

## Healthcare Communication for the Namibian Healthcare Context: A Review of Literature

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### Abstract

*Understanding the patients' history, fears, understandings, and misunderstandings could aid the healthcare provider in effectively administering care to their clients. The current study is a review of studies related to healthcare communication and their relevance to the Namibian healthcare system. It is also intended to fill the existing paucity of literature of this nature in Namibia, making this paper timely and relevant. The researchers identified the need for a review study, which critically investigates healthcare providers' and patients' communication experiences in Namibia, through a critical review of available literature from Namibia, Africa, and the world. As clarified in the reviewed literature, there is a lack of sufficient empirical studies on healthcare communication challenges and how healthcare providers and patients deal with such challenges in Namibia. The main finding in this study is that in addition to linguistic discordance experienced in healthcare communication, other causes of dissonance emanate from the differences in cultural backgrounds, beliefs, exposure, and experiences. As a result of the differences in cultural backgrounds and experiences, the study established that effective healthcare communication is not only affected by the interlocutors' inability to understand different languages, but other factors such as cultural differences, social and status differences, and interpretation services equally contribute to the lack of mutual intelligibility between healthcare providers and patients. The study concludes that the literature available on this topic in Namibia is inadequate and does not cover ample sections of healthcare communication.*

**Keywords:** healthcare providers, communication, patients, linguistic discordance, multilingualism, cultural differences, interpreter, language

### Introduction

Healthcare communication is a growing field within healthcare studies. Healthcare deliberations and interactions can be complex since they involve interaction between individuals in non-equal positions, often non-voluntary, issues of vital importance, emotionally laden, and requires close cooperation (Ong et al., 1995). The healthcare provider usually holds a higher position than the patient, hence may dominate the discussions and in many cases makes the decisions. The patient, on the other hand, is the one who experiences a health problem, carries the pain, and understands its depth. In cases where the patient's situation is not sufficiently communicated or when the healthcare provider fails to take time and tries to understand the patient's story, then the outcome of the encounter may be unpleasant or devastating in some cases. Some results of healthcare communication encounter that have not been dealt with the sensitivity they deserve have resulted in failed healthcare communication, culminating in prolonged hospital stay, wrong diagnosis, breakdown in the healthcare provider-patient relationship and adverse circumstances, and death (Angus et al., 2012). Consequently, while healthcare providers have knowledge about diseases and how to treat them, it is crucial to understand that their roles can only be successful when they understand the origin of the patient's ill health, how long they suffered, how they felt on various occasions and how they feel in the present. Understanding the patient's history of the illness, fears, understandings, and misunderstandings could help the healthcare provider effectively administer care to their clients. This study is a review of research related to healthcare communication and its relevance to the Namibian healthcare context.

### **Significance of this study**

The researchers identified the need for a review, which critically investigates healthcare providers' and patients' communication experiences in Namibia. As clarified in the reviewed literature, there is a lack of sufficient empirical studies paying specific attention to healthcare communication challenges and how healthcare providers and patients deal with such challenges in Namibia. This is because there are many studies, such as by Ong et al. (1995) in the Netherlands, Ha et al. (2010) in Australia, Basey et al. (2004) in Nigeria, Sobane and Anthonissen (2013) in Lesotho, and many others in diverse countries and continents on healthcare communication but scant sources in the Namibian context. Therefore, a study of this nature located in Namibia was necessary. According to Du Plooy-Cillers (2014), "a critical, well-synthesized and integrated literature review study that demonstrates the need and justification for your study... forms a vital part of [research]" (p. 287). The purpose of a literature review is to gain an understanding of the current state of knowledge on a selected research problem. Even though Prilutski (2010, p. 52) claims that "there is a myriad of studies on various specific aspects of health communication in Ghana", an African country, the same cannot be said of Namibia. There is a need for studies of this nature in the Namibian healthcare context. The researchers for the present study are aware of a related study by Mlambo (2017) which focuses on expatriate healthcare providers serving in multilingual Windhoek, Namibia. Another distinguishing aspect of the present study is that it focuses on patients as stakeholders in the provision and reception of healthcare.

