

The presence of a patient's voice in the care process: Implications for patient-centeredness

Konosoang Sobane and Mmakotsedi Magampa

Human Sciences Research Council, South Africa
E-mail: ksobane@hsrc.ac.za; mmagampa@hsrc.ac.za

Abstract

A patient-centred approach to care is increasingly recognised as the hallmark of adequate healthcare delivery since it allows a holistic approach to care. Although there is no agreed-upon definition of patient-centred care, literature on this subject recognises effective communication and patient participation as necessary factors for the achievement of patient-centred care. Despite ample literature on the value of patient-centred care and the patient's voice in it, there is very limited literature on its achievement in linguistically-diverse consultations. There is even less literature on the subject based on research conducted in Sub-Saharan Africa, where multilingual healthcare systems are prevalent and there is a need for policy interventions to regulate such systems. This paper traces the presence or silence of the patient's voice in linguistically-diverse consultations and the implications that it has for achieving a patient-centred approach to care. The findings suggest that the language barrier submerges the patient's voice at many of the points of the care process. Where it is visible, it is not on the basis of participation in decision-making, but in responding to questions asked. The paper therefore makes recommendations for a strategic communication framework that will enhance the presence of the patient's voice in language-discordant consultations.

1. Introduction

A patient-centred approach to care, which emphasises the visibility of a patient's voice, is increasingly recognised as the hallmark of adequate healthcare delivery. This is because of its holistic approach to care and its implications for adequate healthcare delivery. According to Rohrer, Wilshusen, Adamson and Merry (2008:548), patient-centred care is most essential where there is a need to address psychosocial factors relevant to a patient's problem; therefore it is more relevant in primary healthcare. With the care of people with the Human Immunodeficiency Virus (HIV), patient-centeredness is even more essential, because the success of the treatment is dependent on the patients' buy-in to the proposed treatment and care, and these patients become chronic patients who are present in the system for a long time. The presence of their voice is imperative. Given its perceived value in the achievement of positive health outcomes, research on enablers and dis-enablers of patient care is crucial, and is of interest not only to linguists and healthcare researchers, but also to policy makers.

Literature on patient-centred care, for example Mead and Bower (2000:1087) and De Silva, Slade, Bateson, Scheeres, McGregor and Weisberg (2015:275), notes that although there is no agreed-upon definition of patient-centred care, there is a shared understanding of the concept and the value of patient-centred communication as a tool to achieve patient-centeredness. There is also agreement on the value of patient participation as a pertinent component of the care process (Mead and Bower 2000:1089; Wensing, Elwyn, Edwards, Vingerhoets, and Grol 2002:2; and De Silva et al. 2015:277), thereby rendering the patient's voice throughout the care process indispensable to the achievement of this kind of care. In particular, the principle of shared decision-making, which calls for the patient's involvement in decision-making about treatment and care, illuminates the need for the presence of the patient's voice in achieving patient-centred care (Zoffman, Harder and Kirkevold 2008:670).

Also of particular relevance is the need to take into account the importance of patients' agency in decision-making about treatment. Mackinlay (2002:37) explains agency as active engagement that makes one's voice be known and heard. In decision-making about treatment, Bishop and Yardley (2004:468) note that agency involves a rejection of the passive 'positionality' of the patient and the assumption of an active position. This implies that patients take some of the responsibility of decision-making and accountability for recovery (Bishop and Yardley 2004:468; Robertson, Moir, Skelton, Dowell and Cowan 2011:86).

There is a wealth of available literature on the value of patient-centred care (Moore 2008:18; Zoffman et al. 2008:670), with some studies valuing it to the extent of highlighting the need for patient-centeredness to be included as part of the curriculum in medical training (Bombeke, Symons, Vermeire, Debaene, Schol, De Winter and Van Royen 2012). There is also extensive literature that points to the significance of the patient's voice (for example Politi and Street 2010; De Silva et al. 2015). There is, however, a paucity of literature that traces the presence or absence of the patient's voice in healthcare centres where the organisation of the care process is multifaceted and services are provided by linguistically-diverse healthcare teams. This paper explores the presence of the patient's voice in the care process in two HIV and AIDS care centres in Lesotho, with the goal of establishing the extent to which the two clinics provide patient-centred care.

