

Research paper

Culture and communication: identifying and overcoming the barriers in caring for non-English-speaking German patients

Raymond Eckhardt RN Grad Cert ICU ARC BN(Hons)

Clinical Nurse Specialist, ICU/HDU Campbelltown Hospital, University of Western Sydney, Australia

Sarah Mott RN PhD FRCNA

Professor of Rehabilitation Nursing, Royal Rehabilitation Centre Sydney/University of Western Sydney, Australia

Sharon Andrew RN BAppSc MSc(Hons) PhD

Lecturer, School of Nursing, Family and Community Health, Penrith South DC, New South Wales, Australia

ABSTRACT

Officially, Australian society recognises the diversity of languages and cultures that make up the population, and encourages respect for different traditions and beliefs. However, the reality is often far from this ideal, especially in healthcare, where those who do not speak English can find themselves at a disadvantage. This study explored the experiences of such patients. It aimed to capture the experiences of six older German-born women who had undergone planned admission to hospital. A qualitative descriptive design informed by phenomenology was applied through the means of semi-structured, in-depth interviews that were tape-recorded and transcribed. Three main themes were identified: 'nursing for the masses', 'nursing the individual' and 'communication and language'. This paper is concerned with the third theme only.

Findings related to 'communication and language' are presented in terms of three sub-themes: barriers, interpreters and culture. Findings demonstrate the effects that lack of communication can have on patients who already feel vulnerable and anxious. While doctors booked interpreters for meetings with patients, nurses did not do so and consequently misunderstandings, frustrations and unsafe practice occurred. Language and communication issues far outweighed considerations about culture. These findings challenge nurses to respond to and address the mutual frustration of language barriers between themselves and patients.

Keywords: communication, cultural care, language barriers, nurse–client partnerships.

Introduction

Over the past century Australia has benefited from the migration of people from diverse countries and, despite the varied languages and cultures of its population, is widely regarded as a model of peaceful integration. An official policy on multiculturalism, reviewed and updated every few years, has guided this process (Commonwealth of Australia, 2003). Australian multicultural policy acknowledges and responds to the diverse nature of Australian society, and encourages social equity.

Multiculturalism encourages social cohesion and implies tolerance of differences, mutual respect between people of various backgrounds and equal access to all rights, opportunities and privileges by all (Commonwealth of Australia, 2003).

Despite this official policy of equity, democracy, freedom, acceptance and openness (Commonwealth of Australia, 2003) there remain service disparities. Daly *et al* (2002) stated that the rhetoric of

multiculturalism and social justice was not meeting the realities of the diverse needs of Australians, for example, elderly people from a non-English-speaking background. Other researchers suggest that it is not only the elderly people whose health needs are not being met, but also other non-English-speaking Australian residents. Inability to speak English places individuals at a disadvantage when attempting to access healthcare (Sharpe, 1992; Shanahan, 1995; Daly *et al*, 2002; Ferguson *et al*, 2003). In addition to access to care, patients who do not speak English may receive suboptimal nursing care. Underlying this may be an assumption or even an expectation that migrants from certain countries will be bilingual, speaking English in addition to their native language because in some countries, children routinely learn English as a second language while in school. However, it is likely that only younger people will have benefited from such teaching. For example, it was not until the late 1960s to early 1970s that English became a compulsory school subject in senior primary grades in German schools (Dallmann and Ludwig, 1979; Craig, 1980). Thus older adults may not have had the opportunity to learn the language. On coming to Australia they may have lived within a closed circle of migrants from the same background, relied on younger family members as interpreters, and worked in settings in which fellow employees spoke their native language.

There is a paucity of Australian research into the manner in which health professionals meet the needs of patients who do not speak English (Sharpe, 1992; Shanahan, 1995; Daly *et al*, 2002). This paper focuses on patients from one particular background, namely Germany, who do not speak English, and presents an account of their experiences of hospital care in terms of the challenges this presented for effective communication.

Research design

Basis of the investigation

This study was concerned with people's experience of care in hospital and, in particular, their interactions with staff. The aim was to capture older German-born persons' experiences of inpatient hospitalisation using a qualitative descriptive design informed by phenomenology which seeks to develop a deep understanding of the nature of everyday experiences (van Manen, 1990). Understanding the meanings of lived experience is gained from the information provided directly by participants. Thus the lived experience is both the object and source of phenomenological investigation.

