

Addressing language barriers to healthcare in India

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ABSTRACT

In spite of a growing recognition of the importance of doctor–patient communication, the issue of language barriers to healthcare has received very little attention in India. The Indian population speaks over 22 major languages with English used as the lingua franca for biomedicine. Large-scale internal migration has meant that health workers are encountering increasing instances of language discordance within clinical settings. Research done predominantly in the West has shown language discordance to significantly affect access to care, cause problems of comprehension and adherence, and decrease the satisfaction and quality of care. Addressing language barriers to healthcare in India requires a stronger political commitment to providing non-discriminatory health services, especially to vulnerable groups such as illiterate migrant workers. Research will have to address three broad areas: the ways in which language barriers affect health and healthcare, the efficacy of interventions to overcome language barriers, and the costs of language barriers and efforts to overcome them. There is a need to address such barriers in health worker education and clinical practice. Proven strategies such as hiring multilingual healthcare workers, providing language training to health providers, employing *in situ* translators or using telephone interpretation services will have to be evaluated for their appropriateness to the Indian context. Internet-based initiatives, the proliferation of mobile phones and recent advances in machine translation promise to contribute to the solution.

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INTRODUCTION

Five years of medical college in Bangalore (now Bengaluru) had barely prepared me for this. As a young intern I was excited about being allowed to see my own patients at our outpatient clinic but I realized that all my newly acquired medical knowledge was not going to help me. In front of me sat a man who spoke only Telugu, the language of the neighbouring state. He looked like he had a story to tell but no one could understand him. Most hospital staff in India pride themselves on being multilingual but as it happened we could not locate anyone who could translate Telugu. Our consultation, awkwardly conducted in sign language and a few broken sentences, ended up being far from satisfactory. A detailed history was difficult to record. I was unable to adequately communicate my analysis of the patient's medical condition and the consultation ended with me prescribing a course of treatment with the patient being only vaguely informed of the rationale behind the prescription.

Such incidents were not uncommon during my days as a medical student and subsequently in the few years I practised medicine in a number of locations in southern India. The Indian health system is inherently multilingual, yet there does not seem to be any serious engagement with the challenges that occur due

to such linguistic diversity in healthcare settings. This may be contrasted with the increasing attention paid to the issue of language barriers to healthcare elsewhere in the world, largely due to the expanding proportion of immigrants in western countries and a greater awareness of language rights. In this paper I attempt to frame the issue of language barriers in healthcare provision within the Indian context and explore some possible means to address such issues.

THE MANY LANGUAGES OF THE INDIAN CLINIC

India is a country of immense diversity and this extends to the languages spoken by the Indian population. The 2001 Census of India lists a total 122 different languages spoken by a population of over one billion.¹ Among these are 22 major languages, each spoken predominantly in one particular region. The division of the country into states in 1956 was done on the basis of these linguistic boundaries. However, there has been a considerable amount of internal migration across state borders over the past few decades linked to the process of urbanization and a growing industrial economy.² Each state has numerous minority groups whose mother-tongue may differ from the official language of the state.³ Each language has a number of dialects and regional variations which might not always be mutually understandable. Based on my own personal experiences, it is not unusual for an Indian doctor to encounter 4–5 different languages during a single day at the clinic, especially if he/she is practising in an urban area. While most doctors in India eventually end up with a functional knowledge of the more frequently encountered languages, it is becoming increasingly difficult to communicate in all the languages one encounters in an Indian clinic. Doctors themselves often migrate out of their home state to train and practice in other states where they are unfamiliar with the local languages.

