interpreter. But it is better than nothing.

R: Yes, it is better than nothing.

P: So I think it still has its value and it still has its place.

R: Do you see any other negative reasons why you wouldn’t use an informal interpreter?

P: I always choose to see the best in people, but you never know if maybe you’re saying one thing and they’re getting the completely different side of the story, and you’re saying “don’t do it” and they’re saying “no it’s fine you can carry on doing it. Have all the sugar even though you’re diabetic. It’s perfectly okay”. If they have some kind of other motives, or not having the patient’s best interest. It can happen.

R: So you don’t know what they’re saying?

P: Exactly. So you on the other end are giving all the information and be as accurate as possible, you don’t know if there’s follow through with that. And I suppose the same could be said the other way around. If your patient is actually in excruciating agony, and your interpreter goes “Oh you know, they’re a little bit sore”, you might be like “Oh okay it’s actually not that severe”. Okay so in that way I understand why it could be both ways. I should say perhaps more so one way, but always have to be a little bit cautious. I suppose the interpreter has to have the best interest of the patient and we can’t always ensure that that is the case.

R: What do you mean by that?
P: We don’t… As the person who doesn’t understand what the message is that’s getting carried over to the patient is, we don’t always actually understand if they’re giving the correct explanation to the doctor, and the explanation from the doctor back to the patient. O you can’t necessarily verify that they’re getting everything spot on.

R: Okay, and then using students to translate for you. How do you feel about that?

P: Oh, I haven’t really given it too much critical thinking… Again it’s probably the best resource I have at that moment, so I will take it. I’d like to think that a fellow student would be aiming for the best interest of the patient as any one of us would respond to our own patient. If I asked a fellow student to help me they would come in with the same respect or desire for the patient’s health. Yes, so I’d like to believe that we’re all on the same page.

R: So how do you think that these language barriers make your patient feel?

P: I don’t think I would like it very much as a patient. I feel like your health is such a personal thing that you want to be able to express it yourself in your own words and make sure that you are understood and that the things that concern you are going to be attended to. So I can imagine it’s quite frustrating for the patients. And our whole, one of our philosophies is this individualised treatment, and if the patient doesn’t feel that they can express themselves as an individual and everything they say is being filtered through a translator, I don’t think that’s really fair on the patient and I wouldn’t like it if I were a patient and I had to have everything I said filtered through a translator. I think, yes, super super frustrating.

R: Okay. So when you said one of our philosophies is this individualisation, do you feel like maybe language barriers affect the Homoeopathic case taking, or the Homoeopathic process more than a normal medical consultation?

P: Definitely. Yes, because we always find that information that is spontaneously given by the patient carries so much value, and if a patient describes their pain as throbbing or sharp or whatever the case is, depending on the patient, some can get quite specific, and then lo and behold you find it in the repertory and you’re like “Wow. This narrows down my remedy selection from twenty or twenty-five to maybe five”. And what a phenomenal opportunity to give the patient something that is so well suited to them. So yes, I do think that in that way it sort of compromises our philosophy and what we strive to offer.

R: And how does it make you feel as the doctor?

P: I think there’s also a frustration, because it’s certainly not the ideal situation where you’re looking for that spontaneous information for that detailed information that you’re hoping to get from your patient so that you can give them a really good treatment plan and make sure you covered all the right physical exams and that type of thing. You don’t want to overlook anything, which can get lost and fall through the cracks when it’s being altered and going through another
person before it reaches you. So yes, and like I mentioned before, it can become disruptive to the case taking process because you’re focused on this one question when you might be missing the full picture for what the patient’s really going through because you want to know “what do you do when you get it?” and this patient’s like… there might not be an exact answer because maybe they don’t know or they can’t explain it… Maybe their interpreter’s like “Oh well she doesn’t know so let’s move on”. You could be losing vital information.

R: Okay. Alright, so when you encounter a language barrier situation with a patient, what do you do?