Method

The study used in-depth once-only semi-structured participant interviews that were audiotaped. Redmond and Sorrell (1999) present different approaches for phenomenological interviews. Where, as in this case, in-depth personal information is required, the structure of the interview must be sensitive yet serve its purpose. This is achieved through asking 'how' rather than 'why'. A phenomenological interview is not used to try to explain, predict or generate a theory, but to understand the shared meanings of the participants' lived experience, from a cultural perspective (Meleis, 1996; Beyea, 1997). A list of formulated, open-ended and pre-justified questions was prepared with focus questions targeted at the experience of care, progression through hospitalisation, and interactions with staff. Some of the structured questions included:

'I would like to know as much as you can recall about the quality of verbal communication between yourself and the nursing staff. Were you well informed about your condition? Tell me about this. If you had a question for the nurse, how were your concerns addressed? What aspect of care were you most pleased about?'

These questions led into more detailed recollections of experiences and these were then further investigated. The duration of the interview time varied from one to two-and-a-half hours.

Data analysis

The audiotaped interviews were transcribed and three stages of data analysis were used (Twinn, 1997) to establish rigour in this part of the study. The first stage involved the translation and transcription of all the interviews into English by two translators working independently as well as back transcription into the German language. The rationale for transcribing the interview back into the individual's language was to allow the researcher to verify the accuracy of each transcription by presenting it to the participant concerned. A second German-speaking registered nurse verified the translations.

The second stage involved content or theme analysis of the six interviews to develop categories and themes (van Manen, 1990; Parahoo, 1997). The final stage was a comparison of the categories and themes generated from the German and English datasets to establish a link between the six lived experiences (Twinn, 1997).

Participant selection and recruitment

This study used specific inclusion criteria to recruit a convenience sample of German-born people living in an Australian regional municipality. The participants

were German-speaking people aged 55 years and over, living in the New South Wales Southern Highlands who had been hospitalised within the last five years. At the time of hospitalisation none felt comfortable about communicating in English without assistance. Participants were recruited through the local German Club. This club is open to local residents who are from Germany or who are interested in German traditions. It meets once a month for conversation and to plan quarterly trips away together. A recruitment information form was provided to the German Club President to request the opportunity to recruit participants from the German Club. Participant information sheets were distributed to the members by the researcher.

A sample of six participants agreed to be interviewed. All were German-born elderly women aged 57–82 years. Participant 1 spent two weeks in hospital for a cholecystectomy. This participant's English-speaking ability was sufficient to communicate basic needs. Participant 2 spent ten days in hospital for a heart valve replacement. This participant could not speak English at all. When she came to Australia she remained at home while her husband went out to work, and although he learnt English she spoke German with her husband. This participant had had little exposure to the English language because she lived in a rural area of Australia where contact with other persons was limited.

Participant 3 had a total left hip replacement and was hospitalised for two weeks. This participant stated that her ability to read and write in English was proficient. However, her ability to communicate verbally was poor. Participant 4 was hospitalised for ten days for a left partial knee replacement. This participant describes her English-speaking ability as very poor, although she was able to understand spoken English but could not read or write it. Participant 5 was hospitalised for one week for removal of a lymph node for non-Hodgkin's lymphoma. This participant said she did not speak or understand English. Her sister's daughter translated for her if really necessary. Participant 6 was hospitalised for one week for a hysterectomy. This participant described her English-speaking competency as poor. She was more comfortable with certain commands if the person spoke very slowly, clearly and using simple wording, but her ability to speak in English was limited to keyword sentence formation.

Ethical approval

Approval to undertake the study was obtained from the appropriate institutional ethics committee. Before participating in an interview the participants gave informed written consent to the researcher who conducted all interviews. The consent included all the required information about the purpose of the study,

the voluntary nature of their consent and ability to withdraw from the study without any consequence, conduct of the study including audiotaping of the interview and measures taken to maintain confidentiality.