### **Healthcare communication - the nature and importance of communication**

The lexeme communication is derived from the Latin word *communis*, which means common. The definition underscores that unless a common understanding emerges from the exchange of information, there is no communication (Lunenburg, 2010). "Communication is a very common concept in everyday life and takes place in every setting, organisation, area, or place. No work or operation or function is carried out without effective means of communication" (Radhika, 2018, p. 1). The basic understanding of communication is that it has to do with the transmission of verbal and non-verbal messages. This transmission involves a sender (from whom the message/communication originates), the receiver, (for whom the message/communication is intended), and the channel (the route through which and how the communication takes place) (Munodawafa, 2008). Communication is therefore the process of transmitting information and common understandings from one person to another (Lunenburg, 2010). For effective communication to take place, the sender and the receiver should be prepared and willing to take part fully, as either speaker or receiver of the message. Another aspect necessary for effective communication is that the participants should exhibit a positive attitude in the way they communicate. Munodawafa (2008) further explicates, "communication requires a full understanding of behaviours associated with the sender and receiver and the possible barriers that are likely to exist" (p. 1). The people involved in sharing or communicating ideas, views, or opinions can only do so effectively when they accept and understand the interlocutor's behaviour and at times why such behaviour is displayed. If the above is not experienced, then communication falters and the intended information is lost.

Healthcare communication is commonly (though not exclusively) about the communication encounter between healthcare providers and patients (Angus et al., 2012). Prilutski (2010, p. 51) emphasizes "health communication is widely considered to be a major aspect of any public health campaign. It plays a vital role in public health campaigns designed to prevent infectious diseases in the developing

world". To succeed in establishing effective health communication and intervention, the participation of intended beneficiaries throughout the communication process is a foundation (Munodawafa, 2008). The active involvement of the patients in healthcare communication, especially during consultations with the healthcare providers or during their hospital visits, is of great importance for the success of healthcare administration (Angus et al., 2012; Ong et al., 1995; Ha et al., 2010). If the latter is ignored, the outcome might be negative. The diagnosis and treatment might not be directed at the real situation since the patient did not explain and clarify their medical history. Medical history usually assists the healthcare provider to arrive at the correct diagnosis and the subsequent provision of effective treatment (Hornakova, 2006; Ha et al., 2010).

The following researchers define health(care) communication in different ways, paying attention to different aspects of the phenomenon. Masumoto (2010, p. 51) defined health communication as "the study, or impact, of the communication process on health and healthcare delivery." The US Department of Health and Human Services, the National Institutes of Health National Cancer Institute (1988) defines healthcare communication as "the study and use of communication strategies to inform and influence individual and community decisions that enhance health." These definitions focus attention on the 'impact/influence' of communication on healthcare success or failure. Communication enables both the providers and recipients to contribute to the choices and decisions made on and about the medical condition in question.

A breakdown in the flow of information and medical history can cause serious miscommunication, which is a potential pitfall in terms of patients' understanding of their prognosis, the purpose of care, expectations, and involvement in treatment (Ha, et al., 2010). In cases such as these, there is a likelihood that the healthcare provider may be tempted to make decisions on the medical situation and the treatment plan of the patient. This is usually not the best, given that the patient might have their wishes and preferences, which, if engaged could be very different from that which the healthcare provider might make or opt for on the patient's behalf. Overall, poor communication between patients and healthcare providers leads to problems for patients, including more medical errors, less satisfaction with healthcare, and misinformed switching of doctors (Ong, 1995). In sum, poor communication with patients can also cause burnout and frustration for doctors (Burns, 2013). Healthcare providers who are unable to communicate effectively are prone to stress, causing anxiety and job dissatisfaction (Gibson & Zhong, 2005).

Masumoto (2010) proposes that,

there is a need for the scope of the definition of healthcare communication to be broadened to encompass all health promotions which influence an individual's decisions, antecedent social and cultural conditions, or public policy to change the environment and make such supportive of healthier behaviours (p. 51).

