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The Linguistic Gap in Doctor-Patient Communication in Algeria

ABSTRACT
The main purpose of this paper is to shed some light on language use in the Algerian healthcare settings where a multilingual situation is prevailing. It reports on communication and linguistic barriers that both patients and doctors encounter during medical visits. The Algerian physicians are taught and trained exclusively in French. Thus, they feel more comfortable when they use French as it enables them to be more informative when they speak about symptoms, diagnosis and treatments. Consequently, when they talk to their patients they inevitably use much French and medical terms which are likely to be unintelligible mainly when they address patients who are not bilinguals or have little or no health literacy in the French language. Thus, we suppose that communication problems arise as a result of linguistic barriers which are due to issues related to proficiency levels in some language varieties, mainly French, as it predominates over Modern Standard Arabic (MSA), Algerian Arabic (AA) and the other Algerian local varieties in the Algerian healthcare settings.
Keywords: bilingualism; doctor-patient communication; language predominance; linguistic barriers; translation difficulties

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1. Background

In multilingual contexts, it is likely that language disparities impact communication between doctors and patients. Actually, there are a large number of studies in social sciences and other disciplines dealing with language use in doctor-patient communication, e.g. Woloshin et al. 1995, Joos et al. 1996, Jacobs et al. 2001, who all have stressed the importance of effective communication between doctors and patients for good health outcomes. Algeria is characterized by an unbalanced Arabic/French bilingualism at both micro and macro levels. French is not equally parcelled out across the Algerian population. It is largely monopolised by the urban rather than the rural, the educated rather than the uneducated. Thus, it is assumed that bilingualism in Algeria is not homogeneous; it is rather heterogeneous. So, whoever travels across the country can meet people with different degrees of proficiency and *bilinguality* ranging from the very high to the very low in different regions due to different dimensions as pointed by Hamers and Blanc (2000: 06) "psychological, cognitive, psycholinguistics, social, sociological, sociolinguistics, sociocultural and linguistic." Many Algerians understand French but cannot speak it, others have no understanding or knowledge of French at all. This situation generates some communication problems between speakers and non-speakers of French, especially, in certain contexts where French predominates and is the most used variety, like in medical settings where doctors and medical students are deeply influenced by the use of French and the medical jargon as characteristic to their linguistic behaviour.

Since the colonial period and even after independence, medicine is still taught exclusively in French. Algerian doctors and medical students use French in their work and trainings to speak about the medical procedures and performances. Therefore, they are more comfortable when they speak to each other or when they talk about medical matters in the language in which they have acquired medical knowledge rather than using Arabic. It is worth mentioning here that Algerians use one of the regional colloquial verities in their everyday conversations, AA dialects or one of the Berber dialects which are

spoken in Berber speaking regions. However, AA and Berber can be regarded as lay languages because they do not receive scientific linguistic updates, unlike the other major languages such English, French, Russian, MSA, etc., due to their non-standardised nature. For this reason French became a practical means of communication in the Algerian medical settings rather than AA, Berber, or even MSA, though this latter is a standard variety but it is commonly not used in everyday conversations of Algerians. Thus, in this paper it is supposed that it is inevitable to suffer from failure in communication when doctors are confronted with patients lacking proficiency in French. Doctors are likely to meet difficulties to use an intelligible language free of French and jargon during medical encounters with non-bilingual patients with low educational and social backgrounds. Hence, patients may not understand their doctors and follow their instructions.

Therefore, the current study examines communication problems that are induced by the coexistence of several language varieties in Algeria. Focus will be mainly put on the relevant issue that while there is an overall bilingualism among doctors, patients are not all bilinguals. This creates a linguistic gap caused by disparities in French language proficiency between doctors and patients and which should be addressed. Moreover, the medical context requires doctors to use a specific register that is characterised not only by the use of French but also a specific medical jargon. In addition to this, the busy nature of medical context and the difficulty to translate medical terminology to AA or Berber makes it difficult for doctors to immediately find equivalents of highly medical technical terms in the local non-standard varieties that lay and non-bilingual patients can understand to successfully communicate with doctors and learn about their health problem and treatment procedures

2. Methodology and research instruments

A mixed research methodology was used to collect data at some private medical offices and the university hospital of Sidi Bel Abbes, a town in the Northwest of Algeria. The inhabitants of this area are

mainly arabophone, i.e., AA is the variety that the majority of speakers use.

