

MULTILINGUALISM AND LANGUAGE BARRIERS IN HEALTH DELIVERY SYSTEM IN GHANA

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Abstract:

In this paper, we explore language differences among health givers and seekers as a potential barrier to quality healthcare delivery among the urban ethnolinguistically diverse population in Accra, Ghana. 134 patients and 42 health workers from five health facilities were selected as respondents to fill questionnaires and be engaged in semi-structured interviews which aimed at investigating the general language situation in healthcare delivery and determine whether language differences cause barriers to quality healthcare delivery. Using descriptive statistics and the thematic analysis of findings, the data revealed that both patient and health worker participants have varying ethnolinguistic backgrounds (speaking many different L1s). In addition, 65% of the patient population and 70% of health worker population in urban Ghana access and provide healthcare respectively in a second language, mainly English and Akan. For a highly linguistically diverse population, these findings have a potential to cause language barrier and raise miscommunication in the healthcare delivery process in urban Ghana - 64% and 81% of patient and health worker populations respectively admitted to experiencing communication barrier (occasioned by language differences) in the health care system. The findings of this paper corroborate earlier findings in the literature, e.g., Adams and Fleck (2015), Belaskri (2012), Chachu 2022 and Schyve (2007). The paper, therefore, concludes that health authorities in highly multilingual contexts need to pay (more) attention to the language needs of ethnolinguistically diverse populations to ensure quality and safe healthcare delivery.

Key words: Language barrier, Healthcare delivery, Ghana, Multilingual, English Language

1. Introduction and Background

This paper discusses language differences among health givers and health seekers as a potential barrier to quality and safe healthcare delivery among urban populations in Ghana. There is a growing concern among researchers in the health sciences, e.g., medicine, nursing, and health care policy, regarding the need to pay more attention to the role of language in healthcare and healthcare delivery around the world. For instance, Schyve (2007) has identified language differences between health workers and patients as a barrier to quality and safety in healthcare in the US. If we described healthcare as information management, where the collection of accurate and comprehensive patient-specific data is the basis for proper diagnosis and prognosis, then effective communication between healthcare practitioners and patients could be argued to be a core component of healthcare (Schyve 2007). Thus, language differences among healthcare givers and seekers can impede effective communication and adversely affect quality healthcare delivery. It has been argued that language barrier can lead to, and often leads to miscommunication in healthcare delivery, and that such miscommunications can be life threatening (Meuter et al. 2015). For instance, Adams and Fleck (2015) report that in public health, the linguistic disconnect between those providing health information and those who need that information affects not only clinicians and patients but also public health managers and policymakers.

Linguistic diversity, particularly in migratory situations, has been identified in the literature as one of the main causes of language barrier in the healthcare delivery process. With the ever-increasing spate of migration/immigration around the world, language barrier in healthcare has become a global problem. It is very common, globally, to find increasing number of patients who do not share a common language with their health workers/providers. Many countries around the world have clearly identified this situation as potentially problematic and are trying to address this growing concern through policy, practice, or both.

For instance, in the US, section 1557 of the Affordable Care Act (2010) requires hospitals to provide qualified interpreters (in person, by phone or video) to help facilitate communication between clinicians and patients. A typical example is *CyraCom*, a language services company (that is recognized by the American Hospital Association and American Dental

Association) that provides a 24/7 interpreter services to the healthcare system to bridge communication gaps in the healthcare delivery process. The Affordable Act (2010) also requires hospitals not only to post notices of language services availability but to also have such notices translated into the top 15 languages that are spoken in the area where the hospitals are located. In fact, before this act, there were several laws and policies on language access in healthcare.

In Australia, the health system of the Western Australian State has instated a language services policy since 2017, which is committed to providing high quality, safe and accessible health care to all Western Australians who may need language assistance in health communication, including those who cannot effectively communicate in English, like the Aboriginal people, people from culturally and linguistically diverse backgrounds, and people who are deaf or hard of hearing who communicate in Auslan (WA, Department of Health, 3). Similarly, the Victoria State Government in Australia has instituted language services policy and guidelines in health which are meant to provide language (translation and interpretation) services to support the health and wellbeing of Victorians from culturally diverse background.

Even though Africa is one of the world's most linguistically diverse continents in the world, very often, a colonial language (for example, English, French, Spanish and Portuguese) is used as official language and is used in formal education. For instance, despite the over 80 languages in Ghana, English is the de facto official language, and the language of formal education by policy. Per Ghana's language-in-education policy, English is the sole medium of instruction for upper primary to the tertiary level (Owu-Ewie, 2006; Ansah 2014). This means that healthcare practitioners e.g., nurses, doctors, etc. are trained in English.

For example, the University of Ghana Medical School syllabus (that holds true for the other health training institutions) ostensibly has no place for language and communication as an integral part of the training of health workers in Ghana. According to the University of Ghana Medical School course structure, whereas year one of medical school is spent in the faculty of science to "upgrade the level of science of the SSCE candidates to levels currently prevailing at the GCE Advanced level in the sciences", years 2 and 3 courses are limited to the following courses: *Medical sociology, History of western medicine, Psychology, Anatomy, Medical biochemistry, Physiology, Chemical pathology, Hematology, Microbiology, Pathology, Pharmacology*.