P: So, always try and speak clearly, slowly, try use simple words… I think that’s the best way to take it forward. I try not to get too convoluted… Small, short sentences. Wait for them to respond so that you know you haven’t lost them, you’re on the same page with them- I think that’s really important. I think that even if there’s a language barrier, it’s still important to try engage with them as much as possible. So you do look at things like body language, gesticulation, where do they point to, if they have throbbing are they tapping on the table [tapping on the table], things like that. Maybe there could be other cues to indicate how they are feeling without using words necessarily. So I think things like that are very important. When you’re doing a physical exam notice facial expressions- are they wincing, are they pulling away- because they might be telling you it’s sore but perhaps you don’t understand. I’m not a professional in communication, but they do say that the words we speak are only a limited percentage of the way people communicate, so maybe we need to try tap into some of our other senses as well and be a bit more aware of them as a person and maybe try and use that as our individualised approach when we look at their gesticulation and their body language as well as what they’re saying to try and fully understand what it is that they’re trying to say.

R: So do you think that those objective findings, like wincing and that kind of thing, do you think that that is enough for you to diagnose on and make a treatment plan for the patient?

P: It’s difficult to ride an entire diagnosis or an entire treatment plan based on that because, again, what might cause one person to wince is not going to cause another to wince. And so that is all so relative, right? So then it does become, I would say, a little bit inaccurate. But they are useful tools that we can use when faced with language barriers. I think if we were not faced with language barriers and given the opportunity to say “Is that sore”, “How does that score out of ten”, “Is it more or less sore when I do this or when you cough” etcetera. So there’s more of an opportunity to explore where is that objective finding coming from. But when we don’t have the opportunity to do that I think we need to at least be aware of those objective things so that we can at least be guided a little bit when you can’t actually ask the questions.

R: Also better than nothing.
P: Yes.
R: And then you mentioned engagement with your patient. So I know you were talking about tapping into who they are and seeing them as an individual, but engagement as in relationship as well?
P: What do you mean when you say relationship?
R: Like forming that rapport with a patient.
P: Yes, well I don’t think that should go out the window just because you can’t understand each other. So, for example, if my patient doesn’t understand me, it doesn’t mean I should just jump in with the physical exam, I must still indicate to them “Okay I’m going to touch you now”, let them see my hands [holding hands up], then move slowly. So I mustn’t just be like “Okay well you don’t understand anyway, so put on this blood pressure cuff and let’s get it over with”. You still need to be a professional and you still need to treat that person respectfully, and still follow your procedures as best you can. Is that kind of what you’re asking?
R: Yes. So do you think that language barriers make forming that rapport with your patient more difficult? Or do you think that it just changes your approach?
P: I think ideally it should just change our approach because we shouldn’t treat our patients differently just because of the language barrier. Just because you can’t understand someone doesn’t mean you shouldn’t still be trying your best to make sure they’re getting the best care. It does make it certainly difficult, that’s why it’s a barrier, it makes it more difficult, but I think if we take on the attitude to just write them off just because we don’t understand them then I don’t think we are fulfilling our duties. We chose to do this, and we should still try our best to make sure that patient is comfortable. If they’re wincing I’m not going to keep digging into their tummy if I can see that is causing them pain just because I don’t understand them when they tell me “Well okay that’s sore”. Do you know what I mean? I think things like that is about building up that relationship of care and trust because you need your patient to trust you.
R: So what do you think would remedy the situation of language barriers?
P: That’s a tough one. That’s very difficult. I don’t think it’s a quick fix. Certainly not. In facilities perhaps where it’s a very common thing then there should be employment opportunities for translators which are not informal but formal put in place. And I mean that would benefit so many people on so many different levels. So maybe something like that is worth considering. It would be lovely to say we should all go out and learn new languages but who really has the time, and sometimes even the skill and the talent, to do that. Sometimes we struggle just to get our grammar right with our home language, let alone trying to take on a new one. And then that could turn into more hiccups where you think you understand someone and you actually don’t, and vice versa. So I do think that maybe the best thing would be for establishments that face this
kind of a challenge to make provisions for it by having someone nearby to facilitate and help wherever necessary. Preferably someone who understands the philosophy of what we do, someone who is maybe familiar with some terminology, just so that at the end of the day the patient still feels like they’re getting information from somebody who is knowledgeable and who is giving them sincere and well indicated advice and treatment. And also, again, that will help stimulate that good rapport with the patient because you really are looking out for their best interest when you ensure that there’s someone like that on hand. Lovely to say, lovely to have ideas on how we can remedy it, great. I think that’s great. It would be great if we could say it and it could just be. Obviously it’s not always that easy putting it into practice- there’s a lot more that goes into it. Ideally that would be a good place to start.

