INTERLINGUAL AND INTERCULTURAL COMMUNICATION DISCORDANCES AS IMPEDIMENTS TO THE PROVISION OF QUALITY PUBLIC HEALTHCARE SERVICES: CASES OF CECILIA MAKIWANE HOSPITAL, NKQUBELA CHEST HOSPITAL AND FRERE HOSPITAL

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TABLE OF CONTENTS

CHAPTER 3: LITERATURE REVIEW

CHAPTER 4: INTERPRETING IN HEALTHCARE: AN INTERNATIONAL PERSPECTIVE

CHAPTER 5: INTERVENTION MEASURES TO LANGUAGE AND CULTURAL COMMUNICATION IN THE HEALTHCARE SECTOR

CHAPTER 6: LANGUAGE AND TEACHING IN DOCTOR TRAINING: SOUTH AFRICAN CONTEXT

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CHAPTER 1: INTRODUCTION

1.1 CONTEXT AND BACKGROUND OF THE STUDY

This study seeks to explore interlingual and intercultural discordances between clinicians and patients during treatment processes in selected public hospitals in the Eastern Cape. The two languages under investigation are English and isiXhosa. Intercultural communication refers to a phenomenon in which people who speak different native languages are engaged in a conversation (Gudykunst 1993).

Allwood (1985) defines intercultural communication as 'the sharing of information on different levels of awareness and control between people with different cultural backgrounds, where different cultural backgrounds include both national cultural differences and differences which are connected with participation in the different activities that exist within a national unit. Culture can be defined as a social system which consists of norms, values and protocols of behaviour in a human environment (Issa and Yunusa 2015). Culture and communication are closely related phenomena in the sense that the learning and acquiring of cultural aspects cannot occur without engaging in the process of communication (*Ibid*.). Issa and Yunusa (1998) define culture from a standpoint that indicates the strong relation between culture and communication when he purports that culture is a 'pattern of learned, group related perceptions including both verbal and non-verbal language, attitudes, values, belief systems, disbelief systems and behaviours that is accepted and expected by an identity group.'

Solomon et al. (2012) defines communication as a process that is concerned with the exchange of meaning. This assertion is endorsed by Issa and Yunusa (2015), who argue that

communication is a meaning-making exercise. The economic nature of Issa and Yunusa's definition reveals that a central aspect of communication is the ability to comprehend the transfer of thoughts which occurs between participants engaged in communicative behaviour.

Intercultural communication occurs frequently in the South African medical discourse due to the multilingual landscape of the country. In the South African context, intercultural communication in the public healthcare sector is evident between clinicians and the patients to they provide the healthcare services. The prevailing scenario is such that clinicians are trained in English to provide services to majority of the people who are not or are less literate in English. This emanates from the fact that English is a dominant language of instruction at schools and universities and the language of business. The use of one language in a linguistically diverse society is a huge challenge particularly in a country that acknowledges this linguistic assortment through its constitution and the public discourse of a "rainbow nation" (Hussey 2012). Oftentimes, communication between clinicians and patients is affected by lack of a common language leading to comprehension problems.

Rendi-Wagner and Kahr-Gottlieb (2016) posit that in situations where there are cultural differences, these forms of differences often breed difficulties to the communication dynamics of clinicians and patients which in turn could result to negative health outcomes. This notion is reinforced by Poternotte et al. (2017: 170) who maintains that patients who have ethnic origins and cultural backgrounds which are different to those of the healthcare professionals tend to have a less pleasant healthcare experience than patients who share their cultural background with clinicians and this is mainly attributed to communication complications which lead to compromised mutual understanding and less satisfaction. Soahatse (2000) adds that the misunderstanding which occurs between patients and clinicians as a result of differences in language is a disservice to the patient and may beget severe health complications for the patient. To show the importance of language in the medical field, Soahatse (2000) gives an example of a doctor who opted for the use of physical gestures to communicate with the patient who was ultimately discharged from the hospital. Three days later, the patient was re-admitted with his health condition having deteriorated. In consideration of the points raised above, Hussey (2012) is correct in saying that in South Africa, language barriers continue to deprive most of the population quality access to and of healthcare services.

In a bid to circumvent linguistic challenges, many doctors seek the services of nurses to act as intermediaries between the treating clinicians and the patients. On surface level, this may seem

like a ready-made solution to the problem, after all, they are bilingual and can speak the two required languages. However, these nurses are not trained as translators or interpreters and they function in a highly specialised field – medicine – where misinterpretations can mean life and death for patients. Crawford (1999) carried out research into the use of nurses as interpreters in Cape Town and found that nurses omitted information that they perceived unimportant which the doctor would have deemed critical had they been proficient in the language of the patient. Additionally, nurses made diagnoses that they were not qualified to make consequently exacerbating the health problems of the patient (Crawford 1999). According to Crawford, this resulted in an atmosphere of antagonism between nurses and doctors which was not conducive for the healthcare space and the provision of quality healthcare. Crawford's study, which was carried out more than a decade ago, presents a disturbing picture of a system that is broken by communication discordances leading to major challenges in the workplace. There is need for a follow-up study, to determine if there have been changes in this field and the study needs to be broader to capture the many voices of the affected stakeholders so that intervention measures may be found.

The problem of utilising nurses as interpreters is not unique to South Africa. Research shows that this is a common trend in many countries in Africa and abroad. Elderkin-Thompson et al. (2001) reveal that in the United States nurses who are proficient in Spanish and English avail themselves to provide interpreting services, however, there is a limitation to their interpreting abilities because the nurses are not trained on interpreting biomedical terminology. Krupic et al (2017) highlights that in Sweden, there are instances when patients have to contact the healthcare system through the mediatory assistance of a healthcare professional who occupies the ad hoc position of an interpreter. A disadvantage of this phenomenon is that in their capacities as interpreters, healthcare professionals do not optimally and diligently apply themselves as healthcare communication practitioners as they are also required to attend to the biomedical needs of patients and thus neglect the communicative needs of the patients who require interpreting services throughout clinical consultations (Krupic et al. 2017). A research project conducted in the south of Spain by Plaza del Pino and Veiga (2014) on the communication dynamics between Spanish doctors and immigrants from Africa indicated that the patients experienced high levels of dissatisfaction when they were attended by a healthcare professional who did not speak the same home language as them and that patients often resorted to the use of hand gestures to describe their symptomology.

Elderkin-Thompson et al (2001) found that in the United States patients from immigrant populations who are not fluent in English attribute incorrect diagnoses, unsatisfactory medical care, and inappropriate hospitalisation of their children to language and cultural differences between them and the healthcare workers. Soahatse (2000) is of the view that patients are often endangered and their health compromised as a result of health decisions which are taken without full understanding of the patient's medical history and symptomology due to inter-lingual communication. In the light of the discussion above. This study will be carried out within the legal prescripts of the Constitution of the Republic of South Africa which advocates the respect and promotion of all official languages of South Africa and the Batho Pele Principles which are a public service guideline on the delivery of satisfactory public service across all government departments.

1.2. AIMS - METHODOLOGY AND OBJECTIVES OF THE STUDY

In view of the research problem articulated above, this study aims to explore the interlingual and intercultural discordances that exist between clinicians and patients in the public health sector specifically investigating the cases of Cecilia Makiwane Hospital, Nkqubela Chest Hospital and Frere Hospital.

The objectives are as follows:

- to investigate the language and communication challenges and experiences of clinicians, nurses and patients in the health sector and the effects thereof;
- interrogate the challenges that nurses encounter when interpreting specialised and culture-specific terms in the health sector;
- identify and recommend intervention measures that are related to language and communication issues in the health sector.

1.2.1Methodology

This section of the proposal articulates the theoretical frameworks which underpin the arguments expressed in this study and the technical processes adhered to in collecting and analysing data. The central argument of this study will be discussed within the theoretical parameters of Functionalism and Communication theory.

Functionalism is a translation theory which was developed in Germany by Veremeer (1978) who is considered as the father of skopos. The term is used to refer to a group of translation

theories which conform to the view that every translation should be governed by its purpose in the target environment (Zheng 2017: 623) Nord (1991:9), one of the major proponents of the framework, explains the concept of skopos saying "the function of the target text is not arrived at automatically from an analysis of the source text. It is defined by the purpose of the intercultural communication, which means, the function or purpose of a text must be the guiding factor for carrying out a translation". This theory is applicable to this study because it upholds the importance of purposeful translation or interpreting. That is, the patient and his or her needs must be at the centre when interpreting so that accurate and coherent interpreting takes place. The concepts of accuracy, coherence and fidelity which are central themes in this theory are important to this study which views interpreting as a profession meaning interpreters and translators need to be trained before attempting it. Poternotte (2017:174) maintains that focusing on a patient-centred communication approach is an effective paradigm in intercultural communication which allows for effective participation of patients in their encounter with clinicians and that this approach provides explicit attention to helping patients be comfortable and empowered in a health system they are not familiar with. The notion of a patient-centred approach is consistent with the participatory paradigm (Zwane, 2020) which advocates for the exchange of knowledge between biomedical experts and community members whereby reciprocal dialogue is the most effective technique for enacting agency, stimulating the intellect of patients and empowering them to share their health circumstances.

Functionalism will be complemented by communication theory. The communication theory refers to the body of theoretical frameworks that inform our comprehension of communication dynamics (van Ruler, 2018). The communication theory is relevant for this study as it views communication from three perspectives; communication as a one-way process of constructing meaning in which the sender attempts to reimagine and manufacture the meaning developed by the recipient of the message; communication as a dual process of meaning reconfiguration in which two or more participants construct new meanings in tandem; and communication as an omnidirectional diachronic process that is invested in the continuous fabrication of meaning itself (*Ibid.*). For the purpose of this study, the focus will be on the understanding of communication as a process that is executed by multiple actors in a dialogue as is traditionally the case in clinical consultations which require the third-party intervention of an interpreter. Furthermore, the engagement of all the involved parties in the clinical consultation is congruent with the interpersonal communication theory which views communication between multiple participants as a direct reciprocal dialogue (van Ruler, 2018). The communicative reciprocity

in a clinical consultation is evident through spoken examination of a patient and feedback process which are communicated by the interpreter who acts as a conduit between the clinician and the patient.

1.2.2 Data collection and analysis

Data are collected from two public healthcare institutions in the Eastern Cape. The researcher applies for clearance to record consultations between the clinicians and patients, where the presence of a nurse interpreter is required. The biggest challenge would be to obtain the ethical clearance on time due to the bureaucratic structure of the provincial administration at the Eastern Cape Department of Health as well as the optimal extraction and recording of information at the earmarked health institutions particularly because of the enforced Covid-19 protocols.

1.2.3 Observing and recording: The sensitive nature of healthcare consultations does not permit for observing and audio recording of patients' healthcare information as that would contravene the patients' right to privacy and confidentiality. In seeking to understand how nurse interpreters interpret specialised and cultural terms, the participating clinicians, nurses and patients will be interviewed to determine their language and communication experiences. Semi-structured questionnaires and interviews will be used. This means:

- 17 clinicians were interviewed to understand and register the linguistic and cultural difficulties they experience when examining patients, they do not share a common language with.
- 10 nurses were interviewed to provide an account of the linguistic challenges they encounter when interpreting a biomedical dialogue between patients and clinicians. The interviews will extend to understand the extent through which the key performance area of nurses of ensuring the health and well-being of patients are adversely affected by their extended responsibility of interpreting and the effects of backlog on their work.
- 17 patients were interviewed to solicit their experiences of inter-lingual communication, capacity to comprehend information and satisfaction with services they received.

Comparative and contrastive analysis is used to analyse interpretations that are collected from the medical sector. This manner of comparison falls within the DTS methodology which requires a *tertium comparationis* (TC) that will serve as the basis of comparison between the source text and its translation (both at macro- and micro-levels) (Kruger 2000:11). This method of analysis gives the researcher sufficient information to analyse interpretations at word, phrase, sentence, paragraph levels and make judgements on the entire document. Thematic analysis will be used to complement this method and to analyse the information collected from clinicians, nurses and patients.

Bowen (2009) describes thematic analysis as a way of recognising a pattern that stems from the content contained in the documents and states that thematic analysis is characterised by thorough re-reading and presentation of data in a categorised fashion. Bowen (2009) maintains that an advantage of thematic analysis is that it enables the use of categorised themes to create a solid foundation for the incorporation of theoretical framework. The findings will be presented using themes.

1.2.4 Ethical considerations

This research is concerned with retrieving information from human participants thus ethical behaviour is expected. The researcher applies for ethical clearance from Rhodes University and the Eastern Cape Department of Health prior to the commencement of any collection of data. A consent form detailing the purposes, rights of participants, benefits, duration and storage of information will be drafted, and every participant will be requested to sign it, prior to participating in the study. Issues of anonymity, privacy, confidentiality will be addressed, and the participants will be assured of their anonymity and the confidentiality of their information. The use of pseudonyms will be applied to conceal the true identity of participants and patients. It is be communicated to all participants that there will be no form of remuneration for their participation and that the study is solely for academic purposes and that the information will be accessed by myself – the researcher – and my supervisor. All information will be backed up on cloud and Google drive and both copies will be encrypted to prevent unauthorised access to the information.

CHAPTER 2: RESEARCH METHODOLOGY

2.1 Introduction

This section of the thesis focuses on theoretical approaches that are selected to underpin the translational arguments delivered on this thesis. Functionalism was coined by Vermeer in the 1970s and has its ideological roots in Germany (Arbabi and Farahani, 2019). Functionalism focuses on the purpose of the text and the translation (Zheng, 2017). Functionalism is an umbrella term for different theories that subscribe to a purpose-oriented climate of thought when it comes to translation of texts (Zheng, 2017). The concept of functionalism consists of the assemblage of different functionalist theories such as the Skopos theory developed by German academics, the theory of dynamic/functional equivalence which was founded by American intellectual Eugene Nida and the text-type classifications and communicative vs. semantic translation which were coined by English scholar Peter Newmark (Zheng,2017). A common feature of these theories is that they all study translation theory and practice from the point of view of the purposes of texts although there are subtle differences between these theories (Zheng, 2017).

2.2 Analysis of theoretical paradigms

The primary principle of protagonists of functionalism is that translation exceeds the ideological boundaries of archaic concepts such as equivalence, literal translation and free translation (Arbabi and Farahani, 2019). Equivalence is defined by Shuttleworth and Cowie (1997) as "the nature and the extent of the relationship which exists between SL and TL texts or smaller linguistic units. For Palumbo (2009) equivalence refers to the connection that exists between a translation and the original text. The key difference between literal translation and free translation is that according to Oxford (2014) literal translation actively pursues the direct corre-

spondence in terms of words between the source language and the target language. Free translation on the other hand is explained by Barbe (1996) as a translation practice that focuses on expressing the overall sense and meaning of the message in the target language.

The Skopos theory which originates from Germany consists of two leading advocates in Hans Vermeer and Christiane Nord, with the latter succeeding the former (Zheng, 2017). An etymological analysis of the word "Skopos" reveals that Skopos is a Greek word which means "purpose, intent, goal, aim and function; and Skopos often pertains to the intention of the text (Zheng, 2017). The Skopos theory is underpinned by three guiding principles: skopos rule, coherence rule, fidelity rule. According to Reiss and Vermeer (1984) the principal rule for any translation is the skopos rule which maintains that the translation action is influenced by its Skopos so long as the outcome is sufficient irrespective of the methods applied. Zheng (2017) maintains that the source language text does not dictate the translation process, but the purpose for which the target text will be used for. This means that whichever strategy the translator opts to apply is sufficient and effective so long as the translation is usable and comprehensible to the end-user. This indicates then that under the skopos rule the notion of an appropriate strategy of translation is subjective and is dependent on whether the intended recipient of the message can understand the message. In the context of interpreting in the public healthcare sector, the primary focus should be on the articulate manipulation of the translation process by the interpreter for the benefit and understanding of the patient and not the critiquing of the strategies of interpreting the interpreter applies.

Reiss and Vermeer (1984) define the coherence rule, which is the second principle of Skopos theory, as a rule that stipulate that a translation becomes satisfactory when it becomes compatible with the cultural compass of the receivers of the message. When interpreting the message should fall within the remit of acceptable cultural standards and it ought to conform to the communicative and speech standards that are synonymous with polite discourse in the language of the patients. The interpretation has to be sensitive to the cultural speech censorship dynamics of the language of the patients and in the context of isiXhosa this often is achieved through the use of euphemisms that are culturally appropriate. The third principle of the Skopos rule is the fidelity rule or intertexual coherence. Zheng (2017) defines the fidelity rule as the presence of common features in both the source text and the target text. The notion of fidelity rule emphasizes that the target text should resemble the source text in either form, content or effect (Zheng, 2017). In short, the translated text should not be a complete reinvention of the source but instead it should embody some of the source text elements whilst manipulating others so that it

becomes congruent with the needs of the targeted readership. The three fundamental rules of the Skopos theory are listed according to order of importance as intertextual coherence is secondary to the coherence rule and both these rules are subordinate to the Skopos rule (Reiss and Vermeer, 1984).

Apart from these three rules, there is another principle, the "Function plus Loyalty" principle that is put forward by Nord (Zheng, 2017). Under this principle, it is imperative for the translator to demonstrate loyalty towards the language practice personnel involved in the translation process including the author, the individual who started the translation process, and the recipient of the translated text (Zheng, 2017). There are distinguishable characteristics between fidelity or faithfulness and Function plus Loyalty. Zheng (2017) points out that fidelity or faithfulness refer to a textual relationship between the source text and the target text whereas Nord (2001) highlights that Loyalty is an interpersonal phenomenon that refers to a social relationship between people.

Arbabi and Farahani (2019) state that the overarching principle maintained by chief scholars of functionalism is that translation has a function that it ought to fulfill and that this purpose ought to be identified prior to the commencement of the actual translation process. The notion of a good translation is the hallmark of functionalism (Arbabi and Farahani (2019), and a good translation is achieved when (Yue, 2013) the meaning contained in the source text and the cultural properties entrenched in the language of the source text are sufficiently delivered in the target language and successfully evoke the same feeling from the target audience that the source language audience has about the source language text. The concept of a good translation is a salient aspect in the interpreting process that takes place in the public healthcare sector because it would ensure that the patients receive interpretations that are both linguistically and culturally accurate. However, in the contemporary language landscape this is difficult to achieve in a systemic fashion due to the monolingual nature of the public healthcare system which coerces the majority of patients to access healthcare through language-mediated engagements instead of first-hand contact with healthcare through their native languages. Unlike antiquated dichotomies of translation such as literal translation and free translation, command of good translation does not confine itself to solely linguistic approaches of translation (Arbabi and Farahani, 2019)

According to Zheng (2017) notes that function pertains to the factors that make a target text meet the communication needs of the target situation it is meant for. The amalgamation of

function and loyalty creates an additional principle that completes the Skopos Theory and provides the translator with a degree of freedom in the translating process to attain the desired purpose of the target text and the notion of function is integral in keeping the translator in close proximity to the intention of the original author (Zheng, 2017).

American translator Eugene Nida deviates from a conservative approach to translation by adopting a functional approach to translation and differentiating between dynamic equivalence and formal equivalence (Zheng, 2017). There is a theoretical difference between these two forms of translational equivalence and Nida and Taber (2004) when explaining dynamic equivalence, state that: "dynamic equivalence is there to be defined in terms of the degree to which the receptors of the message in the receptor language respond to it in substantially the same manner as the receptor in the source language". This is to say that the translated body of text ought to have the same effect in the target language as the original text has to native speakers of the original text. Dynamic equivalence is concerned with ensuring that the response by the target audiences of the respective texts is significantly similar although it is imperative to register that there are social elements that avert the responses from being identical. Nida and Taber (2004) pronounce that it is impossible for the response to be matching due to the cultural and historical circumstances upon which the texts are manufactured, however, there should be a proliferated extent of equivalence of response or the translation would not realise its aim. The view that dynamic equivalence equates successful equivalence to the holistic consideration of social factors involved in communication is supported by Zheng (2017) who points out that dynamic equivalence realises equivalence beyond the bounds of language with the intention of engineering the equivalent effect of the message on the recipient.

Formal equivalence refers to producing the target text by faithfully adhering to the formal elements that have been used to construct the source text and that the source text and the target texts must have shared functions in the respective languages (Zheng, 2017). A crucial feature for establishing whether the target text faithfully complies with the source text, the focus should be comparing the response of the intended recipients and not focus on the formal structure between the two bodies of text. (Zheng, 2017). If the formal structure of the original text hinders the receptors from understanding the text, then the translator ought to rework the text in order to make it comprehensible and acceptable to the readers and for it to accomplish the purpose it was designed for (Zheng, 2017). These adjustments may be on various strata of communication which include phonology, lexicon, syntax, and discourse (Zheng, 2017). In the context of interpreting between English and isiXhosa, these adjustments will be greater because

of the vast differences between these two languages as a consequence of these humongous linguistic differences the interpreter has to conjure up all the necessary adjustments to ensure that the patient comprehends the interpretation whilst considering social factors the reside beyond the ambit of language.

The transfer of information between patients and clinicians is a mutually informative exercise where the patient informs the clinician about the status of their health conditions and the clinician is responsible for providing the patient with medication, counselling and precautionary and preventative measures to take to stay healthy. The interpreter involved in transferring the message contained in the dialogue needs to know the purpose of the message and curate the manner in which they interpret to fit the intention of the communication. The ethos of functional approaches to translation is that the function of the text dictates the strategies of translation to be used for translating into the target text. This philosophy also applies to the Text Typology and Translation Methods which was a contribution made to translation as a professional discipline by Katherina Reiss and Peter Newmark. Zheng (2017) explicates that text type and genre refer to a distinguishable category of discourse of any type, spoken, written or with or without literary aspiration. Furthermore, Zheng (2017) asserts that text type as a crucial feature of text express linguistic function, collection thinking systems informed by beliefs and lived experiences, and cultural norms. Zheng (2017) avers that every text has peculiar elementary communication functions and that according to Reiss (1989) the unique nature of each type of text needs different translation techniques.

Another theoretical framework that is salient in comparing different cultural elements is the Hofstede Cultural Model which is named its protagonist and Dutch social psychologist Geert Hofstede. Under the concept of this Hofstede Cultural Model, Hofstede defines ‘culture’ as “the collective programming of the mind that distinguishes the members of one group or category of people from others". This understanding of culture focuses on the cognitive engineering and mental works of persons including the manner in which their behavioural patterns are influenced by how they are socially conditioned. The notion of behaviour patterns is a crucial element that ought to be carefully examined when studying and exploring the co-existence of different people in a particular environment. There are six dimensions labelled in the Hofstede Cultural Model and are as follows: power distance, uncertainty avoidance, individualism vs collectivism, masculinity vs femininity, long-term vs short term orientation, indulgence vs restraint. This study will focus on selected cultural dimensions that are most applicable to this study. It is imperative to note that Hofstede defined these cultural dimensions

Hofstede (2011) defines power distance as the degree to which members who occupy the lower ranking strata of organisations and institutions accept and expect power to be distributed unevenly. Power distance characterises the level of inequality in society and that this disparity in society is advocated for by the subordinates as much as it is supported by the leaders (Hofstede, 2011). The inequality between patients and healthcare professionals in the Eastern Cape public healthcare context is multi-layered and exists across different points in the socioeconomic spectrum and this affects the distribution of power in the clinician-patient interactions. The vast majority of clinicians in the South African healthcare landscape are not native speakers of the indigenous languages and this widens the communication gap between the healthcare professionals and the patients. Generally, most public healthcare patients have modest levels of education and this, coupled with the language gap, hinders effective communication and grants power to the clinicians and leaves patients in the margins of critical decision-making processes regarding their health. Furthermore, most healthcare professionals are white and cater to a predominantly black patient population and thus often operate from a place of perceived superiority and this is linked to the political history of South Africa.

For the purposes of this study, this section will interact with three of the six dimensions: namely power distance, individualism vs collectivism, and masculinity vs femininity as these cultural dimensions are more prevalent in the public healthcare system in the Eastern Cape. Hofstede defines these cultural dimensions from societal characteristics and not at an individual level.

Power distance is defined as the degree to which the less powerful affiliates of organisations and institutions accept and expect that power is disseminated unevenly (Hofstede, 2011). The notion of power distance defines inequality from the perspective of the less powerful members of a group and it purports that the level of inequality in society is supported by the followers as much as it is endorsed by the authorities (Hofstede, 2011). The quintessentially submissive nature of patients to instructions, decisions, and health opinions of doctors encourages the status quo of power imbalances between clinicians and patients.

Hofstede (2011) defines uncertainty avoidance as the indication of the degree to which a culture conditions its members to respond comfortably or uncomfortably in formless situations. According to Hofstede (2011), the unstructured situations are situations that are new, unknown, surprising, and different from the norm of a particular group. The idea of uncertainty avoidance is linked to how different the idea of normalcy is and in the context of communicating with

people across language and cultural barriers interlocutors may encounter several novel experiences. These novel communicative experiences include exposure to unknown vocabulary to one of the interlocutors and cultural mannerisms that dictate features of communicative competence and good behaviour. In the climate of communication in a linguistically diverse medical discourse the language barrier extends to the obscurity of biomedical jargon for patients coupled with the general incomprehensibility of languages of communication between the healthcare personnel and patients. Different cultures have different ways of observing culturally competent and what is a noble and benevolent gesture in another culture may be an offensive and derogatory gesture in another culture and this has the potential to beget tension and conflict. Cultural differences in communication may also lead to confusion as most African cultures have a long and elaborate way of communicating before addressing the crucial matter at hand. This is seen as a polite way of preparing the listener for what you are about to say and allowing them to register your mood. This elaborate style of communicating is seen as being courteous and polite and is vastly different to the western model of communication that tends to be brief and direct.

The notion of individualism vs collectivism observes the unity and cohesive societal dynamics of a people in their forms of as groups. Individualism refers to the extent to which people are integrated into societal groups whilst collectivism is concerned with integrating people from their earliest stages of human development into fortified and organised in-groups which often include extended family members in which social viewpoints of other organised cliques are profusely refuted in exchange for protection and commitment to the in-group (Hofstede, 2011). The Xhosa people fall culturally fall under the category of collectivist cultures as they value the ability to co-exist and rely on close family members with a consciousness of the collective and companionship. This way of living is different from the cultures of people from the global north which is individualism that is based on having an independent concept of self and individual members of these cultural groups an accentuated social distance between themselves and other members of the group including members of the nucleus family (Gelfand et al. 2004). This demonstrates that individualist cultures have a self-defined and definitive concept of self. According to Gelfand et al. (2004) collectivist cultures differ from individualist cultures in that members of the collectivist cultures share material resources and abstract resources such as time, affection and ways entertainment with people they have shared identities with and with whom they share their selves.

The resource sharing process in collectivist cultures is of co-dependent idea of self as well as a socialism technique that strengthens interrelationship among a group of people (Gelfand et al. 2004). Interdependence is mirrored in the communication of one's own outcomes, whether constructive or adverse, with the outcomes of others and the feeling of participation in their lives (Gelfand et al. 2004). Xhosa people, particularly nucleus family members, involve themselves in all the aspects of life of their relatives including health issues. The notion of subscription to communal ways of life is reflected in the way Xhosa people tend to attend clinical consultations – which is in the company of their family members of confidantes. This is different to individualistic cultures which view the screening and examination of patients in the biomedical arena as a private exercise that needs to be conducted in secrecy and with the information strictly and only shared with the concerned individual. Due to the collectivist nature of Xhosa culture, Xhosa people quintessentially people refrain from identifying as single units who are members of a larger group instead, they do not utilise the physical self as a form reference and actively shape the identity of self by the extent to which they resemble members of the in-group in terms of abstract characteristics such as principles and climates of thought. Resemblance with other members of the in-group is a crucial quality as there is almost no space to accommodate peculiarity. This means that individualist cultures adhere to egocentric and self-centred schools of thought whereas collectivism cultures are founded on principles of symbiotic relations and altruism.

Cultural Studies is one of the schools of thought that can be utilised to understand the shared understandings and values of the different groups that interact in the medical space in the Eastern Cape. Cultural Studies is defined by Johnson (1986) as being "about the historical forms of consciousness or subjectivity, or the subjective forms we live by, or, in a rather perilous compression, perhaps a reduction, the subjective side of social relations". Johnson (2004) further purports that as an intellectual and political climate of thought Cultural Studies consist of different theoretical paradigms that study cultural phenomena in a multidisciplinary approach. This means that Cultural Studies is invested in the critical study of social histories and power continuities in the different social spaces. Cultural Studies is more than academic expression that is founded theoretical frameworks, rather it is an intellectual-political discourse that aims to create social reform through analysing power dynamics and social responsibilities (Johnson, 2004). Johnson (2004) further explains Cultural Studies as an intellectual-political academic field comprises of various theoretical paradigms that observe the cultural elements that shape

the world views of different cultural groups across the humanities and social sciences spectrums.

