Communication with African Patients. The Reality in the Hospitals of Southern Spain

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Abstract

Objectives: To assess communication barriers between healthcare providers and African patients.
Method: Following the Grounded Theory.
Results: There were 31 resulting categories which were organized under two main categories: non-professional interpreters and no communication/translation.
Discussion: The use of non-professional interpreters has negative consequences which should be taken into account. The lack of translation intrudes on the patient’s principle of autonomy as they cannot understand the information about their situation and hence cannot take part in the decision making process. The new multicultural reality requires the presence of professionals having the necessary tools to overcome the increasing language barriers.

Keywords: immigration, healthcare, communication, Africans, hospital.

1. Introduction

Immigration has become a phenomenon of great demographic and economic relevance in Spain since the 1990s. According to the Spanish Statistical Office (INE, 2012), 5.2 million people living in Spain in January 2012 had been born abroad. This figure represents 11.2 per cent of the total population, which officially has nearly 46.8 million
inhabitants. According to the Statistical Office mentioned above, there are 153,000 foreigners registered in the census of the province of Almería, where the studied was conducted. This figure represents 21.8 per cent of the total population of the province, which has 703,000 inhabitants. More than a third of the immigrants come from African countries, mainly Morocco, which is logical since Almería is to the north of the African border.

The high diversity in the local and immigrant population has an impact on basic aspects of healthcare, which include appointments, examination of symptoms, patients’ description of the problem, healthcare providers’ knowledge of patients’ family and personal situation as well as communicating and understanding the diagnosis or following the treatment (Figueroa-Saavedra, 2009). Authors such as Bischoff (2003) point out the negative consequences that language barriers between healthcare providers and patients may have for the diagnosis, follow up, admission, readmissions, adherence to treatment, patients’ satisfaction, etc. Communication between patient/users and healthcare providers is paramount to guarantee an efficient relationship in public medical settings. This study analyses the relation between healthcare providers and foreign patients from the patients’ point of view. The subjects taking part in the study were foreign patients whose mother tongue was not Spanish. More precisely, this research group selected African immigrants since their countries of origin are close to Spain and they represent a high percentage of the immigrant population in the area where the study was conducted in relation to the total number of foreigners.

2. Objectives

To assess language barriers between healthcare providers and African patients in the public healthcare system.

3. Materials and method

3.1. Study Design

Following the Grounded Theory, our research group performed a qualitative study. Strauss and Corbin’s (1998) methodology was used to collect and analyse data as the aim of the research project was to understand what was happening and how the subjects played their roles (Dick, 2005).

3.2. Data Collection

Using thorough semi-structured interviews and discussion groups. The number of informants had a theoretical objective. Interviews and discussion groups were recorded with participants’ consent. To guarantee the qualitative validity of the study, special attention was paid when collecting data. Informants spoke freely and did not feel they were being judged.

Data were collected from May 2010 to June 2011.

3.3. Informants

Africans admitted into a hospital in Almería and who freely agreed to take part in the study.

When choosing the informants, the objective was to obtain the widest variety in age, gender, nationality, time living in Spain, and level of command of Spanish.

- 37 interviews; 23 Moroccan interviewees and the rest came from Sub Saharan Africa. Their ages ranged between 19 and 57 years old. 21 of them were men and 17 women.
- 4 discussion groups; Moroccan males, Moroccan females, Moroccan males and females, and Sub Saharan males and females.

The language used in discussion groups with Moroccan interviewees was Arabic and the one used with Sub Saharan interviewees was Mandiacu. The total number of participants was 32.
3.4. Ethical Aspects

Regarding the ethical aspects of the study, it follows the ethical principles of the Research Ethics Committee and the Declaration of Helsinki of 1975 with the revision of October, 2000. Participants were informed about the objectives and methodology of the study. Each participant was assigned a code to ensure anonymity and confidentiality.

The study was presented to the Research Ethics Committee of Almería and received approval from it.

