AN INVESTIGATION OF THE USE OF THE ENGLISH LANGUAGE IN MULTILINGUAL COMMUNICATION: A CASE STUDY OF DOCTORS IN THE KHOMAS REGION

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Abstract

The present study investigated the use of the English Language in multilingual contexts. It focussed on communication between English speaking expatriate and local doctors from public and private hospitals with their Namibian and non-Namibian patients. The study's aims were firstly, to determine the multilingual communicative resources and needs in the selected public health centres and private practices in Windhoek Khomas region. Secondly, the study sought to determine how communication is managed, from the perspective of the doctors. Finally, the study sought to determine the role played by the use of the English Language in a multilingual communicative context. The study utilised a qualitative research design and in order to achieve the above objectives, a qualitative questionnaire was completed by 17 medical doctors based in Windhoek. The data collected through the questionnaire was analysed by content analysis methods of coding and categorising. The findings revealed insights regarding linguistic profiles as well as the communicative aspects of multilingual doctor patient communication. Most of the respondent doctors are multilingual. However, it was realised that there are a few expatriate doctors who communicate solely in the English Language, while others use the English Language as well as one or more Namibian languages. Regarding communication between doctors and patients, it was realised that there is language discordance between doctors and some of their patients, especially in the public health facilities. In instances when the doctor cannot *get-by* as some referred to it, interpretation, is done by nurses, friends or other patients. However, while some did not object to interpretation, others reported of interpreters lacking in contextual knowledge which misleads the doctor's judgement. Thus, while working in the Namibian multilingual healthcare system is rewarding for the multilingual doctors, the challenges experienced by the doctors who solely communicate in the English Language or by bilingual (the English Language and a local Namibian language) doctors persist.

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Dedication

I dedicate this thesis to God, my husband, Steve Basimike and to our amazing daughter, Imani Basimike.

Declaration

I, Katrina K. Basimike, hereby declare that this study is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any institution of higher education.

_____ _____

Katrina K. Basimike Date

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CHAPTER 1

INTRODUCTION

1.1 Background of the study

Globalisation has created opportunities for people to work wherever they choose to or as the need arises. Due to globalisation, multilingual and multicultural interaction is a common phenomenon across the globe. Multilingual communication refers to communication between members of different linguistic groups (House & Rehbein, 2009). It is the ability of an individual speaker or community of speakers to communicate effectively in three or more languages (Auer & Wei, 2010). There is an ever increasing need for a common language to aid communication in multilingual and multicultural settings. The English Language is increasingly assuming a hegemonic position across the globe and oftentimes is utilised for communication in most official business including multilingual and multicultural health care consultations. However, the English Language is not always known by all interlocutors, thus interlocutors are often faced with a task to ensure mutual understanding in multilingual communication encounters.

Effective communication hinges on multiple factors including mutual intelligibility of the language utilised between and among interlocutors. Diverse linguistic backgrounds thus call for the ability by interlocutors to effectively interpret their thoughts into words, however when the words should be sought in a language other than mother tongue, there may be some challenges. Baker (as cited in Fawole, 2010) stresses the fact that languages are different and they are not mere nomenclatures but articulations of realities of the speakers. Thus, when

people from different cultural and linguistic backgrounds interact, the problem encountered in communication becomes complex. Effective communication is at the core of any successful transaction, especially in health care encounters. The doctor-patient consultation can be equated to a transaction, whose success is determined by effective communication.

Namibia is a multilingual country (Klang, 2017), with many languages that are not mutually intelligible. Since Independence, Namibia has experienced a shortage of expertise in various fields, including healthcare (Hickling-Hudson, Preston, & Gonzalez, 2012). The country thus relies on the services of expatriate doctors. The utilisation of expatriate doctors further complicates Namibia's multilingual status. According to Mlambo (2017), the expatriates with many languages in their repertoire find themselves working in a multilingual environment that has a heightened linguistic diversity.

Even though the English Language assumed the status of Namibia's official language, only 8% of the Namibian population are native English speakers (Frydman, 2011), thus Afrikaans and other national languages are increasingly utilised as lingua franca in situations where the English Language is not known or understood (Aukongo, 2015). However, the unintelligibility of local Namibian languages causes communication barriers that can be challenging to doctors. Arguably, the situation cannot be corrected by employing local doctors, since they too may have linguistic repertoires that do not match that of their patient compatriots. This can negatively affect health service delivery to a greater extent. It was thus the purpose of this study to investigate the management of multilingual health communication by doctors working in public and private facilities, in Windhoek.

1.2 Statement of the problem

Previous studies (Fawole, 2014; Mlambo, 2017; Sobane, 2017) have explored language barriers in the doctor–patient communication in the African context. Fawole (2014), focussed on communicative strategies by the English Language-speaking foreign doctors in South Africa; Mlambo (2017) focussed on the communicative experiences of expatriate doctors only in Namibia; and Sobane (2013) explored the challenges faced by physicians who limitedly speak both the local language and the lingua franca. It therefore appears that no study could be found that explored the use of the English Language in the multilingual doctor-patient situation in Namibia focussing on both local and expatriate doctors. This is compounded by Nida and Wonderly's (1971) assertion that indeed "language barriers hamper health service". There is therefore need to ascertain how the use of the English Language in multilingual healthcare communication affects the health delivery service. Moreover, given the nature of the language situation, it may be safe to presume that interpretation may be utilised. Thus, it was necessary to investigate the utilisation of interpretation and determine its accuracy amidst a uniquely diverse linguistic scene in the doctor–patient communication in Windhoek (Quan, 2011).

1.3 Research questions

The general objective of this research was to explore the utilisation of the English Language in multilingual communication, with a focus on doctor-patient communication in Windhoek. From the perspective of doctors only. Besides documenting the linguistic profiles and associated competencies amongst selected participants in Windhoek, Namibia, the study investigated ways in which the various linguistic repertoires are put to use where the English Language supposedly enjoys the primacy of official language. The study's driving question

was: what are the challenges that emanate during the use of the English Language in the doctor–patient communication between doctors (both local and foreign) and local multilingual Namibians? The specific questions which the study sought to answer are:

1.3.1 What are the linguistic profiles of the participating expatriate and local doctors in this study?

1.3.2 According to the doctors, what are the linguistic profiles of the patients that they treat in Namibia?

1.3.3 What communicative challenges arise from the use of the English Language between doctors and patients?

1.3.4 How do the doctors mitigate the challenges encountered?

1.3.5 How do the doctors perceive their own linguistic profiles as well as the linguistic environment in which they operate?

1.4 Significance of the study

It is possible that Namibia will still have to rely on the services of expatriate medical doctors for some time to come due to the shortage of qualified medical personnel and also because those who have worked in the country for some time have made Namibia their home and as such they may wish to continue offering their life saving services. Whilst on the other hand, the linguistic diversity in Namibia is a natural and permanent phenomenon which can be a resource in various fields. In view of this, it is envisaged that the findings of the study will be beneficial in various ways as it further builds on the available literature on this topical issue, and it serves to sensitise those in academia and policy makers about the necessity to recognise the challenges and opportunities that the use of the English Language in healthcare communication pose within the Namibian context.

This study might also aid the Ministry of Health and Social Services of Namibia in formulating programs that can assist to strengthen the linguistic preparation of both foreign and local doctors prior to their deployment and integration into the Namibian healthcare system. The study can also benefit scholars interested in health communication and multilingualism as the study seeks to raise awareness about the problems and opportunities associated with multilingual doctor–patient communication in contexts where the English Language is utilised as the official language. Moreover, the study may assist medical personnel in Namibia as well as other countries with diverse linguistic populations, in dealing with multilingual communication when attending to their patients, as a means of improving the quality of health care delivery.

Furthermore, scholars and policy makers may use the study as a useful reference source and this study may help promote more research on healthcare communication. The study also complements the body of literature on multilingualism in Africa.

1.5 Limitations of the study

It is not possible in a study of such limited scope to do a comprehensive and representative qualitative survey. Thus, the study only investigated the management of multilingual communication by medical doctors, expatriate and local, working in selected public and private facilities in Windhoek and not in the whole country. Additionally, it was a challenge to get doctors to fill in the questionnaire and as such not all the distributed questionnaires were returned, hence a smaller sample than anticipated was obtained, especially with regards to expatriate and private doctors. However, a smaller data set was deemed suitable to find answers to the research questions. This enabled the researcher to investigate and understand the social

phenomenon of multilingual communication in medical care in a limited set of cases, providing indicators of what works, what does not, what strategies participants in this setting prefer.

1.6 Delimitation of the study

Due to the limited nature of the study as described at 1.5, the study only focussed on three main aspects. Firstly, it only focussed on doctors in Windhoek, not on doctors in the whole country. Secondly, the study did not include patients even though the focus was on doctor – patient communication. Lastly, the study did not include the other health care practitioners such as, nurses or physiotherapists.

1.7 Organisation of the study

The study has five chapters. The first chapter presented the title and the background of the study. The research problem and the research questions are also presented. The chapter further highlighted the significance of the study, and the limitations and delimitations of the study. Finally, an outline of the methodology was presented. The second chapter presents the literature review and identifies the gap revealed by the review of literature related to the study. Furthermore, the chapter presents the two theories (Linguistic Relativity Theory and Communication Accommodation Theory) that placed the study in context by providing a discussion of each theory. The third chapter describes the research design and methodology that was employed to carry out the research, including the explanation of tools and techniques for data collection. The fourth chapter presents and discusses the findings from the questionnaires. The discussion was guided by the Linguistic Relativity and Communication Accommodation theories and supported by reviewed literature in the second chapter of this

study. Chapter five reports on the conclusions and the recommendations that emanate from the study.

1.8 Chapter summary

This introductory chapter presented the background and the research problem identified in the study. Furthermore, the research questions, significance of the study and finally, an outline of the chapters was also presented.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents a discussion from the existing national and international research in the area of communication between doctors and patients. The chapter is divided into the following sections: 2.1 Introduction, 2.2 Health Communication, 2.3 Gaps identified 2.4 Theoretical framework, and 2.5 Chapter summary.

2.2 Health communication

Communication is at the centre of every relationship and more so the doctor-patient relationship. Communication is defined by some scholars (Lunenberg, 2010; Munodawafa 2008) as the process via which information and common understanding is transmitted between and among people, verbally and non-verbally. On the other hand, health communication has been defined by some scholars (Feeley & Chen, 2013; Nkanunye & Obiechina, 2017; Prilutski, 2010) as the dissemination of health information. Notably, there is little mention of language in many communication definitions, even though definitely, there can be no communication without language (Farzadnia & Giles, 2015). When participants of a communicative act have attained common information and common understanding, the communication process is said to have been effective. However, the clarity of messages may be distorted by what is often referred to as barriers (Lunenburg, 2010). A typical example of messages distorted in the process of transmitting information is the game played by many in their childhood referred to

as the “Broken Telephone”. The game begins with one person whispering something in the next person’s ear and the process continues until the same message reaches the last person. Often, by the time the message reaches the last person, it would have been a distorted one. This scenario suggests that information is likely to change in the process of any communication, including health communication, when there are mediators between the sender and the receiver.

There are factors upon which effective communication is dependent. Some of these factors are common or shared language, context and culture. Some doctors and some of their patients in the Khomas region, do not share a common language, context (health/academic knowledge) or culture (Mlambo, 2017) and in most cases the English Language or Afrikaans is often the lingua franca between doctors and patients in Namibia (Frydman, 2011; Aukongo, 2015; Mlambo, 2017) even though the English Language is not spoken by all Namibians. This study therefore sought to investigate the effects of the use of the English Language in multilingual doctor-patient communication in Windhoek, Namibia.

2.2.1 Doctor-patient communication

According to Shyve (2007), effective doctor-patient communication is considered vital to quality care, and barriers to the communication, if not checked, may result in medical error. The barriers to effective communication with patients may include differences in language and culture as well as low health literacy. Thus, a hospital’s communication practices should cater for all the communication hindrances, including language differences in order for effective communication to take place.

In countries where there are shortages of doctors, expatriate doctors are most likely to be employed in local hospitals. The expatriate doctors may not be conversant in local languages, so they often use the English Language to communicate with their patients as is the case with Namibia (Mlambo, 2017). Most patients, however, may not be conversant in the English Language (Quan, 2011) and this is the major challenge that is found in Namibia where Mlambo argues that the English language proficiency among patients is limited. The linguistic barriers may thus limit such patients to access health care. In other parts of the world, the same sentiment is echoed by Logan, Steel and Hunt (2014), who reported the difficulties that language disparity placed on effective communication for both doctors and patients.

Moreover, other multilingual health studies outside Namibia, (Blignault, Ponzio, Rong & Eisenbruch, 2008; Jirojwong & Manderson, 2001) reported that language was a significant barrier for patients to communicate symptoms and to express emotions. The barriers result in failure to seek help and engage effectively in communication with health professionals.

Similarly, other studies (Cross & Bloomer, 2010; Rosenberg, Richard, Lussier, & Abdool, 2006; Sandhu, Bjerre, Dauvrin, Dias, Gaddini, Greacen & Priebe, 2013) reported that patients' language and literacy abilities were a major barrier for clinicians when language disparity was present. Furthermore, doctors reported difficulties with semantics and an inability to describe symptoms in simple terms when a language barrier existed (Cross & Bloomer, 2010; Rosenberg et al., 2006). Lack of language fluency was a common cause of clinicians' failure to understand patients' problems, an inadequacy in judging symptoms severity and consequently an impaired ability to correctly diagnose (Sandhu et al., 2013). When this difficulty occurred, doctors often failed to seek clarification or patients failed to speak up, for fear of being further misunderstood (Rosenberg et al., 2006).

In the Namibian context, the communicative situations above are also prevalent, considering the presence of expatriate doctors attending to multilingual Namibian patients as well as local doctors who may not be able to speak some of the up to 30 languages spoken across a vast country of just slightly above two million people (Mlambo, 2017; Frydman, 2011).

Arthur et al. & Sandhu et al. (as cited in Logan, Steel & Hunt, 2014) report on the utilisation of family members as interpreters when language differences are present. Family interpreters are utilised in order to negotiate health communication and to enable healthcare workers and patients to work in a collaborative manner. Family based interventions may be appropriate and they may aid communication in certain cultural contexts, such as assisting in the clinicians' understanding of patients' behaviour and symptoms when language differences exist.