These cultural elements include shared understandings such as belief systems, biases, and histories. It is on the backdrop of the assumption that the subjectivities of people inform their cultural dogmas that this study ought to use Marxism Theory (commonly referred to as Marxism) to make sense of the extent to which consciousness frames the cultural identity of a group. Johnson (2004) accentuates that Marxism emphasises that consciousness has an overt cognitive connotation. The process of interpreting requires extensive cognitive functions that intertwine linguistic proficiency with cultural acumen particularly in medicine as it is a filed with specialised terminology and knowledge.

Scholarly literature identifies several important concepts of Cultural Studies however this study will focus on three key concepts of Cultural Studies that are aligned to the study. According to Rai and Panna (2015) Cultural Studies is concerned with non-reductionism and articulation among other things. Non-reductionism is an integral conceptual feature of Cultural Studies which views each culture as being peculiar and having its own specific meanings which are impossible to reduce or interpret using the metrics of a particular social category or social grouping (Rai and Panna, 2015). This exclusively illustrates that schools of thought and behavioural patterns from different cultural formations ought not to be interpreted using instruments and values from foreign cultures. This notion of accepting and endorsing cultural differences is important in the culturally diverse biomedical space of the Eastern Cape to allow patients to express themselves in a manner that does not confine them to the remits of what is socially acceptable in a health environment that is under the influence of western socialisation. The understandings of sickness and modes of sickness are interpreted differently by patients to health professionals due to differences in cultural backgrounds and levels of education. It is crucial for healthcare professionals to have the ability to reconcile by the indigenous Xhosa interpretation of health with the scientific analysis to better understand the patient and not reduce the cultural position of a patient to a peripheral abstract cultural object.

The idea of articulation in Cultural Studies is used to form theories about relationships among different features of a social construction (Rai and Panna, 2015). The healthy trident relations of patient-nurse-clinician are the backbone of an efficient healthcare system and a breakage in the communication chain between the three participants obstructs the provision of effective patient-care.

There are significant commonalities between Marxism Theory and the Hofstede's Cultural Dimensions Model. Both these theoretical paradigms explore the relationship between culture and the construction and maintenance of social power as well as the manner in which people interact with the hegemonic social ideology in their immediate spaces. In the Eastern Cape healthcare fraternity, the dominant social structure is the use of English as a means of accessing healthcare and the use of nurses as untrained interpreters to bridge the language and knowledge gaps between patients and clinicians. Marxism Theory is a component of Cultural Studies that falls under the political economy theories branch and observes the construction of economic ecosystem by the powerful members of society and how that relates to the exploitation of labour for capitalistic benefits. It is important to link the interpretation responsibility taken up by nurses without remuneration with the exploitation of labour as interpreting medical discourse falls outside the remit of their collective job descriptions and scope of work. Marxism Theory encourages the dismantling of the powerful social order against the will of its proponents with the less powerful members of society seizing power. The ought to be active steps that are explored and implemented to ensure that the patients are provided with a public healthcare system that competently permits them to have contact with it in their indigenous languages. In the context of the Eastern Cape and South Africa at large, there is a direct relationship between the economic status of speakers of indigenous languages and the use of their languages in higher domains of human interaction including the health space. This disenfranchisement of the indigenous population of South Africa and the marginalisation of indigenous languages of South Africa is connected to the systemic oppression of the indigenous population under various socio-economic and socio-political dispensations that preceded the democratic era. Rai and Panna (2015) elucidate that political economy theories are conceptual paradigms that focus on how economic power provides a foundation for ideological and political power.

2.3 Data presentation and analysis

2.3.1 **Theoretical framework of data presentation and analysis**

This chapter is concerned with the presentation and analysis of data that has been collected through interviews and questionnaires that were administered to the three human population groups, namely: clinicians, nurses and patients. Technically, data presentation is a process of using different formats of articulating information between various sets of information so that

an informed conclusion can be made based on them. Three types of data presentation will be utilized to comprehend the information which has been gathered. The data presentation methods are textual, tabular and diagrammatic. Textual data is presented as transcripts of interviews, field notes, memos, and extracts from essays, diaries and stories (Burnard, 1996:278). The emphasis is that the data presented is on paper. The responses that participants provided are recorded in the questionnaires and as on-field notes.

The method in which data is collected informs the format that will be applied in analyzing it (Burnard, 1996: 278). Similarly, to the analysis of textual data, structured interviews provide the researcher with the opportunity to analyze all the responses provided to each answer by each participant (Burnard, 1996: 278). The advantage with using structured interviews and analysis of questionnaires is that the same level of structure is produced in the data. This form of analysis is what Krippendorf (1980) describes as content analysis. Building from the concept of content analysis as described by Krippendorf, Burnard (1996:278) professes that the aim of content analysis is for the researcher to explore the written information with the intention to categorize excerpts of information that have commonalities in terms of expression and convictions.

As extensively discussed in academic literature, by (Berelson 1971, Knafl & Howard 1984, Polit & Hungler 1991, Miles & Huberman 1994), this chapter will follow the application of the marque stages of content analysis:

1. The researcher thoroughly reads through the gathered data and identifies headings and classifications which consider all the aspects that are discussed in the data Berelson 1971, Knafl & Howard 1984, Polit & Hungler 1991, and Miles & Huberman 1994). The researcher notes utterances on the periphery of the paper that provide a succinct overview of the passage of information (Burnard, 1996: 279);
2. The data presented in the form of interview transcripts is fitted under the appropriate categories. At this stage of content analysis, all the collected data should be subsumed under the correct form of categorization, if not, then the applied system of classifying information ought to be revised;
3. A report is written in which the content classification groups form the sub-titles of the report. Each sub-title contains a word by word account which serve as specific illustrations of that particular category. Furthermore, the researcher is permitted to make remarks based on the illustrations.

This categorisation system ensures that no aspect is discussed as the aim of this type of analysis is to identify salient issues.

A list of questions asked in a set order forms part of the data collection methods. This form of questioning is referred to as structured interviews. Structured interviews are similar to verbal questionnaires with a rigidly structured interview schedule that acts as a guideline for the trajectory of the interview (Crabtree and Miller, 1992:16). This type of interview is most effective when adequate reliable information has already been gathered which serves as a platform on which to construct the interview schedule (Crabtree and Miller, 1992:16).

The processes of data collection are followed by data analysis mechanisms that are applied depending on the type of data collection processes applied. There are four main categories of data analysis which exist along a continuum. At one end of the spectrum exists analytic techniques that are collectively referred to as quasi-statistical and are characterized by being more impartial – the researcher is removed from the purpose of the researcher – scientific, general, technical, and standardized (Crabtree and Miller, 1992:17). A band of data analysis techniques labelled as immersion/crystallization also exists ad this refers to techniques that are emanate from the researcher, intuitive, focus on details (personal and hinge on context), focus on daily existence, connected to meaning and generative (Crabtree and Miller, 1992:17). Editing and template analysis styles are situated in the middle of the spectrum, are the most ordinarily used and are more subjective and codebook-based respectively (Crabtree and Miller, 1992:17).

2.3.2 **Identification of patients in healthcare institutions**

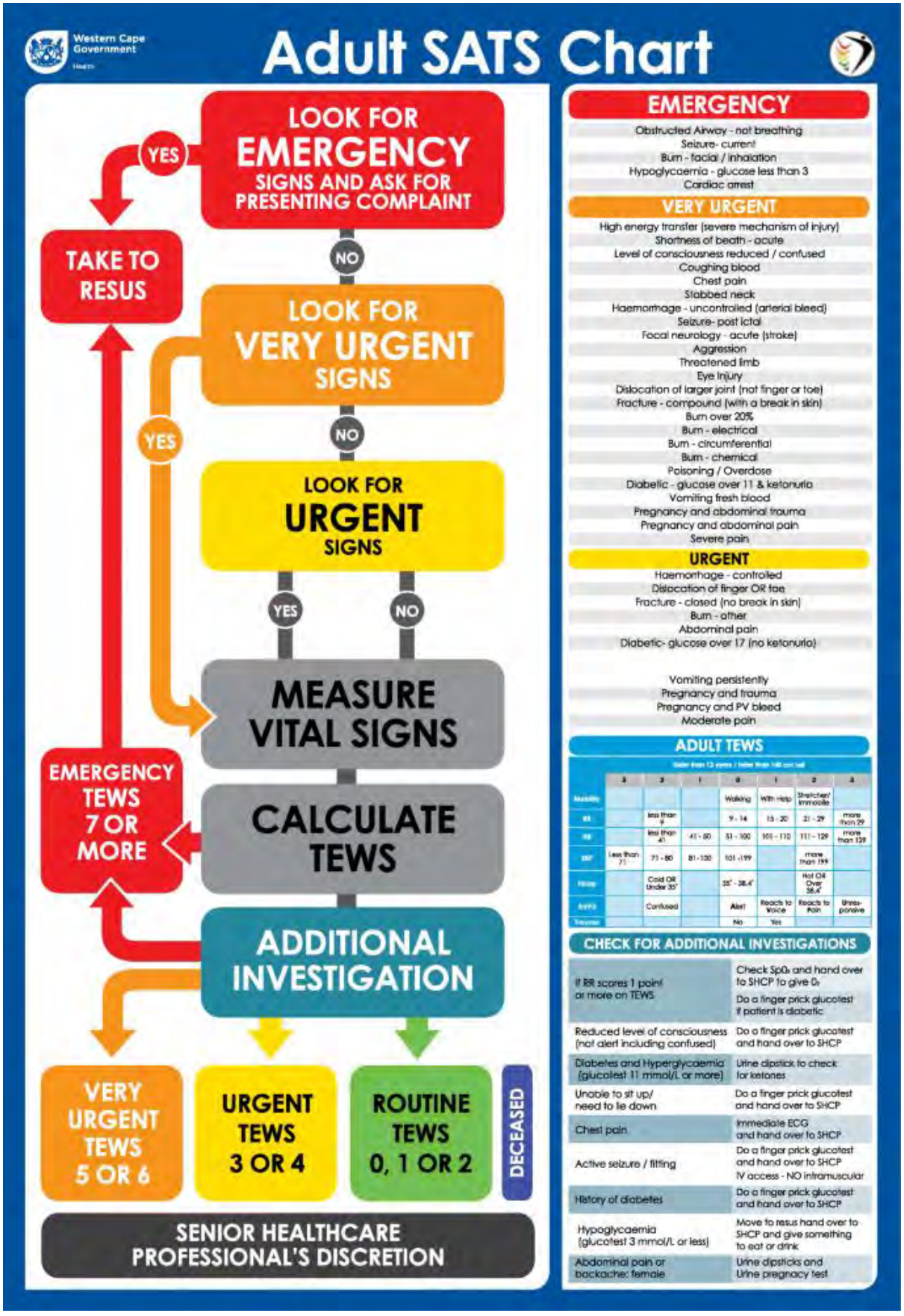
The data collection process adhered to the principles and legislative provisions that prioritise patient safety and care and without causing disruption to the daily routine and protocols of provision of quality service. On the background of this, the research will lean on the application of the South African Triage Scale (SATS). The SATS is a system of determining the preliminary assessment of patients or the wounded in order to establish the seriousness of their need for healthcare and the type of treatment needed. It is imperatives for this research to prioritise patients who do not need urgent medical attention. The triage system has a 5-level categorisation system that uses a symptom-based approach on the extremity of the condition of the patient. The colour-themed categorisation system is as follows:

Table 1.1 SATS priority levels and target times to be managed

Priority colour	Target time for treatment	Management
Red	IMMEDIATE	Take to the resuscitation room for immediate treatment
Orange	< 10 min	Refer to majors for very urgent management
Yellow	< 1 hour	Refer to majors for urgent management
Green	< 4 hours	Refer to designated area for non-urgent cases
Blue	< 2 hours	Refer to doctor for certification

Source: *South African Triage Score (SATS) Training Manual* (2012:7)

Below is the Adult SATS Chart which extrapolates the symptoms under each categorisation.


Western Cape Government
Adult SATS Chart
LOOK FOR EMERGENCY SIGNS AND ASK FOR PRESENTING COMPLAINT
YES
TAKE TO RESUS
NO
LOOK FOR VERY URGENT SIGNS
YES
NO
LOOK FOR URGENT SIGNS
YES
NO
MEASURE VITAL SIGNS
CALCULATE TEWS
EMERGENCY TEWS 7 OR MORE
ADDITIONAL INVESTIGATION
VERY URGENT TEWS 5 OR 6
URGENT TEWS 3 OR 4
ROUTINE TEWS 0, 1 OR 2
DECEASED
SENIOR HEALTHCARE PROFESSIONAL'S DISCRETION
EMERGENCY
Obstructed Airway - not breathing
Seizure- current
Burn - facial / inhalation
Hypoglycaemia - glucose less than 3
Cardiac arrest
VERY URGENT
High energy transfer (severe mechanism of injury)
Shortness of breath - acute
Level of consciousness reduced / confused
Coughing blood
Chest pain
Stabbed neck
Haemorrhage - uncontrolled (arterial bleed)
Seizure- post ictal
Focal neurology - acute (stroke)
Aggression
Threatened limb
Eye injury
Dislocation of larger joint (not finger or toe)
Fracture - compound (with a break in skin)
Burn over 20%
Burn - electrical
Burn - circumferential
Burn - chemical
Poisoning / Overdose
Diabetic - glucose over 11 & ketonuria
Vomiting fresh blood
Pregnancy and abdominal trauma
Pregnancy and abdominal pain
Severe pain
URGENT
Haemorrhage - controlled
Dislocation of finger OR toe
Fracture - closed (no break in skin)
Burn - other
Abdominal pain
Diabetic- glucose over 17 (no ketonuria)
Vomiting persistently
Pregnancy and trauma
Pregnancy and PV bleed
Moderate pain
ADULT TEWS
Walking
With Help
Stretcher/ Immobile
Alert
Reacts to Voice
Reacts to Pain
Unresponsive
CHECK FOR ADDITIONAL INVESTIGATIONS
If RR scores 1 point or more on TEWS
Check SpO2 and hand over to SHCP to give O2
Do a finger prick glucotest if patient is diabetic
Reduced level of consciousness (not alert including confused)
Do a finger prick glucotest and hand over to SHCP
Diabetes and Hyperglycaemia (glucotest 11 mmol/L or more)
Urine dipstick to check for ketones
Unable to sit up/ need to lie down
Do a finger prick glucotest and hand over to SHCP
Chest pain
Immediate ECG and hand over to SHCP
Active seizure / fitting
Do a finger prick glucotest and hand over to SHCP
IV access - NO intramuscular
History of diabetes
Do a finger prick glucotest and hand over to SHCP
Hypoglycaemia (glucotest 3 mmol/L or less)
Move to resus hand over to SHCP and give something to eat or drink
Abdominal pain or backache: female
Urine dipsticks and Urine pregnacy test

The use of the SATS system creates an enabling healthcare space for both the patients and healthcare personnel. The efficacious implementation of this system has the following benefits:

1. expedite the delivery of time-critical treatment for patients with life-threatening conditions.

2. ensure that all patients are appropriately prioritised according to their medical urgency.

3. improve patient flow.

4. improve patient satisfaction.

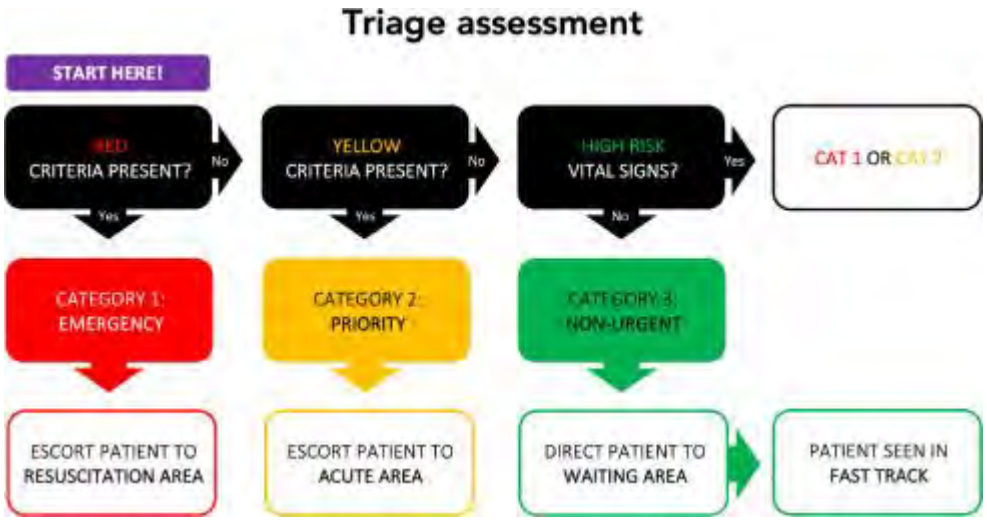
5. decrease the patient's overall length of stay.

6. facilitate streaming of less urgent patients.

7. provide a user-friendly tool for all levels of health care professionals.

The application of the triage system is particularly important in the data collection process in these hospitals as this system was developed to combat unsatisfactory service delivery and to categorise undifferentiated active short-term care to patient presenting to healthcare facilities in low-resourced African communities. Both Cecelia Makiwane Hospital and Frere Hospital have large volumes of patients from low-income and disenfranchised backgrounds with the former being situated in a largely destitute residential area. The SATS enhances the processes of operation in a healthcare institution.

Below is a diagram showing the practical application of the SATS colour-themed symptoms approach:



2.3.3 **Selected OPDs for data collection**

The OPD is the part of the hospital that which is an area of communication and clinical consultation between patients and healthcare professionals. After clinical consultations, patients who make use of hospital OPDs return home in possession of medication prescribed by healthcare professionals without spending the night at hospital. The acronym OPD stands for Outpatient Department.

2.3.4 **Data collection methods**

This sub-segment of the research is concerned with detailing research instruments that will be used when collecting data and explaining the reasoning that informs the selection of each research instrument. This chapter will also detail the underlying ideology about how data in this type of research ought to be gathered, analysed and used. Moreover, this chapter will extend to identifying what type of research the study is and the research strategy that is aligned to this study including highlighting the point(s) in time of when the data will be collected.

The sampling strategy and the data collection methods will be discussed in-depth as well as exploring the data analysis techniques that will be used in this study; the methodological limitations that will surface; and end the chapter with a concluding summary that succinctly revisits the content that is already discussed in the chapter.

The two dominant research philosophies are positivism and interpretivism. Positivism views the researcher as the sole authority figure of knowledge from which action will arise and the only initiator of action to be taken on an essentially inert world (Warfield, 2010). Interpretivism differs from positivist paradigm in that social reality is seen and interpreted by the individual according to the philosophical position in which they subscribed to and that knowledge is experienced at a personal level rather than obtained from or exerted from outside (Intergrity, 2016).

Saunders et al (2009) explain research philosophy to be a system of beliefs and conventions about the technical ways in which knowledge is developed. A consistent set of assumptions will create a trustworthy research philosophy which will underpin methodological design choices such as the research strategy and data analysis techniques (Saunders et al. 2009). Research philosophy is defined by Scotland (2012) as a set of beliefs which pertain to a particular phenomenon of reality that is being investigated and that the choice of the type of research philosophy that is utilised in a domain of research study is determined by the knowledge that

is being studied. This means that the research philosophy adopted for a research study influences the type of theoretical research apparatuses used and has to be compatible with the used research theoretical apparatuses to arrive at scientifically credible conclusions. Interpretivism is a salient research philosophy for focusing on the subjective experiences of human beings, the ways in which people configure the social world through sharing meanings, and the manner in which people interact with or relate to one another (Intergrity, 2016). The two languages which will be examined in this study are isiXhosa and English and the manner in which the clinicians and patients construct meaning of clinical consultations, interact with each other and how they relate to one another. Social constructs such as language, consciousness, and shared meanings are devices which are utilised to acquire access to understanding of reality. This research, therefore, will seek to understand how communication shapes the meaning and understanding of the concept of health for clinicians and patients and how both members of each group make sense of their experiences in the health sector encounters. The research philosophy that will underpin this research is interpretivism.

Interpretivism is applied in research situations that attempt to comprehend phenomena using exploration or elucidation of people's perceptions, language, shared values and meaningful symbols in a dynamic social environment (Gilland, 2014). This research will intend to establish the manner in which clinicians and patients perceive effective communication and interpret courtesy in an environment merges language, culture and medical knowledge to provide effective medical care.

There are two fundamental distinctions in the types of ways in which data is collected, namely qualitative research and quantitative research. Quantitative research is concerned with impartially collecting and investigating numerical data to describe, predict, or control variables of interest and is a type of research that focuses on quantities and numbers. (McLeod, 2019). Quantitative data is data that is presented in the form of numbers or information that can be translated into numbers and can be tested using statistics (Gilland, 2014).

This study falls under the category of qualitative research. McLeod (2019) defines qualitative research as the process of collecting, analysing, and interpreting word-based information such as language. The focal point of this study is the use of language in the healthcare sector and how the communication dynamics in this social sector affect the delivery of healthcare services. Qualitative research, through observing phenomenon that can only be observed and not measured, intends to comprehend the lived experiences of individuals, groups and cultures in the

best possible manner from the perspective of the participants and this is the reason populations are studied in their natural environments (McLeod, 2019). In this study, the participating individuals from healthcare employees and patients will be engaged with in the healthcare institutions in which they work and receive healthcare treatment respectively. This is consistent with the assertion made by Gilland (2014) is that trademark aim of qualitative research is to study people in their natural environments and document their feelings, social situations, and experiences in non-re-enactment spaces through relying on analysing the words, actions and motivations of people.

As previously mentioned, the hallmark research philosophy of this study will be interpretivism. Intergrity (2016) explains that interpretivism is underscored by three philosophical branches of interpreting human engagement with knowledge, namely *phenomenology*, *ethnomethodology*, and *symbolic interactionism*. According to Chege and Otieno (2020) defines phenomenology as a qualitative research technique that seeks to gain an understanding of the viewpoints and perceptions of participants about their social realities. The practical application of phenomenology in this study will be the attempt to comprehend how the clinicians and patients navigate the language relations in the health sector.

Ethnomethodology is a field of research that focuses on people's implicit, unacknowledged, taken-for-granted assets of social action, their common sense and their interactional astuteness (Arminen, 2011). The ethnomethodology aspect of the research is highlighting the tacit position of indigenous South African languages in the health sector wherein these languages are in the periphery of medical discourse. Indigenous knowledge systems which pertain to healthcare are relegated to the margins of biomedical dialogue and cultural philosophies are largely placed in obscurity and this often causes tension between medical practitioners and patients. The outlying role of indigenous cultural healthcare knowledge and indigenous South African languages reflects the nature in which these languages are looked down upon and this compromises the interactional relations between clinicians and patients which ultimately culminates into poor delivery of healthcare services.

Symbolic interactionism accentuates comprehension and interpretation of communicative engagements that occur between human beings (Arminen, 2011). This abstract element of interpretivism seeks to understand the interaction of human beings from a symbolically meaningful

perspective wherein people have the capacity to create human interaction that can be understood. Symbolic interactionism views language as an organised function of social interaction in which meaningful objects of communication are produced.

The aim of interpreting the data that will emerge from in-depth interviews with healthcare workers and patients is to intervene and effect positive change in the language and communication dynamics in the healthcare sector. Synonymous with interpretivism is the concept of praxis. Chege and Otieno (2020) articulates that praxis is concerned with the art of acting in challenging situations with the intention of effecting change and is guided by good judgment. The concept of praxis is congruent with one of the aims of this research which is to establish and recommend intervening measures that are associated with language and communication problems in the health sector. This research aims to devise pragmatic solutions that will solve the communication and cultural problems that arise during clinical consultations between healthcare workers and patients.

This research will utilise research design strategies that will be used to collect data and arrive at scientifically valid outcomes. Gilland (2014) describes research design as an architectural design or an outline of a research project, and the implementation of the design, the research design or methodology as the building method using methods and theoretical frameworks. The research design choices embedded within the research strategy paradigm are experiments, case studies, ethnography, grounded theory, action research, and phenomenology. The research strategies which will be used in this research are ethnography and phenomenology. According to Naidoo (2015) defines ethnography as a qualitative method that is concerned with the beliefs, social interactions, and behaviours of small communities involving participation and observation over a period of time. For Denzin and Lincoln (2011), ethnography refers to a social science device that includes the social scientific observer, the observed personnel, the textual form of the research report, and the intended audience to which the text is presented.

There are different types of ethnography, namely: reflexive ethnography, auto ethnography, performance ethnography and critical ethnography. Reflexive ethnography is concerned with criticizing the power relations and unfairness that happens within a particular culture (Naidoo, 2015). This research paper will examine the imbalance of power that exists between health professionals due to language and cultural dynamics. The clinicians tend to exert their own cultural mannerisms using English which is a language that is not fluently spoken by the ma-

jority of patients in the health sector. This creates an absence of equilibrium in the communication dynamics between healthcare workers and patients where the latter group are submissive to the culture of the health sector where they accommodate the monolingual nature of the health sector at the expense of receiving quality healthcare that is sensitive to their cultural dogmas.

Auto-ethnography is concerned with exploring the ways in which dominant historical accounts are responsible for keeping structures of influence and control and the difficult social trajectory of people in pursuit of ways to deconstruct power relations (Naidoo, 2015). The hegemonic use of English as a tool of communication in healthcare is a social inequality that is a legacy of the oppressive history of South Africa in which the indigenous local languages were systematically deprived of use in important social domains. This research will show the salience of actively incorporating indigenous local in the biomedical discourse and how this can significantly improve the provision and receipt of healthcare in the Eastern Cape. This is congruent with the aim of auto ethnography which, according to Naidoo (2015), is to achieve an equal and just society and evidently demonstrate where power, privilege and impartialities lie.

Performance ethnography connects various disciplines of social science and is a suitable instrument for exhuming new knowledge and presenting it to an audience as well as illuminating power structures (Naidoo, 2015). According to Warren (2006) performance ethnography has the capacity to ourselves and others by disrupting the aspect that is taken for granted in a particular practice thus making that practice more meaningful. In the context of this research, indigenous South African languages, cultures and thought systems are on the margins of biomedical discourse. The fluency of healthcare professionals in the native languages of the patients they serve is not prioritised and this research will aim to position the fluency of medical professionals at the epicentre of quality healthcare provision.

The type of ethnography that resonates the most with this research is critical ethnography. Critical ethnography operates on a moral realm by assuming the ethical responsibility to address processes of unfairness within a specific field (Naidoo, 2015). According to Naidoo (2015) the sense of ethical responsibility; is triggered by respect for human freedom and well-being as well as compassion for the anguish felt by human beings. This research will intend to illuminate the suffering that the patients are exposed to due to communication challenges that stem from language barriers between them and the clinicians. The suffering that the patients receive relate to them receiving inadequate physical analysis and unsatisfactory communication of diagnosis

and treatment procedures. The injustice in the health sector which pertains to language is indigenous local languages of patients not being utilised as tools of scientific medical dialogue thus relegating the patients to the fringes of matters which directly pertain to and affect their health.

The data for this research will be collected using observational studies. Observational studies refer to phenomena in which researchers record data about their subjects without exerting their influence or making changes to the environment of investigation Bhat (2020). Observational studies are conducted using two main types of correlation research, namely longitudinal research and cross-sectional research. Cherry (2020) defines longitudinal research as a type of research that involves observing variables over an extended time period and this research take weeks, months and months to complete. Bhat (2020) defines cross-sectional study as an observational study at one point in time to examine the relationship between variables of interest. This research study will employ the longitudinal study as the research will be conducted over a period of weeks in different geographical areas in the Eastern Cape.

The use of observational studies operates in tandem with the collection of data from sources of information for the research. According to Kandace and Landreneau (ibid) sampling refers to selecting a portion of the population, for the purposes of the research area, which will serve as a representation of the entire population. There are two types of sampling designs which are involved in the collection of data. *Probability sampling* refers to a form of arbitrary selection in selecting the elements of research (Kandace and Landreneau, ibid). An advantage of this sampling design is that it has a high probability of accurately representing the demographic that is under investigation and is characterised by a selection method in which each element has an equal and independent likelihood of being chosen (Kandace and Landreneau, ibid). Probability sampling consists of four main strands: simple random, stratified random, cluster, and systematic.

Non-probability sampling refers to the use of non-random techniques to select elements that make a sample and unlike the probability sample, this sampling design is predisposed to producing samples that are not representative of the population. (Kandace and Landreneau, ibid). The three fundamental devices of non-probability sampling are convenience, quota, and purposive.

This research will apply probability sampling because this type of sampling design produces the most accurate and credible results when compared to the non-probability sampling design.