Given that the trainee health workers, after their training, will professionally interact with linguistically diverse populations many of whom either do not speak English at all or speak it as a second language (with varying levels of competences), this situation creates a very serious linguistic gap in the training of health workers in the country. In addition, even though the Patients' Charter of the Ghana Health Service suggests the need for (health) caregivers to reach care seekers in a language that is accessible to the patient, there is no clear language policy in the country's health care system (Amfo et al. 2018). The lack of language policy in the health system together with a high doctor-patient ratio in Ghana (in 2016, this was 1: 6,355, though the World Health Organization's standard is 1:1000)¹ increases the chances miscommunication in the healthcare system occasioned by language differences among healthcare practitioners and their patients.

While language and health communication has been researched and discussed extensively in the literature in Europe (Semino et al. 2015, 2016), US. (Meuter et al. 2015; Flores et al. 2008; Youdelman 2008) and Canada (Bourhis and Montreuil, 2017), very little research (e.g. Amfo et al. 2018; Belaskri 2012; Chachu 2022) has focused on language and health communication, particularly, language barrier in healthcare delivery in sub-Saharan Africa even though it is one of the most linguistically diverse parts of the world. Thus, there is the need for research in the language and health nexus not only to fill the gap in the literature but also to raise awareness about the important role language plays in the health care system, particularly, in ethnolinguistically diverse contexts. The objectives of this paper, therefore, are:

- i. To explore the language situation in healthcare delivery in Accra, the most ethnolinguistically diverse city in Ghana.
- ii. To determine if language differences create a barrier in healthcare delivery in this context.

2. Language and health communication research

Language barrier in health care can have significant impact on the success of the health care encounter (Jacobs et al. 2006). It has also been established that in health care services, the success of the health care encounter is particularly important as it may have an impact

¹ [Ghana Records Improvement in Doctor-to-population ratio - DailyGuide Network](#)

on patient's survival and health in the long run. Language barrier can lead to a doctor misunderstanding the full nature of a patient's problems (Sarver and Baker 2000). Findings from research in health communication in the US, for example, suggest that, many U.S. patients with limited skills in English, popularly known as 'Limited English Patients (LEP)', are less likely to receive the care they would need (Jacobs et al. 2006), more likely to be admitted to the hospital, are at a greater risk of suffering medical errors than fluent English speakers (Flores et al. 2003), and often have longer hospital stays for medical and surgical conditions than patients who speak English as their native language (John-Baptiste et al. 2004). It has also been suggested that language barrier between a patient and a doctor may cause excessive ordering of additional medical tests and unnecessary diagnostic testing, as the doctor tries to establish a proper diagnosis in the absence of sufficient patient history (Morales et al. 1999).

Language issues in health care have traditionally been of special interest in the North American contexts due to large amounts of ethnic minorities and immigrants who do not speak English. Consequently, the literature on language barrier in health care is heavily tilted towards limited English proficiency (LEP) patients whose native language is not English (Carrasquillo et al. 1999; Fagan et al. 2003; Jacobs et al. 2006; Karliner et al. 2007). However, language barrier in health communication goes beyond lack of English proficiency, and research in other jurisdictions are coming up. Meuter et al (2015) conducted a hospital-based study that examined interactions between healthcare practitioners and their patients to understand language barriers and miscommunication in healthcare delivery systems in situations where at least one speaker in the health care system uses a second language. Among other things, the study sought to understand how language barriers affect health care encounters, how health care companies overcome language barriers in medical encounters and the role and importance of native language in health care services. The findings of this study which used empirical data drawn from semi-structured interviews indicate that language barriers are in many ways problematic in health care services, with various potential negative impacts on patients. However, various interventions, e.g., using professional and non-professional interpreters, could be helpful in overcoming these barriers and potential negative implications for patients. The study therefore concluded that patient's native language has an important role in health care services.

Previous studies that have reported potential negative implications of language barrier in health communication include Holmqvist (2011), Carrasquillo et al. (1999), Morales et al. (1999), Sarver and Baker (2000), Fernandez et al. (2004), Jacobs et al. (2006) and Bitner

et al. (1997). For instance, Jacobs et al. (2006, p. 111) have argued that an efficient dialogue between a doctor and a patient is “of a diagnostic import and therapeutic benefit”. Similarly, Bitner et al. (1997) have argued that patients are part of the health service production process as they contribute to the process by providing information about their ailment and symptoms, and that if patients provide precise medical information about themselves in a timely manner, their doctors are able to do more accurate diagnoses. On the one hand, the quality of information that the patient provides can ultimately affect the quality of the treatment outcome. On the other hand, patients also need to follow their doctors’ advice to receive the desired outcome, so the patient also needs to participate and engage during the treatment process. Again, Morales et al. (1999, p. 414) have opined that optimal treatment outcomes depend strongly on “satisfactory communication between patients and physicians on medical test results, medications and treatment options”. Rivadeneyra et al. (2000) also contend that the quality of the doctor-patient relationship influences the diagnosis, treatment and even the recovery of the patient while Jacobs et al. (2006, p.111) emphasize the role language and communication play in health care, arguing that miscommunication in medical encounters can lead to lost work time due to delayed diagnoses, unnecessary visits to clinic or hospital and even preventable medical errors.

