Speech-language therapy consultation practices in multilingual and multicultural healthcare contexts: Current training in South Africa

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Patients who do not speak the same language as their healthcare professional receive limited health services compared with those who do, which may result in poor health outcomes. Speech-language therapists in multilingual and multicultural hospital settings often face these challenges. Language and translation issues have a marked impact on information received by patients and their families or caregivers. Despite clinicians' challenges experienced in multilingual settings, they seem to find that their working experience is an important leveller when there is an interpreter present during consultations. Human or linguistic rights-based teaching frameworks should include how to work with interpreters and be a culturally competent clinician. Evidence suggests a slowly increasing number of African language-speaking speech and hearing therapists. There is evidence that some of the existing workforce in the public and private sectors are not culturally competent, as required by the Health Professions Council of South Africa (HPCSA). Academic curricula and the clinical practice of speech-language and audiology students and professionals should transform application of theoretical knowledge when treating speech and hearing disorders in a multilingual and multicultural context, enhancing the efficacy of management of communication disorders. Furthermore, the profession needs to work on developing culturally and linguistically relevant intervention tools.

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In a world where language is important for self-understanding and relating, the work of a multilingual speech-language therapist (SLT) can bring a person from the margin into the community and from silence to communication. In South Africa (SA), where language was a means for structural exclusion under apartheid, the work of an SLT supports empowerment for clients. However, in a context where many SLTs do not speak the language of their clients, their work might be limited. The paradox remains a structural mechanism in contemporary SA public health that does not respond to citizens' needs. Communication across cultures and languages in hospital settings remains a challenge.[1]

SLTs working in SA state hospitals find themselves in challenging cultural and language contexts, where therapists and clients often do not speak the same language. The context is further limited by existing interpreter resource challenges. As communication disorder professionals, their scope of practice requires that they be clinically and culturally sensitive and competent. However, it appears that training institutions might not be preparing them fully for the type of situations and scenarios that they encounter as part of their lived experiences within their profession.[2] According to Penn *et al*.,[2] this lack of preparedness for the SA public health context includes challenges with professional, technical, systemic, managerial, interpersonal and ethical issues. These can be attributed to a variety of complex factors – key being gaps in resources, including research, culturally appropriate intervention tools and relevant human resources.

The link between culture and language cannot be overemphasised. Health Professions Council of South Africa (HPCSA) regulations relating to the undergraduate curricula and professional examinations in speech-language therapy[3] state that 'the curriculum (academic and clinical) must be consistent with exit level outcomes of the Professional Board. Education and training must:

- Be relevant to the needs of South Africa;
- Ensure that provision of services to clients/patients is not compromised where the clinician does not speak the client's/patient's language.'[3]

However, numerous local studies have shown that despite this regulation, many SLTs employed in the public and private sectors still do not have culturally and contextually relevant intervention tools.[4-8] Some authors found that SLTs not competent in African languages assess non-English-speaking adults and children in English or Afrikaans. Annual evidence from the National Forum (Department of Health grouping of all SLTs nationally) confirms findings from these studies directly from practising clinicians who service 80% of the population, who make use of public health facilities (K Khoza-Shangase – personal communication, 30 January 2018). SLTs remain unaware of cultural implications and clients are compromised when assessed in a language that they are not proficient in, indicating that more transformative training and cultural competence skills for the current workforce are pivotal. Curricula for undergraduates appear limited in linguistic and cultural diversity training for effective preparation of SLTs.

State hospitals are multilingual and multicultural platforms where SLTs implement their practical professional training. Trainee SLTs are required by the HPCSA to take the Hippocratic Oath – a mandate guiding the physician-patient relationship. The oath is taken at the beginning and the end of their training and is based on the premise that they will treat and serve their patients to the best of their ability, upholding principles, such as confidentiality and the ethics of social justice.[9] Despite this professional training context and individual responsibility, evidence suggests that many SLTs qualify without the requisite cultural competence and critical diversity literacy. However, this cannot be generalised, as there are graduates from one predominantly Black institution that has been training SLTs since the early 1990s.[10]

This opinion piece was motivated by my exposure and experience as a clinical educator in the Department of Speech-Language Pathology and Audiology at the University of the Witwatersrand, Johannesburg, SA. This encompassed observing challenges faced by SLTs during consultations with caregivers seeking help for their children who have communication disabilities. Communication difficulties encountered by both SLTs and caregivers in these multicultural and multilingual contexts resulted in limited understanding on both sides and rendered the intervention process ineffective. I could empathise with the caregivers' discomfort when they were treated by medical professionals from a different cultural background, particularly when due consideration is given to the power dynamics created by SA's sociopolitical history.

Failed communication and ineffective interventions in multicultural and multilingual contexts raise several pertinent questions for researchers in speech-language therapy. How does a mother cope with her disabled child when she cannot understand that her child has a severe intellectual and/or physical disability? How does a practitioner function effectively when overwhelmed by the inability to speak informatively with patients/caregivers? How do practitioners operate in the context of laws related to language and human rights? Interestingly, in a national study by Southwood and van Dulm,[7] SLTs with less experience claimed that they could provide services for diverse clients, including African-language speakers. This is potentially problematic, as they might be unaware of their bias and lack of skills.