Stratified random sampling is defined by Elder (2009) as the division of the target population into groups based on features which the researcher perceives. For the purposes of this research, the two fundamental sampling groups will be clinicians and patients and there can be substrata under the clinicians' category for various professions from the medical field. The advantages of opting for stratified random sampling are minimised sampling error; allows separate control over design selection of the sample within each division, more representativeness of the features of the population; reduced data collection expenses including but not limited to travel (Elder, 2009). The stratified random sampling design will operate in tandem with the cluster sampling approach and according to West (2016) cluster sampling is about dividing the population into discernable 'clusters'. The participants which will be interviewed will be categorised into recognisable groups and be studied scientifically using methodological approaches. Simple random sampling refers to a sampling design in which every member of a population has an equal opportunity of being incorporated in the sample and where all possible samples of a particular size have an identical chance of being selected (West, 2016).

The data collection methods which will be applicable to this research are interviews, questionnaires, and participant observation. Interviews are pivotal data collection techniques for collecting detailed data; suitable for flexible and complex situations when questions have to be manipulated in order to be appropriate for different people; appropriate for examining feelings, beliefs, emotions and experiences of people; and exploring sensitive social phenomena (Gilland, 2014). Interviews are categorised into four main types: unstructured interviews, semi-structured interviews, structured, and group interviews.

Unstructured interviews tend to produce a lot of exploratory information when participants are permitted the opportunity to verbally express themselves without much involvement from the researcher (Gilland, 2014). *Semi-structured interviews* consist open-ended and closed-ended theme questions but permit participants to be expressively share information, feelings, experiences and emotions in dialogues and exploratory information is collected (Gilland, 2014). *Structured interviews* are characterised by pre-determined, unchanging, identical questions for all participants, quintessentially with pre-coded answers (Gilland, 2014).

Participant observation refers to a phenomenon in which a researcher closely studies the day-to-day operations of the participant which relate to the study in the natural setting in which the phenomenon is being studied. In this research, participation observation will be carried out through observing clinical consultation interactions between medical staff and patients at

healthcare facilities. Schmuck (1997) states that participant observation is important in providing researchers with ways to observe non-verbal expression of feelings, identify who interacts with whom, register the manner in which participants communicate with each other, and detect the amount of time is spent on different activities. Furthermore, according to Marshall and Rossman (1995) participant observation grants researchers the opportunity the meanings of words that participants use in interviews, witness events that interviewees may be unable or reluctant when divulging this information would be impolite or insensitive and this form of data collection equips researchers with the ability to observe situations which participants have shared in interviews thereby making them cognisant changes and inaccuracies in the answers the interviewees provided in the interviews. Due to the technical nature of the medical jargon, the researcher will most probably be required to seek laymen explanation of the terminology the participants will be using during interviews particularly the healthcare professionals. The differences in cultural interpretations between the medical personnel and the patients will create a situation in which certain topics regarding health and anatomy will be a taboo for patients and this phenomenon will be abated by differences in education and health knowledge.

A key differentiating factor between structured and unstructured data collection procedures is that structured approaches prioritise making comparisons between people, environments, time, and researching personnel whereas unstructured approaches focus on the issue being investigated (Gilland, 2014). The unstructured interview approach will be the most suitable data collection method for this research as it focuses on the communication discordance that arises from language and cultural asymmetries between clinicians and patients.

The successful and complete collection of data in research inevitably leads to the process of data analysis. Data analysis is informed by data collection methods used and the type of research study being conducted. Thematic analysis will be used to interpret and comprehend the data that would have been gathered at the completion of the data collection process. Thematic analysis is used for analysing taxonomies and present the themes that are relevant to the gathered information (Alhojailan, 2012). Boyatzis (1998) proffers that it provides an in-depth explanation of data and deals with varied subject matters using interpretations. Thematic analysis is viewed as the most appropriate for any study that attempts to discover a particular phenomenon using interpretations (Alhojailan, 2012). This research will be compatible with thematic analysis as it will be seeking to discover patterns that hinder translucent communication between clinicians and patients. Upon the finding of these patterns, they will be analysed in detail.

Alhojailan (2012) pronounces that thematic analysis permits the researcher to associate an investigation of the regularity of a pattern with the pattern of the whole content.

Another instrument of analysis that will be used to profoundly engage with data. The principal idea of contrastive analysis is that it is possible to identify the challenging areas a certain foreign language will present to the first language speakers of another language by systemically drawing comparisons between the two languages and cultures Lennon (ibid). In instances where the two languages and cultures are similar, there are significantly reduced learning difficulties and instances where the languages and cultures are vastly different, the learning problems are exacerbated (Lennon, ibid). The greater the difference, the more difficult it is to acquire linguistic fluency in a foreign language and mastery of a culture of a different cultural group (Lennon, ibid). There are a lot of dissimilarities between isiXhosa and English lexical terms as well as the vast differences in cultural ideologies between native speakers of the two languages. The language and cultural differences disrupt the transparent transmission of messages between professional healthcare providers and patients during the provision and receipt of healthcare respectively.

The limitations to this research will be having to conduct the research in manners that confine to Covid-19 restrictions. The research has to obey social distancing, use of hand sanitizers when touching materials such as questionnaires which will be used by participants, and wear masks at all times during the interviews. Another challenge of conducting interviews the pandemic could be the number of people which can gather at one time in a particular place and this has the potential to delay the amount of time it will take to complete the interviews as well observing the participants in their natural setting of study.

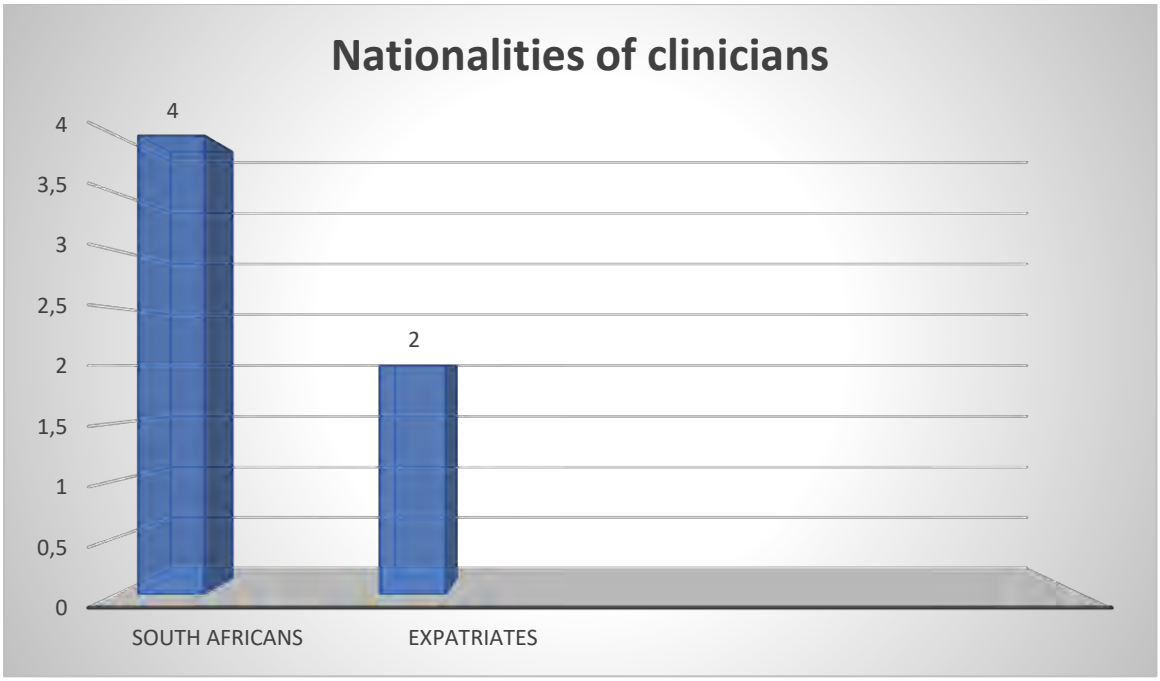
2.3.5 **Cecilia Makiwane Hospital statistics**

A total of fifteen (16) participants were interviewed at Cecilia Makiwane Hospital under the following three categories: clinicians (6), nurses (5) and patients (5).

Clinician profession	Fluent in isiXhosa	English and other language

Medical doctor	No	Yes
Pharmacist	No	Yes
Medical doctor	No	Yes
Medical doctor	No	Yes
Medical doctor	No	Yes
Medical doctor	No	Yes

Out of the six clinicians who were interviewed, none of them speak can speak isiXhosa. Despite only the home language English-speaking medical doctor being the only monolingual medical doctor, none of the bilingual and multilingual medical doctors are skilled in communicating in isiXhosa despite a fairly broad linguistic repertoire. Two of the clinicians are expatriates working in South Africa. One is a Zimbabwean male doctor and the other is an Indian female pharmacist. They speak Shona and Malayam respectively and both these languages are very different to isiXhosa which is the home language of the majority of the patients they provide a healthcare service to. The other four clinicians who have clinical degrees in the Bachelor of Medicine and Bachelor of Surgery (MBChB) are South Africans who are non-fluent in isiXhosa and are tow mother tongue speakers of English, one Xitsonga speaker and a native speaker of Afrikaans. The English-speaking medical doctors are both females and are 24 and 26 years old. Both the Xitsonga and Afrikaans-speaking medical doctors are males who are 24 and 25 years respectively.



The clinicians unanimously agree that there are advantages to using isiXhosa when communicating with their patients and that the patients understand them better they communicate in isiXhosa. The highlighted advantages

Universally, the clinicians agreed that not all patients are fluent in English, most patients have minimal English fluency and a sizeable portion of the patient population do not speak English at all. The clinicians aver that such communication dynamics are supplemented by the use of an interpreter in the form of a nurse.

There are conflicting opinions on the possibility of using traditional African medicine with scientific medicine. Four out of the six clinicians agree that there is space for traditional and modern biomedical science to work collaboratively. The clinicians are in complete accord that it is imperative that language courses should be part of training of healthcare professionals.

The following are selected verbatim responses from healthcare professionals who endorse the notion having in-house interpreters in public hospitals:

"The sisters (specifically female nursing contingent) are understaffed and not always able to assist with translating. In-house interpreters who speak other language[s] would also be beneficial especially for foreign patients." – 24-year old South African English-speaking female medical doctor.

"Because we need to communicate with patients regardless of their language[s] and [an] interpreter will form a bridge between the language barriers." – 24-year old South African Xitsonga-speaking male medical doctor

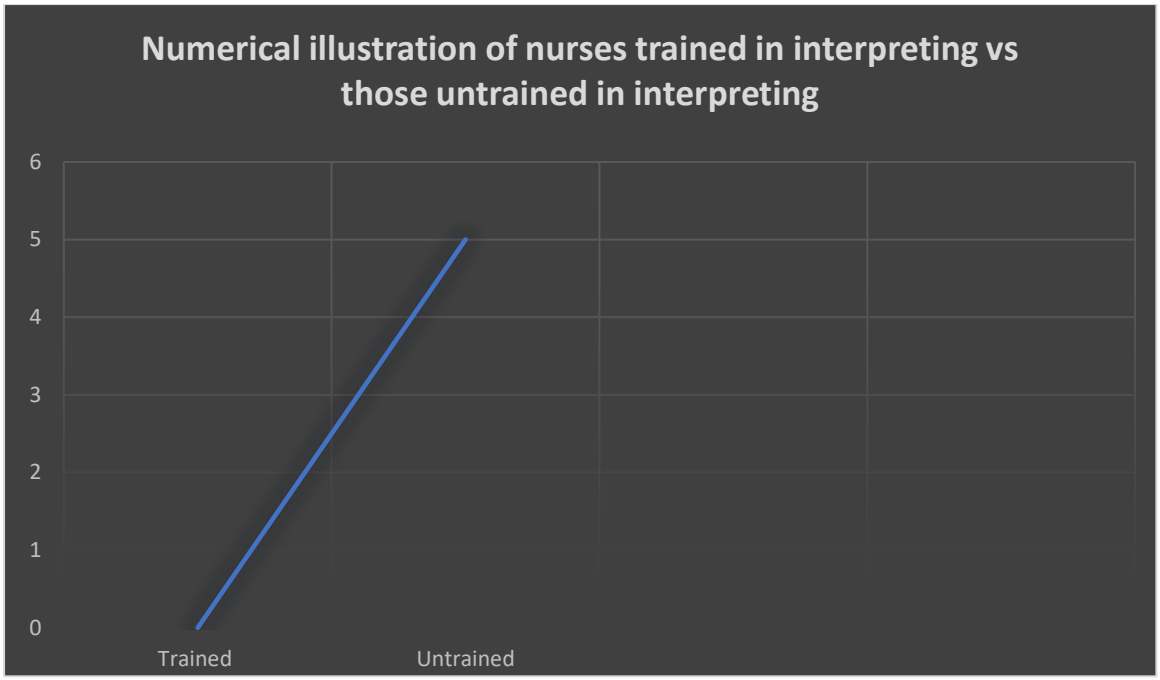
"If there [are] any [in-]house interpreters it will make the work easier" – 45-year old Indian Mayalam-speaking female pharmacist.

The gulf in education levels, scientific biomedical knowledge and language competence (particularly in English) between clinicians and nurses may largely compromise their interpreted messages and undermine the intended meaning of their interpreted messages. The nurses ought to operate as a communicative link of language and knowledge between clinicians and patients. All the interviewed nurses are females who are first language speakers of isiXhosa and have experience in interpreting medical messages between medical doctors and patients using isiXhosa and English.

The nurse with the highest qualification has a Diploma in Nursing whilst the rest having nursing certificates. None of the nurses have received formal training in translation or interpreting. Two out of the five nurses interpret daily during doctor-patient interactions whilst three nurses interpret occasionally. A 35-year old bilingual nurse with a Diploma in Nursing replied the biggest challenge she encountered when interpreting between doctors or nay other medical staff member and patients is:

"Patients not being able to understand the clinical terms [and] having to explain in a simple language".

The nurses state that when they encounter medical terms that are difficult to explain to the patient they either ask the medical practitioners to explain to them the medical concepts in simpler terms or they ask their colleagues to assist with interpreting duties. Their overarching interpreting philosophy when relaying interpreted messages that contain spiritual beliefs of patients is to provide the doctors with the full and detailed account of what the patient said. However, one nurse indicated that she formulates her own explanation that sounds plausible. The disadvantage of that is a potential misdiagnosis as a result of the doctor not having the sufficiently accurate information to assist the patient due to substandard and unethical interpretation by an untrained nurse.



The informed consent of patients is severely compromised in instances where they are unable to communicate in English and this has an adverse effect on the healthcare they receive from healthcare professionals. The nurses state that due to some patients being unable to converse in English they:

"Some patients give or sign consent forms without understanding the [medical] procedure [that will be done to them]" – 48-year old nurse

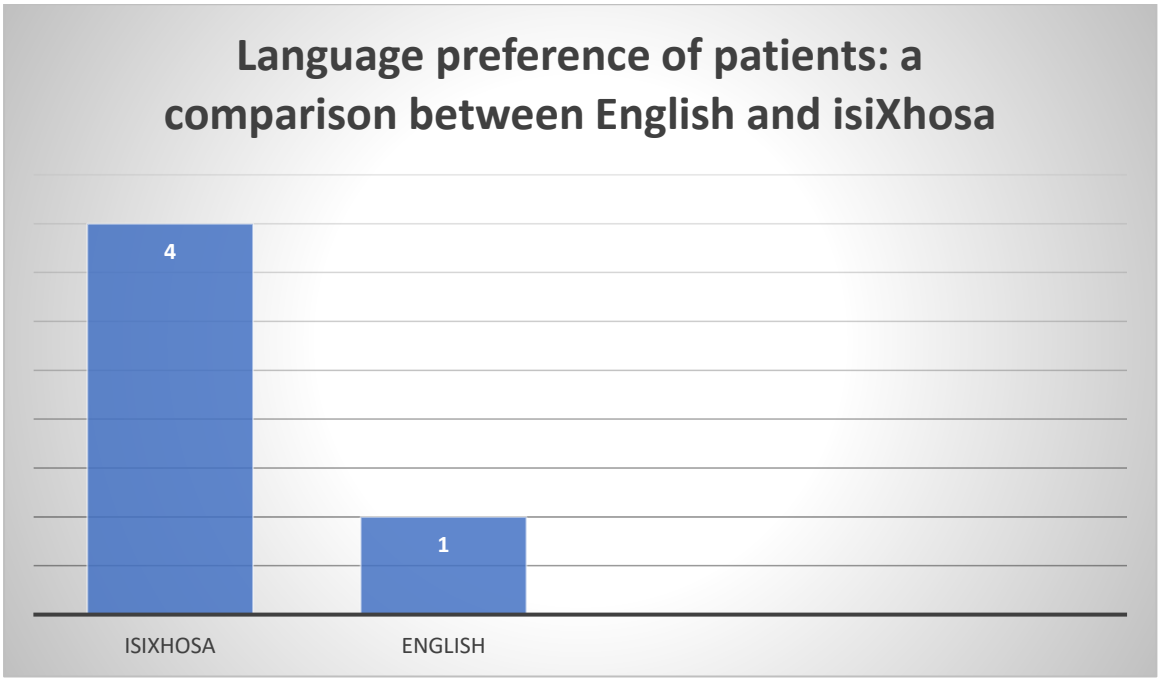
"Patients have a tendency to say they understand something when they actually [do] not" – 35-year old nurse

The nurses opine that not having formal interpreting training may negatively affect the interpreting services they provide to clinicians and patients as a patient may take an incorrect and uninformed decision based on the interpretation they received from the nurse who is an untrained interpreter. One of the nurses averred that interpretation falls outside the ambit of their scope of practice and it is a distraction when they are occupied with clinical work. The nurses stated that they receive no remuneration for assuming interpreting duties this is despite the prevalence of cases where patients have been adversely impacted by language barriers when communicating with doctors. The nurses cited that patients experience language challenges when in communication with doctors during clinical consultations, when a medical practitioner

is explaining to them medical procedure that, and that patients experience difficulties explaining their social problems to medical practitioners across language lines.

To combat the language barriers in the public healthcare sector the nurses suggested the employment of designated interpreters in hospitals and provision of language courses to healthcare professionals by healthcare institutions to deal with language problems. These suggestions are particularly salient in alleviating language barriers as the nurses do not have language resources in the form of dictionaries and glossaries as tools of aid when interpreting.

The demographic profile of patients indicate that they are susceptible to experiencing communication discordance when interacting with medical practitioners. All the patients who patients from this Cecilia Makiwane Hospital who participated in this study are 50 years and older. All the patients indicated that they have minimal command of English with only two of the five patients who have successfully completed high school. None of the patients have tertiary education qualifications. Four out of the five patients prefer to communicate with healthcare practitioners in isiXhosa to English. Except for one patient, all the patients have consulted with a doctor and a nurse was called in to interpret for them. The patients concur that their privacy is compromised when another person is brought into the consultation room when they are consulting and that challenges presented by language differences have an impact on the quality of healthcare they receive. These challenges are exacerbated by the use of heightened diction by medical practitioners that is underscored by obscure medical jargon.



The patients subscribe to traditional belief systems which inform their understanding to believe that sickness can be caused by witchcraft or ancestral spirits. Despite this unanimous admission, the patients opt not to explain their sickness to doctors in terms of witchcraft or ancestral spirits. One patient, a 61-year old male, said that him choosing to explain his sickness to doctors in terms of witchcraft or ancestral spirits depends on the race of the doctor. The other patient asserted:

"Xhosa-speaking doctors do say so when they are unable to treat a certain condition and some of them suggest the use of traditional belief mechanisms when they see fit". – 62-year old male patient

2.3.6 **Nkqubela Chest Hospital statistics**

Building from the remarks uttered by the 62-year old patient at Cecilia Makiwane, the research set out to emphasize the significance of language concordance and cultural congruity between healthcare workers and patients, all participants from this particular hospital are native speakers of isiXhosa except for one clinician who is an isiZulu speaker; a South African language of the Nguni language group and is mutually intelligible with isiXhosa. Mutual intelligibility is the ability for two people from different language backgrounds to communicate effectively and in a manner devoid of language impediments without receiving prior formal learning of each other's languages due to similar or identical meanings in the vocabularies of the languages of conversing. At Nkqubela Chest Hospital, a total of 15 participants were administered questionnaires regarding their language and cultural experiences in their engagement with the healthcare system. The statistics for the research participants from this hospital are as follow: six (6) clinicians, five (5) patients and four (4) nurses.

All clinicians indicated that they speak in isiXhosa with their patients and that this does not adversely affected their line of communication with patients at all. The four nurses consist of three female nurses and one male nurse. A 62-year old female isiXhosa-speaking nurse asserted the following regarding the advantages of using isiXhosa when communicating with patients:

"Yes, it [using isiXhosa when communicating with patients] makes patients to fully understand everything about his or her sickness and treatment to be taken and its side effects."

A 37-year old isiXhosa-speaking male doctor concurred with these remarks and observed that:

"Yes, patients understand the instructions more clearly and information given to them about their [health] conditions when instructed in isiXhosa."

Despite the language concordance between clinicians and patients, language challenges present and manifest themselves in different ways. According to the 62-year old isiXhosa-speaking nurse, she has experienced difficulties with providing optimal clinical care to a patient due to language differences. Two of the cases she cited are when she dealt with expatriates residing in South Africa and South Africans from other provinces who speak languages that are distinctly different from isiXhosa.

Pertaining to cases where language affected her capacity to care for patients, a 41-year old female isiXhosa-speaking nurse opined that patients with auditory impairment are affected as she does not have sign language skills. None of the nurses possess a qualification in interpreting or translation. Despite the nurses' lack of theoretical and practical training in language practice disciplines, three of the four nurses translate occasionally. A 55-year old female nurse maintained that the biggest challenges that she encounters when interpreting between doctors or any other medical staff and patients is interpreting scientific terms and culture-specific words. A 64-year-old female isiXhosa-speaking nurse said that the inability to be conversant in English by some patients has an effect on the same care they receive from healthcare workers in the different biomedical disciplines because potential interpreting mistakes make the patient vulnerable to misdiagnoses. The nurse further explained that in instances where she has to interpret for a patient she knows then the privacy of the patient becomes compromised particularly if the patient has a "confidential diagnosis" as the patient may they the nurse will disclose the health information of the patient to unauthorized personnel. Universally, nurses resort to regurgitating in full what the patients communicated when the patients explain their health status in terms of their spiritual beliefs whether that is through Christianity or the traditional belief system.

However, three of the four nurses admitted that there not having formal interpreting training negatively affects the interpreting services they provide to clinicians and patients. A 55-year-old female isiXhosa-speaking female nurse pointed out that there are challenges when a patient speaks a language other than isiXhosa and English which are the two which she can speak. A 64-year-old female isiXhosa-speaking nurse highlighted that a lack of formal interpreting services has the potential to contain health and legal implications as the patient might delay getting healthcare or be misdiagnosed and then may complain as a result of that. A 59-year old

nurse states not having formal interpreting qualifications makes it difficult to interpret for patients who have a rich repertoire of isiXhosa as she may sometimes interpret wrongly.

The nurses are not offered remuneration for providing interpreting services, but all expressed the eagerness to participate in training in the field of translation or interpreting if they would to be offered that opportunity. Three of the four nurses make use of lexicographic materials to aid with providing adequate interpreting services. The central argument of the nurses regarding dealing with language problems in the healthcare sector is that there is a need to provide formal language lessons to improve the language skills of healthcare interpreters. There are different opinions on who the formal interpreters ought to be. The 48-year-old isiXhosa-speaking male nurse avers that there is a need for more interpreters and that it is necessary for nurses to be trained formally in interpreting. The 64-year-old isiXhosa-speaking male nurse suggests minimizing the workload of nurses by suggesting that healthcare institutions should create database for designated language experts to use for interpreting services.

The six clinicians are isiXhosa-speaking medical doctors, and their numerical composition is five females and one male. These medical doctors speak in isiXhosa with their patients as this is the home language of their patients and a language that their patients prefer and understand better. Dissimilar to clinicians who speak a native language that is not isiXhosa, these medical doctors do not require communicative assistance from nurses in the form of interpreting services as there are no language hindrances between them and isiXhosa-speaking patients. Their fluency in isiXhosa eliminates any possible language problems that may arise in a clinical consultation between patients and medical doctors. Two clinicians, both females, out of the six expressed that they have experienced difficulties interpreting for patients who are members of the deaf community. The clinicians are of the view that language issues in the healthcare sector can be remedied by introducing formal training services in interpreting and two doctors specifically highlighted the significance of receiving training in South African sign language.

Half of the medical doctors have had experiences where the patients interpreted their health conditions in ways that are informed by their spiritual belief philosophies. A 58-year-old female isiXhosa-speaking doctor said of the patient noted that he needed to go home in order to speak with his ancestors. A 55-year-old female isiXhosa-speaking doctor narrated that patients from Jehovah's Witnesses do not believe in participating in blood transfusion. Blood transfusion is the process of moving blood or blood products into a patient's bloodstream through a vein. None of the doctors advise patients to consult traditional healers based on their

sickness although four of them said there is sufficient space traditional and modern medicines to work in conjunction. The explanations provided by the medical doctors for believing that traditional pharmaceutical medicine can work collaboratively is that:

“Some conditions need traditional medicines to be cured and some need both [traditional and pharmaceutical medicines] – 37-year-old isiXhosa-speaking male doctor

“[It is] because traditional medicines are made from herbs which are also used in modern medicine” – 41-year-old female doctor

Two medical doctors declined to provide an answer on the extent to which traditional and modern medicines can be used together whilst the other two medical doctors said these two health models can work in union but did not expand by means of providing an explanation. Six out of the six medical doctors stated that they do not advise patients to consult traditional healers based on their sickness. The medical doctors all agreed on the imperative nature of having in-house interpreters in all hospitals to help with easier communication and flow of information between clinicians and patients particularly amongst the members of the patient population who live with blindness and deafness. Moreover, the medical doctors unanimously concur that, based on their experience working in the medical field, language courses should be part of training of healthcare professionals.

The five selected patients from Nkqubela Chest Hospital expressed their language and cultural experiences when engaging with the public healthcare system. All five patients are Xhosa-speaking males between the ages of 27 and 58. Except for a 42-year old patient who has a tertiary education qualification in the form of a certificate in Production Management, all of the patients did not complete high school and are monolingual. All five of them stated that they prefer to communicate with healthcare professionals in isiXhosa over English and provided their responses in isiXhosa. The patients made the following remarks when justifying their reasons for isiXhosa to be their language of preference in formal medical environments:

“I speak isiXhosa fluently. I have native-language fluency in isiXhosa” – 56-year-old male patient with Std. 7/ Form 2 education (currently referred to as Grade 9).

“[It is] because I express more eloquently in isiXhosa than I do in English” – 58-year-old patient with Std.7/Form 2 education (currently referred to as Grade 9).

“IsiXhosa is the language that I understand best” – 27-year-old patient with Grade 10 education.

“I prefer speaking in isiXhosa because there are English words that I do not understand” – 33-year-old patient with Grade 10 education.

Three out of the five patients indicated that they have previously consulted with a doctor and a nurse was called in to interpret for them. The 56-year old patient is the only patient out of the five patient who ever explained his sickness in terms of witchcraft or ancestral spirits to the doctor. Following the explanation of his sickness using a cultural lens, the patient said he was encouraged by the doctor to the course of his medication prior to considering using traditional concoctions as using the Tuberculosis (TB) treatment with traditional medication may cause health complications. What this particular patient deduced from this specific interaction with the doctor is that some doctors respect traditional beliefs in relation to health. The other four patients never had interactions with doctors in which traditional belief systems emerged their opinions that the healthcare professional respect traditional belief systems were based on the premise that they had never heard clinicians speak negatively about traditional belief systems.