Findings

Three themes were identified: 'nursing for the masses', 'nursing the individual' and 'communication and language'. The first two themes divided into subsidiary components. Nursing for the masses divided into two approaches to nursing care, namely 'habitual nursing care' and 'generalised nursing care'. Nursing the individual also subdivided into two components: 'the effects of individual care on participants', that is to say awareness of client's needs and developing trust through feeling valued, and 'participant responses to individual care, suspension of self, loss of control and client dependency on nursing staff'. In every aspect of these two first themes participants' experiences centred on the issue of communication and the limitations in their ability to exchange information. The findings in this paper concentrate on this issue of communication and language which divided into three components: 'barriers', 'interpreters' and 'culture', each of which is discussed below.

Barriers

This theme highlights the barriers faced by both nurses and participants in relation to communication and language, from the perspective of the participants. The issues raised focused on education, information provided to the participants about their condition, instruction on how to use pain-relieving devices and associated plans, frustrations related to medication administration as well as an expectation of poor communication due to similar previous experiences from past hospitalisations.

One participant did not express any expectations of the nurses' ability to converse with her during her hospital stay yet identified the ever-present language barrier. In her experience:

'I've been to hospital quite a few times now and nothing changes. I go to hospital, I always have problems not being able to talk with them, one doesn't understand the other, I find out bits and pieces through my friends and husband and then I go home. Lucky it's always gone smoothly, hey?'

This participant also had a certain degree of apprehension about the nurses' skills and their ability to address the language needs of patients who could not speak English, stating that:

'The nurses I had did well enough helping me to the toilet and doing the things they do, but when it came to the

language problem they didn't know how to help me. Most didn't even try German cards or stuff like that.'

Another participant described a concern about the clinical competency of her nurse. Her niece had spotted a potential error in the medication about to be administered to her aunt and informed the nurse. The participant reported feeling fearful of what could have happened, and helpless because she herself could not have intervened if her niece had not been present. After this event the woman stated that she was very cautious about nursing actions. She reported:

'I had my eye on the nurses then. Most of them were good but I didn't want to risk it. You see, it only took a split second for a mistake to happen ... my niece's and my own biggest worry was my poor English to speak out when I saw something was wrong, but don't worry, I'm not too shy to scream for my life if it came down to that.'

The importance of verbal interaction was noted by another participant through her use of the patient-controlled analgesia (PCA) device. She stated that:

'I knew how to use that morphine machine well because the doctor told me I would need it before I came to hospital. But when it was removed, I wasn't told of the new method where I had to ask for pain relief when I needed it. I found out about it when my daughter told the nurses I was in pain.'

This participant received an explanation of the PCA device pre-operatively and felt competent in using it. However, nurses did not explain changes in the procedure for pain relief and she was unaware of them until her daughter served as an interpreter. It was not the technique that the participant had difficulty with, but the lack of nursing education to provide continuity of care.

Interpreters

On a psychosocial level, one participant pointed out that next time she was in hospital she would ask for an interpreter, stating that:

'Next time, let's hope I won't have to, but if I do have to come to hospital again I'll ask for an interpreter straight from the start.'

Although she valued the nurses, she was disappointed that she missed out on information because she did not understand most of the content of her conversations with the staff. She felt it was a nursing responsibility to ensure she understood, yet their skills in information delivery were poor. She stated that:

'I'm sure it was the nurse's responsibility to assess if I needed help with my English. Otherwise there was the risk that I wouldn't know what was going on, or what I had to do ... I felt a little upset that the nurses didn't do this for me, I mean knowing what's going on is as important to me as having my tablets or bandages changed.'

Another participant supported this statement, placing as much value on nurses addressing the language barrier as she did on other nursing duties.

The need for an interpreter was expressed by three different participants. One participant was offered an interpreter by her surgeon before coming into hospital so that she could receive an explanation of the requirements and expectations of hospitalisation. In her view:

'This was good for me so I knew what was coming. I didn't know what to expect before I was told by my doctor with the translator.'

Another participant was very impressed with her preparation from her doctor. He organised a date and time and asked her to think of any questions she or her family might have and to bring them to the pre-arranged consultation. She added that:

'This was even better than coming to a consultation and trying to think of all the questions on the spot. This way I had time to prepare, and ask my family who might think of other things I'd have missed.'