R: So you mentioned formal translators. Like professionals? Is that what you mean?

P: I suppose you could call them that.

[interruption]

P: Mm yes, formal. What I basically mean by that is to have someone who this is their primary job to do. So that only allows them to be really good at it as opposed to having a family member or the person who just happens to be available to help out or that type of thing. And if there was somebody who was dedicated and with a responsibility like that, it would give them the opportunity to become familiar with the philosophy of why it’s important to get exactly what the patient is saying, and why it’s important that they receive the right translation from the doctor or student, and also to become familiar with names terminology, things like that, so that the patient then feels really comfortable and happy.

R: Okay. So you don’t necessarily think it’s important to have someone who’s studied translation and got a degree in translation. You think it’s more important to have somebody who is able to understand what we need and that’s their job?

P: I suppose I hadn’t really thought of it in terms of, like as a qualified person. I suppose there would be nothing to lose. I think that would be wonderful. Again putting it into practice, that’s tough. But yes, great if there’s somebody who’s actually equipped to do it and qualified to do it. Even better.

R: Okay, great. So then do you think that it would be useful for us to have a language course in our university syllabus?

P: …How in depth?

R: So as in depth as you think. Whatever you think.

P: I think it might be challenging to have it as part of the course material- if it were very in depth training. And I say that, not because of my own hesitancy to learn it, but because I feel like the course is already quite densely packed. So to take on another responsibility like that, it might not
become a priority for a lot of people. Not to say it doesn’t have value. But just in light of how the course is structured and how the workload can become quite a lot. I don’t think that many people would take to it, or at least give it that time and attention that it might even warrant because of that. If it were basic greeting skills, “How are you”, maybe just like a few words, also so that the patient feels comfortable with you and it helps to build that relationship and rapport. You’ll always find on a follow up if you ask someone, “Oh you were sick last time, how are you doing now?” or “Your kid, how did their exams go? They were so stressed” they’re like “Wow you were actually paying attention to me”. So it builds that kind of a relationship with people, that like okay there is some genuine care here, there’s more trust and I feel a little bit more comfortable being myself in their company. So things like greetings and minor conversation points like that, that could be really nice. And I think that’s probably more attainable than doing a full-on in-depth language course. Because as a student myself, I think that if we were told that I needed to go do that, I’d be like “Another thing I have to go do”. Not to say it doesn’t have value, I just don’t know if it would be given the right amount of attention.

R: Do you think that it’s the doctor’s responsibility to learn the patient’s language? Do you think it’s the patient’s responsibility to learn the doctor’s language?

P: I don’t really think it’s fair to put that on the patient. And I don’t really think it’s fair to put it in the practitioner either. I understand that in the UJ setting patients don’t necessarily come for a particular student, they’ll come for a particular service. So in that case it’s really hard to, almost funnel patients to a student that would be best suited for them. For example, if we have someone in the clinic who speaks French, and we have a patient who only speaks French, it would be ideal to pair them up because you know that’s going to be a relationship that’s probably going to work better. But because of the way the clinic is structured, we don’t always have opportunities to pair them up to facilitate communication. In the real world however, I do think that patients who are looking for a particular service, will look for it with somebody with whom they feel more comfortable. And if that is, if they feel that they are more comfortable with someone who speaks a particular language, they’ll most likely seek that particular practitioner, because then they’ll feel more at home. So again, in UJ setting it becomes difficult. However, I do think that there have been times where certain patients have really enjoyed their experiences here because there has been someone who could speak their language, in which case I think that’s great because as fate should have it, they got somebody who understood them. Unfortunately it doesn’t happen all the time and also unfortunately I don’t think there’s always enough students to fulfil the needs of all the people who might have language barriers.