### **Healthcare communication practices and challenges in Namibia, Africa, and globally**

Healthcare communication practices vary depending on the nature of the society in which healthcare is provided and sought. Sobane (2013), Levin (2006), Ulrey and Amason (2001), Harnakova (2006), and Masumoto (2013) observe that healthcare communication, diseases, and deliberations regarding healthcare provision and reception are closely linked to the social context in which people live. In Namibia, it can be assumed that although the population is only 2.5 million, the number of languages and cultures practiced, shared, and lived are many (Maho, 1998). This makes Namibia one of many

multilingual societies whereby more than one language is spoken, and even more, cultures are practised (Maho, 1998; Totemeyer, 2010). This is not specific to Namibia only, it is a common characteristic of many African and Asian societies (Bamgbose, 2011). Given the above observations, it can also be understood that diversity is a commonplace trait in the healthcare sector, especially relating to healthcare communication.

In Namibia, given its multilingual nature, English has been chosen as an official language and a language of communication. As explicated by Mlambo (2017), English serves as a lingua franca in Namibia. It follows that healthcare providers tend to communicate with their clients in English and it is expected that the clients (patients) too, must comprehend and communicate in the same. Even though patients understand English, the medical register can be a problem because of its technical and specialised nature. Such a complication in language use and discipline-specific register disallows flawless communication to happen. This is explained by the reality that there is still a reasonable number of Namibians who cannot understand and speak English (Cantoni, 2007). Hence, Totemeyer (2018) claims that even after 27 years of independence, Namibians struggle with the English language. As indicated in the introductory part of this study, the linguistic situation in Namibia changed abruptly soon after independence. Before independence, Namibians used Afrikaans as a lingua franca. The Ministry of Basic Education, Sport, and Culture (2003) clarifies that the selection of English as an official language left many Namibians wondering how to acquaint themselves with the 'new' communication tool. As observed by Mutumba (1999), there has been a challenge in disabusing and transforming the Namibian society from using Afrikaans to English in the public sphere. Therefore, the language policy 'residue' created a society stuck between English, Afrikaans, and indigenous languages, leaving the majority, not at all fluent in any of the languages used in the healthcare system (Cantoni, 2007). This could be inferred as a cause of communication challenges across the service provision sectors in the country, specifically in healthcare.

The situation presented herein is not specific to Namibia only. Literature consulted for this study such as by Sobane and Antonissen (2013), Deumert (2010) and Levin (2006) demonstrates that other African countries such as South Africa, Zambia, Lesotho, and Nigeria battle with the same linguistic complexities. The countries listed above equally have many languages and cultures, which cause challenges in communication. There are evident linguistic challenges that assail the healthcare communication practices in those societies. These challenges are presented in studies by Levin (2006), Sobane (2013), Sobane and Antonissen (2014), Underwood, et al. (2007), and Basse, et al. (2004).

There is research evidence suggesting that the variation in healthcare communication is not solely an African phenomenon. There are also significant hurdles and impediments in spaces such as Asia, America, Australia, the Netherlands, and Japan. Researchers in the lineage of Ha, et al. (2010) wrote on doctor-patient communication: a review; Hornakova (2006) on intercultural communication in healthcare; and Ong, et al. (1995) on doctor-patient communication: a review of the literature. Ulrey and Amason (2001) studied intercultural communication between patients and healthcare providers: an exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety; while a study by Angus, et al. (2012) focused on visualising conversation structure across time: insights into effective doctor-patient consultations; as well as Masumoto (2010) on perceptions of the salience of intercultural communication in the contexts of public health and medical practice. All these authors have cataloged the multitude of challenges related to healthcare communication. Healthcare

communication settings, like all other communication settings, necessitate continued research and studies to improve practices. This is bound to generate effective service provision and the reception thereof.

While communication is enhanced by what people know as languages (Sobane, 2013), for example, English, Oshiwambo, and others, it is important to mention here that healthcare contexts are also characterised by a specific type of language, the medical language. Speakers of this language (healthcare providers) make use of words specific to the medical field (Ha et al., 2010; Angus et al., 2012; Ong et al., 1995). Possible interpreters, who are usually non-professionals in the medical field are not language experts and usually, misinterpret such terminology. The misinterpretation ultimately leads to failed healthcare provision and reception because of the specificity of the jargon (MacFarlane, et al., 2008). MacFarlane et al. (2008) perceive this misinterpretation as a worrisome factor as the healthcare seeker is likely to get an incorrect diagnosis and prescription. There could be professional interpreters, but again they are not trained specifically for medical language translation. It is equally noted that unprofessional interpreters are used, which is a bothersome trend (Ulrey & Amazon, 2001). The special and specific terminologies used in healthcare communication need to be understood correctly in their contexts for effective healthcare provision and reception. There is an unquestionable need for interpreters who are trained specifically for hospital settings. The researchers in this study admit that the reality described is related to that of Namibia and needs to be further studied for the attainment of effective healthcare communication in Namibia.