Although the experiences of these two participants with their doctors were positive, the offer of an interpreter was not made at any time by the nursing staff. The participants realised the impossibility of organising an interpreter to be present the whole time, but identified occasions, such as pre-operative consultations, where one would have been beneficial. One participant stated the nurses sometimes communicated through her husband. In her opinion this was useful because:

'The important points were told to my husband, who then told me. This helped me a lot because even though I might have got the general point, there were details I would otherwise have missed out on.'

This example emphasises the benefit of using family members to communicate and interact for continuity of care, as opposed to no communication at all. However, not everyone had relatives to help them, and one such participant stated that:

'For the first time in a long time I felt fear. For an independent person, going to hospital was a frightening thought. I was scared of not being able to cope, or because of the language difference I had fear of the unknown.'

The importance of interpreters was highlighted by these three participants who held in high esteem professionals who organised planned meetings with interpreters. In contrast, unpredictable nursing care delivered without the provision of an interpreter was, in their view, detrimental to their wellbeing. Participants benefited from the presence of family members able to interpret, but those who did not have this support stressed the difficulty of coping with the hospitalisation and fear of the unknown.

Culture

This theme was concerned with the cultural difficulties based on differences in both language and understanding of hospital culture. The nurses were in a familiar environment, whereas the participants experienced hospital as strange and frightening. Communication difficulties were perpetuated throughout hospitalisation. In the view of one participant:

'It was obvious how difficult it was for the nurses to care for me because even when they went to do my dressings they did them quietly. Most of the time I didn't even know what they were about to do until I saw their equipment and they took the old bandages off. Sometimes I felt nervous until I knew what they were doing.'

This is an example both of the difficulties the nurses faced in not being able to explain and educate the patient about a procedure they were about to perform, and the feelings of the participant about the nurse's failure to inform her about what was going to happen. This participant also felt the language barrier should have been addressed to help her understand her medications. She added that:

'All my medications were different in hospital and the nurses didn't give me my usual ones, so I kept mine in a tissue and took them when they didn't see. I didn't know why or what they were doing ... it was quite a shock when I realised that Panadol and Panamax are the same thing ... the nurses were giving me Panamax and my normal ones were Panadol ... I still wonder what all the other tablets I took were ...'

Another participant had mixed feelings about the language barrier, adding that:

'The staff smiled a lot and this made me feel good because it made me think they were happy with how things were going, but it did seem they [the nurses] felt limited in what they could do because we couldn't talk to each other.'

The presence of body language through facial gestures was noticed by the participant, and the smiles provided comfort. However, she also noted the frustration felt by the nurses who could not communicate with her.

Discussion

Communication is a two-way process whereby the meaning of the information being conveyed must purposefully reach the party to which it is being presented. Communication from the nurses to the participant was often described positively by the participants, with an obvious attempt to speak in praise of the efforts of the staff in bridging the communication barrier. However, there were examples of direct

communication breakdown, superficial levels of communication, or miscommunication. These occurred during initial interactions with nurses and at times when effort was essential to gain information about certain aspects of care. The participants' descriptions are strongly suggestive of a sense of superiority among the nurses that reflects ethnocentrism, a term described by Geiger and Davidhizar (1999) with reference to the belief that one's own culture is superior and better than the cultural background of other people.

The emphasis on language overrode other considerations such as culture. Participants felt that they had few or no difficulties culturally, even though one participant was moved from a room due to racist views voiced by another patient about her supposed ethnic affiliation. When referring to nursing attitudes about cultural differences, participants considered that cultural care was not compromised. One participant stated that because she did not have any special needs or requests, her cultural background was indistinguishable from that of the staff and therefore it was not an issue for her. This may be because the German healthcare system is very similar in structure and function to that of Australia in that its roots are founded and shaped by white Western healthcare ideologies. The participants' expectations of the daily pattern and functioning of the hospital reflected such ideologies. Minor concerns such as using tap water instead of bottled water for drinking were mentioned, yet the system as a whole was familiar. Cultural expectations or traditional practices did not stand out from what was viewed as the 'norm'; no special food was required and there were no religious requests or challenges. Consequently, communication barriers were experienced as the major threat to culturally competent and safe nursing care, a factor supported by Lee (1999) and Lui and Mackenzie (1999) who studied elderly Chinese Hong Kong residents, and identified communication difficulties and language barriers as the most pressing problem areas. Chevannes (2002) interviewed 22 health professionals working in five different healthcare settings in an ethnically diverse city in England. She found that the staff reported difficulty in communicating with patients who spoke very little English, and that they believed that communication was the factor which affected their ability to give care. Shanahan (1995), Culley (1996), Redmond and Sorrell (1999), Rundle (1999), Tang (1999), Yam and Rossiter (2000), Gravely (2001) and Knott (2002) also highlight that the biggest difficulties for non-English-speaking patients during hospitalisation were the communication limitations that potentially compromised care.