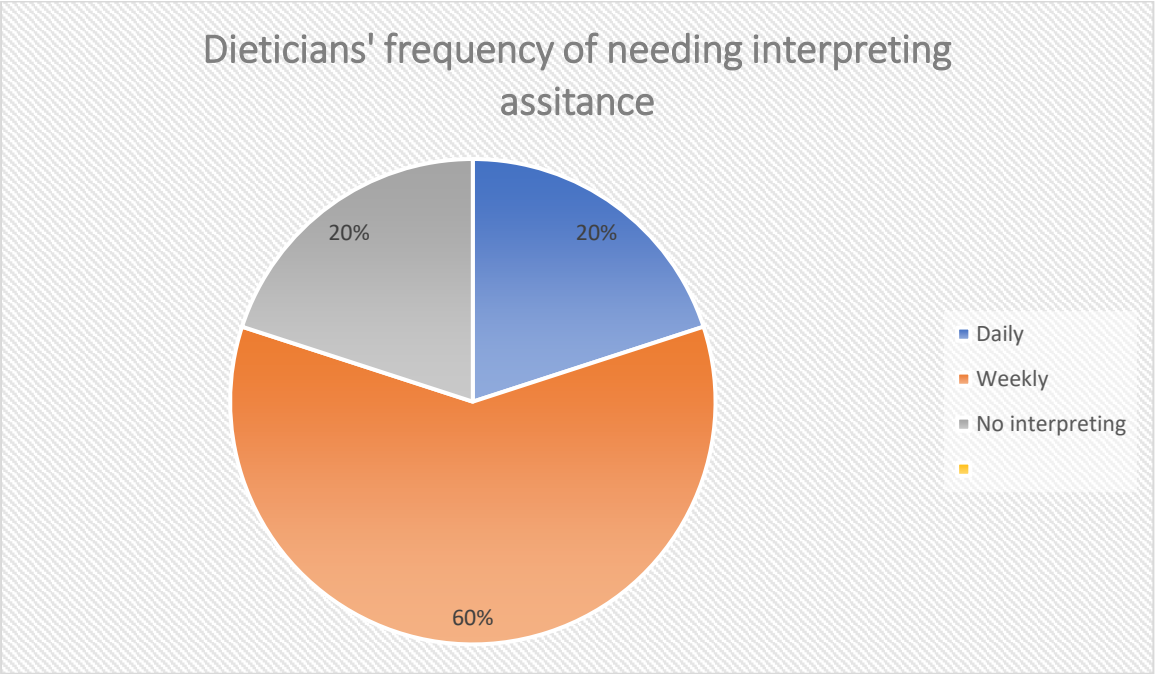
2.3.7 **Frere Hospital**

At Frere Hospital a total of 13 participants took part in the research study. There were five (5) participating clinicians who were all dieticians, seven (7) patients and one (1) nurse. The biggest challenge at Frere Hospital was having access to nurses who were available and willing to participate in the study. The language composition of the dieticians was three native English speakers, one mother tongue speaker of isiXhosa and a home language speaker of Afrikaans. The isiXhosa-speaking dietician was included for the purpose of comparing and analyzing the degree of effectiveness of quality healthcare in contexts in which there is language and cultural concordance between a healthcare specialist and a patient and juxtapose it with scenarios where a clinician and a patient are both from different language and cultural backgrounds. The nurse and the rest of the patients were isiXhosa-speaking research participants.

Out of the four dieticians who are non-mother tongue speakers of isiXhosa only one dietician has a basic command of isiXhosa whilst the rest of the group cannot speak isiXhosa. When communicating with patients - one dietician – a 25-year old English-speaking female relies on code-switching whilst others make use of an interpreter. All four of them agreed that not all the patients comprehend information when it is communicated in English and that some patients become confused when they are addressed in English. When the dieticians have come across a patient who does not understand English they use the following strategies to communicate with the patient:

a) They use a nurse or other healthcare professional to communicate
b) They use family members of patients to communicate
c) They use a combination of English and isiXhosa
d) They use a combination of English, isiXhosa and gestures

The dieticians depending on their ability to exploit all of the above strategic communicative avenues to convey their messages to patients often tend to ask nurses to interpret for them. A 40-year-old female dietician stated that she asks nurses on a daily basis to interpret for her. She added that they also have a female Nutrition Assistant who interprets for them. The three other dieticians mentioned that they ask nurses to interpret for them on a weekly basis. The dieticians collectively assert that the nurses experience challenges with interpreting specialized terms and that these language barriers have a negative effect on the quality of medical care patients receive from the hospital as medical concepts may not be correctly understood by both the interpreting nurses and patients. Furthermore, the dieticians explicated that huge bodies of information are not adequately interpreted and thus their exhaustive meanings are lost in the interpretation process. According to a 25-year old English-speaking female dietician sometimes patients would just agree or pretend they understand what the dietician is saying when they do not.



The dieticians alluded to different examples when describing cases where language problems affected their nous to provide healthcare to patients.

"I once did not understand what a patient asked so I could not assist them. I felt helpless and could not come to the patient's aid" – 40-year old Afrikaans-speaking female dietician

The cases that the dieticians described where language inhibited seamless healthcare provision are providing counselling on infant feeding, counselling a patient on diabetes, nutrition counselling and providing nutrition prescription to mothers in their wards for their babies. The recommendations provided by the dieticians to lessen language issues in the healthcare domain are having designated interpreters and encouragement of healthcare personnel to attend language lessons.

The dieticians have been exposed to dichotomies that exist between traditional medicine and modern medicine which include explanations of sicknesses by patients based on upon traditional dogmas.

"Babies have been admitted to hospital very sick due to use of herbal medicines and in some occasions, patients stabbing themselves due to *[uku]thakatha*" (witchcraft) – 25-year old English-speaking female dietician.

"We see a lot of babies given herbal medication" – 35-year old English-speaking female dietician

The dieticians apply a culturally sensitive approach and culturally tolerant method that is informed by an open-minded and progressive school of thought when addressing disparities between traditional beliefs and modern science.

"I wouldn't stop a patient from using their traditional medication if the traditional medication does not interact with the modern medication. If there's an interaction, I would explain it to the patient." – 24-year-old English-speaking female dietician.

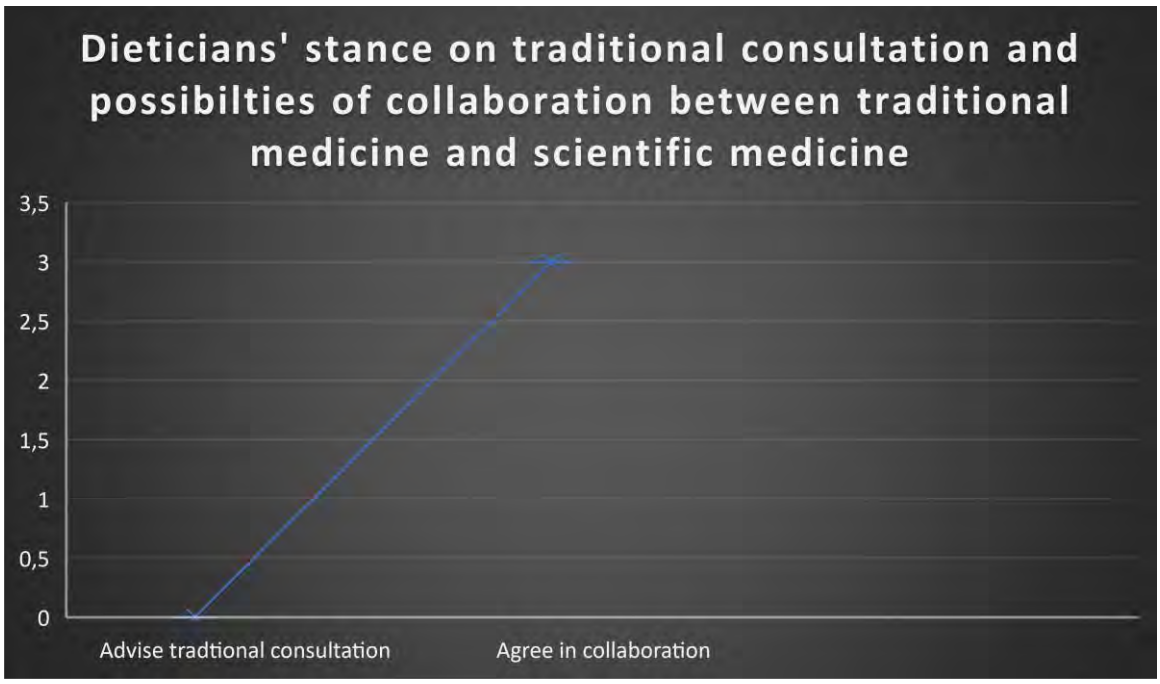
"It's important to understand the patient's medical history. Some [patients] say they've been bewitched; however, they haven't been adhering to their medication or they only started seeking medical attention too late. But it's important not to discriminate based on an individual's beliefs rather help them see how on the medical side we can help." 27-year old Xhosa-speaking female dietician.

All five dieticians do not advise patients to consult traditional healers based on their sickness despite three of them agreeing that there is a possibility of traditional and modern medicine to work in collaboration.

"There can be [a collaboration] if only there could be laws to regulate all medication. Lots of studies need to be done looking at possible drug interactions, side effects etc. before they can be used together." – 27-year-old female isiXhosa-speaking dietician.

"If a patient wants to use traditional medication for flue purposes, I would not stop them especially if it does not interact with any modern medicine that they are using." – 24-year old female English-speaking dietician.

"If the traditional medicines are not harmful to the patient they can be used collaboratively with modern medicines" – 40-year-old Afrikaans-speaking dietician.



There was an accentuation on the salience of formal language learning for healthcare professionals who are practicing in the various biomedical fields to significantly improve the communication dynamics between the clinicians and the patients.

"It would benefit me greatly to be able to communicate thoroughly in isiXhosa with my patients" – 35-year-old English-speaking dietician

"I would love to communicate in a third language and for my patients to understand me better" – 25-year-old English-speaking dietician

"As a clinician, your job is to best serve your [patient], how is that possible if the two parties can't communicate properly?" 27-year old isiXhosa-speaking patient.

"It becomes difficult to communicate to patients and they do not understand you. It would be better if the patients understood what was being said" – 24-year-old English-speaking dieticians.

The 35-year-old English-speaking dietician further suggested that the introduction of language courses in clinical fields ought not to arbitrary but be a well-thought process that considers the language make up in the various provinces and the challenge that may be posed by clinicians not being aware of where they will be posted.

"Making language courses a part of training of healthcare professionals may be tricky as one will not know what province they will work in and what language course to do, for example isiXhosa or isiZulu etc. – 35-year old English-speaking dietician.

The dieticians fully endorsed the notion of having in-house interpreters in hospitals and they mentioned how the advantages would benefit the clinicians and nurses as well as the patients.

"It would be nice to have [in-house interpreters]. Healthcare workers and patients would greatly benefit from the service." – 27-year-old isiXhosa-speaking dietician.

"I would always call another person who speaks isiXhosa if a patient is struggling to understand me. Therefore, I would advise [the employment of in-house interpreters] because sometimes it is too busy for someone to come and interpret for you." – 24-year old English-speaking dietician

"[It would help] to avoid having to ask already overworked and understaffed nurses to interpret." – 25-year-old English-speaking female dietician

"I would love to communicate in a third language and for my patients to understand me better." – 40-year-old Afrikaans-speaking patient.

"So that an interpreter is always available, and I don't take a nurse away from her duties to interpret for me" – 35-year-old English-speaking female dietician

Unlike, her colleagues who speak English and Afrikaans as their first languages, the isiXhosa-speaking dietician does not encounter language difficulties when dealing with patients as she

communicates with them fluently in isiXhosa. She pointed out an advantage that directly affects the patients when patients and clinicians communicate in a shared in a language without any difficulties.

“The patients are able to understand you more, therefore, they’re able to better adhere to guidelines and feeding instructions that are given.” 27-year-old isiXhosa-speaking female dietician

The isiXhosa-speaking dietician’s ability to speak isiXhosa negates the need for a nurse to interpret for the dietician. Although this dietician does not experience communication difficulties when engaging with patients and thus has never asked a nurse to interpret for her a clinical consultation with a patient, the isiXhosa-speaking dietician elucidated that some of the nurses struggle with specialized terms when interpreting and attributed the interpreting difficulties experienced by nurses to the professional level of the nurse, for example is the nurse an assistant nurse or a professional nurse.

The dietician is of the perspective that language obstacles affect the healthcare patients receive from the hospital particularly in her professional field which involves rigorous and requires careful interaction with a patient.

“In Dietetics, a lot of nutrition counselling is done, therefore, the patient needs to clearly understand what’s being communicated to them so that they can apply it.” – 27-year old isiXhosa-speaking female dietician.

The language obstructions are not limited to only interactions between isiXhosa-speaking patients and clinicians who are not mother tongue speakers of isiXhosa although this is the prevalent language discordance phenomenon in the Eastern Cape public healthcare setting. The 27-year old isiXhosa-speaking patient provided two cases where language compromised her clinical competence because she did not have the adequate language skills when engaging with a patient.

“When I had to counsel an Afrikaans-speaking patient, we couldn’t understand each other. – 27-year old isiXhosa-speaking dietician.

“I struggled to communicate with the mother of a patient who is a foreign international particularly with having to explain how to mix formula correctly.” – 27-year old isiXhosa-speaking patient.

The isiXhosa-speaking dietician advised two strategies that can be applied to address language issues in the healthcare sector. The first suggestion is to provide systemic training of healthcare

workers in the local languages other than English. The second recommendation is to ensure to proliferate cultural diversity among healthcare workers to ensure that the language and cultural demographics of clinicians reflect the language and cultural statistical data of the patient population that clinicians interact with daily in their respective health disciplines.

The nurse who consented to participating in the study is a 56-year-old isiXhosa-speaking woman with a Diploma in Comprehensive Nursing. The nurse stated that she daily interprets clinical interactions between different clinicians and patients. The biggest challenge for her when interpreting emanates from communication derailment as a consequence of language barriers.

"Being a referral hospital, we receive patients from Sterkspruit and other areas where there are Sotho-speaking people and I don't understand and can't speak Sesotho. Foreign nationals also struggle with understanding local South African languages" – 56-year-old isiXhosa-speaking female nurse.

The nurse indicated that she does not receive payment for taking up interpreting duties on top of her the clinical responsibilities that are her job specifications. She is adamant that the language problem in the public healthcare fraternity can be solved through introducing healthcare personnel to language lessons of the areas in which they will be working for easier communication with the patient populations of their respective residential areas of employment. However, on a personal level the nurse would decline taking the interpreting lessons despite currently not having access to dictionaries to supplement her interpreting abilities.

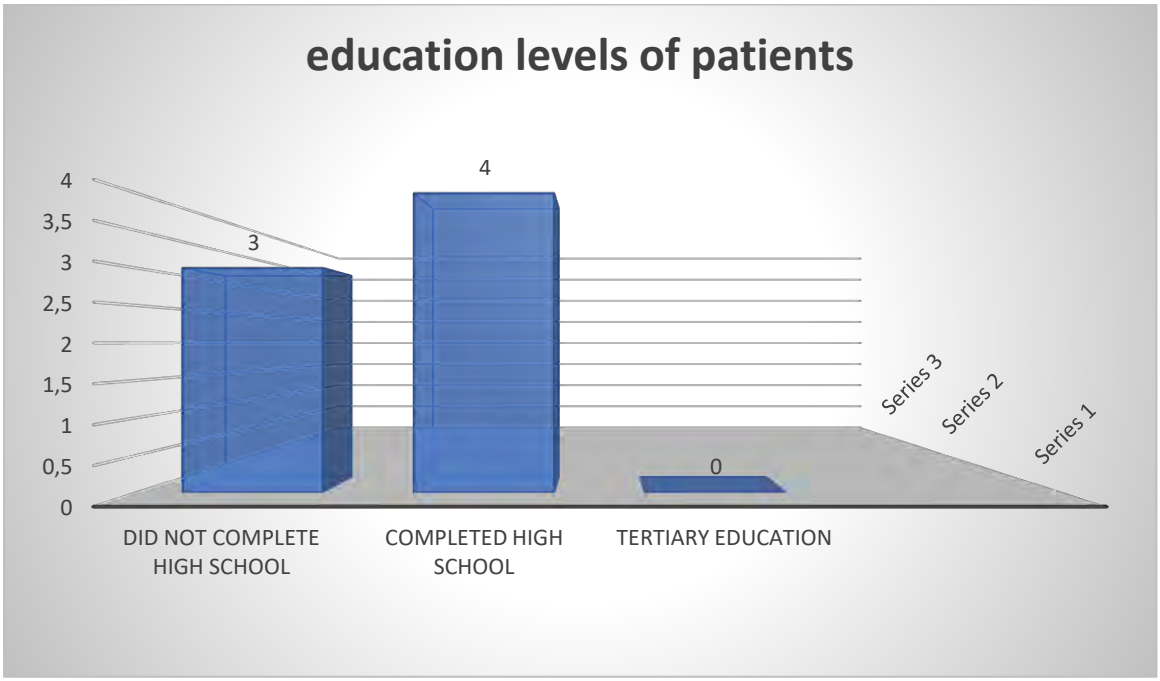
Seven male isiXhosa-speaking participants took part in the research study. Their ages ranged from 19 to 50 years old. Three of the patients aged 23, 35 and 50 years old did not successfully complete high school education. The other four patients who are 19, 20, 25 and 30 years old have all completed high school successfully but do not possess tertiary qualifications. The trio of patients who did not complete high school are monolinguals who are only fluent in isiXhosa and the quadrant of patients who completed high school have indicated that they have limited English proficiency. All seven patients indicated that their language of preference when in communication with healthcare professionals is isiXhosa. All the patients who are under the care of doctors who are not fully proficient in isiXhosa indicated that doctors use high-end diction that they do not understand.

"There are certain things I won't be able to articulate in English because it is difficult to understand the meaning of some words" – 19-year-old isiXhosa-speaking male patient.

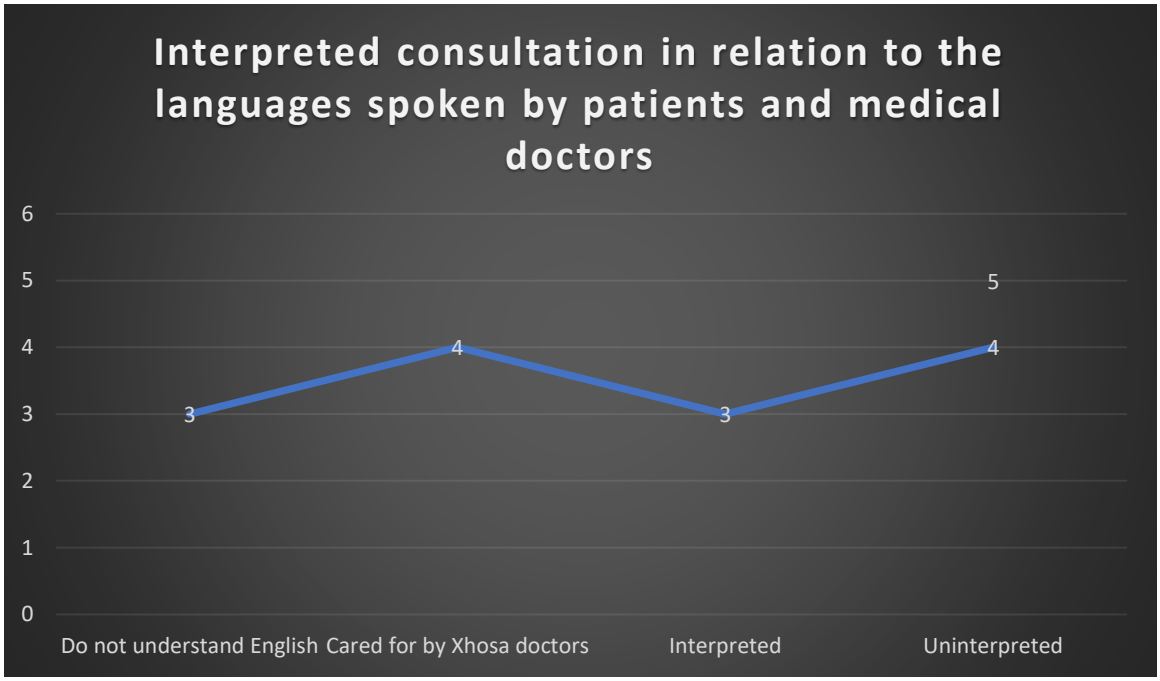
"I prefer communicating with doctors in isiXhosa because I want detailed explanation about everything that's happening and about my sickness." – 25-year-old isiXhosa-speaking patient.

"I prefer speaking with the doctor in isiXhosa so that I may understand them better." 35-year old isiXhosa-speaking patient.

"I choose speaking with doctors in isiXhosa because that is when I best understand what they explain to me" – 20-year-old isiXhosa-speaking male patient.



Three patients elucidated that they did not understand what the doctor said directly to them in English and nurses were called in to interpret for the patients what the doctor had said to the patients. The other four patients are under the care of isiXhosa-speaking doctors and not experience any language barriers in their interactions with the doctors. There are diverse opinions on whether clinicians respect traditional beliefs. Two patients said that they believe that doctors respect traditional beliefs, four patients disagreed with that notion and one patient was uncertain on whether clinicians in African traditional beliefs. Undividedly, the seven patients maintained that they believe that sickness can be caused by witchcraft and ancestral spirits.



2.3.8 **Conclusion**

In conclusion, in order for research to have credence the appropriate research design methods have to be opted for and applied. The utilisation of these compatible methods produces research results that are scientifically valid and logical. The appropriate use of method designs when conducting particular research is beneficial in encountering difficulties and complexities in the latter stages of the research which may impede on the production of credible outcomes. Qualitative research and quantitative research require different research designs that are methodically designed for each type of research so as to yield comprehensible outcomes. It is salient to arrange the practical sequence of research designs in a fashion that systemically and seamlessly builds from one research design to another without disrupting the methods of data collection and data analysis.

CHAPTER 3: LITERATURE REVIEW

3. 1. Introduction

The previous chapter introduced the study by providing the context and background of the study, aims, and methodology which will be used to collect and analyze the information in the study. It was stated that the study explores the interlingual and intercultural discordances during clinical consultations in selected public hospitals in the Eastern Cape namely: Ceclila Makiwane Hospital, Nkqubela Chest Hospital and Frere Hospital. The two languages that are under exploration are English and isiXhosa. This study, therefore, focuses on aspects of language and culture as they relate to access of healthcare in public healthcare facilities. In line with the above stated aim. Language and culture are under investigation as they are two phenomena in the communication process between healthcare professionals and patients which underpin the degree of success in the provision of quality healthcare. During clinical consultations, language serves as the primary vehicle for the efficient transportation of information between clinicians and patients. Between these two groups of interlocutors, the cultural element influences the conceptual understanding of what constitutes health, acceptable healing processes and sickness.

This chapter discusses in details the inequal use, access and prestige of official languages of South Africa, namely English and isiXhosa in the public healthcare fraternity. The investigation of extent of access to and quality of healthcare service in the above-mentioned languages will extend to the examination of cultural elements in communication when communicating in these languages. The focus will be on communication that occurs during clinical consultations between healthcare professionals who use English as a medium to provide healthcare services and native speakers of isiXhosa who have minimal or no understanding of the English language.

According to the Constitution of the Republic of South Africa, which is the overarching

legislative body of work, all South African citizens have the right to access quality healthcare services in a fashion that holistically satisfies the health and well-being of patients. Articles

This means that access to healthcare ought to cater for the language needs of the patients; however, this is not the case in South Africa as English enjoys a hegemonic position in healthcare. The Batho Pele principles, which are eight guidelines intended to facilitate effective implementation of acceptable standards of service delivery in the public sector, emphasizes, amongst others, the notion of access to information and the Patient Rights Charter protects the right of patients to participate in the decision-making process that pertains their healthcare and granting informed consent. The provisions in these legislative frameworks are compromised and that deprives patients the full attainment of their rights.

This research argues that there is no quality provision of service without communication as communication is the bedrock of quality service delivery. For as long as the healthcare providers are not proficient in the language the patients use to access the healthcare, then treatment will be hindered. The right to access health operates in tandem with the right to language as access to health in the preferred language of patients leads to effective treatment. Several language and health doctrines stipulate that patients have the right to communicate with health providers in their preferred languages, however, this does not occur in South Africa as shown by research. The access to healthcare becomes further limited for uneducated patients who are not proficient in English as the medical field has a highly technical jargon that is difficult to comprehend even for the educated people who have layman medical knowledge.

The chapter will focus on the following; defining language, defining culture and showing the relationship between the two, the history of the Xhosa people, the belief systems of the Xhosa people as they relate to their understanding of medicine and healing, and cultural sensitivity and awareness of language dynamics during intercultural healthcare provision, language training for health practitioners, language and cultural communication challenges, terminology challenges in the field, prior studies in the filed internationally and locally, among other issues. The following sub-section presents arguments on the connection between language and culture.

Language and culture are two aspects which are central in the discourse of this research, therefore, it is apt to define these terms in relation to this study. Lebron (2013) defines culture as a distinctive feature of a social group; the values and usual standards differentiate it from other social groups. The isiXhosa culture of the overwhelming majority of patients in the Eastern Cape is vastly different to the cultures of the clinicians that provide them with healthcare. The differences in culture means that the patients and the clinicians and have asymmetrical ways of thinking and doing things in certain life circumstances including in dealing with health and when these cultural differences arise they lead to a breakdown in communication. Amberg and Vause (2010) purport that a critical cog to effective communication is the comprehension and recognition of the relations between a language and its native speakers. Cultural dynamics are key in determining the contextual meaning of words and without this being taken into consideration communication between people from two different cultures may collapse. Rubinstein (1999) notes that language plays a significant part creating a context of dialogue and in permitting communicators to prepare for inter-cultural communication.

Verderber averred in (1999) that language is a common body of words and the systemic way in which the words are applied to communicate to the people of the same community, nation, the same geographical area or the same cultural group. IsiXhosa is spoken widely as a first language by more than 80% of the Eastern Cape population and Xhosa people subscribe to the same cultural practices throughout the province.

In chapter 1, it is argued that culture and communication are strongly connected social phenomena. Communication patterns and dynamics are strongly influenced by cultural characteristics of the communicants who are involved in the communication. According to Putri (2014) communication is any action by which an individual gives to or receives information from another person about that person's needs, desires, knowledge or the underlying emotional state. Verderber (1999) maintains that, amongst other things, the purpose of communication in the lives of human endeavors is to communicate with other people with the intention of having needs met; to establish healthy relationships; and communicating with the aim of accessing information. The vital functions of communication that are stipulated by Verderber apply in the communication contexts involving healthcare providers and patients during clinical

consultations. Patients communicate with clinicians so that healthcare professionals can cater to their health needs and this is key in establishing rapport between patients and clinicians. The purpose of communication between the clinicians and patients is to access information – the clinicians need information from patients in order to utilize the right testing systems and correct diagnosis and the patients need to have the language skills to communicate their health status effectively and efficiently to the healthcare providers. However, in the context of the public healthcare sector in South Africa these intended outcomes of communication are not achieved as communication collapses due to patients and clinicians often not understanding a common language to use for interactions.

The notion of inseparability of language and culture is articulated by Thanasoulas (2001) who expresses that: "… (l)anguage does not exist apart from culture, that is, from the socially inherited assemblage of practices and beliefs that determines the texture of our lives."

This statement means that language carries and manifests the cultural nuances the communicator subscribes to thus making the speech performative behaviour of people an intersection of language and culture. Furthermore, language reflects a people's perception of the world. Elmes (2020) purports that the architecture of a language shapes how speakers of that language view the world. Language serves as the tool through which people articulate their world views and embedded in the lexicon of each language group are cultural perspectives and dogmas that serve as guidelines on how to view the world. Sehan (2010) argues that language is one of the tenets of culture and that because of this association with culture, language consists of social conventions in utilizing and comprehending words and cultural identities. This argument reinforces the notion that for translators it is important to have mastery of language and culture. The interlink between language and culture as it relates to competent translation is emphasized by Kastberg (2007) who proffers that it is imperative for a translator to have cultural competence of both the source language and the target language. This means that a translator must effectively and appropriately have the linguistic knowledge and cultural acumen to display awareness of language gap between the source language and target language and the cultural differences of the languages involved in the discourse. The connection between language and culture is further supported by remarks by Amberg and Vause (2010) that language is inseparable from our ideas of

who we are at an individual level as well as at a social group scale. Belshek (nd) maintains it is impossible to understand a particular culture without taking into consideration its culture and vice versa. Hargie and Dickson (2004) expand the notion of an intrinsic link between language and culture by stating that language used in verbal communication is not a undeviating way of verbal expression, instead it is a way of communication that is profoundly embedded in culture. According to Belshek (nd) in cross-cultural communication, the effective meaning of the message being conveyed and received is influenced and informed by each individual's cultural accustoming.

Specifically, the language competence aspect refers to the ability of translators to proficiently express the ideas contained in the source language in the target language and using diction that has the same linguistic weight as the one applied in the language, they are attempting to transfer the message from to ensure equivalent transfer of message. The ability of translators to compensate for the asymmetrical nature of two languages involved in a translation through finding new categories of language expression is an extension of the junction in which language knowledge and cultural acumen intersect. Mastery and understanding of cultural elements are salient in interpretation as Amberg and Vause (2010) pronounce that language use involves communicating individual thoughts and cultural beliefs and practices of the communities the speakers are from a family level to other broader social associations.

It is crucial to first understand the concept of culture through a pedagogical lens. Gohring defines culture: "Whatever one has to know, master or feel in order to judge whether or not a particular form of behaviour shown by members of a community, in their various roles, conforms to general expectations. Where behaviour does not conform to the society's expectations, one can expect to bear the consequences associated with unacceptable behaviour." (1978:10)

As far as cultural acumen is concerned, translators ought to understand the manner in which culture informs the feelings, thoughts, and personality traits of people of a particular language and cultural group and attach to this the position of language as a vehicle to communicate these human elements. In translation, it is salient that the translators are able to have the ability to censor what is understood as socially unacceptable by

members of a particular language and cultural group without omitting critical knowledge.

