THE ROLE OF INTERPRETERS IN MEDICAL COMMUNICATION IN THE EASTERN CAPE

THESIS

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by

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ABSTRACT

This study aimed to investigate the role of the interpreter in medical communication in the Eastern Cape. This role was found to be a complex and varied one. Interpreters do not only change the words of one language into equivalent words in the other language, but act as advisers, explainers, cultural mediators, supervisors and advocates of the patient. In order to fulfil these functions, they communicate independently within the medical consultation and do not merely interpret what has been said by each participant. Rather, they tailor the message to the participants and the situation by adding to the message, omitting parts of it and changing it where necessary. This does not happen in an arbitrary fashion, but is subject to influence from a number of non-linguistic and linguistic contextual factors. These factors are discussed in this study and included in a suggested model of the interpreted medical consultation, which differs from other models of interpreting which were found to be more adequate for the situation of conference interpreting than for community interpreting, of which medical interpreting is an example.

Data was collected from interviews with interpreters and patients and from interviews and questionnaires given to medical professionals. The results suggest that using trained medical interpreters in the interpreted medical consultation may solve some of the problems that arise and medical professionals should be encouraged to learn the languages of their patients to alleviate some of the misunderstanding which occurs. The study also raises questions about the way in which we view interpreting and shows that community interpreting does not always observe the ideals envisaged by theories of interpreting.

CHAPTER 1

INTRODUCTION, BACKGROUND AND AIMS

1.1 INTRODUCTION

> Translation is not a problem for us - when the patient doesn't understand, we just speak English.
>
> (Fifth year Afrikaans-speaking medical student from Stellenbosch University)

> When we need something translated, we ask the Sister.
>
> (Grahamstown medical doctor)

These viewpoints were the stimulus behind this investigation into the interpreting needs of health professionals[1] in South Africa. Unfortunately, the solution proposed by the student is not often an adequate one in the South African medical encounter and the one offered by the doctor is problematic in ways which will become evident in this study.

This thesis will attempt to investigate the role of interpreters in medical consultations and the extent to which they enable health professionals and patients to communicate across different languages. Because data will be gathered in the Eastern Cape, it will look at health professionals who speak only English or Afrikaans and patients who speak only Xhosa and only a little or no English. The majority of health professionals and their patients in the Eastern Cape fall into

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[1] I use the term health or medical professionals to denote doctors, social workers, pharmacists, nurses, etc. who need to use interpreters in order to understand their patients. The term nurse/interpreter is used for those who interpret for health or medical professionals, although it should be remembered that nurses are professionals in their own right.

these two categories.

As current theoretical models of the linguistic process of interpreting were found to inadequately represent interpreting in the South African medical context, a new model will be developed. This model will be based on Shannon & Weaver's general theory of communication, illustrated in the Message Model (Akmajian, Demers & Harnish, 1984:11), and a refined version of it by Bell (1991:19) which includes the interpreter. The Message Model does not, however, adequately represent all the linguistic and non-linguistic factors which influence the interpreted medical consultation in South Africa.[2] For this reason, this thesis will be proposing a more inclusive model[3] which takes these factors into account. The elements of the model are gleaned from interviews with health professionals, interpreters and patients who have participated in interpreted consultations, as well as the reports of others who have studied the interpreted medical consultation, e.g. Crawford (1994a), Drennan, Levett & Swartz (1991) and Ngqakayi (1994).

1.2 BACKGROUND

South Africa's discriminatory education policies have resulted in a situation where White doctors treat the majority of Black patients. Few of these doctors speak or understand the languages of their patients and they also generally do not have a thorough knowledge of the cultural differences which may influence the medical encounter, impinge on the patient's view of illness

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[2] These models are presented in Section 2.2.

[3] This model will be discussed and developed in Section 7.1.

and determine whether doctors' suggestions are followed.

The 1987 census results, which are set out in Table 4, reveal that the distribution of medical personnel does not represent population demographics. Senior health professionals are overwhelmingly White, while junior staff such as enrolled nurses and nursing assistants tend to be non-White.

TABLE 1[4]

FULL-TIME MEDICAL STAFF

	Total	White	Coloured	Asian	Black
General practitioners and clinical assistants	5 270	4 223	91	559	397
Specialists	1 355	1 206	21	103	25
Interns	923	754	24	86	59
Registered Nurses	39 560	15 409	4 440	1 066	18 645
Enrolled Nurses	15 526	2 645	2 862	362	9 657
Nursing Assistants	28 309	6 912	5 878	684	14 835

The result of this situation is that most patients in South Africa are not receiving medical care in their mother tongues. This situation is problematic for at least two reasons: firstly; with

[4] This table shows the employment of full-time medical staff by population group for all establishments i.e. private and government hospitals and clinics, as well as private practices.

regard to the constitutional right to use any of the eleven official languages in South Africa and, secondly; because of the inadequacy of current interpreting services.

1.2.1 LANGUAGE RIGHTS

In terms of South Africa's Constitution, which recognises eleven official languages, it could be argued that all speakers of official South African languages should receive public health care in their own languages. Turi (1993:15-16) states that in principle what should be included in official usage of languages, is "not only the right to express oneself and to communicate, but also the right to demand to understand, to be understood and served in the language or languages used". Shackman (1992:4), who works in Britain, where English is the only official language but many other languages are spoken, goes one step further:

> Statutory national and local agencies have a responsibility to ensure that their services are as accessible as possible to all their clients. In a multilingual and multiracial society they may need to make special provision to reach and communicate with those clients whose first language is not English and to ensure that such clients have full access to the services offered. No agency can provide a fair or effective service to people with whom it cannot communicate. The effects of non-communication are many and various. They range from frustration, misunderstanding and time-wasting on both sides, to, for example, serious misdiagnosis in the field of health care... An increasing number of local agencies acknowledge that the provision of a monolingual service in a multilingual society is discriminatory.

Breton (1993:123) argues that it is the duty of the authorities to provide specialised materials, staff, organisation and finance to "adjust the scope of collective life and public services to those [linguistic] needs". In order to provide equitable medical services to speakers of official South African languages, health professionals who do not speak the languages of their clients will need to use interpreters and the next sub-section will look at the state of interpreting services in South

Africa.

1.2.2. CURRENT INTERPRETING SERVICES

Crawford's (1994a:11) study of translation needs in Cape Town hospitals reported that doctors could only take very basic and inadequate medical histories and had to base diagnoses and treatment on them, because of the poor interpreting taking place in these hospitals. She found that interpreting may, at present, be carried out by nurses, nursing assistants, non-medical hospital staff, family members or friends of the patient, or by other people in the waiting room. Often, the patient does not understand what was said and this results in a high return rate of patients who have not been cured or have not followed instructions. She found that at least half of all patients seen daily in the hospitals and clinics she studied needed interpreting services and that even those who could speak some English were generally "unable to express themselves confidently and couldn't begin to ask questions" (Crawford 1994a:2).

There may be serious consequences for the patient who does not understand the health professional or the explanation given by the interpreter. An example from data collected for this study is supplied by Sister Q:

> A few months ago, we had a lady. This lady was married, she had three kids, she decided to go for sterilisation. She went for sterilisation there in Johannesburg, now somewhere along the line she lost two kids, she has got one. Now she's stayed with another boyfriend, they are about to marry. Now she puts it like this: she was closed then, now she want another child, she has come to open up. You see, she doesn't know the fact that if you have been sterilised, you cannot be opened again ... I'm sure there was a misinterpretation during that time when she was going for the operation.

Another example is of a patient in Grahamstown who was told through an interpreter that he had a tummy bug. He understood this to mean that he was being eaten alive by insects from inside and he consequently developed severe psychological problems.

As trained medical interpreters are generally unavailable in South African medical encounters, the mediator is often a nurse who speaks both the health professional's language and the patient's language, although with differing degrees of proficiency (Wood 1993:352). This role of interpreter is a complex one, and does not simply involve the direct translation of the words of one language into the words of the other language. On the contrary, Crawford (1995:10) found that it may also include:

1) Explanation of concepts which often may not be accessible to one of the parties;

2) Mediation between two often entirely different cultures; and,

3) Bearing the brunt of emotional responses when the message interpreted is not a welcome one, as it was often assumed that nurses had adequate counselling and communication skills to deal with imparting bad news because they spoke the same language as the patient, while they did not have these skills.

Despite the obvious significance of all these tasks, the importance of the interpreter role is rarely stressed, the nurse seldom receives recognition for these tasks, and training and remuneration is generally not supplied (Wood 1993:352, Crawford 1995:10). Indeed, interpreting is not part of the nurse's job description, although Crawford (1994a:20) found that nurses may spend up to 80 percent of their time on this task when working with a doctor and according to Wood

(1993:352), nurses have been made to feel that interpreting is their responsibility. This is often for economic reasons as medical services lack funds for full-time interpreters.

1.2.3 ECONOMICS

One of the questions which may be asked, is why a situation where patients do not have good interpreting services available to them has been allowed to develop. Bloom (1965:167) may have one of the answers when he cites a fundamental contradiction in a hospital: it must be run along business lines and with a profit motive, while retaining its function of serving the community. Reconciling these two functions is not always an easy task. A recurrent theme in Crawford's (1994a) study is that administrators say there is not enough money to provide adequate interpreting services in hospitals, while many medical personnel argue that good translation would decrease patient return rates and increase the quality of medical care.

With a government policy of providing free health care to a large sector of the population, the majority of whom do not speak the doctors' languages, new solutions may have to be implemented so that public health services may be run more efficiently and cost-effectively. Good interpreting services may be one way of decreasing the patient load in the hospitals and ensuring better health care, and ultimately lowering the cost of health services in South Africa.

Thus it would appear that South Africa has predominantly White senior health professionals who are largely unable to communicate with patients who do not speak English or Afrikaans. Although constitutionally, patients may be able to demand medical care in their own languages,

the current interpreting services are inadequate and economic constraints prevent the training of non-nursing staff who can act as interpreters.

1.3 AIMS

This research has four main aims:

1) To identify the non-linguistic contextual factors which influence the communication in the interpreted medical consultation;

2) To investigate the role of interpreters in medical consultations and assess how this role affects the message conveyed by the interpreters;

3) To investigate the linguistic problems with interpreting in hospitals, which include a shortage of terminology, a lack of knowledge about the subject matter under discussion and inadequate proficiency in one or more of the languages used in the medical interview; and,

4) To develop a suggested model of interpreted medical consultations, which will look at the actual process of interpreting in the light of other theories of interpreting and communication and data collected for this and other studies.

1.4 OUTLINE OF THE THESIS

The theoretical background for this thesis is discussed in Chapters 2 and 3. Chapter 2 looks at interpreting theory and some models of the interpreting process. It will also examine attitudes to changing the message as presented in theoretical accounts, because this will be shown to be an important component of the data.

Chapter 3 discusses the effects of power and cultural differences in medical relationships. Specific areas of Xhosa culture which could cause problems in the medical context are highlighted. This chapter also includes a discussion of the structure of medical discourse and the problems associated with it. Power and cultural differences, together with the nature of medical discourse, will be shown to have an effect on the interpreting process throughout the thesis.

Chapter 4 introduces the methodology used for data collection and tables the limitations of the study.

Chapters 5 and 6 present the data collected for the study, which has been grouped into the non-linguistic (Chapter 5) and the linguistic (Chapter 6) factors which influence the interpreted medical consultation.

In conclusion, Chapter 7 draws together the most important factors influencing the communication in an interpreted medical consultation. These factors are presented in a suggested model of the interpreting process in a South African medical consultation. In addition, this model attempts to overcome some of the weakness exhibited in the models suggested by other theorists.[5] Finally, some implications of the study are presented and recommendations are made where problems have been identified from the study.

[5] These are presented in Section 2.2.

CHAPTER 2

LITERATURE REVIEW

2.0 INTRODUCTION

In order to understand some of the theoretical background to interpreting across the world, this literature review will focus firstly on interpreting theory. Interpreting theory has its roots in translation theory and many early theorists do not draw a distinction between the two. In recent years, it has been argued that translation and interpreting differ considerably and that separate theories should be developed. These theories necessarily assume communication theories and communication models that have been adapted to the interpreting process will be discussed. Finally, the importance of communication in the medical context will be argued, as it will be posited in later chapters that successful communication is essential for adequate medical care to occur.

2.1 INTERPRETING THEORY[6]

Several theories of interpreting will be discussed in this section as a background to the presentation of a model (see Section 7.1) which differs from those presented in the literature. These theories and models tend to work fairly well for the unique situation of conference interpreting and for formal written translation. It is argued that they do not, however, account

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[6] In the literature, the term translation is generally used to refer to written and oral translation and the term interpreting or interpretation refers only to oral translation. I prefer to use the term translation only for written translation and the term interpretation or interpreting for oral translation, because the processes and requirements of the two differ in some respects.

for the case of more informal community interpreting, of which medical interpreting is an example.

This section will examine interpreting theory in terms of:

2.1.1) Definitions of interpreting and translating;

2.1.2) Models of the process of interpreting;

2.1.3) Changing the message;

2.1.4) Attributes of the good translator; and,

2.1.5) Linguistic problems encountered with interpreting.

Before further discussion of interpreting, a definition of interpreting is necessary.

2.1.1 DEFINITIONS OF INTERPRETING AND TRANSLATING

> The first and most obvious requirement of any translator is that he [or she] has a satisfactory knowledge of the source language. It is not enough that he [or she] be able to get the "general drift" of the meaning or that he [or she] be adept at consulting dictionaries. Rather, he [or she] must understand not only the obvious content of the message, but also the subtleties of meaning, the significant emotive values of the words, and the stylistic features which determine the "flavour and feel" of the message. Even more important than knowledge of the resources of the source language is a complete control of the receptor language. In addition to a knowledge of the two or more languages involved in the translation process, the translator must have a thorough acquaintance with the subject matter concerned.
>
> (Nida 1964:150)

Although this definition is applicable primarily to translation, many of the elements are also necessary for interpreting. The ideals expressed here are also often cited as ideals in interpreting, although they are virtually impossible to attain, even in conference interpreting, and are not entirely necessary and certainly quite unattainable in more informal community interpreting.

Interpreting does not involve a simple replacement of a word in one language with a word in another language, but requires competence in a variety of elements in the communicative situation. Nida's (1969:12) definition of translation as "reproducing in the receptor language the closest natural equivalent of the source language message, first in terms of meaning and secondly in terms of style" is deceptively simple, because it assumes that there are always equivalent words and concepts available in two languages and it assumes the existence of equivalent styles. It also assumes the ability of the translator/interpreter to translate/interpret in this way. Much translating/interpreting does not adhere to this definition and yet it is still recognised as a translation/interpretation, albeit usually with a quality judgement attached.

In contrast to Nida's assumptions, Seleskovitch (1978:8) describes interpreting as more than the oral translation of words, but a process involving also the uncovering of meaning to make the message explicit to others. The hearer of an interpretation cannot return to the text to discover or clarify meaning - it must be made explicit by the interpreter. Newmark (1991:36) has this to say about the difference between translation and interpretation:

> The only generalisation I can make about the difference between translation and interpretation is that other things ... being equal, but they never are - an interpretation is likely to be more colloquial, less detailed, deprived of the original's metaphors, with more emphasis on the essential points and the gist of a paragraph, a sentence or a phrase.

Newmark is thus pointing to the more conversational tone of an interpretation which paves the way for more recent emphasis which has been on the importance of translation/interpretation as a communicative act which is governed more heavily by contextual factors than by the need for strict equivalence between the words of the two messages. Kussmaul (1995:1) captures the

essence of these more recent definitions when he says that:

> Translation [or interpretation] ... is not just an exchange of words and structures, but a communication process that takes into consideration the reader [or receiver] or the translation [or interpretation] within a particular situation within a specific culture.

The move away from seeking strict equivalence has come about with the growing realisation that there is not always simple equivalence between source and target languages. Baker (1992:21) suggests examples of non-equivalence between languages which are likely to cause problems during interpreting:

1) There are culture-specific concepts, (e.g. traditional healer, amafufunyana [spirits]);

2) The concept is not lexicalized in the other language, although the concept is known, (e.g. sterilisation); or

3) Two languages make different distinctions in meaning (e.g. amahlaba are sharp pains in the chest or back only and ukugcuma means to writhe from pain when the patient is suffering from injury only and not from natural ailments).

Instead of taking this slightly negative view, Hatim & Mason (1990:27) contend that strict equivalence is unnecessary because all natural languages can express all of the range of experience of their cultural communities, and they can expand via borrowings, metaphor and neologisms when they come into contact with new situations.

So, interpreting seems to be less obligated to adhere to strict equivalence and is able to make use of devices which explain meaning because the mode of transmission is speech and the hearer cannot return to the text to discover meaning.

2.1.2 MODELS OF THE PROCESS OF INTERPRETING

The actual process of interpretation is described in a variety of models, one of which is discussed here.[7] In this section, it will be shown that there are several factors which are important in a model of the process of interpreting. At this stage, factors which are presented in the theoretical literature will be reviewed, but at the end of the study, a larger number of factors will be collected and included in a revised model based on the data. More recent models tend to emphasize the entire discourse situation and cultural elements while including the actual process of interpretation which was the focus of older models. As Snell-Hornby (1990:81) summarises:

> What is dominant in the series of new approaches ... is the orientation towards cultural rather than linguistic transfer; secondly, they view translation not as a process of transcoding but as an act of communication; thirdly, they are all oriented towards the function of the target text (prospective translation) rather than the prescriptions of the source text (retrospective translation); fourthly, they view the text as an integral part of the world and not as an isolated specimen of language.

Gerver & Sinaiko's (1978:37) model (see Figure 1 over the page) is an early example of the newer models which stress the role of interpreter as cultural and linguistic analyst. The model begins to show that a variety of factors will influence the messages sent during the communication.

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[7] The psycholinguistic approach to explaining translating and interpreting, (e.g. Bell 1991:59) is not examined here, as this approach is not the focus of the thesis.

FIGURE 1

THE INTERPRETING PROCESS

SENDER	Culture Situation Language Paralanguage	INTERPRETER ANALYSIS PROCESS	Culture Situation Language Paralanguage	RECEPTOR
	MESSAGE		MESSAGE	

In this model, the sender sends a message which is shaped by his/her culture, situation, language and paralanguage. The interpreter analyses it and converts it into a message which is suitable to the culture, situation, language and paralanguage conventions of the receptor. In this model, the interpreter is described as the "analyst", "processor" and "executor" who has three linguistic/cultural capacities: firstly; as linguistic and cultural analyst, secondly; as processor of the information, and thirdly; as intercultural communicator (Gerver & Sinaiko 1978:37). The elements of culture and situation are dealt with briefly at this point as they are perceived to be important in interpreting theory.

2.1.2.1 Culture

Vermeer (in Bassnett and Lefevere 1990:82) stresses the importance of the role of intercultural communicator. He views translation/interpretation as primarily cross-cultural transfer and believes that the translator should be bicultural because "language is an intrinsic part of culture". This ideal of biculturality is rarely attained in the average interpreter and it will be shown that it is particularly not attained in the untrained, relatively uneducated South African medical

it is particularly not attained in the untrained, relatively uneducated South African medical interpreter, who tends to have fairly limited knowledge of English and Western culture.

2.1.2.2 Situation

The "situation" element of the model is explained more fully by Hatim & Mason (1990:71) who view the discourse situation in the following way:

SOCIAL OCCASIONS

are reflected in

GENRE (conventional)

which is expressed in

DISCOURSE (attitudinal)

which is realised in

TEXT (communicative, goal-oriented)

According to this model, it becomes important for the interpreter to realise that interpretation does not take place only at the text-level, but that all of the levels above that of text have an important bearing on the actual message conveyed and that all of these levels introduce potential differences in the way they will be realised in different cultures.

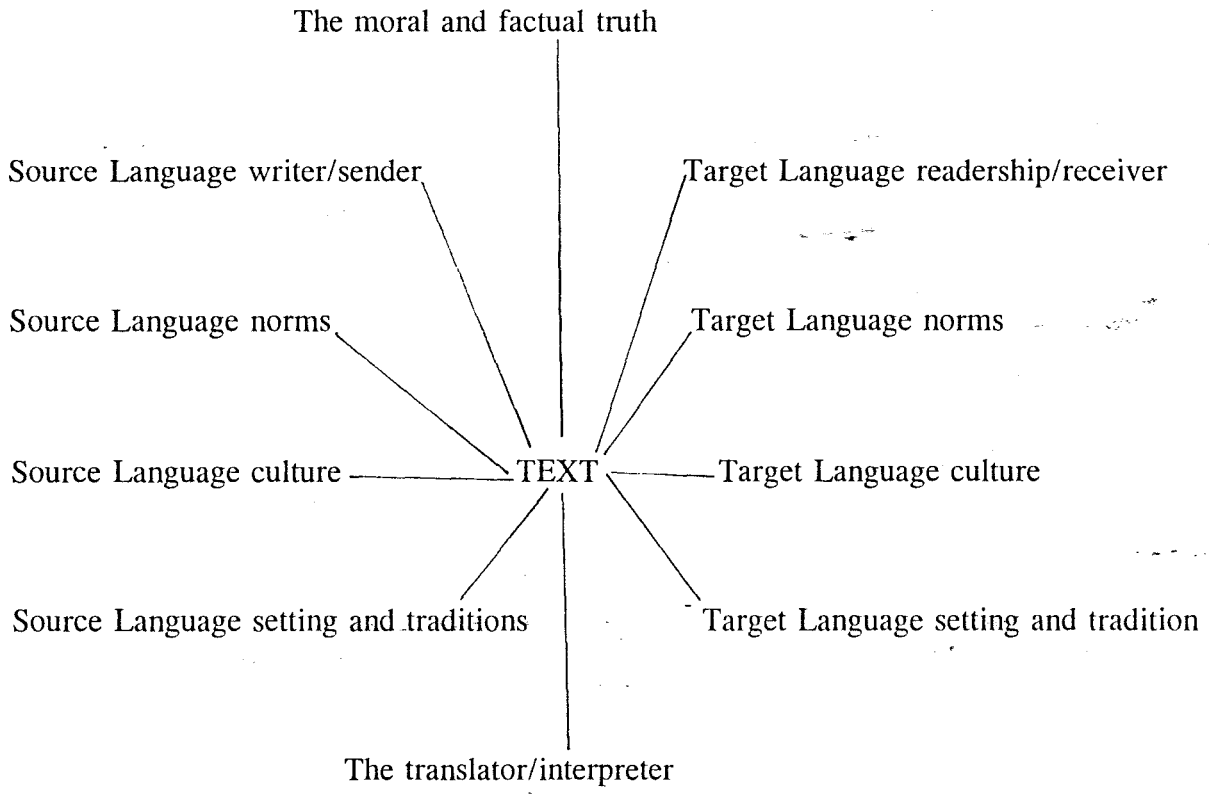
2.1.2.3 Further refinements

In a later development, Newmark (1991:31) presents a different model (see Figure 2) which takes into account other factors which shape the text, i.e. the moral and factual truth, the three

participants, and norms of both languages. The culture and situation elements included in Gerver and Sinaiko's model (see Section 2.1.2) are retained as they are recognised as important elements of the model. The models presented are thus becoming more detailed with recognition of increased influences on the text. The possibility of strict equivalence and transference is thus shown to be smaller, as several elements are shaping the message.

FIGURE 2

VARIOUS FACTORS THAT IMPINGE SEMANTICALLY ON A TEXT (Newmark 1991:31)



2.1.2.4 Roles of interpreters

Although the models discussed above increasingly take into account some of the factors influencing the interpreted medical consultation, neither of the models adequately specifies the

roles which the interpreters were found to play in the interpreted medical consultation. Wood (1993:348) explains five "conceptual models of translation", each of which accords different roles to the interpreter and three more are suggested by Knapp-Potthoff & Knapp (1987:182), Shackman (1992:21) and Gile (1995:29-30). Wood's (1993:348) models are as follows:

1) Interpreter as Interviewer

The interpreter interviews the patient, following general guidelines provided by the doctor, who does not interact directly with the patient. The interpreter effectively decides what to translate. Andreyev (1987:1534) recounts experiences of using interpreters in the Middle East, and how, although he wished to provide explanations to his patient, he was unable to do so, because the interpreters did not believe that the patients understood or wanted explanations. Here the interpreter is acting as an independent communicator and is not actually the person in the middle interpreting for two participants.

2) Interpreter as transferrer of linguistic utterance

The doctor retains control of the interview and there is direct interpretation of the questions and responses in the interview. Wood (1993:348) notes that although this form is successful in conference interaction, there are many basic medical concepts which are not directly interpretable in medical consultations.

3) Interpreter as patient advocate

The interpreter sees him/herself as protecting the patient from the doctor. He/she advises the patient of the doctor's motives, presents alternatives and encourages resistance to suggestions. The interpreter is acting independently of the health professionals.