In a quantitative study by Eytan, Bischoff, Rrustemi, Durieux, Loutan, and Gilbert (as cited in Logan et al., 2014), ratings of communication with patients were poorest when no interpreter was utilised, better when relatives were utilised, and best when trained interpreters were utilised. However, interpreter services use was often discontinued by doctors once rapport was established (Cross & Bloomer, as cited in Logan et al., 2014). The use of ad-hoc interpreters in Namibian hospitals is prevalent (Mlambo, 2017) though more research still has to be conducted in order to establish its various facets. Thus, this study sought to further extend insight regarding mitigating practices utilised to aid communication between doctors and their patients in Windhoek.

2.2.2 Communication and doctor-patient relationship

The doctor-patient relationship is one of the relationships that are crucial in any medical encounter. Fowler (2008) states that, Talcott Parsons, the first social scientist to theorise the doctor-patient relationship, argued that the doctor's role is to represent and communicate information about illness to the patient, and to control the deviance between the physician and the patient, which in most cases is evidenced by emotional and linguistic distance. However, some exchanged sentiments are necessary in a good doctor-patient relationship in order to build rapport (Sobane, 2013). The present study therefore sought to determine how rapport is ensured by doctors operating in Windhoek whose patients may not necessarily be conversant in the English Language, even though, it is the lingua franca and the official language.

Rapport is ideal between any doctor and their patient. According to Fowler (2008), rapport happens by being accustomed to patients' symptoms, concerns and values. Thereafter, the physician examines the patient, interprets the symptoms, formulates a diagnosis, and then proposes treatment and a follow up plan to which the patient agrees upon (Fowler, 2008).

Furthermore, Fowler (2008) posits that the doctor-patient relationship is also analysed from the perspective of ethical concerns in terms of how well the goals of beneficence, autonomy and justice are achieved from the encounter. The same sentiment regarding doctor-patient relationship is shared by Brindley, Smith, Cardinal, and LeBlank (2014). Given the nature of doctor-patient relationship, it is evident that doctor-patient communication is a crucial determinant of the success of the affiliation between doctors and their patients.

Medical care relies on information management (Ha & Longnecker, 2010). Thus, the collection of accurate and comprehensive patient specific detail is vital, since proper diagnosis and prognosis depends on it. Effective communication will ensure the best collection of patient details. Therefore, good doctor-patient relationship hinges on effective doctor-patient communication. Furthermore, good doctor-patient relationship ensures patients' trust in their physicians' diagnosis and consequently, adherence to treatment. However, the million-dollar question remains, "Are all factors, including linguistic concerns that are considered vital to effective communication in medical encounters, really considered and planned for in Namibia?" Thus, the present study attempted to answer this question by focusing on the use of the English Language in multilingual doctor-patient communication regardless of empirical evidence suggesting that the English Language proficiency in Namibia is limited and that local languages are not mutually intelligible.

Leffler (2015) maintains the view that the minority population (people whose native language is not the one utilised for business) consents to the imposition of hegemonic languages over their own. Hegemonic languages include ex-colonial languages that engulf African languages in wider communication and sweep over minority languages (Leffler, 2015). However, in order for information to spread, it needs to be provided in the language that the community understands best. Unfortunately, due to the reality of multilingualism in most African hospitals, Namibia included, the majority of the doctors who provide health care do not share the same language as their patients, and neither is healthcare provided in the doctor's native language in most cases (Mlambo, 2017; Sobane, 2013; Sobane & Antonissen, 2013). Instead, the English Language or another dominant language serves as the lingua franca between doctors and their patients. The present study sought to determine the effects of the English Language as it is utilised as a lingua franca in multilingual doctor-patient communication in Namibia.

2.2.3 Interpretation

Communication between speakers who do not share a common language has often been enabled by interpretation or interpreting. Interpretation has been described by Angelelli (2004), as a process in which interpreters are one component in a three-factor equation which consists of more dominant speakers, less dominant speakers and the interpreter. Moreover, Angelelli (2004) observes that the role of interpreters in a bilingual encounter can take different forms, for example, interpreters may help minority-language speakers explore possibilities, thereby channelling opportunities for them. This brokering may be achieved by being attentive to the social reality of speakers. Alternatively, interpreters may focus on the message only, disregarding how it is construed by each of the parties involved in the conversation (Fawole, 2014). Therefore, it is necessary to determine how interpretation is conducted by doctors in Namibia.

Some scholars (Fawole, 2014; Sobane, 2013) posit that reliance on unprofessional interpreters including patients' family or friends to provide interpretation for patients can have harmful effects on patient outcomes due to miscommunication. Similarly, Sobane and Antonissen (2013) indicate that medical practitioners' lack of access to competent medical interpreters puts doctors and patients at risk of adverse events and suboptimal outcomes which contribute to minority patients having challenges in accessing equitable healthcare. Some of the suboptimal outcomes include increased risks of complications, longer length of stay and preventable readmissions. The above problems are believed to increase costs and decrease patient satisfaction. Moreover, Sobane (2013) notes that interpreters might omit or filter the information, deeming some information to be unimportant, too disturbing or too complicated to convey. Furthermore, the use of minor children to act as interpreters may put children in

awkward situations that may be unethical, illegal and prone to miscommunication (Sobane, 2013). Thus, this study sought to determine how doctors in Windhoek perceived the information gotten through *ad-hoc* interpreters.

Additionally, Logan et al. (2014) highlight that communication exchanges that involve third parties can be especially challenging. These challenges include limited access to appropriate interpreter services, and abiding by appropriate cultural expectations during family exchanges. The limited nature of access to appropriate interpreter services is supported within the larger literature, with some authors reporting a growing need for competent health care workers and interpreters in order to ensure health care access and utilisation (Fawole, 2014; Mlambo, 2017; Sobane, 2013). Thus, this study also aimed at exploring the issue of limited access to professional interpreters in the Namibian healthcare system.

In order to mitigate the linguistic problem, trained medical interpreters may be necessary (Andrews, 2012; Ferguson & Candib, 2002). In most cases, however, interpreter services may not be available, so family members or medical staff members assist with interpretation. Rice (2014) supports interpretation services, provided that the interpreters are trained professionals since untrained interpreters may not be knowledgeable about medical terminology and as such they may make errors that can cause communication barriers. Hence, the present study focussed on the mitigating practices established by doctors that facilitate or inhibit quality health care in Namibia as this area has largely remained un-investigated within the Namibian context.

Regarding interpretation, Rice (2014) further asserts that despite the caution by health organisations against the use of untrained interpreters including bilingual medical staff, most hospitals continue to use them. The reasons for the use of untrained interpreters include: lack

of funds, time pressures, and procedural challenges of arranging for trained interpreters or ignorance about the availability of trained medical interpreters. However, it has to be noted that these findings were yet to be tested to refutation or confirmation in specific contexts like that of Windhoek, hence the need for the present study.

Furthermore, Naish (2012), in a British newspaper, reports of cases in Britain, in which doctors and nurses put patients' lives at risk because they could not speak the English Language. Similarly, in some parts of the world, where the English Language is the lingua Franca, some doctors and patients alike, have limited proficiency in the English Language (Asante, Negin, Hall, Dewdney, & Zwi, 2012; Fawole, 2014; Sobane, 2013). This phenomenon further complicates multilingual communication, especially as it relates to life and death situations like the healthcare context. Such linguistic disparities therefore need to be taken into consideration when dealing with health communication. This study thus aimed at determining the linguistic background of the doctors in Namibia and how it affects the provision of quality health care.

2.2.4 Culture and communication

According to O'Sullivan (as cited in Junghare, 2015), culture is a multifaceted concept, involving aspects of morals, customs, beliefs, law, knowledge, art and other habits or practices acquired by members of a society. This definition suggests that culture entails the way of doing things that is adopted and accepted by members of a society. That way of doing things is translated into societies' agreements about how they view the world, behave, interact with each other, judge each other, and organise themselves. These agreements which are transformed into rules are learnt as part of growing up and they are transferred from one generation to another through language (Iscan, Karagoz & Konyar, 2017). Thus, since language and culture are

related, both are learnt together. In light of the discussion above, it was necessary in the current study to determine how cultural differences between doctors and patients affect communication between doctors and patients in Namibia, utilising the Linguistic Relativity Theory (Leffler, 2015).

Since language is utilised to transfer culture (Fawole, 2014; Iscan, Karagoz and Konyar, 2017; Leffler, 2015), it may be safe to assume that the lexis of a language is determined by its culture. For instance, if a certain concept is non-existent in a certain culture, it is likely not to contain a term in the said language. Thus, in health care, intercultural communication could pose some barriers to effective health communication if the necessary health communication measures are not in place (Fatahi, Mattsson, Hasanpoor, & Skott, 2005; Fowler, 2008).

Moreover, studies done in Southern Africa (Fawole, 2014; Mlambo, 2017; Sobane, 2013; Sobane & Antonnissen, 2013) have discovered a prevalence of linguistic barriers in multilingual health communication which emanates from linguistic and cultural disparities. Thus, as already indicated, this study sought to uncover the existence of such barriers in Namibia, its effects and consequences on the patient.

Communication, in its larger form, transcends spoken words and as such, a comprehension of cultural aspects can be beneficial to any multilingual communication. Due to cultural differences, the provision of quality health care in linguistically diverse communities may be a challenge (Wilson-Stronks & Galvez, 2007). For instance, there are health related issues that may be a taboo to disclose openly by patients due to their cultural orientation and background, and this in turn poses a challenge to the health practitioner and also affect the patient negatively. Villarruel, Portillo and Kane (1999) support Wilson-Stronks and Galves (2007) and cautioned

health care practitioners to be mindful of cultural implications of topics such as death, sexuality, childbirth and women's health, and probe cautiously before a final decision is taken to care for the affected person.

In addition, Ferguson and Candib's (2002) reviews of literature discovered that differences in language, ethnicity and race bear a substantial influence on the quality of doctor-patient relationship and communication respectively. Thus, patients whose ethnicity, race and language are different from that of the doctor are less likely to attract empathic responses from doctors, as well as establish rapport with doctors, receive satisfactory information and be encouraged to participate in medical decision making. The present study therefore sought to determine the implications of the doctors' linguistic identity with regards to communication in their work place by presenting the Namibian (Windhoek) case study as a test case.

There are many barriers hat hinder health care delivery and language disparities is a major factor (Fawole, 2014; Mlambo, 2017; Sobane, 2013). In order to curb these challenges and find a lasting solution to them, interpretation services are considered but even with that put into consideration, studies have found that most health facilities do not use trained medical interpreters (Fawole, 2014; Mlambo, 2017; Sobane, 2013). Such situations pose a threat to quality health care delivery. (Fawole, 2014). Moreover, the provision of health care in linguistically diverse communities, such as Namibia, poses a very big challenge since there are cultural-linguistic issues that ought to be considered and addressed before handling a patient. Thus the rational for this study was to explore this phenomenon using a context-specific area of concern.

2.2.5 The English Language in Namibia

Namibia gained Independence in 1990 from the then South African apartheid system (Freeman, 1992). As a young independent nation, much had to be done to ensure the country's growth. The country needed to resolve issues related to skills deficit as well as social imbalances. In order to address and resolve the country's issues, a national development strategy called Vision 2030 was launched by the government (Namibia National Development Plans [NDP1], 2012). According to Frydman (2011):

> The aims of vision 2030 included capacity building, aimed at operating a high quality education and training system, achieving full employment in the economy, and transforming Namibia into a knowledge-based society. Vision 2030 was further expected to reduce inequalities and create "a pervasive atmosphere of tolerance in matters relating to culture, religious practices, political preference, ethnic affiliation and differences in social background". The national development strategy is seemingly all-encompassing in the areas it set out to address and the issues it planned to resolve, however, it lacks entirely any mention of language or language policy, despite the fact that language is the medium through which ideas are communicated. The absence of language in the plan is critical since language is not simply an area to be addressed or an issue to be resolved, but rather an issue that affects every other targeted area outlined in the plan. (p. 178)

The above quotation highlights the importance of planning for linguistic needs in all spheres of development in general, which Namibia's development plans have excluded. Consequently, the quote seemingly suggests that Namibia's failure to acknowledge and plan for linguistic

matters might inevitably affect development and hinder progress in all sectors, including the health sector.

Diversity in languages in Africa have contributed to most African countries adopting the languages of their various colonisers as their official language. (Leglise & Migge, 2008; Leffler, 2015). Even though it would have been more ideal to adopt German or Afrikaans as the official language, (her colonisers' languages), Namibia on the contrary adopted the English Language (Frydman, 2011). Despite the undeniably great advantages of the English Language in Namibia, its continued use still poses a threat to effective communication in various spheres including health, hence the rational for this study.

The English Language proficiency among the people of Namibia can arguably be classified into five categories:

- The first category comprises of the Namibian people who were educated in the country before Independence. These people are conversant in Afrikaans as it was the medium of instruction and the language of official and government business. After Independence, majority of them were privileged to learn the English Language through adult education programmes (Shaleyfu, 2012), however, they still did not achieve the basic English Language proficiency. The second category comprises of people who went into exile to English speaking countries, for education and had the privilege to learn the English Language there.

- The third category comprises of young people (referred to as 'born frees') who have been and are being taught the English Language in schools. They learnt a somewhat

deficient English Language, due to limited English Language proficiency by their teachers (Nkandi, 2015).

- The fourth category comprises of the young people who did not get a formal education due to social reasons (Ministry of Education, Arts and Culture, 2015). They cannot converse in the English Language and require interpretation services in order to achieve their communication goals in government and formal situations. The last category comprises of some of Namibia's elderly population who did not attend formal schooling, even during the colonial era (Shaleyfu, 2012).

That being the case, many elderly people are neither conversant in Afrikaans nor in the English Language. In order for such people to receive any services including health care, interpretation is necessary, which is a major the concern of this study.

The adoption of the English Language as Namibia's official language has seemingly yielded communicative problems. This is evident in the necessity for coping mechanisms by the limited the English Language proficient masses in the form of code-switching in order to achieve communication goals (Aukongo, 2015). For instance, the Afrikaans language which was the coloniser's language, still remains widely utilised in southern and central parts of Namibia, seemingly as a second lingua franca. In other parts of the country, most government officials who are conversant in local languages find themselves yet again needing to code-switch from the English Language to the local languages in order for effective communication to take place (Aukongo, 2015). Moreover, those who are not locals and are not conversant in local languages find themselves needing to find a linguistic meeting point to aid communication with the locals.

The linguistic situation also permeates the health sector, thus this study aimed to investigate the use of the English Language in doctor-patient communication in Namibia.