### **Challenges and barriers to intercultural and healthcare communication**

Healthcare contexts in multilingual societies experience diverse linguistic challenges. Jones and Watson (2012) acknowledge, “as an avenue of health communication, the focus on power and status differentials between healthcare providers and patients plays a vital role” (p. 9). In the same line, Levin (2006) shows how language as a barrier in healthcare communication complicates patients’ failure to understand doctors as well as making themselves understood by the doctors. This complication has resulted in the prolonged stay of patients in the hospital or the deterioration of diseases and ailments (Angus et al., 2012). These result from the patients’ or the patients’ caretakers’ inability to clear their medical history and complaints to the healthcare provider, in such a way that the healthcare provider understands them. On the other hand, the healthcare provider’s inability to clearly explain the treatment plan, as well as the patient’s condition in a language understandable by the patient, may, in most events, cause non-adherence to the treatment plan, prolonged hospital stay or worsening of patient’s health state (Ong et al., 1995). In the end, these factors can cause high costs in healthcare. The patients’ prolonged stay in a healthcare facility means that the invalid must pay more money, and family members must travel often to the facility to visit. All this costs money in terms of transport, purchasing prescribed medicine, and other needs for the hospitalised person (Ha et al., 2010).

Bischoff and Denhaerynk (2010) and Ulrey and Amazon (2001) confirm that language barriers have a major impact both on the quality and costs of healthcare. The patient’s inability to explain their health problem to the healthcare provider becomes a basis for several possible negative healthcare outcomes, some of which are indicated above (Masumoto, 2010; Levin, 2006). This might be a cause of misdiagnosis, misunderstanding, and errors in treatment administration. Bischoff and Denhaerynk (2010) outline the following as possible results of language barriers in healthcare communication: unequal access to healthcare, unequal treatment, less success in patient-provider communication,

reduced patient satisfaction, provider dissatisfaction is increased and an increase in the risk of patients' safety.

As a remedy for language barriers in healthcare contexts, the use of interpreters has taken prominence in the facilitation of communication between healthcare providers and patients. Consequently, Sobane (2014, p. 1) stresses that "interpreting is an essential support service in multilingual health systems where language diversity dictates a need to facilitate communication between healthcare providers and patients." MacFarlane et al. (2008) observe that responses to language barriers are done in the form of language assistance, in general practice is *ad hoc* with the use of professional interpreters and informal interpreters (patient's relatives or friends).

Ulrey and Amazon (2001) highlight that there are many barriers to intercultural communication in healthcare. Language can be one major enabler and at the same time, one major impediment to effective communication. Reference cannot be made to language only without considering aspects such as speech, auditory, verbal, visual, and emotional behaviours. Therefore, to clearly understand the possible impacts language can have on healthcare communication, it is essential to define language. Lyons (1981, pp. 2-4) presents the following definitions of language:

- a. Language refers to systems of communication, whether they are natural or artificial, human or non-human;
- b. Language is a purely human and non-instinctive method of communicating ideas, emotions, and desires employing voluntarily produced symbols;
- c. A language is a system of arbitrary vocal symbols employing which a social group cooperates;
- d. language is the institution whereby humans communicate and interact with one another employing habitually used oral-auditory arbitrary symbols.

Considering these definitions, language as a means of communication is more than just a tool. Language as a system stands out to explain how people use it in different ways to achieve their intended purposes. In healthcare communication, language is a system employed by healthcare providers and patients in discussing and negotiating healthcare provision and reception. The healthcare provider and patient can only fully understand each other when their oral-auditory arbitrary symbols are mutually intelligible.