The importance of good communication between health providers and patients has long been recognized. Indeed, Jackson (1998) has described language as medicine’s most essential technology - the principal instrument for conducting its work. In Clark’s opinion, without language, the work of a physician (or other health provider) and that of a veterinarian would be nearly identical (Clark 1983). The U.S. Joint Commission states that communication is a core component, not simply an adjunct or facilitator of health care (Schyve, 2007). Some literature on patient-provider communication (e.g., Kaplan et al.1989; Stewart 1995; Stewart et al. 1999; Stewart et al. 2000; Teutch, 2003) indicate that in addition to effects on patient satisfaction, there is a relationship between the quality of communication and specific patient health outcomes such as pain, recovery from symptoms, anxiety, and physiological measure of blood pressure and blood glucose. Three basic communication processes have been identified as associated with improved health outcomes, namely, the amount of information exchanged, patient’s control of the dialogue, and rapport established (Kaplan et al. 1989). It is obvious that all these processes will be jeopardized in health care encounters where there is a language barrier.

Another dimension of the language in health communication is concerned with the role of native languages in the health care process. In this regard, there is empirical evidence, e.g.,

Fernandez et al. (2004) and Morales et al. (1999) to suggest that patients prefer to communicate in their native language in health care encounters although they may also have a second language they are fluent in. Indeed, both Fernandez et al. (2004) and Morales et al. (1999) report that Hispanic LEP patients in the US perceived higher quality for their medical treatment when they could speak their native language with their doctors. Native language has an important role in trust building between the patient and medical personnel which is a crucial factor in the health care system. For instance, the level of competence in a patient's native language (by medical personnel) is vital in creating trustful relationship between patients and medical personnel, as native language use positively affects patient's identity and well-being. In a study that examined language barrier in health care and social services system among non-French speaking minority population in Quebec, Canada, Ouhmet et al. (2013) found that patients who received healthcare services in a language other than their mother tongue were more prone to receiving inappropriate medication, tended to be prescribed medication more often, tended to be less satisfied with the care they received, spent more time on average in the emergency room, and were more likely to be exposed to undesirable events than majority language patients.

For instance, Samuels-Kalow et al. (2013) found that Spanish-speaking patients in the US were more likely to demonstrate a dosing error than English-speaking patients. In another study, 27% of patients who felt they needed an interpreter but didn't get one did not understand the instruction for taking their medication, compared to 2% of those who got an interpreter or didn't need one (Andrulis et al. 2002). Indeed, patients with language barriers have been reported in several studies as having more difficulty in understanding labels on medications (Masland et al. 2011; Wilson et al. 2005), less likely to adhere to prescribed medication (David and Rhee, 1998; Ens et al. 2014; Karliner et al. 2007; Krueger et al. 2005; Traylor et al. 2010) and are more likely to report complications (see also Yeo 2004). These studies notwithstanding, other researchers in health care communication have focused on how to find solutions to language barrier in health communication. In this regard, there are studies whose findings suggest that implementing certain language adaptation measures in services for minority language patients can lead to better care quality (Karliner et al. 2007; Snowden et al. 2010), lower costs associated with their treatment (Hampers and McNulty, 2002), engender a better understanding in discussions with health professionals (Han et al. 2009) and help health professionals adopt less discriminatory care practices (Bishop 2008). See Bowen (2001) for a critical review of the literature on the impact of language barriers on patient safety within the context of quality of care.

In Africa, Belaskri (2012) has used ethnography and mixed methods, i.e., questionnaires, participant and non-participant observation, discussion forums, online social networking services and emails to examine language use in the Algerian healthcare sector. The findings of the study revealed that majority of doctors in Algeria mixed Arabic and French but used more French to interact with their patients. French was found to be used even in situations where patients did not understand it. Finally, patients with low proficiency in French were found to have difficulties expressing their concerns verbally and were medically less literate/informed.

In Ghana, Chachu (2022) reports that Francophone West Africans in the capital city, Accra, experience language barrier in accessing health care, a finding which Amoah (2022) corroborates during a presentation she gave during a seminar at the University of Ghana, Legon. Blankson et al. (2019) report that language differences (even dialect differences sometimes) among health givers and health seekers was a strong barrier to quality healthcare delivery. They further report that the use of unskilled interpreters (an attempted solution) was not very effective because most of these interpreters have limited understanding in the appropriate medical terminology. Again, patients expressed concern about the possible breach of confidentiality in the use of these unskilled interpreters. Korsah (2011) also found miscommunication (occasioned by language differences) as one of the factors that impede positive nurse-client interactions in Techiman, a major market town in Ghana.

The current study investigates language differences among health givers and health seekers as a potential cause of miscommunication (with potential negative/dire implications for patients) in the health care system in Accra, the most populous and ethnolinguistically diverse city in Ghana.