4) Interpreter as cultural broker

The interpreter bridges the cultural gap between health professional and patient who may be less aware of cultural differences than the interpreter. This allows scope for the interpreter to act independently of the other participants.

5) Model of partnership

The doctor and the interpreter are recognised as having specialised knowledge to offer the patient and they should function as a team if the patient is to receive optimal care. This model combines the role of direct interpreter and independent communicator.

Knapp-Potthoff and Knapp (1987:182) state that in less formal situations, where the interpreter has to process long stretches of language, he/she may both interpret and develop or introduce topics, comment, explain and present arguments. He/she therefore becomes a true third party to the conversation, rather than only a negotiator of meaning between two parties.

Shackman (1992:21) describes the good medical interpreter as someone who should be able to translate meanings, words and ideas. He/she should be able to explain the role of the professional to the client, the cultural assumptions of both parties, and the reactions and feelings of each person during the interview. He/she should support both participants, encourage both sides to ask questions and fill in gaps and background information for both sides. He/she should act as advocate and support for the client, comment on how the interview is going and say when it is going wrong, and make sure that both parties feel they know what is going on and are participating fully. Here, the interpreter is sometimes acting as a direct interpreter, but more

usually is an independent communicator.

Gile (1995:29-30) feels that the interpreter takes a role that encompasses "rotating side-taking":

> To serve the author or speaker, the Translator [or interpreter] should be biased in the favour [of the speaker] (but not to the point of being blind to the possible reactions of the Receiver, as this may lead to a lesser capacity to serve the former) ... If ... the interpreter works alternately for opposing speakers, his/her loyalty shifts from one to the other ... feedback can come in during interpretations and interfere (questions, hostile reactions, interruptions from listeners). In community interpreting, this becomes a key issue.

I would argue (based on data collected for the study presented in Chapters 5 and 6) that all eight of these models are relevant at different times and in different situations during the interpreted medical consultation. Interpreters assume these roles at different times according to the message, participants and other contextual factors.

In terms of a model of the interpreting process, it will be argued after discussion of the data that none of the models presented in this section appear to be adequate illustrations of the interpreted medical consultation in South Africa. Some of the models do, however, allow for a change in the message to some extent.

2.1.3 CHANGING THE MESSAGE

As can be seen from the discussion above, direct or literal interpretation (which is held up as an ideal by many authors) may not be the best way of ensuring that the message is understood, especially where the interpreter is familiar with the abilities or knowledge of the interlocutors.

Additions or alterations may also be necessary to fill in the gaps (Nida 1964:227).

Cluver (1992:7) believes that interpreters will increasingly find that they need to interpret both from language to language and from register to register because often the information required by the broad population uses vocabulary in a register[8] which they do not understand. Grasska & McFarland (1982:1378) view the problem with register as a result of having to translate "on three different levels within each language - technical, standard, and slang". Lewis (1980:152) stresses that the difference between specialist and lay terminology is in "precision and discrimination, in how and where they draw the boundaries between kinds of illness and in the information they convey". This aspect is particularly relevant to medical interpreting where a doctor may be using medical jargon and the patient may have no medical knowledge. The interpreter will have to change the message from a specialized register into an informal register (and possibly explain in much more detail) if the patient is to understand. Some medical interpreters prefer to change the message given by the patient into the specialist register of the health professional and this may cause problems if the interpreter is poorly trained or inexperienced (Diaz-Duque 1982:1380-1381).

Medical jargon cannot always be translated directly into the other language, because there may be no equivalent terms, the same word may have totally different meanings in different cultures

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[8] "Register: A speech variety used by a particular group of people, usually sharing the same occupation (eg doctors, lawyers) or the same interests. A particular register often distinguishes itself from other registers by having a number of distinctive words, by using words or phrases in a particular way, and sometimes by special grammatical constructions"(Richards, Platt & Weber 1985:242).

or the patient may not know the medical term (Jansen 1973:123, Katon & Kleinman 1980:269). Jansen (1973:123) found that "the best method (of translation) is to paraphrase the sense of the concept ... there is no sense in translating literally our western concepts into Xhosa".

So, changing the message would appear to be almost essential in a medical context where the patient has little knowledge of medical terminology. A model of the interpreting process would need to allow for this.

2.1.4 ATTRIBUTES OF THE GOOD INTERPRETER

As mentioned before, a range of people are used as interpreters in medical encounters in South Africa and Wood (1993:348) points out that the wide use of medical, nursing, paramedical, non-medical auxiliary staff and family means that interpreters are often not trained or paid for interpreting and may not be sensitive to issues of confidentiality. Shackman (1992:12) feels that "inaccurate translation and mistranslation due to poor knowledge of English and the patient's language", as well as "bias and distortion" may arise when using untrained non-professional interpreters.

There are a variety of skills and knowledge required by medical interpreters and Diaz-Duque (1982:1380) argues that friends and relatives should not be used as interpreters in the medical encounter because they lack a knowledge of medical terminology, they are unfamiliar with hospital policies, procedures and routines, and they may not be willing to relate embarrassing details or be able to translate distressing news appropriately.

Shackman (1992:114-115) suggests that "interpreters need to learn how to listen accurately and then transmit the total message. This entails more than linguistic skills". She feels that the following items should be given emphasis when training medical interpreters:

* Understanding the sequence
* Picking up tonal emphasis
* Understanding degrees of probability
* Understanding major grammatical differences between English and other languages.
* Learning listening skills
* Learning summarising skills
* Learning memorisation and concentration skills
* Selecting the appropriate register
* Learning specialist terminology and concepts

Sherer (1993:31), Pinchuk (1977:150) and Seleskovitch (1978:70) agree that interpreters need thorough knowledge of their subject field, and the ability to assess both linguistic and non-verbal messages.

Diaz-Duque (1982:1380) also points out that for interpreters to be used effectively, the health professionals who use them should learn about the interpreting process and be familiar with the problems that interpreters encounter. Bal (1981:368) suggests that health professionals should take time to explain their aims to the interpreter and learn to maintain a relationship with the patient.

2.1.5 LINGUISTIC PROBLEMS ENCOUNTERED DURING INTERPRETING

Apart from the problems caused by the use of poor interpreters, there are a number of problems experienced by interpreters which are caused by the non-equivalence of languages and less than

perfect linguistic ability in the languages used in the interpreting situation. Culler (1976:21-22) states that

> languages are not nomenclatures (for a set of universal concepts), that the concepts ... of one language may differ radically from those of another. Each language articulates or organises the world differently. Languages do not simply name existing categories, they articulate their own.

Because languages cannot be translated or interpreted word for word, Pinchuk (1977:219) lists a number of errors that can occur during translating/interpreting which include:

1) Loss of information;

2) Lack of intelligibility;

3) Interference between source language and target language;

4) Incorrect level; and,

5) Errors in the use of target language.

These errors may all contribute to the incomprehensibility of the message which is sent. Examples of instances of these problems are mentioned in Chapter 5 and 6 where data is discussed.

From the above sections, it can be seen that interpreting is not a simple process. It is influenced by a variety of factors including the role of the interpreter, the culture, context and languages involved. It is prone to problems, because there are different ways of seeing the world and encoding these perspectives in language. Medical interpreting is subject to these limitations and complicated by further aspects which are a result of dealing with a specialised field, having participants with unequal status and knowledge, and operating in a particular institutional milieu.

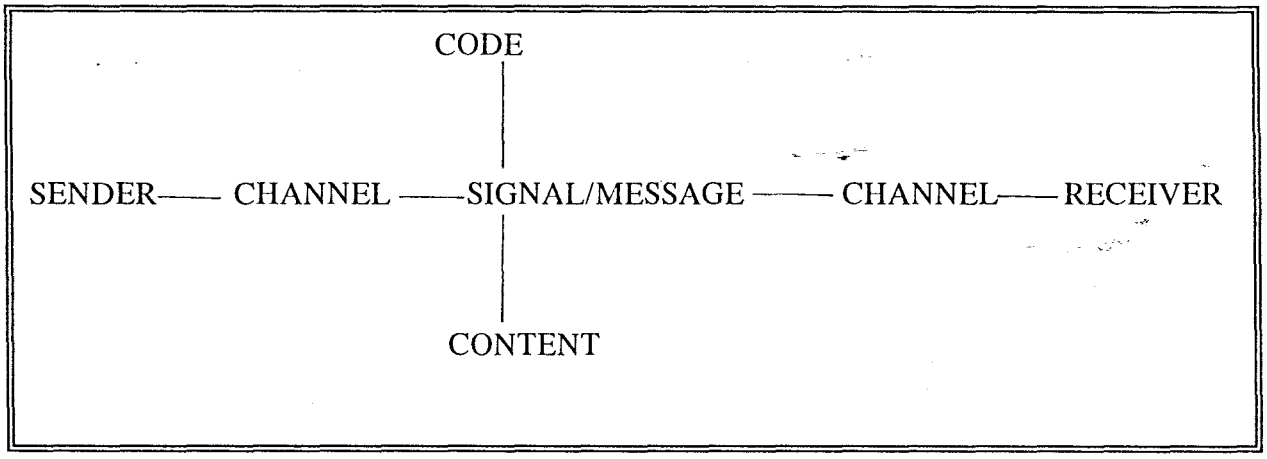
Now, in order to lay a foundation for the model presented in Section 7.1, communication models are examined.

2.2. COMMUNICATION MODELS

Shannon & Weaver's Message Model (in Bell 1991:18) forms the basis of many models of the process of communication:

FIGURE 3

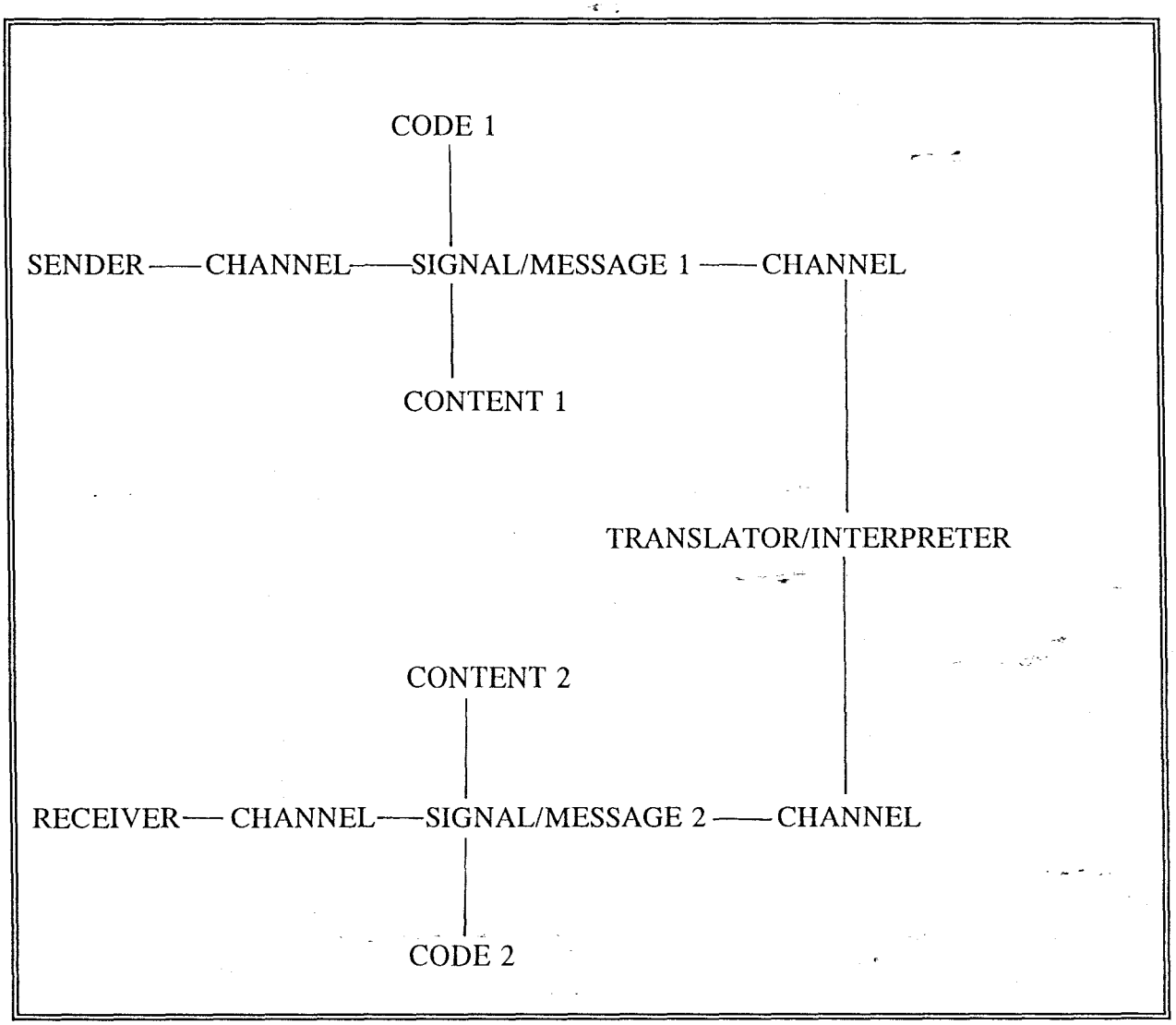
SHANNON & WEAVER'S MESSAGE MODEL



A sender sends a signal or message via a channel (spoken or written) in a code (language) about a subject matter (content) to a receiver who receives the message via a channel. Bell (1991:19) adapts this basic model to fit the interpreter/translator into the process (see Figure 4 over the page) and introduces a second message in a second code which may have different content from the first message.

FIGURE 4

BELL'S REFINED MESSAGE MODEL



This second model will form the basis for a suggested model of interpreted medical consultation, which is presented in Section 7.1. In this section on communication models, it is necessary to discuss the importance of communication in the medical context.

2.2.1 THE IMPORTANCE OF COMMUNICATION IN THE MEDICAL CONTEXT

Any medical encounter is a meeting between at least two people i.e. the health professional and the patient. The interaction which takes place is conducted primarily through language, although there are non-verbal elements involved as well, e.g. body language and physical examination. Jansen (1973:7) believes that both medical practice and care are a matter of communication first of all. Without satisfactory interaction between the health professional, patient and community, any medical care system, however well organized, will be a failure in the long term. Ngqakayi (1994:22) agrees with this emphasis on the role of communication:

> Many people tend to associate health care only with medicinal cure or drug therapy. The association functions to obscure the powerful and complementary role of verbal communication in medical procedures such as history-taking and the establishment of diagnosis. Quality care can be seriously compromised by inappropriate use of language or by inadequate verbal communication.

Crawford (1995:9) believes that the patient's story is an indispensable and easily accessible guide for the doctor who has to negotiate an understanding and treatment with which the patient will comply. Unfortunately, the patient's side of the conversation is not usually regarded as being equally important to the doctor's contribution. Crawford (1995:9) argues that:

> The patient's story, her [or his] experience and construction of her [or his] illness, is not central to the medical interaction. There is an inevitable gap between the patient's version of an illness and the medical view, but medical training doesn't equip doctors to bridge that gap or indeed to see it as a central concern.

Bal (1981:368) argues that one of the forms a response from the patient takes is compliance. He states that patient compliance is a problem faced by health professionals and that the key to compliance lies in patient education which can be improved by better communication. Stoeckle

& Barsky (1980:226) show that explanations are one of the major functions of Western scientific and alternative medicine and they suggest that effective explanation includes the acknowledgement, interpretation and possible resolution of different patient and doctor conceptions of the illness. They feel that explanation of illness enhances the patient's autonomy, cooperation and capacity for self-care. One of the key concepts here, is that a relationship develops between doctor and patient, which can only really be formed and maintained through conversation. Bloom (1965:253) states that the

> limitations of a busy medical practice are not so great that they must prevent the doctor from being sensitive to the transactional aspects of his [or her] relationships with patients... This type of awareness might ... serve a critically useful response.

Health professionals will thus be able to gather important information from their patients which will help them with diagnosis and treatment.

As in many situations in life, a pattern of communication tasks has developed in the patient-doctor encounter. According to this set of expectations, the patient and the doctor are constrained in their topics, questions, answers and discussions. Table 2 (over the page) lists these communicative tasks in the Western medical encounter.

TABLE 2

COMMUNICATIVE TASKS OF THE PATIENT AND DOCTOR IN THE WESTERN MEDICAL ENCOUNTER (Erzinger 1991:95)

PATIENT	DOCTOR
Describe his/her concern	Explore symptoms
Clarify information conveyed by the doctor	Interpret follow-up data
Obtain an adequate explanation	Adequately explain and advise
Develop a personal relationship	Understand the patient's personal situation

The successful completion of these tasks relies on adequate communication and mutual understanding, both of the language used and the cultural differences between participants. If successful communication is a vital component of any medical encounter and if the health professional and patient speak different languages, there is an immediate barrier between them. Sabin (1975:197) notes that when a patient is speaking in a second language or through an interpreter, the instrument (communication) is altered and the results will be affected. A health professional can therefore not rely on communication with the same assurance as when the patient and the health professional speak the same language as a mother tongue. Shackman (1992:11) lists a variety of outcomes of an interview between a health professional and a patient who do not understand each other:

* Health worker frustrated, feels a failure
* Patient totally confused, fears unallayed
* No communication in either direction
* Complete failure of interview and a lack of provision of service
* Time and energy wasted on both sides, exhaustion
* Anxiety, stress, fear, alienation, rage, embarrassment on the part of the patient
* Unfairness, injustice

* Possibly physical injury or mistreatment to client with serious medical consequences

Shackman (1992:1) cites problems with language barriers, the structure of medical discourse, and the difference in power between doctor and patient, as central reasons for poor doctor-patient communication. These power differences are found even when the patient is from the same class as the doctor and speaks the same language.[9]

On the other hand, Wood (1993:352) concludes that interpreted interactions are not always unsatisfactory and that the doctor who decides to use the patient's language needs to be very proficient in that language and have good cultural knowledge of the patient for the interview to be satisfactory.

Thus, it has been suggested that communication between doctor and patient is an essential, but not always successful, part of the medical encounter. Adequate communication should result in patient compliance, quality medical care and a good relationship between doctor and patient. It will ease the task of diagnosis and ensure that important facts are not omitted. Communication via an interpreter can be problematic, but is better than a situation where no communication can take place at all.

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[9] Medical discourse and power differences are discussed in Sections 3.3 and 3.1 respectively.

2.3 CONCLUSION

This chapter has discussed some definitions of interpreting theory and two of the models presented by theorists, as well as attributes of the good interpreter and linguistic problems faced by the interpreter. It is suggested that the models are likely to be inadequate for the specific situation of the interpreted medical consultation and a more specific model will be suggested in Chapter 7.1 in the light of the results of this investigation. The importance of communication should not be underestimated when dealing with the medical consultation and several problems which occur when communication is inadequate were highlighted.

In the next chapter, a further three topics which play important roles in the success of medical communication are discussed. Firstly, the aspect of power differences in medical relationships is highlighted. Crawford (1995:19) argues that there is a great power differential between doctor and patient and Bloom (1965:161,165) and Wessen (1958:328) highlight power differences between doctors and nurses.

The second aspect of cultural differences between health professionals, interpreters and patients and the problems that these may cause is discussed. In addition, a few Xhosa cultural beliefs about illness and the medical encounter contextualise the data which will be presented in Chapters 5 and 6.

The final topic covered in Chapter 3 is that of medical discourse. Medical discourse is shown to have a particular structure which can cause a variety of problems when medical professionals

and patients need to communicate.

Whereas Chapter 2 looks generally at interpreting theory, the role and attributes of the interpreter in medical interpreting as well as linguistic problems associated with interpreting, Chapter 3 will look more closely at the role of cultural and situational aspects which are emphasized in the newer approaches to interpreting theory. These two aspects appear to be very important determinants of successful medical communication and thus warrant fuller discussion.

CHAPTER 3

POWER, CULTURE AND MEDICAL DISCOURSE

3.0 INTRODUCTION

In addition to the roles assumed by interpreters and the attributes of a good interpreter discussed in Chapter 2, three more aspects (power, culture and medical discourse) play important overarching roles in the medical consultation. Power differences will be shown to influence all medical communication. Cultural differences additionally come into play when participants belong to different cultures, as is the case in the interpreted consultation. In order to make the discussion more relevant, a few cultural differences between Xhosa patients and English health professionals are presented. Each of these areas tends to be implicit when health professionals, interpreters and patients communicate with each other, but they can influence communication to varying degrees. It is therefore important to highlight the effect which each one can have in hindering successful communication in the medical context.

3.1 POWER DIFFERENCES IN MEDICAL RELATIONSHIPS

> The relative power and status of language users within social institutions exercise a determining influence not only on language forms used but also on the intended and perceived illocutionary force of utterances.
>
> (Hatim & Mason 1990:86)

Power differentials between participants in a consultation may determine how much each participant speaks, how much value is placed on what is said and the way in which each participant is treated generally. They also determine the status accorded to each participant.

Inherent in the medical encounter is a great power differential between doctor and patient. Crawford (1995:9) discusses it in these terms:

> The doctor is in a powerful position of the one who probes to see what's wrong in the patient's body system while the patient is in the powerless position of the body which is passively subject to scrutiny ... The doctor asks close ended questions in relation to a body of knowledge to which the patient has no access.

West (1984:17) sought an explanation for the linguistic structure of the communication in the medical consultation (discussed in Section 3.3.1) and concluded that it was a function of the less powerful position of the patient. She concluded that:

> Physicians' control of power over patients derives from three sources. First, patients are in a position of situational dependency vis-a-vis their doctors, in that they recognise their needs for health care and their inability to provide it for themselves. Second, physicians are in a position of situational authority vis-a-vis patients, since only doctors possess the specialized knowledge and technical qualifications required to provide medical services. Third, physicians' professional prestige provides them an additional edge in their interactions with patients.

In terms of the doctor-nurse-patient hierarchy, Bloom (1965:161,165) concludes that the doctor still has the most power in the hospital context, although increased responsibility has resulted in other "paramedical" personnel becoming part of the medical team. This membership of the medical team has elevated their status and reduced the power differential between doctor and other medical personnel. However, Wessen (1958:328) concludes that the nurse, whose status is professional, is nevertheless overshadowed by the "overwhelming authority and prestige" of the doctor.

Crawford (1995:10) found similarly that South African hospitals have a rigidly hierarchical

structure which places the doctor at the top and the patient at the bottom. The nurse is found somewhere in the middle, but race, class and gender work together to ensure that his/her status is fairly low in the medical hierarchy. The combination of low status patient and fairly low status nurse/interpreter means that the patient's story is even less likely to be paid attention to than when the doctor-patient communication is direct. Drennan et al (1991:375) found that for reasons of power, prestige and status, and the access to privileged knowledge, many interpreters tend to identify more with the agency (hospital/health professional) than the client. This may be detrimental to the patient, whose voice is silenced even further. Fisher (1983:153) also found that the asymmetry in the relationship between doctor and patient is even greater when the patient is perceived to be poor and powerless.

Power differences between different health professionals and their patients are unlikely to disappear in the near future, but, it may benefit patients if these differences are minimised. If patients can be treated effectively in their own language, if their feelings and views are taken into account and respected, and they are given the knowledge to participate in their treatment, the patient may gain some access to the medical milieu and power differences may be reduced.

3.2 CULTURE

> Culture starts when you realize that you've got a problem with language, and the problem has to do with who you are. Culture happens in language, but the consciousness it inspires goes well beyond it.
>
> Agar (1994:20)

The literature in the field reveals that culture is a pervasive feature of human behaviour and that

it has subtle, but very important effects on the interaction between doctors and patients. "Culture may be said ... to refer to concrete sets of signifying practices - modes of generating meaning - that create communication orders of one kind or another" (Polity Reader 1994:2), while Larson & Smalley (1972:40) define culture as what "gives us our general patterns of dealing with problems". Goodenough's (1964:36) definition is as follows:

> A society's culture consists of whatever it is one has to know or believe in order to operate in a manner acceptable to its members, and do so in any role that they accept for any one of themselves. Culture being what people have to learn as distinct from their biological heritage, must consist of the end product of learning: knowledge ... By this definition, we should note that culture is not a material phenomenon; it does not consist of things, people, behaviour, or emotions. It is rather an organization of these things. It is the forms of things that people have in mind, their models for perceiving, relating, and otherwise interpreting them.

Many South African medical encounters are intercultural because they involve English or Afrikaans-speaking doctors meeting African language speaking patients. Waltzman (1993:253) proposes that intercultural communication takes place "whenever a message produced by a person in one culture must be processed by an individual from another culture ..." Clyne (1994:1) believes that this occurs frequently, because communication can be termed intercultural even in situations where one of the parties uses the language of the other party or where a lingua franca is adopted, and that if one party learns the language of the other party, the problems associated with intercultural communication are not resolved because

> Language represents the deepest manifestation of a culture, and people's value systems ... play a substantial role in the way they use not only their first language(s) but also subsequently acquired ones.