Language can be and is understood, differently by different people. This is evident in the definitions that Lyons (1981) collated from various linguists. Concerning the foregoing, therefore, one concurs that language can facilitate effective communication as well as become a cause of ineffective communication. This depends on the purpose for which language aspects are employed in a specific discourse. It is also dependent on the way the interlocutors communicate in a discourse which may mean that there is an intentional effort made to be understood or to reduce understanding. Lyons (1981) refers to two types of language, namely verbal and non-verbal forms. An understanding of how verbal and non-verbal forms of language are used in healthcare communication is crucial here. Healthcare providers and patients commonly use verbal communication when discussing healthcare-related issues. However, in events where verbal communication is not possible, communication is mediated through non-verbal means (Mlambo, 2017; Sobane & Antonissen, 2013).

In the context of this study, language should be understood as a tool with which healthcare

deliberations are undertaken, both verbally and non-verbally. Language should also be viewed considering the various codes of communication used by different people in their cultures to make known their aspirations, fears, wishes, and concerns. These codes are what we name languages such as Oshiwambo, English, Spanish, Swahili, German, Nyemba, and other codes (Nordguist, 2019). The codes above are comprehensible to different people depending on their exposure to such linguistic codes. If different people understand and use different languages from others, the possibility of a breach in communication is broad. This being a common case in multilingual societies such as Namibia, the likelihood of miscommunication among healthcare providers and their clients who hail from different linguistic backgrounds is expected.

Bischhoff and Denhaerynck (2010, p. 2) confirm that “language barriers result in unequal treatment, and that patients who face language barriers have poor health outcomes.” In their recommendations for future research, Gibson and Zong (2005) suggest that research be carried out to examine the effects that specific languages have on intercultural communication, and to investigate non-verbal communication and intercultural communication. The current study is a response to the above recommendation, in that firstly, it deals with the challenges faced by both healthcare providers and healthcare recipients who speak different languages. The present study also investigates English as a lingua franca and an official language in (Windhoek) Namibia. It focuses on the impact English has on healthcare administration driven by multilingual people and serving multilingual communities.

### **The communicative imperative within healthcare practices**

As with other life enhancers, communication is an important tool in the creation and maintenance of relationships, and societal and organisational growth, including building enabling human relationships. In the healthcare sector, healthcare provision and receipt cannot be possible except through effective communication (Ong et al., 1995; Angus et al., 2012; Penman, 2015). As with other life enhancers, effective communication creates and maintains relationships, and societal/organisational growth, including building enabling human relationships. In the healthcare sector, healthcare provision and reception cannot occur except through effective communication (Ong et al., 1995; Angus et al., 2012; Penman, 2015). Communication between healthcare providers and patients is important in healthcare administration. Effective communication between healthcare providers and their clients, for that reason, is a critical part of healthcare (Angus, et al., 2012). Moreover, Ulrey and Amazon (2001, p. 451) elaborate that,

both the patient and the provider are responsible for the communication to take place; however, professionals are especially responsible for accurate communication because they are expected to use their training and competence to develop positive relationships for effectively diagnosing and treating patients.

Ong et al. (1995, p. 903) proffer that “communication between doctors and patients is attracting an increasing amount of attention within healthcare studies.” The present researchers observed that in Namibia, there is a provision for patients to approach pharmacists to request medication for ailments and diseases they believe they are convinced they are suffering from. This process is called self-medication. When going to the pharmacy for such services, the ailing person does not necessarily know the type of medication they are likely to receive. The patient’s ability to describe and explain their situation to the pharmacist, therefore, lays the basis for the type of medicine the pharmacist may prescribe. The pharmacist, on the other hand, is responsible for clearly explaining the type of

medication, why that specific one and not the other, as well as providing clear directions on how the patient should take such medicine. All these scenarios indicate how effective communication has the likelihood to have patients receiving healthcare without necessarily having to visit any doctor for a prescription.

### **Challenges posed by multilingualism in healthcare: Translation and expatriate labour**

Societies, where two languages are spoken, are called bilingual societies while where more than two languages are spoken are referred to as multilingual resulting in multilingualism. Aronin (2019) defines multilingualism as the use of three and more languages and is distinguished. Namibia is a multilingual society as there are more than three languages spoken. Researchers such as Sobane (2013), Sobane, and Antonissen (2013) carried out studies in areas of multilingualism and profiling bilingualism in South Africa and Lesotho respectively. Similarly, Prilutski (2010) did a study in Ghana, Lindstrom (2008) in Sweden, Penman (2015) in England, and Jones and Watson (2012) did a similar study in Australia. All listed researchers above conducted studies on multilingualism. Overall, their studies are indicating evidence that healthcare communication has become, and is still an area of great importance, relevance, and interest for researchers worldwide (Angus et al., 2012). Other indicators point to the fact that the world has become a global village in such a way that multilingualism and interculturalism are not anymore only specific to naturally multilingual societies. Now more than ever, multilingualism and interculturalism are common characteristics of many, originally, non-multilingual societies the world over. Due to political mobility as well as the freedom of movement and liberty to choose where to live and work worldwide, global migration has made multilingualism and interculturalism new realities.