The language barrier, as experienced by the participants in the study reported here, was either blatantly obvious or formed the basis of specific difficulties. In some instances the behaviour of nurses acted as a

deterrent to effective communication, ultimately limiting the knowledge gained by participants about their conditions. Having to rely on nursing routine and trusting the nurses' judgement prevented the participants from engaging in their own care planning and management. For example, one participant felt offended by the nurse suggesting she was unclean because she did not shower after hydrotherapy. The participant described this situation with frustration and an irritated undertone. For her the experience was centred on not understanding what the nurse had said and either misinterpreting the situation or acting on her feelings. For the nurse, her imperative was for the patient to have a shower, and her urging was interpreted by the patient as meaning she, the patient, was unclean. Two forces are at play here. The nurse continuing her conversation even though the participant cannot understand – an experience shared by other participants – resulted in miscommunication. The participant, through reading body language and single words she may have understood, used this to form her own understanding of the situation. This caused the participant to become upset by the nurse's 'suggestions' and frustrated at the language barrier. Such experiences of frustration are well documented in the literature (Rogers *et al*, 2000; Gerrish, 2001; Foley, 2002) alongside difficulties in understanding what is happening through nurses mismanaging communication (Ward-Collins, 1998). Such experiences highlight the importance of appropriate and meaningful assessment (Narayan, 2003) and the need to include interpreters.

Hospital staff have both a legal and an ethical responsibility to provide interpreting services to patients who do not speak English (Tang, 1999; Gravelly, 2001; Perez, 2002) but, as the findings presented here demonstrate, interpreters were accessed only by the medical profession. Participants stated that the doctors arranged for interpreters to explain the need for hospitalisation, the procedures to be undertaken, and what was to be expected during the recovery process. Knowing that an interpreter would be present allowed at least one participant to prepare questions, discuss issues with family members and present concerns to the doctor on the designated day, thus enabling the participant to prepare adequately for her hospital stay.

Such experiences compared negatively with the nurses' attempts at communication. A good example mentioned by more than one participant was the filling out of diet sheets, a factor that had significant meaning for the participants. The nurses, by not using interpreters, struggled with this procedure, either filling out the diet sheet without consultation with the patient, or not filling it out at all. This resulted in the patients being reluctant to eat the food they didn't like. One participant felt the staff saw her as a trouble-maker because she didn't eat what she was given. This caused her to become anxious and very self-conscious about

her behaviour, for example, not using the call button for a nurse in case this would reinforce her trouble-maker status among the nurses.

From a nursing perspective it would be impossible to predict when an interpreter would be needed. Some of these explanations might only take a few minutes. Tang (1999) argues that using family members for interpreting is unacceptable but those nurses who used relatives to explain procedures were perceived by participants to be more helpful than staff who did not. This could be overcome by an initial assessment of the client's needs by asking, through the interpreter, whether the patient was willing to have family members interpret for routine procedures or any minor questions concerning things like the menu during their stay.

Conclusion

This study raises a number of issues relating to the provision of individualised health, emergency and in-hospital care to people who do not speak English. Patients have a right to adequate explanations about procedures and cannot be assumed to have given their consent in situations in which they would not understand what is happening. Effective care is dependent on good interpersonal skills, and nurses must realise that technical and clinical competence are not sufficient for the provision of safe care. Patients need and want people who can communicate clearly and compassionately.