This research emanates from the researcher's work experience in the healthcare sector as a pharmacist assistant at Cecilia Makiwane Hospital between August 2018 and May 2019. Upon recognising the gigantic language gap between healthcare professionals and patients, the researcher, with the permission of the hospital designed and facilitated isiXhosa language classes to non-isiXhosa-speaking clinicians at the hospital. The groups of clinicians which took up the classes were speech and audio therapists, dieticians, physiotherapists, and radiographers. Each group of clinicians attended the isiXhosa lessons on a different day as each lesson was streamlined for the workplace vocabulary and language needs of each group of clinicians. However, the first few lessons were based on the basics of a conversation starter, cultural nuances and general knowledge around the language such as its official status in the country as well as its footprint in the Eastern Cape and nationwide.

3.2 **Service delivery: discussion of patient-centred care and Batho Pele principles**

When discussing communication in the healthcare sector this study recognises the need to

centralise patient care and patient needs in a fashion that is synonymous with the patient-centred approach. Patient-centre care approach is defined by Araki (2019) as a care that is considerate of and respectful to the individual patient preferences, needs, and values and ensures that patient all values are informed by clinical decisions. Bokhour et al. (2018) states that patient-centred care empowers patients and equips healthcare providers with the capacity to fulfil the needs of the patients. This research explores the effects of interpreting in facilitating and achieving effective patient-centred care through the lens of *Batho Pele principles*. Similarly, to the patient-centred care approach, the South African public healthcare service operates under *Batho Pele principles* which is a government service delivery initiative that is geared to provide economic and efficient healthcare service that prioritises the needs of patients. Batho Pele means "[putting] people first". Service delivery is defined as the performance of work or duty by an official or an act of helping others, or power to control or make use of resources, an organisation or system providing the public with something useful or necessary (*The Universal Dictionary* 1961: 1394)).

According to SIGMA service delivery as an interaction between public administration and service recipients – citizens, inhabitants, and business establishments where the service recipients either look for or provide information, handle their affairs or complete their duties. SIGMA (nd) extends to mention that these services ought to be delivered efficiently, reliably and with courtesy to recipients. The mere provision of a service to the public does not suffice as it is cosmetic compliance, therefore, the effectiveness of service delivery is determined by the level of satisfaction of the people who are receiving the service. Customer care prioritises the non-existence of customer disgruntlements through focusing on tailoring the service to meet the needs of the end user on an individual level. Salient features of customer care are maintenance of positive attitude so as to avoid offending the recipient of the service as well the sagacious deliverance of an efficient problem-solving mechanism to achieve customer satisfactory.

This research understands service delivery under the microscope of public sector thought. Martins and Ledimo (2015) proffer that in the public sector service components are often not tangible possessions but rather are a network of processes, personnel capabilities, and apparatuses that must be appropriately assembled to produce the orchestrated and intended outcome. It is necessary that one of the capabilities of clinicians is to clearly communicate with patients without language difficulties during medical assessments. Furthermore, it is imperative that there are established reporting mechanisms and channels of communication in the public sector for patients to convey their disgruntlements about the services they are exposed to. The availability of adequate clinical infrastructure and paraphernalia is crucial for providing patients with the intended outcome of public health services which is to improve the healthcare of the public.

Key to the definition of public service is the concept of public administration. Public

administration is defined by Gulick and Urwick (1937:191) as is an administrative responsibility of government and is primarily concerned with the executive branch, where the work of government is executed. A definition of public administration that is most suitable with the aims for which Batho Pele principles were founded for is by Corson and Harris (1963:12) which states that public administration is the administrative or action constituent of government, the avenues by which the purposes

and purposes and aim of government are achieved. The *Batho Pele principles* are compatible with this definition as they delineate the steps through which government employees ought to provide a holistically satisfying public service at a public institution to the satisfaction of members of civil society. *Batho Pele principles* describes the eight steps that should be taken by public employees to provide a sufficient service delivery in a public institution.

The provision of service delivery is constructed under two service delivery models, namely *proactive service delivery innovation* and *reactive service delivery innovation*. Martins and Ledimo (2015) purport that reactive service delivery innovation is intended to address perceived irregularities, shortcomings, and inadequacies that are identified by internal or external stakeholders of an entity. The description of reactive service delivery innovation indicates that the changes which are affected are after institutional proceedings are assessed by the relevant authorities. The assessment of the quality of service provided by public institutions is consistent with the observation made by Martins and Ledimo (2015) that public institutions are obliged to engage in service delivery innovation techniques because they are accountable to civil society. In the public healthcare institutions one of the ways in which the institutions can be aware of the areas in which the patient population want service delivery improvements is through the suggestion box feedback mechanism. The suggestion feedback mechanism is a process in which the patients write their healthcare experience in a piece of paper, often in anonymity, and insert it in a suggestion box to criticize, suggest, or compliment the quality of healthcare service based on their medical visit. This method of attaining feedback from patients is consistent with the quality improvement programme which refers to the manner in which an establishment or an institution considers the service recipient's perception of the service and to use those perceptions as a foundation from which to introducer improvements (Baines, 1996). The patient feedback approach that is used in public healthcare facilities is done to determine the customer satisfaction of patients. It can be said, therefore, that the purpose of the Batho Pele principles is to achieve customer satisfaction through meeting the needs of the patients. Falkowski & Tyszka (2009) provide a definition of customer satisfaction on the basis of a positive assessment by a consumer by defining customer satisfaction as a positive reaction of a consumer on product or service evaluation.

The informal introduction of interpreting services by untrained personnel can be perceived as reactive service delivery innovation as a remedying tool after communication problems have been occurring in the public healthcare sector for extended period of time. The provision of interpreting services as a mechanism is a hindsight response to a government oversight of not providing competent interpreters for medical consultations between clinicians and patients. Proactive service delivery innovation on the other hand is aimed at improving institutional practices, procedures, and processes prior to the occurrence of problems and challenges (Martins and Ledimo, 2015). The Batho Pele principles are a service offering guideline that is designed to counteract the emergence of service delivery problems in a way that is specifically satisfactory to each public service user. The erection of Batho Pele principles has not yielded the intended outcomes of bettering the experiences of patients and improving the quality of public health. This is because according to Kaschula (2004) and Bamgbose (1991) most of the policies introduced in African countries remain cosmetic due to a lack of willingness by different African governments to implement the contents of the policies.

3.3 The history of amaXhosa and a brief overview of their culture

In order to fully comprehend isiXhosa, it is salient that this study observes the history of Xhosa people. Amberg and Vause (2010) state that a key factor to effective communication and comprehension is understanding and recognising the link between a language and its users. It is at the background of concurring with this argument that this study will explore the historiography of Xhosa people.

The Xhosa-speaking people are the second largest cultural group in South Africa after the Zulu people (SAHO, 2019). The Xhosa people are members of the Nguni language cluster which consists of three other cultural groups in Zulu, Ndebele and Swati peoples (SAHO, 2019). Archaeological evidence reveals that Nguni language groups are descendants of Bantu-speaking groups which migrated from East Africa around the eleventh century. The overarching ancestral language group from which the Xhosa people descended from is the Niger-Congo language family (Britannica, nd).

IsiXhosa has been influenced by integration of the Xhosa people with people from other cultural groups and the linguistic remnants of this are evident in contemporary isiXhosa speech behavior. As the Xhosa people moved towards the west in groups, they destroyed the Khoi chiefdoms and San communities and isiXhosa adopted Khoi and San words which possess distinct 'click' sound (SAHO, 2019). To support the notion of amaXhosa borrowing words from the Khoi and San, Peires (1982) concedes that there is a widespread borrowing of religious loanwords from the Khoi and San language groups and that there are Xhosa cultural practices which were originally endemic to the Khoi and San include the cutting off of the tip of the little finger (*ingqithi*) and casting stones on wayside man-made heaps of stone. According to Peires (1982) these two cultural practices do not carry profound religious or social importance but function as merely charms to invite strength and good fortune.

Despite the expansiveness of isiXhosa oral diction, the language is yet to develop terminology that is satisfactorily meets the communicative demands of the natural sciences including the medicine field. Currently isiXhosa does not have standard clinical terminology that is universally used and understood by the patients and clinicians and that covers the footprint of English clinical vocabulary. The paucity of standardised isiXhosa vocabulary begets a situation in which cultural and language barriers become significant inhibitions to quality medical care (Levin, 2007). Healthcare professionals often use terminology that is not clearly comprehended by their patients (Levin (2006b). The reason for the continued use of confusing medical isiXhosa terminology by healthcare professionals is because there is a cultural disconnect between the isiXhosa taught in medical schools through rehearsed patient assessment questions and the isiXhosa spoken by home language speakers that is interlaced with culture. The isiXhosa learnt in medical schools is susceptible to influence by other cultures and the level of education of the people who teach it which creates a cultural disharmony when these two versions of isiXhosa are spoken in a conversation.

3.4 **Differences in health models between patients and doctors**

However, Ley (1988) states that even the meaning of some of the common health conditions contain different meanings to the patient than to the doctor and that (Kleinman, 1980) maintains that this is influenced by incompatibility in education, language and culture between clinicians and patients. The teaching and learning of isiXhosa in medical

schools ought to be modified so that it can be presented from the perspective of the patients.

Levin (2007) contends that where a healthcare provider and patient do not have linguistic and cultural compatibility, barriers of class, power and knowledge which are present in every medical consultation are proliferated and can adversely affect outcomes. Research indicates that sometimes even translators have challenges with medical translation (Ebden, et al. 1988) and that English disease names may be used differently by patients and healthcare professionals and may be used to refer to culture-specific models of disease (Kay, 1979).

A study of the translation of a disability questionnaire from English into isiXhosa indicated that there are challenges in translating medical terminology that related to mobility, restraint of patient movement and gender terminology (Levin, 2006b). The absence of specificity of technical medical terminology in isiXhosa does not provide healthcare professionals with sufficient information to make correct diagnosis (Levin, 2006b). At present, isiXhosa relies on the use of general terms to express even the most specific medical terms and this language gap creates a vacuum in which the non-isiXhosa speaking healthcare professionals and patients are unable to interact and mutually comprehend each other.

Baker (1992:20) describes a hyponym as a term in a semantic field that that describes a concept with specific precision. The Xhosa-speaking patients do not refer to the diseases in a uniform manner with the majority of patients using isiXhosa names for diseases and not incorporating semantic details that the clinicians would consider necessary for medical diagnosis of the said disease (Levin, 2006b). The assortment in the manner in which amaXhosa refer to diseases point out the lack of terminology development and terminology standardisation of medical terms. As a result, native speakers of isiXhosa use terms which they have coined themselves without following the prescriptive language development techniques and in some instances, this is influenced by the different dialects of isiXhosa which are spoken throughout the province including effects cultural and linguistic nuances such as *ukuhlonipha* language of married women.

3. 5. D**evelopment of resources to create clinical African languages terminology**

Generally African languages lack the capacity to express scientific and technological terms. Madzimbamuto (2012) argues that clinical and technical information that is

communicated in African languages contains inaccurate terminology and code switching and thus does not have the scientific explanatory rigour that is underscored by the English language. Often, this occurs due to the paucity of existence of words in African languages that specifically refer to specialised terms without any ambiguity when they are used in the specialised subject field.

African languages are not the hallmark tools of academic knowledge production and knowledge dissemination. These languages are often used as auxiliary tools of scholarship in higher education and often do not have the same status as languages of former colonial powers. In the context of isiXhosa in pedagogy, it has a limited footprint that is still confined to certain areas of teaching and learning and has not encroached into administrative use.

From a medical point of view, patients prefer to receive medical care in their native languages but in Africa the development of technical clinical language has been neglected (Madzimbamuto 2012). The rare nature of the existence of standardised medical terminology is a result of the lack of lexicography resources in isiXhosa and the translation of medical jargon to isiXhosa. Translation of scientific terminology to another language helps a language to expand its vocabulary and fill a language gap in its list of words. Ndhlovu (2014) proffers that in the South African context, many African languages are struggling with terminology and availability of language development resources. This means that many African languages do not have specialised lexicographic material to provide translators with assistance during the translation process, thereby exacerbating the situation of limited specialised terminology in African languages (Ndhlovu, 2014). The responsibility of language elaboration, therefore, becomes one of the duties of translators in Africa. Huysteen (2003) defines language elaboration as creation of new terms in order to achieve the scientific, educational and technical demands of a particular language. For translators in Africa, due to the lack of sufficiently developed tools of reference, they are forced to coin terms to express both new and foreign concepts despite many of them not having the capacity to develop terminology in this way (Ndhlovu, 2014). Ohly (1987) reinforces this argument by stating that due to time constraints translators in Africa in times of urgent translations, the translators use intensive borrowing and impromptu coinage of terms. In the public healthcare sector in South Africa, the difficult task of attempting to convey translational equivalence between specialised medical jargon and

the African languages is done by nurses and family members who have no formal and technical training in translation or other specialised fields of language practise.

The patients who do not possess English proficiency may experience difficulty in articulating their illness experience and on the other hand most clinical experts do not have the mastery of medical jargon in their African languages for the information they communicate to the patient community because they access technical medical knowledge through English medium formal education rather than their native African languages (Madzimbamuto (2012). The scenario of one group not being fluent in the languages spoken by another between patients and clinicians is a common occurrence in the South African public healthcare scene. This phenomenon is closely connected to the peripheral position of African languages in education particularly in specialised fields that use scientific and technical terms. In South Africa, at the moment, African languages are not used as medium in both basic education institutions to institutions of higher learning.

As a consequence of the minimal role of African languages in academia, there is a huge gap between African languages and languages from other parts of the world in their differing abilities to efficiently convey information that carries scientific and technical terminology. To aid in reducing this language gap, Madzimbamuto (2012) suggests linguistic based approaches which can be adopted to elevate the scientific status of African languages in the medical space. These approaches are concerned with the engineering and modification of words to ensure that they satisfactorily embody the linguistic meanings they have in their original texts. Given the limitations that African languages have in articulating scientific and technical terms, there is a need to intellectualise African languages.

According to Finalyson and Madiba (2002: 53) in the South African language landscape there is a need for thorough intellectualisation procedure that is aimed at accelerating the growth and development of previously underdeveloped African languages to amplify their capacity to effectively interact with the with contemporary developments, theories and concepts. The practical implementation of this is the creation of new words in a manner that ensures they do not lose meaning contained in their original source words similarly to the term development strategy used in Latin and Greek for medical vocabulary (Madzimbamuto, 2012). One of the strategies is the use of compound noun

formation as a method of constructing new terminology for language (Madzimbamuto, 2012). The intended outcome of these changes is to ensure that African languages have the capacity to precisely express specialised terms.

However, the process of accelerating African languages to a point in which they competently convey specialised terms is attributed to their delicate connection with tuition. A challenge to the advancement of African languages is the limited exposure of many African scientists in formal training in their African languages or in other African languages and that language practitioner usually have lay understanding of science fields (Madzimbamuto, 2012). This illustrates that African languages have a limited role as conscious facilitators of innovation, logical reasoning and dialogues in specialised fields.

Consequently, Madzimbamuto (2012) encourages for the implementation of a collaborative effort between scientists and language experts to develop the scientific rigour of indigenous African languages. Language teaching at medical schools ought to be prioritised to enhance the level at which African languages are used by native speakers so that terminology development in the science fields can be fully congruent and compatible with subject knowledge (Madzimbamuto, 2012). These attempts at elevating the ability of African languages to be active apparatuses are expounded by Khumalo (2017) who expresses that in the context of South Africa intellectualisation translates to the seismic transformation of the capacity and role of indigenous African languages of communicating all forms of knowledge in all domains of life. Therefore, radical development of a language is not limited to the mechanics of linguistic expansion but extends to the spaces in which the language is used. There has to be a conscious effort and exerted attempts from government and non-government entities to implement policies that ensure the effective implementation of the suggestions contained in the language planning frameworks.

There have been attempts to centralise the scholarship role of indigenous African languages. Musau (1996) concedes that dual language at higher education level has been utilised as a way a mechanism of ensuring that African languages have a footprint in institutions of higher learning as non-language subjects and this has added to language development. Despite the presence of these languages in tertiary education institutions there are still structural challenges like insufficient availability of teaching

paraphernalia and meticulous presentation of these languages to galvanise interest from scholars from other language groups; instil pride in the native speakers or sufficiently indicate the instrumental value of indigenous African languages as tools of social mobility in competitive occupational markets. For example, Rhodes University has made commendable progress in introducing isiXhosa for Pharmacy as a subject component to aid pharmacy students to be fluent in isiXhosa and the University of Cape Town offers an MBChB programme that incorporates the teaching of isiXhosa as an in-built tool of tuition in the programme.

Madzimbamuto (2012) adds that using African languages as in the higher education system as dual language teaching apparatuses with other languages as is the case in South Africa with Afrikaans can improve the scientific landscape of African languages. The uses of African languages in advanced spaces of learning are crucial in developing the scope of the diction of these languages and provide them with the elasticity to interface with specialised subject fields such as medical professions. It is imperative to develop a platform where the utilisation of African languages is advocated for in publications and gatherings and to increase the use of African languages in medical education so that African culture so that it can stop occupying a peripheral position in the biomedical conversation (Madzimbamuto, 2012). The continuous disenfranchisement of African languages as tools of teaching and learning deprives these languages the opportunity to develop the capacity to linguistically interface with medical fields and this provides patients with difficulties in communicating their health needs because of the language gaps in the medical repertoire of their indigenous languages.

As a consequence, patients have to be interrogated to ascertain their medical condition as they possibly might be referring to a generic condition on the particular part of their body as they do not use a specific term (Levin, 2006b). A research study conducted by Levin (2006b) revealed that isiXhosa-speaking patients did not understand the English respiratory terminology utilised by medical professionals and that interpreters would be requested to provide basic explanations in isiXhosa to elicit responses from patients regarding their symptoms. Interpreting by explanation would significantly help in situations whereby a specific isiXhosa medical term is yet to be established so that the patient can engage with the healthcare professional at a knowledge and language level in which they are compatible.

The research study by Levin (2006b) also revealed that the isiXhosa respiratory illness terminology is inconsistently interpreted by the indigenous speakers of the language and this has the potential to confuse the clinicians. Furthermore, Levin (2006b) avers that the patients use disease terminology differently to clinical experts and this may lead to incorrect diagnosis and wrong administering of medical treatment. This problem can be averted through an extensive effort to collect medical vocabulary that is used in the public healthcare sector of the province and translate and standardise and then disseminate it to the community for healthcare education in isiXhosa.

To combat language and cultural incompatibility between patients and clinicians, it is salient to create a frequently updated systemic study of the utilisation of medical language by isiXhosa speakers and the compiled vocabulary ought to be taught to healthcare professionals to improve their communication with patients as well as enhance the quality of healthcare patients receive (Levin, 2006b). Additionally, healthcare workers should be cognisant of common culture-specific models of illness in order to meritoriously identify a mutual explanatory model that will better their relationships, communication and the compliance of patients to medical advice and treatment (Levin, 2006b). This means that a language-based approach by healthcare professionals to learn isiXhosa without considering the prospect of combining it with culture lacks the impetus required to provide a holistically culturally sensitive and aware patient care.

The notion of censoring offensive speech is a hallmark of Xhosa biomedical discourse as Xhosa people subscribe to euphemism when communicating information that relates to sexual intercourse, sexual transmitted diseases and infections and sexually reproductive body organs. Euphemism is defined by Webster (1989) as "the substitution of an agreeable or inoffensive expression for one that may offend or suggest something unpleasant." The Xhosa people consider it offensive to make explicit reference to reproductive anatomy and sexual functions thus they prefer to use less blunt terms for the ones considered to contain vulgarity. Lutz (1989) maintains that euphemism is used to indicate concern for someone else's feelings or respect for an established cultural or social taboo. Euphemisms, therefore, can be understood as substrata of taboos as it acts as a speech censoring agent in Xhosa communication.

According to Ndhlovu (2012) taboos function as both moral and cautionary agents for speech and behaviour and as a consequence they determine how members of society conduct

and articulate themselves. The definition of taboos by Ndhlovu as enforcers of normative mannerism in society with Nord's definition of culture in this research.

Nord's definition of culture magnifies the cultural influence of taboos as enforcers of morally acceptable behaviour in society. Mfazwe (2003) takes the argument further by noting that linguistic taboos are present in most cultures where tabooed words are often culture-specific and pertain to biological functions or aspects of culture that are sanctified. Explicit discussion of sexual activity and sexually acquired diseases amongst Xhosa people is taboo and is often associated with promiscuity and moral degeneration whereas a detailed reference to sexual anatomy organs is perceived to be use of expletive vocabulary. Therefore, there may be a disconnection in the veiled way in which a patient explains their symptoms compared to the direct and explicit wording that the medical practitioner may opt for. The doctors are trained in a manner that expects patients to utilise blunt speech that is not sanitized with euphemism.

The use of euphemisms when referring to these biological functions carries positive associations such as being cultured and disciplined. Typically, there is a high level of censorship around actions and word choices within the isiXhosa culture which are not abided by in scientific medicine spaces. In providing the etymology of the word *taboo*, Ndhlovu (2017) states that the word is borrowed from Tongan, a language that is spoken by Polynesians in the extensive group of islands in the Pacific where any sacred or humble things are prohibited to be touched or discussed. The Collins Dictionary (1999) defines a taboo as any prevention which emanates from social or other conventions, particularly something that is viewed sacred or unclean. For Wardhaugh (2000), taboos refer to the prevention or circumvention in any society of a behaviour perceived to be toxic to its members that has the potential to cause them anxiety, embarrassment or shame. Xhosa people subscribe to the use of taboos to neutralise and at times eradicate the vulgarity contained in unveiled speech particularly when discussing certain body parts and information regarding sexual activity. Ndhlovu (2017) identifies that in relation to taboos, body parts can be grouped into two categories: general and respected. 'General' body parts are anatomical organs which are responsible for transparent physical functions such as facial and their senses as well as limbs (Ndhlovu, 2017). 'Respected' body parts are biological structures that perform reproductive responsibilities and 'private' duties such as excretion of bodily fluids and human excrement. For Xhosa people, discussing issues which relate to reproduction and

sexual activity with someone you are not sexually intimate with is frowned upon and this can make it difficult for a clinician to illicit information from a patient. It is also considered taboo for Xhosa people to be nude in front a person you are not either married to or intimate with and this may hinder effective physical examination of a patient. Communicating in a different language that most patients are not proficient in or have limited command of whilst observing these taboos causes more communication challenges between clinicians and patients. In some instances, the communication difficulties are exacerbated by having to communicate these across gender lines in a different language.

Mansour-Hamdan (2016) avers that in certain cultures, there may exist certain stigmas connected to discussing health issues and this makes it difficult to confront these concerns. It can be extremely difficult for a Xhosa woman to openly discuss her sexual activity life to a doctor because generally amongst amaXhosa there is a lot of moral value attached to being free of sexually transmitted diseases and infections and deterioration in health due to sexual transmitted disease is often associated with many transient sexual relationships. Mfazwe (2003) articulates that in most African societies, the reputation of a woman hinges on the standard of her monogamous sexual behaviour. These stigmas are not limited to only women, for most African men discussing health frailties can be seen as an emasculating endeavour and this can prevent them from receiving the immediate help they need. In circumstances such as this patient assessment and diagnosis then becomes difficult as, according to Mansour-Hamdan (2016), much of medical practice especially diagnosis, hinges a lot on the ability for a patient to express themselves eloquently. Lutz (1989) states that when discussing elements of sex people in every culture use euphemism because sexual intercourse is often seen as a private matter that is inappropriate to be discussed for public consumption. The application of euphemisms when referring to sex extend beyond the sexual intercourse itself but to events prior to it and after it such as courtship, pregnancy, giving birth and the body parts involved (Lutz, 1989).

There are various motivating factors for the adoption of euphemisms. Euphemisms can be divided into two sub-strands. Sebkova (2012:12) differentiates between *instinctive euphemism* and *strategic euphemism*. The instinctive sphere of euphemisms includes avoidance of swearwords and religious expressions in contexts in which the religious expressions may hurt or offend someone, avoiding embarrassment when mentioning

body parts and their functions Sebkova (2012:12). Strategic euphemism on the other hand is seen as an extension of political correctness. Both strands of euphemisms are show sensitivity to offensive terms and opt for the use of acceptable of widely accepted choice of words in conversation. The euphemistic utilisation of words does not only avoid the use of offensive speech but it also ensures civility and contributes to a positive self-image and revered social status on the part of the speaker. The use of euphemisms is indicative of language dexterity as speakers are able to eloquently manipulate language by replacing derogatory and displeasing words with polite and mannerly substitutes without distorting information or being incomprehensible. The explicitness with which the patients are expected to express themselves is against their cultural philosophy of amaXhosa as discussing diseases and making overt referral to some anatomical parts and bodily functions is seen as profanity and obscenity. It is, therefore, important for medical practitioners to understand the cultural ideologies of their patients.

The communication that occurs between patients and healthcare professionals in South Africa often occurs across cultural frontiers and that impedes on effective communication. Mgogo and Osunkunle (2020) define intercultural communication as a communication process that happens between two or more people of distinguishable for accomplishment of a particular aim. Mansour-Hamdan divulges that the coinage of the concept of intercultural communication is attributed to American anthropologist Edward T. Hall who applied the premiere use of the term on his book *The Silent Language* in 1959. Mansour-Hamdan (2016) defines intercultural communication as a situation in which people from different cultural backgrounds communicate with another. This means that for a communication encounter to be perceived as an intercultural communication the participants involved in the engagement have to be from distinct cultural backgrounds and this connotes differences in the conception of central beliefs and philosophies which inform the worldviews of people of a particular language and cultural group.

The overwhelming majority of patients come from indigenous South African cultural backgrounds whereas the majority of healthcare professionals come from cultural backgrounds

with strong western culture influences or from outside of South Africa. The common goal of astute assessment of the patient which would result in correct diagnosis and prescription of medication collapses due to discordances in cultural mannerisms of the patients and the clinicians. Mgogo and Osunkunle (2020) identify differences in language and culture as the main hindrances to effective intercultural communication which then beget ethnocentrism, prejudice and stereotypical behaviours. According to Magogo and Osunkunle (2020) ethnocentrism and prejudice are the beliefs that one's culture or cultural group has a higher social rank and status and one can have preconceived ideas about members of other cultural groups before having known them. For Bizumic (2015) there is a distinction between ethnocentrism and prejudice with ethnocentrism referring to perceiving members of a particular demographic as superior and being at the centre of existence whereas prejudice refers to unfavourable predetermined judgements about other people. Both ethnocentrism and prejudice are constructs of negative attitudes towards members of an out-group which generally cannot be supported by rigorous scientific evidence.

The challenges presented by intercultural communication in healthcare can be neutralised by cultural competence which is quintessentially characterised by appropriately and effectively by the ability of healthcare professionals to be cognisant of their own cultural norms; to comprehend the unique perspective of the patient; and to effectively modify their behaviours to provide optimal care to patients (Mansour-Hamdan, 2016). To ensure effective intercultural communication, Mansour-Hamdan (2016) the practising of cultural sensitivity which refers to the use of cultural knowledge while communicating with patients and considering cultural nuances during discussions and recommendation of treatment.

Interlingual communication refers to communication that happens between two or more people who do not share the same native language. Often times, the circumstances under which this type of communication occurs is inundated with grammatical errors which makes the intended message incomprehensible to its intended recipient. One of the contributing factors to conversation derailment in interlingual communication is that native speakers tend to apply the language rules of their home languages when speaking in the target language due to a limited command of the target language. In the South African public healthcare system this phenomenon is exacerbated by the fact that the ad language mediators are often nurses who have limited biculturalism and bilingualism

due to not having formal interpreting knowledge training and skills as well as a superficial comprehension of some of medical concepts when compared to other healthcare personnel.

3.6 The belief systems of amaXhosa in relation to health

Fore Peires (1982) it is impossible to discover by investigation the unadulterated original evolution of the Xhosa religion. Despite this assertion Peires (1982) the central premise of the amaXhosa religion is a very hazy indistinct conception of a supreme being and the view of good and evil spirits is interpreted in relatively uninteresting terms of ancestors and witches. Despite Peires' remarks about the unclear genesis of a higher being, SAHO (2019) state that the supreme being of Xhosa people is called *uThixo or uQamata*. Similarly, to the religions of many other Bantu groups, God is only rarely involved in everyday life. Qamata may be approached through ancestral mediators who are honoured through ritual sacrifices (SAHO, 2019). Ancestors commonly communicate their wishes to the living through dreams. Xhosa religious practices are characterised by detailed and lengthy rituals, initiations, and feasts (SAHO, 2019). There is a recognition of existence of witches on earth and there is a strongly held belief that when the witches die, they manifest into evil spirits whilst there is a lot of respect that is afforded to ancestors (Peires, 1982).