Sobane (2013) expounds that there is a growing trend of migration around the globe, which has been ascribed to various socio-economic and political factors. The increased migration has led to increased linguistic and ethnic diversity around the world. As a result of the reality above, the continued mixing and interaction of people who hail from different cultural backgrounds, as well as, who speak different languages; the linguistic repertoires are likely to be affected.

Studies such as those by Rahimian (2013), Rajnovic (2015) focus on single aspects and single areas of healthcare or health communication, such as communication accommodation and linguistic accommodation in the media respectively. Other studies such as Mlambo (2017) pay specific attention to a single category of healthcare communication stakeholders which are expatriate physicians only. In Namibia, there are not many studies, as far as this research has established, which focus on either the singled-out aspect of healthcare communication or singled-out healthcare communication stakeholders. There is, therefore, a need for studies, which seek to investigate, examine, analyse, and critically focus on the communication challenges experienced by both healthcare providers and patients, because of language discordance. This is because there are different languages and cultural backgrounds of healthcare providers and patients within the Namibian multilingual healthcare landscape.

As highlighted by *The Guardian* (2019) and Maho (1998), another main reason why researchers must focus their attention on this phenomenon is that

Namibia naturally, comprises multiple cultures and languages, and its people live in the same locations and consequently share healthcare facilities. It is not surprising that where people



from varying cultural backgrounds and language groups interact, challenges in the communication process are encountered. Therefore, the present researcher identified this aspect as one of the vital aspects that form the basis for this current study.

Another common barrier to effective healthcare communication, which is related to language in contexts such as Namibia, is cultural differences. Cultural differences are related to the lack of sameness in experiences, upbringing, language knowledge and experience, cultures, norms, values, and so forth. Cultural diversity is becoming increasingly important and in today's culturally diverse world, intercultural communication has become progressively important (Gibson & Zong, 2005; Ulrey & Amazon, 2001). To understand the impacts of cultural differences, one needs to understand the meaning of culture. Piore (1993) explains that culture, in any of its meanings, is a property of a human group, which can be only well defined when one can understand the meaning of the term 'group'. Consequently, a group can be defined as a set of people who have a history with each other, who have shared experiences, where membership is sufficiently stable to have allowed some common learning to occur and which subsequently translates to culture being "the shared learning output" (Piore, 1993, p. 313). In the above definition, the following terms and phrases are of interest to the current researcher sets of people, history, experiences together, common learning, and ultimately shared learning output. People who live together, and do things together experience similar situations, ultimately sharing a language and common practices. Common practices can be believed to have grown into norms and values that usually become binders, which hold them together as a people with a common belief system. It is within the belief system in the definition of what a group of people does, how they do it when they do things, as well as where the taboos and the unsayable can be defined. This is usually different from a group of people, which subsequently, become strange to other groups of people (healthcare providers and patients) who do not have a common experience and thus a shared learning output (Piore, 1993).

Considering the above, healthcare encounters which involve people whose cases emanate from different cultural backgrounds can likely be unsurprisingly riddled with misconceptions, misinterpretations, and possible lack of mutual understanding (Masumuto, 2013; Hornakova, 2006; Sobane, 2013). The current study is an empirical inquiry that sought to establish the depth and width of the impacts of culture on healthcare provision and reception in Windhoek Namibia. It also investigates how the various cultures of healthcare providers, and their clients impact their work as well as how culture contributes to healthcare outcomes. The above can be clarified through Ulrey and Amazon's (2001, p. 451) exemplification that "for instance, people from different cultures do not always report pain in the same ways, which can easily lead to miscommunication regarding diagnosis and treatment".

