

**INTERCULTURAL CUMMUNICATION IN THREE EASTERN CAPE
HIV/AIDS CLINICS**

THESIS

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By

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DECLARATION

I, the undersigned, hereby declare that this thesis is my own original work and has not, in its entirety or part, been submitted at any university for a degree.

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V.M. Mandla

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DATE

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ABSTRACT

Intercultural communication in three Eastern Cape HIV/AIDS clinics

There are many inequities that exist in health-care that stem from culture related communication misunderstandings. In most cases where doctors and patients from different cultural and linguistic background interact, doctors use medical language which is different from everyday language used by patients. Patients enter this communication context with anxiety because they depend on the physicians to give them accurate information concerning their health, but they do not always understand all the terms used by physicians to inform them about their conditions. In some cases interpreters are used but their expertise is often inadequate and the interpreting of the patient's statements to the health staff is also prone to distortion by interpreter / doctor because of the lack of proper understanding of the messages / languages. This may result in a deterioration of the patient's health condition and unavoidable complications.

This research is motivated by the need to improve communication between doctors and patients, who do not share the same cultural and linguistic repertoire when attempting to communicate. In this study I explore the intervention strategies used by the doctors who are not proficient in isiXhosa when communicating with their patients; identify problems which occur in the interpreting process from English to isiXhosa and vice versa; examine how cultural differences between doctors and patients contribute to miscommunication; and establish whether the isiXhosa mother-tongue speaking doctor has developed communication strategies which can be of assistance to non-Xhosa-speaking doctors. The findings reinforce the need for trained health interpreters to work exclusively as translators and to employ them thereafter.

CHAPTER ONE

INTRODUCTION

1.1. STATEMENT OF THE PROBLEM

There are many inequities that exist in health-care that stem from culture related communication misunderstandings. The perpetual misunderstandings that occur between physicians and patients lead to dissatisfaction for the parties who communicate in this health-care context. In most cases where doctors and patients interact, doctors use medical language which is different from the everyday language used by patients. Furthermore this is often done in a language that a patient cannot understand, namely, English.

The interpersonal interaction between physicians and patients is intriguing because it involves two parties that have divergent forms of communication that do often mesh well in the medical interview. Physicians come from an academic background in which they learn restricted technical terminology to identify medical terms, and they often are unable to convert this technical language into words their patients can understand. Where medical terms are used, there is often a danger of mutual misunderstanding; the same term, for example may have an entirely different meaning for the doctor and patient. Also the use of the same terminology by the doctor and patient is not, therefore, a guarantee of mutual understanding. The terms and their significance, may be conceptualized by both parties in entirely different

ways. Patients enter this communication context with anxiety because they depend on the physicians to give them accurate information concerning their health, but they do not always understand all the terms used by physicians to inform them about their conditions.

An example of this is evident in the case of a Xhosa woman from a rural area in Peddie, who took her child who was suffering from an acute Gastro- Enteritis (GE = inflammation of the intestine) to a doctor in an Outpatient Department at Peddie clinic "A". The doctor spoke of "stools" and the patient who did not understand the medical meaning, literally interpreted the term to mean an object on which one sits, thereby distorting the entire message regarding how the medicine should be taken (interview, November, 2007). The results of this could be devastating. In addition, most of the written medical orders are abbreviated and a medical register is used. For example, the instruction for taking the medicines was written as:- "4 Tabs stat and 2 after every stool", meaning that the patient had to take four tablets immediately and two tablets after every defecation. The instruction was interpreted as doubling the dosage namely: 2x4 tablets after every defecation resulting in deterioration of the child's health condition and other sicknesses. Instead of recovering the child suffered severe constipation.

In some cases interpreters are used, but their expertise is often inadequate and the interpreting of the patient's statement to the health staff is also prone to distortion by the interpreter/doctor because of the lack of proper understanding of the messages/languages. This may result in a deterioration of the patients' health condition and unavoidable complications.

Having grown up in Peddie, a small town between Grahamstown and King William's Town, and having spoken isiXhosa since childhood, I have observed non-Xhosa speaking doctors interacting with patients from these remote rural settlements. I have also been intrigued by the manner in which they communicate with them. One is able to witness communication breakdown stemming from their different cultural backgrounds. My interest in this area of communication and communication breakdown has led me to do this research. I, therefore, contend that there are serious miscommunication problems that exist in some HIV/AIDS clinics as a result of inadequate communication between patients and doctors. This is also shown in the research conducted in the Western Cape. There are cases of misdiagnosis, incorrect medication prescribed and patients' inability to understand instructions regarding the taking of medication (Anthonissen 2000).

My research took place within the context of the health-care system in three Eastern Cape HIV/AIDS clinics. One clinic is situated at Peddie – a remote settlement, where doctors are Cuban monolingual who have limited knowledge of

English. The patients are isiXhosa speakers, with no knowledge of English and others with a limited knowledge of English. The nurses play a dual role in the sense that they are both nurses and interpreters. The second and third clinics are in Port Elizabeth. In the second clinic doctors use English and have limited knowledge of isiXhosa while the patients speak isiXhosa and English but are not fluent in the later. In the third clinic the doctor is isiXhosa mother-tongue speaking and has a good knowledge of English. The patients are largely isiXhosa mother-tongue speakers.

Based on my observations as far as language use in the health-care sectors is concerned, there is a “laissez faire” approach. In other words, no one in authority really cares whether or not doctors understand what their patients are saying and vice versa. Language use in most South African health sectors is not monitored at all. Inadequate knowledge of languages by either patients or doctors is a concern in multicultural and multilingual South African hospitals, hence cultural factors (such as norms and values, traditions, *hlonipha* language of respect), dietary restrictions/taboo and technical terms/register need to be considered and understood in an effort to find ways to communicate more efficiently with each other, particularly, doctors and patients who do not have similar cultural origins. It is my purpose to research the communicative strategies employed in these three clinics.

1.2. MOTIVATION FOR THE STUDY

My research is motivated by the need to improve communication between patients and doctors, who do not share the same linguistic medical repertoire when attempting to communicate. We have, then, the basic problem of how speakers can say one thing and mean another. There is, therefore, also the converse problem of how hearers may perform long strings of interpretations on any utterance they hear (Stubbs 1983: 5).

In communication between people from different cultures, language can pose major problems. For example, even if people from different cultures communicate in a language they all understand, not all cultural groups will attach the same meaning to the same words. Misunderstanding can occur due to differences in interpretation (Tjale & de Villiers 2004: 114). This was explored in relation to the targeted clinics.

Kramsch (1984: 8) defines intercultural communication as: "...referring to the dialogue between minority and dominant cultures." Furthermore, that it is associated with the issues of bilingualism and biculturalism. In intercultural communication we are presented with the challenge of having to understand each other's cultural background and the influence this has on the way we behave toward and communicate with others. Awareness and understanding of

the cultural variables help us to understand how others interpret and express these variables (Tjale & de Villiers 2004: 112).

The problem which doctors and patients from different cultures must deal with, involves language barriers. It is therefore, of vital importance that doctors and patients must be willing to move beyond their cultural differences and adapt their communication style to improve the likelihood of positive outcome in intercultural health encounters. Also since language is inseparable from the culture of its speakers, the researcher explores the impact of and the role of language and cultural difference between doctors, nurses and patients. It is of interest to compare the communicative strategies of an isiXhosa speaking doctor with those who do not speak isiXhosa.

I believe that this research suggests remedies and solutions for these communicative inequalities.

1.3. THE GOAL OF THE RESEARCH

The aim of the study is to observe the communicative behavioral pattern of the three Eastern Cape HIV/AIDS clinic staff personnel and clients. The purpose is to:

- ❖ Explore the intervention strategies used by doctors who are not proficient in isiXhosa when communicating with their patients.
- ❖ Describe and identify problems which occur in the interpreting process from English into isiXhosa.
- ❖ Examine how cultural differences between doctors and patients contribute to miscommunication.
- ❖ Establish whether the isiXhosa mother-tongue speaking doctor has developed communication strategies which can be of assistance to non- Xhosa speaking doctors.