Contemporary rituals quintessentially pertain to matters of illness and mental well-being (SAHO, 2019). The hybrid nature of dual adherence by amaXhosa to both Christian principles and indigenous beliefs places the interpreting nurses in an ambivalent position of attempting to reconcile the two philosophies of religion which affect the manner in which patients take medication and how they perceive healing. Commenting on the role of the Khoi and San in converting sizeable portions of amaXhosa to Christianity, Peires (1982) wites that the presence of Christianity in modern Xhosa life can be attributed to the indirect influence of Khoi and San belief systems in creating fertile ground for Christianity to permeate the Xhosa community through acquainting amaXhosa with analogues of God and the Devil.

From a Christian perspective the patients believe that they can summon divine intervention through prayer to heal any form of health deficiency. The indigenous traditional isiXhosa knowledge system holds the view that Western medicine does not have the

healing properties to provide safety from spiritual harm. This idea creates a conflict of ideas between patients and clinicians in instances where patients might believe that their health condition requires indigenous spiritual intervention and the clinicians suggest pharmaceutical treatment of the health problem. The divine healers in the form of *amagqirha* and *amaxhwele* are the leading protagonists of healing for amaXhosa and use solely indigenous means of healing. *Amagqirha* are the divine healers who draw their supernatural prowess from enlightenment by ancestors and also assume guidance roles in family traditional ceremonies. *Amaxhwele* are experts of manipulating traditional concoctions for different health and well-being needs. These two groups of traditional amaXhosa practitioners are different to the numerous specialised fields found in the medical profession who focus on niche areas of healthcare.

Both *amagqirha* and *amaxhwel*e serve as the conduits through which amaXhosa are connected to their ancestors as they relay the messages from the ancestors and draw from them the strength and guidance to provide healing. Unlike clinicians, *amagqirha* and *amaxhwele* do not have specific areas of healing in which individual divine healer is streamlined and confined to operate as a specialist. *Amagqirha* and *amaxhwele* occupy the general practitioner tier of healing as they help with physical and spiritual health. For amaXhosa, healing is not only physical but it also extends to spiritual elements. Both groups of divine healers provide clairvoyant readings which are quintessentially followed by administering of traditional medicine. This is a reversed approach to the one patients are exposed to in the scientific healthcare system wherein the health practitioner seeks to evoke responses from patients by asking them questions and allowing the patients to explain to them the state of their well-being and then provide them with medication that is appropriate for the symptoms explained by the patients as well as evidence shown in the tests that are often taken.

The consultation mannerisms in traditional Xhosa medical treatment from traditional healers are different to that of scientific Western medicine. Traditional Xhosa healthcare does not observe the exchange of pleasantries until the assessment of the patient is complete and is satisfied. Another point of difference is that the examination of a patient during traditional Xhosa healthcare does not necessitate close physical contact as the traditional healers use their spiritual compass to locate the health deficiency of the patient. There is minimal physical contact between the healers and the patients in Xhosa

culture and it is normal for a clairvoyant reading and the dispatching of medication of an individual to be done in the presence of their family or confidants.

In medical science, there is a lot of physical contact between the clinicians and patients and a lot of emphasis on respecting the privacy of the patient and these differences in the healing processes may result in Xhosa patients not being comfortable in a medical environment. Fundamentally, the traditional Xhosa consultation process is a collectivist approach that allows group members other than the person whose health is being assessed to be participate in the asking of questions and the making of decisions. The western medical model of patient consultation is individualistic and prioritises the privacy of the patient and is often one-on-one encounters between the healthcare professional and the patient concerned. There are certain elements that are different between western medicine and traditional amaXhosa medicine. Unlike western medicine, Xhosa traditional medicine which is administered by *amagqirha* and *amaxhwele* does not have specific units of measurement to quantify dosage. Usually, the traditional regimens of healing do not require strict adherence to diet and often patients in traditional spaces are not probed about their allergies and dietary history. Furthermore, because of cultural awareness, *amagqirha* and *amaxhwele* usually work with teams of protégés that have males and females to create a comfortable environment for patients in circumstances where the patient has to be touched physically in delicate areas of the body or when they have to be nude. In western medical care, there is insistence that any healthcare professional can examine a patient across gender lines because they are expected to conduct themselves in a professional fashion. It is quite common in Xhosa culture for a patient to share the traditional medication they received from *igqirha* or *ixhwele* with a family member they believe is suffering from the same health problem as them. In biomedicine, self-diagnosis and sharing of medicine with family and acquaintances is vehemently discouraged. The differences in the health methods of amaXhosa and those of western healthcare impact on the access of healthcare. The differences in the healing philosophy of amaXhosa and that of the modern world are informed by culture and the differences between the two healing systems may make it difficult for a patient to acclimatise to the biomedical process of healing and thus adversely impact their health.

With the Eastern Cape being a predominantly rural province, the low education levels of rural dwellers not only present language challenges for the clinicians but also carry the

dimension of a different healing ideology that is different to Western medication. The perception of healing for amaXhosa is different to that of Western medicine ideology. Traditionally, Xhosa people believe in the use of herbs for the betterment of bodily human elements as well as perceived spiritual problems. The herbs are free of pharmaceutical processes and treat an array of bodily ailments and spiritual complications.

Moreover, oftentimes when amaXhosa consult traditional healers they often seek for confirmation of what they suspect to be a problem as how that problem can be either eradicated or alleviated. In these circumstances, the patients pre-determine the sickness and the satisfaction of patients and the legitimacy of the traditional healer depends on accurate identification of the health problem without attempting to elicit the medical history of the patient from the patient. In the Western medicine sphere, patient assessment requires intimate bodily contact, and the diagnosis process involves eliciting responses from the patient.

3.7 I**nterpreting in the South African healthcare sector**

An interpreter is defined in the Oxford Learner's Dictionary (2021) as a person whose occupational responsibility is to articulate what someone is saying in another language. Currently, there is no official provision of interpreters in healthcare facilities and this has an adverse effect on the experiences of patients when they encounter the health system (Drennan and Swartz, 2002). The issue of the introduction of interpreting as an intervention to alleviate communication difficulties and achieve language concordance in the public healthcare sector has been explored

in previous research endeavours. According to Kanter et al. (2009) define language concordance as the interaction between a healthcare professional and a patient using a common language that is preferred by the patient. In instances wherein the clinician and the patient are both not sufficiently capacitated to communicate in a common language then services of an interpreter are sought. The linguistic and cultural diversity of the South African population and constructs of apartheid segregation have exacerbated the language problems in the healthcare system. Crawford (1999) argues that the monolingual nature of the public health system is a construct of apartheid where voices of black people were systemically and historically subjugated. The notion of apartheid as an enabler of inequality is reinforced by Murie (2009) who asserts that the

healthcare services of South Africa are still significantly influenced by the structural effects of apartheid, amongst a plethora of other inequities, have a low number of black doctors who speak the native languages of the black population has resulted in a situation where it is a challenge for patients in the public health system to access high quality, optimally accessible, and equitable service. According to (http://www-cs-students.stanford.edu/~cale/cs201/apartheid.hist.html 1995), the ratio of doctors to white people was 1/400 compared to 1/44 000 for black people. In 1975, six black South African doctors completed their studies in medical schools in South Africa and this was less than 1% of the total graduates although black people consisted 70% of the population (Beaton and Bourne, 1978).

Crawford's research on language issues in the healthcare sector focuses on power relations between the nurses and doctors and the impact of power relations in this setting on communication dynamics. Crawford explores communication in the healthcare sector through power dynamics within the historical context of South Africa wherein she identifies race and gender as pivotal currencies in the power dynamics. Her research argues that white male doctors occupy the upper echelon of healthcare workers and command a level of respect that the dominantly black female nurses do not obtain. In agreeing with the sentiments purported by Crawford about language discordance presenting skewed power dynamics in patient-doctor relationships, Meuter et al. (2015) profess that language challenges in clinical relationships between patients and healthcare professionals can be utilised to impose or manipulate the power dynamic and that the importance of acknowledging and correcting this is crucial when considering the already profoundly engrained inequality in the South African society. In observing power dynamics in communication in the courtroom, Aronsson et al. (1987), mentions the asymmetric nature of communication that is reflective of hierarchy between decision-makers and their subjects. Harris (1989) expands on the notion of power dynamics to note that the inequality between communicators extends to power and status. In South Africa, the healthcare professionals have power to make decisions that affect the health and well-being of patients with patients occupying a peripheral position in the process due to language inhibitions. Furthermore, when compared to patients to the majority of the patient population who have modest educational levels, the healthcare providers have an elevated social status that is enabled by their level of medical knowledge and knowledge.

Crawford's research emphasises the significance of interpreters in the healthcare sector and does not focus on interpreting itself. Furthermore, Crawford highlights the disempowered position of patients in the medical discourse who do not have the linguistic repertoire to communicate with healthcare workers in their preferred language of communication as they are largely passive individuals whose own description and account of their sickness is not perceived to be salient in the diagnosis process and the construction of a treatment approach.

3.8 I**mplementation of Batho Pele principles**

The application of Batho Pele principles is an extension of customer care approach. Customer care is intended to improve the rapports with and techniques of handling customers (Baines, 1996). This sub-section of the study will focus on the eight Batho Pele principles in relation to language and cultural dynamics in the public healthcare in South Africa.

Civil society participation in government decision-making processes has significantly changed in the democratic dispensation era in South Africa following the drafting of the new South African Constitution in 1996. According to the Batho Pele principles, consultation is concerned with informing of and seeking contributions from all affected groups of people on the nature, quantity and quality of services to be provided in order to establish the needs and expectations of the consumers.

Public participation evaluations contain two distinguishable traits in that they either emphasise on *process* or the *outcome* (Albeson & Gauvin, 2006:12). Process evaluations are concerned with the mechanics of what occurs while a program is taking place and relate to the stage of the program that is being observed (Weiss 1998: 335). The suggestion box feedback mechanism is a form of outcome evaluation approach as it designed to assess the extent of the successful attainment of the intended outcome of the initiated public participation programme. According to Weiss (1998:334) focus on assessing whether or not the initiative has yielded the envisioned program effects and consequently relates to the results of the program.

This study will examine the contents of the National Department of Health Language Policy

within the ambit of Batho Pele Principles and the legal instruments of the Constitution of South Africa. The National Department of Health Language Policy is a doctrine that delineates the legislative doctrines which inform its content and it is a policy that is

applicable to all employees of the National Department of Health and the written materials that are published and printed by the National Department of Health. There is a disjuncture between the principal provisions of the Language Policy and the use of selected languages for communication purposes with the public. The National Department of Health (NDOH) has the following Principles:

- commitment to the promotion of official languages in the NDOH in order to ensure constitutional language equity and language rights as required by a democratic dispensation;
- facilitate equitable treatment of official languages of the Republic and ensure equitable access to the services and information of the NDOH;
- promotion of good language management by NDOH to ensure efficient and effective public service administration that meets the needs of the public;
- prevention of use of any language(s) for the purposes of exploitation, dominance and discrimination within the NDOH.

Despite the Constitution of South Africa and the NDOH Language Policy itself advocating for the parity esteem of official languages of South Africa, the Policy states that certain languages are not utilised for certain channels of communication and English is used across all platforms of communication. This depiction of language roles by the Policy retards several aspects of *access* as enshrined in the Batho Pele principles. The *access* tenet of the advocates for the use of indigenous languages and sign language as well clear and helpful signage. However, with the way communication roles are spread across indigenous languages in the language roles of the Policy it means that some indigenous languages will not fulfil certain roles as corporate publications of the NDOH are available in only two indigenous languages, namely: isiZulu, Sesotho. Although the Batho Pele principles promote the facilitation of South African sign language and the conversion of written material into Braille for the hearing impaired, these services are not systemically available. Consequently, the cosmetic nature of this provision on the Policy does not improve the service delivery to physically disadvantaged persons as the Batho Pele principles envision.

The limited use of official languages as depicted in the NDOH Language Policy limits access to *information*. This limited use of language results in the failure to successfully avail

information in various official languages. Thus limitation by the NDOH deprives patients the opportunity to access information that is pivotal to the betterment of their health including information on medication, treatment procedures, preventative methods and alternative health avenues. The notion of *redress* in the Batho Pele principles relates to the establishment of a feedback mechanism that articulates any public disgruntlements about the public health services. Despite the provision of this feedback approach, there is no *openness and transparency* in terms of the due processes that are taken to effect positive change.

The Batho Pele Principles endorse accountability of government wherein the citizens are informed of how the departments are run; the cost implications of operation; and the hierarchy. The public's inability to access this information would equip them with sufficient knowledge to contest the government's inability to provide health information and language services to the public in the manner that the public prefers. The public would achieve this by assessing whether the government does have the financial capabilities and knowledgeable personnel in strategic positions that deal with the use of language and provision of inclusive language services in government healthcare facilities. The level of openness and transparency that is enshrined in the Batho Pele principles would afford solidify active and functional citizenship that permits civil society to contribute to decision-making process that are facilitated by government organs.

Consultation is one of the instruments of the Batho Pele principles. Consultation is the formal inclusion of the broader community in the decision-making processes of government to solicit constructive contributions and criticisms to advance the delivery of adequate public services that meet the needs of the population. The public participation method by government through the implementation of the consultation principle has customer surveys, campaigns, *izimbizo* and workshops as feedback mechanisms from which to ascertain the satisfaction of patients about public healthcare services. Section 195(1) of the Constitution of the Republic of South Africa, 1996 (108 of 1996), the government must utilise communication to indicate that it is not aiming to fulfil its own agenda but rather it is focusing on the welfare of the citizenry by promoting the democratic principle of advocating the public to part-take in policy formulation.

Consultation under the Batho Pele principles is designed to incorporate the relevant stakeholders in the infancy stages of policy-making through initiatives of learning and dialogue and ensuring amicability between civil society and government. Dodoo (1997: 115) comments on the role of public participation in effecting civil agreeableness by stating that one of the fundamental reasons for agreeableness public service to embark on is that accord should be achieved in all facets of public life. Furthermore, a positive effect of public engagement is that it reinforces the validity policy and averts non-compliance to policies (De Vries, 1997: 161). The willingness of government to include in the decision-making process can be understood as an extension of Ubuntu as Msila (2008) pronounces that true Ubuntu recognises as differences and always seeks to attain unanimity rather than impose monolithicism on the issues.

Beyond its role in the construction of policies that are tailored to suit the needs of the broader population, public participation is geared towards entrenching freedom of speech and expression as well as affording members of the community political and social participation on issues which pertain to their livelihood. Moreover, public participation encourages social cohesion and accountability of government to the citizens of the country through legitimate and transparent administrative mechanisms.

The Batho Pele principles emphasise the provision of public service in courteous and considerate manner where public service users are served in a polite fashion. The courtesy rhetoric is particularly significant when serving compromised population such as patients. The courtesy concept is closely linked with the philosophy of Ubuntu which generally viewed as an African dogma of entrenching social cohesion and cultivating humanity. Lefa (2015:5) expresses that Ubuntu manifests itself in every aspect of African life and is expressed through respect for people through accommodating human endeavour, acknowledgement of human susceptibilities, and pursuance of collective good to augment the prosperity of others. Lefa (2015:14) views Ubuntu as an act of goodwill that yields positive results as he interprets Ubuntu as caring for the health and well-being of other people and showing spirit of reciprocal support. Ubuntu is the expression of altruistic human activities with the sole purpose of helping those who are in compromised social positions and did not the resources and the capacity to provide aid to themselves and that Ubuntu is underscored by collective agency with the purpose of successfully attaining a collective triumph. In discussing Ubuntu, Msila (2008) highlights five social elements embedded in the collective finger theory that underpins

Ubuntu, namely: survival, solidarity, compassion, respect and dignity. These values of Ubuntu are catalysts for a considerate approach of healthcare provision and are sensitive to the needs of patients. The provision of a healthcare system based on Ubuntu entrenches principles of care, harmony and hospitality that extent to the manner in which humankind are interconnected. Ubuntu is a social ideology that promotes the concepts of collectivism in which an action is considered moral when it is motivated by generosity and if its results contribute to the happiness of others people.

The vast majority of the health-care workers in South Africa are nurses (Crawford 1999) as such the healthcare system is based on nurses. Therefore, the provision of quality healthcare that does not undermine Ubuntu and the Batho Pele principles is largely dependent on the attitudes of nurses. Haskins et al. (2014) maintain that the provision of quality healthcare is dependent on the positive of attitudes of nurses. However, the undesirable working conditions demoralise the nurses and this has a negative impact on the approach to healthcare provision to patients. The reasons the nurses provide for having negative attitudes towards patients are a combination of much needed governmental intervention as well as lack of professionals. These reasons are insufficient number of healthcare personnel, high volume of patients, absenteeism, and poor interpersonal communication. This study focuses on interpreting, therefore, interpersonal communication is a pivotal cog of this discourse. Poor interpersonal communication has adverse effects on patient care as it could result to severe health problems for patients as disease control and management education is compromised. Poor attitudes of nurses result in poor patient care that undermines the ability of the health system to provide high standard care and improve the well-being of patients (Haskins et al. 2014).

An indication of the poor quality of the South African public health care system is that according to an article published on BusinessTech (2017), the South African public healthcare sector is ranked 119 out of 195 countries worldwide in the Lancet Healthcare Access and Quality Index. The research measured the standard of healthcare provided by analysing mortality rates, the access to healthcare across the population, the cost of healthcare per person, and health mediations across 11 common categories (BusinessTech, 2017). This research also considered the ratio of doctors to patients

(BusinessTech, 2017). To emphasise the notion of a shortage of doctors in South Africa, Strachan et al. (2017) maintain that the ratio of doctors to patients from 1996 to 2016 was consistently one doctor per 1 000 patients. A major contributing factor to the unequal spread of healthcare providers across the patient population is that according to The 2018 Academy of Science of South Africa (ASSAf) Consensus Report the retaining of healthcare professional graduates, specifically, doctors and nurses is a huge challenge in South Africa.

The public institution is defined by Fox et al. (1991: 231) as institutions which operate in a space where there is minimal market exposure and there is a lot of dependence on sums of financial injection that are officially allocated by authoritative organs and that public institutions are influenced by distinct political dynamics. The public institution is defined as an entity that is under the rule of government and is dependent on government subsidy for financial support and is not a profit-oriented establishment. Public healthcare facilities are public institutions which are under the management of government and do not require a patient to pay a fee in order to receive healthcare. For this reason, *the value for money* Batho Pele principle does not apply in the provision of public healthcare as healthcare is free.

3.9 **Interpreting in the healthcare system as a global phenomenon**

Immigration of nationals from developing countries to developed countries due to political instability and economic deficit contributes to the emergence of language issues in healthcare systems of different countries worldwide. This phenomenon begets an increasingly globalised world where there is active cultural consolidation and linguistic amalgamation through coexistence of populations from different social communities. Yalcin (2018:2) defines globalisation as: "[a]n extensive network of economic, cultural, social and political interconnections and processes which go beyond national boundaries.

This illustrates that globalisation is an outcome of myriad social elements which are mutually expressive in the daily lives of individual and group members of civil society. For the developing world, economic insecurity such as inflation and rapidly decreasing value of currencies are the central facilitators of migration including socio-political elements such as poor ethnic or racial relations. Migration from the developing world to the

developed is underscored by material conditions as citizens of the developing world often migrate in pursuance of attaining social mobility and obtaining materials of instrumental value. Access to ameliorated social systems that contribute to the systemic enhancement of one's life is one of the reasons people migrate from their countries of origin to their countries of residence and a better equipped health system is one of the attractive social elements of the developed world. This subsection of the study discusses the communication challenges that healthcare workers encounter when providing healthcare to immigrant patients and compatriots from different language and cultural groups internationally, in Africa as well as in South Africa.

CHAPTER 4: INTERPRETING IN HEALTHCARE: AN INTERNATIONAL PERSPECTIVE

4.1. International view of interpreting

The vast majority of instances of compromised healthcare consultations occur between

healthcare professionals and patients who do not converse in a common language. Often times, in these scenarios, the healthcare professionals are native speakers of English and the patients they encounter communication problems with are Spanish-speaking patients. In a research study observing the communication dynamics in a paediatric hospital ward Flores et al. (2003) aver that interpreting errors are exceedingly present in interpreting that involves non-professional interpreters in the form of healthcare professionals and children. The common types of interpreting errors are omission, false fluency, substitution, editorialisation, and addition.

Omission refers to the exclusion of information that was relayed either by the physician or the patient; false fluency is the incorrect self-confessed ability to master a language in all its communicative forms and have the diction that is suited for all the registers of the language; substitution is the replacement of one item by another that does not accurately convey the message in another language; editorialisation is a phenomenon in which the interpreter relinquishes objective interpreting and uses opinion. Addition refers to supplementary information that is communicated by the interpreter which was not part of the verbatim expression of the patient. These interpreting errors have clinical consequences as healthcare professionals consider the interpreting to be accurate, and thus, its contents are perceived as the precise representation of the experience of patients and are analysed for diagnosis.

Errors which lead to clinical consequences include the exclusion of questions about allergies to medication; leaving out interpreting instructions on the quantity of medication to be ingested, frequency of medicine intake, and duration of certain medicines and hydration

fluids (Flores et al. 2003). Additionally, interpreting errors include instructing the extent to which a patient can engage with a clinician on personal health issues, leaving out information on changes to the initially prescribed medical treatment, and incorrectly relaying treatment procedures to patients (Flores et al 2003).

Building from the earlier work with colleagues, Flores (2006) acknowledges that the use of ad hoc interpreters is error prone as ad hoc interpreters are susceptible to committing interpreting errors which may lead to adverse clinical consequences due to a lack of training in medical terminology and protection of confidentiality of the medical information of patients. Medical terminology embodies scientific rigour that is not easily discernible to the untrained personnel and it is often difficult for untrained interpreters to have the linguistic elasticity to convey information presented in medical jargon to the language of the patient. Helman (1981) states that clinical consultations are normally conducted in a hybrid of regular everyday language and medical jargon, however, technical medical terminology has increasingly become difficulty to comprehend for members of civil society with occupations outside of medicine.

In certain instances, the priorities of ad hoc interpreters may be in conflict with those of a patient and their presence during the clinical consultation may avert deliberations on sensitive matters such as domestic violence, substance abuse, mental illness, and sexually transferred diseases (Flores, 2006). This means that the ethical conduct of ad hoc interpreters is often questionable due to conflicts of interest that arise from their relationships with the patients that they are interpreting for. This further illustrates that interpreting requires a stable moral compass and objective unadulterated transfer of messages.

It is particularly dangerous to allow children to occupy the role of interpreting as they may not have proficient command of two languages or medical jargon. Furthermore, children regularly make errors with significant medical outcomes and they are particularly likely to evade discussing sensitive information (Flores, 2006). The language development of

Benfeldt-Diaz (2016) highlights that there is less representation of healthcare workers from the

Latino community as a result the Spanish-speaking patient contingent do not have access to healthcare professionals who provide them with culturally pertinent and culturally sensitive care. The dichotomy in culture between patients and clinicians is exacerbated

by the language aperture between the two groups of communicators (Benfeldt-Diaz, 2016). The paucity of the availability of clinicians who are fluent in Spanish deprives Spanish-speaking patients the opportunity to directly converse with healthcare professionals about issues which affect their health as they often rely on the intermediary role of ad hoc interpreters who are often family members and other close acquaintances. The following section will discuss interpreting in the European healthcare fraternity.

In discussing the effects of increasing linguistic and cultural diversity in the Spanish healthcare sector, Plaza del Pino & Veiga (2014) identify immigration of to Spain as a leading contributing factor. Immigration is the international relocation of people from to a destination country of which they are not born in and not have documentation that legally recognises them as the citizens of that country. The high levels of demographical diversity in the local and immigrant population has an impact on fundamental aspects of healthcare provision such as appointments, inspection of symptoms, patients' explanation of the problem, healthcare workers' knowledge of the personal and immediate social environment situation of patients as well as communicating the diagnosis or adherence to treatment (Figueroa-Saavedra, 2009). The adverse consequences of language hindrances between healthcare providers and patients may compromise the quality of healthcare provision in areas such as follow-up, admission, readmissions, adherence to treatment, and satisfaction of patients (Bischoff, et al. 2003).

Low levels of mutual comprehension in clinical consultations between patients and healthcare providers have the propensity to destabilise the entire treatment process a patient due to the unclear elucidation of medical points. Immigrants are particularly susceptible to healthcare provision that does not cater for their communicative abilities as the healthcare system in their adopted country is not inherently constructed for them. The study conducted by Plaza del Pino and Veiga (2014) reveals that patients who were most dissatisfied with the level of healthcare they received are the ones who cannot speak Spanish and thus relied only on gestures to describe their health problems and that oftentimes the patients who had no mastery of Spanish are susceptible to isolation and unfair discrimination due to being misunderstood. The necessity to combat language barriers between healthcare professionals and patients is addressed through the introduction of ad hoc interpreters and these are often non-medical staff, partners,

children, relatives or strangers such as people who are in the company of other patients and members of immigrant associations and NGO's (Plaza Del Pino and Veiga, 2014). The use of ad hoc interpreters reduces the quality of information medical interpreting requires expert knowledge and skills which are obtained through training and practice (Abril and Martin, 2011). The dangers presented by the use of interpreters to the lives of patients are a result of ad hoc interpreters not having clinical knowledge and the language proficiency to accurately convey the message fluently from one language to another. Moreover, the independence and confidentiality of patients is taken away as the patient is not sufficiently informed about their healthcare to make informed health decisions and lifestyle choices. The non-existence of a common language of clinical consultation deprives patients the opportunity to receive nurturing from clinicians and establishing a healthy clinician-patient rapport. The following section will introduce the clinician-patient communication dynamics in Africa.

Africa is a culturally and linguistically diverse continent and this makes interpreting to be a prominent feature in most cross-cultural interactions. In his research on multilingualism in the private healthcare sector of Namibia, Mlambo (2017) highlights the use of non-professional interpreters to help the provide clarity to patients with the linguistic needs to have satisfactory medical consultations. Unlike this study, Mlambo focuses on the linguistic repertoire of expatriate healthcare professionals and the study focuses on the private healthcare sector. However, there is a commonality between Mlambo's research and this study in that they both focus on the effects of language and cultural differences between clinicians and patients in the provision of quality healthcare. The following section explores the research literature on healthcare communication in South Africa.

Similarly, to Mlambo, the research conducted by Soahatse (2000) acknowledges the effect expatriates have on the communication dynamics in the healthcare but the focus of the latter research is patient-oriented and explores the language landscape of the healthcare public scene. Soahatse (2000) remarks that the patient population at a particular healthcare facility in Soweto near Johannesburg is reflective of the language and cultural diversity of urban South Africa due to the assortment in demographics of patients from within South Africa and those who come from the southern Africa region. Saohatse (2000) attributes to the misunderstanding which occurs between patients and clinicians to linguistic diversity to in the area the hospital is situated including the

language varieties which are active in Soweto. The language discordance between patients and healthcare providers is a disservice to the patient and can have negative effects on the patient. In South Africa, unlike in the scenarios discussed in this study in which there are language discordances and cultural gaps between healthcare providers and patients, it is the languages of the majority groups which are at the periphery of mainstream language use in public healthcare and have a less prestigious status in platforms of higher domains.

One of the effects of communication discordance due to language barrier is significant misdiagnosis and incorrect management of the disease. To support this argument, Soahatse (2000) describes a scenario in which a doctor who could not get interpreting assistance from the nurse opted for the use of physical gestures to communicate with the patient who was ultimately discharged from the hospital and as a consequence of the miscommunication which occurred between the doctor and the patient, the patient was re-admitted after three with his health condition having deteriorated (Soahatse, 2000).

A study conducted at a district hospital in Cape Town by Schlemmer and Mash (2006) shows that the provision of informal interpreting and the use of an untrained interpreter compromises the quality of the healthcare service rendered to patients by healthcare professionals. The interpreter, who is often a nurse, is a consequence of the fact that despite South Africa having eleven official languages the majority of the healthcare employees are proficient in only one or two languages (Schlemmer and Mash, 2006). The use of nurses as interpreters has multiple negative effects on the quality of healthcare that is provided to patients. In the first instance, the nurses are not linguistically equipped to bridge the language gap between clinicians and patients as their training focuses on provision of healthcare treatment and not interpreting skills. This results then in interpreting services that have errors that tarnish the reputation of nurses as competent healthcare providers and put the health of patients at risk due to errors in the interpreting process. In addition, interpreting for nurses is an added responsibility that is not acknowledged through remuneration yet increases the workload of nurses. The increment in the workload of nurses due to interpreting results in patients not receiving the ideal attention to detail that they should be receiving from the clinical care of nurses.