This article is particularly important in the context of post-apartheid expectations for human rights and service delivery. SA is reputed to have a most progressive constitution, including socioeconomic rights, yet inequities in access to and utilisation of health services continue.[11,12] As part of the problem and possible champions of the solution, SLTs must first examine their own practices to find solutions across the public health system.

Studies of doctor-patient communication reported that problematic communication leads to reduced health outcomes, poor compliance by patients, and patients' poor commitment to the intervention and treatment regimens.[13-15] Thomas[16] posits that the communication challenge across all healthcare practitioners comprises unequal encounters in doctor-patient communication. Research on interpretation is also challenging, because it cuts across diverse areas of practice, encompassing spoken and unspoken language. Consequently, documentation of challenges related to interpretation and effective work between practitioners and interpreters is limited.[17]

Professionally, speech-language therapists face similar challenges to those of other healthcare practitioners in attempts to communicate with their clients.[18] Yet, the use of language and speech lies at the core of SLT service delivery: the tools of diagnosis and intervention for SLTs are mainly centred on communication methods and approaches. Executing SLT service delivery can be hindered by cultural and linguistic differences between clinicians and clients, thus having an effect on communication. In post-apartheid SA, such differences replicate historical power dynamics, rendering clients even more silent, particularly as the language of practice for many SLTs is English, which is not the first or second language of many clients. Without clear demand-driven engagement, SLTs cannot provide effective interventions. This in effect creates a cycle of exclusion of patients/clients entering the healthcare system, but exiting without receiving effective treatment or care, as language remains a barrier.

Speech-language therapy thus creates a unique and communication-focused context within which to examine the challenges of healthcare communication in a multilingual and multicultural setting.

Challenges

Research has shown that interpretation may not necessarily address challenges of multilingualism and multiculturalism in contexts such as international conferences, court interpretation and, to some extent, medical interpretation.[17] Yet, knowledge production in the field of interpretation is in its infancy.[17] It is challenging because it cuts across diverse areas of practice, encompassing spoken and unspoken language. Therefore, documentation of challenges related to interpretation and how practitioners could work effectively with interpreters in the clinical fields of speech pathology and audiology has been limited.[17]

Given that cultural and linguistic diversity profoundly affects how families and professionals interrelate cross-culturally and participate together in treatment programmes,[19] the Department of Health should invest in recruiting trained interpreters to assist healthcare providers and patients in the public service. In public settings where there are no mediated/interpreter services, the objectives of the National Language Policy Framework[20] are contravened. Publications on interpreting in SA healthcare establishments are lacking. Existing studies have looked at mediation in different languages and at factors contributing to facilitating/inhibiting interpretations.[1,13,15]

As noted in my observations and research, most of the SLTs working in SA hospitals are not trained in critical diversity literacy and power dynamics, and therefore have a limited understanding of patients' multicultural and linguistic needs. Limited knowledge of clients' culture is not conducive to collaboration with diverse families. For communication intervention to be successful, it should be culturally and linguistically appropriate. Culture and language can be a barrier in working collaboratively when parties do not understand each other in a multicultural and multilingual setting. Working from a human rights perspective is also imperative.

Recommendations

To be successful as SLTs in providing quality rehabilitation, we need culturally appropriate resources (e.g. assessment and treatment tools) and to work in ways that do not distance our clients culturally. This is important for ethical and professional behaviour and is to our clients' benefit. I recommend the following based on my experience as a clinical educator and researcher:

- Transformation of admission criteria of trainee SLTs in undergraduate programmes in historically privileged institutions to increase accessibility to African language-speaking students. This will transform and redress practice and balance of power of the workforce in public hospitals.
- Curricula should comprehensively include cultural competency skills. Extensive training is necessary. It would be important to incorporate teaching on the effect of race, ethnicity and culture on clinical decision-making. The effect of stereotyping, for example, can be addressed by training SLTs to be aware of stereotypes.
- Training institutions should enact language policies that bring redress. This will translate to trainee SLTs studying at least one SA language or having a basic or introductory knowledge it.
- The integration of service learning in the curriculum to inculcate the importance of social justice and human rights of citizens. SLTs are bound by the ethical principles of justice, beneficence and human rights. According to the SA Speech-Language Hearing Association (SASLHA), SLTs should 'ensure that services are made available and accessible and that these services are appropriate to particular individual and

community needs'. This could be conducted by using formal, informal and in-service training of qualified SLTs on cultural competence.

- Training institutions should encourage students to conduct and disseminate action and emancipatory critical research that can guide the regulatory body, such as the HPCSA, in drafting position statements on language, culture and codes of conduct for SLTs.

Conclusion

The solution to this problem lies in understanding how we can work effectively with interpreters in a multilingual and multicultural society. For this, an overhaul of the training of SLTs is required, including an understanding of diversity and human rights regarding patients. Fortunately, with increasing numbers of graduates who speak African languages, the majority of whom are trained by one institution, service delivery to the multilingual and multicultural population might be improved.

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