Arguably, in spite of the persistent limited English language proficiency among many Namibians, the English Language remains Namibia's only official language. The continued utilisation of The English Language in multilingual Namibia raises concerns, hence the rationale for the present study.

2.3 The gaps identified

Various studies (Fawole, 2014; Fowler, 2008; Ha & Longnecker, 2010; Harris 2017; Quan, 2011; Sobane, 2013; Sobane & Antonissen, 2013), were conducted in the area of multilingual health communication, however, each of the studies focussed on different areas of health multilingualism outside Namibia. Nonetheless, Mlambo (2017) carried out research in multilingual health communication in Namibia, a study upon which the present one builds. However, Mlambo's (2017) research explored the management of multilingual communication in general, by expatriate doctors operating in private facilities only. The present study further extends Mlambo's by focussing on the use of the English Language in multilingual communication in both private and public health facilities as well as by both local and expatriate doctors in Windhoek, Namibia.

2.4 Theoretical Framework

Since the English Language is the official language in Namibia, it is also the language of health care consultations in Namibia (Frydman, 2011, Mlambo, 2017). In multilingual health contexts, a lingua franca is utilised to aid communication, however, a lingua franca is often inadequate to attain effective communication, when it is not utilised by all interlocutors (Fawole, 2014). Therefore, interlocutors often need to find a linguistic meeting point to aid communication in such cases. Nonetheless, multilingual communication is complex, requiring the study of language and the cultural dynamics involved in the process of communication (Farzadnia & Giles, 2015). As such it is necessary to sensitise doctors about linguistic and cultural issues involved in multilingual communication in order to achieve effective multilingual and multicultural health communication. Thus, the study has employed two theories, the Communication Accommodation Theory and Linguistic Relativity Theory to explain the framework which underpins it.

2.4.1 Communication Accommodation Theory

In most cases, interlocutors in multilingual contexts find themselves needing to find a linguistic meeting point. There are thus strategies employed in order to attain the communicative goals. As such, it was necessary, for the purpose of this study, to refer to the Communication Accommodation Theory (CAT) as one of the theories framing this study. The CAT, originally known as the Speech Accommodation Theory (SAT) was presented by Howard Giles in 1970 (Orbe & Harris, 2008). Additionally, Orbe and Harris (2008) posit that:

> CAT explains how speakers from different cultures adjust their speech styles to accommodate others during interactions. CAT goes beyond what is said to include all

> aspects of communication in intercultural interactions which may involve 'accent, rate, audibility, vocabulary, grammar and gestures'. The theory proposes that speakers make adjustments in two ways, namely: convergence and divergence. Convergence involves ways a speaker makes adjustment to become more like the other speaker while divergence involves ways employed to highlight differences between speakers. (p. 126)

Moreover, the CAT is described as a "framework for understanding the interpersonal and intergroup dynamics of speakers (and communicators) adjusting their language and nonverbal patterns to each other" (Farzadnia & Giles, 2015, p. 18). Besides, the theory asserts that communicators accommodate those they respect, trust, like, and admire and, in a way, social and communicative differences are mitigated (Gasiorek & Giles, 2013). The present study involved expatriate doctors working in a multilingual context together with multilingual local doctors in Namibia. The doctors and patients in Namibia utilise the English Language in spite of its limited proficiency by the masses, which implies that linguistic barriers exist and necessitate mitigation. Thus, the CAT was utilised to extend insight on how communication barriers were mitigated.

Also, according to Farzadnia and Giles (2015), "a unique feature of CAT is its position that speakers accommodate (or not) where they *believe* or expect their interactants to be, linguistically." (p. 18). Similarly, Gasiorek and Giles (2013) assert that CAT focuses on how, when, and why speakers attune their messages to match that of their interlocutors (accommodation) or not (non-accommodation) and the ways in which conflict can be managed. In other words, in a doctor-patient scenario for instance, the first interaction between the doctor and the patient will determine the next course of action regarding how to communicate.

However, Hewett, Watson, and Gallois (2015) observe that non-accommodation can be manifest in under- and over-accommodating another.

In addition, Giles, Gasiorek, and Soliz (2015) note that CAT proposes that accommodation-non-accommodation can be enacted by means of at least five sociolinguistic strategies namely: approximation, interpretability, interpersonal control, discourse management, and emotional expression. These strategies have been further expounded on by Farzadnia (2015) as illustrated in the following table, Table 1:

Table 1

Strategy	Explanation
Approximation	refers to making one's language and communication patterns more similar or dissimilar from another
Interpretability	relates to accommodating another's perceived or expressed ability to understand what is going on in the conversation.
Interpersonal control	refers to how individuals adapt communication based on role relations, relative power, and status.
Discourse management	pertains to the adjustment of communication based on the perceived or stated conversational needs of the other interlocutor.
Emotional expression	has to do with responding to the other's cognized or reported emotional and relational needs.

Five sociolinguistic strategies adapted from Farzadnia (2015)

Griffin (2009) argues that "…communication accommodation theory has morphed into a communication theory of enormous scope... [and it]…can be beneficially applied to any situation where people from different groups or cultures come into contact" (pp. 397-398). For instance, from the five strategies for CAT, Mlambo (2017) only considered the first two strategies, approximation and interpretability. Similarly, Fawole (2014) did not isolate the strategies but utilised CAT in its entirety.

Furthermore, Littlejohn and Foss (2005) argue that CAT is "one of the most influential behavioural theories of communication" (p. 147). Moreover, CAT has the ability to appeal to a wide array of qualitative analyses as well as an incisive appeal to furthering the understanding of a broad range of language and healthcare issues (Farzadnia, 2015). Thus, on these merits, the CAT was chosen as one of the most appropriate theories to frame this study.

2.4.2 Linguistic Relativity Theory

There is a general belief that the lexis of a language is determined by the culture of its speakers (Fawole, 2014) hence the consideration of Linguistic Relativity Theory for the study. The Linguistic Relativity Hypothesis is an old idea that can be traced back to Romanticism and the work of Wilhelm von Humboldt, a German diplomat and linguist who wrote various views about language (Duranti, 2000; UNESCO, 2000). One of Humboldt's famous ideas that relates to linguistic relativity is the idea that each language has its own world view (McNeely, 2011). It was a pretty radical idea which received a great deal of attention, but as innovative as it was, it was flawed because of the proposition that some languages and their worldviews are better or more civilised than others (Holland, 2012).

Holland (2012) notes that, after von Humboldt, Franz Boas became a pioneering figure in the field of Anthropology and refuted the then prevalent idea, that some languages and cultures are more advanced or primitive than others. According to Harris-Jones (2014), Franz Boaz's field work with the Inuit demonstrated that the language one speaks can reflect differences in thinking. That idea substantiates the theory of linguistic relativity.

Edward Sapir was one of Boas' students (Blackmore, 2012). Sapir is also known as the father of American linguistics. He is famous for his various influential theories about language. One of Sapir's students was named Benjamin Lee-Whorf. Whorf too came up with influential ideas about language and his most famous ideas concern the idea of linguistic relativity. Thus, the linguistic relativity theory is also known as the Sapir-Whorf hypothesis (Nordquist, 2018), even though the two did not actually work much, if at all together on the idea.

According to Neuliep (2015), Sapir published a paper in the journal *Language* in 1929 that influenced the study of language and culture. Sapir's proposition in that paper was that the language of a certain culture has a direct effect on how people think. In the paper, Sapir (1929) wrote:

> The network of cultural patterns of civilisation is indexed in the language which expresses that civilization…Language is a guide to "social reality"… Human beings do not live in the objective world alone…but are very much at the mercy of the particular language which has become the medium of expression for their society. (p. 69)

Whorf, who was persuaded by Sapir's writings, further developed Sapir's idea of language influencing people's view of the world. Whorf wrote,

> The background linguistic system (in other words, the grammar) of each language is not merely a reproducing instrument for voicing ideas, but rather is itself the shaper of ideas … We dissect nature along lines laid by our native languages. The categories and types that we isolate from the world of phenomena we do not find there because they stare every observer in the face; on the contrary, the world is presented in a kaleidoscope flux of impressions which has to be organized by our minds—and this means largely by the linguistic systems of our minds. We cut nature up, organize it into concepts, and ascribe significances as we do, largely because we are parties to an agreement to organize it in this way—an agreement that holds throughout our speech community and is codified in the patterns of our language ... all observers are not led by the same physical evidence to the same picture of the universe, unless their linguistic backgrounds are similar, or can in some way be calibrated". (Carrol, 1956, p. 214)

Like Sapir, Whorf held the belief that the people who speak different languages are directed to different types of observations; therefore, they are equivalent as observers and they must arrive at somewhat different views of the world (Carrol, 1956, p. 221).

Other scholars view the linguistic relativity hypothesis differently. Salzmann (as cited in Neuliep, 2011), contends that the Sapir-Whorf Hypothesis delineates two principles. One is the principle of linguistic determinism, which says that the way one thinks is determined by the language one speaks. Taken at its extreme, this principle means that if we do not have a word for it, then we cannot think about it. The second is the principle of linguistic relativity, which says that the differences among languages must be reflected in the differences in the world view of their speakers. Since the first principle appears to be flawed due to its view that the way one thinks is determined by their language, this study adopted the second principle of

linguistic relativity which supports the view that different world views are determined by differences in languages. The choice of the latter lies in the fact that Namibian health care communication occurs in a multilingual context where the English Language is the lingua franca, even though, there is limited shared proficiency between the doctors and their patients.

Similarly, Blackmore (2012) and Lucy (1997) posit that the Sapir-Whorf Hypothesis has two versions, a weak and strong version. The strong version alludes to the idea that language determines the way we think since different languages cut up and name the world differently. We cannot perceive the world differently than via the language we use. The weaker version suggests that language does not determine absolutely how we think, however, different language structures influence and cause people to perceive and interpret the world in different ways, in how we approach problems and remember facts. The strong version is considered false as it implicates the understanding of intercultural communication as well as interpretation (Blackmore, 2012; Lucy, 1997) whereas the weak version is considered to be true. The controversy has left a vast middle-ground for researchers to seek to test linguistic relativity. To other scholars, however (Wolff & Holmes, 2010), research has yielded findings that find linguistic relativity to comprise a 'family' of related proposals that do not necessarily fall along a single strong-to-weak continuum. Similarly, this study adopted the Linguistic Relativity as the theory since the study dealt with health communication, which includes medicine. Some western medical terms that litter the medical fraternity do not have African linguistics equivalents, hence the question then is: how does that affect health communication, hence this has been a gap which the present study sought to fill.

The principles about linguistic relativity as discussed above raise some important issues for cross-cultural communication. If how we think is a reflection of the language, then speakers of

two very different languages must think very differently. This could render ineffective and unsuccessful intercultural communication as it is the case in the Namibian health communication context. According to Wolff and Holmes (2010), the linguistic relativity hypothesis holds three theses. The first thesis is that languages can differ significantly in the meanings of their words and syntactic constructions, a notion that is strongly maintained by linguistic, anthropological, and psychological studies of word and phrasal meanings across languages. It may be safe therefore to assume that the direct interpretation of words or utterances from one language to another may often result in misunderstandings. Thus this study sought to determine whether such a phenomenon exists in the Namibian health communication context. The second thesis holds that the semantics of a language can affect the way in which its speakers perceive and conceptualise the world, and in the extreme, completely shape thought. Finally, since language can affect thinking, Linguistic Relativity holds that speakers of different languages think differently. Thus, intercultural and multilingual communication, as the one in the Namibian health care system, need to be approached and conducted carefully.

Some examples from some of the areas of linguistic studies may prove Linguistic Relativity as a real phenomenon which deserves attention (Ashworth, 2014). The areas are prepositions, classifiers, lexicalisation, colour terms and directional systems. These areas are part of everyday communication, including health communication. Since they are perceived differently in different languages, it was seen necessary to determine how they affect multilingual communication like the one in the Namibian health care context.

Prepositions are another aspect of linguistic studies that can be used to prove linguistic relativity. Talmy (as cited in Slobin, 2004) has described a typology of satellite-phrased and verb-phrased languages. The typology is concerned with the means of expression of the path

of movement. In verb-framed languages ("V-languages") the path is conveyed by the main verb in a clause ('enter', 'exit', 'ascend', etc.), whereas in satellite-framed languages ("S-languages"), prepositions assert the direction that something follows ('go in/out/up', etc.). For example, The English Language is called a satellite- framed language. Spanish on the other hand is a verb framed language. That is seen in the following examples. In The English Language, the sentence, "*The bottle floated into the cave*." reveals that the preposition '*into*' is responsible for indicating the direction that the bottle travelled. Whereas in the Spanish sentence, "*La botella entro la cueva flotando*." reveals that the verb '*entro*' indicates where something is going or went (Hovav & Levin, 2007). There is no preposition present in the sentence. Even though Spanish does have prepositions, the example above seeks to illustrate how Spanish is a verb-framed language, thus, mostly verbs indicate the direction in which something goes, not prepositions. After all, when considering '*enter*', as compared to '*exit*', there is a difference in the direction that something goes. The previous examples connect to linguistic relativity. It does so by illustrating that the language one speaks forces one to attend to certain aspects of one's reality. That happens by relying on aspects such as prepositions as is the case in the English Language, to assert a trajectory, or in Spanish, the use of verbs to assert a trajectory.

Another example involving the English Language and German illustrates that the English Language only has one preposition to indicate that something is 'on', whether it is on a vertical surface (wall) or it is on a horizontal surface like a table (Bauer, 2017). For example, in the sentences, "*The flower vase is on the table*." and "*The photo frame is on the wall*." The same proposition is utilised. Whereas the German language has two prepositions where the English Language just uses one. For example, preposition '*an'* in German refers to vertical surfaces and '*auf*'' refers to horizontal surfaces. In the above example, linguistic relativity is proven.

For a German speaker, the prepositions '*an*' and '*auf*' are part of their reality that the speaker has to pay attention to when speaking. It is not sufficient to just use '*on*' as is the case in the English Language. The speaker must decide whether they are dealing with a vertical or horizontal surface in order to choose the correct form of preposition. Thus, in Namibia, for instance, interpretation may be utilised in consultation between a doctor and a patient who only understands German. In light of the above discussion regarding types of prepositions the interpreter has to be careful and ensure that the correct surface is interpreted in order to choose the correct preposition in the target language.