2. Theoretical framework

This paper draws mainly from Mead and Bower (2000), who explain patient-centeredness in terms of five dimensions, and Blackman and Sadler-Smith (2009), who provide a framework explaining the concept of 'voice' and offer a taxonomy of different dimensions of silence. The paper brings together these frameworks to conceptualise patient-centred care and its components and how the patient's voice is relevant in patient-centeredness.

Mead and Bower (2000:1088-1090) propose a framework of patient-centeredness that is made up of the following five dimensions:

- (i) The biopsychosocial dimension, which takes a broader view of a person's illness by addressing the biological, psychological and social issues of the illness; thereby tasking a healthcare provider with the responsibility of addressing even non-medical aspects of a patient's problem;

- (ii) The perception of a patient as a person; in other words, as an experiencing individual with their own interpretation of their illness and unique understanding of the broad life settings in which the illness happens. A provider of patient-centred care needs to strive to understand this individual interpretation, the context surrounding the illness as perceived by the patient, as well as the patient's psychological world, such as their fears. In this way, the patient's individuality and the uniqueness of their problem are accounted for;
- (iii) The promotion of the ideal of an egalitarian doctor-patient relationship in which power and responsibility are shared. This relationship emphasises mutual participation and has given rise to the prevalence of concepts such as 'user involvement', 'negotiation', 'concordance' and 'patient empowerment'. Patients are increasingly being regarded as active consumers who actively participate in decision-making about treatment;
- (iv) Putting emphasis on the value of the doctor-patient relationship in fostering a therapeutic alliance necessary for effecting therapeutic change in patients. Some of the important aspects of this relationship include patients' perception of the relevance and potency of the interventions offered, agreement on the goals of the treatment, and the perception of the doctor as a caring person;
- (v) The perception of a doctor as a person with personal qualities which have an influence on medical decisions taken. This dimension emphasises awareness of doctor subjectivity because of the potential effects that it has on patient behaviour and responses. Both parties therefore need to be sensitive of each other's emotions.

The above-mentioned dimensions, as well as other frameworks of patient-centeredness, highlight the importance of a patient's voice and of successful patient-centred communication in the achievement of this kind of care. According to Moore (2008:18), patient-centred communication encompasses four aspects, namely eliciting and understanding the patient's perspective; understanding the patient within his or her unique social context; reaching a shared understanding of the problem and its treatment; and helping patients to share power and responsibility through involvement in making choices. The patient is therefore treated as an active participant in the medical consultation, with a voice that is important in taking part in decision-making (De Silva et al. 2015:17). The conceptualisation of the presence of the voice in this paper is drawn from the work of Blackman and Sadler-Smith (2009:573-578), where 'voice' is seen as an expression or manifestation of different forms of knowledge that a speaker has, such as tacit knowledge and intuitive knowledge. A voice can be suppressed or silenced by several factors, such as:

- (i) The influence of power relations, where the less powerful participant feels they do not have the right to challenge the more powerful participant;
- (ii) A language barrier between participants; more specifically a lack of competence and confidence in the language used in the organisation;
- (iii) A feeling that the participant is less knowledgeable about the subject being discussed.

This theoretical framework underpins the understanding of patient-centeredness and the place of a patient's voice in a patient-centred approach to care. It helps to concretely conceptualise 'patient-centeredness' and how it is manifested in the patient's voice. It also forms the basis according to which the observational and interview data are analysed.

3. Methods

The data on which this paper is based were collected from two clinics that offer HIV care in Lesotho. The two clinics are staffed by expatriate doctors who are mostly from Francophone countries such as Congo, Cameroon and Gabon. They are mostly first-language speakers of African languages such as Kiswahili, Lingala, Tshiluba and Ewondo and second-language speakers of French. The doctors' work in Lesotho entails communicating with a patient population in which Sesotho speakers are the overwhelming majority, and clinical staff who are largely bilingual speakers of Sesotho and English. Sesotho is the first language of more than 90 percent of the population in Lesotho (Khati 1995). This situation has created a language barrier between doctors and patients and is the reason for the prevalence of interpreted consultations in the two clinics.

Data collection was done using observational methods and semi-structured interviews. Observational methods are recommended by Henning, Van Rensburg and Smit (2004) and Walshe, Ewing and Griffiths (2011) due to their ability to provide understanding of the care processes; thereby enhancing researchers' understanding of patients' experiences of their journey of care. In this study, observations were done to elicit data on the organisation of care processes and communicative roles and routines in the clinics. These observations were done over a period of three months, during which I visited each clinic twice a week. Each observation lasted for a period of two hours. During the observations, each service point was visited and observation notes were taken on the following:

- (i) Services rendered at the point;
- (ii) Communicative processes associated with the services rendered;
- (iii) The communicative roles of participants.