3. Methods

The study was conducted using the mixed method. Data was collected using questionnaires and semi structured interviews with participants. The questionnaire for patient participants and health worker participants contained questions that were appropriate for each group. A copy of the questionnaire for each group is attached to this paper as appendix. The questionnaires were analyzed using descriptive statistics while the transcripts from the interviews were thematically analyzed. The questionnaires were written in English. However, the interviews were conducted in English and Ghanaian languages with some amount of

code switching as it became necessary. The data was sampled from the following selected health facilities in Accra:

- The University of Ghana Hospital, Legon (quasi-public)
- Nyaho Clinic (private)
- SSNIT hospital - Osu, Adenta, Accra-central, Dansoman (private)
- Accra Ridge hospital (public), and
- Mamprobi Polyclinic (public)

All these health facilities are in Accra, the capital city of Ghana. The facilities are also located in communities with diverse demographics such as ethnic/cultural, educational, social, and economic orientations. For instance, the University of Ghana community is a city within the capital that has become the residence of over 30, 000 students, staff, faculty, and workers of all levels, who are Ghanaian and international. Nevertheless, the Legon hospital is accessible to residents of neighboring communities, including East Legon, Madina and even residents of rural Greater Accra and Eastern regions. The other sites from which data was collected are also culturally and socially diverse.

Two sets of respondents/participants were randomly selected from the facilities. The first set consisted of participants drawn from a patient population while the second set was drawn from a health worker population. Permission for data collection was granted by the University of Ghana College of Humanities Ethics Board as well as the appropriate bodies in the selected health facilities. Individual participants also gave oral/written or both consent before data collection began. The characteristics of individual participants are provided below:

There were 134 patient participants comprising 123 (92%) male and 11 (8%) female. As expected, the participants were of varying ethnolinguistic backgrounds. Their ages ranged between 18 years and 40 years, but most of them (91%) were between the ages of 18 years -25 years. Only 1(1%) was below 18 years; 1(1%) between 31- 40 years, and 8 (6%) between 26-30 years. Two (1%) of the participants did not indicate their age. The age distribution reflects the national population distribution in Ghana (Ghana Statistical Services, 2014). Finally, majority, 128 (96%) of the patient participants indicated that they are students; 1 was unemployed and the rest comprised a pastor, a graphic designer, an auditor, a technology assistant, and a trader. Table 1 below summarizes the number and distribution of patient participants across the health facilities:

Table 1: Number and distribution of patient participants across health facilities

Research sites	No.	Percentage
Legon	104	78
SSNIT	23	17
Nyaho	7	5
Ridge	0	0
Mamprobi	0	0
Total	134	100

As expected, many participants traced their ethnic origins to one of 14 different indigenous Ghanaian ethnolinguistic groups, while 6 did not indicate their ethnic group, as indicated in Table 2 below:

Table 2: Ethnolinguistic profile of patient participants

Ethnic Group	No.	Percentage
Akan	87	65
Ewe	20	15
Ga-Adangme	8	6
Mole-Dagbani	2	1
Kasena	2	1
Nzema	1	1
Kotokoli	1	1
Chanbah	1	1

Frafra	1	1
Gonja	1	1
Gurun	1	1
Guan	1	1
Dagaati	1	1
Bimoba	1	1
No answer	6	4
Total	134	100

There were 42 health worker respondents consisting of 30 (71%) females and 12 (29%) males. 5 (12%) were between the ages of 18-25; 13 (31%) between 26-30; 16 (38% between 31- 40; 1(2%) each between 41-50 and above 50 years of age. 6 (14%) did not indicate their ages. 17(40%) of these respondents were nurses; 7(17%) medical doctors; 4 (10%) physiotherapists; 3 (7%) each of physician assistants and midwives; 2(5%) each of dentists, pharmacists, and cashiers; and 1 (2%) each of an administrator and records officer. The number of health worker respondents and the health facilities from where they were randomly selected is presented in Table 3 below:

Table 3: Health worker participants distribution

research sites	no.	Percentage
Legon	18	43
SSNIT	15	36
Nyaho	5	12

Ridge	1	2
Mamprobi	3	7
Total	42	100

Consistent with the patient population, health worker participants traced their ethnolinguistic origins to many different ethnolinguistic groups as shown in Table 4 below. It is important to note that even though Accra, the city in which data were collected, is the indigenous home of the Ga-Adangme ethnic group, as the table above shows, many of the respondents for both patient and health worker group, were of the Akan ethnic group. This is not surprising since the Akan ethnic group makes up 39.8% of the population of Accra (Essegbey 2009: 120) and 47.3% of the population of Ghana (Ghana Statistical Service 2014:61).