A researcher-completed questionnaire was used to interview 53 patients. This approach was used because patients had different social backgrounds and might not all be able to read, write or even understand the questions. It allowed me to paraphrase or translate, when necessary, either to AA or to French to solve problems of misunderstandings, to ask for additional details that appeared to be valuable and helped me confirm suspicion and deal with paradoxes.

On the other hand, due to the busy-nature of the doctors' work, I decided upon a respondent-completed questionnaire approach which allowed me to put doctors at ease. Besides, a number of questionnaires were sent to doctors via emails and the social networking services. All in all, 60 questionnaires were completed and returned. Both doctors' and patients' questionnaires included open-ended and closed-ended questions to obtain reliable quantitative and qualitative data.

Other unstructured interviews were conducted with patients, and doctors. They aimed at validating the quantitative data Additionally, the researcher observed language use in interactions in the hospital's corridors and consultation rooms.

3. Findings and discussion

3.1. French language proficiency

A question was asked to both doctors and patients to examine the doctors' level of French proficiency and then compare it to the patients' level of understanding French to determine whether there exists a linguistic gap between doctors and patients. The results show that the majority of doctors ranked themselves in the 'Excellent' and the 'Good' categories with 31.36% and 61.66%, respectively, while few patients ranked themselves in these two categories. The lowest levels in understanding French obtained the highest percentages by patients.

Table 1. Doctors' and patients' French proficiency

Doctors' self-assessment of proficiency in French		**Patients' ability to understand French**	
Competency degree	**Percentage (%)**	**Competency degree**	**Percentage (%)**
Weak	0	Weak	32 .07
Average	6.66	Average	37.73
Good	61.66	Good	28.3
Excellent	31.66	Excellent	1.88

3.2 Use frequency of French

I also compared doctors' and patients' French use frequency in day-to-day conversations within four categories as shown in the figure below.

Table 2. Doctors' and patients' frequency of use of French.

Doctors				**Patients**			
Never	Sometimes	Often	Always	Never	Sometimes	Often	Always
0%	3 .33%	33.033 %	63.33 %	26.41 %	50.94%	13.20 %	7.54%

There is a remarkable divergence in the contrasting rates of the frequency of use of French between doctors and patients. A percentage of 63.33 of doctors said that they always used French, while only 7.54% of patients said they always used it. In the 'Often' category doctors recorded a rate of 33.33% whereas patients' score was 13.20%. Nearly half the patients' population stated that they sometimes used French, while only 2 doctors (3.33%) used French occasionally. These results with those of the former question reflect the existing linguistic gap between patients and doctors, especially as regards the frequency of use of French, which is primary to discuss

medical topics in Algeria. The study also shows that 70% of the questioned doctors said that French is the most used language at healthcare settings. On the other hand, the majority of patients (86.79%) said that doctors mixed Arabic with French to talk to them. So I asked them what language doctors used most to see whether switches to French were limited to a few words or they used long stretches of sentences. The results show that 76.08 % said that doctors used more French than Arabic.

This result is supported by our own observation during data collection. I noticed that French was widely used, especially by doctors in the different departments of the hospital. For instance, the first time I went to the hospital to ask for permission to carry out my research, I asked a female doctor for directions to the office of the Head of Pedagogical Activities. I, purposefully, used Arabic to address her but I was surprised to be answered in French: *justement on le cherche aussi, patientez là-bas à son bureau c'est le premier à droite* (Actually, we are looking for him, too. Wait over there in his office; it is the first one on the right).

Also, in the radiology department, two male doctors were using AA for greeting when they met and for discussing their personal affairs. However, they switched to French when they started talking about a patient's x-ray image. Further, while I was waiting for the head of the internal medicine department, a female doctor used French to a patient's care-giver when she was giving him some instructions in the corridor. I also observed that female doctors talked to each other mainly in French, unlike male doctors who used mainly AA but switched to French when they addressed the head of the department who used only French to give orders and instructions to the doctors, the nurses and the medical secretaries. However, both male and female doctors used French to talk to each other in the consultation rooms in front of the patients. This occurred even if the doctors were talking about the patient's health situation. Crystal (1987) explains that one of the reasons this code switching occurs is that the participants who switch to the second language wish to exclude the other participants from the conversation.