Where necessary, ad-hoc interviews were held with participants to seek clarity on some of the phenomena observed.

The observations were followed by semi-structured interviews with a purposively-selected sample of 30 participants, comprising 6 doctors, 10 patients, 10 nurses and 4 interpreters. All those involved in the process of care in the two clinics were included in the sample. The interviews were meant to elicit data on participants' experiences of the care process. Their value derives from the fact that they elicit guided responses from the interviewees, but allow them the flexibility to expand where necessary (Schensul, Schensul and LeCompte 1999:150).

The interviews were done over a period of two months, with each lasting between 25 and 60 minutes. They were audio-recorded and later transcribed and translated; except in the cases of interviews with doctors, which did not need translation because they were done in English.

Data were analysed by means of content analysis, guided by themes derived from Mead and Bower's (2000) framework of patient-centeredness. The analysis looked at descriptive themes on the nature of the services provided at each point, together with the communicative processes and roles of each group of participants throughout the process of care. Of particular importance in the analysis were recurring themes on the communicative roles, routines and practices of each group of participants in the consultation, and how these related to the five dimensions of patient-centeredness discussed in Mead and Bower (2000). The analysis also traced the perceived recurrence of the patient's voice at each of the service points in order to determine

the presence of the patient's voice and therefore the prevalence of patient-centeredness at each service point.

4. Results

The care process in the two clinics is structured in accordance with the Lesotho National Anti-Retroviral Therapy (ART) guidelines¹ provided by the Ministry of Health and Social Welfare. The aim of these guidelines, which were instituted in 2004, is to ensure that treatment practices in Lesotho are standardised. The guidelines provide a comprehensive approach to ART, including the introduction of routine and provider-initiated HIV testing and counselling and the initiation of Highly Active Anti-Retroviral Treatment (HAART) for adults and adolescents with CD4 counts below 350. The guidelines therefore determine the structure as well as the services provided at each of the consultation points. Figure 1 below shows the complete care process that patients go through; starting from the point of arrival at their first visit to the clinic and ending either at exit without treatment for those who are not in need of treatment, or assimilation into the system as chronically ill patients for those eligible for treatment. The latter group of patients will return regularly to the clinic for continued medical care.

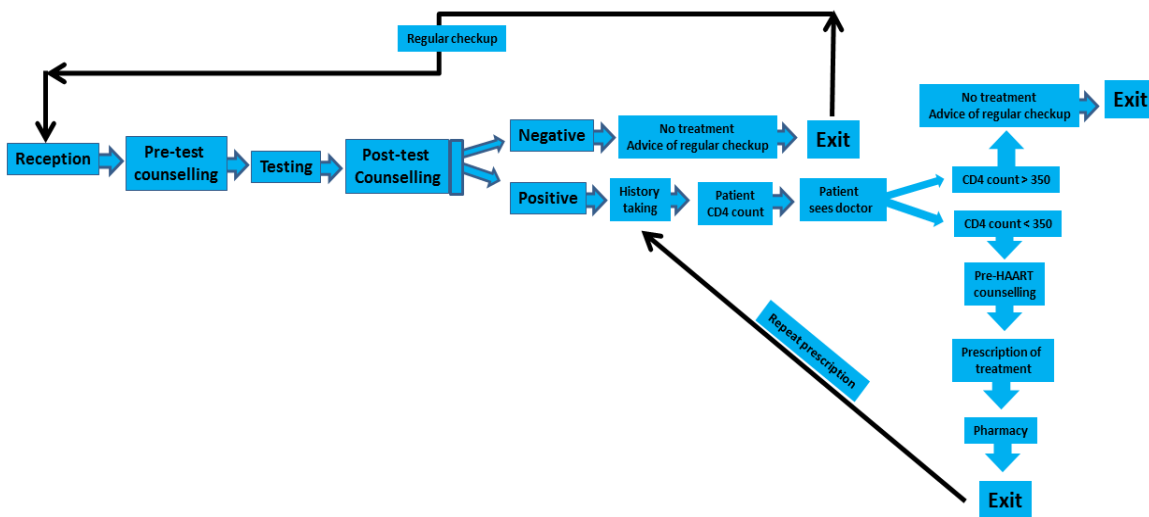


Figure 1: A representation of the organisation of care in the clinics in Lesotho under study

The care process is organised into three phases, which I have named the “pre-consultation phase”, “consultation phase” and “post-consultation phase”. These phases follow each other in terms of the services rendered, their purpose, and the staff responsible.

