



## Language capabilities of Free State doctors

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**To the Editor:** The population of the Free State is 2.7 million, with more than 2.3 million people having a home language other than English or Afrikaans.<sup>1</sup> The tuition languages at most South African medical schools are English and Afrikaans, with the University of KwaZulu-Natal and Cape Town requiring an undergraduate indigenous language course. Various studies have demonstrated that health care workers' inability to communicate with patients can lead to patients experiencing health-related adverse effects and limited access to health services.<sup>2-4</sup> Patients require quality information in order to participate in health care decision-making.<sup>5</sup> The goals of this study were to demonstrate the language capabilities of doctors practising in the Free State.

This descriptive study included 800 randomly chosen medical doctors younger than 65 years of age and practising in the Free State. Questionnaires and a covering letter explaining the study were posted to the doctors. Five doctors participated in a pilot study, participation was voluntary, and doctors remained anonymous. All respondents gave written informed consent and the Ethics Committee of the Faculty of Health Sciences, University of the Free State, approved the study.

A total of 308 questionnaires were received; of these, 277 were included in the study (31 were excluded because doctors were older than 65 years or were not practising in the Free State). The respondents were mostly male (72.9%) and had a median age of 46 years (range 26 - 65 years). Most respondents were in private sector employment (61.0%), followed by public service (33.6%), and some were in private sector and public service employment (5.4%).

Most respondents (46.2%) had completed their undergraduate training at the University of the Free State medical school, followed by the University of Pretoria (22.7%), Stellenbosch University (14.8%), the University of KwaZulu-Natal (4.3%), the University of the Witwatersrand (4.3%), and other South African universities (3.7%). Eleven respondents (4.0%) were educated in a foreign country. Most respondents (84.8%) indicated Afrikaans as their home language, followed by English (6.5%), Sotho (5.8%), Tswana (1.8%) and Xhosa

(1.1%). Ten respondents (3.6%) indicated that they had more than one home language. Regarding the respondents' language capabilities, the majority had some knowledge of English (98.6%) and Afrikaans (96.4%) and a large group (38.9%) had some knowledge of Sotho, but only 32.9% were able to speak Sotho. Interestingly, knowledge of German (16.6%), not an official language, fared marginally better than Zulu and Xhosa, which are South Africa's most spoken home languages. The respondents' language capabilities are given in Table I.

Table I. Respondents' language capabilities (N = 277)

Language	Frequency	%
Afrikaans	267	96.4
English	273	98.6
Sesotho	108	38.9
German	46	16.6
IsiZulu	39	14.1
IsiXhosa	31	11.2
Setswana	29	10.5
Sepedi	23	8.3
French	8	2.9
SiSwati	8	2.5
IsiNdebele	7	2.2
Dutch	6	1.4
Indian dialects	4	1.1
African dialects	3	1.1
Russian	3	1.1
Tshivenda	3	1.1
Arabic	2	0.7
Italian	2	0.7
Portuguese	2	0.7
Spanish	2	0.7
Xitsonga	2	0.7
Chinese	1	0.4
Polish	1	0.4

Only one-third of respondents could speak Sesotho, the language most spoken in the Free State.<sup>1</sup> In order to improve doctors' language proficiency, from 2006 the Health Sciences Faculty at the University of the Free State has introduced a compulsory Sotho language-speaking course for its first-year medical students. An Afrikaans language-speaking course has also been introduced for students not familiar with Afrikaans.

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## Duplex appendicitis

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**To the Editor:** We report a case of the rare condition of double appendicitis. Appendix anomalies may have grave consequences if overlooked during an operation, or have forensic implications where a second exploratory laparotomy reveals a 'previously removed' vermiform appendix.

A 42-year-old man presented with a 5-day history of central colicky abdominal pain associated with nausea and vomiting. He had had two previous similar attacks in the past year. On examination, he was tachycardic, dehydrated and pyrexial with a raised white cell count. The abdomen was markedly distended and peritonitic with absent bowel sounds. With a presumptive diagnosis of perforated appendicitis with small-bowel obstruction, an exploratory laparotomy was performed. There were multiple dense adhesions between the bowel loops with free pus in the abdomen. The appendix, 3 cm in length, was retrocaecal, acutely inflamed and perforated. Exploration of a further small mass felt through the medial wall of the caecum below the ileocaecal junction revealed a second short appendage, 3 cm in length, arising from the posteromedial wall of the caecum that was also acutely inflamed and perforated. The appendages were excised and microscopic examination of both showed features of acute appendicitis with perforation and fibrinopurulent peritonitis. The patient's convalescence was complicated by wound sepsis.

### Discussion

Duplication of the vermiform appendix, originally described in 1903, is rare with a reported incidence of 0.004%.<sup>1</sup> This condition needs to be distinguished from a solitary diverticulum of the caecum, which is found on the inner side of the ileocaecal angle; on histological examination the wall of the diverticulum does not contain lymphoid tissue.

Duplication of part of the alimentary tract, in particular of the vermiform appendix, is of embryological curiosity

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and may be associated with other congenital duplications.<sup>1</sup> Histologically the appendix can be distinguished from other intestinal duplications by the presence of a complete and separate inner and outer longitudinal muscle layer and the amount and arrangement of lymphoid tissue. In their classic work *The Vermiform Appendix and its Diseases*<sup>2</sup> Kelly and Hurdon examined 54 human embryos to explain the origin and development of the appendix. The caecum of the 6-week-old embryo had a minute budding resembling a 'beginning appendix'. This small 'transient appendix' had disappeared in the 8-week-old embryo. Wallbridge<sup>3</sup> modified Cave's original classification<sup>4</sup> of duplicated vermiform appendix as follows:

- A: Single caecum with one appendix exhibiting partial duplication.
- B: Single caecum with two obviously separate appendices.
- B1: The two appendices arise on either side of the ileocaecal valve in a 'bird-like' manner.
- B2: In addition to a normal appendix arising from the caecum at the usual site, there is also a second, usually rudimentary, appendix arising from caecum along the lines of the taenia at a varying distance from the first.
- C: Double caecum, each bearing its own appendix and associated with multiple duplication anomalies of the intestinal tract as well as the urinary tract.

In an unusual case reported by Tinkler<sup>5</sup> three separate appendices were found to arise from a single caecum in a child with extrophy of the urinary bladder.

Our case was type B2, the most frequently encountered duplication, thought to represent persistence of the 'transient appendix'. The clinical and medicolegal significance of the type B2 duplication was reported in a case in which a child had an appendicectomy performed twice within a 5-month period.<sup>6</sup>

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