Another area of linguistic study that proves the linguistic relativity hypothesis, and may be of interest to multilingual health communication, is the aspect of classifiers. Classifiers (morphemes that indicate belonging) are utilised by some languages, including Chinese, Sign language, and Japanese, with the exception of others, particularly the English Language (Ashworth, 2014). In the language 'Navajo' (Navaho), there is a very elaborate system of classifiers that indicate belonging. For example, the word for 'pencil' in Navajo, will also have a classifier to indicate that it belongs to a class of items that are generally stiff, and slender. The same goes for a word such as paper, which also requires a classifier that indicates that paper belongs to a set of objects that are thin and flat (Armstrong & Wilcox, 2007). Thus, speakers of those languages have to remember what category the items belong to in order to choose and utilise the suitable classifier.

Moreover, the concept of classifiers is taken to a greater extreme in a language called Dyirbal, an indigenous language spoken in Australia. There is also a very elaborate set of classifiers utilised in this language (Aikhenwald, 2003). In Dyirbal, there is one classifier that is utilised to indicate that something belongs to a group including men, kangaroos and boomerangs.

Whereas there is another classifier that indicates that something belongs to a group including women, fire and dangerous things. Thus, a speaker of Dyirbal needs to remember which classifier to use with which word or item at a particular time. Thus, speakers of those languages have to remember what category the items belong to in order to choose and utilise the suitable classifier. In the Portuguese language (Spoken by some immigrants in Namibia) for example, adjectives which are also classifiers are said after a noun, but it is the other way round in the English Language. For example *a big bag* in the English Language will read *pasta grande* in Portuguese. Therefore, in the case of multilingual communication as is the case in the Namibian health context, care has to be taken when using classifiers in order to maintain mutual understanding of messages.

Lexicalisation refers to the process of forming words, and languages differ in this regard. For example, a comparison between the English Language and Inuit indicates different strategies of lexicalisation viewed in the notion of 'snow' (Kaplan, 2003). In the English Language, descriptive words or adjectives precede the word 'snow' in order to specify the form and quality of 'snow', for example, *wet* snow, *powdery* snow, *dry* snow, *spring* snow, *good* snow, *snow ball throwing* snow, just to mention a few. There is a myth that the Inuit language has hundreds or thousands of words for snow, however, contrary to popular belief, Inuit only has approximately 4-6 words for snow (Kaplan, 2003). It is still a richly lexicalised category in comparison to the English Language. The Inuit language has two basic forms of the word snow, which are *ganir,* which refers to snow in the air and *apun* which refers to snow on the ground (Kaplan, 2003). Affixes are then added to the two basic forms to do what the English Language requires extra words for. The addition of affixes thus results in the many words referring to snow. Similarly, the Oshiwambo expression *Ota ndi ehama pomwenyo nenge pomutima* translates *I have indigestion or heartburn.* However, if the interpreter lacks background

knowledge of the Oshiwambo culture, they may interpret the phrase directly as, *my heart hurts or I have pain on my heart.* Such interpretation may result in medical error, mainly if the patient expresses the illness without using gestures. Thus, the use of the English Language in multilingual health communication as in the Namibian health care context, where interpretation is likely to be utilised, requires regulation and a careful approach in order to reduce the possibility of misunderstandings that may lead to medical error.

Another interesting linguistic area to prove linguistic relativity relates to the study of basic colour terms across the world's languages. According to Bowman (2006), Berlin and Kay (1968) conducted a study in which they sought to understand how speakers of different languages categorise the colour spectrum. One of the findings of the study indicates that speakers tend to break up the colour spectrum in different ways, depending on the language which they speak. Additionally, a discussion by Crawford and Moss, (as cited in Davies, Roling, Corbett, Xoagub and Xoaxub, 1998) has revealed that there is an implicational hierarchy that organises basic colour terms. Berlin and Kay (as cited in Uuskula, 2007), argued that basic colour terms in all languages are drawn from a universal inventory of just 11 colour categories (see Table 2). According to their theory, every language has between two and 11 basic colour terms, and they present a hierarchy which specifies a limited number of evolutionary paths that a language can take when adding new colour categories. Languages start with two basic colour terms: BLACK and WHITE the third term to be acquired is RED; the fourth term is either GREEN or YELLOW; the fifth term is whichever of GREEN or YELLOW is missing; the sixth term is BLUE, and so on.

Thus, if a language has a particular basic colour term, then it should also already entail all the earlier basic colour terms of the hierarchy. Some languages do not have all eleven basic colour

terms, for example, the Damara language in Namibia which has only seven (Davies, Roling, Corbett, Xoagub & Xoaxub (1998). Other languages such as Dani and Papuan have two basic colour terms. Dani falls under type one which has the colour terms 'dark/cool' and 'light/warm'. It does not mean that different language speakers cannot perceive differences between colours, such as blue, red or green and white (Kay & Maffi, 1999). All humans can perceive gradations in the colour spectrum in different ways (Gleason, 1961 in Kay & McDaniels, 1978). Berlin and Kay's emphasis was on basic colour terms (red, blue, green and brown) rather than other terms that are sub categories of other colours like navy and turquoise which are part of blue. The implicational hierarchy begins that way as illustrated in Table 2.

Table 2

Type 1:	Dark/cool & light/warm					
Type 2:	Dark/cool & light/warm	+ red				
Type 3:	Dark/cool & light/warm	+red +	+ either green, or yellow			
Type 4:	Dark/cool & light/warm	+ red	+ either yellow or green			
Type 5:	Dark/cool & light/warm	+ red	+green &yellow	+blue		
Type 6:	Dark/cool & light/warm	+red	+green & yellow	+blue	+brown	
Type 7:	Dark/cool & light/warm	+ red	+green & yellow	+ blue	+ brown	+ purple, pink, orange/grey

Basic colour terms adapted from Berlin and Kay, as cited in Uuskula (2007)

There are many languages that are considered type two. A type two language will have a word that corresponds to dark/cool and light/warm plus the colour red. Type three languages build on the above by containing all the colours above plus either green or yellow and on it continues as illustrated by figure one above. The English Language is an example of type seven language as it contains all the colour terms above as well as purple, pink, orange or grey. There are, yet other languages which break up the colour scheme finely than the English Language does. One of them is Russian. Russian makes a lexical distinction between light blue (*sinij*), and dark blue (*goluboj*) (Davies, Roling, Corbett, Xoagub & Xoaxub (1998). Hungarian does the same with red. The implicational hierarchy is the finding that came out of the study by Berlin and Kay (1968). The languages which fall under type six or seven are not more advanced than other languages. The Berlin and Kay's ideas of basic colour terms have not gone uncontested.

An example in Oshiwambo relates to the classification of the yellow colour. In an event of a patient complaining of vaginal ailment, the doctor may probe about the colour of the discharge and inquire whether it is clear, green, cream, or white. An Oshiwambo speaking patient may, for lack of an Oshiwambo equivalent of colour cream, respond that the discharge is yellow "*onshunga*". The information of a wrong colour given to the doctor may result in the wrong diagnosis of the patient ailment.

Thus, the above discussions regarding various languages and cultures' perceptions and classifications of colour proves the theory of linguistic relativity. The colours familiar to one culture seem not to have names in another. The examples on colour suggest a possibility of miscommunication in multilingual interactions in the absence of cultural background regarding colour terms. Thus it was necessary to investigate the utilisation of the English Language

amidst various local, mutually in-intelligible languages in Namibia and how it affects health care delivery.

Lastly, the spatial or directional systems of reference illustrate the lexical variation in different languages. According to Wolff and Holmes (2010) representations of space utilise one of three possible frames of reference. These are an absolute (or geocentric) frame of reference involving a coordinate system in which the main axes are placed within the larger environment (e.g., a building facing north). An intrinsic (or object-centric) frame of reference places the axes in objects (e.g., the back of a couch). Finally, a relative (or egocentric) frame of reference defines the axes based on the viewer's body (e.g., the lady to my right). Some languages, such as the English Language, use all of the above systems, for instance, when they give directions to find a place, "To get to the fire station, turn to your right from the traffic circle into Crater Street, then left into Perseus Street, face south towards the University and there the fire station will be." (Wolff & Holmes, 2010). Other languages however differ, in that they only rely on one of the systems, either the geocentric system, the intrinsic or the egocentric system (Ashworth, 2014). Thus, an English Language speaker who is forced to use only the geocentric system for instance, may struggle to express directions in an egocentric language. Similarly, a non-English speaker who is forced to use only the egocentric system may struggle to express directions in a language that uses the geocentric system.

To conclude, the above examples suggest that the languages we speak influence our choice of words to some extent. However, in any language, the speaker is at liberty to say whatever they want, but the structural aspects of each language differ to a certain extent, and they constrain the speaker to view certain aspects of the world around them in a certain way. That is what languages do very well. Thus by the time children are five to six years old, they master the

system, making it difficult for them to unlearn it. Therefore an awareness of cultural influences on language use is necessary in order to enhance effectiveness in multilingual communication. It is against this background that the use of the English Language in multilingual health communication in Namibia provoked interest by the researcher to determine effectiveness thereof.

2.4. Chapter summary

This chapter reviewed some of the relevant literature related to the topic, as well as the aims and research questions of this particular study. Firstly, it explored Health Communication. It also discussed The English Language in Namibia and identified the research gaps. The chapter also highlighted the theories utilised to explore and explicate multilingual and multicultural communication. The subsequent chapter presents the methodology that was employed in the study.

CHAPTER 3

METHODOLOGY

3.1 Introduction

The previous chapters focussed on the introduction and literature review of issues relevant to this study. This chapter discusses the research methodology utilised in the study. It focuses on the research design, sampling methods employed in the study, the instrument utilised in the collection of data and the ethical issues considered.

3.2 Approach and design

This study adopted a qualitative approach which was descriptive in nature; it described the utilisation of the English Language in doctor-patient communication between expatriate and local medical doctors working in both public and private health facilities in Windhoek, Namibia, from the perspective of the doctors only. The qualitative design was adopted on the basis that it offers an "understanding and represents the experiences and actions of the people as they encounter, engage and live through situations and where the researcher attempts to understand the phenomena from the perspective of those being studied" (Qazi, 2011, p. 12). The research design of the study was qualitative due to the following reasons as enunciated by Creswell (2009, pp. 175-176).

1. It is usually conducted in a natural setting rather than a laboratory setting
2. The researcher is the key data collector
3. Multiple sources of data are utilised

4. The use of inductive data analysis by building patterns from the bottom up

5. There is a focus on the participants' point of view

6. Researchers view studies through the lens of the society, for example, culture, gender etc.

Based on the aforementioned characteristics, this study was conducted in hospitals and health centres where 21 questionnaires were distributed, in two selected public hospitals, two public clinics and two private health practices in Windhoek Namibia. In line with characteristic number two, the researcher was the main data collector; however, assistance was sought from some doctors to refer the researcher to other willing doctors to fill in the questionnaire. Fitting in with characteristic number three above, due to the nature of the study, a small scale one, data was only collected from doctors, expatriate and local, in public and private health facilities, since the focus of the study was on doctors' perspective only. Following characteristic number four, the researcher utilised content analysis to draw out themes from the questionnaires. Characteristic number five was adhered to via effort made to report findings through the perspectives of participants and the society in which the study took place, in this case, expatriate and Namibian doctors working in Namibian health facilities.

3.3 Population

The population included all doctors, locals and expatriate, who work in both the public and the private domains in Windhoek, Namibia, irrespective of whether they are specialists or general practitioners. It appears as though there is no current statistics on the number of doctors working in Namibia as at 2018, however, in 2010, the number of doctors registered and eligible for practicing medicine in the public and private sectors was estimated at 677 (Amakali, 2013).

3.4 Sample

It was not feasible to include all expatriate and local medical doctors in the study, thus it was necessary to draw a sample from the poll of available population and draw conclusions based on data collected from them. Snow-ball sampling was thus utilised. Snow-ball sampling has been defined by Naderifar, Goli and Ghaljaie (2017) as a convenience sampling method which is applied when it is difficult to access subjects with the target characteristics. In this method, the existing study subjects recruit future subjects among their acquaintances; Sampling continues until data saturation. The sampling procedure was considered due to the nature of the work that doctors do. Doctors are often too busy on the one hand and on the other hand, the expatriate doctors may not readily warm up to being studied for fear of being scrutinised. Thus, snow-ball sampling was the best option.

The purposive sampling method was utilised in the selection of the hospitals to be utilised in the study. There are only two public hospitals in Windhoek, thus both of them were utilised. There are several private hospitals; however, there are no resident doctors at such hospitals thus the researcher had to rely on private practices which are in Windhoek. Consequently, two public hospitals, two public clinics and two private practices were selected. The study investigated a total of 17 participants who included 11 local doctors and six expatriates, all from two hospitals, two clinics and two private practices in Windhoek, Namibia.

3.5 Research instrument

The study utilised a questionnaire as the research instrument. According to Kothari (2004) a questionnaire is a data collection instrument consistent of a series of questions and other

prompts for the purpose of gathering information from respondents. The questionnaire used was adopted from Mlambo (2017) in order to corroborate and extend the research on multilingual health communication in Namibia. The questionnaire utilised in the present study consisted of three sections. Section A recorded the metadata and contained questions eliciting personal information on age, gender, nationality, linguistic profile, level of education and place of training. Section B recorded data about the participants' knowledge and use of languages, which contained two questions eliciting responses about the participants' linguistic profiles. Lastly, Section C consisted of questions which elicited data regarding the distribution and uses of language in the workplace.

3.6 Procedure

The data was collected using a questionnaire, over a period of two weeks in selected two public hospitals, two clinics and two private practices. Due to the nature of the respondents who were sometimes not readily available, a questionnaire was the convenient way, both for the researcher and the respondents to collect data. Considering the nature of the study which involves the collection of data in hospitals, and the University's regulation on using humans as sources of information in research, ethical clearance was obtained, first from the University of Namibia's Research and Ethics Committee, then the Ministry of Health and Social Services, before proceeding to the hospitals and private practice facilities for data collection. Each respondent was given a brief but detailed explanation of the study and given the assurance that confidentiality would be maintained at all times. The respondents were handed the questionnaires in person. All respondents signed the consent forms which were removed from the questionnaires and kept with the researcher. A date for collection of the completed questionnaire was agreed upon and the researcher collected the completed questionnaires.

Anonymity of participants was maintained by utilising pseudonyms, when they were provided, otherwise numbers were utilised. Secondary data was collected from books, journals and the internet. The data collected was stored in a personal computer and was analysed as presented in Chapter 4.