Table 4: Ethnolinguistic distribution of health workers

Ethnic Group	No.	Percentage
Akan	20	48
Ga	11	26
Ewe	8	19
Builsa	1	2
Guan	1	2
Dagaari	1	2
Total	42	100

4. Results

4.1. The language situation in healthcare delivery in Accra

In this section, we present the findings on the first objective, which was to investigate the language situation in the healthcare delivery system in Accra. In order to do this, we present and discuss responses to the following questions which point us in that direction: (i) what

are the linguistic repertoires of respondents including the language (s) they are more comfortable speaking and therefore prefer to use in giving or seeking health at a health facility; (ii) what language(s) do health facilities tend to promote (directly or indirectly); (iii) what language(s) do respondents use/choose to initiate conversation at the health facilities and what informs such choices, and (iv) is there availability and accessibility of language services in the health facilities.

4.1.1 The Linguistic repertoires of Respondents

As has been indicated above, the data revealed that both patient and health worker respondents come from diverse ethnolinguistic backgrounds. Nevertheless, in many African contexts, there is a high possibility where people's ethnic identities do not necessarily match their linguistic identities. In addition, there is a high chance of bi/multilingualism among many African populations. Consequently, we asked respondents to indicate the language(s) they are fluent in both in terms of speech and writing. From the patient responses, 75% indicated fluency in English and one or more indigenous Ghanaian languages; 14% were fluent in one indigenous Ghanaian language only, while 11% indicated fluency in English only². In terms of writing, however, whereas 60% reported that they could read and write in English only, the remaining 40% said they could read and write in English and, at least, one indigenous Ghanaian language. Thus, it is safe to say that majority of the patients in this study are bi/multilingual, but mono literate.

Similarly, the results of health worker respondents showed that out of 42 respondents, only 4 (10%) reported oral fluency in English only; the remaining 38 (90%) were fluent in English plus one or more indigenous Ghanaian language(s). Regarding written language(s) however, 16 (38. %) of health workers reported literacy in English only; the rest 26 (62%) were literate in English and one or more indigenous Ghanaian languages. These results also show that the health workers in this study were mostly bi/multilingual and bi/multiliterate. Tables 5 and 6 below summarise the linguistic repertoires and literacy status (respectively) of both patient and health worker participants:

² This corroborates the recent phenomenon of the emergence of a sub-population in Ghana who are native speakers of (Ghanaian) English (see Afrifa et al 2018).

Table 5: Summary of participants' linguistic repertoires

Languages	Patients	(%)	Health workers	(%)
English only	15	11	4	10
One Indigenous language only	19	14	0	0
English and one or more indigenous languages	100	75	38	90
TOTAL	134	100	42	100

Table 6: Literacy status of participants

Languages	Patients	(%)	Health workers	(%)
English only	80	60	16	38
One Indigenous language only	0	0	0	0
English and one or more indigenous languages	54	40	26	62
TOTAL	134	100	42	100

Thus, from the results presented above, it is obvious that the linguistic repertoires of majority of our respondents (both patients and health workers) are multilingual. Considering that it has been established in the literature, e.g., Mufwene (2008), that multilingual speakers are often motivated to make language choices that are conditioned by the socio-economic and other dynamics of their spaces while negotiating their daily lives, we asked respondent to indicate which of the languages in their linguistic repertoires they prefer

and/or choose for health care encounters. Tables 7 and 8 below summarise respondents' preferred and chosen language (s) respectively in health care encounters:

Table 7: A summary of respondents' preferred language (s) in health care encounters

Languages	Patients	(%)	Health workers	(%)
English only	74	55	11	26
One Indigenous language only	25	19	4	10
English and one or more indigenous languages	35	26	27	64
TOTAL	134	100	42	100

Table 8: Language (s) chosen in health care encounters

Languages used to initiate conversation	Patients	Percentage	Health workers	Percentage
English only	86	64	16	38
1L1 only	13	10	3	7
English and L1s	35	26	22	52
No response	0	0	1	2
Total	134	100	42	100

A comparison of the figures in Tables 6, 7 and 8 above show some disparity between participants linguistic repertoires and their preferred language(s) on the one hand, and their preferred language(s) and their chosen language(s) on the other hand. For instance, even though only 11% of the patients indicated that they were fluent in English only, 55% of the same population preferred to use English only, and 64% choose to use English only in health care encounters. In other words, 44% of the patients reported as choosing a language they are less fluent (competent) in during health care encounters. This has a potentially very serious implications for quality health care, since patients' ability to describe the symptoms of their diseases accurately and adequately, is vital for accurate prognosis and diagnosis. Similarly, while majority of the health workers (90%) indicated that they were bi/multilingual in English and one or more Ghanaian languages, only 64% preferred to use more than one language in health care encounters, and 55% indicated that they adopt bi/multilingual practices (choose more than one language in health care encounters).

The most striking observation for us is the differences (in percentages) in the disparities between health worker populations and patient populations regarding language preference and language choice in health care encounters against their respective linguistic repertoires. For instance, on the one hand, while 55% of patients preferred English only but 64% chose English only (even though only 11% were competent in English only), only 26% of health workers preferred English only but 38% chose English only (even though only 10% said they were fluent in English only). On the other hand, 26% of patients preferred multiple languages (even though 75% had bi/multilingual competencies) while 52% of health workers preferred multiple languages (even though 90 % had bilingual competencies). What these results show is that there must be something other than linguistic ability that is influencing language choice among both populations in health care encounters among multilingual populations. The next section presents responses to the question of what informs language choice in health care encounters.