On the other hand, the inevitability of the use of French by doctors is very apparent in doctors' linguistics practices. The following example shows how complex the situation is when it comes to doctors to talk to monolingual patients. A female doctor was using mainly French to address a 21-year-old pregnant patient coming from a rural area with a primary educational level and a very low French language proficiency level. Sometimes, the use of non-verbal language, when referring to body parts, helped the patient to understand the doctor's language which was loaded with French words and utterances:[1]

> *les poignets et les épaules /jddurru:k/?*
>
> 'Do you feel pain in your wrists and shoulders?'

showing the wrists and shoulders. But when the doctor said:

> */ʃu:fi/ quand on va faire le test on va être trés limité, /kajən/ des radios et des analyses qu'on ne peut pas faire euh euh /kifaʃ ngu:llək/ pour explorer euh /baʃ nʔeksplori ʔddur li rah fik ʕlabal/ le bébé*
>
> (Look, we will be very limited in the test that we will do. There are some x-rays and biological tests that we cannot do to, euh euh, how to tell you, to explore, euh, to explore your disease because of the baby).

The patient was staring blankly at the doctor without responding. This can be understood that the patient did not understand a great deal of what she had been told. The doctor switched between AA and French. Her hesitations from time to time reveal that the switches were due to linguistic deficiency in AA to speak about medical matters and that she was aware about the patients' inability to understand French. Notably, when she attempted to use some Arabic, the doctor translated the French word *explorer* (to explore) simply by adapting it morphologically to AA */nʔeksplori/*, however, though AA contains many French words that have been adapted to Arabic such as */nkonikti/* 'to connect' or */jfonksju:ni/*, the word */nʔeksplori/* has a technical nature and is not commonly used in AA and thus cannot be understood by non-speakers of French.

[1] IPA symbols are used here to transcribe and refer to the AA words that were used by doctors as she switched from AA to French.

3.3. Patients' need for French

The aim of this question was to check whether patients believed it was necessary for them to speak French in order to discuss and get access to medical information. The majority of patients (92.45%) wished they could speak French. They also believed that a good mastery of French would have helped them understand better their illnesses, and effectively communicate with doctors. To illustrate, here are some of the patients' comments on the importance of French in medical encounters:

> I wish I could understand what doctors say about my disease to other doctors.
>
> There are many doctors who use much French, female doctors in particular.
>
> I need French because doctors explain things in French and I don't understand it.
>
> I need French to understand better my thyroid problem.

3.4. French as a language barrier

Studying and practicing medicine in a language that is neither the country's official language nor any Algerian's mother tongue, and which is witnessing a sharp decline in terms of mastery and fluency at the different levels of the society, maybe one of the possible barriers affecting the doctor-patient communication. The following table shows whether or not this language is believed to stand as a barrier to communication between doctors and patients.

Table 3. French as a language barrier to doctor-patient communication.

Never	Sometimes	Often	Always
10%	55%	25%	10%

Ninety percent of doctors admitted that French created a language barrier to effective communication, however, their answers ranged in terms of frequency. These results are very acceptable because French is not always used since all doctors can use AA. Let us consider a

comment given by a doctor on this question that I posted on a medical page on Facebook:

> Yes, French raises problems, most of the patients do not understand it, the doctors do not know how to explain things in Arabic without recourse to French i.e., to make a scientific translation of what they have diagnosed.

Within this same discussion another doctor said:

> French is an unavoidable cause of communication ineffectiveness.

The doctors' comments highlight the fact that it is difficult for them to speak about symptoms, diagnosis, treatment procedures, dosage etc., in the local language. One reason is that the AA is not a standard language and it is not elaborated well enough to serve medical and technical matters, unlike French which cannot be completely avoided because of its internal structure. French is a major language which possesses the necessary resources and vocabulary for a scientific interpretation. It allows doctors to express their thoughts in an accurate and explicit manner even though it is not often understood by their patients.