Biomedicine in India exists almost solely in the realm of English. This is a legacy of British colonial rule in India. The Medical Council of India insists on English proficiency as a prerequisite to enter medical college.⁴ Students read medical textbooks written in English and are expected to answer their examinations in English. Consequently their technical understanding of biomedical conditions is in the English language. The situation is similar with other health professionals such as nurses and paramedical workers although within these disciplines some of the training and a few basic textbooks are available in other Indian languages. The absence of an adequate vocabulary for technical terms in most Indian languages and the fact that health workers are often not completely fluent in languages that are not their mother-tongue often results in non-English-speaking patients receiving very simplistic messages or crude translations, free from the nuance that is essential for a patient to make a genuinely informed decision. This is compounded by the fact that patients who are more likely to experience language discordance in the clinic such as members of linguistic minorities and illiterate migrant labourers are also more likely to access care in overcrowded, understaffed public hospitals and clinics where health workers cannot spend much time with each individual and the power differential between doctors and patients is greater.

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CURRENT STATUS OF RESEARCH ON LANGUAGE BARRIERS

The issue of language barriers to healthcare in India has received almost no attention from health researchers. A search in PubMed and Google Scholar carried out with the key words ‘communication barriers’, ‘language barriers’ and other related terms does not reveal a single study or paper specifically looking at language barriers or issues arising out of multilingual clinical settings in India. Most of the research on language barriers has been done in high-income countries in the West, predominantly on Spanish-speaking populations within the US health system. The findings show that in cases of language discordance between the doctor and the patient there are issues with access to care, problems of comprehension and adherence, and a decrease in the satisfaction and quality of care.⁵ In settings where the costs of healthcare are borne by the state or private insurance companies, trained medical interpreters were found to be both cost-effective and better than either *ad hoc* interpreters or health workers with an incomplete knowledge of the patient’s language.⁶ Research in low- and middle-income non-western countries on language barriers is scarce. Research done in South Africa indicates that patients commonly identify language as a barrier to accessing care⁷ and that the practice of using nursing and other paramedical staff as *ad hoc* translators can itself generate tensions.^{8,9} Research conducted in Nigeria¹⁰ and Papua New Guinea¹¹ highlight problems associated with the common practice of using *ad hoc* translators in resource-poor settings.

ADDRESSING LANGUAGE BARRIERS IN EDUCATION AND PRACTICE

The lack of effort to address language barriers to healthcare in research is mirrored by a similar lack of effort to address such barriers in education and practice. Based on my experiences, health professional education in India does not ensure that a student will be equipped to work in increasingly multilingual clinical settings. Most institutions do not have programmes to train students and health workers in the commonly encountered languages in their particular local setting. Simple resources such as phrase books that could act as a quick reference for a health worker are scarce. Language ability is often not used as a criterion during the appointment of a health worker to a new job. Professional translation services are almost unheard of in Indian medical settings and in most cases the patient’s family members or other staff at the clinic are used as *ad hoc* translators. However, such practices are not ideal for good doctor–patient communication and have many implications such as those relating to patient privacy especially when it is related to stigmatizing medical conditions such as HIV/AIDS.¹² Being untrained, such translators may misinterpret key points made by both the patient and the doctor, omit embarrassing parts of the patient’s story or embellish parts of it based on their own perceptions and relationship to the patient.

THE POLITICAL WILL TO ADDRESS LANGUAGE BARRIERS

In 1966, India ratified the UN International Covenant for Economic, Social and Cultural Rights. Article 12 of the Covenant states that the ‘States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, and that in order to fully realize this right there has to be the ‘creation of conditions which would assure to all medical service and medical attention in the event of

sickness’. By virtue of Article 2.2 and Article 3, the Covenant proscribes any discrimination in access to medical services on the grounds of ‘race, colour, sex, *language* [emphasis added], religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status’.¹³ The lack of a policy to address language barriers is a failure to live up to the principles of such a covenant.