This research is restricted to isiXhosa-speaking patients and the non-Xhosa speaking doctors. The isiXhosa mother-tongue speaking doctor serves as an example of what should be effective communication.

1.4. RESEARCH METHODOLOGY

1.4.1. Literature study

Since the HIV/AIDS pandemic is no longer a health issue, but has become a social, economic and political issue; the body of research concerning intercultural

communication is continually growing as more researchers are realizing the effect cultural diversity has in medical encounters. Researchers such as Tjale & de Villiers (2004) and Gudykunst (2003) have found a connection between socio-cultural issues and intercultural health. These works form part of my literature review which form part of Chapter Two of this thesis.

1.4.2. Interviews

I was able to conduct interviews with three different doctors and ten patients in each clinic. Questions based on their personal impressions, observations and experience gained over a long period of time regarding intercultural communication were asked.

These interviews offered descriptive insights into the experience and perceptions of doctors caring for their patients, many of whom do not speak English or have limited English proficiency.

1.4.3. Questionnaires

Two types of questionnaires, namely for doctors and patients, were compiled. Examples of these questionnaires are contained in Appendix 1 and 2. The purpose of the questionnaires was to allow the participants to voice their opinion regarding whether language and culture affect the manner in which they

communicate in the medical encounter. Open-ended questions were used to assess doctors' and patients' intercultural communication effectiveness and satisfaction. Five questions were drafted to which each party had to respond.

1.4.4. Observation

Two to three weeks were spent in each clinic observing and issuing the structured list of questions to doctors and patients while consultation and management of patients was in progress. This assisted in getting first hand information and experience about the problem in the appropriate scenario. Data collected and observation notes were analyzed. The following theories form part of the research:

- ❖ **Discourse analysis theory**, which focuses on the basic problem of how speakers can say one thing and mean another (Stubbs 1983). It becomes clear that for communication effectiveness, doctors and patients must share knowledge effectively.

- ❖ **Intercultural communication theory**, which focuses on the exchange of cultural information between two groups of people with significantly different culture (Gudyskunst 2003).

❖ **Ethnography of communication theory** forms part of the methodology. It is a description of all factors that are relevant in understanding how the particular communicative event achieves its objective. It involves participant observation (Hymes 1996). Doctors and patients were observed as they participate in their daily encounters in the clinic.

The researcher had to obtain the co-operation of patients and doctors via medical authorities. Permission to undertake the research was obtained from patients and doctors in terms of the Rhodes ethic.

1.5. PLAN OF STUDY

Chapter 1

Introduction

Chapter 2

A Comparative Literature Review

Chapter 3

An analysis of Ethnographic Data

Chapter 4

Conversational analysis

Chapter 5

Conclusion and recommendations

- ❖ Bibliography
- ❖ Appendix 1: Survey used by patients
- ❖ Appendix 2: Survey used by doctors
- ❖ Appendix 3: Sample conversation

In the following chapter an extensive literature analysis will be provided so as to properly locate the research topic within the theoretical paradigm of intercultural studies.

CHAPTER TWO

A COMPARATIVE LITERATURE REVIEW

2.1. INTRODUCTION

Language barriers between doctors and patients pose problems, especially in South Africa with its eleven official languages. There are unfortunately not enough trained nurses or counselors able to address patients in their language. Doctors have no choice but to use nurses, translators or interpreters to rephrase what they say in a way that is understandable to the patients. Using the services of a third person always creates a problem in any kind of communication. Translators or interpreters often translate according to their own personal frame of reference; they may add their experience, interpretation, prejudice and comments in their message to the patient. Confidentiality may be violated and the relationship between doctor and patient may be jeopardized.

In addition to the language barrier, some problems in communication may be caused by cultural differences between two or more speakers, which may lead to diverging expectations concerning the content, goals and process of interaction. In any interaction, the basic goal of the participants is to understand and be understood.

Within intercultural communication, a great deal of research has been done on miscommunication. This is not surprising because people who do not share the same linguistic and cultural background often have problems interpreting each other's message (Deen 1997: 25).

This chapter focuses on intercultural communication. It aims to summarize the scholars' different points of view on intercultural communication, and thereafter, a comparative analysis is undertaken. Each of these ideas will be dealt with individually to highlight the main points made by each scholar. It has to be noted that not all the aspects related to intercultural communication as mentioned by these scholars will be covered. The focus will be on those relevant to this study for reference purposes.

2.2. GUDYKUNST, W.B.

According to Gudykunst (2003: 259) "...intercultural communication involves the exchange of cultural information between two groups of people with significantly different cultures". In relation to the subject of intercultural communication he mentions the following aspects as important: communication with strangers; function of communication; mindfulness and components of competences. Ting-Toomey (1999: 16) defines intercultural communication as "...the symbolic exchange process whereby individuals from two or more different cultural communities negotiate shared meanings in an interactive situation". It is clear

from these scholars that effective intercultural communication only occurs when communicators from different cultural backgrounds accommodate each other's culture in their encounter.

2.2.1. Communication with strangers

People are drawn close to one another by their common nature, but habits and customs can keep them apart. Misunderstandings do occur in intercultural encounters stemming from not knowing the norms and rules guiding their communication when interlocutors come from different cultures and ethnic groups. Language and culture are inseparable; therefore, if we understand others' language, but not their culture, miscommunication can still occur (Gudykunst 1991: 2).

Gudykunst argues that language and culture are not the only factors that contribute to misunderstanding in intercultural and interethnic encounters. He believes that attitudes and stereotypes create expectations that often lead us to misinterpret messages we receive from people when they are coming from different backgrounds. This may lead people who are different to misinterpret the message they receive from us (Gudykunst 1991: 2). This means, therefore, that communication is a process involving the exchange and the creation of meaning. When we communicate we attach meaning to messages we construct and transmit to others as well as messages we receive from them.

2.2.2. Functions of communication

Gudykunst (1991: 12-14) identifies various reasons as to why people communicate, for example; to inform someone about something, to entertain a person, or to change another person's attitudes and behaviors. He further says that when we interact with people from other cultures and/or ethnic groups, we experience uncertainty and anxiety resulting from our inability to predict and explain the degree to which we can predict strangers' attitudes, beliefs, feelings, values and behavior. We also feel uneasy, tense and worried about what might happen. We experience more uncertainty and anxiety when we communicate with members of out-groups than when we communicate with members of in-groups.

Gudykunst, in Wiseman and Koester (1993: 33-68) argues that effective communication is moderated by our ability to mindfully manage our anxiety and reduce our certainty about ourselves, because if our uncertainty and anxiety are too high and we communicate mindlessly, we interpret strangers' behavior using our own cultural frame of reference.

2.2.3. Mindfulness

Effective communication is moderated by our ability to mindfully manage our anxiety and reduce our uncertainty about ourselves and the people with whom we are communicating. Gudykunst (1991: 38) also believes that our communication behavior is based on the following three sources:

- We engage in much of our communication out of habit. When we communicate habitually, we are following scripts – “...a coherent sequence of events expected by an individual involving him/her either as a participant or an observer” (Abelson 1976: 33). The greeting ritual is one example of a script; the ritual of greeting others reduces the vast amount of uncertainty and anxiety present in initial interaction to manageable portions and allows us to interact with others in a coordinated fashion.
- Our communication is based on the intentions we form. When we think about what we want to do in a particular situation, we form intentions.
- We base our communication on affect, feelings, or emotions. We often react to others on a strictly emotional basis. If we feel anxious, for example, we may avoid interacting with strangers.