3.5. Data Analysis

Once the first interviews had been transcribed, open coding was carried out to identify topics and key patterns (Strauss & Corbin, 1998) in order to obtain the first categories on which the research group would work. Later, following the constant comparison method by which new findings were compared with existing ones, axial coding was used to make connections and reduce the categories and create a system of core categories representing the research situation to guide the selection and coding of new information (selective coding) and, hence, finish the analysis.

Finally, discussion groups were carried out in order to compare their conclusions with the results obtained from the interviews. Throughout all the process the research group was thorough but not rigid.

4. Results

Thirty-one codes referring to communication were found, codes that presented no communication problems because the immigrant had a good command of Spanish were excluded in the presentation.

First, it must be noted that informants were aware of the importance of speaking the language and of how this fact may affect the patient-healthcare provider relationship in a medical setting. This is how they expressed it:

TH5 The most important thing was to speak in order to know everything. If I spoke, they gave information and I could be aware of the situation.
(Moroccan male aged 33; 9 years in Spain. Interview conducted in Arabic. He speaks little Spanish)

PM3 when you are with the doctor, he speaks in Spanish and you speak in your language, you can only point where it hurts but you cannot explain. He will not know what the problem is.
(Moroccan female aged 32; 5 years in Spain. Interview conducted in Arabic. She speaks no Spanish)

HH2 Not speaking the language has an effect. For instance, I have a good command of Spanish and I can socialise more with people, I ask questions and so on. As a result, they spend more time with me; they see what I am like. However, if someone cannot speak the language, he will be isolated in his own world and people will say, and this guy, what is he doing? What is he thinking? And they start judging him because he is quiet. I think this aspect has a strong influence on discrimination.
(Moroccan male aged 18; 7 years in Spain. He speaks Spanish.)

In the first classification of codes, they were classified depending on whether there were communication problems or not:

- No Communication Problems. It includes all codes in which there is normal communication and, hence, no language barrier.
- No Communication. It includes all codes referring to the existence of a language barrier, the solutions given and the consequences that language barriers may have had e.g. no translation, healthcare providers do not try to communicate, professional interpreters available in the hospital, ad hoc interpreters, healthcare providers ask for an ad hoc interpreter, problems due to lack of translation/interpretation, patients do not decide, under-informed patients, trust.

4.1. Core Categories

After the first classification, the research group realised that there were two core categories around which the
other categories revolved: ad hoc interpreters and lack of translation.

4.1.1. Ad hoc Interpreters
As a result of not being able to communicate with healthcare providers for not speaking Spanish and for not having a professional interpreter available (almost in all studied cases), Limited Spanish Speaking (LSS) patients ask for ad hoc interpreters such as their own children, partner, friends, the patient with whom they share the hospital room… The following comments describe this situation:

TH1 No, I did not speak about that, it was my sister (….). Yes, she was the one who spoke, her husband went with her. She came with my brother in law to speak with the doctor. Before I did not know...
(Moroccan male aged 53; 12 years living in Almería. Interview conducted in Spanish and Arabic).
GH3 I always had to go with someone who spoke Spanish because I knew that if no one came with me, healthcare providers would not understand me. My cousin was my interpreter.
(27 years old, 2 years living in Almería. He speaks some Spanish.)

Informants were aware of the limitations of using ad hoc interpreters as this interviewee pointed out:

MA5 Communication is not easy even when a friend interprets, because someone who does not work in a hospital cannot explain medicine related issues correctly.
(26 years old, 4 years living in Almería. He speaks no Spanish.)

In some cases, healthcare providers themselves asked for ad hoc interpreters to overcome language barriers.

PH4 In Torrecárdenas Hospital the doctor asked me to find another Moroccan person who could speak Spanish so that he could come and explain everything.
(Moroccan male aged 43; 10 years living in Almería. Poor command of Spanish).

4.1.2. No Communication-Interpreting.
Far too often the research group found informants who could not speak Spanish and who were in hospital with no access to an interpreter throughout their whole stay in hospital. They did not ask for their right to be informed about their situation, treatment and prognosis. As a consequence, they lost their ability to decide. This is how different informants referred to their situation:

PM3 (in the delivery room) At first, I told them that I did not understand anything and they did their job but without explaining anything (…). I was very worried because I do not speak Spanish and I did not understand anything (...). They gave me pills after meals, I worried a lot about not being able to speak Spanish but what could I do? I was in hospital and that’s it (...). I signed a document for an injection on my back but I did not want it, the doctor told me: “Why did you sign? If you sign, it is because you agree” but I did not know what it was for.
(Malian male, aged 25. Interview conducted in Bambara. He speaks no Spanish. Admitted into hospital because of TBC, during the interview he told the interviewer that he did not know what disease he was suffering from.)