3.7 Data coding

The study utilised the coding technique before analysis. Coding is defined as a type of analysis that looks mainly at what the data say and aims at identifying patterns within the data (Gottschalk, Stein & Shapiro, 2007). The researcher developed coding rules that allowed for coding of information consistently throughout the thesis. Irrelevant information was ignored while the other information was used to re-examine and alter the coding system. Coding was initially done manually for the researcher to recognise errors easily. The categories were then fed into the computer for content analysis programs to automate the coding process and examine the huge amounts of data quickly and efficiently. Data analysis was done soon after the coding process.

3.8 Data analysis

After the collection of data, the researcher engaged in the process of analysis. Data analysis is defined by LeCompte and Schensul (1999) as a process used by researchers to reduce large amounts of collected data to enable the researcher to make sense of them. According to Patton (1987), data analysis occurs in three phases namely, data organisation, data reduction via

summarisation and categorisation, identification and linking of emerging patterns and themes. The organisation and reduction of data occurs during the coding process as indicated at 3.7 above. Whereas, the identification and linking of emerging themes occurs during a qualitative process of data analysis called Content Analysis. Content analysis is a widely utilised qualitative research technique (Hsieh & Shannon, 2005). Thus for this study, data was analysed using content analysis. Content analysis is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action (Krippendorff, 1980). Guided by the above definition, doctors' responses from the questionnaire were categorised into emerging themes, as it appears in Chapter 4. Thereafter, insights and facts regarding the linguistic backgrounds of doctors operating in Windhoek, as well as the effects thereof on doctor patient communication unfolded, as presented in Chapter 4. Moreover, the insights provided possible action that could be employed to enhance doctor-patient communication in Windhoek, with particular emphasis on the doctor, as per the focus of this study. The latter appears in Chapter 5.

3.9 Research ethics

Permission to conduct the research was sought from all stakeholders, UNAM (through UREC), Ministry of Health and Social Services as well as from the participants. The researcher informed the participants about the purpose of the study which was for academic purposes only. Participation was voluntary and participants were free to withdraw from the study at any time and they were assured that they would not face any negative consequences when they decided to do so. The names and identity of the participants were protected. To ensure the protection of identity, pseudonyms were utilised, when they were provided by the doctors,

otherwise, the researcher assigned numbers to act as pseudonyms. Both soft and hard copies related to the research were kept out of reach of the public.

3.10 Chapter summary

This Chapter 3 discussed the research design and methodology of the study. It focussed on the research design, sampling methods employed in the study, the instruments utilised in the collection of data and the ethical issues considered. The analysis of the data collected is discussed in the next chapter.

CHAPTER 4

DATA ANALYSIS

4.1 Introduction

The previous chapters focussed on the introduction, literature review of issues relevant to this study, and the methodology employed. This chapter presents the analysis of the data that was collected via the questionnaires that were distributed to doctors in selected public and private health centres. A total of 17 questionnaires were distributed, all 17 questionnaires were returned to the researcher. Of the 17 returned, 11 were from local doctors and six were from expatriates. The 17 doctor respondents were further classified into the following categories: 14 respondents were from the public sector (and of the number 10 were local and four expatriate, while only 3 came from the private sector with one local and two expatriates. The questions in the questionnaires sought to determine seven main factors, namely, 4.1. introduction, 4.2 the linguistic profiles of the doctors, 4.3. gender, age and employment history, 4.4. doctors' age and place of language acquisition, 4.5. language in the work place (the English Language or other languages) and challenges emanating from the utilisation of the English Language amidst various languages, 4.6. communicative practices to mitigate language barriers 4.7. the utilisation and challenges of interpretation during doctor-patient consultations 4.8. Doctors' opinions regarding being multilingual and working in a multilingual setting.

4.2 The linguistic profiles of the participating doctors in Windhoek

The linguistic profiles of the doctors, local and expatriate were representative of many languages including the English Language. Moreover, the expatriate doctors each reported

differing abilities to read, speak and write in the English Language, and in addition to the English Language they could communicate in other languages from their countries of origin. Furthermore, some reported various abilities to speak, read and write some of the local languages. The expatriate doctors originated from: Cuba (one participant), Nigeria (one participant), Kenya (one participant) South Africa (one participant), Germany (one participant) and Democratic Republic of Congo (one participant). The local doctors similarly recorded varying indigenous linguistic profiles which reflect Namibia's linguistic diversity. Furthermore, only one of the participating local doctors studied in Namibia. The rest studied abroad, with four having studied in non-English Language countries (one in Ukraine and the other three in Russia), where they had to learn the language of instruction in the respective country. Learning in a foreign language suggests further complex linguistic profiles for the abovementioned doctors. The language profiles of all the participating doctors are presented in Table 3 below.

Table 3

Pseudonym	Gender	Age group	Completed medical training at	Duration in Namibia	First language	Lang of learning and instruction	Other language (s)	Country of origin	Employment History	Total number of languages
ONE	Female	25-35 years	University of Namibia	Approx.7 years	Yoruba	English	French	Nigeria	Windhoek Central Hospital (WCH) 2017-date	3
TWO	Female	25-35 years	University of Nairobi	Approx.2 years	Kiswahili and kikuyu	English	German	Kenya	WCH, 2016-date	4
THREE	Male	36-45	UCT & John Hopkins University	Approx. 22 years	Farsi, English	English	Afrikaans and German	Germany	Katutura Hospital, 2003 - 2004	4
FOUR	Male	36-45 years	Stellenbosch University	Approx. 18 years	Afrikaans	English, Afrikaans	German	South Africa	Katutura Hospital 2000-2001, Private practice, 2001- date	4
FIVE	Female	25-35 years	Yaroslavl State Medical Academy – Russia	Approximately 35 years	Oshiwambo	English Afrikaans and Russian	None	Namibia	Katutura Hospital 2015-217, WCH 2018-date	2

SIX	Female	25-35 years	Mordovia State University – Russia	Approx. 23 years	Afrikaans and English	English, Afrikaans and Russian	None	Namibia	Katutura Hospital 2008-2010 (Nurse), WCH doctor) 2018	3
SEVEN	Female	25-35 years	University of Pretoria	Approx. 25 years	Otjiherero	English and Afrikaans	Oshiwambo	Namibia	WCH,2012-2018	4
EIGHT	Female	25-35 years	University of Pretoria	Approx.22 years	Otjiherero	English, Otjiherero	Afrikaans	Namibia	Katutura &WCH, 2014-2018	3
NINE	Female	25-35 years	University of Stellenbosch	Approximately 24 years	Silozi	English and Afrikaans	None	Namibia	Katutura Hospital 2011-date	3
TEN	Female	25-35 years	University of Pretoria	Approx. 24 years	English and Afrikaans	Afrikaans	None	Namibia	Katutura & WCH 2014-2018	2
ELEVEN	Female	25-35 years	Walter Sisulu University	Approx. 27 years	Oshiwambo	English	Afrikaans, IsiXhosa, Portuguese	Namibia	WCH, 2009-date	5
TWELVE	Female	25-35 years	Zaphorozhye State Medical University-Ukraine	Approx. 25 years	Oshiwambo	English, Russian, German and Afrikaans	None	Namibia	WCH, 2015-date	5
THIRTEEN	Male	36-45 years	Santiago de Cuba	Approx. 12 years	Spanish	Spanish	Portuguese	Cuba	Opuwo State Hospital 2006-2007	2

FOURTEEN	Female	46-55 years	University of Lubumbashi – DRC	Approx. 7 years	Kiswahili	English Kiswahili and French	Luba and Oshiwambo	DRC	Oshakati Ou Nick Health Centre 2010-2014, Windhoek clinics 2014-date	5
FIFTEEN	Female	36-45 years	Tambov University – Russia	Approx. 26 years	Oshiwambo	English and Russian	Afrikaans and Otjiherero	Namibia	Katutura & WHC, 2011-date	5
SIXTEEN	Male	56 years and older	University of Pretoria (pre-grade) and University of Stellenbosch (Specialised)	Approx. 56 years	Afrikaans	English and Afrikaans	German	Namibia	Katutura and WCH, 1979-1983, Tygerberg Hospital, 1983-1987, Windhoek Private Practice 1987-date	3
SEVENTEEN	Female	25-35 years	University of Namibia	Approx. 26 Years	English	English Afrikaans and German	None	Namibia	Katutura Hospital, 2016-2017,Katutura Health Centre 2018	4

Biographies of the respondent doctors

Section A (Metadata) of the questionnaire recorded the respondents' linguistic profiles in addition to other biographic information such as their age groups, educational background and employment history.

The linguistic profiles included the respondents' first language, language of instruction in schools, including medical training, and other languages learnt along life's path. Regarding the language of instruction, all 17 respondents, comprising of 6 expatriates and 11 locals, reported that they had the English Language as their language of instruction. In addition to the English Language, 8 other languages that were recorded as language of instruction, namely: Afrikaans, Russian, German, Spanish, Kiswahili, French, Otjiherero and Portuguese. Since Namibia does not have bilingual education, all the languages afore-listed, excluding, Russian were learnt as a first language subject in school. Afrikaans was the highest recorded language of instruction having been recorded by 9 respondents, followed by Russian. A noteworthy aspect about the Russian language is that the respondents who listed Russian as a language of instruction, learnt it in a compulsory course in their first year of medical training in Russia. As such, English remains the language they use in Namibia.

The data regarding other languages of instruction in addition to the English Language indicate the hegemonic position of the English Language in Education which implies that the respondent doctors are all conversant in the English Language and are likely to utilise it in their consultations with their patients. However, knowledge of the English Language by the doctors is not sufficient since research (Aukongo, 2015; Mlambo, 2017; Nkandi, 2015) record that the masses in Namibia are still unable to communicate in the English Language thus there exist linguistic barrier between doctors and patients.

The linguistic profiles presented in Table 3 are indicative of the prevalence of diverse multilingualism among doctors in Windhoek's public hospitals, private health centres, as well as the Namibian community. As such, it confirms what literature records (Aukongo, 2015; Frydman, 2011; Mlambo, 2017) regarding the diversity of languages in Namibia. Moreover, out of 10 categories of widely spoken languages in Namibia (Lusakalalu, 2007), only six were represented namely, Afrikaans, Silozi, the English Language, German, Oshiwambo languages and Otjiherero languages. However, none of the six languages listed above are mutually intelligible. Thus, the linguistic data above is once more a further indication of the existence of language barriers in doctor-patient communication in Windhoek. Those instructed in Spanish or Russian may not be competent enough in their communication with patients. In a positive light however, the linguistic repertoires listed in Table 3 also suggest a possibility of a doctor workforce that is richly equipped linguistically and has the linguistic capacity that would enable them to communicate with patients who do not necessarily originate from Namibia, for instance, the doctor respondents who recorded Russian, Portuguese, Spanish and French as their other languages of instruction.

Section B of the questionnaire recorded the respondents' knowledge and use of languages. In question seven, the respondents had to list all the languages that they knew regardless of the level of proficiency. They were also requested to assess their ability to understand, speak, read and write the languages they listed, indicating ability on a scale of i – v, with i being poor and v being excellent. For obvious reasons such as being the official language of most countries and being a world language, the English Language was the first and compulsory entry. About 15 respondents out of 17 Namibian and expatriate doctors alike, recorded excellent abilities for all the four skills in the English Language. The result of excellent abilities in all the four skills in the English Language is indicative of the fact that the doctors are supposedly proficient in

the English Language, and in an ideal situation where all the patients possess the same linguistic ability in the English Language, the doctor-patient communication process would not have significant barriers. Unfortunately, it is not the case.

Moreover, the two respondents who did not record excellent for all the skills in the English Language were not too far behind from the others. One recorded a 'good' for all the skills, which was deviant from the prescribed method of using numbers 1-5 to indicate the level of proficiency in the language; however, the researcher could still infer that the 'good' implies a 4(iv). Another respondent recorded a 5 for understanding and reading, and a 4 for speaking and writing in the English Language. Another respondent deviated from the prescribed method of indicating the level of proficiency in the questionnaire and rather ticked only on some of the skills, leaving some blank, thus the researcher could not determine the level of proficiency or ability in all the listed languages.

The respondents, local and expatriate, also recorded different abilities in the other languages that form part of their linguistic profiles. Afrikaans, German, Oshiwambo, Otjiherero, Spanish, Portuguese, Farsi, Kikuyu, Yoruba, Silozi, Swahili, Luba, Bahasa (Indonesian), Russian and IsiXhosa were recorded with various abilities. Out of the 16 languages listed above, only five are indigenous to Namibia, the rest are foreign. Another interesting observation is that Russian and IsiXhosa were listed by local respondent doctors. Four respondents indicated Russian and one indicated IsiXhosa. Russian and IsiXhosa were listed by respondent doctors who studied in the countries from where the said languages originate, with Russian having been the language of instruction. Notable is the idea that the doctors who studied Medicine through languages other than English, in this case Russian and Spanish, may need to translate their thoughts from the other language to the English Language. What the researcher could not

determine are the effects, if any exist, about such intrinsic interpretation on doctor-patient communication. However, the Linguistic Relativity Theory (Fawole, 2014) suggests that any cross-lingual interpretation may be challenging due to differing world views as discussed in Chapter 2 where five different linguistic aspects are discussed as they differ in different languages and expressed necessity of knowledge of different cultural backgrounds in multilingual communication.

Moreover, out of the five expatriate doctors, three indicated ability to speak one of the Namibian languages, one of them indicated an ability to use Oshiwambo in all the four skills (See Table 4). The other two indicated excellent abilities for all four skills in Afrikaans and level three ability in understanding and spoken ability in German. The information about expatriate doctors' knowledge of Namibian languages suggest an inclination towards learning the Indo-European languages spoken in Namibia and not the local Bantu and Khoesan languages which are widely spoken compared to the Indo-European languages. However, the researcher could not determine the reason for that choice, though it can be inferred that the obvious reason may be due to the status of Indo-European languages, mainly the English Language, as world languages and as such placing anyone who learns them at an advantage. Moreover, it is highly probable that the respondent doctors did not have access to Bantu languages or the Khoesan languages may be too difficult to learn. Unfortunately, in the Namibian context, knowledge of Indo-European languages mainly the English Language, without Namibian languages bears more disadvantages than advantages as it pertains to inclusion in various spheres including doctor-patient communication on which good health care delivery hinges.