Gudykunst in Wiseman & Koester (1993: 38-41) suggests that, for effective communication in a situation, we must become mindful of our thought processes, i.e. creating new categories (skill factors such as ability to empathize, tolerate ambiguity, adapt communication, accommodate behavior and gather appropriate information); openness to new information (motivational factors such as needs, attraction, social bond and self- conception) and awareness of more than one

perspective (knowledge factors such as expectations, shared networks, knowledge of alternative interpretations and knowledge of similarities and differences).

He goes on to say that lack of linguistic and cultural knowledge contributes to misunderstanding because we listen to the speech, form a hypothesis about what routines are being enacted and then rely on social background knowledge and co-occurrence expectations to evaluate what is intended and what attitudes are conveyed. Generally speaking, the greater our cultural and linguistic knowledge and the more our beliefs overlap with strangers with whom we communicate, the less the likelihood there will be misunderstandings (Gudykunst 1983: 12-26).

According to Gudykunst (1983:28 – 34) , when we are communicating with strangers and basing our interpretations on our symbolic systems, ineffective communication usually occurs. For example, lack of eye contact between a black student and a white teacher may be interpreted differently - to a black student, looking down when speaking to the teacher is a sign of respect, whereas to a white teacher it can be interpreted as a sign of guilt or disrespect.

He further suggests that when we become mindful, there are several things we can do to improve our communication effectiveness. For example, we can negotiate meanings with other people by seeking clarity in the middle of the conversation i.e. when we realize a misunderstanding has occurred, and we can

use “repairs” by asking other people to repeat what was said when we do not understand.

2.2.4. Components of competence

Three components of competence have been identified by this scholar as motivation (a desire to communicate appropriately and effectively with others), knowledge (awareness or understanding of what needs to be done in order to communicate appropriately and effectively) and skills (ability to engage in the behavior to communicate appropriately and effectively) Gudykunst (1983: 104).

In summary, to be “intercultural” we need to work at the cognitive, affective and skills behavioral competences. These three are interdependent. Without understanding and appreciation of differences, which depend on knowledge, we cannot fully feel for others and respect other ways of acting. Without empathy and insight into our own behavior, we cannot unjudgementally accept sets of values held by others which are different from our own. Without skills we cannot act in a way that is quietly acceptable to others. Thus, we can work successfully to reduce our own and others’ uncertainty and anxiety only if we understand the differences that exist, care about them, and work at our own skills for ensuring that they do not prevent effective communication (Gudykunst 1983: 107).

Gudykunst's views on intercultural communication are necessary for this research, because an encounter between a patient and a doctor from different linguistic and cultural backgrounds is similar to communication between strangers. High levels of anxiety and stereotypes may occur between doctors and patients, and may lead to miscommunication if these communicative events are not mindfully managed by the communicators. It is therefore, of vital importance that doctors know how to deal with these aspects in order to communicate effectively with their patients.

2.3. DODD, C.H.

Intercultural communication occurs when a message that must be understood is produced by a member of one culture for consumption by a member of another culture. This circumstance can be problematic because "...culture forges and shapes the individual communicator" (Porter & Samovar 1994: 19).

Dodd (1998) believes that interaction with someone from a contrasting group background is inescapable in today's world and such encounters initiate a person into a state of some degree of needing knowledge and skills. In his study he looks at dynamics of intercultural communication. He argues that culture pervades what we are, how we act, how we think, and how we talk and listen. He also believes that intercultural communication involves understanding the influence of culture, personal communicator style, and interpersonal relationship

attributes as these affect communication and perception of differences. These factors include two people in building a third culture or communication climate from which they find commonality, reduce uncertainty and anxiety, and provide a context basis for continued communication (Dodd 1998: 16). This scholar also believes that **culture, personality difference and relationship attraction** are the cause of perceived cultural differences. This becomes evident when people claim “this is the way my culture does things” or “I thought I knew you, but I can’t trust you anymore” or “you and I are from the same culture but we are individuals who think and act differently” (Dodd 1998:16).

Due to uncertainty and anxiety experienced when people are involved in an intercultural communication, Dodd introduces the **adaptive model of communication** which calls for participants to suspend judgment and bias while they engage in the third culture created by the intercultural participants to explore mutual goals and common concerns. Almost everyone develops an adaptive style or set of procedures when faced with uncertainty and anxiety, hence Dodd identifies these three principles to make this third culture successful:

- There must be a positive feeling toward the other person or group (**affective level**), such as, trust, comfort, safety, affirmation, or lowered anxiety. Without this feeling – the one is regarded as worthy and can experience mistakes without being ridiculed or ignored. A person is less likely to communicate well with another who is different.

- Recognizing the beliefs we bring to intercultural encounters (**cognitive level**). These include expectations, uncertainties (because of things we do not yet know about a person or lack of accurate observation), misunderstanding of rules or procedures, lacking appropriate strategy to exercise communication competency, and activation of cues that triggers negative or positive social cognitions (such as stereotyping and attribution). Without accurate understanding a person is less likely to communicate well with another who is different.
- Developing actions and skills (called the **behavioral level**), such as, verbal and nonverbal communication performance, survival skills, and interfacing with systems and institutions in a new culture (Dodd 1998: 6-10).

The relationship between two communicators affects how the message is interpreted, for example, if your friend says: "Could we get started on this project?" That statement can be interpreted as a simple request for starting a task. However, if the boss says: "Could we get started?" the meaning is likely to be different. Dodd (1998: 23) argues that in our interpersonal encounters we encounter ambiguity about our relationships ("how does he feel about me?", "what are her attitudes?", and "what can I expect to happen next in this relationship?") We experience discomfort with questions about our relationships, and so to reduce our discomfort, we engage in behaviors that enhance our

choices of maximum understanding. The less guesswork about a message and a relationship, often the better we feel about the situation.

According to this scholar, culture influences how we adapt and learn language, habits, customs, expectations and roles – it shapes thinking, acting and communicating according to group expectation. It is, therefore, important to understand the overall reasons why culture influences communication. Dodd (1998: 36-37) contends that culture teaches us three important things:

- **Rules, rituals and procedures**; attitudes toward time, how to dress, when and what to eat, when to come and go, how to work , etc,
- **Values**; what is good or evil, what is truth, and understanding of the world are taught in a cultural context. It teaches the value of hard work, thrift, privacy, competition, fair play and direction.
- **Relationship with others**; how to smile, where to stand, when to visit and the level of formality in language are highly influenced by the nature of the relationship with the interactant.

Dodd contends that there are cultural patterns which form part of communication. Every culture has a language and a set of interactional rules for conversation such as, codes understood by only their fellow members. In addition to the language codes, there are many conversational and interaction rules associated with communication patterns in a culture. For example, there are certain words

and phrases expected in greeting and leave taking rules, such as, “well, I have an engagement, and it’s time for me to go”. Other aspects of communication patterns are adaptability and change, ethnocentrism, nonverbal communication such as, body language, spatial relation and time and communication of rewards, recognitions, and gifts (Dodd 1998: 47-48).

Dodd (1998: 51-52) goes on to mention that hospitals and medical clinics are relatively new innovations in some cultures, and sometimes an interesting mixture of the traditional medicines with the modern medicines appear in hospital rooms. Not only is it important to understand the health system of a culture in order to manage it effectively from within, but the nature of health delivery is equally important in order to disseminate health information.

Richard Brislin, in Dodd (1998: 52) identifies some reasons for poor physical and mental health associated with culture as follows:

- lack of financial resources causes people to wait too long before calling a health professional;
- traditional remedies may be used either because modern medicine is too expensive or it is seen as ineffective;
- little trust in health professionals;
- inadequate or inaccurate information provided for the family;

- cultural values toward the age at which mothers pay more attention in their infant's health needs;
- accurate indicators of physical or psychological distress are not viewed as significant indicators of illness to report. In other words, symptoms that modern health professionals look for in examinations may seem irrelevant to an acculturated individual;
- world-view intervenes in preventing modern medicines; for example, a person who believes in animism (witches and spirits) need to be evaluated in light of the entire cultural beliefs. By western psychological standards, a person having a vision may seem mentally unstable, but by traditional African standards the person would be normal (Dodd 1998: 51-52).