In India as elsewhere, knowledge of English is directly related to social class and power.¹⁴ In the 2001 Census of India, merely 230 000 persons or 0.02% of the population listed English as their first language. The number of English speakers increases to 125 million or 12.2% of the population when those who speak English as a second or third language are also factored in.¹⁵ Most of this 125 million belong to that section of the population that has the greatest access to healthcare in India. In a highly privatized healthcare system such as India, the ability of this section of the population to pay for costly diagnostic procedures and therapeutic interventions means that they are preferred by private practitioners who form the bulk of Indian doctors.¹⁶ It is this ‘consumer class’ that often sets the agenda for research and the structure of clinical services. Since they are less likely to be affected by language barriers, there has not been much political pressure to extend research and improve practice in such areas. The creation of evidence by health researchers on how language barriers prevent the poor and the disempowered from accessing quality healthcare can be a powerful tool to bring such issues to the forefront and generate the political pressure necessary for systemic change.

ADDRESSING LANGUAGE BARRIERS

In resource-rich settings in the West, there has been a history of research and advocacy on issues related to language barriers. In most cases, such barriers are addressed by employing *in situ* professional interpreters or by using telephone interpreters. Such initiatives might be feasible in some settings within low- and middle-income countries (LMIC) such as India but there is a need to explore other options that are appropriate to the local context. An increased awareness of the possibility for reduced outcomes of healthcare in settings of language discordance is the first step in addressing language barriers. Simple resources such as clinical language phrase books and patient information leaflets for common conditions and procedures in common languages prevalent in the region can be easily produced.

Further research is necessary to provide a better understanding of the nature and extent of language barriers in India. Research will have to address three broad areas: the ways in which language barriers affect health and healthcare, the efficacy of interventions to overcome language barriers, and the costs of language barriers and efforts to overcome them.¹⁷ In a setting in which a large proportion of healthcare expenditure is through out-of-pocket payments, arguments regarding the cost-effectiveness of trained medical interpreters are more complex, since the additional costs arising out of language discordant settings are transferred to the patient. Provision of trained interpreters for patients accessing healthcare in the private sector is possible only if there is a perceived need. However, vulnerable populations are likely to access healthcare from the public and voluntary sector where costs of providing language services can be borne by the provider if institutions are convinced that such services will improve health outcomes.

There is a need to create better mechanisms which allow students and health workers to obtain a functional knowledge of

languages they encounter in the clinic. This includes language programmes at educational institutions and access to language learning resources. A recent initiative in USA that aims to create resources for American health professionals encountering Hindi- and Urdu-speaking immigrants is one example of how such programmes can be structured.¹⁸ The consideration of language skills in health worker recruitment policies may create motivation to improve language skills. The exponential increase in the use of mobile phones in India may provide some solutions. As of June 2013, India had 873.36 million mobile phone connections and 176.50 million people who accessed the internet through mobile devices.¹⁹ The past few years have witnessed an increasing number of mobile phone applications that provided machine translations as well as linked users to telephone interpreters.²⁰ A telecom company in India is already offering phone-based interpretation services in 16 Indian languages.²¹ Such technologies promise new ways of addressing language barriers to healthcare but by themselves are not a total solution.

CONCLUSION

Over the past few years there has been increased discourse regarding achieving universal access to healthcare in India²² and the rest of the world. However, universal access implies that people not only have access to technology and human resources but also to explanations that allow them to give meaning to their health conditions and their causes. This enables patients to exercise greater control over their bodies and their spending on healthcare and helps them to be less vulnerable to the power imbalance between health workers and patients. Effective communication between health workers and patients is a key to creation of such understanding and empowerment and a determined and sustained effort to address language barriers is the first step in this direction. Addressing language barriers in India and other non-western countries, however, cannot be done simply by exporting strategies that have been developed in the West. This is primarily because strategies in the West focus on foreign immigrants who often constitute a small minority. In contrast, language discordance in many countries in the Global South is often the result of the population being constituted by native language groups of unequal sizes and the fact that health workers may be trained in a lingua franca such as English, Spanish or French which is not their first language. There is a need for more research and advocacy, knowledge translation and exchange and an exploration of new technologies to develop solutions that are appropriate to the local context.

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