Overcoming Patient-Provider Language Barrier: A Project Designed to Teach Health Professionals Afaan Oromoo Language

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Abstract

Background: Provider-patient miscommunication in the health care setting can have fatal consequences. It is especially a common occurrence in multilingual countries like Ethiopia. Yet, providers in such settings tend to rely on untrained ad hoc interpreters with no systemic solution in place designed to solve the problem. Our quality improvement project aims to evaluate one such intervention deployed in a high-volume tertiary hospital, Saint Paul's Hospital Millennium Medical College (SPHMMC).

Method: A baseline assessment was conducted to assess the language mix of patients presenting to the hospital. Medical Afaan Oromoo (MAO) project was then designed to teach Afaan Oromoo to health care professionals in a 3-month period. The effectiveness of the project was evaluated with standardized pre and post training assessment tools.

Findings: The baseline assessment showed the majority of patients seeking care at the hospital speak Afaan Oromoo (56.1%). And more than half of these patients (55.4%) were unable to speak Amharic (the working language). Only 8.9% of health care providers were able to communicate with Afaan Oromoo. The language training project was able to improve language proficiency from a baseline of Interagency Language Roundtable (ILR) scale level 0 to level 2 in 96% of trainees.

Conclusion: There was a substantial discrepancy in self-reported Afaan Oromoo language communication ability between providers and patients at the hospital. Although the language training program brought about a significant change in language proficiency (Level 0 to 2 in 96% of trainees), further research is needed to ascertain its impact in actual Afaan Oromoo language incongruous clinical setting.

Keywords: Patient-physician communication; Language barrier; Patient communication

Background

The second most populous country in Africa, Ethiopia is a multi-ethnic nation of over 100 million people and 70 distinct languages [1]. Among these ethnicities, the Oromo people contribute for the majority of the Ethiopian population accounting for around 34.5% [2]. However, the language associated with the Oromo people, Afaan Oromoo, is not the most widely spoken language in Ethiopia. The working language of the country is Amharic, which has the largest number of speakers [3].

Saint Paul's Hospital Millennium Medical College (SPHMMC) is a specialized teaching hospital located in the north-western part of Addis Ababa. Its catchment population is well over 7 million making it one of the largest referral centers in the country. As a tertiary center, it receives patients from every corner of the country even though the vast majority of them come from Oromia region where a large segment of the population speaks Afaan Oromo language (see baseline assessment below). With the majority of health care professionals speaking Amharic, there are often significant problems faced during patient-provider interactions.

Barriers to effective and equitable healthcare can result from linguistic differences between patients and clinicians [4]. While language barriers between providers and patients are a global phenomenon, the nature of these barriers is regionally varied. In the west, the language used by healthcare providers is typically the country's official language, such as English, French, or German.

Patients with migration backgrounds who are not communicative in a given language may rely on an ad hoc interpreter, such as a family member or staff member at the hospital, or an appointed interpreter, to which they are legally entitled in many countries. In the global south, interpretation is typically not a legal right and often done on a case-by-case basis, such as through a staff member who can translate.

Language discrepancies have been shown to have increased psychological stress and medically significant communication errors for already anxious patients, something to which language-matched patients are less vulnerable [5]. Moreover, it is not just language that can cause barriers to equitable healthcare: inequities inherent in the social dynamic of the patient-practitioner encounter are well documented, and these inequities occur independent of whether the language is shared [6], although this particular issue is not the focus of this article. Understanding language in the context of a medical encounter is thus critical for understanding the problems that might result when patients and healthcare practitioners speak a different language [7].

This study attempts to evaluate one practical approach to solving language barriers in the medical setting. To our knowledge, there are no researches done on the effectiveness of language training for health care providers at the work setting. We hope to provide new insight on the matter and explore alternative options.

Methods

Baseline assessment

A simple random sampling technique was used to enroll health care providers and patients seeking care at the hospital. Data was collected over the course of 5 working days using a structured questionnaire. Language proficiency of participants was evaluated. Their view and perception towards tailored language training was also assessed. Moreover, pre and post training questionnaires were used to assess the impact of the training.

Medical Afaan Oromoo (MAO) project grant approval

A project proposal was written and submitted to the management committee of the hospital. The project manager (the primary author of this article) also presented the findings of the baseline assessment and the details of the project in a scheduled meeting. After months of deliberation, the project grant was approved on May of 2017 and officially launched on January 10, 2018. The project was entirely funded by the hospital.