The pre-consultation phase and the relevance of the patient's voice

Interview data drawn from participants' descriptions of the care process and observations of the care process show that patients' initial encounter in the clinic occurs in a section that I call the “pre-consultation phase”. This phase of the consultation takes place in the reception, the testing unit and the history-taking room. From the reception, first-visit patients are directed to the counselling and testing centre, where they will be counselled, tested and counselled again, while

¹ Lesotho National ART guidelines (2004:3).

subsequent-visit patients are directed to the history-taking room. Interviews with nurses who work in this phase reflect that the medical purpose of the pre-consultation phase is to gather preliminary data and information about the patient, as well as to prepare patients for the doctor's consultation. This is also supported by data from patients which show that this is their first point of contact with the healthcare centre. For example, one of the patients describes this phase as follows:

“Re itlaleha hona mona pele, ebe batla o etsetsa file o tsebe ho ea ka tlabollong o lo testuoa.”

(We report here first and then they make a file for you so that you can go for counselling to be tested.)

During observations it was established that the first point of communicative engagement between patients and clinical staff is the reception, where the main goal of communicative activities is to gather basic information about the patient, register new patients, organise patients' files in preparation for the physician's consultation, provide basic information about procedures that patients have to follow, and direct patients to where they should go next. This point therefore serves as an information-giving centre at the entry point in the clinic. An observation of clinic staff and patients' recurring descriptions of the reception show that a range of activities occurs at the reception. These are best summed up in a receptionist's description of her duties, which is as follows:

“ke keepa li file tsa bakuli ... ha ba tlile ba fihla, ke tla be ke phetla file tsa bakuli ke monithara hore na u ea labong kapa ho etsahala joang ka eena, ntlha ea pele ke ho keepa file tsa bona le ho bonts'a ba eang HTC (HIV Testing and counselling) hore na ba ea kae...”

(I keep the patient files and ... then when they have come I open the file, look and monitor if s/he is going to the lab or what is happening first thing is to keep their files and show those that are going to HTC (HIV Testing and counselling) where they are supposed to go...)

The results show further that more information is exchanged in the testing unit and history-taking room, where the intention is to give HIV, AIDS and tuberculosis (TB) education; to counsel patients about how to live positively with or without HIV and TB; and to collect more biophysical information about the patient. In essence, it can be said that the pre-consultation phase is an information-sharing division of the clinic, where an attempt is made to understand the patient and the problem presented.

Since this is the initial phase in which an attempt is made to establish and understand the patient's problem, the patient's experiential knowledge as an individual who experiences the problem is very crucial. It is also at this point where the biophysical dimension of patient-centeredness as articulated by Mead and Bower (2000:1088) begins to be operationalised, because the healthcare providers collect information that is not only medical but also psychosocial in order to fully understand the patient's problem. The patient's voice in providing insight into the illness and the social context that surrounds it becomes paramount in this phase in order to create a broad understanding of the problem presented (Moore 2008:18; Blackman and Sadler-Smith 2009:575).

Despite the ideal of the presence of the patient's voice in this phase, this study's data show that this voice is silenced through repression, which is defined as controlled exclusion of certain pieces of information in Blackman and Sadler-Smith (2009:577). Suppression, on the other hand, is defined as involuntary silence in perceived compliance with the norms of the interactional event (Blackman and Sadler-Smith 2009:577). The theme of repression is found in 8 out of 10 patients' interviews and in all nurses' interviews. In most of these instances, nurses were the actors responsible for repression, and the repression happened in the history-taking room. The following table reflects the instances of repression in the pre-consultation phase, as found in the data.