REFERENCES

- Beya SC (1997) Qualitative and quantitative approaches to nursing research. *AORN Journal* 66(2):323–5.
- Chevannes M (2002) Issues in educating health professionals to meet the diverse needs of patients and other service users from ethnic minority groups. *Journal of Advanced Nursing* 39(3):290–8.
- Commonwealth of Australia (2003) *Multicultural Australia: united in diversity*. http://www.immi.gov.au/multicultural/_inc/pdf_doc/united_diversity (accessed 19 February 2006).
- Craig GA (1980) *Deutsche Geschichte 1866–1945. Vom Norddeutschen Bund bis zum Ende des Dritten reiches*. Muenchen: CH Beck'sche Verlagsbuchhandlung.
- Culley L (1996) A critique of multiculturalism in health care: the challenge for nurse education. *Journal of Advanced Nursing* 23(3):564–70.
- Dallmann H and Ludwig W (1979) *Grosses Hand Lexikon in Farbe*. Guetersloh: Lexikon-Institut Bertelsmann.
- Daly J, Davidson P, Chang E *et al* (2002) Cultural aspects of adjustment to coronary heart disease in Chinese-Australians: a review of the literature. *Journal of Advanced Nursing* 39(4):391–9.

- Ferguson W, Keller D, Haley H and Quirk M (2003) Developing culturally competent community faculty: a model program. *Academic Medicine* 78(12):1221–8.
- Foley G (2002) Improving communication: a constant challenge. *Cancer Practice* 10(3):117.
- Geiger JN and Davidhizar RE (1999) *Transcultural Nursing. Assessment and intervention* (3e). St Louis: Mosby.
- Gerrish K (2001) The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *Journal of Advanced Nursing* 33(5):566–74.
- Gravely S (2001) When your patient speaks Spanish – and you don't. *RN* 64(5):65–7.
- Knott P (2002) How does culture influence health care? *Physician Assistant* 26(4):21–22, 25–26, 28, 37.
- Lee B (1999) Tackling racism. *Nursing Standard* 13(28):14–16.
- Lui MHL and Mackenzie AE (1999) Chinese elderly patients' perceptions of their rehabilitation needs following a stroke. *Journal of Advanced Nursing* 30(2):391–400.
- Meleis AI (1996) Culturally competent scholarship: substance and rigor. *Advances in Nursing Science* 19(2):1–16.
- Narayan M (2003) Cultural assessment and care planning. *Home Healthcare Nurse* 21(9):611–18.
- Parahoo K (1997) *Nursing Research Principles, Process and Issues*. London: MacMillan.
- Perez M (2002) Limited-English patients *AORN Journal* 75(5):919–20.
- Redmond GM and Sorrell JM (1999) Studying patient satisfaction patient voices of quality. *Outcomes Management Care for Nursing Practice* 3(2):67–72.
- Rogers AE, Addington-Hall JM, Abery AJ *et al* (2000) Knowledge and communication difficulties for patients with chronic heart failure: qualitative study. *British Medical Journal* 321:605–7.
- Rundle AK (1999) Guidance for caregivers to address issues of multicultural patients *Massachusetts Nurse* 69(9):12–13.
- Shanahan M (1995) Are nurses aware of the differing health care needs of Vietnamese clients? *Journal of Advanced Nursing* 22(3):456–64.
- Sharpe I (1992) Let us not forget our ethnic aged. *Australian Nurses Journal* 21(10):16–18.
- Tang SYS (1999) Interpreter services in healthcare: policy recommendations for healthcare agencies. *Journal of Nursing Administration* 29(6):23–9.
- Twinn S (1997) An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of Advanced Nursing* 26(2):418–23.
- van Manen M (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. Albany, New York: State University of New York Press.
- Ward-Collins D (1998) 'Noncompliant.' Isn't there a better way to say it? *American Journal of Nursing* 98(5):27–31.
- Yam BMC and Rossiter JC (2000) Caring in nursing: perception of Hong Kong nurses. *Journal of Clinical Nursing* 9(2):293–302.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Raymond Eckhardt, Clinical Nurse Specialist, ICU/ HDU Campbelltown Hospital, University of Western Sydney, School of Nursing, Family and Community Health, Campbelltown Building 7, Locked Bag 1797, Penrith South DC, NSW 1797, Australia. Tel: +61 2 46203323; fax: +61 2 46254252; email: r.eckhardt@uws.edu.au

Received 1 April 2005

Accepted 30 January 2006