Dodd's work is important in this research because doctors and patients from different cultural backgrounds need to build a third culture or communication climate where they find commonality. There must be a positive feeling of trust, comfort and lowered anxiety for communication effectiveness. Without this feeling, a person is less likely to communicate well with another who is from a different background. It therefore calls for doctors and patients to set aside their culture or suspend judgment and bias while they engage in a third accommodative culture. The purpose of this research is to assess whether this accommodative culture exists amongst the doctors that are used as research subjects.

Each culture has an interpretation of reality, or perceptual “window” through which people see self and others. When we communicate we use language and codes, conversational and interaction rules associated with communication patterns in a culture (Dodd 1998: 40).

2.4. STEYN, M.E., & MOTSHABI, B.K.

Steyn & Motshabi (1996: 13) believe that now that fundamental change is taking place in almost every sphere of South African life, good intercultural communication is exactly what South Africa needs.

In contrast to what some scholars believe to be a pre-requisite to effective communication i.e. a sound knowledge of the other interlocutor’s culture, these scholars state that it is not necessarily a condition for effective intercultural communication. Some South Africans, mainly whites, believe that if they have some knowledge of the cultural backgrounds of blacks, they will succeed with communication. They tend to think that they need information instead of a change of heart. In other words, positive attitudes, openness to all the risks and problems of communication and the ability to listen on an empathic level are the keys to effective intercultural communication.

Knowledge of a person’s language, traditions, customs, values, and beliefs, to name a few, may help a lot, but if an individual is not sensitive and perceptive to

the needs, motivations and intent of his or her communication partner, the total communication effort may be in vain (Steyn & Motshabi 1996: 13).

2.4.1. Influencing Factors

According to Steyn & Motshabi (1996: 14) many factors influence the exchange of message and the creation of meaning in an intercultural encounter. Different cultures have different verbal and nonverbal patterns of behavior and often parties do not know how to interpret and understand the actions of relative strangers because they are unfamiliar with the implicit and explicit rules of communication. People also talk of qualities like tolerance of ambiguity, the ability to handle fundamental differences in values and beliefs, and the knowledge of handling new experiences.

These scholars identify factors such as; **perception, values, beliefs** and **attitudes** as having influence on the exchange of message and the creation of meaning in an intercultural encounter. They contend that:

Culture acts as a screen between a person and social reality, coloring it in such a way that his or her interpretation and understanding of reality may be totally different from that of a person of another culture.... people tend to block out or avoid receiving messages that they do not like. This is particularly true of intercultural situations. If people of one culture think

they are superior to members of another culture, they will tend to receive only those messages which confirm this belief (Steyn & Motshabi 1996: 14).

Expectations may add a dimension to selective perception that can, in some cases, be a serious stumbling block. In some Western cultures, it is highly valued to be on time for appointments, meetings, or social events. In African cultures, the mere fact of attending the event is far more important than the time of arrival. Positive and negative attitudes may also influence the way people expect others to behave under given circumstances. If a person from a specific culture behaves in the way that a person from another culture expects him or her to behave, the actual behavior reinforces existing cultural expectation.

Personal values may overlap with cultural values which are of great importance in intercultural situations. Cultural values provide a person with information on what is good and bad, right and wrong, true and false, positive and negative. These values are learned and differ from culture to culture, setting the standards and guidelines that establish appropriate and inappropriate behavior in a society. To ensure meaningful intercultural communication, values clarification is important. Each party must know or discover the critical value structure of the other in order to limit possible confusion, mistrust and conflict. Unless one tries to understand the value differences of the other, intercultural communication may be painful for both parties (Steyn & Motshabi 1996: 15).

One of the many problems concerning intercultural situations is the tendency for people from one culture to judge people from another culture according to the formers' set of values.

According to Steyn & Motshabi (1996: 16) "...a belief is an acceptable or conviction that something, like an event or object, is probably true or that it exists..." for example, values and beliefs are learned and are not easily changed in communication with other people.

Cultural influences like customs, traditions, rituals, and other cultural sources play an important part in forming informational beliefs. In intercultural communication, however, there should be no rights or wrongs as far as beliefs are concerned. If someone believes that the voices in the wind can guide their behavior along the proper path, we cannot throw up our hands and declare the belief is wrong; we must be able to recognize and to deal with that belief if we wish to obtain satisfactory and successful communication.

Beliefs and values contribute significantly to the development and context of attitudes. Attitudes are learned, like beliefs and values, in a specific cultural setting. Whites, for example, may have a negative attitude towards a Black township because they believe that their neighborhoods are unsafe and that it is

unwise to go there alone. This belief manifests itself in avoidance behavior (Steyn & Motshabi 1996: 14-16).

Steyn & Motshabi (1996: 17) argue that from a vast array of possible influences, three factors particularly inhibit the information of meaningful intercultural relations. These are stereotyping, prejudice and ethnocentrism.

In South Africa there are numerous stereotypes among whites about blacks and vice versa. On the one hand, some whites describe blacks as very militant, violent, inferior, and uncivilized; some blacks, on the other hand, regard whites as very cruel, oppressive, dominating and materialistic.

Prejudice is closely related to stereotype, it is the prejudgment that cannot easily be reversed when exposed to new information. Prejudice can either be positive or negative. Most of the time it is a misjudgment about people. It is strongly influenced by in-group communication and because of its inaccuracy; it is unfair, irrational, and emotionally rigid.

Steyn & Moshabi's work is important for this research because doctors and patients need to be aware of these influencing and inhibiting communication factors in their communicative encounters. Also, it is important for doctors coming from a different cultural background to respect and understand patients' beliefs, and to avoid unnecessary prejudgments. If doctors and patients are not

sensitive and perceptive to the needs, motivations and intents of each other, the total communication effort may be in vain.

2.5. TING- TOOMEY, S.

Ting-Toomey (1999: 16) defines intercultural communication as the “...symbolic exchange process whereby individuals from two (or more) different cultural community negotiate shared meanings in an interactive situation.”

2.5.1. Explanation of Intercultural Communication Characteristics

The following points highlight the possible complexities of intercultural communication and define some key concepts:

- **symbolic exchange** refers to the use of verbal and nonverbal symbols between a minimum of two individuals to accomplish shared meanings.
- **process** refers to the interdependent nature of the intercultural encounter. Once two cultural strangers make contact and attempt to communicate, they enter into a mutually interdependent relationship. Intercultural encounters are often filled with misunderstandings and second guesses because of language problems, communication style differences, and value orientation differences.
- **different cultural community**; a cultural community refers to a group of interacting individuals within a bounded unit who upholds a set of shared traditions and way of life.

- negotiate shared meaning, refers to the general goal of any intercultural communication encounter, i.e. to be understood. When interpretation of the meaning of the message overlaps significantly with the intention of the meaning of the message, we have established a high level of shared meanings in the communication process. For example, if both communicators are using the same language to communicate, they may ask each other to define and clarify any part of the exchanged message that is perceived by them as unclear and ambiguous (Ting-Toomey 1999: 17-19).

This scholar believes that a sense of urgency is needed in this century to increase our understanding of people from diverse cultures and ethnic backgrounds. With rapid change in the global economy, transportation, and immigration policies, the world is becoming a small, interesting community. We find ourselves in increased contact with people who are culturally different, working side by side with us. She also believes that in order to communicate effectively with dissimilar others, we need to be mindful of how others prefer to be “named” and identified. She argues that mindful intercultural communication requires us to be sensitive to how others define themselves on both group membership and personal identity levels. The feelings of being understood, respected, and supported are viewed as critical outcome dimensions of mindful intercultural communication.