Health professionals and patients are therefore operating within their own (often different)

cultural systems. Erzinger (1991:91) describes intercultural communication as a process whereby the patient and the doctor interpret verbal and non-verbal cues based on culturally determined beliefs and values, which, in turn, are reflected in their interactional behaviour. Responses are based on how each culture views the routine of doctor-patient behaviour.

So, it is not only the actual words used in an utterance which determine its meaning or are used to decode it. Sinclair (1992:64) notes than non-linguistic factors in the form of context are important for bridging the gap between the linguistic meaning of an utterance and the meaning that the communicator wishes to convey. Contextual, background and world knowledge are all important elements in the determination of utterance interpretation. Nida (1964:243-244) considers features such as time, place, author, audience, intent and recorded response as vital to message decoding because "words have meanings only in terms of the total cultural setting, and a discourse must be related to the wider sphere of human action or thought". If culture is important in all spheres of life, there must be cultural aspects in medical consultations as well.

3.2.1 CULTURAL DIFFERENCES IN THE MEDICAL CONSULTATION

Cultural differences in the medical consultation can affect the communication that occurs. Shuy (1983:189) suggests that "a great deal hinges on small, unperceived differences in the assumptions and communication between physician and patient". He identifies three areas of interference in successful medical communication:

1) The vocabulary used by the participants may be understood in different ways, or not understood at all.

2) There are cross-cultural differences which involve terminology, attitudes toward illness and social distance.

3) The structure of the discourse may be unfamiliar to the patient.

These factors may work singly or together to create a sense of confusion, fear and/or helplessness and may result in non-cooperation, non-compliance and/or withdrawal from the encounter, which in turn leads to more frustration and discouragement (Marshall 1988:201).

Suchman (1958:147) found that "the patient's cultural mode of expression affected how the doctor viewed him [or her] and how he [or she] was medically evaluated". Cultural differences, which may be difficult to perceive, may result in members of one culture viewing members of another culture negatively, because they behave differently and this may impact adversely on medical treatment (Katon & Kleinman 1980:285, Weaver & Sklar 1980:363). Crawford (1995:9) concludes that "where the world view of doctor and patient diverges widely, the chances of developing a genuinely therapeutic relationship that can facilitate healing, as distinct from controlling or curing a disease, are greatly reduced". Taylor (1970:199) and Marshall (1988:201) agree that communication can be diminished when participants have diverging cultural views about medical treatment and illness.

It could be argued that where interpreters and patients share a culture with patients, problems could be eased, but Katon & Kleinman (1980:269) found in their study that "few interpreters are trained in biomedical terminology, few may have systematic knowledge of their own culture's folk-medical concepts and terms, and some may be so acculturated or otherwise alienated from

indigenous concepts and norms that they fail to adequately interpret the native perspective". Consequently, they cannot act effectively as mediators between the cultures of the health professional and the patient.

Also, the reliance on context and cultural frameworks creates a tension within the interpreter. The interpreter is pressured by his/her own social conditioning while trying to assist in the negotiation of meaning between source and audience who operate within their own social contexts (Hatim & Mason 1990:1). For example, some interpreters interviewed for this study experienced tension between their own beliefs in traditional medicine (which corresponded with those of the patient) and their belief in Western medicine (which corresponded to that of the health professional).

One of the areas of cultural difference which may influence the entire medical encounter is the way in which illness is perceived by the participants. Wessels (in Kirkby 1988:279) emphasize that "all people understand illness and misfortune in terms of their specific cultural model. Explanations and treatment outside this model are unacceptable, confusing and ineffective". Sherer (1993:29) notes that:

> Cultural misunderstanding can get in the way of a patient's ability to follow a medical regimen because it is often more powerful and basic than anything Western doctors could dictate. Many cultures won't tell doctors that they don't agree with treatment, don't understand the diagnosis, or don't intend to follow the physician's advice.

Battle (1993:228) and Marshall (1988:214) believe that educators of health professionals should be aware of cultural differences which may affect the provision of health care services and

should teach skills which will enable students to provide effective medical care to people from different cultural and linguistic groups, because "the patient's perception of illness ... may be at odds with the doctor's perception which has been built largely from academic training and clinical experience" (Marshall 1988:201).

A second area of cultural difference is found in what is termed "illness behaviour", which Mechanic and Volkhart (in Suchman 1958:145) define as the "way in which symptoms are perceived, evaluated, and acted upon by a person who recognises some pain, discomfort, or other signs of organic malfunction". A doctor may, therefore, find that patients come to him/her with what they believe are serious illnesses, while he/she does not view them as such, or vice versa.

Cultural differences can, therefore, be seen to influence a variety of areas in the medical encounter. Culture has an impact on the way in which doctors and patients act and communicate during the consultation, the outcomes of the communication, the way in which illness is perceived and the illness behaviour that is deemed appropriate. In order to contextualise the data of this study, a brief section on Xhosa culture is necessary at this point.

3.2.2 XHOSA CULTURE[10]

There are a variety of traditional beliefs in Xhosa culture about illness, treatment, and the role of medical professionals which differ from those of Western culture. Jansen (1973:100), who worked amongst the rural Xhosa as a doctor, found that taking family histories was an impossible task, because the Xhosa do not know or recognise heredity as an important factor when determining the cause of a disease. Rather, disease is believed to be sent by someone who wishes the person ill. The primary questions, then, are: who sent the disease? and why did that person wish me ill? rather than the Western approach which attributes the cause of a disease to infection, age, lifestyle, etc.

Another fundamental difference is in the approach to a medical consultation. The Xhosa culture assumes that the healer has all the knowledge about the illness and must find the origin and reason for it. The patient assumes a passive role (Thiba, 1996). Mead (in Jansen 1973:74) states that "part of the definition of a good doctor or diagnostician is that he [or she] should know everything". Consequently, the Western doctor, who has to ask questions before he/she knows, is distrusted. Jansen (1973:74) explains that the doctor "presents himself [or herself] as the man [or woman] dependent on the response of his [or her] patients and cannot start his [or her] work properly without this interviewer-respondent relationship". On the other hand, the traditional healer arrives at a diagnosis without questions and may only ask for confirmation occasionally,

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[10] The beliefs mentioned here are fairly generalised. They may not be held by all members of Xhosa society and may be present to differing degrees in Xhosa people. For example, a Xhosa doctor may share some traditional beliefs with his/her patients and yet hold other beliefs which fit Western medical practice and contradict traditional beliefs, or urbanised Xhosa may have rejected some of the traditional beliefs and practices.

or receive unsolicited confirmation from the patient or relatives (Buhrmann 1977:464).

3.2.2.1 Taboo Areas

The Xhosa have very strict rules about taboo subjects. Areas such as menstruation, sexually transmitted diseases, AIDS, abortion and infertility may not be mentioned generally. Euphemisms are common when talking about sex and sex organs, the workings of the digestive and urinary systems, childbirth and death (Zotwana 1991:165). Some examples of these are:

1) isifo samakhwenkwe - venereal disease (lit the disease of boys),

2) ihashe elimhlophe - syphilis (lit the white horse),

3) ukuba nzima - to be pregnant (lit to be heavy).

These taboos are particularly strong when females are interacting with males or when young people are interacting with older people and this may cause problems when patients talk to doctors. Oblique references may be made by the patient to avoid the taboo term and this may increase the potential for misunderstanding, e.g using the word headache for problems relating to the penis and i-pain for menstrual cramps. Patients may find it offensive when doctors use direct terms and this creates a barrier to further communication. Taboo areas may also create difficulties for a Xhosa interpreter, who may be embarrassed about discussing them.

Other examples and ways of dealing with taboos and cultural differences are discussed in Section 6.4 where the data is presented. It can, however, be seen from this section that there are cultural differences between health professionals and patients in South Africa which may cause severe

problems during communication. Apart from power and cultural differences which occur during communication, there may be problems which are caused by the particular type of language used in medical communication termed medical discourse.

3.3 MEDICAL DISCOURSE

The language used in Western medical consultations has been studied and found to have a number of characteristics which distinguish it from other registers (West 1984:4-5). Medical discourse plays an important role in the structuring of the Western style medical consultation and can affect the messages sent in it. It is structured in particular ways for particular reasons and this structure may lead to a variety of problems.

3.3.1 THE STRUCTURE OF MEDICAL DISCOURSE

The basic structure of medical discourse is that of an interview with a question-answer format. West (1984:71) suggests that this is so because patients are the best and often sole sources of information about personal medical questions. Shuy (1983:194) prefers to describe the question-answer format in terms of two elements: topic introduction and topic response. The topic introduction sequence is rigid and topics are mainly introduced by the health professional (Shuy 1983:194, West 1984:82). Also,

> Physicians may change the topic with questions that, to the patient, seem out of context with the previous discussion, and that often interrupt patients with questions or comments... Patients, on the other hand, interrupt with word fragments that remain unrecognised by their doctors.
>
> Erzinger (1991:93)

Fairclough (1992:141) feels that "through the question-response-assessment cycles the doctor pursues a pre-set agenda, in accordance with which he controls the taking, content and length of patient turns, and the introduction and shift of topics".

So, the patient who is inexperienced in this type of discourse may feel alienated, angry or bewildered by a medical professional who interrupts, refuses to listen and only asks questions. The discourse is severely constrained in terms of what may be said and who may say it. So for example, the patient may respond to the topic introduced by the doctor in a number of alternative ways. Shuy (1983:194) found that the patient may:

1) Request clarification;

2) Interrupt;

3) Pause;

4) Express hesitation or uncertainty while presenting the response;

5) Agree; or

6) Respond directly.

The alternatives are limited, however, in that the patient may not:

1) Expand the topic;

2) Amend the topic;

3) Disagree with the topic; or

4) Ignore the topic.

Paget (1983:57) shows how the doctor directs the conversation by using questions, requests for action, abrupt shifts or breaks, and commands which allow him/her to introduce, develop and dissolve topics. The patient, in turn, helps to develop the topic by responding to questions and sometimes by suggesting and expressing his/her concerns, although these are often ignored by the doctor.

Generally, patient-initiated questions are "dispreferred", (West 1984:82), although West (1984:72) argues that patients should have equal opportunities to ask questions, to be answered and to be listened to, because the patient pays the health professional to obtain specialised knowledge that he/she does not have, and physicians risk misdiagnosis, mistreatment and charges of malpractice when mutual understanding is not achieved.

This type of discourse may thus be fairly alienating to the patient and it emphasizes the power differences between patient and health professional. For the Xhosa patient, this discourse pattern may be even more uncomfortable, because it differs from the traditional form where the doctor does not ask questions.

3.3.2 REASONS FOR THE STRUCTURE OF MEDICAL DISCOURSE

Two reasons for the structure of medical discourse are given in the literature. Firstly, Davis & Fallowfield (1991:15) attribute the structure of the medical discourse to the "expert model", where the doctor is the expert in the interaction and the patient is assumed to lack knowledge. Fairclough (1992:144) agrees with this thesis and submits that the patient lacks the medical

model which the medical professional has and therefore does not know what is relevant and what is wasting time and therefore, he/she consents to interruptions and conversational control by the medical professional. This model may lead to the neglect of the patient as a person, an underestimation of the importance of communication and a lack of respect for the patient which needs to be present if he/she is to enjoy long-term benefits (Davis & Fallowfield 1991:15).

West (1984:17), on the other hand, proposes that doctors tend to control the interaction because

> It is the physician, within Western cultures who is charged with the legal responsibility for restoring the patient to normality. 'The practitioner must have control over the interaction with the patient, ensuring that the patient will comply with the prescribed regimen. If patient compliance is not ensured, then the ability of the practitioner to return the patient to a normal functioning state is undermined.' (Wolinsky 1980:163) The essential asymmetry of the physician-patient relationship is ... the key to the therapeutic practice of medicine. (The patient) equates the practitioner's interactional control with the ability to treat them.

3.3.3 PROBLEMS WITH MEDICAL DISCOURSE

A variety of problems have been identified with medical discourse. These problems tend to disempower the patient and make the consultation an alienating and uncomfortable encounter where he/she may leave with more questions than answers. Firstly, there are unequal opportunities to speak and "information exchanged in medical encounters is not always organized as a two-way 'swap'" (West 1984:72). Korsch et al (in West 1984::72) found that questions "are often ignored, given ambiguous responses, or met with a change of topic by doctors". West (1984:61) found that often a patient's replies to questions are cut off and that the physician who does so is both violating the patient's right to speak and "systematically cutting off potentially valuable information on which he (or she) must himself (or herself) rely to achieve a diagnosis".

Sufficient explanation may also be lacking as Wallen et al (in West 1984:72) found that "less than one percent of total time spent in information exchange is devoted to physicians' explanations to patients".

Marshall (1988:213) identifies another problem in the lack of sufficient contextualisation of doctors' statements. Cicourel (in Marshall 1988:61) suggests that insufficient contextualization may be a result of differing cognitive strategies where the doctor uses a decision-making framework which makes sense medically, but which leaves the patient uncertain as to the relevance of a particular question. This lack of contextualisation may be exacerbated by a lack of education, little previous experience of the consultation context and differing cultural expectations of the medical consultation.

Medical jargon is another source of problems. West (1984:97) suggests that a failure to understand specialist words is a major reason for mishearing and misunderstanding in medical interviews, even between first language participants. Ley & Spelman (in West 1984:97) note that many diagnostic terms have little meaning to patients or are incorrectly understood by them. Again, poor education may exacerbate the problem.

Davis & Fallowfield (1991:7) list a number of other characteristics of medical consultations which may lead to potential misunderstanding when doctors communicate with patients:

1) They may fail to explain their own actions.

2) They may not elicit easily available information, especially major worries and expectations

and do not provide information about diagnosis, treatment, side effects, or prognosis.

3) They may accept imprecise information and do not seek clarification.

4) They may fail to check that their understanding of the situation matches that of the patient's and do not ask about the patient's feelings and perceptions of the illness.

5) They may fail to encourage questions or answer them appropriately and avoid information about the personal, family and social situation.

This is exacerbated in encounters involving a third party, owing to a lack of mutual lingua franca.

West (1984:98) concludes that "in real life situations doctors and patients have no way of assessing one another's reactions to the words that they use as they use them other than by observing the other's responses to them at the time". Consequently, patients and doctors may leave the consultation misunderstanding or not understanding what was said.

All of the problems mentioned above can cause miscommunication within the medical consultation which may be exacerbated by the loss of information which sometimes results from poor interpreting.

3.4 CONCLUSION

This chapter discussed power differences in medical consultations, the importance of culture differences in the interaction between the participants of the consultation and the structure of medical discourse. Each of these elements is an important factor in the process of message

formulation and decoding in the interpreted medical consultation and should be taken into account when formulating a model of the interpreted medical consultation.

The preceding chapters have looked at theoretical aspects of interpreting and some of the many elements which influence the communication taking place in an interpreted medical consultation. The next four chapters present the study which was done for this thesis and the conclusions which are reached. The next chapter is thus a discussion of the methodology used for the study and limitations which should be borne in mind.

CHAPTER 4

METHODOLOGY

4.0 INTRODUCTION

This chapter will detail and critically assess the methodology used to collect data for this research project and critically examine the limitations which may have resulted from the use of this methodology. Interviews and questionnaires were used to collect the views of medical professionals, nurse/interpreters and patients. The primary aims of the questions were to elicit views on and experiences of the interpreting which is taking place in the Eastern Cape and to find out what problems were encountered. This data could then be analysed and trends and patterns could be extracted. Finally, a picture could be created of the interpreting situation in the Eastern Cape.

4.1 METHODOLOGY

The research is qualitative in nature and seeks to gain an in-depth view of the medical consultation where interpreters are used. Daly, McDonald & Willis (1992:9) feel that the qualitative method is indispensable for the study of aspects of health care where social interactions between individuals or groups occur. A case study approach was used in order to look broadly and in depth at a few subjects rather than covering many subjects at a superficial level (Adams & Schaneveldt 1985:114). The criteria used for selecting participants was availability, because the commitment necessary could not be guaranteed from a random sample.

4.1.1 METHOD OF DATA COLLECTION

Data was collected in two ways. Firstly, semi-structured interviews were conducted with seventeen nurses, one social worker's interpreter (see Appendix B, pg 155), one social worker and three doctors (see Appendix A, pg 152). These interviews were tape-recorded and transcribed. Gorden (1980:11) believes that "interviewing is most valuable when we are interested in knowing people's beliefs, attitudes, values, knowledge or any other subjective orientations".

Secondly, structured questionnaires were given to three doctors (see Appendix C, pg 158) and ten patients (see Appendix D and E, pgs 160 and 161). Permission was obtained from the Superintendent of Settlers Hospital to interview staff and patients. Respondents were assured of anonymity and any identifying features have been removed from transcriptions. All interviewees were told that I was investigating the translation needs of medical professionals.

4.1.1.1 Interviews

> The objective is to describe social realities from the perspective of the subjects ... The definition of the situation of the people being studied includes their observable behaviour and also their subjective motives, feelings and emotions.
> Chadwick, Bahr & Albrecht (1984:207).

Semi-structured interviews were used to allow for flexibility during information gathering, as suggested by Gorden (1980:11) who states that "the exploratory value of the unstructured interview is impossible to attain in a questionnaire where there is no opportunity to formulate new questions or probe for clarification". Some questions became irrelevant in the light of previous replies and additional questions were used to clarify some answers during interviews.

In general, however, the full questionnaire was used.

Interviewees were interviewed in English, although English is a second language of all the interpreters interviewed. English is, however, the language used in medical communication in this part of the Eastern Cape and, although I have passed Xhosa 3, my knowledge of Xhosa is too limited to have used it in interviews successfully. The use of English did prove problematic at times when interviewees did not fully comprehend the question, especially where the questions asked were longer than a simple sentence (e.g. "Have you ever found that there are no Xhosa words for the English words the doctor uses?). It was sometimes necessary to repeat questions or simplify them when comprehension was not immediate. Care was taken, however, not to simplify in such a way that a specific answer seemed to be required. If the interviewee still did not understand the question after repetition, it was omitted. This happened twice with questions number 15.1 and 16.1. in Appendix B (pg 155) ("Have you ever found that there are no Xhosa words for the English words the doctor uses?" and "Have you ever found that there are no English words for the Xhosa words the patient uses?") and once for question 20.1 in Appendix B (pg 155) ("Have you ever found that there are cultural differences between the patient and the doctor which make communication more difficult?").

4.1.1.2 Questions for interviews and questionnaires

The questions were generally open-ended and where Yes/No answers were given, fuller answers were elicited by asking for explanations and examples relating to the questions. Fowler (1984:87) cites four advantages of using open-ended questions:

1) They permit the researcher to obtain answers that were unanticipated.
2) They also may describe more closely the real views of the respondent.
3) Respondents like the opportunity to answer some questions in their own words.
4) Open questions are appropriate when the list of possible answers is longer than it is feasible to present to respondents.

The questions in the interview for interpreters can be divided into five main themes:

1) There were general questions about procedures followed in a consultation where there is an interpreter, including questions relating to his/her role and the amount of time spent interpreting.

2) There were questions relating to choosing an interpreter, training received for interpreting and knowledge required for interpreting.

3) There were questions relating to interpreters' attitudes towards interpreting.

4) There were questions relating to practical, linguistic, cultural and emotional problems encountered during interpreting.

5) There were questions relating to how the interpreter actually interprets, for example, what is omitted and added and how metaphors are interpreted.

The questions in the interviews for health professionals who use interpreters in their consultations can be divided into six main themes:

1) There were questions relating to when an interpreter is used in a consultation.

2) There were questions relating to the perceived attributes and knowledge required of an interpreter in a medical interpreting situation.

3) There were questions relating to procedures followed when using an interpreter in a consultation.

4) There were questions relating to practical, linguistic and cultural problems encountered when using interpreters.

5) There were questions relating to the evaluation of the interpreting which occurs during consultations.

6) There were questions relating to what professionals would like to change about their current interpreting situation.

The questionnaire for medical professionals retained from the interview questionnaire what I considered the most pertinent questions and the questions which were most conducive to full written answers which were used in the interview questionnaire. The questions were open-ended and covered areas such as who is used as interpreters, characteristics and knowledge required by good interpreters, practical, linguistic and cultural problems encountered when using interpreters, perceptions of accuracy of interpreting and current interpreting needs.

The aim of the questionnaire for patients was to enable the researcher to form a general impression of the quality and accuracy of the interpreting which occurred in the consultations they had had with medical professionals. The questions can be divided into four main themes.

1) There were questions relating to the patient's knowledge of what was wrong with him/her.

2) There were questions relating to the patient's comprehension of interpreted messages and English messages.

3) There were questions relating to perceptions of interpreter accuracy.

4) There were questions relating to the patient's degree of comfortableness with the presence

of a third person at the consultation.

All the patients were satisfied with the interpreting in their consultations and as the answers to this questionnaire were not particularly interesting, they will not be discussed further.

Interviewers were instructed not to ask about the nature of the illness of the patient, because it was felt that this would be an invasion of privacy and could alienate the interviewee. Responses to questions were written down in Xhosa and later translated into English.

Another questionnaire, which aimed to assess the availability and knowledge of terminology for medical conditions, was distributed to four Xhosa-speaking students at Rhodes University. This questionnaire consisted of twenty-two English terms for medical conditions which respondents had to translate into Xhosa. As respondents came from different parts of the country, a range of terms was supplied. The results are presented fully in Appendix F (pg 162) and selected examples are discussed in Section 6.2.

The range of questions was inspired primarily by reports of research carried out in similar settings and on similar topics (especially Crawford 1994a) and from problems with using interpreters which have been identified in other literature, e.g West (1984), Wood (1993), Shackman (1992).

4.1.1.3 Interviewees and Questionnaire Respondents[11]

As mentioned in Section 4.1.1, eighteen interpreters were interviewed. Of the seventeen nurses interviewed, six were retired nurses, four were Nursing Sisters and seven were professional nurses or nursing assistants. These nurses all worked or have worked at Settlers Hospital or Settlers Day Hospital in Grahamstown. One interpreter for a social worker who works for a national agency was interviewed.

The interviewees were recruited in three ways: firstly, from a list of retired nurses used as interpreters in a practical component of the Pharmacy 4 students' course at Rhodes University; secondly, by approaching the Sister in charge of the Day Hospital nurses; and thirdly, by placing a notice on the nurses' notice board at Settlers Hospital calling for volunteers. Interviewees were all remunerated for their services.

Of the four medical professionals interviewed, two are full-time staff members of Settlers Hospital and one doctor has a surgery in Grahamstown and does part-time work for Settlers Hospital. The social worker works for a national agency. These professionals were recruited by approaching them personally and requesting an interview.

Structured questionnaires, which required written answers, were used to elicit views from three doctors who were unavailable for interviews. The doctors all have private practices and work in hospitals on a part-time basis. Two of the doctors work in Grahamstown and one works in

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[11] A description of individual respondents is presented in Appendix G (pg 164). [11]

Somerset East in the Eastern Cape.

A structured questionnaire was used to interview ten patients about their experiences of having interpreted consultations with doctors. The patients were approached for interviews when they were leaving the grounds of the hospital. Taylor (1970) obtained more reliable data from discharged patients than from current patients, because patients are unwilling to jeopardise their care while still in hospital.

Patients were interviewed by one of two trained fieldworkers whose first language was Xhosa (one male and one female) who used a structured questionnaire with questions in Xhosa. The questionnaires were translated independently by two Xhosa speakers and then a negotiated translation was used.

4.1.1.4 Interview Setting

Nine of the interpreters were interviewed either in their own homes outside of working hours and nine at their places of work during lunch hours, tea breaks or before working hours. Interviews lasted between twenty-five and fifty-five minutes. No other people were present at the interviews.

The medical professionals were interviewed at their places of work and interviews lasted between forty minutes and two hours (three 40 minute sessions). These interviews occurred during working hours (three) and during a lunch hour (one). No other people were present at

three of the interviews, while there were interruptions from other medical staff in the course of the other interview which took place over three days during three 40 minute sessions.

4.2 LIMITATIONS

There are a number of limitations which should by borne in mind when reading this research. Most of the limitations are a result of the methodology and method of data collection employed in this research. The limitations discussed here are:

4.2.1) Lack of triangulation;

4.2.2) Generalisability;

4.2.3) Respondent honesty;

4.2.4) Strategies used to cope with language barriers;

4.2.5) Distance from the problem;

4.2.6) Time constraints;

4.2.7) Difficulty of self-reflection; and,

4.2.8) Interviewer behaviour.