TH6 My disease? I do not know its name.
(Senegalese male aged 35; 2 years living in Spain. Interview conducted in Wolof. He speaks no Spanish.)

PH4 When I went home, they did not explain anything. No one told me anything.

A fragment of an interview is reproduced as it clearly depicts a situation of no communication:

TH4 No, I did not understand. P You didn’t understand anything? R No, I didn’t P Does anyone interpret or not? R No P Does anyone explain the situation in Bambara? R No, nothing. People speak but not in Soninke or Bambara. P They explained the situation in Spanish and you did not understand anything. R Yes, in Spanish and that’s it. I come from Mali. They did not ask other people, only me (...), No, I did not ask what they were saying.

(Malian male, aged 25. Interview conducted in Bambara. He speaks no Spanish. Admitted into hospital because of TBC, during the interview he told the interviewer that he did not know what disease he was suffering from.)

Only in one out of the three hospitals studied, there was a cross cultural mediator. There are different comments about the effectiveness of this service:

PH4 The doctor asked a Moroccan girl to come once, she explained that later I had to go to the hospital in Almería to receive a stronger treatment.
PM3 They asked a Moroccan girl to speak to me (...). When I went in in the morning, she talked to me but not
The research group found informants who claimed that some healthcare providers did not try to overcome the language barrier and they just did not communicate with their foreign patients. They even presumed that there was a language barrier even when it was not the case.

\textit{PH5} At first, when they see you are Moroccan they think you cannot understand the language...
\textit{PH2} They admitted me into hospital and every time they had to give me some treatment they came. (Senegalese male aged 34; 4 years living in Almería. Interview conducted in Wolof. He speaks no Spanish)
\textit{PM3} When the nurses speak to you and realize you do not speak Spanish, they do their job and leave.

In other cases, healthcare providers and patients found solutions to overcome language barriers:

\textit{TM5} There was no problem, everything was in a picture. (Moroccan female aged 33; 6 years living in Almería. She speaks little Spanish.)
\textit{PH4} If they spoke like you, I understood like I do now, they spoke slowly and with gestures...
\textit{PM3} When I left, they gave me a book in Arabic and Spanish about children related topics.
\textit{TH6} They spoke in Spanish but they spoke slowly so that I could understand everything. If I did not understand, I said “What are you saying? What is that?” and they explained everything slowly.

In many cases they say that they did not feel the need for an interpreter because they trust the healthcare system and its professionals.

\textit{PH2} The truth is I understood nothing, but I believed that what they were doing was the best for me. I had to accept what the healthcare providers said and did. Really, I did not have the ability to decide for myself or oppose, but, really, my trust in the fact that they knew what they had to do was everything (…) I just had to trust them knowing that they were professionals who would cure me (…) I was not worried at all, I only thought about the future, that they would cure me and that was all.
\textit{TH6} When I was ill and in hospital, I trusted the white people, the Spaniards…

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\caption{Fig. 1 Categories-Communication/Patients-Healthcare providers}
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5. Discussion.

First, it must be noted that African patients were aware of the importance that optimal communication with healthcare providers has because not speaking Spanish and not having a cross cultural mediator-interpreter make it
impossible to have a normal patient-healthcare provider relation.

The need to overcome language barriers is leading patients and/or their families to use ad hoc interpreters if possible. These people have no knowledge about medicine and, in many cases, have a limited command of Spanish. For these reasons working with them may be even more dangerous than having no interpreter at all (Bowen, 2010). Medical interpreting requires expert knowledge and skills achieved through training and practice (Abril & Martin, 2011).