Ting-Toomey (1999: 7) further mentions that as we enter the 21st century, direct contacts with dissimilar others in our neighborhoods, schools, and workplaces are inescapable part of life, and that each intercultural contact can bring about identity dissonance or stress because of attributes such as an unfamiliar accent, way of speaking, way of doing things and way of nonverbal expression.

Ting-Toomey (1999: 7-8) contends that:

Most of us prefer to spend time with people who are similar to us rather than different from us. Among people with similar habits and outlooks we experience interaction predictability. Among people with dissimilar habits and communication rules, we experience interaction unpredictability. In a familiar cultural environment, we feel secure and safe. In an unfamiliar cultural environment, we experience emotional vulnerability and threat.

In her study, Ting-Toomey (1999) focuses on mindfulness as an effective communication tool. She explains the characteristics of intercultural communication, five core assumptions and mindful intercultural communication (verbal and nonverbal communication).

2.5.2. Five Core Assumptions of intercultural communication

Mindful intercultural communication requires that we support others' desired self-concepts, including their preferred cultural, ethnic, gender, and personal identities. Ting-Toomey (1999) identifies five core assumptions that increase the understanding of intercultural communication processes that are necessary in this study.

- **Intercultural communication involves varying degrees of cultural group membership differences.**

When individuals from two cultural groups communicate, there exist both differences and similarities between the two individuals. In practicing mindful intercultural communication, we need to develop an understanding of the valuable differences that exist between identity groups; yet at the same time, we continuously recognize the commonalities that exist on a pan-human level.

- **Intercultural communication involves the simultaneous encoding and decoding of verbal and nonverbal messages in the exchange process.**

The effective encoding and decoding process leads to shared meanings. With clarity of understanding, we can mindfully choose words and behaviors that make dissimilar others feel included and affirmed.

- **Many intercultural encounters involve well-meaning clashes.**

“Well-meaning clashes” basically refer to misunderstanding encounters in which people are “...behaving properly and in a socially skilled manner according to the norms in their own culture” (Bristin 1993: 10).

Unfortunately the behaviors that are considered proper or effective in one culture can be considered improper or ineffective in another culture. For example, using direct eye contact is considered a sign of respect in the Western culture, whereas direct eye contact can signify disrespect in the amaXhosa culture. The term “well-meaning” is used because no one in the intercultural encounter intentionally behaves obnoxiously or unpleasantly.

- **Intercultural communication always takes place in a context.**

Intercultural communication does not happen in a vacuum, it is always context bound. Patterns of thinking and behaving are always interpreted within an interactive situation/context. To gain in-depth understanding of an intercultural communication process, we have to mindfully observe the linkage among communication patterns, context, and culture.

- **Intercultural communication always takes place in embedded systems.**

We are programmed and acculturated into our culture via our family and education systems, religious and political systems, government and socio-economic systems, as well as paramount influence of media in everyday life. We are surrounded by people who subscribe to similar ideology, values norms, and expectations.

In learning about another culture or dissimilar groups, we should commit ourselves to make mindful choices and use different cultural viewfinders so as to see things from their perspective.

2.5.3. Mindful intercultural communication.

Ting-Toomey (1999: 50) defines mindful intercultural communication as “...the process and the outcome of how two dissimilar individuals negotiate shared meanings and achieve desired outcome through appropriate and effective behavior in an intercultural situation.”

She further mentions that it emphasizes the importance of integrating the necessary intercultural knowledge, motivations, and skills to manage process-based issues satisfactorily and achieve desired interactive goals

appropriately and effectively. Mindful intercultural communication relies heavily on the perception of the communicators in evaluating each other's communicative performance. What may appear effective in one cultural context can be viewed as ineffective and inappropriate from another cultural perspective and vice versa (Ting-Toomey 1999: 50).

Ting-Toomey (1999: 50) further contends that:

Without culture – sensitive knowledge, cultural communicators may not be able to match cultural value issues with identity – related behaviors. Thus, we need to be mindful of what is going on in our thinking, feelings, and experiences to increase our knowledge. Through mindfulness we can learn to be more aware of the commonalities and differences that exist between dissimilar individuals and groups.

She believes that new information concerning intercultural communication can be acquired through multiple means of learning – attending intercultural classes, readings, interacting more in depth with dissimilar colleagues and classmates, daily mindful observations, and traveling.

She identifies four stages along which intercultural communication competence can be conceptualized. **Unconscious incompetence** – the ignorance stage in which an individual is unaware of the communication blunders he or she has

committed in interacting with a cultural stranger; **conscious incompetence** - the stage in which an individual is aware of his or her incompetence in communicating with a cultural stranger but does not do anything to change his or her behavior or situation; **conscious competence** - the stage when an individual is aware of his or her intercultural communication “nonfluency” and is committed to integrate the new knowledge, motivation, and skills into effective practice; and **unconscious competence** - the phase when an individual is naturally or spontaneously practicing his or her intercultural knowledge and skills to the extent that the intercultural interactive process flows smoothly and out – of – conscious awareness (Ting–Toomey 1999: 50–53). “The feelings of being understood, respected, and intrinsically valued form the outcome dimensions of mindful intercultural communication” (Ting– Toomey 1999: 53).

2.5.4. Mindful intercultural verbal and nonverbal communication

Language is a taken for granted aspect of our lives. Intercultural communicators achieve shared meanings and thus understanding, through the effective exchange of verbal and nonverbal messages. While language and verbal communication can easily create misunderstanding, it also fortunately can clarify misunderstandings. Sensitive language usage is a pivotal vehicle in reflecting our mindful attitudes in communication with them. Therefore, in order to understand culture, we have to understand the premium role of language in it (Ting–Toomey 1999: 84-85). In a doctor–patient encounter, language plays a vital role in

clarifying misunderstandings resulting from verbal and nonverbal communication. It is, therefore, necessary for doctors and patients to be mindful of each other's verbal and nonverbal communication.

2.5.4.1. Cross – cultural verbal communication styles

Ting-Toomey (1999: 100-101) identifies low and high-context communication which refer to communication patterns of direct mode (straight talk, nonverbal immediacy, and sender – oriented values) and communication patterns of indirect mode (self – effacing talk, nonverbal subtleties, and interpreter – sensitive value). She mentions that in low-context communication, the speaker is expected to be responsible for constructing a clear, persuasive message that the listener can decode easily, whereas in high – context communication the listener / interpreter of the message is expected to “read between lines,” to accurately infer the implicit intent of the verbal message, and to observe the nonverbal nuances and subtlety that accompany and enhance the verbal message. We use low-context communication when we stress the importance of explicit verbal messages to convey personal thoughts, opinions, and feelings. High-context communication is used when we stress the importance of multilayered contexts (e.g. historical context, social norms, roles, situational and relational contexts) that frame interaction encounter. In a medical sphere low – context communication is usually used in an encounter between doctor and patient who do not share the same language and culture.

- **Direct and indirect verbal interaction styles**

This scholar argues that the tone of voice, the speaker's intention, and the verbal content reflect our way of speaking, our verbal style, which in turn reflect our cultural and personal values and sentiments. She further mentions four stylistic modes of verbal interaction (i.e., direct vs. indirect person oriented versus status oriented, self-enhancement versus self effacement, and talk versus silence) that are used when a message is interpreted (Ting –Toomey 1999: 103).

The direct and indirect verbal styles differ in the extent to which communicators reveal their intentions through their tone of voice and the straightforwardness of their content message. In the direct verbal style, statements clearly reveal the speaker's intentions and are enunciated in a forthright tone of voice, whilst in the indirect verbal style, verbal statements tend to camouflage the speaker's actual intentions and are carried out with a more nuanced tone of voice (Ting–Toomey 1999: 103-104).