4.1.2 Factors that inform language choice in health care encounters

To explain the disparities identified above, we analysed respondents' responses to the questions on what informed their choice of language in health care encounters. A second dimension to this was to ascertain whether, in the perception of respondents, certain languages were expected (promoted) to be used in/by the health facilities where they work or

seek health care. Tables 9 and 10 below thematically present what informed health workers' and patients' choice, respectively, of language(s) while Table 11 presents results on the languages perceived as being promoted by health facilities:

Table 9: Factors that inform health workers' choice of language

What informs choice of language	No	Percentage
Ease of/ effective communication	7	17
Patient-driven (whatever language the patient begins to communicate in)	20	48
Patients' level of education	3	7
Dominant language in community	5	12
No common L1	1	2
No reason	6	14
TOTAL	42	100

Table 10: Factors that inform patients' choice of language

What informs choice of language	No	Percentage
Ease of/ effective communication	45	34
Health worker -driven	36	27
Dominant/prestigious/official language	19	14

Random	9	7
No reason	25	19
Total	134	100

From the tables above, most of the patients (34%) said they choose the language that they are most comfortable with and in which they feel they can effectively communicate. Given that majority of the patient population (64%) indicated that they choose to use only English in health care encounters, we can conclude that English appears to be most dominant language in health care encounters even though majority of the patients are bi/multilingual. There are two ways to explain this state of affairs: (1) majority of our patient participants were from the university community where the default official language is English; (2) that health communication is potentially face-threatening, containing topics that are classified as taboo in Ghanaian cultures (sexuality, reproduction). In the case of the latter, English, which is acultural then becomes the most appropriate medium of communicating culturally sensitive topics.

The second highest reason for choosing a language in health care encounters among the patients was health-worker driven (patients chose the language health workers used in such encounters). 27% said they choose health-worker driven languages as shown in this example: *“If the health workers communicate in Twi, I respond. Also, I do the same for Fante and English”* Again, other patients said they choose the language they feel the health workers would better understand (mostly English). As two patients put it: *Almost all health workers can speak English; This is because most health workers are fluent and more comfortable with English.* Thus, the overwhelming preference and choice of English by patients in health care encounters may also mean that patients are simply accommodating to the perceived linguistic needs of health workers. Finally, the third highest (14%) reason patients’ language choice was the perceived prestige or dominance or official status of a language. English and Akan were the most selected languages in this regard.

Interestingly, the top two factors that influence language choice among patients were the same for health workers: ease of /effective communication and patient-driven languages. Nevertheless, the topmost reason for health workers was ‘patient-driven’ (48%) while the 2nd highest reason was ease of communication (17%). 12% mentioned language dominance while 7% mentioned patients’ level of education. Other health workers said they

choose whichever language they feel would promote better communication between them and the patients. Of course, such health workers must be highly multilingual to be able to do this. However, whether the patients would feel the same is another matter altogether. Interestingly, quite a sizable number of patients (19%) and health workers (14%) gave no reasons for their choice of a particular language(s) in health care encounters.

The final concern of this section was to determine whether participants' choice of language in health care encounters is overtly or covertly influenced by their perceived understanding that a particular language(s) is/are the norm in the facilities where they provide/seek health care services. In other words, we wanted to find out what language(s) participants thought their health facilities promoted. Table 11 below summarises the results of responses:

Table 11: Participants perception of the language(s) that are promoted at their health facility

Languages	Patients	(%)	Health workers	(%)
English only	57	43	24	57
One Indigenous language only	9	7	9	2
English and one or more indigenous languages	65	48	8	19
Two or more indigenous languages	3	2	1	2
TOTAL	134	100	42	100

Even though none of the health facilities used in this study reported to have any laid down policy on what language(s) to use (in fact, no health facility in Ghana does), majority of health workers (57%) and many patients (43%) believe that their health facilities promote an English only policy. In other words, both patients and health workers perceive English as what most facilities promote by practice or circumstances, or both. If the general perception of both patients and health workers is that English is the normative/expected language of communication in health facilities in urban Ghana, how do the facilities cater to the needs of non-English-speaking populations among their clients? In the next section, we

present results on the questions of availability and accessibility of language services in the health facilities we studied.

4.1.3. Availability and accessibility of language services in the health facilities

When we asked whether language services were available at the health facilities, 61.9% of the health workers said no such services were available at their facilities. However, only 38.9% of this number said the available language services are made accessible (made known) to patients. Similarly, 60% of the patients indicated their awareness of their health facilities offering language services even though majority said such services are not usually made accessible to them upfront. For a highly linguistically diverse population, the lack of language services or its accessibility is a potential challenge in health communication. Considering that there are many health facilities without language services, we asked the more direct question of whether, in their opinion and experience, language differences among health seekers and givers pose a potential or real barrier to health communication in the health care system. We discuss participants responses to this question and related ones in the next section.