Using ad hoc interpreters in medical settings has negative consequences such as lack of accuracy when giving medical information: wrong translation of diagnosis, treatment and care. Besides, it could lead to misunderstandings and lack of confidentiality of medical information. It should not be forgotten that ad hoc interpreters are not members of hospital staff but may be partners, minors, friends or even people who the patient does not know such as people who are with other patients, members of immigrant associations or NGOs. In addition, ad hoc interpreters could distort the information. This happens mainly when ad hoc interpreters are people close to the patient.

However, when neither the patient nor their families speak Spanish, having no cross cultural mediator-interpreter makes interpreting impossible. Consequently, patients lose autonomy since they have no information about their situation.

It is surprising that when there was no communication at all, healthcare providers did not find a solution to not having an interpreter. What is more, patients did not ask for an interpreter to obtain information about their situation either, although they were entitled to one. This resignation to not being informed on the part of the African informants was due to their trust in the healthcare system and its professionals. This positive perspective leads them to accept treatment about which they have no information, sign non translated consent forms to undergo diagnostic test or surgical procedures, and be discharged without understanding the medical report.

Having no interpretation/translation means that patients cannot take part in the decision making process in the medical setting, even if these decisions affect them and may have unpredictable consequences for the patients themselves (not knowing their diagnosis, prognosis or treatment or recommendations they should follow after discharge will make their improvement more difficult and will increase the risk of a relapse and readmissions) and for the people around them (this is the case with patients who suffered from infectious diseases such as TBC, HCV, HIV...). As patients do not have interpretation/translation, they are under-informed and unable to take preventive measures with the people around them. This fact may produce public health issues.


The objective of our suggestions-proposals is to overcome language barriers between African patients and Healthcare providers:

5.1.1Cross Cultural Mediators-Interpreters

This research group suggests hiring cross cultural mediators-interpreters who work with the largest cultural groups. Cross cultural mediators-interpreters can overcome language barriers with more accurate and objective translations/interpretations and know the patient's cultural background. Language and culture cannot be separated. Linguistic meaning is always found in a context and has a cultural component; accurate transmission of meaning depends not only on language but also on the above mentioned factors (Abril & Martin, 2011).

Hospitals with a high percentage of African patients are suggested to hire a Moroccan and a Sub Saharan cross cultural mediator-interpreters. The latter should speak the main languages and dialects of Senegal and nearby countries (Bambara, Wolof, Mandiacu, Sonike...)

Using professional interpreters instead of ad hoc ones improves healthcare to the point in which its quality is similar for LSS patients and Spanish patients (Karliner et al, 2007). Moreover, patients and healthcare providers are more satisfied with the quality of communication and healthcare when professional interpreters are present than in any other situations (Bagchi et al, 2010).

5.1.2. Language Banks.

To overcome language barriers with less frequent languages, this research group suggests what could be called
language banks, that is a list of people who can speak another language apart from Spanish and who can interpret when required. Having a record of people who would be willing to work as interpreters if needed would solve many communication problems.

5.1.3. Healthcare Providers Trained in Intercultural Communication Competence

In addition to the availability of cross cultural mediators-interpreters and language banks, healthcare providers should be aware of their responsibility when communicating with patients. Managers of hospitals and other medical institutions should make sure their staff receive training to develop their Intercultural Communication competence (Vilá, 2006). This involves acquiring cognitive and affective abilities to interact and communicate adequately with our patients, their families and the communities with a different cultural background we care for.

Cognitive abilities include knowing, understanding and being aware of every cultural and communicative aspect that speakers have which favour effective communication. Affective abilities allow positive emotional responses and control those emotions which could have a negative effect on intercultural communication. Finally, healthcare providers should improve their abilities for verbal and non-verbal communication, social skills, interpersonal competences, linguistic competences, etc. (Plaza del Pino, 2010)

5.1.4. Other Tools to Promote Communication

To promote the use of tools which make communication with non-Spanish speakers easier, for instance: pictograms, information translated into different languages, telephone interpreter service, etc.

If the objective is to provide all patients with quality healthcare without discrimination, the system must find the tools to overcome the obstacle that compromise equal access to healthcare. Without a doubt, language barriers are one of them.

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References