- **Person – oriented and status – oriented verbal styles**

The person - oriented verbal style emphasizes the importance of respecting unique, personal identities in the interaction, whereas the status – oriented verbal style emphasizes the importance of honoring prescribed power – based membership identities. The style of speaking, in short, reflects the overall values and norms of a culture. The cultural styles of speaking in many speech communities reflect the hierarchical social order, role positions, and power distance values of the different cultures (Ting–Toomey 1999: 106-107).

- **Beliefs Expressed in Talk and Silence**

Silence can often say as much as words. When silence occurs in interaction contexts in cultures around the world, how it is interpreted and evaluated differs across cultures and between persons. The process of silencing or refraining from speaking can have both positive and negative effects.

Intercultural miscommunication can thus often occur because of the different priorities placed on talk and silence by different groups. Silence can serve various functions, depending on the type of relationship, the interactive situation, and the particular cultural beliefs held. Intercultural clashes arise when we unintentionally use our own culture – bound evaluations in judging dissimilar other’s talk and silence (Ting–Toomey 1999: 110-111).

2.5.4.2. Mindful intercultural nonverbal communication

Ting-Toomey (1999: 115) defines nonverbal communication as “...the nonlinguistic behaviors that are consciously or unconsciously encoded and decoded via multiple communication channels.”

She contends that:

[N]onverbal messages are the nonlinguistic aspect of the communication that carry powerful emotional meaning, and can help to complement, substitute, and even contradict the meaning of the verbal message. They can create miscommunication or clarify communication.

She further provides reasons for intercultural friction and confusion that nonverbal messages can create.

- the same nonverbal signal can mean different things to different people in different cultures;
- multiple nonverbal cues are sent in each interaction, thereby creating interpretive ambiguities; and
- factors of personality, gender, relational distance, socio-economic status, and situation create tremendous variations of nonverbal display patterns in different cultures (Ting-Toomey 1999: 114-115).

Nonverbal messages can oftentimes express what verbal message cannot express and are assumed to be more truthful than verbal messages (Ting-Toomey 1999: 115).

Nonverbal communication shares many features with verbal communication; nevertheless, nonverbal messages have the following distinctive characteristics;

- they are analogical messages that carry continuous meanings (e.g., via various ranges of tone of voice);
- they are sent via multiple interaction channels;
- they have sensory immediacy, appealing to our senses of sight, smell, taste, hearing and touch
- they can be simultaneously decoded (e.g., decoding facial expression and tone of voice together); and
- from a perceived perspective, nonverbal communication takes place both intentionally and unintentionally (Ting-Toomey 1999: 116).

In attempting to understand within – culture and across – culture nonverbal variations, interpersonal sensitivity, respect, and patience in dealing with such differences serve as a good first step in gaining nonverbal entrance to a culture (Ting-Toomey 1999: 140).

In summary, mindful intercultural communication requires the application of flexible, adaptable interaction skills. Ting-Toomey's work is important for this

research because if doctors and patients are not mindful when communicating with each other, there are slim chances of communicative effectiveness. It is, therefore, of vital importance for doctors and patients to be willing and committed to learn from their cultural differences and reflect their ability to change mindsets, behaviors, and goals to meet each other's specific needs in any communication encounter. They, both, should signal their desire to understand, respect, and support the other's cultural identity and way of communicating and to do so with sensitivity and mindfulness.

2.6. SAVILLE–TROIKE, M.

Saville-Troike in her study on Ethnography of Communication describes and analyses culture as it influences communication. She argues that:

One of the best means by which to gain understanding of one's way of speaking is to compare and contrast these ways with others, a process that can reveal that many of the communication practices assumed to be natural or 'logical' are in fact, as culturally unique and conventional as the language code itself.

In her approach to this subject of intercultural communication, she focuses on the various aspects, to mention but a few:

- communicative competence
- patterns of communication
- indirectness

She mentions that **communicative competence** involves knowing not only the language code but it should be extended to both knowledge and expectations of who may or may not speak in certain settings, when to speak and when to remain silent, who one may speak to, how one may talk to persons of different statuses and roles, what appropriate non-verbal behaviors are used in various contexts, what the routines for turn taking are in conversation, how to ask and how to give information, how to request, how to offer or decline assistance or co-operation, how to give commands, how to enforce discipline and so on. In short, everything involving the use of language and other communicative dimensions in particular social setting (Saville-Troike 1982: 23). Clear cultural differences can and do produce conflicts or inhibit communication. For example, indigenous language conversations may involve several persons talking at the same time, a practice which would violate White English middle-class rules of interaction.

She contends that clear cultural differences can and do produce or inhibit communication, for example, Black people's conversation may involve several people talking at the same time, a practice which would violate the White middle

– class rules of interaction. Also such matters as voice levels, eye contact, and/or space, differ from culture to culture and participants may be misconstrued because of different expectation patterns for interpretation (Saville-Troike 1982: 22-23).

Shared cultural knowledge is essential in any cross-cultural communication and it explains the shared presuppositions and judgments of truth value which are the essential underpinning of language structures such as contextually appropriate usage and interpretation.

According to Saville-Troike interaction requires the perception, selection and interpretation of salient features of codes used in actual communication situations, integrating with other cultural knowledge and skills, and implementing appropriate strategies for achieving communication goals. She speaks of **patterns of communication** and the fact that different languages are used for different reasons and in different situations, that is, varieties of languages. Patterning occurs at all levels of communication, societal, groups and individuals. At a societal level, communication usually patterns in terms of its function categories of talk, and attitudes and conceptions about language and speakers (Saville–Troike 1982: 13 -14).

She argues that the physical setting of an event may call for the use of a different variety of language, even when the same general purpose is being served, and

when the same participants are involved. For example, the language used in a church may differ from the language used in the streets. Also, language restrictions or taboos are related to setting, such as constraints against talking about certain topics at the dining table, swearing in the church or whistling in the house.

Communication also patterns according to particular roles and groups within a society, such as, sex, age, social status, and occupation: e.g. a teacher has different ways of speaking from a lawyer, a doctor, or insurance broker. Ways of speaking also patterns according to educational level, rural or urban residence, geographic region and other features of social organization (Saville-Troike 1982: 14).

The relationship of form and function is an example of communicative patterning along a different dimension. For example, asking someone in English if she has a pen is readily recognized as a request rather than a truth-value question because it is part of regular structural pattern for requesting things. If a person answers “yes, I do” without offering, one is joking, rude or a member of a different speech community. In isiXhosa for example, such a response serves as a confirmation and would be followed by a request (Saville-Troike 1982: 11-13).

Another aspect in Saville-Troike’s (1982: 36) theory is ‘**indirectness**’. A speaker might say something in a way that is completely clear to other members of the

culture, who can identify the meaning of the utterance immediately and unambiguously, even if the words themselves seem “indirect” to a member of another group. For example, a person, instead of asking a ride to town, one may use indirect “fishing” type questions such as, what time are you leaving?

Whereas directness and indirectness are cultural themes, they are always language related. Direct acts are those where in surface form matches interactional functions as “be quiet!” used as a command, versus indirect “it is getting too noisy in here”. Indirectness may be reflected in routines for offering and refusing or accepting gifts or food. A “yes” or “no” intended to be taken literally is more direct than an initial “no” intended to mean “ask me again” (Saville-Troike 1982: 28-36).

There is no doubt, however, that there is a correlation between the form and content of a language and the beliefs values and needs present in a culture and its speakers. Hymes (1996: 116) as cited by Saville-Troike contends that:

People who enact different culture do to some extent experience distinct communicative systems, not merely the same natural communicative condition with different customs affixed. Cultural values and benefits are in part constitutive of linguistic relativity.

As in all ethnographic studies of communication, the analysis of a cross-cultural event requires an emphasis on the functions of communication and on the situational context within which it occurs. While many of the languages are universal, the ways in which communication operates in any one society to serve these functions is language specific.