3.5. Medical jargon as a language barrier

Medical terminology is one of the most easily identifiable linguistic criteria in health care communication. Margaret Simmons (1998) asserts that it is difficult for any patient to use or understand scientific vocabulary. As a result, a patient cannot fully and easily take part in a conversation with a doctor. In the following examples the doctors' use of jargon was inappropriate because the patients were old and illiterate it was impossible for them to understand the technical words:

> *Le cholesterol /kan ta:ləʕ men/ les corticoids* (Cholesterol level was high due to corticosteroids);
>
> */lqawlək/ l'acide urique?* (Have they found uric acid?);
>
> */hada jʃu:fah/ l'ORL* (It's an ENT who should see it).

Using AA to translate the medical jargon into plain language is not always an easy task. Furthermore, what makes translating such words more problematic is that each doctor and each patient translate and

interpret these terms according to their meaning in their regional dialects because of the coexistence of different linguistic varieties in Algeria. Rodreques (2004:46) refers to this as *semantic noise*. For instance, there are people who refer to tonsillitis as */ħlaqəm/* or */ħla:dʒəm/*, others use the word */wədni:n/* which can confuse doctors because it may be understood as 'ears' too. Similarly, the terms 'diabetes' and 'goitre' can be referred to as */əssukkur/* or */lħluwwa/*, and */lʕubra/*, */lɣu:ɣa/* or /lʕunq/, respectively, depending on the individual's dialect. Besides, the message usually gets lost when translated because it is usually weakened by the use of general terms.

4. Conclusion

Based on the obtained results and without claiming that I have carried out an exhaustive research, I can maintain that in the Algerian medical settings, due to language variation and language differences, communication problems are becoming very pronounced and deserve further investigation. Differences in linguistic proficiency in French highly impact effective doctor-patient communication and make their relationship more asymmetric.

The supremacy of French over Arabic in clinical environments has deeply influenced doctors' linguistic practices. They cannot be as informative as they should without using French and medical terminology. Furthermore, doctors do not only use French, they also use a great deal of jargon which is at the same time difficult to be understood by most patients, whatever their educational and linguistic background are, and very hard to be translated into plain language. Patients with low proficiency in French have difficulties expressing their concerns verbally. Even worse, they do not ask for clarification or further explanation. They are less informed about their health condition and less satisfied than patients with a good proficiency in French. On the other hand, the vocabulary of non-standard variety of AA is not well established to cover the medical terminology. It merely allows patients to get general information about their diseases and its use often confuse doctors when they miss interpret it. Another assumption is that although it might seem that doctors and patients are

not aware enough about the problematic linguistic situation that prevails in Algerian healthcare settings, they both agree on meeting difficulties in expressing their thoughts and concerns, to fully understand each other. Surprisingly, MSA (the standard and formal variety of Arabic) that can considerably narrow this gap, especially since it can be understood by most patients as practically most of them have at least a secondary or university educational level, is largely marginalised and still believed to be imperfect for the medical scientific discipline.

References

Crystal, D. 1987. *The Cambridge Encyclopedia of Language*. Cambridge: Cambridge University Press.

Hamers, J. F., Blanc, M. H. A. 2000. *Bilinguality and Bilingualism*. Cambridge: Cambridge University Press.

Jacobs, E. A., Lauderdale, D. S., David, M., Shorey, J. M., Wendy, L., Thisted, R. A. 2001. Impact of interpreter services on delivery of health care to limited-English-proficient patients. *Journal of General Internal Medicine*, 16, 468-474.

Johnson, B. R., Onwuegbuzie, A. J. 2004. Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26.

Joos, S. K., Hickam D. H., Gordon, G. H., Baker, L. H. 1996. Effects of a physician communication intervention on patient care outcomes. *Journal of General Internal Medicine*, 11(3), 147-155.

Simmons, M. 1998. A sociolinguistic analysis of doctor-patient communication. In: T. Orr (ed.), *The Japan Conference on English for Specific Purposes Proceedings*, Aizuwakamatsu City, Fukushima, Japan, November 8, 1997, 91-99.

Rodriques, M. V. 2000. *Perspectives of Communication and Communicative Competence.* New Delhi: Concept Publishing Company.

Woloshin, B. S., Bickel, N. A., Schwartz, L. M., Gany, F., Welch, G. H. 1995. Language barriers in medicine in the United States. *Journal of the American Medical Association*, 273(9), 724-728.