R: Alright. Can you give me any examples of any instances of language barriers that have stuck in your mind?
P: I find it more intensely in our Soweto clinic, and also funny enough with the kids at Ennerdale. But that’s not so much… It can be a language barrier because English isn’t their first language and of course now they have to explain themselves in a language that’s not their first with their limited vocabulary on top of that, so that’s also another language barrier. I find, in my experience, it more at the satellite clinics we have that bit of a glitch. I had a patient have a seizure while I was taking the consultation, during which time she spoke to me in English, although not her first language, but it flowed, it was okay. I felt that sometimes perhaps I didn’t understand the detail, so the detail got a little bit lost. She told me that she was fainting. So I took a case as though she was fainting, and then I saw her collapse and it wasn’t a syncope, it was a seizure. And then I thought, okay we’ve kind of gotten the wrong story here. And then after this patient of mine collapsed and had the seizure, we then took her to a plinth and let her recover, recovery position and all that. So she had lost consciousness, and when she woke up and started to come to, she would only speak her language and then that’s when I needed help because I couldn’t understand what she was saying. So yes, that particular case stands out to me because form the very start I don’t have the right picture in my mind. Because I’m thinking why is she fainting. Is she dehydrated, is there a… there could be so many reasons why she’s passing out… how’s her blood pressure, all these things are coming to my mind, but when I actually saw it happen, and I’m grateful that I actually saw it happen because then I would have sent her home with the very incorrect prescription.

R: Do you think she told you she was fainting because of the language problem, or because of a medical literacy problem?

P: Might be a bit of both. Because I had asked her if she was on any medication and she said that yes she had gotten medication from Bara [Baragwanath Hospital]. The doctor had given her to help her stop fainting. So then I assumed that she had seen a doctor or perhaps even a neuro at Bara who had medicated her, but she couldn’t then tell me what medication it was and she couldn’t give me more details. There’s so many things, because if she didn’t understand her doctor at Bara then perhaps he just said “This is so that you don’t faint” because he thought to explain this is going to be a mission and she doesn’t understand.

R: Because of the language barrier or…

P: Yes, we don’t really know where the train went off the tracks. But I was grateful to have seen it because then of course, our treatment plan went in a more accurate direction. It was quite frightening though, because that made me realise all this time I’ve just been taking what people are saying as the gospel truth and this is really what they’re experiencing. And maybe it’s not actually what they’re experiencing. I think you make a very valid point about medical literacy as well. And when there is a language barrier people might not understand, you’ll say something to
them like “glucose” and they’re like “no it’s fine” and then they say “oh yes but my blood sugar’s high” and you’re like but I just asked this question. So again there you start to see how maybe the words we choose are not appropriate for people with language barriers.

R: Okay. Last question. Do you think that culture plays a role in creating a barrier between you and your patients?

P: We’re not talking about language; we’re just talking about culture?

R: Just culture.

P: I think it can. I think it’s really important to try and stay open minded about people’s backgrounds and where they come from, and a lot of cases it might be very different to your own. It’s very easy for us to put up a bit of a wall, like it’s different, it’s foreign. Maybe even be a bit critical or judgemental, because we’re all human. So yes, it’s possible. We need to make a concerted effort to not let it be the case. Because when you start talking to people, my favourite thing to be in consultation with people, is that although you might live worlds apart and have hugely different experiences, you find that the things that worry them are the same things that worry you. “Oh my dad got sick” or “My brother passed away and I’ve been struggling with grief” or financial concerns, whatever the case is, it’s so fundamental that everyone can relate despite language, culture, anything like that. So we need to try and be a little bit understanding and open-minded. I think we have enough barriers as it is so if we can be a little bit more accepting of people and their differences it makes us do our job better, and it makes them feel better from the moment that they leave us, from before they’ve even taken their first dose, they’re already on the road to recovery because they already feel better from the treatment that they got. And when I talk about treatment I’m not talking about the medicines but about how they were treated by the practitioner or by the student. It’s really important, I think.

R: Yes. Okay. Is there anything else you’d like to add on the topic of language barriers and the delivery of our healthcare?

P: No. I think it certainly is a barrier. I just think that one thing to remember is that just because we don’t always understand doesn’t mean we should slack on the quality of what we do. And I think that’s really important. It’s difficult to maintain because you get frustrated and you’re like “Oh these people don’t understand, I can’t finish my exam because they’re not understanding my instructions” or whatever the case is, but just, we need to try.

R: Find a way.

P: Mm. We just need to try.

R: Okay. We’ll stop there. Unless there’s anything else?

P: No.

R: Okay. Thank you.