Saville-Troike's work will form part of participant observation, interviews and data analysis. The doctors and the patients will be observed in their communicative encounters. Their communication will be analyzed using this theory.

2.7. COMPARATIVE INTERCULTURAL PERSPECTIVES

2.7.1. SIMILARITIES BETWEEN THESE SCHOLARS

Many scholars have done research on intercultural communication. There is commonality on how these scholars view this topic. Here I am going to compare the views of the authors I have dealt with previously.

All scholars agree that misunderstandings are bound to happen in any conversation regardless of a speakers' background. The inability to understand cultural concepts, the inability to assign the correct reference to the words, and the different levels of interpretation are the cause of difficulties in conversation

among speakers. Even if people come from the same cultural backgrounds and speak the same language, miscommunication may occur because they may not attach the same meaning to the same words. For example, two isiXhosa speakers may speak of *imihlambi*, one may mean “livestock”, whilst the other speaker is referring to a “group of followers”. Also communication may suffer an apparently minor breakdown because of an unknown word. Gudykunst (1991) and Dodd (1998) agree that except for language and culture, attitudes, stereotypes and attributes may result in miscommunication.

These scholars believe that communicative competence is an important factor in intercultural communication and it leads to intercultural effectiveness. Gudykunst (1983: 104) identifies three components of competences: motivation, (a desire to communicate appropriately and effectively with others), knowledge (awareness or understanding of what needs to be done in order to communicate appropriately) and skills (ability to engage in the communication appropriately and effectively). Dodd (1998: 11) mentions cognitive style (tolerance of ambiguity, trust in people, self confidence), communication behavior (communication openness, conversation management, interpersonal comfort) and situational and systems factors as intercultural competency factors associated with intercultural effectiveness.

Ting-Toomey (1999) believes that new information concerning intercultural communication can be learned through multiple means of learning. She further

identifies four stages along which intercultural communication competence can be conceptualized: Unconscious incompetence – the ignorance stage in which an individual is unaware of the communication blunders he or she has committed in interacting with a cultural stranger; Conscious incompetence – the stage in which an individual is aware of his or her incompetence in communicating with a cultural stranger but does not do anything to change his or her behavior or situation; Conscious competence – the stage when an individual is aware of his or her intercultural communication “nonfluency” and is committed to integrate the new knowledge, motivation, and skills into effective practice, and finally; Unconscious competence – the phase when an individual is naturally or spontaneously practicing his or her intercultural knowledge and skills to the extent that the intercultural interactive process flows smoothly and out-of-conscious awareness.

Saville-Troike (1982) believes that communicative competence goes beyond knowing the language codes to what to say, to whom, and how to say it appropriately in a given situation. It also involves the social and the cultural knowledge speakers are presumed to have which enables them to use and interpret linguistic forms.

The above scholars recognize the importance of nonverbal communication in an intercultural encounter. For example, it is culturally unacceptable in a Black culture to look a person directly in his/her eyes while communicating, which

signals disrespect. This may differ to a White English-speaking middle-class person who believes that failing to make eye contact with a person one is talking to, signals dishonesty or guilt. For effective communication, both participants should be aware of these nonverbal communications and their significances.

2.8. CONCLUSION

A COMPARATIVE SUMMARY

It has been mentioned earlier that we cannot communicate effectively, nor can we interpret a stranger's message or make predictions about the stranger's behavior if our anxiety and uncertainty are too high.

Gudykunst (1991: 28-34) argues that anxiety and uncertainty can only be managed if we are **mindful** of our communication. He goes on to say that if we are mindful of our communication, we can negotiate meaning with the other person – seeking clarification of meaning in the middle of our conversation when we realize a misunderstanding has occurred. Alternatively, we can use repairs – thus asking the other person to repeat what was said when we do not understand. He further mentions other causes of miscommunication such as stereotyping and attitudes of the speakers. He, therefore, believes that effective communication is moderated by our ability to mindfully manage our anxiety and reduce our uncertainty about ourselves and the people with whom we are communicating.

Ting-Toomey (1999: 47-110) is of the same view as Gudykunst in that she believes that the feeling of being understood, respected, and intrinsically valued, form the outcome dimension of mindful intercultural communication. She further suggests that by conveying our respect and acceptance of group-based differences, we encourage interpersonal trust, inclusion, and connection. She believes that, to be mindful intercultural communicators, we need the knowledge of both verbal and nonverbal communication in order to communicate sensitively across cultural and ethnic boundaries. Hence, she identifies cross-cultural verbal communication styles, for example, direct and indirect verbal interaction styles; person-oriented and status-oriented; self enhanced and self effacement; and beliefs expressed in talk and silence.

Dodd (1998: 9 - 11) believes that one way of solving anxiety and uncertainty is to introduce an **adaptive model** of intercultural communication, Dodd argues that when two people from different cultural background interact, they indirectly form the third culture of commonality, hence he talks of adaptive model of intercultural communication, which calls for participants to suspend judgment and bias while they engage in the third culture created by the intercultural participants to explore mutual goals and concerns. He identifies three principles that are important in developing a successful interaction in the third culture, e.g. feelings or affective level (trust, comfort, safety); beliefs or cognitive level (expectations, uncertainties, misunderstanding of rules and procedures); action or behavioral level (verbal and

nonverbal communication performance, survival skills). Steyn & Motshabi (1996: 13-17) on the other hand identify influencing factors (e.g., perception, values, beliefs, attitudes) and inhibiting factors (e.g., stereotypes, prejudice, ethnocentrism) that must be considered for effective intercultural communication.

Saville-Troike (1982: 36) mentions **indirectness** as a way of cultural communication. She contends that:

Indirectness may be reflected in routines for offering and refusing gifts or food, for instance, a “yes” or “no” intended to be taken literally is more direct than an initial ‘no’ intended to mean “ask me again”.

She gives examples of indirectness such as, proverbs, criticism, joking, using passive voice rather than active.

Saville–Troike (ibid) differs from other scholars in the sense that she believes that **patterning** occurs in all levels of communication, societal and group communication. At the societal level, communication usually patterns in terms of its function categories of talk, and attitudes and conceptions about language and speakers. It also patterns according to roles and groups within the society, such as sex, age, social status, and occupation. She also mentions varieties of

languages such as, varieties associated with setting, social class, role-relationship, sex, and age.

In the same vein as all of the above scholars, Porter & Samovar (1994: 19) argues that the link between culture and communication is crucial to understand intercultural communication because it is through the influence of culture that people learn to communicate. He further argues that to understand the other's words and actions, we must try to understand their perceptual frame of reference, we must learn to understand how they perceive the world.

This scholar believes that in order to be effective in intercultural communication we must be aware of the relationship between culture and language. It further requires that we learn and know about the culture of the speaker with whom we communicate so that we can better understand how his or her language represents that person (Porter & Samovar 1994: 174).

Like other scholars, Porter & Samovar (1994: 227) recognizes the importance of understanding nonverbal messages and behaviors in an encounter. He contends that nonverbal behavior is largely unconscious. We use nonverbal symbols spontaneously, without thinking about what postures, what gestures, or what interpersonal distance is appropriate to the situation.

Culture tends to determine the specific nonverbal behaviors that represent specific thoughts, feelings, or states of communication. For example, what might be a sign of greeting in one culture could very well be an obscene gesture in another. Or what might be a symbol of affirmation in one culture could be meaningless or even signify negation in another.

Culture determines when it is appropriate to display emotions or communicate various thoughts, feelings or internal states. There are cultural differences in which emotions may be displayed, by whom, and when or where they may be displayed (Porter & Samovar 1994: 227).