Table 4

Language	Number of respondents
Oshiwambo	1
Afrikaans	3
Otjiherero	1
German	1
Portuguese	1

Local respondents' knowledge of other languages indigenous to or spoken in Namibia that are not necessarily their first language

The linguistic data in Table 4 above presents the main languages that are widely spoken in Namibia as well as the number of local respondents who speak either of the languages in addition to their first language. Notably, local doctors' linguistic profiles mostly consist of first language and the official language, the English Language. Only a few doctors could communicate in languages other than their first language or the English Language. Thus the language of consultation is the English Language, however it has been established by Mlambo, (2017) that majority of Namibian patients possess limited proficiency in the English Language. Furthermore, the in-intelligibility of the various local languages further complicate communication between doctors and their patients. Other Namibian languages, namely, the Khoesan languages, Kavango languages and the Caprivi languages were not represented at all in either group of respondents. The expatriate doctor respondents indicated knowledge of some Namibian languages and the data regarding the local languages spoken by expatriates are presented in table 5.

Table 5

Language	Number of respondents
Oshiwambo	1
Afrikaans	2
German	2

Expatriate respondents' knowledge of languages spoken in Namibia

As per the data in the table above, majority of the respondents (4) indicated an ability to speak the Indo-European languages, with only one expatriate doctor indicating knowledge of Oshiwambo, a local Bantu language. The ability to communicate only in Indo-European languages has implications with regards to language barriers for doctors working in African countries (Leffler, 2015). Additionally, the Linguistic Relativity Theory echoes the idea that people's language influences their world view; therefore effective multilingual communication requires mutual cultural understanding (Sapir, 1929; Fawole, 2014). Thus, the expatriate doctors in Windhoek require an awareness of the cultural backgrounds of Namibian patients in order for them to achieve effective communication; though to some extent this also applies to local doctors as they consult with patients that are from completely different linguistic and cultural backgrounds.

4.3 Gender age and employment history

Gender, age and employment history were considered to determine their role in the linguistic profile of the respondents, both local and expatriate. The gender demography was the first to be explored in an attempt to determine the influence of gender on linguistic profiles. There

were more female (3 expatriates and 11 local) respondents in the study compared to their male counterparts who were two expatriates and one local. Two of the female expatriate doctor respondents (FOURTEEN and TWO) reported to have had knowledge of a Namibian language. FOURTEEN reported proficiency in Oshiwambo, rating it 5 for understanding, and 4 for speaking, reading and writing. TWO on the other hand indicated an ability to communicate in German, scoring it two for the understanding and speaking skills, while reading and writing were scored three respectively. The only two male expatriate doctors (THREE and FOUR) each recorded an ability to communicate in two other Namibia languages, Afrikaans and German. THREE opted to tick only the speaking skill for German and only the reading for Afrikaans, for which the researcher could not determine THREE's proficiency in both Afrikaans and German. FOUR on the other hand recorded five for all the four skills in Afrikaans and three for understanding and speaking German, as well as a two for reading and 1 for writing. Notably, for FOUR and THREE, only German is their other language since it was recorded that Afrikaans is another first language for both of them. There is, thus far, no noted influence of gender to language learning since both male and female respondents are seemingly multilingual. The local respondents had a rather unusual representation of the two genders. The local female respondents were more than their male counterparts, with only one local male respondent while the females were 11. As such, the researcher did not compare the two genders due to the severity of the inequality in representation, consequently, no insight could be drawn from this demography as it pertains to the influence of gender on linguistic profiles.

The subsequent demographic characteristic after gender was age. Majority of the doctor respondents in this study were from the age category of 25-35 years old (10 respondents) among whom eight participants indicated between three to four languages in their linguistic

profiles. The number of respondents with more than one language was less in the older age category compared to the younger respondents (See Table 6). This could be attributed to a variety of language development opportunities experienced by young age groups as compared to what the older ages experienced in the olden days.

Table 6

Age group	**Number of languages**	**Number of respondents**
25-35 years	1	0
	2	1
	3	4
	4	3
	5	2
36 and older	1	0
	2	1
	3	2
	4	1
	5	2

Number of respondents with more than one language

Based on the data recorded in Table 6, the older the doctor respondents, the less the number of languages in their repertoires. This implies that there is either a limited interest in older doctors to learn new languages, or that they were not exposed to them.

The employment history appeared to have influenced the language acquisition for the expatriate doctor respondents. The respondents who worked in Windhoek or South Africa reported to have learnt Afrikaans or German. While two of the expatriate doctor respondents

who had worked in Northern Namibia (one in Opuwo, but did not indicate any language learnt) and the other worked in Oshakati and indicated to have learnt Oshiwambo fluently. Thus the employment history played a role in the languages acquired. Another interesting phenomenon observed here is the ability for one doctor to have learnt fluently a local language while the other did not. The respondent who learnt Oshiwambo is a native speaker of 'Luba', a Bantu language whose lexis and grammar is close to Oshiwambo. While the other respondent who did not learn the local languages of Opuwo, is a native Spanish speaker. This language acquisition variance can therefore be attributed to the Sapir and Whorf hypothesis of Linguistic Relativity (Fawole, 2014) discussed in Chapter 2.

4.4 Age and place of language acquisition of doctors in Windhoek

In question eight, the respondents were asked to provide information regarding the place and age when they acquired the languages that they had listed. There were numerous indications. Out of the six expatriate respondent doctors, only one indicated having learnt the English Language when he came to Namibia, at the age of 30 and indicated a "good" in all the four skills of his ability to use the English Language. Another one also indicated having learnt the English Language a bit later in life, at the age of 15. The other 4 learnt the English Language in childhood, with two recording it as their mother tongue or birth language. The remaining two expatriate doctors indicated having had acquired the English Language between the ages of 2-6 years. The local doctors on the other hand all learnt the English Language in their childhood, with 3 having acquired it before the age of 4 and the other 5 learnt it between the ages of 5 and 6. Therefore, they all indicated excellent in all the four skills. The eldest (over 56 years) local respondent doctor reported to have had learnt the English Language between the ages of 14-18, in high school and recorded a level five in the skills of understanding and

reading, while for the skills of speaking and writing, he recorded a level four. Notably, the eldest respondent doctor learnt the English Language much later in life due to the fact Namibia's dominant language of business and education prior to Independence was Afrikaans (Frydman, 2011). Moreover, the recurring languages spoken by most respondents in this study are German and Afrikaans, which similarly were the official languages in Namibia prior to independence. the English Language acquisition age of the elderly doctor is a projection of the elderly patients in Windhoek who, unlike the elderly doctor respondent, may not have gone to school to learn the English Language, and therefore may struggle to communicate with doctors in case of language discordance.

4.5 Language in the workplace

Section C of the questionnaire focussed on the language utilised by the respondent doctors at work (during consultations or with colleagues). The English Language is the official language in Namibia (Frydman, 2011), thus the doctors, like other professionals, are expected to conduct official business in the English Language, as much as possible. All the doctors, expatriate and local, indicated that they use the English Language, among other languages, at work despite the fact that the English Language proficiency of most patients in Windhoek, especially in public hospitals, is limited (Mlambo, 2017). Second from the English Language, Afrikaans was the most listed language. Multilingualism in Namibia was evident when all the doctors listed at least more than one other language, in addition to the English Language as language of consultation or business. Notably, the three respondent doctors in the private sector only listed the English Language and Afrikaans as their language of business. The dominance of the English Language and Afrikaans in the private health sector was an indication that the patients who see private doctors had some level of education that enabled them to learn either the

English Language or Afrikaans. Therefore, private doctors seemingly did not have as much linguistic challenges as their public counterparts. The languages utilised at work in the public sector, in order of most to least listed, were, Otjiherero (13) followed by Afrikaans (11), Damara Nama (8), Oshiwambo (8), Rukwangali (7), Silozi (4), Portuguese (3) and German (1). On the other hand, the languages most represented in public hospitals in Windhoek were Otjiherero, Afrikaans, Damara Nama, Oshiwambo and Rukwangali. The dominance of the listed languages further affirms literature's records regarding Namibia's multilingualism in the health sector (Mlambo, 2017). The public sector, being the larger sector, caters to the country's population masses, which may not possess a sufficient level of education to enable them to speak the English Language, or even Afrikaans.

Another noteworthy fact is the prevalence of the Portuguese language which outnumbered German, despite Portuguese being a foreign language, mostly utilised by Namibia's neighbouring citizens, Angolans. Furthermore, the expatriate participants were no exception in indicating the many indigenous languages spoken by Namibians as languages encountered during consultations, despite their inability to communicate in such languages. Such a linguistic situation calls for the necessity to draft a national language policy for Namibia to regulate the use of the English Language amidst the various diverse and mutually unintelligible local languages. The policy would cater for the linguistic needs of the country at large and the health ministry in particular for the enhancement of health care provision, free of linguistic errors, thereby minimising the possibility of medical error.

4.6 Communicative practices to mitigate language barriers

Question 12 requested the respondent doctors to indicate the course of action they take when faced with a linguistic barrier in consultation. All the respondent doctors, local and expatriates, indicated two recurring solutions, namely, code-switching and interpretation. The majority of the respondents (9), indicated that they would first code switch and when it failed, the second option was to get an interpreter. Seven respondent doctors reported that they immediately seek an interpreter without an attempt to code switch. Furthermore, one of the respondent doctors indicated the use of body language in an attempt to communicate as well as the use of an interpreter. The above discussion about strategies utilised to mitigate language barriers supports the Communication Accommodation Theory, one of the theories that framed this study. The theory holds the view that interlocutors from different cultures adjust their speech styles to accommodate others during interactions (Fawole, 2014; Mlambo, 2017; Orbe & Harris, 2008). Therefore, in this case the utilisation of interpretation, code-switching and body language/gestures were the doctors' attempts to accommodate their patients.

Moreover, the use of body language and gestures, a type of non-verbal communication utilised by one of the respondent doctors in Windhoek, as indicated earlier on (section 4.6), similarly affirms what literature records (Fawole, 2014; Mlambo, 2017; Sobane & Anthonissen, 2013;). Moreover, body language is advantageous due to its universality (for example touching a sore head or other body parts); however, it is limited to physically manifesting illnesses only (Sobane & Anthonissen, 2013), and thus its utilisation cannot cater for all communication needs in a language discordant consultation.

Furthermore, the code switching and interpretation strategies utilised by the respondent doctors in Windhoek corroborates literature (Aukongo, 2015; Mlambo, 2017; Sobane & Anthonissen, 2013), which documents how code-switching and interpretation are often utilised as communicative strategies in linguistically discordant situations. Literature, however maintains that language discordance in health-care consultations pose a threat of medical error (Naish, 2012; Nida & Wonderly, 1971; Sandhu et al., 2013; Sobane, 2013). Thus, the utilisation of the English Language between doctors and patients in Namibia amidst various mutually in-intelligible local languages has resulted in linguistic barriers. The linguistic situation requires urgent interventions in order to minimise or eradicate the possibilities of medical error.

Question 13 required the respondent doctors to describe the interpretation services that they utilised in their consulting rooms. Notably, all doctors, local and expatriate, public and private in Windhoek, Namibia, utilised interpretation, at some point in their consultations, which some referred to as translation. The private doctor respondents (3) indicated that the patients who needed interpretation, mostly Angolans, brought their own interpreters to the consulting room. However, in the public sector, the respondent doctors (14) indicated that when they were faced with language discordance in the consulting room, the doctor had to find an interpreter. It became apparent from the respondent doctors that there are no professional interpretation and translation services in the health care system in Windhoek, Namibia. Due to the unavailability of professional interpretation services in Windhoek, Namibia, the respondent doctors had to make use of medical professionals (nurse or doctor) who were proficient in the target language, other patients "when confidentiality is not an issue" and relatives or family members of the patient. The kind of interpretation services described by the respondent doctors is referred to as *ad-hoc* interpretation (Andrews, 2012; Fawole, 2014; Mlambo, 2017; Sobane & Anthonissen, 2013). Although *ad-hoc* interpretation affords the consultation the convenience

of communication, it is not ideal. It oversteps the bounds of patient confidentiality, the quality of diagnosis is compromised and in the long run, it is costly, when errors result in the necessity for more tests and follow up sessions. Thus, it is essential to consider professional interpretation services in Windhoek, Namibia.

The respondent doctors had varying views in response to question 14, which dealt with the *get-by* concept, a situation in which interlocutors each use their own language and somehow understand each other (Fawole, 2014; Sobane & Anthonissen, 2013). Four local respondent doctors working in public hospitals indicated that they do not use the *get-by* strategy due to the possibility of confusion and misunderstanding. The other 13 doctors, six expatriates and seven locals indicated that they utilise the *get-by* strategy which often works in situations when patients understand the English Language but struggle to speak it. Or when a doctor understands an indigenous language but cannot speak it, so the patient speaks the local language, such as Afrikaans or Oshiwambo and the doctor utilises the English Language. In other cases, the English Language does not feature at all and the doctor utilises one local language, and the patient utilises another, for example, Oshiwambo and Rukwangali, and they *get-by*. Other doctors indicated having learnt a few basic words in different local languages, which are highly likely to feature in a consultation conversation. The doctors therefore utilise the learnt words to *get-by*. Getting by as a strategy of communication, may not be ideal due to the possibility of interlocutors not being completely sincere with one another regarding their level of understanding of the languages utilised. Some of the reasons why interlocutors may not be sincere with one another include politeness, being shy or even intimidation. Additionally, the Linguistic Relativity Theory by (Sapir, 1929; Fawole, 2014) alludes to the fact that shared cultural awareness is key to effective multilingual communication. Thus, the

get-by practice utilised by doctors in Windhoek may not be ideal unless there is shared linguistic background or cultural awareness.

4.7 The utilisation and challenges of interpretation in the Namibian healthcare context

Question 15 requested respondent doctors to indicate whether or not they would utilise professional interpreting services if they were available. The responses varied, with the majority (8 out of 10) of the local doctor respondents from public hospitals completely in favour of interpretation services.

> FOURTEEN*: "Yes, just facilitating the communication and management… of patients."*(Public, expatriate)
>
> ONE: *"Yes. Helps relieve work burden on other professional utilised as interpreters"* (Public, expatriate)
>
> FIFTEEN: *"Yes, that way it would really be easier since I won't have to go around looking for interpreters or letting the patient go without completely understanding his/her disease or the treatment proposed/given."* (Public, local)
>
> SEVEN: *"Yes, consultation would be faster, as sometimes a patient needs to wait until a suitable interpreter is found"* (Public, local)

One local doctor respondent from the private sector was partially in favour of interpretation whereas one expatriate from the public was in favour of interpretation but was concerned about confidentiality.

> *SIXTEEN: "Yes, as long as patient arranges for himself."* (Private, local)
>
> THIRTEEN: *"It depends on the confidentiality status."* (Public, expatriate)

Two local respondent doctors from the public sector were completely opposed to the idea, while one expatriate from the private felt that it was not necessary.