4.2 Language differences as a barrier to communication in healthcare

As has been discussed in the literature, language differences among health care seekers and care givers lead to a barrier in communication in healthcare delivery in other jurisdictions. One main aim of this study was to find out whether this phenomenon occurs in urban Ghana where populations are generally linguistically diverse. Table 12 below summarises the responses provided by participants on whether they felt that language differences among care givers and health seekers lead to communication barriers in health care system:

Table 12: Do language differences lead to communication barrier?

Language dif- ferences cause barriers?	Patients	Percentage	Health workers	Percentage
Yes	86	64	34	81
No	48	36	8	19

Total	134	100	42	100
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From Table 12 above, it is obvious that most of both patient and health worker populations see language differences as a barrier to communication in the health care system. As a follow up to the question of whether language differences cause communication barrier in the health care encounters, we asked participants who responded in the affirmative to indicate the ways in which such a barrier may occur. Participants’ responses are presented with illustrations below:

4.2.1 Barrier for Patients

This section thematically presents responses of patient participants regarding the ways in which they have experienced communication barrier that is caused by language differences in health care encounters:

- **Inability to explain illnesses in terms that the health workers could understand**
 - i. Couldn’t describe my illness properly*
 - ii. Lack of better wording or wrong choice of words*
 - iii. I could not get the right words in English to explain it, so she understood it differently from what I was trying to express*
- **Inability to understand medical terms used by the health workers**
 - i. Communication not effective because of technical terms and language expression*
- **Misinterpretation given information**
 - i. due to difference in languages spoken*
 - ii. misinterpretation during my time explaining myself in the consulting room*

4.2.2 Barrier for Health workers

This section thematically presents responses of health worker participants regarding the ways in which they have experienced communication barrier that is caused by language differences in health care encounters. Here, we provide more than bullet points and sample responses because respondents provided a bit more detailed information in their responses.

- **Quality of care compromised**

Several health workers opined that, from their experience, language differences lead to poor assessment of patients because they impede health workers' ability to obtain precise medical information (history and description) from the patients on the conditions and symptoms they are suffering. Poor patient assessment, they indicated, leads to wrong or poor diagnosis and treatment outcomes. This finding corroborates what is already known in the literature from other jurisdictions. Indeed, it has been established in the literature that when health workers fail to explain or counsel patients in a language that patients can understand, patients are typically unable to comply with or follow treatment plans fully (Karlner et al. 2007; Snowden et al. 2010; Morales et al. ,1999). All these affect the quality of health care patients receive. The health workers felt this is a very serious issue that needs to be addressed since it undermines their core roles as health care providers as is illustrated in the examples below:

- i. *For all patients to get the best results in our therapy, it starts from doing a proper assessment. The assessment is done in two parts: subjective and objective. Subjective assessment deals with how a patient perceives her symptoms and this enable us to understand how she feels about her condition. If there is a difficulty in understanding our patient during assessment, therapy may not be effective.*
- ii. *It is difficult understanding what the client means hence I am unable to make proper assessment and diagnosis*
- iii. *It makes it very difficult to triage patients*
- iv. *It interferes in every aspect of the care*

- **Invasion/ breach of privacy**

Inasmuch as the need and use of interpreters becomes important, in the absence of qualified and trained interpreters, the use of non-qualified people including family members, staff or complete strangers leads to a breach in privacy and the loss of vital information needed for proper diagnosis and treatment. The use of such unqualified personnel leads to miscommunication between health worker and patient. In fact, according to some of the health workers, the use of these interpreters sometimes makes their work even more difficult and causes the patients so much discomfort that there is a complete breakdown of communication.

- i. *It makes my patient very uncomfortable.*
- ii. *Some patients end up doing things contrary to the instructions given them.*
- iii. *This usually results in poor outcome of treatment.*

- **Patient dissatisfaction**

Health workers are service providers and aim to please their clients, but the barriers caused by language differences interfere with this (Stewart et al., 2000; Teutch, 2003). When they can use a language that the patient is fluent in, it enhances communication and trust, so that the patient leaves satisfied and hopeful of full recovery. On the other hand, inability to communicate effectively results in patients mistrust and dissatisfaction in the health worker, and health worker frustrations as illustrated in the excerpts below:

- i. *When I speak a language that a client understands, they can open up to tell me any challenges they have with their medication.*
- ii. *Patients leave with less understanding and more confusion.*
- iii. *Patients sometimes are not pleased you are unable to use the language pertaining to the locality you work. They forget you are also from another tribe and may not have had the opportunity to learn their language.*

It is important to note that all the specific ways in which language differences create combination barrier among the participants in this study have also been reported in the literature and have been established as impacting negatively on health care delivery.

4.2.3 Navigating language barrier in health communication

In the literature, some studies, like Karliner et al. (2007) and Snowden et al. (2010), have proposed ways to navigate communication barrier that is caused by language differences in health encounters to mitigate the negative effects on the health care process. In this current study, we also tried to ascertain the methods our health workers employed to navigate the communication barrier language differences create in health care encounters.