According to Schlemmer and Mash (2006) the effectiveness of quality healthcare mainly rests on a positive relationship between a clinician and patient, however, this relationship is damaged in the context where there is no mutual understanding because of a lack of a common language in which they both can proficiently converse in. Clinical consultations between patients and healthcare providers that are underscored by language discordance lack the warmth and cultural sensitivity which are salient characteristics of interpersonal relationships in African settings. The history of racial segregation in South Africa has compounded the effects of language gap difficulties between patients and clinicians. Racial segregation was legislated and enforced during apartheid through the implementation of the Group Areas Act of 1950. This Act endorsed the segregation of residential and commercial areas in towns and cities along racial lines which resulted in the force removal of Black, Coloured, and Indian people from areas which were categorised for occupation by white people. The limited social interaction between people of different race and language groups limited multilingualism in South Africa and this has adversely affected the communication dynamics in the public healthcare sector.

The foundation to a good relationship between the clinician and the patient is through good communication and efficacious use of language (Woloshin et al. 1995). Lavizzo-Mourey (1995) adds that high quality healthcare that prioritises the satisfaction and needs of patients is dependent on patients understanding and adhering to the medical advice of the health specialists and on healthcare professionals listening to and comprehending the needs of their patients. Mutual understanding on language grounds between patients and healthcare workers during clinical consultations is pivotal for creating an enabling environment for the correct detection of illnesses and prescription of treatment by healthcare providers and adherence by patients to suggested health-enhancing routines. However, it is difficult for enabling patient-clinician relationships to be built from a foundation of solid linguistic and cultural understanding if they are from different cultural backgrounds due to lack of profound social integration from members of different racial and language groups.

The language barrier causes significant rift in the relationship between patient and doctor, which is a pivotal aspect of quality healthcare, as doctors struggle to instruct the patients and at times may exhibit a degree of belligerence due to frustration (Schlemmer and Mash, 2006). In response to the impatience of the doctor, a patient would be upset at

the doctor for the entire duration of the consultation (Schlemmer and Mash, 2006). The communication barriers extend to differences in cultural nuances which may also provoke offence from the patients due to differences in approaching topics of discussion which pertain to certain phenomena. For example, there is a need to consider gender sensitivities which are embedded in cultural rhetoric. It is considered uncomfortable for a heterosexual couple to discuss issues which pertain to nudity and being nude in the presence of one another when they do not have an intimate romantic relationship or are not married to one another.

There is a wide range of ethical and medico-legal predicaments which occur as a result of communicative problems due to inter-lingual conversations between patients and clinicians. Plenty of patients experience difficulty navigating consent documents and providing informed consent for surgical procedures as they do not comprehend the content of the consent forms (Schlemmer and Mash, 2006). The confidentiality of the patient is often violated as a doctor who cannot provide counselling in the language the patient is fluent in has to request interpreting service of other patients (Schlemmer and Mash, 2006). The security of confidential information is compromised when the patient cannot be medically examined without the assistance of a third party in the form of another patient that serves as an interpreter. Furthermore, the unavailability of isiXhosa in the consent documents prevents patients the opportunity to make informed decisions about their healthcare and well-being and limits their extent of fluency in articulating their reasons for declining or accepting a particular health procedure.

Inter-lingual misunderstanding has resulted in antagonistic attitudes between patients and the clinical personnel as each group has negative preconceived ideas about one another. The non-isiXhosa-speaking staff has developed a negative attitude towards the isiXhosa-speaking patient community because of previous encounters as some members of the healthcare professions believe that non-isiXhosa speaking patients deliberately do not comprehend what the healthcare professionals utter. (Schlemmer and Mash, 2006). On the other hand, the isiXhosa-speaking patients argue that the English-speaking doctors do not care about them and do not consider their feelings (Schlemmer and Mash, 2006). The differences in language have the potential to nurture the exacerbation of poor race relations due to the political legacy of South Africa. This illustrates that multilingualism is one of the anchors of social cohesion and it has the ability to facilitate racial unity.

The notion expressed by the isiXhosa-speaking patients in Schlemmer and Mash (2006) that doctors do not care about them is accentuated by Mlambo (2017) that language discordance between patients and doctors results in substandard communication which arises due to not understanding the reported medical symptoms, making an accurate diagnosis, taking control of general misunderstandings, challenges in the construction of healthy relationships and trust, incorrect prescriptions, compromised health results, and an increased probability of patients getting harmed. Generally, poor communication between clinicians and patients impedes the patients' constitutional right to access quality healthcare due to not fully comprehending the treatment instructions from healthcare providers.

There are language difficulties which emanate from inter-lingual clinical care and are often are detrimental to the patient. The research conducted by Schlemmer and Mash (2006) suggests that the quality of patient care decreases immensely due to language barriers as some patients are discharged without knowing the identified illness or health problem which is examined by the doctor; the patients are not knowledgeable on how to ingest their medication; and do not know what to do with the letter they obtained when discharged. The communication channels are not helpful to the patient due to not understanding the language of record and communication in the public healthcare system. The direct results of this are unconscious non-compliance to medication treatment and a lack of understanding of the diagnoses and the treatment. Consequently, the health and well-being of patients deteriorate because of the unclear message that results from language challenges.

Schlemmer and Mash (2006) note that as a consequence of the misunderstandings which

emanate from the cross-lingual divide in communication between patients and doctors, many tests are repeated unnecessarily. In the research study, Schlemmer and Mash (2006: 1086) point out an instance where patients are dying because of a language hurdle as one of the nurses mentioned a case whereby a patient who responded incorrectly to his name died after a drain was put into his healthy chest. A central aspect of proficient language learning is enunciation. Enunciation is a feature of pronunciation that is concerned with the audible and clear pronunciation of sounds in a particular language. Due to the tonal nature of isiXhosa, it is imperative for non-native isiXhosa speaking clinicians to acquire the mastery of correctly enunciating words as there are instances

in which the names of male and female isiXhosa speakers are spelt in an identical fashion. An indication of whether the name is of a male or female isiXhosa speaker is in the in the manner in which the name is pronounced.

In contexts where a language barrier exists in an interaction between parents and clinicians,

parents perceive that negative health outcomes occur including the prescription of unsuitable medication (Levin, 2006). Furthermore, patients experience difficulty in understanding the diagnoses, the prescribed medication, follow-up measures and adult patients do not adhere to medical advice as well as in paediatric spaces (Levin, 2006). The adherence of patient to prescribed treatment measures relies on the patients fully comprehending the message from the healthcare providers and frequently in the public South African healthcare space inter-lingual discourse results in a handicapped patient understanding of treatment. A study by Levin (2006) indicates that interpreter errors occurred regularly in a paediatric outpatient ward and this resulted in considerably negative medical outcomes.

Levin (2006) further lays emphasis on the limited proficiency that healthcare professionals have in the home languages of their patients and the absence of adequate interpreting by pointing out that the incorrect pronunciation of isiXhosa names in the waiting rooms resulted in delays and translations mainly comprised of errors. The research done by Levin (2006) at the Red Cross War Memorial Children's Hospital (RCH) in Cape Town where a majority of doctors are speaking English as a home language, followed by Afrikaans with isiXhosa-speaking doctors being a minority group in a hospital where an overwhelming majority of the patients are isiXhosa-speaking reveals the extent to which this phenomenon enables inter-lingual and inter-cultural disjuncture that is to the disadvantage of patients. In this hospital, Levin (2006) points out that the availability of the interpreting service is accommodated only during office hours and that there are only two interpreters available.

The problem with the way the interpreting services are availed at this particular health institution is multi-layered. To begin with, there are not enough personnel available to interpret simultaneously during every clinical consultation which illustrates possibility of the existence of numerous interpreting errors that occur within the allocated interpreting hours. In addition, the limitation of interpreting to only during office hours creates a high probability of interpreting errors to occur in the absence of the

interpreters. Furthermore, there is a systemic disregard of the patient majority at the hospital as there are limited services in place to provide for their communication needs. Consequently, most patients at this hospital attributed their dissatisfaction by the quality of healthcare services provided to language and cultural barriers than to structural and socioeconomic hindrances (Levin 2006).

Levin (2006:1076 page) proffers that the isiXhosa-speaking patients mentioned language as prevention to optimal and satisfactory healthcare. The patients described that the language problem caused them to be dissatisfied with the service they received from the patients or encounter problems in the communication process, with the most common problem being the inability of patients to understand English, particular words or medical terminology (Levin, 2006). The nature of language aperture in the medical field in relation to indigenous African languages is two-fold. Firstly, there is a gap that exists between English and indigenous African languages because there two languages are not mutually intelligible and originate from unrelated language families. The other reason is that there is an asymmetry between the vocabularies of English and indigenous African languages wherein the latter do not have advanced terms to optimally articulate the specialised terminology of the medical discourse. These language problems create a double hindrance for isiXhosa-speaking patients and are further compounded by differences in worldviews which are informed by subscription to different cultural beliefs. Other communication problems were the patients being unable to make themselves understood to the doctor and being unable to pose questions (Levin, 2006).

The foundation to quality healthcare and a healthy relationship between the patient and a doctor is facilitated by good communication through the use of a mutually understood language. In South Africa, language barrier continues to deprive the majority of the population quality access to and of healthcare services (Hussey, 2012). The use of a monolingual healthcare system in a linguistically diverse society is a huge challenge particularly in a country that acknowledges this linguistic assortment through its constitution and the public discourse of a “rainbow nation” (Hussey, 2012).

In stark contrast to the idea of a multilingual and multicultural South Africa, the hegemonic use of English as a language of communication and in the healthcare, system marginalises the majority of South Africa which overwhelmingly consists of primary speakers of indigenous African languages. This means that the patients who have an

improved connection with the healthcare system are those who have a reasonably good command of English. Hussey (2012) states that the connection between English fluency and access to education in post-apartheid South Africa means that the communities which were disenfranchised under apartheid continue to be marginalised to experience the inequality of power particularly in the healthcare system. The connection between English proficiency and education under the apartheid regime stems from the introduction of the Bantu Education Act 47 of 1953 during apartheid. The Act enforced racially divided educational institutions with different academic content for the different racial groups. The general argument is that the Bantu Education Act aimed at curtailing the potential of students of colour and averting them from accessing lucrative opportunities of social mobility through producing unskilled labour. In many instances, patients blame their limited linguistic versatility instead of holding the healthcare professionals accountable for a lacklustre provision of healthcare (Hussey, 2012).

A research study which was conducted by Hussey (2012) at Madwaleni Hospital in the rural Eastern Cape sub-district of Mbashe within the geographical and administrative confines of the greater Amathole district showed that the majority of patients at the hospital speak isiXhosa as a mother tongue and that it is their exclusive tool of communication. According to Hussey (2012) this causes language difficulties in communication between the healthcare professionals at the hospital and the patients and thus prevents the provision of quality healthcare. The overwhelming majority of rural inhabitants in the Eastern Cape have moderate education levels and this is a result of contemporary structural and economic problems which have amassed momentum from the apartheid legacy of economic and educational disenfranchisement of black people.

In Schlemmer and Mash's (2006) research the language challenges doctors mentioned which emerged because of not comprehending isiXhosa included the inability to discover the main complaint of the patient, obtain a comprehensible medical history and the inability to discover malingering and psychosocial problems. Furthermore, language difficulties provided by the inability of doctors to be fluent in isiXhosa included a decline in the ability to be compassionate, benevolent, and approachable and to resolve psychosocial problems and a reduced application in providing patient counselling and education (Schlemmer and Mash, 2006). One doctor gave an account stating that due to communication problems as a result of language dissimilarities, the consultations which

occur between clinicians and patients are "healthcare taking place across a barrier" (Hussey, 2012). Typically, the amaXhosa expect the healthcare professionals to exhibit empathy and understanding and where a need arises, they also need to show unreserved respect for their beliefs, and this will lead to a more receptive engagement instead of being pathologized.

4.2 **Conclusion**

Language and cultural challenges in the health sector are barriers to the prevention of empathetic and optimal healthcare. The prevalence of language challenges in the healthcare system between and patients in South Africa compromise some of the rights that the citizenry of the country is eligible to receive.

Due to a lack of language congruity when patients engage with the health system, some patients are deprived of rights which are provided in the legislative frameworks. The Patients' Rights Charter (2007) protects the right of citizens to actively participate in the decision-making process that affects their health; however, the miscommunication that often occurs in clinical consultations alienates the patient from active decision-making participation regarding their health. Closely linked to this provision is the right to make informed consent which is based on access to complete and accurate about the condition of the patient's illness, medical processes involved in detecting the disease, the suggested treatment and the costs involved (Patients' Rights Charter, 2007). Without the full comprehension of what the clinician communicates to the patient, it becomes difficult for the patient to make informed consent.

The confidentiality and privacy regarding the health status of the patient is often violated as an ad hoc interpreter would often be called upon to provide interpreting services to aid with eradicating inter-lingual and inter-cultural inhibitions during clinical consultations as such the information regarding the health status of the patient becomes available for consumption to parties who they patient might not have wanted to share the information with. Levin (2007) emphasises that the presence of a third party in the form of an interpreter is a common act when patients and healthcare providers speak different languages. The World Health Organisation (1983) articulates that informed and an active participatory role by the civil society is crucial in the improvement of health for the people. However, Murie (2009) states that it is a difficult principle to achieve in South Africa due to the prevalence of language barriers in the public healthcare system.

CHAPTER 5: INTERVENTION MEASURES TO LANGUAGE AND CULTURAL COMMUNICATION IN THE HEALTHCARE SECTOR

5.1 Intervention strategies

The communication challenges that are experienced by both clinical professionals and patients and this requires intervention measures which aid in removing the communication difficulties. Jacobs et al. (2001) argue that the purpose of introducing interpreter services is to reduce language barriers which impede on access to healthcare and to potentially improve healthcare. Interpreting would provide patients with ability to fully express themselves with the assurance that their words would be articulated correctly. Furthermore, the availability of interpreting would grant healthcare professionals the opportunity to be linguistically in sync in their engagements with patients. There is empirical evidence which indicates that the use of professional interpreters during clinical consultations between clinicians and patients results in fewer communication errors (Flores et al., 2003). The trained interpreters would provide accurate linguistic meaning of medical terminology due to a developed capacity to create terminology and apply equivalence when interpreting. Interpreters also carry cultural elements which are evident in their communication. This shows in the choice of words to use when interpreting for each communicant in a manner that is sensitive to the ethical benchmarks of the cultural background of each communicant without compromising the accurate transfer of information from one language to another.

The instituting of a professional interpreting program increases the delivery of healthcare to patients (Jacobs et al. 2001). Interpreters are crucial in facilitating the receipt of precise medical knowledge from healthcare professionals in a way that the patients are not able to obtain without professionals interpreting services. Without comprehension due to differences in the language and cultural characteristics of patients and the medical professionals the patients have an unpleasant encounter with the healthcare system. The availability of interpreting services enables patients to have increased access to office visits, prescription writing, and prescription filling (Jacobs et al. 2001). The use of interpreters has the ability to improve patient satisfaction, understanding of disease, adherence to

care and follow-up appointments (Jacobs et al. 2001). The use of professional interpreters in the biomedical sector positively affects the communication dynamics and significantly improves the receipt of clinical and preventative care which is often presented to patients in a specialised diction and a different language to theirs.

In-person professional interpreting services has demonstrated to be the most effective interpreting model as it permits the interpreter to incorporate visual cues to augment communication (Karliner et al. 2018). This notion is endorsed by Price et al. (2012) who contend that professional interpreters report better understanding of the patients' social background and cultural philosophies and have greater ease in facilitating a benevolent relationship between the patients and the clinicians.

It is necessary for pedagogy to create fertile platforms which encourage language teaching and learning in medical schools to improve language concordant communication between patients and healthcare professionals. Molina and Kasper (2019) purport that language concordance is pertinent for medical students who are involved in health care around the globe. As a consequence of viewing medical schools as spaces which are central to equipping clinicians with language skills which promote language concordant communication in healthcare provision, Molina and Kasper (2019) are advocating that medical schools to broaden opportunities for medical courses which focus on language acquisition and incorporate these medical language courses with evidence-based teaching strategies, tuition material on health equity, and standardised language assessment tools.

The creation of organic and non-scripted consultation dialogues that centralise the cultural aspect of interpreting are necessary to equip prospective medical practitioners with the ability to combine cultural awareness with linguistic prowess when interpreting. The languages taught in medical schools should mirror the language needs of the patients where the school is situated and where the school is engaged worldwide (Molina and Kasper, 2019). It is crucial that the institutions of higher learning in the Eastern Cape take into consideration the language dynamics of the province and initiate the teaching and learning of isiXhosa that is particularly specific to various clinical fields that are offered at the tertiary institutions that are available in the province.

It is pivotal that the academic content of language courses at medical schools should consist of key areas of how to conduct a history and bodily exam; pertinent health inequalities which normally affect patients who come from different language backgrounds; cultural sensitivity and humility particularly when it pertains to beliefs and practices which affect health and wellbeing; and how to work effectively in language discordant environments with interpreters and other modalities (Molina and Kasper, 2019). Meticulous language assessment is imperative to guarantee equity in communication prior to allowing students or healthcare providers to utilise their language expertise in clinical encounters (Molina and Kasper, 2019). Kanter et al. (2009) agree with the notion of language assessment and state that it is necessary to administer a formal test for language fluency to clinicians. Kanter et al. (2009) further express that efforts should be made enhance the health education of patients in their native language. Kanter's language concordance approach is a reciprocal initiative that is aimed at both the patient community and healthcare professionals. The acquisition of isiXhosa by non-native isiXhosa-speaking healthcare professionals would significantly improve the patient-healthcare provider relationships and provide the patients with the confidentiality that they need in clinical consultations as proficiency of healthcare professionals in isiXhosa would eliminate the dependence on interpreters. The professionalization of language fluency in medical schools can improve the patients' trust in individual clinicians and the profession of clinical medicine in its entirety; improve the health safety of patients and health results; and promote health equity for the patient community (Molina and Kasper, 2019). Furthermore, this would expand the vocabulary of isiXhosa to sufficiently express specialised terms embedded in the terminology of various strands of medicine.

It is important to consider the process of teaching and learning of the indigenous local languages in medical schools as salient according to the cost vs benefit analysis. According to Burgoon et al. (1994) communication efforts can be viewed from a cost vs benefit paradigm. This paradigm considers the advantages of acquiring particular language skills as a benefit and the cost as the effort that ought to be invested to acquire the communication expertise. In the context of providing the teaching of isiXhosa in medical schools, the cost of the process would be the identification of qualified academic personnel who would impart the language and cultural knowledge to the students and the production of academic resources and infrastructure to create an

enabling educational environment. The benefits of this would be to produce graduate medical students who are equipped with the language skills and cultural aptness to engage with the patients in a manner that facilitates the delivery of quality healthcare to patients.

Krashen (1981) proposes two attitude-based factors which relate to the acquisition of a second language: integrative motivation and instrumental motivation. These two attitudinal factors are pivotal in predicting the level of success a person can attain in learning a second language (Murie, 2009). Integrative motivation is viewed as the aspiration to be accepted and valued by members of the community who speak a particular language and can be shown to be the better predictor of second language proficiency (Murie, 2009). This phenomenon is based on the lure of wanting to be appreciated by a certain community group through linguistic immersion outside of formal and scientific learning of language. Integrative motivation encourages the communicant to interact out of interest and encourages easier acquisition of a second language (Murie, 2009). Currently, the class and education gap between the healthcare providers and the patients is huge and the fluency of non-Xhosa speaking clinicians in isiXhosa does not have the aristocracy and the prestige that is associate with English and therefore fluency in isiXhosa is not perceived to be an attractive cultural identity. This has its roots in the apartheid system which systematically relegated indigenous African languages into community languages with peripheral scholarship roles.

Instrumental motivation is the willingness to acquire fluency in a second language due to practical motivations (Murie, 2009). Instrumental motivation stems from the realisation that proficiency in a second language begets opportunities of upward social mobility. Similarly to integrative motivation, instrumental motivation also results in language acquisition but at a reduced extent compared to integrative motivation (Murie, 2009). There are negative attitudes towards indigenous African languages from both the native speakers as well people from other language groups. The condescending attitudes stem from the opinion that indigenous African languages are devoid of the capacity to propel their speakers to the upper echelons of social mobility due to their limited elasticity in technical and scientific fields as well as their marginal presence in specialised fields and in prestigious basic education facilities.

According to Murie (2009) instrumental motivation is the most probable motivation for most healthcare workers in the public sector wishing to learn a new language as they need to be competent in the language for practical reasons in order to make their professional lives more convenient but do not necessarily intend to integrate and become cherished members of the community which speaks the language they have the desire to learn. Proficiency of healthcare professionals in isiXhosa would provide them with job satisfaction and reduced work-related stress as they would be able to effectively communicate with patients. This would lead to most clinical professionals finding it easy to adapt and acclimatise to the cultural setting of the hospital as well as being in tandem with the patients culturally and linguistically as the majority of the Eastern Cape citizenry are home language isiXhosa speakers mainly from the rural areas. Moreover, clinicians who are fluent in isiXhosa would be prioritised in the placement of clinicians in health facilities as their multilingualism would be an asset in the provision of service delivery that is sensitive to the needs of the majority of the population of the province.

Levin (2006b) encourages the wide use of interpreters in medical interactions between patients and healthcare providers and that healthcare professionals need to be taught how to efficiently use the services of interpreters. It is imperative that healthcare providers acquaint themselves with learning basic greetings and health assessment questions in African languages and learn more about the cultures of their patients and their models of illnesses (Levin, 2006b). The ability of healthcare professionals to have a healthy and functional relationship with professional interpreters would help them understand the patients better particularly the manner in which amaXhosa articulate their models of illness. The amaXhosa models of illness are informed by two attributes: the cultural beliefs of amaXhosa as well as the ambiguity of isiXhosa and its lack of the ability to extend its vocabulary to the minute specificities of medical nuances.

Levin (2006b) suggests against the use of specialised terminology when interacting with patients or when used, he suggests that is used with full explanations with the support of an interpreter. The explanation of medical jargon in isiXhosa is a practical example of the functional relationship between healthcare providers and professional interpreters. The explanation of specialise terms would help the patients comprehend the diagnosis and the health assessment process better and would significantly improve the extent of participation of the patient in the clinical consultation engagement. According to Squires (2018) who comments in support of the use of interpreting

services remarks that interpreter services contribute to increased patient satisfaction and enhanced customer care amongst patients who experience language barriers when communicating with clinicians. Interpreter services are associated with increased access to healthcare as they are associated with increased visits to clinicians, increased prescription of medication by clinicians to patients, and receipt of preventative services among the patient population (Brach et al. 2005). The professional interpreters and the clinicians ought to engage in a collaborative effort to reconfigure the linguistic architecture of the medical message to be comprehensible to the untrained cognitive network of the isiXhosa patient who is not conversant in English.

Some scholarly arguments observe that the process of professional interpreting in the biomedical space is not immaculate as it has its disadvantages. Interpreters make errors which include the substitution, exclusion, addition and reduction of utterances made by both the healthcare workers and patients (Putsch, 1985; Diaz-Duque 1982). A study conducted Baker et al. (1998) indicates that patients prefer to communicate with a clinician directly in their native language and that the use of interpreters related adversely to patient satisfaction when compared with direct language communication in the native language of the patient. It is imperative to note that professional interpreters are not healthcare specialists; therefore, they are not exempt to making errors due to their myopic understanding of the biomedicine. In these errors, both clinicians and patients are in a compromised position as the messages they purport are distorted or wrongfully contracted leaving out crucial information that both parties need to make informed decisions.

Patient dissatisfaction is more prevalent in clinical consultations involving interpreter use than in instances when then there is language concordance between the clinician and the patient (Ngo-Mertzer, 2007). The use of trained interpreters during healthcare consultations minimises language barriers, however, the ideal situation language concordance where the clinician is fluent in the patient's native language (Waibel, et al. 2009). The epitome of inter-cultural communication is patients and clinicians interacting without language barriers and without the assistance of an interpreter. This form of inter-lingual and intercultural communication yields the best results in the provision of patient care and also solidifies patient-clinician ties. The use of interpreters does compromise certain of communication between healthcare providers and patients

and the outcome of the lacklustre communication is less than ideal clinical outcomes (Waibel et al. 2009).

There are several salient areas which need to be included in programs that aid healthcare providers with cultural competence training and these are communication skills which facilitate the construction and establishment of rapport; handling of emotional circumstances and inclusion of shared decision-making skills; language competence through the use of interpreters or receipt of language training; and cognisance of prejudices and negative preconceived ideas (Cooper and Powe, 2004). People from different cultural groups use different mechanisms to handle emotionally charged scenarios. For example, amaXhosa deal with trauma through the use of emotional support of family and acquaintances. Normally, due to the severity of their health condition, a Xhosa person would ask their confidant who is usually a kin to accompany them to hospital to provide emotional refuge. According to the Western cultural model, there is often a need to isolate the patient from others and assess them in solitude and this often detaches them from their source of emotional strength.

The decision-making amongst amaXhosa often submits to hierarchy in terms of age. Therefore, a patient might want to discuss their decision with an older sibling or a guardian prior to taking it to elicit words of advice. It is important for healthcare professionals from different language and cultural groups to be aware of these dynamics and not exert their own cultural biases. This can be achieved through the introduction of cultural competency training as part of the scholarly and professional advancement of healthcare providers across all tiers of development (Cooper and Powe, 2004). Medical schools ought to make curricula modifications that prospective clinicians acquire appropriate knowledge, mannerism, and skill (Cooper and Powe, 2004). These additions in medical school curricula would equip prospective clinicians with the sensitivity not to use their cultural beliefs as the centre of logical reasoning and prevent them from unfairly discriminating patients for subscribing to a different world view.

Cooper and Powe (2004) propose that it is imperative that guidelines are eructed which will be consistently utilised to implement and evaluate cultural competence training initiatives. Professional bodies which regulate clinical professions should make available opportunities for the provision of these guidelines at local, regional and national levels (Cooper and Powe, 2004). Cooper and Powe (2004) suggest that future research need

to provide more understanding into the nuances by which concordance of patient and clinician in various sociocultural factors which include language, culture and ethnicity language influences processes of healthcare provision.

Considering the observation that governments in African countries are the primary stakeholders in language planning processes, Alexander (2004) is convinced that unless the primary speakers of the language/s are satisfactorily included in the language planning discourse and non-governmental institutions are included at foundation level of any language planning process, language planning will subject people into subjugation and will eventually be resisted. It is important to create a strategic platform for isiXhosa language doyens and specialists to be active participants in the formulation language planning processes that are geared to elevate the status of isiXhosa and centralise it in the provision of healthcare. The reason this is important is that these language practitioners are closely connected to the lived experiences by virtue of being members of the community whose language they are re-engineering and are knowledgeable about the science that facilitates language development.

The reason Webb (2009) provides for concurring with this suggestion is that language planning directly affects myriad avenues of the social life of people; therefore, their significant contributions are warranted. Alexander (2004) advocates for a democratic planning 'from below' to achieve radical social transformation undertaking. This approach by Alexander is similar to the notion of public participation in the Batho Pele Principles as it encourages that a language planning strategy must be devised by the people it will affect and then be presented to the government and non-governmental authorities for approval and implementation. This approach concentrates on considering the feelings of the citizens and their role in participative governance.

Webb (2009) concedes that the top/down and bottom/up approaches can be reconciled to beneficial effect as government can facilitate the availability of resources which enable language development and financial infrastructure and generation of information, engage with community members with the intention of including them in the process and then various stakeholders take ownership of the process and are responsible for implementing the process. Mhlauli (2016) states that an example of this collaborative approach in the public healthcare sector would see a three-way union between government authorities, healthcare professionals and patients whereby all three fronts

discuss and reach an amicable point on the suitable strategies to employ in dealing with the language needs of the patients in the healthcare environment. The three-prong approach suggested by Mhlauli is crucial in providing patients with a platform to influence the way the language difficulties they encounter in the public healthcare system can be resolved from their own perspective.

Kamwangamalu (2000) proposes that the current multilingual language policy of South Africa does not contain provisions that detail how multilingualism can be preserved to ensure that African languages are not passive components of the policy. Consequently, Kamwangamalu (1997) suggests *reverse covert planning* as a structure for enhancing the status of African languages. Kamwangamalu (1997) defines *reverse covert planning* as a conscious attempt to ensure that African languages contain the power and privileges of the type that is associated with English or Afrikaans at the height of apartheid prior to the construction of avenues to significantly elevate African languages as communicative tools in the media or the work setting. Currently, the legislative frameworks acknowledge and promote the use of isiXhosa as a language patient can use in the Eastern Cape to access public healthcare; however, this still remains impractical in most scenarios. The creation of canvases on which a collaborative effort centralises the recognition of public opinion and is sensitive to patient complaints and suggestions around language issues in public health would provide practicality to the theory presented by Kamwangamalu.