4.2.1 LACK OF TRIANGULATION

It proved impossible to find medical professionals who would allow interpreted consultations to be tape-recorded or observed. They felt that it could be an invasion of the patients' privacy, it could break doctor-patient confidentiality and that patients might not understand (or could later claim that they had not understood) if their permission were sought for tape-recording or observation of their medical consultations. Legal proceedings could then be instituted against

them and me if the patient could prove this. It was also felt that if the presence of a tape recorder were misconstrued or misunderstood in the wider community, it could lead to them being known as medical professionals who did not respect confidentiality and that they could lose the trust of their patients and possibly lose future patients.

This limitation is an important one, because it has made it impossible to verify the information given by the respondents. However, the fact that several interpreters and professionals were interviewed has mitigated this limitation to some extent, because several members of the different parties have independently related similar information during their interviews. Also, most of the data supports findings from other studies mentioned in the literature review. In addition, observation or tape-recording of actual behaviour may have reduced the spontaneity of the informants and affected their behaviour.

4.2.2 GENERALISABILITY

The interviews give insight into the practices and problems of a small group of people, and although the findings are not generalisable, the same kind of issues are probably coming up in hospitals throughout the Eastern Cape if other studies are taken into account e.g. Sobahle & Sobahle (1996). If the results of several case studies such as this one are combined, it could produce a useful source of information for hospital authorities, health professionals and interpreters.

4.2.3 RESPONDENT HONESTY

I am not sure that respondents were always completely honest and they did not always give complete responses when they answered questions. Many may have felt that there was a correct answer and sought to supply this. Others may not have wished to pursue certain lines of questioning and said that they could not answer or could not supply examples. This could not, however, be verified without alienating the respondent, but this limitation is listed by Gorden (1988:119) and Bradburn & Sudman (1979:14-15). Alternative strategies must be used in situations where questioning could be considered a threatening act (e.g. asking about somebody's ability in a language and enquiring about problems which have occurred is a threatening act).

Bradburn & Sudman (1979:14-15) found that the use of open-ended questions was most appropriate for threatening questions and that longer questions (over thirty words) decreased response effects for threatening questions. The use of these two devices when structuring the questions could have lessened the ego threat in the interviews. Gorden (1980:119) lists ego threat as an inhibiting factor during interviews and some of the questions may have been perceived as threatening by the interviewees.

4.2.4 STRATEGIES USED TO COPE WITH LANGUAGE BARRIERS

The level of proficiency in English varied greatly across interviewees. At times, respondents struggled to articulate what they wanted to say and sometimes did not complete what they wanted to say because they could not express themselves. Several respondents said that they could not find the right English word with which to express themselves. Occasionally, they

would use a Xhosa word to express what they felt because they did not know or could not retrieve the English word, but this did not prove to be too problematic, because I could usually understand what was said.

I found that I sometimes had to repeat or simplify questions so that respondents could understand them. Occasionally, it proved impossible to attain comprehensibility without implying that a particular answer was required and I moved on to the next question. I tried to speak slowly and clearly because my accent and speech patterns would be unfamiliar to the interviewee.

4.2.5 DISTANCE FROM THE PROBLEM

I found that the retired nurses who were interviewed tended to be more positive about their experiences as interpreters. Those who were interpreting for the Pharmacy students did not feel that their current roles as interpreters were particularly demanding or difficult. Their negative experiences while interpreting for doctors may have been dimmed by time. This reason is impossible to verify, but Gorden (1980:119) proposes that forgetting is a common problem when subjects are being interviewed. Nurse/interpreters who currently interpret, did appear to give information based on daily problems and examples that they had encountered, so overall, the data should not have been too heavily influenced by the input from retired nurses.

4.2.6 TIME CONSTRAINTS

Gorden (1980:119) lists time pressures as one of the inhibitors of optimal performance during interviews. Those respondents who were interviewed at their workplaces were restricted in terms

of the time available to them. The pace of the interviews tended to be faster and comprehensive answers may not have been given. The atmosphere at the medical institutions tends to be pressured as there are long queues of patients and limited staff. For practical reasons, this often proved to be the only context in which to obtain an interview. Medical professionals who completed written questionnaires were also constrained in terms of available time and comprehensive answers may not always have been supplied, although all the questions were answered.

4.2.7 DIFFICULTY OF SELF-REFLECTION

Interpreting has become an integral part of the duties of medical personnel and an everyday occurrence in their lives. For this reason, very few have ever stopped to think about the situation. There is no special status accorded to interpreting and it is often felt that if one can speak more than one language, one is able to interpret. Consequently, many respondents found it difficult to reflect on their actions and name and exemplify problems. Respondents may have listed only the main problems which occurred and omitted what they perceived as lesser problems simply through over-familiarity. Again this claim is difficult to verify, although some respondents said that they were giving the main points and some said that they had not previously thought about the smaller details of interpreting.

4.2.8 INTERVIEWER BEHAVIOUR

Gorden (1980:119) states that etiquette transgressions and unconscious behaviour on the part of the interviewer may cause problems during interviews. It must be remembered that I was a

stranger to the medical environment and to the culture of many of the interviewees. I may have inadvertently offended, irritated and/or alienated some of the interviewees by my conversational or general behaviour, which may not have been acceptable in a different culture with different norms. Participants in all speech acts will assess the other participant and react accordingly and consequently, responses may be biased or skewed by these reactions. Again, it is impossible to verify when or if this happened and what the possible response biases were to these possible transgressions of etiquette.

4.3 CONCLUSION

In summary, then, the chief methods of data collection were interviewing and using questionnaires. These methods yielded much in-depth information about the use of medical interpreters in the Eastern Cape, but these methods do have a variety of limitations which should be borne in mind when reading this research.

A lack of triangulation and generalisability resulted form the methodology used. The use of interviews may have affected respondent honesty, made it necessary to use various strategies to overcome language barriers and made interviewer behaviour a possible problem. The interviewees may have been constrained in terms of giving full answers by distance from the problem, time constraints and the difficulty of self-reflection.

The next two chapters will present and discuss the data which was obtained from the interviews and questionnaires discussed in this chapter. This data has been analysed and grouped according

to the non-linguistic and linguistic factors which influence the interpreted medical consultation.

CHAPTER 5

NON-LINGUISTIC FACTORS INFLUENCING THE INTERPRETED MEDICAL CONSULTATION

5.0 INTRODUCTION

There are a number of non-linguistic and linguistic contextual factors which influence the messages transmitted in the interpreted medical consultation. This chapter will report on some of the non-linguistic factors which may influence the message, and linguistic factors will be discussed in Chapter 6. The chapter will look firstly at who is doing the interpreting and why these people were chosen. The level of training and the attitudes displayed by interpreters to their task will also be examined. Then, some of the problems experienced in interpreted medical consultations will be discussed and analyzed. Some of these problems include difficult clients, the emotional aspects of interpreting, dealing with social problems presented by patients and cultural factors influencing the medical consultation.

The choice of nurses as interpreters is usually determined by their availability in the physical vicinity, but there are other factors which are also considered if a choice is available. These include linguistic ability, confidentiality, knowledge of medical terminology, personality, experience, age and gender matching and interpersonal relations.

5.1 WHO ARE THE INTERPRETERS?

At Settlers Hospital and Settlers Day Hospital, the task of interpreting is carried out by one part-

time interpreter and, when she is unavailable, nursing staff in the wards interpret. In private practices in Grahamstown and Somerset East, it is carried out by receptionists or full-time interpreters. Usually, the junior staff such as nursing assistants interpret in routine consultations. One doctor admitted to using patients from the waiting room when a nurse/interpreter was not available, but this practice does not seem to be as wide-spread as reported in Crawford's (1994a) study. Some comments from the nurse/interpreters interviewed are:

> I was enrolled as a nursing assistant so there were times that there was a shortage here in Day Hospital we must come and interpret for doctors. (Nursing Assistant G)

> To be an interpreter that is usually part of the job that we do when we are nursing assistant. You interpret and when you finished interpreting after the doctor has seen all the patients, you just look after the patient. (Nurse E)

More senior staff are called in when problems arise or when more serious matters, such as operations, are under discussion:

> Where I'm working, everybody is an interpreter... we choose the higher rank to interpret especially in cases where there will be procedures like in operations that will be performed because we want to make sure that what is being said is what is being interpreted to the next person, because if there's any misinterpretation it means that one can agree for an operation that one is not willing to take, because the message was not given properly across. (Sister Q)

5.2 CHOOSING AN INTERPRETER

None of the interpreters who were interviewed were planning specifically to be interpreters when they took their jobs. They had trained as nursing staff or receptionist staff or progressed from being domestic staff. In their own words:

> I didn't choose to be ... the interpreter. I was looking for a job to be a secretary, passed my Standard 10 I go to a technical college to do secretary because unfortunately because

of no jobs I take this one. (Social Worker's interpreter)

At the hospitals, the senior nurse in charge assigns nurses to interpret for doctors who need interpreters and doctors do not have any say in the matter. As Doctor 3 said:

I didn't use any criteria [to select an interpreter]. You use whoever is there.

However, in many cases there are preferences as to whom interprets for a medical professional. These preferences are often based on a variety of criteria which will be discussed in the sections that follow. These include linguistic ability, confidentiality, knowledge of medical terminology, personality, experience, age and gender matching and interpersonal relations.

5.2.1 LINGUISTIC ABILITY

In many cases, the interpreters were coopted to interpret because they had a basic knowledge of English and spoke Xhosa as a mother-tongue.

> They choose you if you are fluent in English. Myself, I am fluent in English I think they chose me to interpret because I was a lady teacher so I know English and Xhosa. (Nurse C)

The level of ability in English varies quite significantly across the spectrum of interpreters. While interviewing the interpreters, I became aware of the need to use very simple language to minimise miscomprehension with some of them, while with others the level of competence was not as low.

Bilingualism is one of the main criteria used by medical professionals in employing their

interpreters in surgeries. All the doctors interviewed stressed the need for their interpreters to have good language skills in both English and Xhosa, with less emphasis on knowledge of Afrikaans.

Linguistic ability determines how much the interpreter understands and whether he/she is able to formulate a coherent message. The basic necessary linguistic skills therefore include skills of comprehension and production, as well as formulation of a message in both languages.

5.2.2 CONFIDENTIALITY

Shackman (1992:12) cites confidentiality as an important factor to be taken into account in medical interpreting and this was mentioned by three of the nurse/interpreters interviewed. Using nursing staff as interpreters is often preferable to using other interpreters (such as domestic staff and receptionists), because the principle of confidentiality is likely to be understood and respected to a greater degree. The patient is also more likely to feel that confidentiality will be maintained if medical staff are used as interpreters:

> I think the main reason [that I was chosen to interpret] is to sort of keep whatever information is there within. It must be the doctor, the patient and the nurse. (Nurse B)

5.2.3 KNOWLEDGE OF MEDICAL TERMINOLOGY

Medical knowledge in the interpreter is another factor influencing the interpreted medical consultation and one reason for the extensive use of nursing staff as interpreters is their knowledge of medical terminology. Both nursing staff and doctors pointed out that the requisite medical knowledge may not initially be found among all medical staff who interpret, but that

they acquire this knowledge over time. Four medical professionals said that only a basic medical knowledge was necessary to interpret directly from the professional to the patient, but that more knowledge was useful when diagnosis and explanations were necessary. These medical professionals seemed to place less emphasis on knowledge of medical terminology than authors in the literature, e.g. Diaz-Duque (1982:1380-1381) and Wood (1993:351), although Jansen (1973:123), who practised as a doctor, found that it was easier to paraphrase the concept than use the medical term, in the same way as the doctors interviewed said they did.

Doctor 2 said that if she could choose, she would rather have a nurse as interpreter than someone who only had training in language skills, because nurses tended to be able to diagnose more easily, they could ask pertinent questions on their own, they were trained to assess people and they were aware of other medical services available in the area and could advise accordingly. This suggests that medical professionals leave a lot to the discretion and initiative of the more competent interpreters, who do more than merely interpret, a role described by Shackman (1992:21), Wood (1993:348) and Knapp-Potthoff & Knapp (1987:182).

Sixteen interpreters felt that medical knowledge and knowledge of medical terminology were necessary in order to interpret correctly. There seems to be a high level of awareness that medical terminology is a negative aspect or barrier in the profession and that there is a need to change medical terms into lay terms for people who are outside of it:[12]

> You find that there are terms even if the patient do understand English but there are

[12] This issue is discussed further in Section 6.1.9.

> nursing terms that are not used by the layman, so you must be there so as to help to interpret for the doctor and for the patient. (Sister M)
>
> Some patients ... they can talk with the doctor, but they do not know the nurses' terms and the doctors' terms. They do not know many things that are known by the nurses. They will rather say it in a different way, but if she says it in Xhosa, you will know how to put it in your term, in a medical term to a doctor. (Nurse C)

The chief utility of interpreting for eight of the interpreters was that they increased their medical knowledge and knowledge of medical terminology, because medical professionals made a point of teaching them while they interpreted.

5.2.4 PERSONALITY

There are certain personality traits which emerged as being valued in an interpreter. These personality traits were identified by interpreters and medical professionals alike.

One nurse said that vigilance and insight into the situation were necessary. She claimed that doctors liked her to interpret because she picked up discrepancies and omissions and as Doctor 2 said:

> You also find patient interpreters who are very helpful, who say, "Doctor, you keep writing for such and such but now on asking the patient all the pills are at home and she hasn't taken them or she's taken the whole lot in one go." You know you get very helpful interpreters who pick up something that you hadn't actually expected anybody to pick up.

Patience is another personality trait deemed important by nurse/interpreters. This becomes particularly important when the patient is relatively uneducated or does not want to talk in front of the interpreter.

A friendly demeanour on the part of the interpreter tends to put the patient at ease and he/she is able to elicit more information:

> You also find that if they (interpreters) have a pleasant personality ... the patient is prepared to discuss at length not just yes or no, not to make a simple statement. (Doctor 2)

The level of dependence/independence exhibited by the interpreter can be a matter of conflict between the interpreter and the medical professional. Four medical professionals wanted their interpreters to act independently to some extent, although acting independently in choosing which message to interpret and reinterpretation of what the patient says is not acceptable. One doctor stated that the ability to elicit information depending on the reply to questions and the insight to ask pertinent questions of his/her own was desirable. Three medical professionals said, however, that the nurse/interpreters did not have the requisite knowledge to act independently while interpreting.

All but one of the nurse/interpreters said that they acted independently, adding to the messages sent and omitting some parts of the message. They stressed, however, the need for accuracy during interpreting:

> I'm interpreting the doctor the right thing not the false thing what the patient does not say. (Nurse L)

It would seem, then, that provided the basic message is transmitted, the nurse/interpreter values the ability to provide extra information and omit aspects that he/she perceives as

unimportant.[13] Shackman (1992:21) and Knapp-Potthof & Knapp (1987:182) view this independent communication in a positive light, provided the interpreter is adequately trained in language skills and subject knowledge, but Wood (1993:351) believes that it is a problem and feels that the interpreter should only interpret what the health professional has said.

5.2.5 EXPERIENCE

Experience is another variable factor in the interpreted medical consultation as an interpreter, especially an untrained interpreter, is not immediately able to produce adequate interpretations, but undergoes a learning process. As Toury (1995:250) puts it:

> Socio-culturally speaking, what emerging translators [or interpreters] thus undergo is a socialization as concerns translating [or interpreting]. During this process, parts of the normatively motivated feedback they receive are assimilated by them, modifying their basic competence, and gradually becoming part of it.

More experienced interpreters are usually favoured and interpreting skills are generally learned on the job as none of the interpreters interviewed had received any formal training. Doctor 5 commented that about ten years of experience was necessary to attain adequate levels of interpreting skills when the interpreter was not trained as a nurse. As Nurse L put it:

> So they like me because ... I always interpret of the specialist three or five years I was helping at specialist clinic where all the specialists are coming.
>
> I'm a nurse but ever since I've an experience I've got 17 years experience and I find that I interpret. (Nurse O)

The main problem with inexperienced interpreters was that they did not interpret most of what

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[13] The reasons given for independent communication are discussed extensively in Section 6.1.

the patient said:

> Sometimes [you lose touch with the patient]. With experienced interpreters you don't but with inexperienced interpreters, there is quite often a long discussion between the two and in the end the interpreter says to you, "The patient says yes." Now, for what has the patient said yes? Your original question? Any of those things? That's lack of training for the interpreter and you find that with nurses who are still in training themselves, 3 or 6 months in the system, they haven't yet learnt. (Doctor 2)

Nurses/interpreters found that spending a lot of time interpreting for a particular medical professional made the interpreting task easier.

> If you get to know the doctor you get used to the doctor I don't think it's difficult [to interpret]. (Nursing Assistant G)

5.2.6. AGE AND GENDER MATCHING

Bal (1981:368) felt that

> the interpreter should be able to gain the respect and trust of the patient. A patient may not answer all your questions truthfully if he/she is embarrassed by the interpreter, does not trust the interpreter ... The sex, age and status of the interpreter is important.

In this study, one medical professional felt that he had not encountered problems with having an interpreter whose age and gender did not match that of the patient.

> I found the interpreter is quite conversant with old and young. (Doctor 3)

The primary reason for this is that the interpreter tends to be perceived as a medical person.

> I found that the patient usually looks at, even if it's a receptionist, they look at them as a medical person. (Doctor 3)

The three medical professionals who would prefer to match age and gender found that gender tends to be the more important aspect to match.

> It is fairly important [to match gender]. There are certain conditions which men have which they are not happy talking about in front of women, although if it's a nurse or a Sister then they will talk but they will conceal themselves when they're being examined as much as possible if they can. But, conversely, quite a lot of the women, especially the traditional ones, are very reluctant to open up and to talk in front of a male interpreter even if they are dressed in white which nursing assistants wore. So, yes, there is a problem - I prefer to have a female interpreter for that reason. (Doctor 4)

The five nurse/interpreters who felt that age and gender should be matched had encountered problems, particularly when dealing with older males when they were female. They tended to feel uncomfortable but tried not to show their discomfort.[14]

Age and gender differences between the participants may thus be a factor which influences the communication.

5.2.7 INTERPERSONAL RELATIONS

Although all the factors discussed above contribute to it, successful interpreting often hinges on a good interpersonal relationship between medical professional and interpreter:

> Nurses are trained to ... sum patients up, so that they are very useful if they like the person or at least they not like but they're not on bad terms with the person they're translating for. Then you get a lot of extra information besides what the patient is interpreting for you. If they don't like you or they fear you because you're known to be bad-tempered or something, then you only get the literal translation, nothing thrown in. (Doctor 2)

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[14] Dealing with taboo areas, where problems may be enhanced by non-matched age and gender, is discussed in Section 6.4.

Working regularly with one interpreter allows the medical professional and the interpreter to discuss the best way to work together, although this has to be done carefully at times:

> Where I'm working regularly with somebody then we can get a rapport going and very often I will find if I say, "Does the wee-wee burn?" I will hear there will be a complete thing and the answer will come back with everything concerning the urinary system and the genital system the whole lot. They've asked the lot because they know my way. (Doctor 4)

> In the beginning when she wouldn't translate everything or she wouldn't translate emotions I would speak to her. (Social Worker)

In summary, seven factors which influence the choice of an interpreter have been discussed here. The overriding factor tends to be availability, but the other factors are considered when a choice of interpreters is possible. Table 3 (over the page) summarises these factors and lists which respondents mentioned them.

TABLE 3

FACTORS INFLUENCING THE CHOICE OF INTERPRETERS

FACTOR	MENTIONED BY
Language Ability	Nursing staff: C, M, N, K, P, H Medical professionals: 1, 4, 5, 6, 7
Confidentiality	Nursing staff: B, G, C Medical professional: 1
Knowledge of medical terminology	Nursing staff: D, I, M, J, N, K, Q, H Medical professionals: 2, 4, 5, 6, 7
Personality	Nursing staff: L, J, N, R Medical professionals: 1, 2, 5, 7
Experience	Nursing staff: L, O, G Medical professionals: 2, 4
Age and gender matching	Nursing staff: Q, B, G, H, L Medical professionals: 1, 2, 3, 4
Interpersonal relations	Medical professionals: 1, 2, 4

Training, which is discussed in the next section, is not included in the factors influencing the choice of interpreters because so few interpreters have any training.

5.3 TRAINING

The findings of this study with regard to training are similar to those of Crawford (1994a:19), in that none of the interpreters interviewed had received any formal training for interpreting and most of what they had learnt had been acquired on the job through experience or watching other interpreters.

> ... we learn a lot while we were working ... (Nurse L)
> You get [training] from general experience, general knowledge and experience. (Sister M)

> We don't have training for interpreting except that it's something that I'm doing each and every day. (Sister N)
>
> The Sisters and the doctors used to teach us how to interpret the things from the patient to the doctor. (Nurse R)

These findings also support Buthelezi (1996) who interviewed nurse/interpreters in Natal who "were in agreement that what they practise had been learned over years of exposure, [and] as novices, they [had] fumbled without direction". Training may influence the message which is transmitted, e.g. by setting patterns of what can be omitted and how certain elements are interpreted.

As mentioned before, the nurse/interpreters had been trained for nursing or receptionist duties. Six nurses felt that one could not be trained to interpret. It was felt that interpreting ability is a natural result of knowing two languages and it was a universal skill which could not be taught. The eleven who do acknowledge that interpreting skills can be taught are uncertain as to what those skills are. Asking interpreters whether interpreter training might be useful, was met with hostility from two interpreters and perplexity by three interpreters. Most nurse/interpreters seemed to believe that they were performing adequately and that the extra time and effort needed to train for interpreting was not worthwhile or in their interests. Interpreting is often regarded as an auxiliary function, and three felt that more time should be devoted to improving nursing skills if training was to be offered at all.

Two interpreters felt that they would like training, especially in English skills and general

communication. Three, however, would also like more medical knowledge.

> I think I would really need to know about the diagnosis like if the doctor say "this is asthma" then I know I know how to tell this patient what she has got the asthma is tightness of the chest and all that. (Nursing Assistant G)

Table 4 summarises the views of all the interpreters interviewed with regard to training.

TABLE 4

TRAINING

VIEW	MENTIONED BY
Can be trained	A, G, E, I, F, L, M, J, R, Q, K
Cannot be trained	B, D, C, O, N, P
Want training	A, E
Prefer medical training	G, K, R

Table 5 highlights the attitude of five interpreters to training. They did not see the point of training as they assumed that they could interpret because it was viewed as a natural communicative task if one was bilingual.

TABLE 5

REACTION TO QUESTION ABOUT USEFULNESS OF TRAINING

REACTION	MENTIONED BY
Hostile	C, N
Perplexed	B, D, O

The next section looks at attitudes toward interpreting.

5.4 ATTITUDES

> It shouldn't be part of the nurse's work, it seem as if now we are being misused or abused - you don't have to be a professional nurse in order to interpret. (Sister Q)

Unlike the 115 nurses interviewed in Crawford's (1994a) study, who supported Sister Q's view that interpreting should not be part of their jobs, interpreters interviewed in this study were divided about how they feel about interpreting. Table 6 displays the interpreters' attitudes to their task.

TABLE 6

ATTITUDES TO INTERPRETING

ATTITUDE	MENTIONED BY
Enjoy it	**B, D, G, I, L, O, J, K, R**
Neutral	**E, C, M, H**
Waste of time	**F, N, Q, P**

Those who enjoyed it found that it made their task more interesting and easier, it increased their medical knowledge and it helped to prevent communication breakdown:

> As nurses, before the doctor sees the patient, you do all the basic things: you take the temperature; you test the urine; you take the blood pressure; and you write some history. So that when you refer this patient to the doctor, you find that it takes a shorter time because you have already sort of interviewed the patient. (Nurse B)

> Sometimes when Doctor examine the patient and see there is a thing that he can tell me so that I can learn, he explain to me so that I can learn more. I am proud to interpret because I learn a lot. (Nurse L)

> You see the different treatment he's giving the patients... when the next patient come ... I can advise him that I saw this condition before, a patient like this and she was helped by something... you can advise him ...that I saw this patient before and the doctor

treated him like this. (Nursing Assistant I)

I think interpreting is a good thing because now you'll find that if the patient can be only with the doctor and then you find that there is a communication breakdown, the patient may end up wrong diagnosis, not treated a right problem. (Sister Q)

Twelve interpreters found interpreting easy and six felt that it was a very difficult task.