When we asked health workers to explain how they navigate communication barriers caused by language differences between themselves and their patients, 57% said they randomly looked for translators - anyone at all (another patient, a family member, etc.) who speaks the patient's language and is available/willing at that moment to assist. Neverthe-

less, 29% reported as relying on a staff of the facility who may have some level of understanding of the patient's language. Thus, we may argue that the reported language difference-based communication barrier in health encounters is artificial because majority of health workers seem to have a ready solution to the apparent problem. The challenge with these methods is that they create problems with two fundamental concerns in health care delivery: breach of health worker-patient confidentiality and the invasion of patients' privacy, both of which may discourage patients from expressing themselves freely and being open/truthful about their illnesses. Besides, it may be wrong to assume that anybody who speaks a particular language will have the competence to successfully translate/relay medical/technical information from patients to health workers and vice-versa as trained translators are able to do. Interestingly, 2% of the health workers explained that they used phone (on-line) translators, especially with non-Ghanaian patients. However, they did not indicate whether this involves the use of professional language translators as exist in Europe and the Americas. Though this route is also not foolproof, because there is no third party who is physically present, it reduces the risk of a breach in confidentiality and invasion of privacy. In an extreme case, 2% of the health workers reported as using gestures to navigate communication barrier in health encounters. How effective this is likely to be is everyone's guess. Unfortunately, 10% of the health workers did not respond to this question.

4.2.4 Resolving language barrier in health communication

Since both patient and health worker participants considered language differences to create communication barriers in health encounters, we asked them to suggest possible ways to deal with/resolve communication barriers in health encounters that are caused by language differences between patients and health workers. Sample responses are shown in the bullets below:

4.2.4.1 Patients' view

- A qualified health worker should at least speak English, Twi, and other local dialects. preferably a language dominant in the area of health facility.
- Allow patients to express how and what they are experiencing in a language they are comfortable in. If necessary, translators should be available at the various facilities.
- Basic training should be made for health workers to become familiar with different languages.

- Communicating with patients with the language they feel comfortable with will be one way of solving the problem
- Develop training programmes in local languages.
- Employing language translators in the health sectors.

4.2.4.2 Health workers' view

- There should be a facility or unit in the hospital to help with the translation of languages to aid in communication to be able to render quality health care to every individual.
- Clients should be encouraged to express themselves in other languages. English should not be a major language.
- Communicating mostly in our part of the world that should be our mother tongue. We should make effort to learn most of our local languages.
- Health facilities must provide the means for a professional interpreter in our workplaces.
- Hospitals should inculcate language services.
- Incorporate more than one local language in the primary and secondary school curriculum.
- We should be ready to learn other languages in open mindedness.
- There should be a national policy on language in healthcare delivery.
- We must develop a glossary of medical terminologies in our local languages.
- Health workers must have competence in the dominant language of the area they work in.

5. Conclusion

The language situation in Ghana is such that for most patients and health care practitioners who live in urban areas, the language used in healthcare delivery is Akan and English. For most of these people, this means they are compelled to use a second language. Research has shown that the use of a second language in healthcare delivery leads to miscommunications that affects the success of recovery for the patient and makes the work of health workers more difficult. In other jurisdictions, e.g. in the United States, individual States have begun to emphasize educating health professionals about language access. There is a deliberate attempt to offer training that focus on raising the awareness of how cultural and language barriers can affect the quality of care, with the goal of increasing clinicians' support for and use of language services. For instance, between 2004 and 2006, New Jersey, California, and Washington have enacted requirements for each medical school to educate

students on cultural competency of which language access is a core component. Cultural competency education is required for physician re-licensure. These states have also put in place clinically oriented continuing medical education (CME) programs, whose curricula include cultural and linguistic competency, for physicians and surgeons. Still in the US, several states mandate language services as a condition of facility licensure. Health facilities are required to post notices of interpreter availability in English and, minimally, the three most frequently encountered languages in the facility.

Unfortunately, issues pertaining to language have not been a priority for those in the healthcare delivery system in Ghana in particular. Our study has revealed that the health workers, who are mostly multilingual, are trained in English only and yet they have to offer health services and communicate health information (that they acquired in English) to multilingual patients. They therefore try their best (and sometimes fail) to accommodate to the languages their patients would understand them best in. The patients, on the other hand, though are also largely multilingual, perceive health facilities and health workers as English-speaking and thus accommodate to English at the health facilities they visit (irrespective of their level of competence). Apart from this, some patients also wish to use the most prestigious language, which is English. These differences in choice of, competence in and actual use of languages in healthcare delivery has led to both patients and health workers both agreeing that language differences is a potential source of miscommunication/language barrier in health encounters, though the health workers see this as more of a problem than the patients do.

Also, both patients and health workers suggest and advocate for better ways to resolve language problems in health care system in Ghana. In fact, it is high time all stakeholders in the healthcare care delivery system in Ghana, who are genuinely interested in the human resource of this nation, gave this situation all the seriousness it deserves. We call on the health regulatory bodies, e.g. Ministry of Health, Ghana Health Services, Ghana Medical and Dental Association, the Department of Public Health, to as a matter of urgency, take the appropriate steps to rectify this anomaly in order to improve health care and ensure safe and quality health care system.

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