

LANGUAGE AND ALLERGY EDUCATION

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South Africa is a fascinating and multicultural, diverse society! This adds flavour to our lives, but as medical practitioners it often adds complexity. Most doctors differ from their patients in terms of educational level and the knowledge held about medical conditions, as well as the fact that the patient is ill and wants to see the doctor rather than the other way round. However, in many settings in South Africa, further challenges are found in that patients and providers may differ from each other not merely in these 'usual' ways but also in terms of coming from different backgrounds and speaking different languages.¹

These issues came into stark focus while doing my internship in the Eastern Cape. At Cecilia Makiwane hospital the nurses soon realised that I have a love of languages and my rudimentary attempts to speak isiXhosa were quickly seized upon by the nurses as an excuse to communicate only in isiXhosa, even during resuscitations. As my language skills gradually improved, I came to realise that cross language communication is far more complicated than just understanding the sentences and how they are formed, but that cultural issues and different definitions of the same word when used by different individuals further muddy the waters.

When I started my training in allergology at Red Cross Hospital, Prof Weinberg encouraged me to do research on this most unusual topic. This research showed that difficulty with communication and cultural incompatibility between Xhosa speaking patients and English speaking health care providers are important barriers to quality care at a tertiary paediatric institution, adversely effecting patient satisfaction^{2,3}. These obstacles were ranked equally with socio-economic obstacles as barriers to accessing effective care for these parents' children. Patients believed that these obstacles resulted directly in specific negative outcomes such as misdiagnosis and receiving the incorrect medication. Unavailability, low levels of usage and ineffective use of interpreters prevented these problems from being easily resolved.

A further aspect that arose was language usage differed between patients and health care providers even when they were using the same words! Further research was conducted to examine whether differences in the definitions of common respiratory medical terminology by patients and doctors cause miscommunication. This research demonstrated marked differences in the definitions of terminology, and words were classified as concordant or discordant depending on whether they were used in the same way or in different ways by doctors and patients.⁴ Most Xhosa words were not in the doctors' vocabulary, and some common English words were not in the parents' vocabulary. Where words were in the vocabulary of both groups, significant differences existed in the number and range of definitions, with many clinically significant discordances of definition being apparent. This included words in both languages that most multilingual doctors believe (often incorrectly) have the same meaning when used by their patients, such as "fever/ifiva", "isifuba" and "pneumonia/nyumoniya".

These differences could be ascribed not only to education level, but also to different explanatory models of disease. Doctors naturally hold biomedical models of disease which differ markedly from the lay models of disease held by the patients. Three major culture-specific explanatory models of respiratory illness were described, one of which had not been described in the medical or anthropology literature prior to this.⁵ The culture specific models of disease included *ingqe* (the cold that enters the body to cause disease), *xakaxa* (mucus present at birth if not removed accumulates to cause childhood chest disease) and *idliso* (poisoning via food).

These differences not only have impact on quality of communication and care in clinical settings, but may also have effects on the quality of patient educational materials and consent forms as well as questionnaires used in epidemiological surveys.⁶

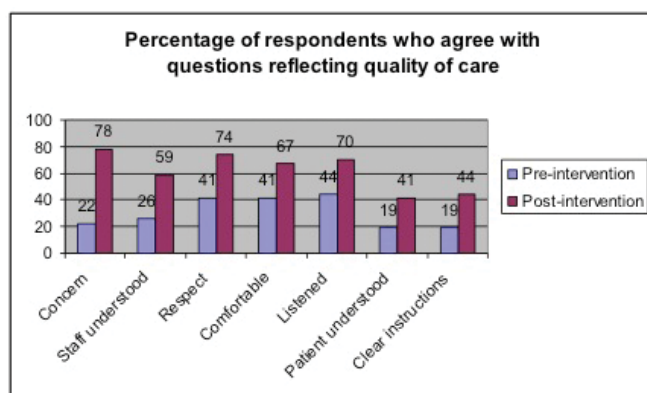


Figure 1. Percentage of respondents who agree with questions regarding quality of care.

Although such research led to interesting thoughts on possible solutions, including using the information to facilitate more effective use of interpreters⁷, it remained to be seen whether anything could really be done about it! A further study was thus conducted at two community health centres and a district hospital in the Western Cape to determine whether teaching Xhosa language skills and cultural understanding to health care workers affects their ability to communicate effectively with Xhosa-speaking patients, their job satisfaction levels as well as impacts on patient satisfaction.⁸ Staff members completed a ten week basic language course comprising ten 120 minute interactive contact sessions developing basic Xhosa speaking and listening skills and cultural competence. The impact of the intervention was marked. Patient satisfaction showed significant improvements. Patients perceived staff to be more understanding, respectful and concerned, and to show better listening skills, after the intervention. Patients were better able to understand staff and their instructions.

Health care workers rated their ability to communicate as improved and experienced decreased frustration levels.

The management of many allergic conditions focusses on four main pillars, viz. environmental control measures, education, pharmacotherapy and allergen immunotherapy. Local guidelines have, for many years, included education as an important aspect and I have been privileged to be able to afford prominence to this in recent articles and guidelines for asthma^{9,10,11}, rhinitis^{12,13} and for pending guidelines on food allergy and eczema.

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