It's not a hard job but it's boring because you'd rather be doing your work than sitting there interpreting. (Sister P)

It's not hard physically but psychologically it's a very hard job. It's really hard because you need to have all the skills and the knowledge and everything because you know you are working with two to three people - there's the person you're interpreting for, there's the person you're interpreting to and sometimes there's an escort or someone. (Sister Q)

The views of interpreters about the degree of difficulty of interpreting are tabulated here:

TABLE 7

EASE/DIFFICULTY OF INTERPRETING

VIEW	MENTIONED BY
Easy	B, D, G, E, I, C, L, M, O, R, P, H
Difficult	A, F, J, N, K, Q

Nurse/interpreters who thought that interpreting was an appropriate task for nurses, felt that their knowledge of medical terminology was invaluable. Those who were opposed to interpreting felt that non-nurses might not feel the emotional strain of interpreting because they were not people who became as involved with their patients. Time factors become important in institutions which are already short-staffed:

It's a waste of time for us as nurses because after interpreting you still have to carry out

> the orders that the doctors have written down. You still have to help the patient in other ways and when you interpret you're wasting time but you've got to because the other things cannot be done before the patient is seen by the doctor. (Sister P)

It was generally the more senior nurses who viewed interpreting as an inappropriate task for nurses, while more junior staff viewed it as an opportunity to gain greater medical knowledge and have closer relations with doctors.

The greatest utility derived from interpreting in the opinion of the nurses, seems to be that it increases their medical knowledge and therefore aids them in their nursing duties. Auxiliary benefits are that the patients are equipped with knowledge about their illness and communication is facilitated.

Interpreting may also be, in some ways, a means of elevating the status of the nurse, as noted by Drennan et al (1991:375). They have the medical knowledge, while the patient does not and this knowledge can be used to increase the nurse's power in a situation where they may be relatively powerless, as discussed by Bloom (1965:161), Wessen (1958:328) and Crawford (1995:10). This would perhaps explain why more senior staff tend to be more negative about interpreting than junior staff. They have more knowledge and are already in a more powerful position, by virtue of their seniority, and do not need to enhance their position.

Interpreting was never acknowledged or labelled by medical professionals as a very difficult or complex task. This possibly leads to a situation where the task is not particularly valued in itself

and, consequently, those who perform it do not receive any recognition for it. I suggest that this taken-for-granted attitude may be resented by the nurse/interpreters who deal with interpreting problems continually. Although nurse/interpreters in this study did not state this explicitly, Crawford (1996) supports this view in her findings:

> There is no recognition by hospital authorities that interpreting is an essential professional skill which necessarily involves negotiating between two different linguistic and conceptual systems. This involves considerably more complex skills than competence in more than one language but this is not well understood by medical practitioners.

So, it can be seen that attitudes to the task may influence the message transmitted - a negative attitude may impact negatively on the quality of message sent. On the whole, interpreters interviewed for this study were positive about the interpreting task. They generally enjoyed it, although some complained about difficult clients, who will be discussed in the next section.

5.5 DIFFICULT CLIENTS

Problems that occur during interpreting are often blamed on what interpreters termed "difficult" or "impossible" patients. There are a number of descriptions of these patients.

Firstly, there are patients who come to the consultation wanting something, whether it be a solution to a social problem or a medical problem e.g. particular medication, more sick leave or a cure for an incurable disease. If the nurse/interpreter does not make these requests adequately in the eyes of the patient, he/she may become angry. If the nurse makes the request and the medical professional refuses, the nurse/interpreter also bears the brunt of the emotional outburst which may follow. Crawford (1995:2) also reports this as a major problem in her study.

Secondly, there are those patients who become irritable after standing in long queues all day, being sent from place to place and who then receive only minimal attention from the medical professional. These patients may be uncooperative or rude to the nurse/interpreter. These patients appear to be 'victims' of the structure of the Western medical consultation which accords them little part in the proceedings, (see Section 3.3).

Patients may be uncooperative because the nurse/interpreter asks too many questions in their view and they believe that he/she is merely being inquisitive. Nurse/interpreters then have to convince the patient that the medical professional and the interpreter are a team who are there to help and that the information is necessary for successful diagnosis. This problem probably relates to the cultural differences between the use of questions in the medical encounter, as described by Jansen (1973:74), which were discussed in Section 3.2.2.

Patients who do not trust the interpretation given by the nurse/interpreter are also perceived to be "difficult" patients:

> Sometimes you know you get when you are interpreting this particular person doesn't think that you are saying to the doctor the real thing that he wants you to tell the doctor. And will tell you mxelele Say it say it the way... Sometimes then it's difficult to say to the doctor the way he is explaining it to you. You try the easy way but the same thing that the doctor must understand what the problem is. (Nursing Assistant G)

The interpretation may be distrusted for a number of reasons:

1) It may seem to be too short in the light of the long story given by the patient.

2) The patient may know that what he/she said could be controversial and therefore changed by

the nurse/interpreter.

3) The patient may know some English and not hear the expected words in the interpretation.

4) The patient may be familiar with English, but does not want to risk speaking for him/herself because of the unfamiliar medical context. S/he then does not hear an adequate interpretation. Nurse/interpreters tend to be offended by patients who do not tell them that they can speak good English, because there is a danger of great loss of face if the nurse/interpreter interprets incorrectly or inadequately:

> Those that are teachers and some of the nurses are the old ones when they have been nursing before they keep quiet they wait for you they want to know what you are saying that you are saying the right thing well anyhow all of a sudden in between interpreting you know nothing is a teacher or what and then all of a sudden she bursts out in a good English and she looks at you down and up then you feel so small. (Nursing Assistant J)

Some patients believe that they can speak good enough English to speak directly to the doctor and this is also noted by Wood (1993:351) who mentions that interpreters are often not used when the patient has some knowledge of the doctor's language. However, the nurse/interpreters in this study who judged the patients' English too poor to speak for themselves expressed irritation with these patients who insisted on speaking for themselves. They believed that often these patients wasted the medical professionals' time because there was a lot of misunderstanding and confusion caused by their poor command of the language. They then had to intervene to remedy the situation:

> Some do not want to be interpreted for claiming that they know English and yet they will end up quarrelling with the doctor because you leave that patient... now they will end up quarrelling with the doctor because the doctor will demand an interpreter because even though the pronunciation, she is not used to the doctor, the nurse is used to the doctor, maybe the doctor is from abroad, she doesn't interpret as we do here in South Africa so she won't understand. (Nurse C)

> It's difficult to interpret for a person that thinks that she knows the language and then she doesn't. He thinks that he has heard what the doctor has said and then you are misinterpreting and yet what he or she has heard is not what was being said. (Sister Q)

Nurse/interpreters also believed that these patients sometimes had an ulterior motive for requesting to speak directly to the medical professional. Usually, a request to speak for oneself was accompanied by a request for the nurse/interpreter to leave the consultation. Sometimes the patients would then harass or threaten the medical professional and ask for money or employment. Doctor 4 mentioned that sometimes, the patient would have lied about what was wrong with him/her and only get to the true reason for the visit when he/she was alone with the medical professional, which would seem to indicate a level of distrust of the interpreter.

The other case where nurse/interpreters are excluded from interpreting for patients is when the patient speaks Afrikaans. Many medical professionals are able to speak Afrikaans, while the nurse/interpreters do not know the language. The nurse/interpreter is then excluded from the interaction and may resent this. The situation is even worse when neither the medical professional nor the nurse/interpreter speaks Afrikaans or another language like Swahili or Shangaan. Patients speaking these languages were often labelled "impossible" by the interpreters.

The nurse/interpreters are in a fairly powerful position when they are interpreting, as they act as facilitators and gatekeepers. When they are excluded from this role, and even worse, when they cannot participate at all in the conversation, they may become resentful. Because the medical professional occupies the more powerful position and because the nurse/interpreter has

to continue working with him/her, it is not wise to become angry with or show anger in the presence of the medical professional for excluding the nurse/interpreter. The perception is that it is of little use complaining about the workload or institutional inadequacies, because the response is usually non-existent or weak. The patient is then perceived as the one causing the problems and is labelled "difficult" or "impossible".

Patients who do not comply with treatment or advice given to them are regarded as "difficult". Nurse/interpreters became angry with those who either forgot to comply with their instructions, could not comply or refused to comply with treatment:

> Others they don't want to listen... (Nurse L)
>
> Sometimes they frightened, but you try your very best to show them an operation is nothing, the doctors will you know, they are good doctors. They think they will die. (Nursing Assistant J)

According to Bloom (1965:16), patients are often regarded by hospital personnel as a "reference group whom they serve and toward whom they orient many of their actions and attitudes". The patient's role in the hospital ranges from being an inactive participant, in the case of acute medical and surgical illness, to being a vital part of the social system in the case of patients with chronic illness. The structure of medical discourse (discussed in Section 3.3) gives the patient a passive role in the discourse. The medical professional initiates and changes topics, while the patient answers questions which relate to knowledge to which the patient has little or no access. The medical professional is the knowledgeable one and the patient is expected to accept this authority (West 1984:17, Fairclough 1992:14 and Davis & Fallowfield 1991:15).

These so-called "difficult" or "impossible" patients seem to be the ones who do not behave according to the accepted norms of the passive patient in the Western medical milieu. They are the ones who ask for things that fall outside the sphere of the medical context, those who are rude and uncooperative, those who do not give relevant and complete information, those who question the interpreting that occurs or reject it, those who speak languages which fall outside the competence of the interpreter and those who do not comply with or refuse medical treatment.

The ideal patient would appear to be one who has a genuine medical problem, who volunteers enough (and not too much) information, who trusts the authority and superior knowledge of the interpreter and doctor and who accepts the interpreting that occurs. These patients play the appropriate patient role in the Western medical context.

On the other side, certain medical professionals may also be difficult to interpret for. Some tend to get irritated at any hitches in interpreting. Some may speak too quickly, say too much at one time or expect too high a level of interpreting ability from the interpreter:

> You know he gets very irritable and he asks another question by the time you trying to explain because you cannot be a good interpreter if you don't understand what the doctor has said. (Sister Q)

Foreign medical professionals may also be difficult to interpret for.

> There are those from overseas their language you can't hear, the Zambian, Nigerians quite a job interpreting for him. I couldn't hear him at all. The Indian doctors and Americans are difficult. They talk so fast, you have to tell him to be slow. (Nurse F)

Only two nurse/interpreters mentioned "difficult" medical professionals, which may indicate either that they do not find it difficult to interpret for them or that it is not advisable to get angry with "difficult" medical professionals, because of their elevated status. So, "difficult" clients may fall into the patient or the medical professional category and they generally hinder the smooth progress of the consultation. At another level, the interpreter must sometimes deal with emotional aspects attached to the interpreting task.

5.6 EMOTIONAL ASPECTS

As mentioned by Crawford (1994a:2), interpreters complained that the emotional aspects of interpreting were a problem. Patients may become angry if they do not receive the care that they want or expect and those who receive bad news about their health may become aggressive or emotionally upset and this may be targeted at the one who is delivering the news, i.e. the nurse/interpreter. These emotional outbursts may influence the messages sent.

A sick person is often not at his/her best in terms of politeness, tolerance and patience, especially one who has had to wait all day for treatment (and sometimes has had to come for several days). The nurse/interpreter may then have to bear the brunt of emotional outbursts from the patient.

It becomes even more difficult when the patient has a life-threatening or chronic illness. Informing a patient that he/she has cancer, HIV or a sexually transmitted disease is an unpleasant task that can involve taboo areas, misunderstanding and emotional responses on the

part of the patient.

> It's difficult to deal with a sick patient. It's difficult to tell him that he will never be healed. You are pressing on his emotions to deal with medical side and emotional side. If you give them bad news, they get angry and have emotional stress and take it out on you. (Nurse F)

> Most of the time they become angry with me because when I'm interpreting they don't take it as the other person who is telling them, they direct it to me. (Sister P)

Nurse/interpreters also found that if the patient does not like what the doctor has said, they blame the nurse/interpreter and they lose faith in him/her:

> If the patient is not happy about what the doctor says it has an effect now on the trust that the patient has got on the nurse. She or he forgets the fact that it's not you who says this, it's the doctor and in any case what she or he says is really the truth... Then you discover that the relationship is affected because you told her the bad news now from the doctor's side and even in town if you are so used to each other you discover that she doesn't greet that much. (Sister Q)

Interpreters for social workers also seem to be vulnerable to emotional outbursts from clients. These clients are often at the mercy of government bureaucracies who decide, for example, not to award disability grants or pensions, or to remove children from a family. In an impoverished area where pensions, disability grants and children may be the sole source of income for a family, the interpreter bears the brunt of the anger and hopelessness expressed by the client when these sources of income are not granted or are removed. Also, many clients seem to have a hazy view of the function of social workers and often demand houses and employment from them. They may also resent the interference of the social worker in their lives. The social workers may be trained to deal with these cases, but their interpreters are usually not.

A nurse is often, by nature, a caring empathetic person who makes the easing of suffering her career.

Nurses are chosen, you feel what the patient feels. (Nurse C)

These people may over-empathize with the patient and allow the problem to influence their own lives too much. This places an intolerable burden on this staff who learn the history of the patient, their social circumstances and their prognosis, which they then have to relay in the consultation room. Nurses who act as interpreters may be exposed to the stories of the patient to a greater degree than they would in the normal role as nurse, where they might not hear the full story or prognosis given by the doctor and would not play an important role in revealing the prognosis to the patient.

The task of calming down the patient who has received bad news and possibly persuading the patient to accept and consent to treatment may also fall to the interpreter. Medical professionals sometimes tell the nurse/interpreter to tell the patient that he/she needs certain treatment or a particular operation and they leave it to him/her to deal with any objections, fears and questions. This cannot be an ideal situation, especially where the nurse/interpreter has limited knowledge of the side-effects, medical consequences and procedures used in operations. A patient may end up agreeing to an operation without being fully aware of the possible dangers and problems. The patient may also have less faith in the nurse/interpreter and may be aware that his/her training may be inadequate.

Interviews revealed that nurse/interpreters counteract emotional responses in two ways to

minimise the threat to themselves. Firstly, they may react by transferring the cause of the anger onto the illness itself. As Nursing Assistant G said:

> Sometimes, you know what I always think - it's the sickness, sometimes you know. For instance, TB patients gets aggressive for a little things but at the same time now I understand them when they are like that.

Secondly, they often try to prevent or minimise emotional responses by counselling the patient before telling him/her about the results of tests or diagnoses:

> Before you tell her the bad news you start counselling the patient with the doctor when you see that there is something that is bad you're going to tell her. You start with counselling you must counsel the patient before you tell her about the bad news. (Nurse C)

> The patient should be counselled before you break the bad news. In fact even then when you are doing the tests like for instance HIV, the patient before she signs a consent for the blood to be taken and to be tested, you must counsel the patient that when their results come they might be positive but being positive that's not the end of the world and so you prepare the ground for the bad news. (Sister Q)

Counselling tends to take the form of first calming the patient, explaining the illness, telling the patient that there are many others who have suffered and been cured of the particular disease, giving hope or telling the patient to accept the prognosis. They often resort to religion and state that the illness is God's will and that patients should bear it. Whenever possible, they refer the patient to someone else who has the same diagnosis.

> It's more effective if you refer a patient with a problem to another person who has been through the same door. They feel better when they talk about it amongst each other. It gives them more support when they hear it from somebody who's not a master professional. (Sister Q)

Sister Q felt that they did not have the necessary counselling or communication skills to impart

bad news, as did her counterparts in Cape Town (Crawford 1994a:17). When they fail to allay anxiety, they often resort to asking medical professionals for calming medication.

The emotional burden of interpreting is a heavy one for those who are not well-trained in counselling and communication skills. Often, the task of breaking bad news is left solely to the nurse/interpreter by the health professional who may just say, "Tell So-and-so that he/she has X". Within the time constraints of the medical consultation, the interpreter must deal with emotional outbursts and questions. Often, they deal with these as quickly as possible and send the patient to talk to someone else who has the same disease or illness. This may lead to a vicious circle, where each patient is armed with a little information and inadequate advice and misinformation and distortion may occur when it is passed on.

Nurses are often fairly compassionate people, and some of them talk about a 'calling' to be a nurse. They tend to become emotionally involved with their patients when they have to counsel them and this can increase their own stress levels. If they were equipped to deal with emotional situations by training or skills development, they might not have to suffer as much as they do at present.

In a poverty-stricken area, there are many social problems from which patients may seek relief at a medical institution and the ways in which interpreters deal with this is discussed in the next section.

5.7 SOCIAL ASPECTS

Nurse/interpreters tend to focus solely on medical problems and are not willing to interpret aspects of social problems and emotional issues, as Drennan et al (1991) and Wood (1993:351) reported in their studies. This may cause enormous problems for social workers who use these nurse/interpreters, because they cannot obtain information that is vital to their function.

> Even now I was working in Children's Ward so now this lady social worker used to call me to interpret about it's problems - now it's not to a doctor, it's social problems. It used to be a bit difficult because the social worker used to make peace where there is no peace. (Nursing Assistant G)

Some doctors, too, find that they would like some information about their patient's emotional and social states and this information is not often interpreted for them. As Doctor 5 said:

> The patient - some nurses say the patients (Xhosa) do not have the same emotions as, say, myself, as a White doctor i.e if I ask, "How do you feel about your husband's attitude to you and the family?" I have been told, "That doesn't worry her" - without an in-depth exploration of the problem.

This aspect may therefore influence the message transmitted.

5.8 CULTURAL ASPECTS[15]

> The less interlocutors know about each other, the more likely they are to misunderstand each other on a linguistic, social, or cultural level. Since misunderstandings are particularly pronounced between native and nonnative speakers of a language: they may have radically different customs, modes of interacting, notions of appropriateness and, of course, linguistic systems.
>
> Varonis & Gass (1985:327)

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[15] Theoretical views on the influence of culture on interactions were discussed extensively in Section 3.2.

The cultures of the health professional and the patient differ from each other and this is a potential source of noise in the communication process. Some cultural beliefs concerning medical care amongst the Xhosa were discussed in Section 3.2.2 and specific cases encountered in the Eastern Cape area are described here.

Crawford (1995:9), Erzinger (1991:91) and Shuy (1983:189) discuss the importance of culture on the pattern of interaction, behaviour and results of the medical consultation. They conclude that culture plays a vitally important, though often implicit role in the intercultural medical consultation. Unless linguistic and behaviour patterns are overtly different from the other culture and expressed by the members of the culture, they may hamper communication without the participants realising that they are miscommunicating or not understanding the source of miscommunication.

Firstly, medical professionals and patients may have different expectations of their consultations:

> Our people they believe that when they're coming to social workers they're going to get what they want although the social worker is here to advise the client what she must do so that she can be healthy and survive other things. (Social Worker's Interpreter)

Secondly, problems caused by belief in traditional healers abound. Medical professionals usually place little faith in the care given by traditional healers and there is an either/or approach to the choice between traditional medicine and Western medicine. Six nurse/interpreters seem to be torn between an understanding of the beliefs of the patient and their faith in Western medicine. Where disease is spiritual or emotional, the traditional forms seem to be preferred, but physical

severe embarrassment and lack of cooperation.

Fourthly, circumcision is another cause of conflict between patients and medical professionals as cited by Sister N and Nurses R and K. Some medical professionals see the practice of adult circumcision that is performed at circumcision schools as a big problem. They are presented with patients who have medical problems as a result of the procedure and do not understand that it is compulsory if the patient is to be viewed as a man in his culture. Nurse N said that for female doctors, the consultation resulting from a poorly performed circumcision or infection resulting from circumcision can be even more problematic. Traditionally, the procedures and rituals performed at circumcision schools are kept a secret from those who do not attend them, especially from females. Female medical staff may not be able to obtain relevant information from these patients.

Other practices may seem to be rituals without medical value to the medical professional:

> I remember one day a mother brought her little baby and I knew what it was then the doctor didn't understand. Her hair was whipped into a funny thing it's almost like when you see it like those fat ticks it was in the end of the hair. The child's fontanelle was depressed. I said well you see they believe that thing is a sort of a sticky medicine to prevent the sickness of children. They think there is something a sort of a snake going around that will go into that child's hair, fontanelle, so then that prevents it. (Nursing Assistant J)

The causes of diseases may be linked to traditional beliefs of causation and as a result, remedies which are unlikely to heal physical diseases may be employed:

> If your leg is painful, they think your leg is painful and doesn't get better then somebody else say, [you] just walk through indlela (a road) a snake was going like that and then

> you went across it. You jumped across the line then you've got all that evil thing on that leg you see which is untrue. That person could be having perhaps a slide of polio something like that. (Nursing Assistant J)

> I can make an example of my brother. He's got a persistent cough so I know in our custom he must slaughter a goat and he must hang that band [around his neck] and [drink] Xhosa beer and after that he comes right. (Nurse O)

"Dirty blood" and poison are two oft-cited reasons for illnesses. Poison is sometimes used to indicate infection, and according to traditional Xhosa beliefs, only the traditional healer can remove poison, which indicates a belief in a non-biomedical cause (Sobahle & Sobahle, 1996). The medical professional who then tries to give alternative, biomedical causes is disbelieved and practices which could remove these symptoms are not carried out.

Conflicting beliefs also prevail and cause problems:

> If the doctor tells the patient that when she's got diarrhoea she mustn't use traditional medicine the patients don't usually agree to that because they know that traditional medicine in fact you must cleanse yourself so you must make yourself have more diarrhoea when you've got diarrhoea, so your cultures sometimes they clash. (Sister P)

When a patient comes complaining that he/she has been bewitched, there are problems, as the non-Xhosa medical professional is unfamiliar with the concept of bewitching and its accompanying behaviour.

> [A patient may say,] "No, I've got amafufûnyana," and then it means he has been bewitched there are things that are eating her from inside and things like that so it's difficult to explain that to a person who did not grow up in that environment because now if it's a Xhosa-speaking doctor even if she knows there's nothing like ifufunyana but he knows exactly what we are talking about how is the behaviour of the person and so on when we are talking in those terms. (Sister Q)

Medical professionals seem to be aware of many of the cultural differences between themselves and their patients, although they do not always accept or tolerate them and some may find them irritating. They have become aware of the differences through experience and intervention by their interpreters. Some try and accommodate their patients where possible in terms of showing respect and not looking directly at the patient,[16] although sometimes they find it impossible to follow cultural norms. For example, Doctor 4 mentioned that rural people often see the medical consultation as a big occasion where certain etiquette and greetings are employed. Doctor 4 and Sister Q felt that insufficient time was available for the medical professionals to take part in these rituals and the patient often ends up feeling pressured and frustrated.

Cultural differences between patients and doctors cause many problems. In some cases, medical doctors refuse to treat those who wish to explore traditional methods of healing and for others, the beliefs of their patients result in non-compliance with their orders, which in turn may lead to more severe illness (although I am not suggesting that Western medicine is infallible). Four doctors felt that they were fairly sensitive to differences, but leave interpreters to bridge the gap, while two were sometimes mystified and frustrated. They find it difficult to cope with differing views of disease causation and methods of treatment, some of which are contrary to Western medical beliefs.

As indicated by the roles assumed by the interpreters (see Section 2.1.2.4), the nurse/interpreters

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16 "A Xhosa speaking person tends to avoid looking one in the eye when speaking, as a sign of respect" (Kaschula, 1994:9).

who are in the middle have to try and come to some kind of compromise. They may be uncertain as to what is the more appropriate way to deal with cultural differences. Particularly, in terms of traditional versus Western medical care, the nurse/interpreters may be torn between their own cultural beliefs and their belief in the system for which they work. In the end, the nurse/interpreters either try to convince the patient of the efficacy of the Western medical treatment or they change what the doctor has said into something that is acceptable to the patient. In taking this latter course of action, they may be changing the doctor's message to some degree. Culture thus appears to be a factor which influences the message sent.

5.9 CONCLUSION

It should be clear from this discussion that the non-linguistic factors discussed in this chapter influence the interpreted medical consultation to some degree.

The choice of interpreter can determine the success or failure of the consultation and influence the quality of care provided. An experienced, pleasant and efficient interpreter can elicit appropriate information and put the patient at ease. Unfortunately, a lack of training can take up to ten years of experience to remedy if the interpreter also lacks medical training. Nurse/interpreters do not have sufficient counselling skills to deal with the emotional aspects of interpreting and this can place undue stress on the interpreter and affect the quality of interpreting. The patient may also suffer because of inadequate counselling.

A patient who does not behave according to the acceptable patient role makes the consultation

difficult and may jeopardise his/her care if the interpreter is antagonised. Also, social aspects of the patient's life, which may impinge on his/her disease and the ability to comply or get better, are rarely discussed and tend to be treated as non-issues by the nurse/interpreter. On the other hand, cultural differences between the patient and the medical professional are perceived as important because they may cause frustration and irritation on both sides and are likely to affect the communication negatively. The nurse/interpreter acts as mediator between the two parties.

The patient who perceives him/herself to be at the mercy of an ill-equipped interpreter, the patient who is treated in an insensitive manner, and whose cultural, emotional and social needs are not taken into account may decide to delay seeking medical care and end up with more serious illnesses.