Kamwangamalu (*Ibid*.:1997) maintains that presently a language user would not attempt to acquire proficiency of an African language because currently African languages are not marketable and do not have significance in the broader diplomatic and fiscal discourse. A language has a marketable status if it enables its users to obtain opportunities of active economic participation (Kamwangamalu, 1997). There has to be a rigorous effort to highlight the manner in which isiXhosa provides instrumental impetus for professionals in public clinical care and the provision of incentives that are attached to the provision of quality service delivery to patients due to the ability to connect with them at cultural and language points would escalate the instrumental motivation for healthcare providers to acquire fluency in isiXhosa.

The notions expressed above about the marketability of language concur with Cooper's (1989) assertion that language planning ought to be understood as a marketing problem.

Understanding language planning as a marketing problem involves developing the appropriate *product* which is supported by suitable *promotion* and positioned in the right place at the right *price.*

In terms of the *product*, Cooper (1989) suggests that practitioners involved in language planning must be aware of, detect or design products which the potential consumer will find valuable. This means that the value of isiXhosa as an active role player in the medical course ought to be illuminated in relation to the degree to which the creation of isiXhosa lessons in medical schools make the working easier and more rewarding as easy communication with patients will lead to easy detection of health problems and correct prescription of treatment. It is imperative that these products are defined and clientele be targeted using empirically dictated consumer needs (Cooper, 1989). It is salient that materials of tuition advancement such as curricula, textbooks, study guides and other aspects of course content in various disciplines of clinical studies significantly create a positive atmosphere between patients and clinicians.

Promotion of a communicative invention such as language refers to endeavours to prompt potential users to adopt it and adoption of the language can be seen as awareness, positive attitude towards the language, proficiency or usage (Cooper, 1989). The promotion of a language is concerned with constructing a positive profile of a language and bringing it into close proximity to a community that is not familiar with it and ensures that particular community is aware of the value of the language and the lucrative nature thereof. It is pivotal that healthcare professionals are induced into acquiring proficiency in isiXhosa to help them realise workplace satisfaction and reduced work-related stress levels which emerge as a result of language barriers encountered in engagements with patients.

Place is concerned with the furnishing of suitable pathways of dissemination and response; this means that a person who is interested in acquiring African language fluency must be aware of the channels which can aid them in that pursuit (Cooper, 1989). The aspect of *place* refers to the identification of sustainable ways of language development and intellectualisation such as academic platforms in the form of mainstream use of isiXhosa in academia including in basic education environments in which it was historically not provided as well as in medical schools. This would aid in the dissemination of information about a isiXhosa and increasing its accessibility through

sustainable ways such as the teaching of the language throughout the tiers of tuition and in the context of the health sector it would be having isiXhosa as a central teaching act in the training and tuition of prospective clinical employees in tertiary institutions in the Eastern Cape.

With regard to the *price*, price is viewed as the leading aspect of language which is appealing to the consumer (Cooper 1989). This means that prospective users need to identify the benefits of acquiring isiXhosa in relation to the financial impetus this has and the role isiXhosa plays in the enhancement of the professional profiles of healthcare providers. Clinicians in the public healthcare sector in the Eastern Cape would benefit from mastering isiXhosa fluency as it would reduce frustrations which emanate from the use of different languages and markedly curtail the susceptibility to legal complaints which can put the jobs of most clinicians in jeopardy.

5.2 **Interpreting in the South African medical sector**

Interpreting is one of the most problematic fields in the South African language profession landscape as the professionalisation of the field is not fully recognised in some spaces particularly in the medical environment. The predicament of lack of professional recognition and appreciation of interpreting in other areas outside can be exemplified by the interpreting saga that engulfed Nelson Mandela's funeral in which an interpreter was widely criticised for signalling in a manner that was inconsistent with the expressions of the speakers and thus was not intelligible and comprehensible. The interpreting incident at Nelson Mandela's funeral is a micro example of what is happening in the South African interpreting space wherein most interpreters did not receive professional training. Focusing specifically on courtroom interpreting, Mikkelson (1996) comments that courtroom interpreting is underscored by an absence of a standardised benchmark for training and practise; disorganisation among interpreters; lack of recognition of the profession by end-users of translation services as well as the public, and sub-standard working conditions. Despite Mikkelson's particular focus on courtroom interpreting, the phenomena entailed in Mikkelson's sentiments are universal in the South African interpreting space including the nature of the use of interpreters in the public medical sector. In defining the interpreting in the context of South Africa, Du Plessis (1997) states that interpreting is a distinct, long-standing profession operating within a designed climate in many countries around the

globe, but in South Africa interpreting is yet to mature to a level that enables it to acquire the same status. In the healthcare system, nurses in South Africa often must fulfil interpreting duties wherein they act as information conduit between the patients and clinicians and despite the nurses not receiving professional training as linguists, interpreters and translators they are often expected to create terms ad hoc due to the limited availability of standardised medical terminology in African languages. The nurses are forced to communicate in the best way they possibly can without any quality assurance measures for interpreting to guard against sub-standard interpreting. The lack of interpreting training and absence of a system for assessing the quality of interpreting have resulted in dire consequences in different professional fields in which people access information through language-meditated communication. Lebese (2013) points out that the lack of training for interpreters has adverse effects on the justice system where incorrect interpreting leads to wrongful arrests. In the health sector, errors in interpreting could lead to misdiagnosis; incorrect prescription and administering of medication and even death. Nurses do not possess the balanced bilingualism that is essential in interpreting between two languages. Beyond bilingual competence, nurses lack the scientific expertise to merge pertinent cultural mannerisms with medical language for purposes of communicating effectively in African languages when interpreting.

Nurses find themselves doing interpreting duties as a secondary job that falls outside their official remit of practise. This adds more significant pressure on the nurses who have a demanding job of assessing and observing the health and well-being of patients and this may result in job dissatisfaction for nurses which emanates from immense psychological pressure as nursing in itself is a demanding job. The psychological burden of interpreting adds on the workload of the nurses and has the potential to beget negative workplace relations between nurses and other healthcare personnel as the constant availability of nurses to interpret for patients may be a challenge might be a challenge due to attending their core prescribed duties; displeasure of patients with interpreting proceedings or the clinical personnel struggling to comprehend the interpreting-mediated engagement.

The challenges that emanate from the interpreting practise occur as a result of how the teaching and training of interpreting in South Africa is offered in institutions of higher learning. There are very few tertiary institutions of academic learning in South Africa and most

of these institutions do not offer field or subject-specific interpreting courses as such interpreting in a specialised field such as medicine becomes extremely difficult to navigate more so for untrained interpreting personnel. The limited availability of both general and specialised interpreting learning and training points to a need to find interventions for linguistic and cultural measures. Against the backdrop of this exposition, this study will set out to identify these interventions through engaging with nurses about the challenges they face as interpreters; the challenges patients experience in having to access the healthcare system through language-mediated processes; and establish from clinicians the extent to which provision of quality healthcare is compromised when they have to rely on non-professional interpreting to engage with their patient population.

5.3 **Conclusion**

The effectiveness of patient-clinician consultation hinges on an impeccable understanding both on language and cultural and grounds. Difficulties in understanding the language and culture of one communicator leads to a communication collapse as well as potentially catastrophic healthcare implications. In the wider language practice context, interpreting is a largely underdeveloped area of expertise and its limitations extend to the niche area of medical care where interpreting is done by personnel who are not trained interpreters thus severely compromising the efficiency of interpreting. Interpreting in the South African healthcare sector continues to be unregulated and unprofessional. There is a need to create structured avenues for the development of indigenous South African languages which were marginalized under apartheid so that they can be used to efficaciously carry scientific and technical lexicons. The notion of language development and promotion requires a determined government that is willing to include the native speakers of the languages it intends to develop and promote in the language development processes and aptly implement the language development provisions contained in the legislative frameworks.

CHAPTER 6: LANGUAGE AND TEACHING IN DOCTOR TRAINING: SOUTH AFRICAN CONTEXT

6.1 **Doctor training in South Africa: exploration of language teaching**

The way medical pedagogy is constructed in South Africa continues to enable a

culture of language distance and cultural vacuum between patients and clinicians. Across the curricula of higher education institutions which offer training for doctors, the emphasis is on simulated clinical consultation conversations between patients and clinicians and this limits the scope of the diversity of possible interactions the trainee doctors will encounter in real-life situations. This approach results in the lack of centralization of culture in the teaching and learning platforms of higher education. The language specific nature of the courses relies on language specific dynamics that are choreographed for assessment purposes using external moderators as assessors instead of using scenarios from real patients or exposing the prospective doctors to authentic doctor-patient clinical interactions.

The focal points of language learning in the curricula are basic questions for understanding the medical history of patients, anatomical terms and common illnesses. The learning of these features requires not only linguistic proficiency but also cultural acumen. There are no standardized isiXhosa anatomical terms for use in the medical fraternity for anatomical parts involved in reproduction or excretion of human excrement as an explicit referral to these body parts is perceived to be the use of expletives and the use of those names of body parts without euphemisms may be offensive to some patients. This means, therefore, that the teaching of language in medical courses without centralizing culture lacks the holistic approach that is needed to provide patients with culturally aware healthcare that is sensitive to their ethnographic philosophies.

For example, the University of Cape Town offers *Xhosa for Health and Rehabilitation Sciences* exclusively to students who are registered in the School of Health and Rehabilitation Sciences (UCT, Faculty of Sciences, 2021:234). The course focuses on language learning through considering clinical experiences in various health and well-being fields with competency in pronunciation, grammar and interaction with patients being

the main focal points of the course (UCT, Faculty of Sciences, 2021:234). The proficiency of students is tested through simulated patient interviews for June and November examinations and there are no requirements for admission to the course (UCT, Faculty of Sciences, 2021:234). The course is designed to introduce students to occupation-specific vocabulary and that enables them to communicate effectively with patients across the language and cultural divides (UCT, Faculty of Sciences, 2021:234).

Another language learning course that is offered at the University of Cape Town to assist prospective healthcare professionals is *Beginners' Xhosa for MBCHB*. The course focuses on the technicalities and mechanics of isiXhosa grammar and sentence construction to assist students with fluency in isiXhosa (UCT, Faculty of Sciences, 2021:235). One oral summative assessment is used to grade the language competency of the students to determine whether or not they have passed the course. (UCT, Faculty of Sciences, 2021:235).

Research was conducted to establish the students' perceptions of additional language teaching in the health courses offered at the University of Cape Town. Afrikaans is one of the two additional languages of tuition in the MBChB programme at the University of Cape Town alongside isiXhosa, however, for the purpose of this research, the focal point will be the perception of students with regards to isiXhosa as an additional language of learning and teaching for prospective doctors. The research conducted by Mohamed et al. (2019) indicates that the isiXhosa course is not presented to the extent required to achieve the course goals of creating multilingual medical practitioners in South Africa.

According to Mohamed et al. (2019) more than 45% of the students admitted to only be speaking isiXhosa in preparation for assessments in the course and thus the language does not form part of the daily linguistic repertoire. The students' limited use of isiXhosa exacerbates the South African norm where the most of the South African healthcare providers are unable to communicate in any of the indigenous local languages. Less than a quarter of the students indicated that the communicative competence apparatuses were valid and a low proportion of less than 40% of the students found isiXhosa to be helpful in real-life clinical scenarios (Mohamed, et al. 2019). This points to the imperative nature of refurbishing and reintroducing assessment apparatuses that significantly improve the communicative competence of students as well as cultural awareness. Furthermore, Mohamed et al. (2019) revealed

that the majority of students who learn isiXhosa are comfortable with only exchanging verbal pleasantries but are not linguistically equipped to conduct crucial clinical interview components such as taking the medical history of patients; performing a physical examination on the patient or understanding responses of patients. This means that students get clinical language learning that does not satisfactorily meet their occupation demands and thus impedes on the quality of healthcare they will be able to provide to patients. Their inability to fluently speak isiXhosa with patients proves the necessity to restructure the course to equip the students with language competence. Mohamed et al. (2019) state that only a small section of the students concede that isiXhosa classes provide satisfactory attention to cultural nuances. The students' limited engagement with the conceptual elements of isiXhosa culture through course content material are worsened by, according to Mohamed et al. (2019) by the students' admission to a lack of significant exposure to patients who are home language speakers of isiXhosa. This points to the need to expose the students to language knowledge and cultural assessments outside of the role-plays wherein their language comprehension and cultural sensitivity will be tested in real-life situations and in more regular intervals than the sporadic oral assessments offered in the course.

Deducible from the perceptions of the students about isiXhosa as an additional language of teaching and learning in the MBChB programme at the University of Cape Town is a need to repurpose and redesign the course to align with effective clinical communication that the prospective healthcare professionals will be exposed to in real-life scenarios. The non-alignment of course outcomes with students' perceptions of the course demonstrates that that the course does not holistically apply processes in place to aid with exposure to real-life situations. Due to *Beginners' Xhosa for MBCHB* being offered only to first year students, there is a possibility that the students' command of isiXhosa might deplete considerably in the years following the completion of the course due to lack of use of the language outside of pedagogical compliance. Moreover, this is not a compulsory course for all MBChB students at the University of Cape Town as exemption to complete the course is granted to students who exhibit verbal competency in the oral assessment prior to the start of the course, therefore some sections of the student population may miss out on the opportunity to acquire cultural mannerisms akin to amaXhosa due to their oral skills being deemed sufficient to be exempt from studying the course. The course is only offered for six months, in the second half of the first year

of the MBChB degree, and that is not sufficient time to introduce students to a new language and develop vocabulary elasticity to engage in full clinical consultations with native speakers of isiXhosa or understand the value systems of amaXhosa.

In view of the perceptions of the students enrolled for the MBChB programme at the University of Cape Town, there is also a need to compartmentalize language learning of isiXhosa considering the different medical fields that require training on different vocabularies and mannerisms depending on which aspects of health they are dealing with. For example, dieticians need to master food vocabulary and measurements in isiXhosa; physiotherapists have to excel in knowing anatomical terms and kinesthetic movements, and speech therapists must have superb enunciation and pronunciation of sounds, amongst others. For some fields like gynecology and urology, the learning extends to cultural nuances wherein information that is crucial for diagnosis might not be easy to elicit from patients due to stigma, shame and taboo around discussion of sexual diseases and sexual history of patients. This is because reproductive health complications are associated with promiscuity and philandering and patients might delay reporting these complications, therefore, discussing these issues with patients requires sympathy, patience and warm-heartedness.

6.2 **Translator and interpreter training in South Africa**

Different language practice courses offer different customized services that are intended to equip students with translation and interpreting skills. Training of translators and interpreters in South Africa has limited availability and the paucity of translator and interpreter training in the language professions in South Africa is exemplified by, according to the South African Translators' Institute, (2019) the availability of training in these fields in undergraduate and postgraduate levels in not more than ten institutions of higher education across the country including the offering of translating and interpreting short courses. Commenting on the academic climate of language professions in South Africa, Marais (nd) asserts that translation and translation studies have extended since the adoption of the democratic South African constitution which advocates for the parity of esteem of all languages of the South Africa, however, apart from a few established courses at tertiary education institutions, most institutions have been experiencing difficulty since 1994 to compile courses and implement administrative systems to anchor these courses. In focusing on the fundamental

philosophies and approaches to translator training in South Africa from a pedagogical perspective with the intention of establishing the roles and responsibilities of translators; the context in which the training of translators occurs; exploring the ideology of teaching and learning; and investigating the assessment of competence. For the purposes of this research, the focal point will be the philosophies of tuition that underpin translator training. Kelly (2005) remarks that it is important to align training with the contexts under which the translation takes place. The lack of subject specificity in teaching translation significantly reduces the competence of translators and thus lack the vocabulary and cultural competence to communicate harmoniously and sufficiently across two languages whilst.

The first school of thought is the traditional school which is characterized by classroom-centred; teacher-centred; product-centred and knowledge centred approach (Kiraly, 2000). This is a fundamentalist approach where teaching and learning takes place in a lecture venue context and the lecturer is the primary source of information and the intended outcome is that the students acquire and understand the information that is imparted to them by the lecturer. The second approach to translator training is the cognitive approach which focuses on scientifically investigating the psychological state of a competent translator during translation Lee-Janhke, 2005) and this school of thought views translation as a problem-solving mechanism. The translation of medical jargon to a different language (i.e., English to isiXhosa) that has a significantly underdeveloped medical vocabulary is a complex bilingual and bicultural undertaking that requires a practitioner who is in a healthy state of mind and who embodies linguistic and cultural competence. Furthermore, in the context of medical healthcare, interpreting is a practical undertaking that aims to provide communicative solutions to language challenges and cultural problems that hinder effective communication between the patients and clinicians. The third approach is the socio-constructivist school of thought which maintains training of translators should emulate relate-life scenarios or take place in real spaces (Marais, nd). Second language acquisition as is the case with the University of Cape Town in the MBChB course, the learning of is isiXhosa takes places in re-enacted spaces that do not resemble the communication dynamics between clinicians and patients. A favorable attribute of the socio-constructivist approach is that it ought to minimize the gap between the study of the theoretical components of translation and the praxis of translation (Marais, nd).

6.3 **Conclusion**

There is a direct correlation between patient dissatisfaction and the language in which the patient was addressed by the clinician during clinical consultation. The rudimentary nature of the presence of interpreting in the medical sector in South Africa is the byproduct of a superficial presence of African languages as tools of tuition in medicine and health related courses where the prospective clinicians are not fully prepared for clinical consultations in African languages. The African languages merely operate as languages for teaching and learning and are not carried to the field as part of medical training. Higher education institutions in collaboration with government ought to devise sustainable ways of developing the compass of African languages in a fashion that offers these languages the enticement that is attached to fluency in English. This will aid in significantly narrowing the language gap between clinicians and patients and also capacitate clinicians with ideal language skills to independently communicate with patients thus achieving both patient and clinician satisfaction.

The language and cultural barriers which impede on the provision of satisfactory healthcare service are remnants of apartheid constructs of segregation of people along racial and language grounds. The systemic preferential treatment of white people at the expense of black people during apartheid limited the career options black people could pursue and this has resulted in there being very few black native South African clinicians. The language challenges have been exacerbated by the fact that the overwhelming majority of white people do not have scientific and institutional access to indigenous South African languages and thus do not have the linguistic repertoire to communicate with patients without any difficulties whilst the majority of the patient population do not have English proficiency. From a cultural standpoint, the systemic separation of racial groups has limited integration and amalgamation of different sections of the South African population across different tiers of social interaction.

Language and cultural barriers have the propensity to compromise the quality of healthcare delivered to patients. Ethnographic incongruence between clinicians and patients results in adverse clinical outcomes and sometimes fatality. Furthermore, the handicapped communication limits the participation of patients in the decision-making process and hampers their ability to learn about their own health conditions and the

curative and preventative approaches they can be exposed to. The use of untrained interpreting personnel is an effective tool to reduce the language and cultural incompatibility between patients and clinicians and can lead to severe health results. The institutional introduction of trained medical interpreters reduces the ethnographic gap between clinicians and patients but it is not an ideal tool of communication. Patients quintessentially express satisfaction when there is language concordance between them and clinicians and language concordant clinical encounters generally optimize health outcomes and advance equity to healthcare access.

It is imperative that the art of interpreting is not viewed from a purely linguistic perspective as it embodies cultural elements. Cultural nuances dictate the narrative of each interpretation and the linguistic approaches that are applied to achieve equivalence in the language the primary information is transferred to. It is salient, therefore, for an interpreter to be cognisant of cultural gaps in the target language and have the cultural knowledge and language expertise to adequately compensate for the existing aperture.

Currently, isiXhosa does not have the lexicographical prowess that satisfies the demands of biomedical discourse, consequently, a concerted terminology development effort is required to elevate the clinical vocabulary of isiXhosa. It is necessary for clinician training to include language-oriented initiatives to ensure that clinicians can eloquently and proficiently communicate with patients without the need for the provision of interpreting services. In the South African context, the introduction of indigenous languages as mechanisms of tuition in medical schools ought to be accompanied by the ability to adumbrate the access to these academic programs and the instrumental value of these languages for clinical professionals.

There are legislative frameworks which govern language issues in the healthcare system in South Africa and advocate for the institutional legitimation of a multilingual healthcare system, however, the application of legalities on language discourse in health has been superficial thus rendering the language rights afforded to patients to be cosmetic paraphernalia. The language planning process of South Africa is viewed as bureaucratic and placing public opinion on the periphery and these factors are identified as the key reasons for the lack of progressive implementation of language doctrines for the wide and systemic benefit of the South African population and the eradication of language inequalities in the healthcare system which are residues of apartheid.

In other parts of the world, it is the immigrants or descendants of immigrants with minimal or no understanding of the dominant official languages of their destination countries who are struggling to gain quality care in the public healthcare systems due to language and cultural differences between the immigrant patients and the local healthcare workers. In South Africa, it is the majority of the indigenous population who have a superficial contact with healthcare providers due to language limitations and cultural differences despite legislative attempts to address past imbalances created by the legacy of apartheid. In attempting to officially address the sociopolitical and socioeconomic inequalities of the previous political dispensation, Chapter 1 (6) of the Constitution of the Republic of South Africa (1996) states the that:

"(2) Recognising the historically diminished use and status of the indigenous languages of our people, the state must take practical and positive measures to elevate the status and advance the use of these languages." Despite this legislated provision, indigenous South African do not have the aristocratic status of English and Afrikaans.

CHAPTER 7: RESEARCH FINDINGS

7.1. Field research findings

This Chapter of the study analyses the qualitative data presented in the previous Chapter. The data was obtained through the use of interviews and open-ended questionnaires that were administered to all research participants from the various groups. The findings will focus on a thematic analysis of the data presented in the preceding Chapter in which the themes are emerging from the responses provided by the participants.

The majority of patients are isiXhosa-speaking males with moderate levels of education the majority of whom are monolingual. The patients with the most impressive language repertoire are those with native language proficiency in isiXhosa and elementary commanding of English that is not sufficient to aid them in communicating effectively and independently with clinicians. All patients in this study uttered their preference of using isiXhosa as a language to access healthcare to English.

The inability for most patients to communicate with clinicians in their language of choice compromises the confidentiality and privacy of patients which are rights that are provided in the healthcare legislative frameworks of South Africa. Patients understand their health status, their sickness as well as treatment procedures much better when communicating in their home language – isiXhosa and they provide clinicians with detailed responses when there is language concordance between the two groups of interlocutors. Furthermore, the patients' lack of fluency in English results in patients omitting crucial information that would have provided impetus in the diagnosis process.

Outside of the ambit of language challenges, there are also difficulties that emerge during intercultural communication between patients and clinicians. IsiXhosa-speaking patients believe in a different set of cultural maxims that he Caucasian clinicians do not subscribe to and this may cause a misunderstanding or a perceived collision between the two models of healing and understanding health. The patients believe in witchcraft and ancestral spirits being causes of sicknesses which is a point of view that is an anomaly in modern medicine. Some of the patients are of the opinion that the clinicians do not respect their traditional belief systems although this is not a universally upheld judgement amongst patients.

The communication challenges between clinicians and patients are exacerbated by the humongous gap in education levels between the communicators in these two groups. Even in the rare instances in which a clinician can communicate with a patient who has minimal mastery of English, the patient eventually misses out on understanding crucial minute health-related details when clinicians use specialized terms as those concepts are incomprehensible to patients with layman understanding of the different fields of the biomedical space. The ad hoc interpreting strategies that clinicians use to bridge the linguistic and cultural apertures that exist between patients are devoid of skilled tactical execution and are a disservice to both their users as well as the intended recipients of the messages who are patients.

The fact that clinicians elicit daily and weekly interpreting services from untrained fellow workers positions patients in susceptible health risks as there is no established quality assurance mechanism in place to ensure that the interpreting is of an adequate standard. Due to the incapability of clinicians to communicate in isiXhosa they sometimes do not succeed to perform their core job specifications and thus fail to contribute to the betterment of the health conditions of the patients.

There is strong willingness from clinicians to attend language lessons to eradicate language impediments in their communication dynamics with patients. An alternative method that was suggested by the clinicians in dealing with language problems in the healthcare space is the employment of trained residential interpreters in hospitals.

The nurses have different levels of qualifications as well as areas of expertise and this, as alluded to previously by the 27-year-old isiXhosa-speaking clinician at Frere Hospital, determines the degree to which a nurse consummately interprets the clinical communication that occurs between patients and clinicians. The older nurses were trained under a different political dispensation and some of them did not complete high school but have since furthered their studies despite no completing matric.

There is a huge clinical knowledge gap between the nursing community itself and in the context of South Africa, due to English being the language of teaching and learning across all tiers of education for black learners, there is a direct relationship between one's fluency in English and their level of education. This means that there are nurses who are required to assume interpreting duties on a frequent basis despite not being able to articulately manipulate the English language as well as not having formal interpreting training.

The absence of remuneration for interpreting nurses may result in increased job dissatisfaction especially as interpreting is a duty that's adds on the workload of nurses despite it falling outside of the official scope of practice of nurses in South Africa. A sizeable portion of the nurses are resistant to the idea of taking interpreting lessons if they were to be offered this is despite most nurses admitting to interpreting without any having supporting resources in the form of lexicographic materials such as dictionaries and glossaries.

7.2 Recommendations

There is a need for the provincial Health department to ensure that it diversifies the official languages used for accessing the public healthcare system. Currently, English is the sole language of record in the public healthcare system – this means that the health information of patients is recorded in English even in contexts where both the clinician and the patient are native speakers of the same language which is not English. The presence of a nurses in the consultation rooms in their capacities as interpreters undermines the right to privacy and confidentiality of a patient and can make the patient uncomfortable. An overwhelming number of conversations that take place between clinicians and patients across language, racial and cultural lines require an immediate presence of an interpreter. As much as the interpreting is mainly done by nurses and to a lesser extent by other healthcare workers, there are instances when a family member of the patient is asked to interpret. The primary requirement of the *makeshift* interpreters is their native language fluency in isiXhosa rather than prioritizing the skill set and experience of being a qualified interpreter in the professional healthcare field. As a consequence of the absence of trained interpreters, a lot of crucial information regarding the healthcare status of patients and advice from clinicians is lost. This communication crisis underscores the salience of employing trained interpreters and would markedly take away interpreting from nurses which is a non-clinical and unofficial responsibility that adds on their workload without being compensated for it.

It is imperative that the higher education sector introduces language courses in the mainstream curricula of healthcare courses and that these languages courses ought to be curated to meet the language and communication needs of various clinicians according to their disciplines in the healthcare sector. It is important for language experts and healthcare professionals to work collaboratively in devising language resources that will aid with simplifying and making the

interpretation process easier. The language resources should include dictionaries, glossaries, and translation of all healthcare information that is available in English and these resources should be available in hardcopy and digital forms for easier and wider access for clinicians, patients and the prospective interprets. It is key to work with language strategists to develop scientific terms for the numerous healthcare branches to promote parity esteem of local indigenous languages with English and as that would allow patients optimal access to healthcare information. Furthermore, the department should take into consideration the elasticity of the language abilities of a clinician with the patient population in the residential area the clinician will be employed following putting in conceited effort to help the clinician communicate seamlessly with the patients.

7.3 Conclusion

Furthermore, the language and cultural barriers in the healthcare sector are common due to clinicians not receiving sufficient professional and organized training in the languages of the patients they are providing healthcare to. Moreover, most of the communication occurs cross interlingual and cross-cultural frontiers and this may result to misdiagnoses. The language challenges beget patient dissatisfaction and clinician frustration as both sets of groups experience impediments in conveying their intended messages. There is a lack of a patient-centered healthcare system with regards to the language and cultural phenomenon in South Africa as there are no established communication structures to ensure there is no communication derailment between patients and clinicians. These challenges are further compounded by the sparse and superficial inclusion of language courses in specialized healthcare fields to better equip clinicians during training as well as systemic government provisions to effectively eradicate language and cultural barriers in the healthcare system. Languages and cultural communication problems are also common between interlocutors of the same race and language and cultural challenges also are not limited to South African citizens as there are expatriates who access and make use of the South African healthcare system.

Additionally, most clinicians are not knowledgeable about indigenous knowledge systems and that includes cultural mannerisms and thought processes that guide the viewpoints of patients on their indigenous understanding of what constitutes sickness and health and this may result in deflection in communication. Most of the clinicians subjectively have a modern medicine

understanding of health and they use it as a barometer for healthcare in a culturally diverse setting that does not solely subscribe to modern medicine healthcare. The use of ad hoc interpreters is an ineffective strategy that adds more responsibilities for the nurses, dissatisfies both patients and clinicians and it is a mechanism that is devoid of a structured quality assurance process to ensure that it fulfills its intended outcome.

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