Preparation of training module

Prior to conducting the training, a training module was prepared in collaboration with Addis Ababa University department of Afaan Oromoo Language Literature and Folklore (AOLLF) and endorsed by the university **(Figure 1)**. The module was designed to be used as template for a 3-month course training in the basics Afaan Oromoo. The course was divided into two parts: part 1- Basic Afaan Oromoo training and part 2- Medical Afaan Oromoo training.

Figure 1: Medical Afaan Oromo language training hand book (Edited for the second round of training).

Part 1- Deals with very basic elements of the language but with more attention to the medical environment.

Part 2- Builds up on part one to dive in-depth about patient clerking using different clinical scenarios.

Selection and training of health care providers

The training was then organized and conducted inside the hospital in four venues. Each venue had no more than 20 trainees. A committee consisting of 5 senior physicians from the major clinical departments of the college was organized to manage the activities of the project.

For selection of trainees, the project was announced on staff meetings and disseminated through brochures. The trainees were enlisted on voluntary basis. A standard set of criteria were devised by the MAO project committee to prioritize the candidates **(Table 1)**.

Table 1: Medical Afaan Oromo enrollment check list.

Question number	Questions
1	Are you interested in training basic Afaan Oromo language?
2	Are you a staff of SPHMMC?
3	Can you dedicate 3 credit hours per week for the training during working hours? (training is planned to be conducted from 11:30 AM to 12:30 PM on Mondays, Wednesdays and Thursdays)
4	Do you think the training will be beneficial in improving clinical service?
5	Do you think you are dedicated enough to finish the whole 3-month course?

The following were the criteria used to select from a large cohort of candidates.

1. The candidate must be working at SPHMMC and plans to work as such for at least the coming 5 years.

2. The candidate should not be able to speak Afaan Oromo language.

3. The candidate must be able to dedicate 3 credit hours a week for three consecutive months to attend the training.

Apart from the mandatory criteria mentioned above, candidates with better client/patient contact were more likely to be enrolled in to the program.

Medical Afaan Oromo training

The training was conducted on Mondays, Wednesdays and Thursdays between 11:30 AM to 12:30 PM starting from January 10, 2018. Five trainers were selected from the department of Afaan Oromoo Language, Literature and Folklure (AOLLF), Addis Ababa University (AAU) based on their credentials and experience in teaching the language to beginner audience.

Ethical considerations

Ethical approval was obtained from the college's institutional review board. Informed consent was also obtained from the trainees of MAO project.

Measurement of proficiency

The Interagency Language Roundtable scale (ILR scale) was used to assess the level of language proficiency for trainees.

0) No proficiency: At this lowest level, there is basically no knowledge of the language. The person may know a few words, but can't form sentences or carry on any type of conversation.

1) Elementary proficiency: At this language proficiency level, a person can form basic sentences, including asking and answering simple questions. This is essentially the starting point of the language proficiency levels. This level reflects someone who is traveling to a new country and who has just begun to study a language.

2) Limited working proficiency: Someone at this level can handle basic work commands and social phrases. They can carry on limited casual conversations at the office and discuss their personal life. Someone at this level still needs help with more extensive conversations in the language. They can only operate independently in basic conversations.

3) Professional working proficiency: Someone at this language proficiency level can make contributions to office meetings, have conversations with clients, and carry out most work functions requested of them. A person at level 3 can speak at a normal speed in the language and has a fairly extensive vocabulary. They likely still have an accent at this level and probably require help understanding subtle and nuanced phrasing. Some employers consider this level or above as basically acceptable, depending on the specific job.

4) Full professional proficiency: Full professional fluency is desired by most employers. Someone at this level can have advanced discussions on a wide range of topics about personal life, current events, and technical topics such as business and finance. People at this level may still have a minor accent and may occasionally misspeak or make minor mistakes. Their vocabulary is extensive and they can carry on conversations with ease. Most employers consider level 4 or above acceptable.

5) Native/Bilingual proficiency: Someone at this language proficiency level was either raised speaking the language as their native tongue or has been speaking it so long that they are completely fluent. They have little or no accent.