This chapter has dealt with the non-linguistic factors which influence the interpreted medical consultation, but there are also a variety of linguistic factors which will have an effeet on the communication which are discussed in the following chapter. Together, Chapters 5 and 6 attempt to display the complexity of the nature of the communication taking place in the interpreted medical consultation.

CHAPTER 6

LINGUISTIC FACTORS INFLUENCING THE INTERPRETED MEDICAL CONSULTATION

6.0 INTRODUCTION

This chapter will look at some of the linguistic factors which influence the communication that occurs in interpreted medical consultations. The interpreting taking place in these situations differs from that taking place in conference interpreting, because independent communication by the interpreter, which is not usually acceptable in the conference interpreting situation, is the norm to a large extent in these medical consultations, as proposed by Shackman (1992:21), Knapp-Potthoff & Knapp (1987:182) and Wood (1993:348) in their discussions of the role of the interpreter (see Section 2.1.2.4). This chapter will examine why this independent communication occurs. Also to be discussed, are issues surrounding vocabulary, strategies for interpreting metaphors, as well as taboo areas. Language adaptation by medical professionals and techniques for managing miscomprehension will also be covered in the chapter.

As discussed in Chapter 2, interpreting requires the interpreter to work with two languages at once. These two languages do not always have equivalent structures and vocabulary, and compromises in terms of strict adherence to the actual words of the message in one language are sometimes necessary in order to transmit a coherent and efficient message. The interpreters interviewed felt that they were sometimes hampered by a lack of vocabulary, either because they did not know the item or because no equivalents existed in Xhosa or English. A second difficulty was in formulating coherent interpretations from messages which were sometimes incoherent.

In the words of Sister Q:

> You understand the thing but you cannot correlate between the information that she's trying to give you. You know what she says but cannot interpret it to the next person or try and see how the information fits into each other.

For this and other reasons, nurse/interpreters often resort to independent communication.

6.1 INDEPENDENT COMMUNICATION

Participants in the interpreted medical consultations were aware that, at times, they were not receiving exactly the message that was sent by the other participants. Messages were summarised, parts were omitted, other information was added and changes were made to the message. Crawford (1994a) also found that this kind of linguistic behaviour was occurring. Wood (1993:351) viewed these condensations, omissions, additions and substitutions as errors, and felt that interpreters were inclined to take control of the consultation. Shackman (1992:21), however, has a more positive view of this behaviour - provided that interpreters are trained. Nurse/interpreters in this study gave a variety of reasons for this behaviour, which I have termed 'independent communication.'

Some of the reasons given could fit better in Chapter 5 which dealt with non-linguistic factors influencing the interpreted medical consultation, but as these factors were given as reasons for independent communication (a linguistic matter), they will be discussed here.

6.1.1 ROLE

For the first clue to this behaviour, consideration of the role of the nurse/interpreter seems to

be important.[17] As indicated by the term nurse/interpreter, the interpreter usually takes the role of both nurse and interpreter and he/she has to perform both nursing duties and interpreting duties. These duties and roles are fairly complex and are viewed in different lights by the nurses themselves. For fifteen nurse/interpreters, the role of interpreter did not merely consist of being an interpreter of words of one language into words of another language. They acted independently and took on a variety of other roles and functions, e.g. advisor, encourager, teacher, cultural broker, facilitator, supervisor and advocate (cf Wood, 1993:348, Shackman, 1992:21 and Knapp-Potthoff & Knapp, 1987:182). Brisau, Godjins & Meuleman (1994:90) believe that these views of self are important determinants of performance:

> The interpreter's ideas about what he [or she] thinks he [or she] is, what he [or she] would like to be and what he [or she] thinks other people believe him [or her] to be, and any discrepancies between these three concepts which have evolved during his [or her] developmental process, will have a bearing upon his [or her] performance.

For seven nurse/interpreters, the nursing role took precedence, and they did not see the interpreter role as particularly important. For these interviewees, the nursing role encompassed physical nursing, advising the patient about what the doctor has said and encouraging the patient to follow directions given by the doctor. The communication thus tends to be interpretation and expansion of what the doctor has said.

Five nurse/interpreters viewed their role as an equal mix of nursing and interpreting. Communication consisted of preparing the patient emotionally for examination through

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[17] Refer to Section 2.1.2.4 for eight proposed models of the role of the medical interpreter.

reassurance and exhortation to talk about symptoms, interpreting what the doctor and the patient said and explaining more where necessary.

For two nurse/interpreters, the role they play in the interpreted consultation tends to be mainly an explanatory one and they communicate without prior input from the doctor or with only minimal input e.g. "Tell the patient that he/she has X". The nurse/interpreter explains the procedure to the patient without the doctor giving more than the diagnosis. This is a more independent role than that of the conference interpreter and the nurse/interpreter has to rely on his/her medical knowledge and experience of other similar cases. This is similar to Wood's (1993:348) role of "interpreter as interviewer", and supported by Buthelezi (1996) who felt that "while [interpreting] is a process that occurs as linguistic helping, it is secondary to the more central process of 'explaining'".

Two nurse/interpreters saw themselves as having a liaising role between patient and doctor. The nurse/interpreter was aware that there could be problems caused by cultural differences (cf. Wood's, 1993:348 role of interpreter as cultural broker), and different levels of knowledge between the patient and the doctor and stepped in to overcome these when necessary. The role required independent communication when problems arose.

Nurse F described her role as a "watchful eye and supervisor". She tried to facilitate communication whenever possible, but would not interpret certain things that she believed could cause problems. She presented the patient to the doctor and felt that she was in charge of the

patient, who should follow her directions.

An even more radical view is mentioned by Wood (1993:345) and is expressed by Sister Q:

> You take the role of an advocate, patient's advocacy is what is happening in that consultation room, because now you act on behalf of the patient. In most cases, you tell the patient what the doctor says and then you tell the doctor what the patient says. On the other hand, you try to sort of to protect your patient here and there where possible in any case.

Table 8 summarises the views of individual interpreters on their roles:

TABLE 8

ROLES ASSUMED BY THE INTERPRETERS

ROLE	MENTIONED BY
Nurse is most important	B, G, I, C, O, P, H
Equal Nursing and Interpreting	A, D, E, L, K
Explainer	J, R
Liaisor	M, N
Supervisor	F
Advocate	Q

The role of the interpreter should be included in a model of the interpreted medical consultation as it has been shown to vary and influence the communication. Apart from the way in which nurse/interpreters view their role, there are a number of possible other reasons for communicating independently, which will be discussed at this point.

6.1.2 KNOWLEDGE OF ANSWER OR PROCEDURE

Nurse/interpreters may come across a particular question or problem on numerous occasions and

instead of interpreting it to the medical professional, they may choose to answer or advise directly, because they know the answer or have become familiar with how the medical professional deals with it:

> Sometimes I just answer the question because it's simple and I know my job. (Social Worker's Interpreter)

> You can advise that I saw this patient before and the doctor treated him like this. (Nursing Assistant I)

> You know what the doctor wants to say and you know how to get to the patient and the doctor I think also knows that you can explain better. Even sometimes if the patient is going for operation the doctor will just say, "This patient is going for hysterectomy," then you've got to explain the procedure to the patient and so you know more than what the doctor says more than what the doctor tells you. (Sister P)

Five medical professionals said that they knew that this was happening, and although it was not an ideal situation, they allowed it, especially when time was a problem. Doctors 5 and 6 welcomed this behaviour and said that they wished that interpreters in their surgeries had this ability and sufficient knowledge to perform in this way. Wood (1993:351) feels, however, that certain types of problems may be normalised if the interpreter does not understand the disease process which he/she explains.

6.1.3 ISSUES BEYOND THE SCOPE OF THE SERVICE

The nurse/interpreter may know that what the patient requests is beyond the scope of the service they can provide and may then omit this part of the message.

> There are things really I leave out some things that I know we are not going to do nothing good. (Social Worker's Interpreter)

This seems to be particularly prevalent in medical situations where the patient requests assistance with social problems, as predicted by Davis & Fallowfield (1991:7). Only Nursing Assistant I allowed social problems to be discussed with the doctors. Others said that doctors could do nothing about social problems and it was not necessary to interpret these parts of the message.

6.1.4 THE NEED TO SIMPLIFY THE MESSAGE FOR THE PATIENT OR THE MEDICAL PROFESSIONAL

The message sent by the patient or the medical professional may be judged by the interpreter to be too difficult or too incoherent to convey directly to the other participant and it is summarised or otherwise changed:

> I summarise, because sometimes it's not easy to say to the patient the exact thing that the doctor says. You've got to make it simple. (Nursing Assistant G)

Simplifications may lead to distortion of the message which can then have negative consequences for the quality of patient care.

6.1.5 SOFTENING AND COUNSELLING

The message sent by the medical professional may be bad news to the patient. The interpreter may feel that he/she needs to soften the impact of the message by rephrasing it and saying it in a way which will cause the least discomfort to the patient. In the words of Nursing Assistant G:

> You've got to make it [the message] .... that he or she can accept. Because if the doctor says, "You are going to die," I can't say to him or her, "You are going to die." I must think first and say it in a polite way.

6.1.6 TIME FACTORS

Although time factors are a reason for many of the other reasons given for independent communication, it can be a factor in it's own right. Sherer (1993:29) found that "language differences can cause treatment to take 25-50 percent longer than treatment for English-speaking patients", and Faust & Drickey (1986:137) found too that time constraints hamper adequate interpreting.

The patient load of medical professionals in Grahamstown is enormous and there is great pressure in terms of time. For this reason, interpreters tend to summarise and interpret only what they believe to be important.[18] As two nurse/interpreters put it:

> We just take the main points. (Nurse O)
>
> I summarise because if I take all those complaints will take us a whole day. (Sister N)

A possible consequence of the lack of full interpretation may be that patients return several times, because the consultation was rushed and all the information was not given or something important was left out. Sister Q said that sometimes patients forgot to tell them all the important things because they felt rushed.

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[18] These findings are supported by Crawford (1994a:17).

6.1.7 PATIENT HAS A LONG STORY

> Discourse behaviour within English culture requires one to be succinct and to the point, whereas the Xhosa tradition with its strong oral ... history prefers behaviour which proceeds at a steady, measured, dignified pace. It would be rude to be precise and to the point.
>
> Kaschula (1994:10)

It is quite common for Xhosa patients to give a life history or an account of illnesses that have occurred over a long period of time when they are asked about their symptoms (Thiba, 1996) and interpreters sometimes have to ask patients to tell them which symptom actually brought them to the doctor on that particular day. At other times, nurse/interpreters decide which symptoms are important to relay to the medical professional:

> Sometimes the patient will tell you a lot of things at the same time but you pick up important points which will lead to something. (Nurse C)
>
> You do summarise because with our language there are long stories you can't go into details. (Nurse R)
>
> [You leave out] those that you think are not relevant. (Nurse F)

The danger, expressed by Doctor 3 and Shackman (1992:21), lies in the fact that the nurse/interpreter may not know what is relevant and what can safely be omitted.

6.1.8 CHANGING FROM LAY INTO MEDICAL TERMS[19]

The nurse/interpreter may rely on medical knowledge and previous experience of a condition to change a lay description into a medical diagnosis. As Sister M put it:

> You just put things in .... one word for instance if they say "I've got a headache radiating down the neck to the pain to the lower back," you just call it it's general body ache.

Although this practice may save time, misdiagnosis can be a problem, as suggested by Wood (1993:351). Doctor 2 described this kind of interpreter as "overhelpful".

Changing from the patient's lay description into medical terminology may be unnecessary, because most doctors encounter lay terminology daily when they speak to patients who can speak English to them. Most patients will describe their symptoms in lay terms for which the doctor will know the medical term. I suggest that nurse/interpreters who do this may be asserting their medical knowledge and showing solidarity with the medical professional. Their knowledge is displayed by their use of the language of the profession. Using the language of the group also signals that one belongs and the ability to diagnose in this way may increase one's perceived power in the consultation. Drennan et al (1991:375) note that interpreting may be a means of elevating the status of the nurse/interpreter.

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[19]See Section 6.3 on metaphor for further examples of this.

6.1.9 CHANGING FROM MEDICAL INTO LAY TERMS

Medical professionals may use medical terms which could be unfamiliar to their patients and nurse/interpreters then have to change these into lay terms or explanations which are more likely to be understood by their patients:

> There are cases that the doctor you know do abbreviations so you make it describe it more fluent and easy to the patient. (Nurse O)
>
> [The doctor] just named the diagnosis now you have to try and put it in a way so that she can understand it. (Sister M)

Shackman (1992:21) describes this as a positive characteristic in the trained interpreter.

6.1.10 EXPLAINING MEDICAL CONDITIONS OR TREATMENT

Medical professionals do not always explain conditions extensively to patients (West 1984:72 and Davis & Fallowfield, 1991:7,15). All but one of the medical professionals interviewed (the social worker) admitted that they did not explain enough to their patients. There are four possible reasons for lack of explanation:

1) Two medical professionals said the there is not always enough time to explain.

2) Four medical professionals perceived it to be futile to explain to patients because of their lack of education and medical knowledge.

3) In practice, many medical professionals seem to have faith in the nurse/interpreter's ability to explain adequately, as evidenced by the common situation where the nurse/interpreter is told to tell the patient that he/she has X.

4) The distance between the medical professional and patient which may be caused by a lack of

direct contact may lead to reduced sensitivity to the needs of the patient for comprehensive explanations.

The task of explaining may be left to the nurse/interpreter or taken on on his/her own accord:

> [After the doctor has finished] now you must as interpreter you must take the folder and explain to the patient that the doctor says this and this and that and that. (Sister N)

> What the doctor is going to tell you is that OK I'm taking this patient to theatre for a Caesarian section OK because the baby is not breathing normally inside and then you have to explain to the patient what is a Caesarian section. (Sister Q)

In summary, the factors which encourage independent communication are:

1) The role of the nurse/interpreter;

2) Knowledge of the answer or procedure;

3) Issues beyond the scope of the service;

4) The need to simplify the message for the patient or the medical professional;

5) Softening and counselling;

6) Time factors;

7) Patient has a long story;

8) Changing from lay into medical terms;

9) Changing from medical into lay terms;

10) Explaining medical conditions or treatment.

Finally, in this section, interviewee opinions on independent communication are discussed.

6.1.11 INTERVIEWEE OPINIONS ON INDEPENDENT COMMUNICATION

Independent communication seems to be particularly prevalent between the nurse/interpreter and the patient. This may be due to the patient's lack of knowledge and the need for extensive explanation which the medical professional may not provide. Interpretation to the medical professional, however, was sometimes more exact and literal, because nurse/interpreters realised that the doctor needed to be able to make a diagnosis based on what the patient had said. Four medical professionals said that they insisted that the nurse/interpreters told them exactly what was said and did not want them to act too independently when they relayed information from the patient. Doctor 3 felt that:

> The nurses do not have the experience or the knowledge or the expertise to decide which is relevant and which is not relevant. That is why I always insist on the receptionist or the nurse to tell me everything that the patient says and I will decide and try to not to put that in her words but to say exactly the way the patient says.

Not all doctors felt this way, though. In answer to a question about what he/she thought were characteristics of a good interpreter, Doctor 5 answered:

> The ability to elicit information depending on the reply to her questions (i.e. the insight to ask pertinent questions of her/his own). Be able to act independently to a certain extent (i.e. explanation of disease processes and instructions with do's and don'ts).

Fifteen nurse/interpreters realised that they do not and often cannot interpret everything that is said and that this is not always acceptable to the medical professionals. Twelve nurse/interpreters were aware that excessive summaries frustrated and irritated them.

Apart from frustration on the part of the sender and receiver, independent communication cannot

always be the ideal way of interpreting, because it may promote miscommunication, misinterpreting and subsequent misdiagnosis and mistreatment. Some nurse/interpreters realise that summarising information can cause problems:

> Sometimes you discover that there is a communication breakdown ... I mean if someone is telling you something and then you tell it to the next person it doesn't go straight somewhere along the line when you are trying to summarise there is something that you put in or leave out when you are trying to interpret for the next person. (Sister Q)

Medical professionals are aware that what they say is not interpreted completely and accurately at times. They try and compensate for this by simplifying their speech, saying things which are more likely to be interpreted (e.g. avoiding taboo areas and medical terminology) and trying to listen to the interpretation if they have a rudimentary knowledge of Xhosa. Five medical professionals felt that important parts of the message are sometimes lost during interpreting and all felt that the interpreted medical consultation is not an ideal situation:

> When I'm giving advice then I know for a fact that what I'm saying is being re-interpreted and put across quite often erroneously. If I pick it up then I correct but very often I don't but it's only subsequently on a return visit you'll find, "But you told me to do this." "No, I didn't, I told you to do this." "The nurse said to me or the interpreter said to me I must do this." (Doctor 4)

> Sometimes ... a patient gives a long story and the interpreter summarises that and sometimes misses certain parts and this is where you have to listen very carefully to what the patient says. (Doctor 3)

> Emotions, feelings mostly are not translated in most cases. It just as I see this closeness that you feel, this one on one just isn't happening. You just feel you miss a lot of what's happening because the client's saying so much but you are getting a shortened version basically of what's being said. (Social Worker)

Doctor 2 commented, however, that over time one gained confidence in one's interpreter:

> You only feel confident [that your interpreter is giving an accurate version of your message] after you get to know a particular interpreter. That comes with time.

The next section deals with problems in the area of vocabulary and terminology.

6.2 VOCABULARY/TERMINOLOGY

Vocabulary and medical terminology may cause problems for interpreters, as predicted by West (1984:97). Jansen (1973:125) felt that

> the paraphrase of the Western diagnosis into Xhosa idiom can best employ the current terms for disorders. Additionally have to be invented words to expand the existing vocabulary, sofar as these are appropriate to convey our concepts. The process of acculturation stimulates the extension of the Xhosa vocabulary which is supplemented with new words from European languages.

Interviewees cited examples from English and Xhosa which have proved problematic for them. The most common way of overcoming problems with vocabulary is to use explanations rather than single words. Seven nurse/interpreters characterised Xhosa as being a language which used several words where single ones were available in English. If one looks at Xhosa dictionaries, one finds that many of the vocabulary items which have been developed for Xhosa are multiple-word explanations, rather than single-word items. Interpreters also found that explanations proved more useful when they were dealing with a fairly uneducated patient.

> Most of the words in English it is a long interpretation because we call things in big words whereas you've got only little wording. (Nursing Assistant G)

> [When there are no Xhosa words for an English word] we have to break it down in a sentence bit by bit so that the patient can understand. (Nursing Assistant J)

Specific examples of idiophones, English and Xhosa words which have proved problematic are discussed in the following three sub-sections.

6.2.1 IDIOPHONES[20]

The use of idiophones is problematic because often there are no English equivalents for them. English does not have this class of words, which tend to be culture-specific in most cases:

> Maybe she want to say I've got the pain between the shoulders and then she says this, "Kubuhlungu phakathi kwamagxa," and then maybe she's doing something maybe she's lifting something very heavy and then she want to say there's a pain between shoulders she says, "Ukumbethi ngqumrho phakathi kwamagxa." So that pain now is a sound so you must explain to the doctor that there's a sound feeling when she's lifting something. (Nurse K)

> Sometimes they are using the words xhaxhe [goes to] the pain is coming xhaxhe I say, "Ah, Doctor, I don't know what can I use to translate to put the English word so that I can explain clear to you this Xhosa name." I don't know how to translate in English so I am using I am pointing where the patient want to know because I don't know what a pain from her up her xhaxhe down the spinal cord and up here in between the shoulders. (Nurse L)

6.2.2 ENGLISH WORDS

There are English words, most of which appear to be medical terms, which nurse/interpreters cannot translate easily into Xhosa. This may be because they do not know the Xhosa translation or because there is no Xhosa equivalent. They may also not know the word, e.g. Nurse O described an occasion where the doctor used the word phlegm, which she heard and understood

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[20] "Idiophones are words that function adverbially because they give more description of an action or a quality of a noun/pronoun that has been expressed by means of an adjective or relative. They may be imitative of sound; they may describe the manner or they may be used to depict the highest degree of the state in which the noun/pronoun is" (Zotwana 1991:181).

as flame. She had to clarify the meaning before she understood and could interpret correctly.

A number of strategies are employed to overcome a lack of Xhosa equivalent.

Firstly, a lay term or explanation may be employed to overcome this problem:

> For instance, with burning maturation[21] at least it's burning urine. Maturation is medical term but you know maturation is to pass urine you just put it in a similar words. Sometimes when you're interpreting you find that it's difficult to interpret a word now to the Xhosa. But you try to put it in something similar that the patient can be able to understand. (Sister M)
>
> Maybe the doctor says this is congestive then maybe it's difficult for me to explain it to her in Xhosa. (Nursing Assistant G)
>
> We haven't got a Xhosa word for sterilisation but you must explain to the patient what is sterilisation as you know it in English. The doctor is going to make a small operation on your abdomen just to tie the tubes of the uterus and so on. (Sister Q)
>
> For instance, a pelvic discharge, we've got no Xhosa word for that. (Sister P)

Secondly, the English word may be commonly used by patients and no interpretation is necessary. The word, cancer,is commonly used in it's English form, although the Xhosa equivalent, umhlaza, is generally known to patients in this area.

Thirdly, as suggested by Ley & Spelman (in West 1984:97), the patient may not understand the concept involved in the word and an explanation or simplified explanation of the concept may aid comprehension. Some examples of this are:

> Doctor will say, "You've got PID," which is pelvic infection. So I've got to tell him that doctor has found that you've got an infection ... we just call it intsholongwane [literally

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[21] The word is actually micturition, but this Sister does not use it correctly.

> germs]. It's the easiest language that he can understand if they don't know what this infection is. (Sister N)

> Even now there is no word for infection. When I talk to the patient, well I know what infection is... so I tell him or her, well infection is a thing perhaps you get it perhaps you walk into a thorn or a thorn is broken into you and that place is red and painful and hurt. I said all of a sudden you look there's pus in that so that's the thing we call it ukuvunda which means infection. If you have to explain maybe call it that name ukuvunda that's all. (Nursing Assistant J)

Ukuvunda literally means to "cause to ferment, become mouldy, rot" (Pahl 1989:523) and this particular example seems to be problematic in terms of Lewis (1980:154) who states that

> It would be misleading to point out the occasional stigmatizing associations of some kinds of disease without also stressing that most names for diseases are also intended to help guide appropriate action in response to them.

A patient who is told that he/she is rotting or becoming mouldy may be rather alarmed!

6.2.3 XHOSA WORDS

> There are certain cultural issues that are very difficult to put across in the other language, worse still if that language is a "non-African language" such as English or Afrikaans.
> Mtuze (1993:49-50)

The nurse/interpreter may be confronted with a Xhosa word for which he/she does not know the English word or for which there is no English equivalent. Again, explanations are employed to clarify to the medical professional:

> Something like, let's say, "Doctor, I've got idliso." That means that somebody makes a muti for her and that's why she's having this problem. I explain the doctor that she has got this belief this suspicion that somebody has mixed this herb for her to eat that's why she's coming for this complaint. (Sister N)

> There are [words] like inyongo (bile/gall) you just say to the doctor inyongo too. (Nurse R)
>
> Like for instance with, in Xhosa as I have mentioned when the patient has got beliefs that she has been bewitched and things we discovered that those things we haven't got an English term for it like amafufunyana then there is no other name in English that fits into the amafufunyana. And you have to explain that to the doctor in order for him to understand. (Sister Q)

One doctor commented that she had come across instances where the interpreter did not know the Xhosa word that the patient used and that explanations were then employed by the patient.

In terms of medical terminology, the patient who needs an interpreter may be at an advantage compared to those who can speak directly to the medical professional, who may use medical terms which the patient does not know. In the interpreted consultation the interpreter often automatically changes medical terms into lay terms.

Questionnaires[22] filled in by four students at Rhodes University showed that there may be a variety of terms used by Xhosa speakers for the same medical condition. The terms depended on the area from which the student came and the register and varieties of Xhosa spoken by the students. Each area would tend to develop its own vocabulary for the most prevalent diseases. In Grahamstown, there are signs in the hospitals with words like iswekile (literally sugar) for diabetes, high-high for high blood pressure and izifuba (literally chests) for asthma. These are common terms for these conditions in the Grahamstown area.

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[22]See Appendix F (pg 161).

Table 9 shows examples of different terms for the same medical condition, as given by four Xhosa-speaking students from different areas and from books of Xhosa phrases (Wilken 1993, Zotwana 1994). In different areas, these differ and it would seem that it may cause problems if one should learn one term and then be confronted with a patient who knows the disease by another name.