TWELVE: *"No"* (Public, local)

THREE: *"Not needed in my experience and practice."* (Private, expatriate)

A follow up question to question 15 inquired whether or not respondents envisaged any difficulties with formal or professional interpreting services in consultations and to describe such difficulties. To the above question, 12 respondent doctors raised critical concerns. The concerns were, doctor patient confidentiality, misinterpretation of medical terms, omission of important information, patient reluctance in sharing personal information with strangers, time consumed by interpretation, availability of interpreters or whether interpreters will always be available, interpreters not understanding the context or insight of questions asked, inability of the interpreter to translate real problem, patients' failure to mention beforehand that they are unable to speak the English Language and symptoms lost in interpretation. There were only five respondent doctors (one expatriate private; one expatriate public; three local public) who did not envisage any difficulties with professional interpretation services. Seemingly, interpretation services are the most envisaged solution to linguistic barriers in medical consultations, yet a number of concerns surround it.

Questions 17 dealt with language(s) other than the English Language utilised between or among colleagues. The responses to this question culminated in the conclusion that the utilisation of the English Language as Namibia's official language is adhered to by all the doctors; however, when the doctors perceive the English Language to hinder certain social communicative goals such as inclusivity and comfort, a switch is eminent. Eight local doctors who work in public hospitals indicated that they only utilised the English Language when communicating with colleagues. Two local doctors on the other hand indicated that they utilise Oshiwambo to communicate to their fellow Oshiwambo colleagues. The three (one local and

two expatriates) respondent doctors from the private sector all utilised Afrikaans and one utilised German in addition to Afrikaans.

> FOUR: "*Afrikaans and German for referral of patients or investigative reports."* (Expatriate, private)
>
> THREE: "*Afrikaans occasionally, but the English Language primarily utilised."* (Expatriate, private)
>
> SIXTEEN: "*Yes, Afrikaans"* (Local, private)

The other three expatriate doctors indicated that they only utilise the English Language with their colleagues. It is sensible for doctors in Namibia, local or expatriate, to indicate not using other languages apart from the English Language since they do not often share linguistic backgrounds. However, two doctors, one expatriate and one local, from the public sector indicated that they utilise other colleagues' languages.

> FOURTEEN: "*Yes, sometimes when speaking Oshiwambo just to translate the bond/relationship/teamwork."* (expatriate, public)
>
> FIFTEEN: "*Yes … Russian … with the Russian/Ukrainian doctors and it is easier"* (local, public)

FOURTEEN and FIFTEEN's responses are indicative of a desire to establish and maintain unity through learning and utilising colleagues' languages. The desire to learn and utilise a colleague's language affirms the Communication Accommodation Theory as discussed in Chapter 2.

After establishing that language barriers existed between doctors and patients, question 18 sought to determine whether language posed a barrier in communication with colleagues. Two local respondents from the public sector, and one local respondent from the private sector, indicated that there exists language barriers when communicating with colleagues from non-

the English Language speaking countries such as Cuba, Russia and Ukraine. See responses below.

> FIFTEEN: "*Yes, it can be a barrier still, since some of our colleagues are either Russians, Ukrainians, Cubans and their English Language can be a bit unpolished."*(local, expatriate)
>
> ELEVEN: "*Yes, e.g. if you have a colleague from another country e.g. Cuba/Russia who did not do the English Language it is difficult."* (local, public)
>
> SIXTEEN: *No. Except Cuban Doctors*. (local, private)

Twelve local respondent doctors from the public sector as well as two (one local and the other expatriate) doctors from the private sector indicated that there were no language barriers when communicating with colleagues. Notably, the majority of the respondents from this study did not perceive linguistic barriers between colleagues as a challenge, including the colleagues from non-the English Language speaking countries. The rest (3) perceived linguistic barriers when communicating with doctors from countries with non-English Language backgrounds. The barriers culminating from a workforce of doctors from non-the English Language backgrounds in Namibia affirm what literature records (Asante et al., 2012; Fawole, 2014; Mlambo, 2017).

Question 19 dealt with reasons that warrant a switch from one language to the other in an interaction with a colleague or a patient. The recurrent response to question 19 was notably language discordance. The respondents did not specify whether the discordance is with the patients or with colleagues. However, judging from the responses to question 18, it can be inferred that language discordance is mainly between patients and doctors. The switch from one language to another due to language discordance corroborates the findings from literature (Aukongo, 2015; Mlambo, 2017; Anthonissen & Sobane, 2013). Moreover, some respondent

doctors recorded the necessity to maintain confidentiality as the reason that would warrant a switch in language. Arguably, the respondent doctors are aware of the linguistic situation they operate in and they do what they deem necessary to mitigate the challenge of linguistic barriers. It is however not sufficient, hence better communication structures are necessary.

4.8 Doctors' experiences of being multilingual and working in a multilingual setting

The final part of the questionnaire (question 20-21) focussed on the experiences of the respondent doctors. Varying responses, positive and negative were recorded in response to the two questions. The responses to question 20, which dealt with challenges of utilising and encountering many languages, echoed 5 main challenges: (1) confusion resulting from mixing words from different languages, (2) the burden of being utilised as an interpreter (3) pressure to learn more languages, (4) difficulties to learn some of the languages (5) the possibility of medical error and difficulty to interpret medical terms into indigenous languages. The above summary emanates from the following responses:

> FOURTEEN: *It is challenging whenever the patients are speaking the unknown languages.* (expatriate, public)
>
> THIRTEEN: *The challenge is the possibility of medical error* (expatriate, public)
>
> ONE: *Switching from one language to another subconsciously* (local, public)
>
> TWO: *I sometimes do not understand my patients* (expatriate, public)
>
> SIXTEEN: *Purity of language gets lost/words mixed in different languages* (local, private)
>
> FOUR: *Patients attempting to answer in a language they are not proficient in, despite trying to accommodate them in another language* (expatriate, private)

TWELVE: *Medical terms in indigenous languages are usually difficult to explain* (local, public)

FOURTEEN: *Some languages are easier to speak than others* (local, public)

SIX: *I mix them unintentionally and people tend to be confused.* (local, public)

SEVEN: *When especially I find myself working with non-Namibians, I tend to do a lot of translating work or patients simply prefer to be seen by me/any other doctor who understands/speaks the same language* (local, public)

TEN: *Not everyone speaks the English Language* (local, public)

FIVE: *Having to speak different languages* (local, public)

FIFTEEN: *It is the fact that I am forced to learn more languages to enable me to communicate.* (local, public)

ELEVEN: *You will end up seeing a lot of patients really and being a translator for others* (local, public)

Another notable observation is the difficulty to interpret medical terms into indigenous languages as alluded to by participant TWELVE. That is a phenomenon described by one of the theories that drive this study, the linguistic relativity theory (Fawole, 2014; Lucy, 1997; Blackmore, 2012). Linguistic relativity describes a view that the language spoken by an individual determines the way the individual views the world. That view has an implication that one's language only consists of words that name objects, concepts or ideas that exist in the language's culture. Regarding medical interpretation from one language to the other, Fatahi, Mattsson, Hasanpoor and Scott (2005) argue that:

> The biological nature of disease is fairly constant between cultures, but the understanding and meaning of health and illness varies between societies. Pain and behaviour, for example is considered to be a kind of language and knowledge about

which the patient's cultural background is advantageous in order to correctly interpret the symptoms of aching. (p. 159)

Thus, multilingual health communication is complex in general and more so in Windhoek, Namibia, where there is a mixture of expatriate doctors with various linguistic backgrounds, and local doctors who similarly have varying linguistic backgrounds whose languages are not intelligible to one another. Moreover, the English Language is the lingua franca yet the masses do not possess the necessary proficiency in the English Language. Thus, the situation requires not only the acquisition of the indigenous languages, but the awareness of cultural background of the speakers of those languages, if effective communication is to take place.

Multilingual health communication in Windhoek is not only characterised by shortcomings; there are also advantages that emanate from it. In response to the subsequent question in question 20 regarding the advantages of knowing, using and encountering a variety of languages in everyday life, the respondent doctors explained three main experiences. One of those experiences is the ability to communicate with various patients effectively. The second aspect is with regards to the maintenance of doctor patient confidentiality. The last aspect relates to the improved doctor-patient relationship. The aforementioned observations are rooted in the doctors' responses as follows:

ONE: *Being able to communicate with most patients* (local, public)

NINE: *One can communicate well with all patients without difficulty*. (local, public)

ELEVEN: *It helps you to be flexible and work efficiently, fast.* (local, public)

TEN: *The patient can explain himself very well.* (local, public)

SEVEN: *Patients can easily explain their problem; they are well understood and managed accordingly…* (local, public)

FIFTEEN: *The advantage here is the ability to communicate with almost all my patients/colleagues in different languages. No need for interpreters and in that way patient doctor confidentiality is maintained.* (local, public)

SEVENTEEN: *It allows me to interact with people of different cultures* (local, public)

TWELVE: *Patients understand more when explained to in a language that they understand.* (local, public)

FOUR: *This allows building rapport and crossing cultural barriers and determining proficiency* (expatriate, private)

THREE: *It is easy to set other person at ease, to be able to communicate well.* (expatriate, private)

SEVENTEEN: *Understand and communicate better* (local, private)

FOURTEEN: *Communication skills enhanced, patient centeredness assumed, management of patient assumed* (expatriate, public)

TWO: *makes communication easier* (expatriate, public)

THIRTEEN: *The most advantageous factor about knowing a variety of languages is to reduce the challenge of medical error.* (expatriate, public)

ELEVEN: *It helps you to be flexible and work efficiently, fast* (local, public)

NINE: *One can communicate well with all patients without difficulty* (local, public)

ONE: *Being able to communicate with most patients* (local, public)

In order to conclude the research, the respondent doctors were requested to share any other information emanating from their experience in communicating across languages and cultures in the work place which they found relevant to this study. There were some comments that were insightful and that invoked critical reflections on the researcher's side. Some of the comments echo the necessity for multiple sectors of society to partake in the enhancement of

multilingual communication. That observation is rooted in the following responses from THIRTEEN and ONE:

> THIRTEEN: *According to my personal opinion, multi-factorial conditions (Language barrier) require multi – sectorial interventions* (expatriate, public)
>
> ONE: *Communication is quite a difficult aspect considering my background. Therefore, professional services are essential.* (local, public)

Another insightful response referred to the benefits of patients who are treated in a multilingual setting:

> FOURTEEN: *Working in multilingual community allow the patient to be opened to health* workers. *It is a way to develop and manage the patients cross-culturally. We are able to develop the community centred care.* (expatriate, public)

Other respondent doctors referred to the supporting role of the internet on multilingual health communication:

> SIXTEEN: *Google translate is of great help.* (local, private)

There were other responses that referred to the language of study for doctors and the effects thereof on consultations in multilingual and language discordant situations:

> FOUR: *Studying in a certain language allows or restricts interrogation of a patient*
>
> SIX: *We need to study/learn more different languages to make communicating easy.*

Amidst other responses, notable is the response from respondent sixteen who reported that Google Translate is of "*great help".* The researcher wondered whether Google Translate is able to translate local Namibian Languages.

4.8 Chapter summary

This chapter presented the results of the questionnaire which was utilised to collect data from doctors in this study, in relation to communication during consultations. The information was grouped into emerging themes and linked to literature on multilingualism in health care by various scholars. The next chapter concludes the study by summarising the findings and presenting some recommendations.

CHAPTER 5

DISCUSSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary and discussions of findings regarding the utilisation of the English Language in multilingual health communication in Windhoek, Namibia. The summary is based on the results of the analysis of data from the questionnaire utilised in data collection as presented in the previous chapter. The study adopted a qualitative approach using the content analysis tool of coding. Six health care facilities in Windhoek were selected, two main public hospitals, two public district clinics, and two private practices. Questionnaires were handed to doctors that work at these facilities. In total, 17 questionnaires completed by two private expatriate doctors, one local private doctor, four expatriate, public doctors and 10 local public, doctors were analysed. The summary and discussions of the findings are presented below. The summary is followed by a discussion. Recommendations are made based on the findings from the study.

5.2 Summary of findings

The findings have been summarised under guiding themes, influenced by the study's driving questions. The themes are: linguistic profiles of respondent doctors in Windhoek, medium and age of acquisition of languages other than mother tongue, respondent doctors' linguistic backgrounds' effects on communication in the work place, linguistic and communicative practices established to mitigate linguistic barriers, and personal experiences regarding working in a multilingual environment in Windhoek.

5.2.1 The linguistic backgrounds, medium and time of acquisition, for respondent doctors in Windhoek

The 17 doctors who participated in this study recorded a variety of linguistic backgrounds. They had all acquired the languages they knew via different contexts and at various ages. The doctor respondents represented seven home countries. The respondents' data regarding their early schooling and secondary education provided insights concerning the languages they encountered in their childhood. Four respondent doctors, three locals and one expatriate reported to have acquired the English Language in a home environment from childhood, causing them to be first language speakers of the English Language by default. Eleven local respondents had been introduced to the English Language in elementary school at an early age and they continued to learn and utilise the English Language to date. The other three doctors, two expatriates and one local, learnt the English Language much later in life. One expatriate learnt the English Language upon arrival to Namibia, at the age of 30, while the other two, local and expatriate, learnt the English Language from the ages of 14 and 15 respectively. For expatriates and locals alike, working in multilingual environments such as Windhoek resulted

in contact with and knowledge of linguistic variety, thus developing linguistic awareness in all the Namibian languages with which they came into contact.

There was a myriad of languages which formed part of the linguistic profiles of the respondent doctors in this study. The languages ranged from first language, language of learning or education, languages learnt through socialisation and language encountered in the workplace. The languages acquired via education other than the English Language were mainly two, Russian and Spanish. The first languages or languages of the home were nine in total, which are namely, Yoruba, Kiswahili, Kikuyu, Spanish, Farsi, the English Language, Afrikaans, Oshiwambo and Silozi. A total of eight languages that were learnt through socialisation were French, German, Portuguese, Afrikaans, Luba, Otjiherero and IsiXhosa. Lastly, some respondents reported to have acquired some Namibian languages in the workplace. One such language was Oshiwambo. The linguistic backgrounds of the respondent doctors, expatriate and local, echo the complex nature of multilingualism in the health sector in Namibia in general and Windhoek in particular.