Table 1: Instances of repression in the pre-consultation phase

Repression type	Examples	Point of occurrence
Topic pre-announcement	"I tell them in advance that here we stick to the HIV problem only" (<i>nurse</i>)	History-taking room
	"In the morning we brief them and tell them to talk only about their HIV-related problem to save time" (<i>receptionist</i>)	Reception
Asking guiding questions	"We ask questions to guide them" (<i>nurse</i>) "They ask questions that they like" (<i>patient</i>)	History-taking room
Guiding information flow	"We stop them when they go overboard..." (<i>nurse</i>) "They tell you no, don't talk about that" (<i>patient</i>)	History-taking room

Topic pre-announcement

Interviews with patients and staff at the pre-consultation phase show that topic pre-announcement occurs frequently. The staff member concerned announces the topic to the patient to guide the content of the consultation. The first type of pre-announcement is when a service provider, often a nurse in the history-taking room, announces to a patient that their conversation should "stick" to HIV. The use of the word "stick" in this case marks the stated topic as the only topic that may be the subject of discussion in this particular consultation. Other common phrases that were found to be used by nurses to pre-announce the topic are:

- (i) "...do not wander off HIV..."
- (ii) "...concentrate on HIV..."
- (iii) "...stay on HIV problems..."

Announcing the topic at the beginning of the consultation in this way is consistent with Blackman and Sadler-Smith's (2009:577) description of repression as the exclusion of information.

Asking guiding questions

Repression was also found to be achieved by asking patients questions that guide the conversation's flow and content. Further probing into this practice shows that nurses perceive it as a way to help patients and guide them regarding which facts they should concentrate on. In the nurses' opinions, this is done for the benefit of the patients. In contrast, patients express this as inhibiting their own opinion in favour of what the nurses "like". This reflects that patients feel that they do not have enough opportunities to present their information as they prefer to.

Guiding information flow

Another common strategy of repression was found to be the nurses' act of stopping patients the moment they considered them to be wandering off topic. This directs the discussion and also enforces adherence to the nurse's preferred topic.

It should be noted that nurses and patients differ markedly in terms of how they perceive this practice. Nurses see it as a way of helping patients to have a meaningful consultation by assisting them in providing essential information. In their opinion, the nurses determine what is essential on the basis of their expertise and experience. However, patients see this as limiting to them because they cannot adequately express their concerns. I argue that regardless of the nurses' perceptions, this constitutes a silencing of the patient's voice in a consultation phase where this voice is much needed.

Coupled with this repression, data from patients also showed that their voices were frequently suppressed. This is a result of their perception of the power relations inherent in the interactional event, where they position themselves as 'powerless' in relation to those more powerful. The majority of patients indicate that they often experience a feeling of uneasiness regarding speaking up and giving information not requested of them. The sentiment below was found to be very common among patients:

"Che bonneteng ke ee utloe ke ts'aba ho bua ntho tse ngata ke re ke ske ka tloha ka fosa. Ebe se ke araba lipotso feela ke tlohela taba tse ling hobane ke utloa eka ha kea ts'oanela ho bua tse ling (ntle le tseo ba li botsitseng)."
(Honestly I am often afraid to provide much information so that I don't say the wrong things. I then just answer questions because I have a feeling that I am not supposed to give other information (apart from what has been requested)).

This sentiment, characterised by the fear of saying the wrong thing and sticking to just the requested information without supplying unsolicited information, is very common in data from patient interviews. It reflects that patients suppress their voices in order to adhere to what they perceive to be the conversational norms in this context.

As mentioned before, in this initial phase of the consultation the principle of patient-centeredness would necessitate agency from the patient, characterised by visibility of the

patient's voice. This would allow for a complete understanding of the problem presented. However, the data show that this voice is silenced through repression and suppression. This calls into question the extent to which patient-centeredness is achieved in this part of the process. In particular, Mead and Bower's (2000) biophysical dimension, which requires a broad consideration of a patient's problem inclusive of all psychosocial factors that may account for the problem, would seem to be neglected.

The physician's consultation

Following the pre-consultation phase, patients go to the physician's consultation, which is the most important part of a medical consultation. In the physician's consultation, the main purpose of communication is to arrive at a diagnosis and recommend treatment for the patient. Communication at this consultation point is characterised by detailed accounts of the health complaint by the patient and interpretation of that account and of test results in order to reach an accurate diagnosis and determine a course of treatment. Since this is a phase in which treatment decisions are made, the principles of reaching a shared understanding of the problem and its treatment and sharing power and responsibility in making choices regarding treatment are central (Moore 2008; Rohrer et al. 2008).