TABLE 9

DIFFERENT WORDS FOR THE SAME MEDICAL CONDITION

DISEASE	GRAHAMS TOWN	ALICE	UMTATA	EAST LONDON	BOOKS
CANCER	isifo somhlaza	isifo somhlaza	isifo somhlaza	umhlaza	isilonda esikhulu/ intsumpu enkulu/ umhlanza
TB	isifo sephepha	isifo semiphunga	isifo sephepha	isifo sephepha/ isifo samaphaphu	isifo sephepha/ isifuba esikhulu
RASH	ukhwekhwe/ irhashalela	amaqhakuvana arhawuzeleyo	ukhwekhwe/ irhwayibhani ishimnca	ukhwekhwe	ishimnca
MEASLES	---	isifo samaqhakuva asithand ukuhlasela abantwana	ingqakaqha	imasisi	imasisi/ irhashalala

It takes a long time for a new word to reach all members of a community, especially an uneducated one. It would appear, then, that attempts by the National Terminology Bureau to create terms for these conditions and standardise them may be difficult to implement at

grassroots level (Dippenaar 1992:25-26). Jansen (1991:125) states that "any health education translations must be conceptually accurate, linguistically correct and culturally meaningful".

Metaphor, which may be seen as another level of vocabulary, may cause many problems during interpreted consultations.

6.3 METAPHOR

The use of metaphor is a fairly common way of describing symptoms to medical professionals amongst Xhosa speakers. Metaphor tends, however, to be culture-specific and can cause problems for interpreters. The interpreters interviewed in this study make use of four strategies to deal with metaphor.

Firstly, they may interpret the metaphor literally, a strategy recognised by Newmark (1981:88-90). This is the strategy preferred by the medical professionals, because it allows them to make their own decisions based on what the patient has actually said:

> You do tell the doctor that the patient is saying that he has got a pain and this pain moves like a snake and then you try to find out from the patient how it starts and how it goes. (Nurse B)
>
> It gives a more clear picture of what she's saying to the doctor when you try and translate it exactly as she says it. (Sister Q)
>
> They've been told that they must say to us what the patient is saying and then we will take it from there ... The problems arise when they reinterpret what the patient says and tell us what they think we want. (Doctor 4)

This reinterpretation is seen in the second strategy where the interpreter may try and explain the

expression to the medical professional instead of giving an interpretation which may sound incoherent in English:

> I say something like that [metaphor] or explain it and then she'll understand, I'll explain it, but not exactly. (Nursing Assistant J)

> I do, when they like to say they've got a moving ball in their stomach... You say, he's got an abdominal discomfort of which she says in her own language that it's something moving. So we usually tell the patient there's nothing that can move in your stomach, either you're pregnant, you've got a baby or mhlambi [maybe] something like a wind. (Sister N)

This second strategy is also mentioned by Newmark (1981:88-90) in his list of seven strategies to deal with metaphor.

Thirdly, the interpreter may change the description into medical terms. The interpreter who has limited medical knowledge may promote misunderstanding and misdiagnosis if this strategy is followed. An example of this is:

> They usually say they have a ball that goes up and down in the stomach up and down. Sometimes it comes as far as the chest. You tell the doctor that the patient has a pain. You ask the patient if this ball is painful or what. The patient will say when this ball comes up I have a piercing pain in the stomach. When they have the epigastric pain they will say we have a burning pain. Sometimes they say, "I have a belt that starts from the lower abdomen up to the back,"... You will say that she has a lower abdominal pain which goes as far as the lower back. (Nurse C)

Newmark (1981:88-90) labels this strategy "conversion of metaphor to sense".

Finally, interpreters may resort to actions when they cannot find words to describe what the patient says:

> You are going to try to explain maybe like action because sometimes you don't know what is that exactly. Maybe the patient said, "I've got something in the stomach and it's moving like something. Now, maybe sometimes it's difficult to say the doctor, but you

have to try to do the actions so doctor can understand what is exactly. (Nurse K)

A frequent example cited in the Grahamstown area by nurse/interpreter was patients who had "moving balls" in their stomachs. This was diagnosed by doctors as stress or anxiety. Interpreters and medical professionals appear to become accustomed to descriptions like this, which are used widely amongst patients. Often metaphor is employed to talk about taboo areas in a non-threatening way.

6.4 TABOO AREAS[23]

The topic of conversation may influence the success of communication in most conversations and dealing with taboo areas can be problematic for interpreters. Usually, the task of making an utterance about a taboo area acceptable to a patient falls to the interpreter, although medical professionals may learn how to make their utterances acceptable. For this reason, the interpreter's knowledge of the patient's culture is deemed to be an important attribute by doctors. As Doctor 4 said:

> An interpreter should be able to understand the patient's culture and be conversant in the language in order to be able to ask the questions in a way that is not going to be offensive to them, ... very often one will ask an interpreter to, "Look, you know, put this in that way."

When interpreters know that there may be problems because of the topic, they try and explain to the patient that it is necessary for them to talk about it and be examined, even though it may

---

[23] Xhosa taboo areas were discussed in Section 3.2.2.1

be embarrassing. One interpreter told male patients who had to talk about sensitive issues to pretend that she was a male. Three nurse/interpreters said that male patients sometimes asked them to leave when they were being examined in certain areas of the body.

Doctor 2 had sometimes experienced problems when using a young interpreter when questions pertaining to sex and genitalia were necessary. She said that more experienced people were more careful, because they did not want to upset the whole interview.

Patients are often reluctant to talk about a taboo area and may be very oblique in their description of symptoms. The nurse/interpreter then has to find out what is actually wrong:

> Sometimes these patients they are scared to tell you what is actually wrong with them, more especially the male patients, they will say to you as a nurse, "I have headache, my head is sore," but you test everything for the headache ... and now everything is negative ... When you do that when you come to the doctor the patient will change statements. He will say when the doctor asks, "What's wrong with your head? Were you injured or were you hit?" He will say, "No, I didn't mean that head." Which head? "I meant the head of my penis is painful." You see it's a different story and he will say, "No, I can't tell you that - you are a female but I can tell the doctor because he's somebody who help me." They are scared of telling us what is actually wrong with them. Some are scared maybe when she says that is headaches maybe he has warts around the head of the penis or warts underneath if it's a female where she won't tell you. (Nurse C)

Another example is where women who talk about "i-pain" usually mean menstrual pain and nurse/interpreters said that they understood that this was what a patient meant if she used this term.

Sometimes a patient may be unwilling to talk in front of the nurse/interpreter and will hide what

is wrong with them. The actual problem is only discovered after extensive questioning.

Some nurse/interpreters feel uncomfortable when dealing with taboo areas and this occurs especially when the patient is older or of the opposite sex. Some patients are old enough to be their fathers and they empathize with this patient who has to undress in front to them. Nursing Assistant J described how she told patients about illnesses that relate to taboo areas:

> You do feel [embarrassed] but you mustn't smile or giggle you must have a firm you know don't be cross but just in between you know so that they know you want to help them. When the doctor says you got such and such a thing you just tell them nicely. You know the doctor says you've got syphilis like that you know but in a good way but not in a loud voice just tell them that they understand.

The next section deals with the language and behaviour changes which take place when a medical professional has to communicate through an interpreter.

6.5 LANGUAGE AND BEHAVIOUR ADAPTATION

When using interpreters, medical professionals have to adapt their behaviour to some degree from the way in which they would behave if they could communicate directly with the patient and this should be borne in mind when constructing a model of the interpreted medical consultation.

Six of the medical professionals felt that it was easier to speak directly to the patient. Firstly, they could ask personal questions that were often difficult to ask when there was an interpreter speaking on their behalf. This was especially true if the patient was a man and the interpreter

was a woman and the disease appeared to be sexual. Doctor 2 found that patients tended to deny that they consumed alcohol if the nurse/interpreter questioned them, but did not mind admitting to drinking if he/she was not present. It was also easier to discuss emotional aspects, which was often very difficult to do through interpreters, either because patients were shy or interpreters refused to interpret emotions. Wood (1993:351) found that emotional content was the most easily lost component when an interpreter was used. Another possible reason for this inhibition on the part of the patient is that the nurse/interpreter may be known in the community in which he/she lives and patients may not always trust him/her to keep confidentiality.

Thirdly, the medical professional has a much closer relationship with the patient who can speak directly to him/her. Four medical professionals felt that they communicated more with these patients and did not leave out some questions, as they sometimes did when using an interpreter.

> It's just so nice to actually be able to speak not have to think what you'll have to say to your translator to get it through. Also feelings, I'll say the feelings directly to the client and I just think the interviews are so much more smoother and you just feel closer. I think the client also feels closer because we can speak directly to each other and I do feel that my relationships are stronger, my professional relationships are a lot stronger with my clients who can speak English than those who can't, you don't feel them as much as a whole person. It's not easy for them either - they want to speak their hearts out but you know unless they speak two or three sentences so that my translator can tell me that I can pick up a bit but not too much, a lot of the stuff they're saying is lost. So that too if they're speaking directly to me I can get the whole picture which I often don't get with the translator. (Social Worker).

Marcos (1973:173) and Sabin (1975:199) found that affective states could not be assessed reliably through interpreters, because the manner in which words were said was not translated, because interpersonal distance between psychiatrist and patient could not be adequately bridged

and summaries were inadequate.

Gile (1995:24) feels that:

> Since generally all parties wish to communicate [in interpretation], more cooperation can be expected from them than in translation, where they are aware of a text rather than of a communicative situation. This includes cooperation from the speakers, who may try to speak more slowly, enunciate more clearly, choose certain terms and structures and avoid others, and clarify terms and concepts that they would not otherwise bother to explain.

There is always the danger of misinterpretation when there is an interpreter and medical professionals have to adapt their language to try and avoid problems:

> One has to simplify the questions, one has to hope that the interpreter will ask the question the way you want it asked in order to get the answer you're looking for or not looking for. The problem is that very often you're given an answer that interpreters think you want which is not the way to obtain. And they will ask a question in their own interpretation of what you're saying. (Doctor 4)

Medical professionals are aware that they have changed their language in order to deal with the constraints of the interpreted medical consultation. Characteristics of this language seem to be that it is very simple, very straightforward (i.e. assuming as little as possible) and devoid of medical terminology:

> I sometimes I have to really explain what I really want to know a little bit more, use more words or try to explain what I really want. Sometimes a straightforward question might be misinterpreted. (Doctor 3)

> You've got to be very careful on the word that you use. You've got to use a simple as possible and then also you've got to express yourself as well clearly as possible. (Doctor 3)

This language adaptation comes with experience and is usually the result of trial and error. Foreign doctors for whom English is not the first language may have enormous difficulties with interpreters. As both the medical professionals and the nurse/interpreter in this situation have a limited grasp of English, miscomprehension may ensue.

The nurse/interpreters interviewed agreed with Buthelezi (1996) that if they spend some time interpreting for a particular person, they learn to understand the language used by that person and problems are overcome over time:

> At first all interpreters have [problems], when faced with somebody new ... the nurses, for instance, like to interpret for ---- He's quick, he's clear and they know him. They hear him, so to speak, and they also know what he is going to advise over a particular patient's disposals (sic). (Doctor 2)

One doctor tended to avoid terms which involved fairly difficult concepts or were infrequently used. Five medical professionals commented that medical terminology cannot always be used, especially with junior staff. They then resort to the lay term:

> You try and explain things as simple as possible instead of using medical terminology, for instance, instead of saying, "Has the patient got dysuria?" You say, "Does the wee-wee burn or does the urine burn?" whatever. (Doctor 4)

Five medical professionals said that they avoided explanations of illness to a certain degree in interpreted consultations, sometimes because of interpreter problems and sometimes because the patient is too uneducated in their view to understand the explanations. Explanations are also sometimes avoided because of time constraints:

> It's very much a matter of time. If you're very pressed for time, you don't [explain]

> much. But if you are stuck with something that's recurrent and going to be there the rest of the patient's life, epilepsy for instance, or high blood pressure or something like that, you do try and explain a bit and then if you have an impatient translator you realise that your whole sentence is down to three words and that in fact the patient isn't being explained. (Doctor 2)

The nurse/interpreters were unanimous in their belief that explanations were vital for patients.

> It is very important [to explain the illness] because you get patient who you receive from other hospitals in fact and maybe they tell you I've been hospitalised for a month or so but when you ask her or him what was wrong what was actually done she can't tell you because I think as nurses we are very busy to do that to explain things to the patients and as a result they really don't know what is wrong with them. (Sister P)

Sister Q said that she was sometimes torn between explaining and keeping quiet about diseases because of the psychological effects (e.g. depression) which resulted from giving the patient bad news. However, it was often necessary to explain the disease to the patient if it was contagious, if compliance with a medical regimen was necessary or if the patient requested an explanation.

The task of explaining illnesses is often left to the nurse/interpreter, either because the medical professional does not give one to the patient (in accordance with the structure of medical discourse, see Section 3.3) or because the medical professional asks the nurse/interpreter to give a simple explanation to the patient. Sometimes this explanation may be given over a period of time to accommodate patients who are not well educated.

Another possible reason for the greater number of explanations given by nurse/interpreters to their patients is that they may have a closer relationship with the patient because they share a

language, a culture and may be part of the greater community in which the patient lives. The nurse/interpreter may be more aware of the patient as a person rather than a case presenting with a particular set of symptoms. Doctor 4 termed the treatment of many of the patients as "veterinary care" where individual patients did not become known to them and they merely dispensed treatment after a brief consultation. This kind of situation is not conducive to full explanations.

It can be seen from the above that patients who cannot speak the doctor's language are treated in a different way. They are at the mercy of the interpreter who decides what they should hear and what he/she thinks is important to interpret. A patient who goes to an interpreted medical consultation may leave knowing less than one who can speak directly to the doctor. This has implications for compliance and doctor-patient relationships and the ultimate prognosis.

Six medical professionals saw interpreted consultations as problematic. They would prefer to speak directly to the patient and they are uncertain about the quality of interpreting that is occurring. They have to adapt their behaviour and communication patterns to accommodate an interpreter. They all felt that the patient was the one who was losing out in the end. These patients did not receive the same standard of care as those who could speak directly to the doctor and it was placing a heavier burden on the health care system to have patients returning because they had not understood or not sought treatment immediately because they did not feel comfortable in medical consultations using interpreters. Two professionals had countered the situation by learning some Xhosa so that they could act more efficiently or pick up gross

misinterpreting. Miscomprehension does, however, occur.

6.6 MISCOMPREHENSION

Miscomprehension is a feature of the interpreted medical consultation. Nurse/interpreters have developed three strategies to deal with situations where they do not understand what has been said.

Firstly, they may request a repetition of the message. Sometimes they may not have heard the first message, sometimes it has been said too fast for them to understand and sometimes there are words that they do not know.

Secondly, they may request a simplification or an explanation:

> You still ask the doctor to sort of to be simple and try and explain better because you don't want to interpret what is not right for the patient. (Nurse B)

As a last resort, they may call another interpreter or a person of a higher rank, e.g. a Sister.

When it is the patient who needs to understand, nurse/interpreters may watch the patient's body language, ask whether they understand or ask them to repeat what was said:

> You try and explain as much as possible for the patient to understand but sometimes you feel that even if the patient does not tell you that I do not understand. You can see from the facial expression that uh-uh this one does not understand or sometimes you ask the patient to repeat what you have said and then you discover that no she doesn't understand. (Sister Q)

> You explain it again because you find out it's not a matter of not understanding your

> language or not understanding you, it's not understanding the concept so you've got to explain it in other words that she or he will understand. (Sister P)

They may also ask others to intervene:

> If you feel you cannot explain it enough then you ask another person to, "Will you please come and explain this thing for so and so she doesn't seem to understand me." You ask a second person most of the time. (Sister Q)

When the patient has not understood, the nurse/interpreter will explain again, or call someone else to explain. Nurse N found that it was sometimes necessary to use a different register (e.g. informal township slang) to explain things. Three nurse/interpreters said that if patients have not understood, they may go to the nurse/interpreter's house after hours for a better explanation.

Three nurse/interpreters denied that patient miscomprehension was a problem, but said that many patients were stubborn and refused to accept what was said:

> Well, it's rare to get a patient that doesn't understand. The only thing is instead of not understanding maybe the patient is stubborn maybe for the procedure. You ask the patient there for the procedure to be done and the patient is stubborn not really that she doesn't understand. (Nurse R)

Medical professionals said that they are aware that miscomprehension occurs and they try to change or simplify the message if they can.

> I think 90% of the time [she tells me if she does not understand] otherwise she just doesn't reply and I realise that she just doesn't understand what I've just said. (Social Worker)

> Well, I correct the interpreter, I question them to ask them to explain and usually they correct themselves. (Doctor 3)

6.7 CONCLUSION

One of the primary characteristics of the interpreted medical consultation is that the message sent is often quite different from the message received. This may be because nurse/interpreters are acting as independent communicators in the interpreting process, vocabulary and medical terminology cannot always be interpreted directly, metaphor is interpreted in a variety of ways and they have to find acceptable ways of dealing with taboo areas.

Medical professionals have had to adapt their language to facilitate communication in the interpreted medical consultation. Adaptations include simplification of vocabulary and explanations, the use of lay terminology rather than medical terminology and extensive use of explanation. When miscomprehension occurs, attempts are made to simplify or explain further or another interpreter is called in.

It has been shown that there are a number of linguistic aspects which influence the interpreting that takes place in medical consultations. Interpreting in these situations is not a straightforward task and adaptations need to take place on the part of the nurse/interpreter and the medical professional because of practical constraints, non-linguistic and linguistic contextual factors.

In order to reflect the complexity of the communication in the interpreted medical consultation and the variety of factors which influence it, a model of the situation will be presented in the next chapter. This model will attempt to draw together many of the aspects mentioned in this and the preceding chapters.

CHAPTER 7

CONCLUSION

7.0 INTRODUCTION

This final chapter will present a revised model of the interpreting process in the light of the dat presented in Chapters 5 and 6. A variety of reasons will be suggested for claiming that previous models inadequately represent the interpreting taking place in a South African medical consultation. As has been shown in Chapters 5 and 6, there are a large number of factors which influence the interpreting process and communication in the medical context and it is argued that these should be borne in mind when making decisions about medical interpreters in South Africa. Furthermore, the chapter will look briefly at the implications and some recommendations flowing from the research. Finally, suggestions further research are made before conclusions based on theoretical aspects and actual data are reached.

7.1 A SUGGESTED MODEL OF THE INTERPRETING PROCESS IN A SOUTH AFRICAN MEDICAL CONSULTATION

7.1.1 REASONS FOR THE INTRODUCTION OF A NEW MODEL

The models of interpreting in the literature tend to focus on conference interpreting and how to deal with this kind of interpreting effectively. In reality, a lot of less formal interpreting occurs daily all over the world which does not conform to these models and which cannot conform to the ideals of conference interpreting in terms of keeping to the letter and spirit of the message which is sent. A closer look needs to be taken at more informal interpreting and the way in

which the role and function of the interpreter is perceived.

The models discussed in Section 2.1.2 have a number of shortcomings if they are to be adequate for the medical interpreting which was investigated in this study. Gerver & Sinaiko's model (1978:37) accords the interpreter a more active role than older models allowed, which introduces some leeway for changing the message. This amount of leeway is possibly adequate for the conference interpreter who is bound fairly tightly by the ideal of seeking equivalents of meaning in one language for another language. The conference audience tends to be fairly educated, generally has some knowledge of the subject under discussion, and is not seeking explanations outside those given by the sender. However, it does not allow for many of the changes to the message which have been shown to occur in medical interpreting, where part of the audience is fairly uneducated, has little or no knowledge of the subject under discussion and seeks explanations of the information given in the consultation.

A second shortcoming of the model is that the sender, receptor and interpreter are not shown to influence the message directly, as was found in data from this study. A third shortcoming is that there are more contextual elements influencing the message than are mentioned in the model.

Newmark's (1991:31) model increased the number of factors influencing the message, but it is fairly generalised and does not take into account (or only indirectly takes into account) many of the factors which would come into play in the South African interpreted consultation (although

I recognise that a model should be as generalised as possible, I feel that in order to understand what happens in interpreted medical consultations and to identify reasons for what happens, a more detailed, specific model is desirable).

These two models are thus inadequate representations of the interpreted medical consultation.

Wood's (1993:351) finding that "interpreters are a third party in the consultation and influence it because of their attitudes to the other participants, ethical positions and cultural backgrounds" also supports the introduction of a new model which takes these aspects into account.

The suggested model is based on Shannon & Weaver's model of communication (in Bell 1991:18) and its refinements by Bell (1991:19) which accommodate the third participant in the communication.[24] It includes the factors which influence communication and which are potential sources of noise, which were found in my data and other studies.

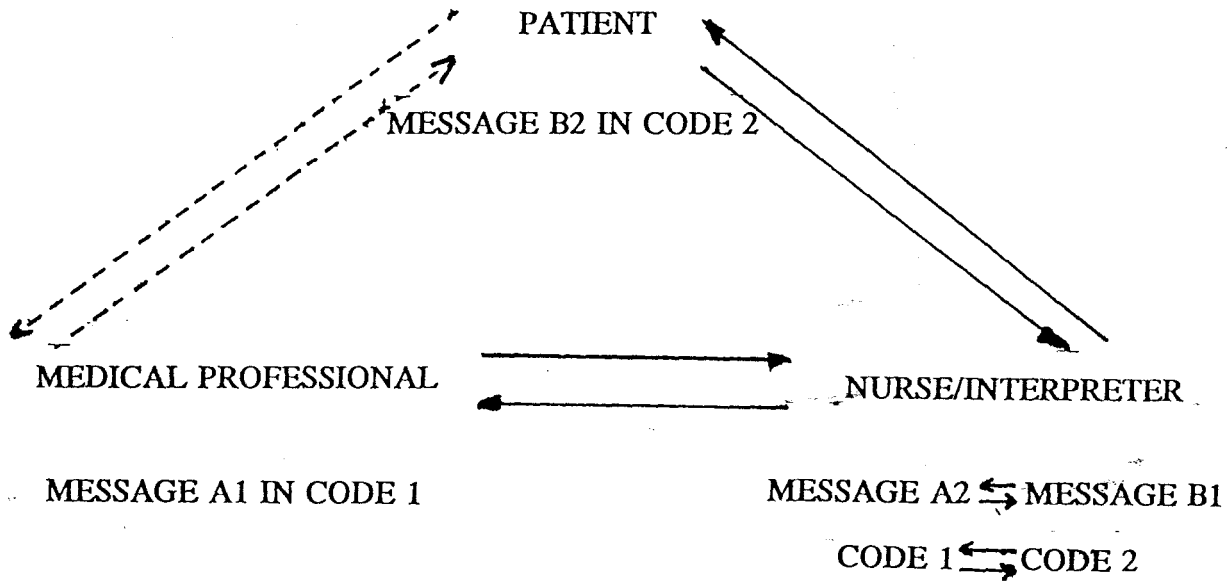
[24] These models were presented in Section 2.2.1.

FIGURE 5

A SUGGESTED MODEL OF THE INTERPRETED MEDICAL CONSULTATION

CONTEXT 1: MEDICAL CONSULTATION (WESTERN STYLE)

CONTEXT 2: INTERPRETED MEDICAL CONSULTATION



FACTORS INFLUENCING THE MESSAGE

Role
Status
Knowledge - world, medical, cultural, contextual
Culture
Personality
Attitudes - to participants and task
Language ability
Training and experience of using interpreters or interpreting
Degree of independent communication acceptable
Topic
Time
Severity of illness
Age and gender

7.1.2 PARTICIPANTS

There are generally three participants in the interpreted medical consultation (i.e. medical professional, nurse/interpreter and patient), although a fourth participant may also sometimes be part of the consultation (e.g. family member or someone who accompanies the patient).

7.1.3 MESSAGES

I suggest that there are four different messages sent and received in this kind of interaction, rather than only two, as suggested by other theorists. Message A1 is sent by the medical professional and its formulation is determined by the factors influencing communication.

The message A2 received by the nurse/interpreter is filtered through the factors influencing communication which affect what is received. These factors also determine the formulation of message B1. The patient receives message B2 which has been filtered through his/her set of factors influencing communication and after potential sources of noise have acted on it.

7.1.4 CODES

The codes (languages) used in this case are English and Xhosa, although any other codes may be used.

7.1.5 CONTEXTS

7.1.5.1 Context 1: Western style medical consultation

This interaction takes place in the greater context of the Western style medical consultation. The

consultation has certain conventional patterns of behaviour, discourse norms (medical discourse) and ways of approaching problems.[25]

7.1.5.2 Context 2: Interpreted consultation

Another set of norms of behaviour and discourse are required in the interpreted consultation. For example, one cannot talk freely or at length, because the interpreter has to interpret what has been said within the limitations of memory and language ability, and there is the possibly inhibiting presence of a third party. The medical professional also adapts his/her language and behaviour when speaking through an interpreter.[26]

7.1.6 FACTORS INFLUENCING THE COMMUNICATION AND POTENTIAL SOURCES OF NOISE

These factors have been included in the model because they were revealed by the data collected for this study, as well as some of the other studies cited in this literature review (see Chapters 2 and 3).