Results

Baseline assessment

The majority of the patients come from Oromia region. In this preliminary survey done on 463 hospital staff and 1466 patients. 30% of patients coming to SPHMMC speak only Afaan Oromoo. In addition, 38.8% of the clients speak both Afaan Oromo and Amharic. We also wanted to assess whether the health care workers at SPHMMC recognize and agree with organizing this training. The overwhelming majority of patients (91%) as well as the hospital staff (83%) wanted the hospital to organize a tailored Afaan Oromo language training for the hospital work force **(Tables 2-4)**.

Table 2: Health professionals profile included in the baseline assessment.

No	Profession	Number (%)
1	Physician	171 (37.2%)
2	Nurse	123 (26.8%)
3	Midwife	57 (12.4%)
4	Health Officer	15 (3.2%)
5	Medical students	22 (4.2%)
6	Laboratory	10 (2.1%)
7	Supporting staff	65 (14.1%)
Total		463 (100%)

Table 3: Self-reported rates of language proficiency by health care providers at SPHMMC.

No	Language for effective communication	Number (%)
1	Amharic only	422 (91.1%)
2	Afaan Oromo and Amharic	41 (8.9%)
Total		463 (100%)

Table 4: Perceived and actual rate of patients' language proficiency.

No	Language	Perceived rate of client language proficiency by health professionals	Actual rate of client language proficiency
1	Amharic	136 (29.6%)	553 (37.1%)
2	Afaan Oromo	103 (22.4%)	462 (31%)
3	Both Amharic and Afaan Oromo	189 (41.2%)	373 (25%)
4	Other languages	3 (0.6%)	78 (6.9%)
	Total	463 (100%)	1466 (100%)

MAO language training

From 483 health care providers enlisted for the training, 150 were selected for the first rounds of training based on the selection criteria outlined on the methods section. The 3 month course was conducted to 150 candidates selected; in two rounds during a 6 month period. All candidates in the program took pre-test questionnaire at the beginning of the course. Almost all candidates (96%) reported to have ILR level 0 proficiency. The remaining candidates were at ILR level 1. In the post training assessment, more than 85% reported ILR level 2 proficiency and 11% reported ILR level 3 proficiency **(Table 5)**.

Table 5: Interagency language round table scale.

No	ILR scale	Pretest rate	Posttest rate
1	Level 0	144 (96%)	0%
2	Level 1	6 (4%)	2 (3.6%)
3	Level 2	0%	48 (85.7%)
4	Level 3	0%	6 (10.7%)
5	Level 4	0%	0%
6	Level 5	0%	0%
	Total	150	56

Only 56 of the initially enrolled 150 health professionals were able to complete the full course; making the training attrition rate (62.7%). The most commonly cited reason for discontinuation being the inconvenient timing of the course **(Figure 2)**.
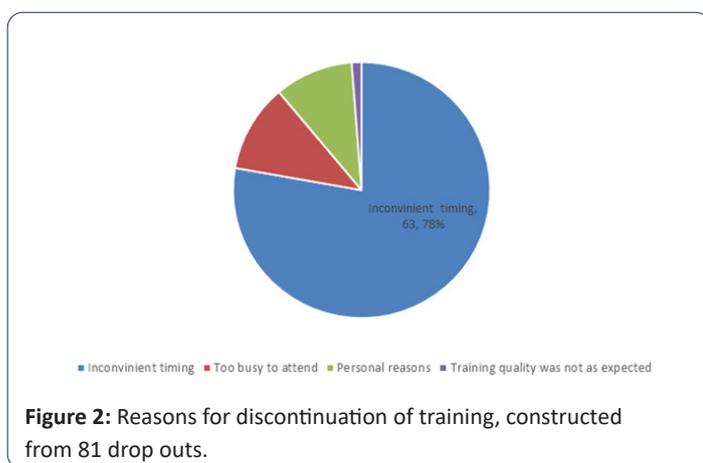

Figure 2: Reasons for discontinuation of training, constructed from 81 drop outs.