The findings show that most physicians' consultations involve three participants, namely the physician, the patient and the interpreter. The presence of the latter is due to the language barrier between physicians and patients mentioned in the previous sections. The contribution of interpreters and the mistakes they make in consultations such as this have been widely documented; for example in Deumert (2010), Kilian, Swartz, Dowling, Dlali, and Chiliza (2014) and Wallmach (2014). This body of work (see for example Drennan and Swartz 2002 and Deumert 2010) attributes the problems that arise to the fact that interpreting practices are neither regulated nor professionalised, and they therefore pose challenges to both healthcare providers and patients. The most significant problem is the compromise in the quality of interpreting. While there is general consensus regarding the need for interpreters in language-discordant consultations², Deumert (2010) and Killian et al. (2014) observe that unprofessional interpreting is marred by questions of quality that seriously affect healthcare outcomes such as history-taking, diagnosis, patient education and informed consent. These authors agree that if equipped with the appropriate skills interpreters would make a meaningful contribution to the consultation (Wallmach 2014:411).

In the clinics under study, the data show that interpreters play an important role because they serve as a communicative bridge between patients and doctors. A close analysis of interview data suggests that interpreters do most of the talking during the consultation, while patients mostly respond to questions and listen to the interpreted versions of the physician's explanations. Interview data also suggest that decisions about which treatment options to take are not made collaboratively with the patient, but are made by the physician and the interpreter and then just communicated to the patient. The following explanation, taken from an interview with a nurse who also performs interpreting duties, explains why this happens. This kind of explanation was found to be common among interpreters and nurses who perform interpreting duties.

² Described by Bischoff, Bovier, Rrustemi, Gariazzo, Eytan, and Loutan (2003:504) as consultations where patient and care provider have no language in common.

“Nna le ngaka rea decida na re mo thusa ka medication ofeng...hoa ts’oana ha re ka re a decide o tla reng because ha tsebe ka meriana, ha qeta utloisise puo hantle.”
(I and the doctor decide which medication to help the patient with...it’s pointless, if we ask them to decide what they will say because they don’t know about medicine and they don’t understand the language properly.)

In this case, the patient is not involved in treatment decision-making reportedly because of the language barrier and his/her lack of medical knowledge. The interpreter however does not give reasons why the decision-making process cannot be interpreted in the same way that the consultation is. Nonetheless, it becomes apparent here that the patient’s voice therefore becomes suppressed, as in the previous phase.

At this point, the patient’s voice is suppressed mainly as a result of the language barrier between doctors and patients. The communicative capacity of patients, which is an element that facilitates collaborative decision-making for the achievement of patient-centeredness (Politi and Street 2011), is compromised by the language barrier. The patient’s voice is overshadowed by that of the interpreter, since the interpreter is the one who guides the conversation and makes decisions on information relevance, quality and quantity. Apart from the language barrier, the need to finish the consultation on time was cited as another reason for silencing or suppressing the patient’s voice. Interpreters point out that if they allow the patient’s voice to be more visible rather than suppress it, the consultation is likely to take longer, and consequently fewer patients will be seen per day.

The post-consultation phase

The physician’s consultation is followed by the post-consultation phase. This phase of the consultation takes place in the pre-HAART counselling unit and the pharmacy. This phase is generally meant to equip patients with knowledge to prepare them for self-care when at home. At the counselling unit, patients are taught about the pros and cons of ART. They are also taught about the benefits of adherence to treatment and improved sexual behaviour. This phase is therefore characterised by intensive information-giving by the healthcare providers.

Since this is a phase in which self-care and behavioural changes are decided upon, the patient’s voice becomes crucial in providing insight into the psychosocial and contextual factors that are enablers or dis-enablers of adherence (Mead and Bower 2000). Data from interviews with both patients and healthcare providers in this phase show that at this point every attempt is made by the clinical staff to understand the patient as an individual (Mead and Bower 2000) and to incorporate patient values and preferences (Politi and Street 2011) in deciding upon the times at which medication should be taken, for example; as well as the requisite and potential behavioural changes. The following excerpt from an interview with a nurse provides an example of how nurses pursue patients’ agency in decision-making:

“Re ba botsisisa hantle hore na mathata a ha eke afeng, a hla a bolele kaofela. Hape rea botsa na o na le mathata a ka mo sitisang ho noa litlhare. We try to cover all the angles a tla tsebe ho noa litlhare hantle.”
(We enquire in-depth about a patient’s problem, so that they can state their problems. We also ask if there are any problems that could hinder them from taking medication... so that they can take medication appropriately.)