7.1.6.1 Role

Each participant has a particular role to play in the interaction. At a basic level, the medical professional elicits the problem and attempts to solve it; the interpreter interprets whatever is said and adds more or leaves out as he/she sees fit; and the patient is expected to be fairly

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[25] These were discussed in Section 3.3.

[26] This was discussed in Section 6.5.

passive, but supply answers to questions asked by the medical professional. The roles of the interpreter were discussed extensively in Section 2.1.2.4 and Section 6.1.1 and those of the patient in Section 3.1.

7.1.6.2 Status

Status is accorded to each participant. Crawford (1994a:8) found that the medical professional has the most status, the nurse/interpreter is in the middle and the patient has the least status, especially if he/she is perceived to be poor and/or uneducated. Status is closely linked to power, which was discussed in Section 3.1.

7.1.6.3 Knowledge

The more knowledge one has, the more power one has in a situation, because one is aware of different acceptable or desirable behaviours, one can create links when contextual factors are lacking and it gives one access to the more powerful position of the professional.

Medical knowledge is held extensively by the medical professional, usually less so by the nurse/interpreter and usually very little by the patient. A nurse/interpreter or patient who has medical knowledge may be able to decrease the distance and power differential between him/herself and the medical professional.

World knowledge tends to be linked to education and it usually increases power. For the patient, contextual knowledge can decrease conflict, enhance the speed of the process and save time,

because the patient knows what to expect and what not to expect and can behave appropriately. Cultural knowledge can be used to decrease the amount of miscommunication that occurs.

7.1.6.4 Culture

The culture of each participant determines his/her modes of behaviour and linguistic formulations. Cultural differences were discussed in Section 3.2 and Section 5.8.

7.1.6.5 Personality

The personality of each participant will determine the 'atmosphere' of the interaction. Pleasant personalities of all the participants can mitigate some of the problems experienced. The effects of the personality of the nurse/interpreter were discussed in Section 5.2.4.

7.1.6.6 Attitudes

Attitudes on the part of all the participants are important, because positive or negative attitudes can be held towards the other participants or the task and can influence the standard of care and linguistic interaction which takes place. Attitudes of nurse/interpreters were discussed in Section 5.4.

7.1.6.7 Language ability

In a situation where communication is very important (see Section 2.2.1), language ability plays a major role. This factor relates to the ability of the participants in both the languages used in the consultation. The medical practitioner may have some idea of the language used by the

patient, the nurse/interpreter needs to be bilingual to some extent and the patient may have some knowledge of English, although his/her knowledge of medical English is likely to be limited. The effects of language ability on the part of the nurse/interpreter were discussed in Section 5.2.1.

7.1.6.8 Training and experience of using interpreters or of interpreting

In this study, none of the medical professionals or nurse/interpreters had been trained to use interpreters or to interpret, but they did have experience in using interpreters or of interpreting. The effects of experience were discussed in Section 5.2.5.

7.1.6.9 Degree of independent communication acceptable

As shown in the discussion of the various roles assumed by medical interpreters (Section 2.1.2.4), independent communication occurs during interpreted medical consultations, whether the participants like it or not. The degree of independent communication acceptable is dependent on many of the other factors discussed here, e.g. knowledge, language ability, time, topic, severity of illness and cultural differences. Reasons for the existence of independent communication were discussed in Section 6.1.

7.1.6.10 Topic

The topic of the conversation can influence the communication to some degree. If a taboo area is under discussion, it has to be discussed quite differently than if a non-taboo area is discussed. Dealing with sensitive subjects was discussed in Section 6.4.

7.1.6.11 Time

Time constraints will often determine how much is said and how much is edited out in an interpreted medical consultation. This issue was discussed in Section 6.1.6.

7.1.6.12 Severity of illness

The severity of the illness is also an important factor during communication. It becomes more or less important to tell the patient about his/her illness and discuss causation and treatment, depending on the severity of the illness. This factor was discussed in Section 6.5.

7.1.6.13 Age and gender

The age and gender of the participants may influence the communication, especially in cultures such as Xhosa culture where age and gender differences are important and may influence ways of addressing the other participants, suitable topics and other linguistic behaviour. The importance of matching the age and gender of the patient and nurse/interpreter was discussed in Section 5.2.6.

So, this model includes a variety of factors which will influence the communication within the interpreted medical consultation. It shows, too, that the message sent and received at each stage is not the same.

7.2 IMPLICATIONS AND RECOMMENDATIONS

This study highlights implications for training, choice of interpreters and other general issues

which include legal questions, patient care, and the feasibility of making national decisions about medical interpreting. Recommendations are made for some of these areas.

7.2.1 TRAINING

Training in several different areas which could ease some of the problems that occur in interpreted medical consultations is recommended. These include training in medical areas, language, interpreting, counselling and culture. Ngqakayi (1994:23) feels that

> there should be a movement towards the establishment of formalised language services in the health care system since the training of more black professionals does not imply the displacement of English and Afrikaans-speaking professionals.

7.2.1.1 Medical

Firstly, medical training would appear to be necessary for a medical interpreter. Medical knowledge seems to ease some of the problems in the interpreted medical consultation and aids comprehension. Interpreters with medical training seem to be better equipped to deal with the independent communication in which they engage and thorough medical knowledge seems to increase the confidence that the medical professional has in the interpreter.

7.2.1.2 Language

Language training also seems to be necessary in many cases, where interpreters do not have enough knowledge of English to function optimally.

In addition, medical practitioners should be encouraged to learn the language(s) of their patients,

although the level of Xhosa knowledge required to communicate directly with a patient would take many years to acquire and interpreters would still be necessary even at an advanced level. Wood (1993:351) found that "the doctor needs to be highly proficient in the patient's language in order to stop using an interpreter". However, the medical professional could have a better grasp of what was occurring in the consultation and be able to clarify questions which were not answered satisfactorily. Kirkby (1988:281) says that "to have medical courses that do not incorporate teaching of local languages, customs and beliefs is nonsensical".[27]

7.2.1.3 Interpreting

Training that teaches would-be interpreters to interpret would seem to be advantageous. Learning skills such as interpersonal skills, summarising, paraphrasing, and dealing with metaphor and inadequate vocabulary should aid interpreters who will have to use these skills in practice. They should be trained to work with a professional and given guidelines as to when independent communication is acceptable.[28]

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[27] Some medical schools (e.g. Durban/Westville and UCT) have tried to make the learning of an African language compulsory during training, but have found that the necessary level of language knowledge is not attained by students, although some training may be better than none. Unfortunately, the language learnt while training may not be relevant when the medical professional moves to another area of the country or is mobile during his/her professional career.

[28] Interpreter training courses are being introduced in other parts of the country (e.g. Cape Town and Durban). It seems unlikely that most of the nurses who interpret interviewed in this study would attend this kind of course, because there would be little incentive to do so. Interpreters who work in private practices and non-nurses who are interpreters may be candidates for training and in time, trained interpreting staff could take over from nursing staff.

Richter, Daly & Clarke (1979:275) found that

> doctors who previously had to call on untrained interpreters found that using professionals has many advantages. One of the most significant is the ease with which they can take a patient's medical history. Training in medical terminology and working exclusively within the health care environment enables interpreters to transmit relevant information swiftly and quickly.

Suggested content for the course includes:

1) Definitions of interpreting;

2) Discussion of contextual factors that influence the message;

3) Potential problems for the interpreter;

4) Discussion of mechanisms and strategies used to overcome problems;

5) Ethical aspects of medical interpreting;

6) Medical terminology and basic medical training;

7) The importance of communication in the medical consultation;

8) Interpersonal skills and psychological aspects.

Medical professionals, too, need to be taught to use interpreters at an optimal level. Training might include teaching them to adapt their language, overcoming problems which are caused by poor interpreting and learning to work with an interpreter.

7.2.1.4 Counselling

Training in counselling could ease the stress of interpreting to some extent.

7.2.1.5 Culture

Medical professionals could benefit from some insights into the culture of their patients. This could prevent some of the misunderstandings which result from cultural differences between them and their patients.

7.2.2 CHOICE OF INTERPRETERS

Decisions need to be made about who is to interpret in medical situations. If nurses feel that interpreting should not be part of their jobs, other interpreters may need to be employed. Unfortunately, financial constraints usually prevent the use of full-time interpreters, although this may be a better solution for all concerned.

Shackman (1992:51) suggests that there are four choices available in terms of interpreters:

1) Employ one's own interpreters;

2) Use an interpreting service;

3) Use sessional, self-employed or voluntary interpreters; or

4) Use a combination of the above.

7.2.3 GENERAL ISSUES

This study makes it clear that a fairly high level of misinterpreting is taking place in medical consultations in the Eastern Cape. If the patient receives poor treatment and is misdiagnosed because of misinterpretation, there may be legal implications for the medical professional. In addition, poor interpreting has implications for the quality of care received by the patient.

The research conducted for this thesis showed that the interpreting situation and needs of the Eastern Cape are not exactly the same as those of the Western Cape (Crawford's 1994a study). Decisions made at a national level may not always be appropriate, because different situations prevail in different areas, and the ideal situation would be to draw up guidelines which could be implemented at provincial and local level.

7.3 FURTHER RESEARCH

There are several avenues for further research highlighted by this thesis. Further research needs to be conducted into:

1) The needs of medical professionals other than doctors, (e.g. pharmacists, radiographers, occupational therapists, optometrists, etc). Each of these groups has slightly different interpreting requirements;

2) The interpreting needs of social workers. In Grahamstown, social workers use untrained receptionist staff and nurses, if they can find any who will help them. There seems to be a reluctance on the part of these interpreters to interpret parts of the message which are vital to the social worker, e.g. emotions, social problems, etc;

3) Non-nursing staff who interpret in private surgeries and clinics. This thesis covered the views of the nurse who interprets and the experience of non-nurses may be different to some extent;

4) The views of patients on the interpreting that is taking place for them;

5) Possible solutions to the various problems highlighted in this thesis;

6) The feasibility and content of training courses for interpreters and would-be interpreters;

7) The kind of interpreting taking place in these consultations. Further research which tests and

adds to the suggested model would be useful when solutions are being discussed. Transcriptions of interpreted medical consultations, which could throw further light on the actual interpreting that is taking place should be included and problems with high frequency vocabulary items should be investigated.

7.4 CONCLUSION

This thesis examined the role of interpreters in interpreted medical consultations in the Eastern Cape. A model of the interpreted medical consultation was developed in the light of the data in the study; this model included the non-linguistic and linguistic contextual factors which influence the message that is conveyed at each stage of the interpreted consultation. The model differs from conventional models of interpreting (which tend to focus on conference interpreting, rather than community interpreting) in that the message sent and received at each stage of the interpreting process may not correspond. A greater degree of independent communication, which is exhibited in summarising and omitting parts of the message and adding to the message, is found in the interpreted medical consultation than in the more formal interpreted conference.

This phenomenon has implications for the choice of the interpreter in the interpreted medical consultation. The interpreter who takes the role of independent communicator may need to have a greater knowledge of his/her subject (e.g. medical knowledge), skills similar to those of the medical professional (e.g. diagnosing, identifying symptoms, etc) and the ability to decide what the medical professional needs to hear and what can safely be omitted. This study suggests that at present, the interpreters may not possess all these skills or possess them to a sufficient degree

to interpret in this way in the best interests of the patient.

Communication lies at the heart of the medical consultation. Without communication, there cannot always be good quality care. The interpreted medical consultation involves three participants who approach the situation with different attitudes, expectations, knowledge and goals. The message that is sent is shaped by a number of contextual factors and this may not be obvious to the participants. Linguistic constraints, which result from the non-equivalence of different languages in terms of vocabulary, metaphor and cultural concepts, shape the message at another level. Together, these non-linguistic and linguistic factors lead to a situation where the message sent does not always resemble the message received. The importance of communication for diagnosis and treatment is often overlooked and this may lead to inadequate or lower quality patient care and frustration on the part of the patient and/or medical professional.

This study has shown that medical interpreting does not always conform to the ideals of conference interpreting, because it is influenced by a variety of other factors which are not as important in the conference situation. The use of untrained interpreters increases the impact of these factors and results in messages which do not always conform to the original messages sent. As a result, there may be a high level of miscommunication and miscomprehension which impacts negatively on the quality of care received by the patient. These problems could be lessened in two ways; firstly, by training medical interpreters to interpret fully, correctly and with insight and; secondly, to encourage medical professionals to learn the language(s) of their

patients. The central role of communication in the interpreted medical consultation should never be underestimated and medical professionals and interpreters should be made aware of the vital role played by medical interpreters. Without adequate communication, there cannot be adequate medical care.

APPENDIX A

INTERVIEW QUESTIONNAIRE FOR HEALTH PROFESSIONALS

1. How do you communicate with patients who speak only Xhosa?

2.1. Who do you use as interpreters?

2.2. Are they easily available?

3.1 What criteria did you use to select your interpreter?

3.2. How important do you think it is to try and match the age and sex of the interpreter with that of the patient?

4. How do you decide when to use an interpreter with a patient?

5. What do you do differently in a consultation using an interpreter from one in which you talk directly do the patient?

6. What kind of role do you think the interpreter should take in the consultation?

7. What do you do while your interpreter is busy interpreting?

8. Have you encountered any practical problems with using interpreters?

9. Do you find that you encounter problems when you use medical terminology?

10. What strategies do you use to cope with it?

11.1. What kind of medical knowledge should an interpreter have?

11.2. Do the interpreters have this knowledge?

12.1. Do you think that your interpreters understand the Xhosa of the patient at all times?

12.2. What happens when they do not understand?

13.1. Do you think that your interpreters understand your English at all times?

13.2. What happens when they do not understand?

14. Do you feel confident that your interpreter is giving an accurate version of your message?

15.1. Have you found that there are cultural differences between you and the patient which cause problems in communication?

15.2. Could you give me some examples?

15.3. How did you come to realise that these problems were the result of cultural differences?

15.4. How did you deal with these problems?

16. Have you experienced any problems when dealing with taboo areas?

17.1. How much do you explain to the patient about his/her illness?

17.2. Do you ever avoid explaining because of interpreter problems?

18.1. Have you found that patients return again and again because they have not understood the interpreter the previous time?

18.2. How often do you think this happens?

19. Have you discussed with your interpreter the best way to work together?

20. Do you think that your interpreter has any problems when interpreting for you?

21.1. Do you think that your current interpreting situation is adequate?

21.2. Is there anything that you would like to change about your current interpreting situation?

22. How would you feel about having a medically trained full-time interpreter available to you?

APPENDIX B

INTERVIEW QUESTIONNAIRE FOR INTERPRETERS

1. Could you describe what happens in a consultation where you are the interpreter?

2. What kind of role do you take in the consultation?

3. Why do you think you were chosen as an interpreter?

4. Have you received any training for interpreting?

5. How do you feel about interpreting?

6. How much time do you think you spend interpreting for the doctor?

7.1. Have you found that you have experienced problems while interpreting?

7.2. If so, what are these problems?

8. Do you interpret everything that is said word for word or do you summarise?

9. How do you decide what to leave out?

10. How important do you think it is for the patient to be given an explanation of his/her illness?

11. Do you ever explain to the patient more than the doctor says?

12. How do you explain to the doctor when the patient uses a metaphor to describe something?

13.1. Are there ever times when the patient uses Xhosa that you do not understand?

13.2. What do you do in this situation?

14. What do you do if you don't understand what the doctor is saying?

15.1. Have you ever found that there are no Xhosa words for the English words the doctor uses?

15.2. Could you give me examples?

16.1. Have you ever found that there are no English words for the Xhosa words the patient uses?

16.2. Could you give me examples?

17. What do you do when the patient does not understand what the doctor has said?

18. How do you check to make sure that patients understand what has been said?

19. Do you think you need any medical knowledge to interpret in your situation?

20.1. Have you ever found that there are cultural differences between the patient and the doctor which make communication more difficult?

20.2. What did you do?

21.1. Are there certain kinds of people whom you find it difficult to interpret for?

21.2. Who are they?

22. What happens if patients become upset because they have just heard bad news about their health?

23. Do you ever have any problems when dealing with sensitive areas that patients do not like to talk about?

APPENDIX C

WRITTEN QUESTIONNAIRE FOR HEALTH PROFESSIONALS[29]

1. How do you communicate with patients who speak only Xhosa?

2. Who do you use as interpreters?

3. What characteristics do you think a good interpreter should have?

4. What problems have you encountered with using interpreters?

5.1 Have you encountered any problems when using medical terminology?

YES _____ NO _____

5.2 If your answer to the previous question was YES, then what strategies do you use to overcome these problems?

6. What kind of medical knowledge should an interpreter have?

7. Do the interpreters that you use have this medical knowledge?

8. What happens if your interpreter does not understand your English?

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[29] Blank lines provided for answers were deleted to save space and costs.

9. Do you feel confident that your interpreter is giving an accurate version of your message?

10. Have you found that there are cultural differences between you and the patient which cause problems in communication? If YES, please give examples.

11. How much do you explain to the patient about his/her illness?

12. Do you ever avoid explanations because of interpreter problems?

13. Have you found that patients return again and again because they have not understood the interpreter the previous time?

14. Do you think interpreters have any problems interpreting for you?

15. Do you think your current interpreting situation is adequate?

16. How would you feel about having a medically trained full-time interpreter available to you?

17. Any other comments?

APPENDIX D

QUESTIONNAIRE FOR PATIENTS

Questionnaire administered by Xhosa speaking students to patients who have needed an interpreter to communicate with the doctor.

1. Has someone told you what is wrong with you?

   If YES, who told you?

2. Has someone explained your illness to you?

   If YES, who explained it to you?

3. Are you satisfied with the explanation that was given to you?

4. Did you understand what the interpreter said to you?

5. Do you think that the interpreter interpreted your message correctly?

6. Do you think that the interpreter left out parts of your message which you think are important?

7. Did you leave out some things that you wanted to tell the doctor because you did not want to discuss them in front of the interpreter?

8. Have you ever been in a situation where you spoke through an interpreter before?

9. How much of the doctor's message can you understand without an interpreter?

APPENDIX E

PATIENT QUESTIONNAIRE - XHOSA VERSION

1. Ingaba ukhona umntu uye wakuxelela into ungalunganga ngawe?

   EWE: Ngubani okuxeleleyo?

2. Ngaba ukhona na umntu okucaciseleyo ngesigulo sakho?

   EWE: Ngubani okucaciseleyo?

3. Ngaba uyiqondile na le nto ubuyixelelwa ngumguquli?

4. Xa ucinga ingaba umguquli uyibeke kakuhle na ingxaki yakho?

5. Xa ucinga ingaba umguquli zikhona na izinto othe wazishiya ocinga ukuba zibalulekile?

6. Ingaba zikhona na izinto othe wazishiya kuba ungafuni ukuzixoxa nogqirha umguquli ekhona?

7. Ngaba wakhe wakho kwimeko yokufuna ukuguqulelwa ngaphambili?

8. Yabangakanani ingcaciso kagqirha owathi wayiqonda ngaphandle komguquli?

APPENDIX F

WORDS FOR ILLNESSES

ILLNESS	GRAHAMSTOWN	ALICE	UMTATA	EAST LONDON
PAIN	intlungu, ingqaqambo	intlungu	iintlungu iingqaqambo	intlungu
GERM	intsholong wane	intsholongwane	inthsolongwane	intsholong wane
INFECTION	isifo esosuleleyo	isifo semiphunga	ukuselela ngesifo	isifo
PREGNANT	ukumitha ukuba nzima	umitho	ukukhulelwa ukumitha ukuthwala	ukukhulelwa ukuthwala
CANCER	isifo somhlaza	isifo somhlaza	isifo somhlaza	umhlaza
HEADACHE	intloko ebuhlungu	ukuqaqanjelwa yintloko	intloko ebuhlungu	intloko
STOMACH ACHE	isisu esibuhlungu	ukuba nesisu esibuhlungu	isisu esibuhlungu	isisu esibuhlungu
HAVE A TEMPERATURE	unobushushu	ukube nobushushu	ukuba nobushushu	uviwo lobushushu
APPENDIX	ithumbu elizikhuleleyo elide	isifo sethunjana	izilonda zomathumbu	ithunjana

TONSILLITIS	uqilikwane	uqwilikana	---	amarhalala
ANTIBIOTICS	izinto zokukhusela ukusasazeka kwezifo	ibulala iintsholongwane	iipilisi zokubulala ukusuleleka kwezifo	amayeza
PNEUMONIA	ukube nengqele	isifo samothambo	isifo samaphaphu	isifo sengqele
CONCUSSION	idumbe	idumbe	ukukhrokeka kwengqondo	uphamiseko ngokwasenqon deweni
ALCOHOLIC	umntu ongenakuphila ngaphandle kotywala	inotywala	inxila	inxila
HEART ATTACK	isifo sentliziyo	ukuhlaselwa yintliziyo	isifo sentliziyo ukuhlaselwa yintliziyo	isifo sentliziyo
LOSE WEIGHT	ukuhla umzimba, ukubhitya	ukuhla komzimba	ukuhla kobunzima bomzimba	ukwehla
BACK ACHE	umqolo obuhlungu	ukuqaqanjelwa ngumqolo	umqolo obuhlungu	ubuhlungu bomqolo
TUMMY BUG	---	---	iitshulube	ukutsjeqa kwesisu

VOMIT	ukugabha	ukugabha	ukugabha ukukhupha	ukugabha ukuhlanza
RASH	ukhwekhwe irhashalela	amaqhakuvana arhawuzeleyo	ukhwekhwe irhwayibhani ishimnca	ukhwekhwe
MEASLES	---	isifo samaqhakuva asithand ukuhlasela abantwana	ingqakaqha	imasisi
EPILEPSY	---	inzololwazi	ukuxhuzula	ukuxhuzula

APPENDIX G

1. MEDICAL PROFESSIONALS

Number 1: Female, English speaking White Social Worker with no knowledge of Xhosa.

Number 2: Female, English speaking White Doctor who works at Settlers Hospital and has about forty years of using interpreters throughout Africa.

Number 3: Male, English speaking Indian Doctor who has a private practice and works at Settlers Hospital part-time, has learned enough Xhosa to function alone for most consultations, but uses a receptionist at other times.

Number 4: Male, English speaking White Doctor who works for Settlers Hospital and has learned some Xhosa after about thirty years of working with interpreters.

Number 5: Female, English speaking White Doctor who has a private practice and works part-time at Settlers Hospital and runs after-hours clinics. She does not know any Xhosa.

Number 6: Male, English speaking White Doctor who has a private practice and works part-time at Settlers Hospital and runs after-hours clinics. He does not speak Xhosa.

Number 7: Male, Afrikaans-speaking White Doctor who has a private practice in Somerset East and works part-time in the hospital. He has no knowledge of Xhosa.

NURSE/INTERPRETERS

A: Female, Xhosa speaking social worker's interpreter, trained as a secretary, 24 years old, low English competence, two year's experience of interpreting.

B: Female, Xhosa speaking retired nurse and pharmacy interpreter, fair English competence.

C: Female, Xhosa speaking retired nurse and pharmacy interpreter, previously a teacher, good

English competence.

D: Female, Xhosa speaking retired nursing assistant and pharmacy interpreter, low English competence.

E: Female, Xhosa speaking retired nurse and pharmacy interpreter, fair English competence.

F: Female, Xhosa speaking retired nurse and pharmacy interpreter, good English competence, very negative about interpreting for doctors.

G: Female, Xhosa speaking nursing assistant, good English competence.

H: Female, Xhosa speaking retired nursing assistant, low English competence.

I: Female, Xhosa speaking nursing assistant interviewed at Day Hospital, good English competence.

J: Female, Xhosa speaking nursing assistant interviewed at Day Hospital, assigned to Doctor on duty at that time, fair English competence, nearing retirement.

K: Female, Xhosa speaking nurse interviewed at Day Hospital, fair English competence.

L: Female, Xhosa speaking nurse interviewed at Day Hospital, fair English competence, very positive about interpreting, interpreted for five years at the Specialist's clinic at Settlers Hospital.

M: Female, Xhosa speaking Sister interviewed at Day Hospital, good English competence.

N: Female, Xhosa speaking Sister interviewed at Day Hospital, good English competence.

O: Female, Xhosa speaking nurse interviewed at Day Hospital, fair English competence, seventeen years of interpreting experience.

P: Female, Xhosa speaking Sister interviewed at Day Hospital, good English competence, had petitioned the authorities to stop using nursing staff as interpreters.

Q: Female, Xhosa speaking Sister interviewed at home, good English competence. Highly

opposed to the use of nursing staff as interpreters.

R: Female, Xhosa speaking nurse interviewed at home, fair English competence.

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