Concerning culture, intercultural communication involves people from different cultures coming together to deliberate issues of common interest, which may likely be understood differently because of the differences in their histories and experiences (Piore, 1993). Gibson and Zhong (2005, p. 622) define intercultural communication as "a competency whereby there exists knowledge, motivation, and skills to interact effectively and appropriately with members of different cultures". This definition has close links to the accentuations of Piore (1993) and Ulrey and Amason (2001) that where people from different cultural backgrounds come together, without proper preparation there is a possibility of occurrences of misunderstandings and linguistic discordance. For example, people come together

without studying and learning about each other's cultures and belief systems. This can be the cause of challenges of the lack of knowledge, skills, and even the motivation to interact with each other and in the end to communicate effectively. This undeniable reality can also likely be found in the healthcare context of Namibia, where the cases of misunderstandings among healthcare providers and their clients result from the lack of understanding of each other's cultural norms and values.

Angus et al., (2012, p. 1) assert "effective healthcare communication is associated with patients' adherence to treatment regimens and with improved health outcomes, and poor communication can result in adverse outcomes for patients". Similarly, in outlining the benefits of effective communication Ha et al. (2010, p. 38) opine that "creating a good interpersonal relationship, facilitating the exchange of information and including patients in decision making and effective doctor-patient communication has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for comprehension of medical information". The multilingual and multicultural nature of Namibia and Windhoek specifically, calls for continued research to bring about the needed and timely improvements, which will accelerate and improve healthcare communication between healthcare providers and their clients.

### **Findings**

The study's main empirical finding is that in addition to linguistic discordance experienced in healthcare communication, other causes of discordance emanate from differences in cultural backgrounds, beliefs, exposure, and experiences. As a result of the differences in cultural backgrounds and experiences, the study found that effective healthcare communication is not only affected by the interlocutors' inability to mutually understand different languages, but other factors such as cultural differences, social/status differences, and interpretation services also contribute to the lack of mutual intelligibility between healthcare providers and patients.

Moreover, the people involved in sharing or communicating ideas, views, or opinions, will do so effectively, usually, when they accept and understand each other's behaviors and at times why such behaviors are displayed. If the above is not experienced and even explained; lack of information disclosure by the patients is likely to come into play. This is a negative component of communication. The diagnosis and the treatment might not be directed to the real health situation when the patient did not explain and clarify his/her medical history. Effective healthcare providers' and patient communication is therefore crucial if providing and receiving healthcare services. Understanding a language does not mean understanding the cultural practices of the people, since in some cultures, for instance, specific diseases and situations cannot be mentioned plainly. Therefore, this review concludes that only those who understand the cultural background of the speaker may fully understand even what is indirectly communicated or implied.

There is a need for interpreters who are trained specifically for hospital settings (Ulrey & Amazon, 2001; MacFarne et al., 2008). The researchers for the current study assume that this reality is like the Namibian situation and needs to be investigated to enhance effective healthcare communication in Namibia. When service providers communicate effectively and to the satisfaction of their clients, the results will most likely be that the clients will keep coming back for their services. The opposite can be true, however, that when a patient feels they have not been communicated to cordially, they may look for the same services elsewhere.

Multilingualism and interculturalism are common characters of many, originally, non-multilingual societies the world over. This is because of global migration due to political mobility as well as the freedom of movement and liberty to choose where to live and work worldwide, making multilingualism and interculturalism new realities. This can be the cause of the lack of knowledge, skills, and even the motivation to interact with each other and in the end to communicate effectively. The findings of this review suggest that the multilingual and multicultural nature of Namibia and Windhoek specifically, calls for continued research to bring about the needed and timely improvements, which will accelerate and improve healthcare communication between healthcare providers and their clients. When healthcare communication is handled satisfactorily from both sides the outcomes will be beneficial for both the healthcare providers and the recipients.

### Conclusions

The current study shows that healthcare or health communication has increasingly become a niche in the world. One revelation made through this review is that in other countries and continents, studies on such a topical issue have been on-going for many years. In other countries, however, such studies are yet to gain prominence. In Namibia, for example, the researchers found that the literature available is not adequate and did not cover ample sections of healthcare communication, and indeed other aspects of healthcare administration. This calls for more research studies to be conducted in this area to enhance the provision of effective and accessible healthcare through effective communication.

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