The nurse's indication that they make in-depth enquiries and try to cover all angles shows that every attempt is made to have a patient describe all the facets of the problem. Despite these attempts by healthcare providers, data from patients and healthcare providers suggest that patients' voices are often suppressed in this phase as a result of the patient withholding information from the healthcare providers. The following excerpt from an interview with a counsellor is typical of what I found in the data:

“Nako e nngoe rea ba botsa haholo bo mmenyana bana ba bacha: o na le bothata bo ka itshireletsa thobalanong? O re ae? O na le bothata bo ka u sistisang ho noa lipilisi hantle ka nako? Ae. The next thing o sa fihla a kula a le joang joang ha noa lipilisi hatle ha itsireletsa, ke hona a chong hore sex partner ea hae e hanne ho sebelisa ho condom, kapa o na sitoa ho noa lipilisi hob a monna o leaveng joale oa mo patela...”

(Sometimes we ask them, more especially these young women: will you have problems using condoms? She says no. Will you have problems taking pills? No. Next she presents with a sickly condition, she did not adhere to treatment, and did not use condoms. It is only then then that she tells you that her sex partner refuses to use a condom or the husband was on leave and she could not take pills because she hides them since she has not disclosed her status to the husband.)

This silence resulting from the withholding of information, which is explained by Van Dyne, Ang and Botero (2003:1365) as purposeful, conscious and intentional, is a manifestation of social powerlessness. In this case, it is a reflection of the powerlessness of women to make decisions about their sexuality which is inherent in patriarchal societies like that of the Basotho. This makes it challenging for healthcare providers to give appropriate patient-centred care, and creates an illusion of patient-centeredness that is false because advice is based on false information from a patient. It should however be noted that a closer look at this question shows that the nurses sometimes phrase the questions inappropriately so that they allow for “yes/no” responses. Therefore the fault does not lie solely with the patients.

5. Conclusion

The findings of this study show that the consultation process is divided into three phases. Throughout these phases, a patient's voice is necessary in order to achieve patient-centeredness. However, the data show that this voice is silenced by repression and suppression in the initial phases of the consultation. The study also shows that nurses and interpreters perceive their repression as a way of assisting patients to stick to the topic and have a meaningful conversation. However, patients find the repression limiting, and view it as hindering them from describing their problem adequately. It can therefore be deduced that during most of the consultation, patients' voices are silenced. The post-consultation phase was found to be the only one in which an attempt is made to hear the patient's voice.

It should be noted that although the organisation of the care process into different service points provides a good environment for the achievement of patient-centeredness, there is also a need for healthcare providers who are skilful in patient-centred communication (Bombeke et al. 2012:338) and for patients who are actively involved throughout the process. In all the phases it is imperative to have a broad understanding of the patient's problem and to involve the patient in decision-making about treatment-related resolutions. A patient's voice becomes a necessary vehicle in fostering such understanding and reflecting participation. Despite the value attached

to a patient's voice, it gets silenced in all consultation phases by suppression, repression and the withholding of information by patients themselves. Among several factors cited as reasons for the silencing of the patient's voice are the language barrier between the healthcare provider and the patient; the quest to keep the consultation short by focusing only on what healthcare providers deem to be important information; and patients' feelings of powerlessness in the consultation because it is an unfamiliar situation. It can therefore be concluded that apart from an appropriate organisational framework, patient-centeredness also requires skills in patient-centred communication. In this case, I argue that the consultations are not patient-centred, but are healthcare-provider-driven.

I therefore recommend that the healthcare system make provision for human resources training in patient-centred communication for nurses and interpreters so that they can adequately assist doctors in providing patient-centred healthcare. The language barrier between patients and doctors should also be attended to in order to empower patients to voice their problems directly to doctors during the consultation. This can be done by means of on-going language training for doctors in order to improve their proficiency in the local language. These interventions have the potential to lead to improved communication between healthcare providers and patients. They will also ensure that the patient's voice is heard to some extent, since these patients usually have to contend with feelings of powerlessness within their society, especially because of their HIV status. In this way, communication will be improved, and the presence of the patient's voice will increase the patient's agency and ownership of the care process.