Discussion

Despite the majority of patients being Afaan Oromo speakers (56%), the vast majority of health care workers cannot speak basic Afaan Oromo for communication (8.9%). These usually calls for unnecessary time wastage in looking for an untrained translator and sometimes even in a substandard clinical care. When communicating the details of a diagnosis or treatment, it is crucial to convey accurately the likelihood of the associated risk factors [5]. Failure to communicate properly the seriousness of risk can have negative consequences: patients may fail to comply with instructions or elect not to have potentially life-saving treatment. Although there has been much information published on communication of risk between patients and healthcare practitioners in healthcare situations, these researches have focused predominantly on language-congruent situations. Also, when clinicians lack the linguistic and cultural skills needed and interpreters are not available [8], patients may have to rely on medically inexperienced, bilingual relatives or non-medical staff, compromising quality of care and worsening health outcomes for patients. In addition, both under and post-graduate medical students face difficulty in communicating with these clients, negatively affecting the teaching-learning process.

The baseline assessment showed more than half of the patients coming to hospital spoke Afaan Oromo language with 30% of them speaking only Afaan Oromoo. This coupled with the fact that only 8.9% of the hospital staff can communicate with Afaan Oromoo is an indirect evidence for the usual miscommunication faced at the hospital. The subjective assessment of both health care professionals and patients also correlates with the magnitude of the problem; with 81% professionals and 91% clients opting for an organized intervention targeting the language barrier. At SPHMMC, as is the case in the whole of the country, there are no trained interpreters which make the aforementioned problems a frequent occurrence.

The training has shown a significant improvement in the language proficiency of health care providers, achieving ILR scale level 2 and 3 in 85.7% and 10.7% of professionals respectively from a majority baseline of ILR level 0 (96%). Although this is a significant achievement, whether it translates in the work space properly is debatable. A consensus exists in the linguistic literature that level 3 or above proficiency level is needed for any language interaction in the professional environment [9]. It is not clear how health-related risk is appropriately and accurately conveyed to a patient when their first language is discordant with that of the practitioner and the wider community. There is evidence that miscommunication is more likely to occur when clinicians use an inadequately mastered language and cannot correctly convey certain nuances of risk and certainty [7]. Complicating matters further, people from different cultural groups describe pain and distress quite differently: culturally-specific terms, expressions, or metaphors can be difficult to navigate even when language competence is high [9]. It is our belief however the training has conveyed the necessary basic platform to encourage practitioners to improve their Afaan Oromo language proficiency. It has also been elucidated in numerous studies that language proficiencies above Level 3 can only be achieved by continuous utilization of the language on a regular basis.

Even with the high acceptability rate of the project, only 56 of the 150 enrolled health care providers were able to finish the full course. The majority attributed the lack of attendance for inconvenient timing (78%) and a busy work schedule (11.1%). The high attrition rate was expected due to the unpredictable nature of the medical field that makes it difficult for a consistent attendance and the ensuing lack of interest it likely provokes for a perceived incompetence by the trainee. We recommend multiple sessions a day in such settings to ascertain attendance. Although limited access to internet is a major drawback in our setting, designing online courses is another convenient approach.

Another solution for language barrier in the medical environment is availing well trained translators. Interpreting in the medical field involves a unique type of contextually bound communication in two languages, which normally takes place under pressure. Linguistic and interpreting abilities both contribute to the success of the communication act. Many agree that language proficiency and interpreting skills must be assessed separately in order to gain a more complete picture of a person's ability to work as an interpreter or language mediator in a multicultural and multilingual healthcare environment [10]. However, patient satisfaction is highly associated with language concordant provider. Furthermore, such association still remains regardless of the fluency of the health care provider.

Language competence can be isolated and measured in order to establish whether interpreters have or do not have sufficient language skills to benefit from interpreter training, or even to perform interpreting tasks at all. Testing language proficiency and interpreting skills separately can contribute to a more informed selection of candidates wishing to work as interpreters. In our setting however, there are no medical interpreting training programs which is a more pragmatic and tested approach for curbing language barrier in the medical setting [11]. We therefore recommend for the promotion and advancement of the medical interpreting profession as an alternate approach.

Conclusion

In closing, although the study setting is limited to one tertiary hospital the problem of language discordance is widespread in a multilingual country such as ours. It is high time we give due emphasis to this problem and device a strategy to tackle language barrier in the medical setting. The quality improvement project was able to bring about a significant change in Afaan Oromo language proficiency. However, further study is needed to evaluate the impact and effectiveness of the training in patient-provider communication in the practical context. We hope this novel project aids medical service providers to become more language-sensitive. Furthermore, we recommend the use of properly trained medical interpreters for a less complicated but a more cost-heavy solution.

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