5.2.2 The effects of the doctors' linguistic background on communication in the workplace

The English Language was the most reported language in the work place. However, the linguistic environment in which the doctors had to operate in consisted mainly of a demographic population that had limited to no knowledge of the English Language. Thus, the doctors, especially those who work in public facilities, both local and expatriate, encountered a myriad of Namibian and non-Namibian languages alike. This situation of language discordance resulted in language barriers to communication. Among the languages

encountered were Afrikaans, German, Oshiwambo, Portuguese, Otjiherero, Rukwangali, Setswana and Damara Nama, just to mention a few. The respondents who work in the private facilities mostly reported encountering Afrikaans and German, thus, they rarely encountered linguistic barriers as they could speak these languages.

Local respondent doctors in the public sector who spoke any of the main or national languages in Namibia such as Afrikaans or Oshiwambo, reported to experience better communication when dealing with patients who spoke the same languages. Moreover, it became apparent that some of the Namibian languages share similar words, such as the Oshiwambo and Rukwangali. In cases like that, language barriers existed but on a minimal level. However, when doctors saw local patients who spoke other languages that the doctor did not understand, language barriers were evident.

Furthermore, it appeared that knowledge of the English Language in itself is not sufficient and that knowledge of as many local languages as possible in addition to the English Language would be an advantage. Moreover, there is also a need to manage the appropriate medical jargon. It was found that those who may lack in this respect still find it difficult to linguistically cope with the demands of a healthcare setting where the use of medical register is a reality on a daily basis.

5.2.3 The linguistic and communicative practices utilised to enhance communication

In an effort to aid communication and possibly mitigate linguistic barrier in consultations or communication with colleagues, doctor respondents reported three main strategies. The first

strategy mainly reported was *ad-hoc* interpretation, the second one was *get-by,* and the last strategy was body language.

It became apparent that professional interpretation was not available for use in hospitals, so *ad-hoc* interpretation (unprofessional interpretation by family members, nurses, or even other patients) was mainly utilised. It also became apparent from the responses by the private doctors, local and expatriate, that there was minimal language discordance in the private sector than in the public sector, but when it existed, the private doctors similarly utilised *ad-hoc* interpretation, which unlike in the public sector, the patients themselves had to arrange for. The respondent doctors reported a general concern for lack of confidentiality, increased medical error and minimal rapport emanating from *ad-hoc* interpretation. However, *ad-hoc* interpretation achieved, to a certain extent, the doctors' communicative goals.

Moreover, *get-by,* a strategy in which interlocutors each utilise a different language and relatively understand each other was reported to have been utilised by respondent doctors in cases of language discordance with regards to patients. While this strategy bore the advantage of maintaining patient confidentiality, it also bore the inevitable possibility of medical error emanating from misunderstandings.

The last strategy, body language, also known as non-verbal communication, was also reported to have been utilised by one of the local doctor respondents who works in the public sector. While body language could be an effective tool in physically manifesting illnesses, internal illnesses require verbal communication.

5.2.4 The experiences of the respondent doctors regarding the advantages and disadvantages of working in a multilingual context

There were some advantages and disadvantages recorded by respondent doctors emanating from working in a multilingual context that utilises the English Language such as the one in Windhoek. The study revealed that working in a multilingual context is of great advantage given the diasporic nature of the world today. The world has become one big village in which people are free to live and work wherever they desire to. When one encounters, learns and utilises many languages, they are also positively exposed to a wide range of cultures. A knowledge of many cultures leads to improved communicative and social skills as a result of empathy, which enables an individual to establish and maintain good human relations. More so, it is an advantage for individuals who work in humanitarian causes including medicine. Thus, knowledge of multiple languages is an advantage to a doctor more than it is a disadvantage. However, multilingualism does not come without challenges. In the midst of encountering, learning and using multiple languages, there is a possibility of language barriers. Language barriers further result in communication breakdowns which lead to such problems as medical error, poor patient satisfaction and adherence to treatment, as well as a poor doctor-patient relationship, emanating from lack of rapport in the context of medicine. There is also a possibility of dilution of languages by the users, thereby losing the purity of one language.

To conclude, the study revealed some insightful information, positive and negative, regarding the utilisation of the English Language in multilingual health communication in Windhoek, Namibia. Three main insights came to the fore. One of the main revelations was that the doctors, expatriate and local, in private and public sectors had diverse linguistic backgrounds, which further reveal the complexity of multilingualism in Windhoek. Many of the doctors in

the public and private sectors, but not all, are proficient in the English Language. However, the English Language alone is not sufficient for effective communication in Windhoek, due to the masses of patients who are not at all able to communicate in the English Language or have very limited knowledge of it. The second revelation was that there was more language discordance in public facilities than in the private ones. A third revelation from this study was that the prevalence of the awareness of doctors regarding the linguistic environment in which they operate and their drive to, despite all odds, adopt strategies that facilitate communication so as to improve health care delivery. The fourth revelation was that the strategies employed by the doctors may have been enabling the doctors and patients to somehow communicate, but they were not ideal due to the shortcomings that they had. The final revelation was that multilingual communication in Windhoek is enriching to the doctors and patients alike due to its potential to develop their linguistic, cultural and social capacity. However, better practices and management of multilingual communication between doctors and patients in public hospitals is an urgent necessity, to ensure improved health care delivery.

5.3 Recommendations

5.3.1 Policy recommendations

Due to the diverse linguistic and cultural nature of Windhoek, it is recommended that orientation programmes be organised for doctors employed in Windhoek in relation to the language and culture therein. Additionally, the development of bilingual medical dictionaries for the doctors can be considered.

Interpretation in medical consultation is better done by professional interpreters. However, it is evident that professional interpreters are not available in the hospitals and nurses, family members and or other patients often do the interpretation. In order to reduce the problems inherent in using *ad-hoc* or untrained interpreters, it is recommended that nurses are trained to interpret, preferably in the Nursing school and not on the job. Language practitioners should be consulted to develop a curriculum for interpreting as part of the basic nursing training. For nurses already working, it will be beneficial to organise courses on interpreting. Nurses need to be aware that they do more than interpreters but also act as cultural brokers for the doctors. Proper training will provide interpretation that is close to a professional level at a reduced cost. More nurses could be employed to help doctors interpret.

5.3.2 Recommendations for future research

Due to the limitations of this study, it is recommended that studies including most parties involved in medical communication be done. Studies which would gain the perspective of nurses and patients can be considered. Moreover, a national study, extending to other regions to gain a wider perspective of the problem can be considered. A study that will capture consultations in order to gain the perspectives of how communication occurs during consultations can be considered. To effectively do that, video recording can be utilised as a data collecting tool for the recording of the consultations. The use of an un-obstructive high-tech video camera will reduce the pretentiousness of the participants as the presence of the researcher is removed. Aspects that were uncovered during this study such as interpretation, getting by and non-verbal communication can be studied separately in order to get an in-depth understanding of each.

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APPENDICES

Appendix 1

QUESTIONNAIRE

Investigating the use of the English language in multilingual communication: a case study of doctor-patient communication in Windhoek, Namibia

Please fill in the following as completely and accurately as possible. There are no right or wrong answers – this is a survey from which the researcher wishes to draw an accurate profile of the multilingual skills and how they are utilised among a particular group of respondents in medical practice in Windhoek.

You are requested to answer the questions in the spaces provided or to tick a box where applicable.

SECTION A: Metadata

Personal information

Surname and name: .....

Preferred pseudonym: .....

Gender: Male ☐ Female ☐

Age bracket: 25 – 35 yrs. old ☐ 46 – 55 yrs. old ☐

36 – 45 yrs. old ☐ 56 yrs. and older ☐

1. Country and place of birth .....

2. Secondary school completed at .....

3. Medical training at .....

.....

4. Any other tertiary qualifications obtained: .....

5. Did you ever have any language other than The English Language as ***language-of-learning***? If so, which one?

.....

6. Employment history:

Place	Facility	Dates
(e.g. Windhoek	Katutura Hospital	2001 – 2005)

.....

.....

.....

.....

SECTION B: Participant's knowledge and use of languages

7. Please list all the languages you know, even if you are not very proficient. Mark your first language as such. For each language, rate your ability in the language for the skills listed in columns (ii) to (v) (understanding the spoken form, speaking, reading, and writing) on a scale of 1 to 5, where 5 is excellent and 1 is poor.

I	Ii	Iii	iv	V
Languages	Understand	Speak	read	Write

The English Language				

8. This question has to do with where and when you learnt the languages you listed in question 6. Please complete the table below for each language you listed. In column (i) fill in the name of the language; in column (ii) give the age at which you learnt it; in column (iii) give the place and setting in which you learnt it; in column (iv) state whether and where you currently use the language.

I	Ii	Iii	Iv
Languages	Age of acquisition	Place/context of acquisition	Current use
English			

SECTION C: Language in the workplace

9. Which of the languages that you listed in questions 6 to 7 do you use

   (i) at home .....

   (ii) at work.....?

10. If at times you use other languages than the English Language at work, explain the circumstances:

.....

.....

11. Name the languages other than the English Language which you encounter in consultation with patients in Windhoek:

.....

.....

12. If a patient is obviously not proficient in the English Language, explain the course of action you take to overcome the communication barrier.

.....

.....

13. Do you ever make use of interpreting services in the course of consultation with or treatment of patients? If yes, please explain (i) who the interpreter is, and (ii) who introduces the interpreter.

.....

.....

14. Have you encountered a situation in which you use one language (e.g. the English Language) and the patient uses another (e.g. Oshiwambo), and you actually get by? If yes, please explain the circumstances.

.....

.....

15. If there were formal or professional interpreting services available for use in your consultations, would you regard that as facilitating? If yes, in which way?

.....

.....

16. If there were formal or professional interpreting services available for use in your consultations, do you envisage any difficulties? If yes, please explain the kinds of difficulties.

.....

.....

17. In communication with colleagues, do you at times use other languages than the English Language? If yes, please name the languages and explain the circumstances.

.....

.....

18. Does language at times pose a barrier in communication with colleagues in the workplace? If yes, please explain the circumstances.

.....

.....

19. Please explain what would make you switch from one language to another in an interaction with either a colleague or a patient.

.....

.....

20. You are a multilingual person working in a multilingual community.

    (a) What do you find *most challenging* about knowing, using and encountering a variety of languages in everyday life?

.....

.....

    (b) What do you find *most advantageous* about knowing, using and encountering a variety of languages in everyday life?

.....

.....

21. Please give any other information on your experience in communicating across languages and cultures in the workplace which you would find relevant to this study.

.....

.....

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.....

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.....

.....

Appendix 2

UNIVERSITY OF NAMIBIA

CONSENT TO PARTICIPATE IN RESEARCH

An investigation into the use of the English Language in multilingual communication: a case study of doctor-patient communication in Khomas region, Namibia

You are asked to participate in a research project conducted by Ms Katrina K. Basimike, a student in the Department of language and literature studies, University of Namibia. The results of this study will be utilised for writing a thesis towards a Master of Arts in the English Language Studies. You were selected as a possible participant in this study because it focuses on the doctor-patient communication in the Khomas region.

1. PURPOSE OF THE STUDY

The study will investigate the challenges posed by the use of the English Language between multilingual doctors and patients in Khomas region.

2. PROCEDURES

If you volunteer to participate in this study, you will be asked (i) to complete a questionnaire on the uses of various languages in your workplace.

3. POTENTIAL RISKS AND DISCOMFORTS

Participation in this study will not hold any risks or discomfort you in any way. If at any stage you do feel uneasy, you may request information to be removed, or you may yourself withdraw your participation.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not benefit directly from this research in terms of material gain. The indirect benefit may be in (i) enhancing awareness of communication as a critical element in medical practice in Windhoek, and (ii) the potential uses of findings and suggestions that result from the study.

5. PAYMENT FOR PARTICIPATION

This exercise is voluntary, and as such there will be no remuneration for participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study will remain confidential in that no personal information will be divulged in the presentation of data and results. All data will be handled by myself and my supervisor, and will be anonymised before it is processed or analysed. Confidentiality will be maintained by means of the use of pseudonyms. All data will be in my safe custody. If you wish to review it to be sure that what it contains is what you really wish to say, that is possible at any stage. The data will be utilised for academic purposes only.

7. PARTICIPATION AND WITHDRAWAL

Taking part in this project is entirely voluntary. You are allowed to withdraw at any time, or not answer some questions but still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Ms Katrina K. Basimike researcher, on +264 812129921, e-mail katrinakshiwaya@yahoo.com and Dr Nelson Mlambo, supervisor, on +264 814218613 , e-mail: nlambon@unam.na (University of Namibia)

SIGNATURE OF RESEARCH SUBJECT

The information above was described to *me* by *Ms Katrina K Basimike* and *I am* in command of this language. *I* was given the opportunity to ask questions and these questions were answered to *my* satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

.....

Name of Subject/Participant

Appendix 3

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: FHSS /383/2018 Date: 6June, 2018

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy And Guidelines. Ethical Approval Is Given In Respect Of Undertakings Contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: AN INVESTIGATION INTO THE USE OF ENGLISH IN MULTILINGUAL HEALTH COMMUNICATION: A CASE STUDY OF DOCTOR PATIENT COMMUNICATION IN THE KHOMAS REGION

Researcher: BASIMIKE KATRINA KAUNAPAWA

Student Number: 200529706

Supervisor(s): Dr Mlambo

Faculty: Faculty of Humanities and Social Sciences

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
(c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
(d) The UREC retains the right to:

(i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
(ii) Request for an ethical compliance report at any point during the course of the research;

UREC wishes you the best in your research.

Dr. J.E. de Villiers: UREC Chairperson

Ms. P. Claassen: UREC Secretary

Appendix 4

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198	Ministerial Building	Tel: 061 – 203 2537
Windhoek	Harvey Street	Fax: 061 – 222558
Namibia	Windhoek	E-mail: btjivambi@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 **KB**
Enquiries: Mr. B. Tjivambi

Date: 12 November 2018

Ms. Katrina K. Basimike
PO Box 32046
Pioneers Park
Windhoek

Dear Ms. Basimike

Re: An investigation into the use of English in Multilingual Communication: A case study of Doctor patient communication in the Khomas region

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purpose;

3.2 No other data should be collected other than the data stated in the proposal;

3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

3.4 A quarterly report to be submitted to the Ministry's Research Unit;

3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry for the publication of the findings.

4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

PERMANENT SECRETARY
MINISTRY OF HEALTH & SOCIAL SERVICES

MR. B.T. NANGOMBE
PERMANENT SECRETARY

"Health for All"