References

- Blackman, D. and E. Sadler-Smith. 2009. The silent and the silenced in organizational knowing and learning. *Management Learning* 40(5): 569-585.
- Bischoff, A., P.A. Bovier, I. Rrustemi, F. Gariazzo, A. Eytan and L. Loutan. 2003. Language barriers between nurses and asylum seekers: Their impact on symptom reporting and referral. *Social Science & Medicine* 57(3): 503-512.
- Bishop, F. L. and L. Yardley. 2004. Constructing agency in treatment decisions: Negotiating responsibility in cancer. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 8(4): 465-82.
- Bombeke, K., L. Symons, E. Vermeire, L. Debaene, S. Schol, B. De Winter and P. Van Royen. 2012. Patient-centeredness from education to practice: The "lived" impact of communication skills training. *Medical Teacher* 34(5): 338-348.
- De Silva, J. H., D. Slade, D. Bateson, H. Scheeres, J. McGregor and E. Weisberg. 2015. Patient-centred discourse in sexual and reproductive health consultations. *Discourse & Communication* 9(3): 275-295.
- Deumert, A. 2010. 'It would be nice if they could give us more language.' Serving South Africa's multilingual patient base. *Social Science and Medicine* 71(1): 53-61.
- Drennan, G. and L. Swartz. 2002. The paradoxical use of interpreting in psychiatry. *Social Science and Medicine* 54(12): 1853-1864.

Henning, E., W. Van Rensburg and B. Smit. 2004. *Finding your way in qualitative research*. Pretoria: Van Schaik.

Kilian, S., L. Swartz, T. Dowling, M. Dlali and B. Chiliza. 2014. The potential consequences of informal interpreting practices for assessment of patients in a South African psychiatric hospital. *Social Science & Medicine* 106: 159-167.

Khathi, T.G. 1995. A language profile of Lesotho. In V. Webb (ed.) A selected survey of Lesotho and selected papers presented at the second LiCCA conference. Pretoria: LiCCA Research and Development Programme. pp.29-42.

Mackinlay, E. 2002. Engaging with theories of dialogue and voice: Using Bakhtin as a framework to understand teaching and learning indigenous Australian women's performance. *Research Studies in Music Education* 19(1): 32-45.

Mead, N. and P. Bower. 2000. Patient-centeredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine* 51: 1087-1110.

Moore, M. 2008. What does patient-centred communication mean in Nepal? *Medical Education* 42(1): 18-26.

Politi, M. C. and R.L. Street. 2010. The importance of communication in collaborative decision making: Facilitating shared mind and the management of uncertainty. *Journal of Evaluation in Clinical Practice* 17: 579-584.

Robertson, M., J. Moir, J. Skelton, J. Dowell and S. Cowan. 2011. When the business of sharing treatment decisions is not the same as shared decision making: A discourse analysis of decision sharing in general practice. *Health* 15(1): 78-95.

Rohrer, J. E., L. Wilshusen, S.C. Adamson and S. Merry. 2008. Patient-centredness, self-rated health, and patient empowerment: Should providers spend more time communicating with their patients? *Journal of Evaluation in Clinical Practice* 14(4): 548-551.

Schensul, S. L., J.J. Schensul and M.D. LeCompte. 1999. Essential ethnographic methods: Observations, interviews and questionnaires. In J. J. Schensul and M. D. LeCompte (eds.) *Ethnographer's Toolkit* (vol. 2). Walnut Creek, CA: Altamira Press.

Van Dyne, L., S. Ang and I.C. Botero. 2003. Conceptualizing employee silence and employee voice as multidimensional constructs. *Journal of Management Studies* 40(6): 1359-92.

Wallmach, K. 2014. Providing truly patient-centred care: Harnessing the pragmatic power of interpreters. *Stellenbosch Papers in Linguistics* 43: 393-414.

Walshe, C., G. Ewing and J. Griffiths. 2011. Using observation as a data collection method to help understand patient and professional roles and actions in palliative care settings. *Palliative Medicine* 26(8): 1048-1054.

Wensing, M., G. Elwyn, A. Edwards, E. Vingerhoets and R. Grol. 2002. Deconstructing patient centred communication and uncovering shared decision making: An observational study. *BMC Medical Informatics and Decision Making* 2(2): 1-8.

Zoffman, V., I. Harder and M. Kirkevold. 2008. A person-centered communication and reflection model: Sharing decision-making in chronic care. *Qualitative Health Research* 18(5): 670-685.