This scholar differs somewhat from the others because he argues that human interaction takes place within some social and physical setting that influences how we construct and perceive messages. He further identifies three interrelated assumptions in which the sway of context is related. Firstly, communication is governed by rules, i.e. each encounter has implicit and explicit rules that regulate or conduct. These rules tell us everything from what appropriate attire to what topic can be discussed. Secondly, the setting helps us define what regulations are in operation. We behave differently from courtroom, classroom, hospital, church or to dance hall. Thirdly, most communication rules we follow have been learned as part of cultural experience. Concepts of turn taking, time, space, language, manners, nonverbal behavior, silence, and control of the

communication flow largely on extension of each culture (Porter & Samovar 1994: 175).

It is, therefore, necessary for doctors whose cultural background differs from their patients, to know, not only about their culture and the culture of patients with whom they are communicating, but that patients must also know about their culture and the doctors' culture as well. Unless there is mutual acknowledgement of each other's culture and a willingness to accept those cultures as a reality governing communicative interactions, intercultural communication cannot rise to its highest possible level of human interaction.

In the following chapter, the information gathered from different sources and clinics will be analyzed with specific reference to doctors and patients from the same and different cultural and ethnic backgrounds in selected HIV/Aids clinics.

CHAPTER THREE

ANALYSIS OF ETHNOGRAPHIC DATA

3.1. INTRODUCTION

This chapter deals with the analysis and interpretation of data collected from three Eastern Cape HIV/Aids clinics. I will be using Dell Hymes's ethnographic framework for the purposes of data analysis. Data is collected by means of participant observation, interviews and questionnaires. The clinics investigated are Peddie – Nompumelelo and Uitenhage – Laetitia Bam clinic, as well as the Uitenhage Provincial Hospital.

- Peddie is a small remote rural area between Grahamstown and King William's Town. It has twenty-six villages; eighty percent of its residents are illiterate. There is only one Hospital, and five clinics, other clinics are mobile. Doctors chosen in the clinic under investigation are Cubans who speak limited English with no knowledge of isiXhosa language at all. The patients are mostly isiXhosa mother-tongue speakers, some with limited understanding of English and others with no knowledge of English.
- Uitenhage is a smallish town which is 35km from Port Elizabeth. Doctors chosen in these clinics and the Provincial hospital are Indian and English speakers, with limited understanding of isiXhosa. In the Letitia Bam clinic,

the doctor I will be looking at is an isiXhosa mother tongue speaker who is fluent in English. Most isiXhosa speaking patients in these clinics have limited understanding of English.

3.1.1. Background knowledge

According to Webb (2003: 21), background knowledge is to a large extent, culturally determined. He classifies three types of background knowledge:

- ❖ Encyclopedic knowledge: knowledge of the world and things of the world: (e.g. how airports function)
- ❖ Knowledge of each other: (participants in conversation)
- ❖ Contextual knowledge: (intertextuality) (e.g. reference to previous conversation)

I fully agree with Webb, and further elaborate by offering my view of “background knowledge” of a person as referring to:

- Where the person comes from? (contextual and cultural knowledge)
- Who the person is? (encyclopedic knowledge)
- How the person speaks? (knowledge of each other, past and present)
- The person as a product of his/her life–world experiences (combination of all three types of knowledge as identified by Webb above).

I find that my view of the background knowledge is practical and applicable in the Peddie – Uitenhage clinics where:

- The white doctors come from an environment dominated by a Western culture behavior, such as an urban lifestyle. Some doctors have limited understanding of isiXhosa and others have no knowledge of isiXhosa at all. The black patient is from an African cultural environment with rural style and is an isiXhosa mother–tongue speaker. The Cuban doctor, for example, may not understand how Africans do things. Most Uitenhage dwellers believe in gender equality and the rural Peddie dwellers still maintain the cultural superiority of males, meaning that decision–making in the household rests solely with the fathers. There is no power sharing or gender tradition awareness on the part of the doctor while attending to an elderly rural Peddie male patient and this can derail the communication process. Doctors need to be aware of these social dynamics in order to communicate effectively. Examples of miscommunication will be provided later in this chapter.
- The white doctor has been exposed to a technologically oriented environment (hospital) that will include the use of equipment like stethoscopes, computers, etc. The Xhosa patient is from a rural environment in which technology is often totally unknown. The use of this

equipment by the doctor and the strangeness of the hospital environment to the rural Xhosa patient may affect his/her cognitive functioning and thus strain and derail their communication.

- It would be inappropriate for a white doctor to use medical language only when speaking to a black patient, who does not understand English. Doing this, will show that the doctor is not context-sensitive to their communicative encounter. The world that the participants come from plays a big role in their linguistic behavior. The world tends to mould the way people think, speak and the way they behave. The patients' world contains a lot of taboo and is completely different from the doctors' world.

For example, in my observation in the Peddie clinic (02 July, 2007), a middle-aged patient came for an HIV/Aids test. The doctor in charge was a female Cuban doctor and could not speak isiXhosa well. The patient did not understand English, and a nurse was used as an interpreter because communication was conducted in English (see Appendix 3).

Doctor: Good morning *mfana!*

Molo, mfana!

Patient: (angrily) Molo gqirha!

Good morning, doctor!

The use of the word '*mfana*' was offensive to the patient because he had passed the stage of being called '*mfana*' and hence he was upset. This is exacerbated by the fact that the doctor is a woman. The doctor was using what Ting–Toomey (1999: 50) in chapter two of this thesis, identifies as unconscious incompetence. She is unaware of the communication blunder she has committed in her interaction with the patient, but continued.

Doctor: You seem so upset this morning, what happened?

Ukhangeleka unomsindo kusakanje, kwenzeke ntoni?

Patient:(ethetha nomongikazi) Xelela lo gqirha ukuba andiyontanga yakhe
Andizanga kudelelwa nguye apha, ndifuna ingxelo yovavanyo qha.

*(talking to the nurse), Tell the doctor that I am not here to be
belittled by her, I want my test results.*

Doctor: (embarrassed) Do you have multiple partners?

Uthandana nabantu abaninzi?

Again, in this instance, the doctor shows a lack of communicative competence. In the Xhosa culture, there are some things one may not say and questions one

may not ask to a person older than him/herself. Motshabi & Steyn (1996: 13) agree with this statement in chapter two of this thesis when they say "...hierarchy becomes an important factor within the consulting room. Older people will always see young people as young, whether they are doctors or not." Failing to understand that may lead to miscommunication.

Patient: Unayo imbeko lo gqirha? Yinto anokundibuza yona akugqiba ukuba ngumntwana, namntwana obhinqileyo? Akayazi ukuba ndinelungelo lokuba nawo nokuba mangaphi amankazana? (uthabatha itasi yakhe aphume, alahle ucango).

Does this woman have any respect? How dare she asks me such a stupid question? Doesn't her age and sex tell her what to ask to a grown up man like me? Doesn't she know that I am entitled to have as many girlfriends as I want? (He took his bag, banged the door and left).

It is evident from this scenario that cultural background plays a vital role in intercultural communication encounters, and that male superiority is maintained in rural areas like Peddie. If the doctor was competent in her communication with the patient, that situation would have been handled in a different way. She would know that to call a middle-aged man 'mfana' was unacceptable in Xhosa culture, and would have used 'hlonipha' language when speaking to an elderly patient

about sex-related matters. This is in agreement with what Saville-Troike (1982: 22) in chapter two of this thesis argues regarding communicative competence. She believes that communicative competence involves knowing not only the language code, but also what to say to whom, and how to say it appropriately in any given situation. She is further supported by Steyn & Motshabi (1996: 13) who believe that knowledge of the person's language, traditions, customs, values, beliefs, may help a lot, but if an individual is not sensitive and perceptive to the needs, motivations and intent of his/her communicative partner, the total communication effort may be in vain. The doctor-patient communication was derailed because of the language problem.

We have all had trouble communicating with our doctors from time to time, and not understanding some of the words they use. But how much more difficult would that be if you were sick and communication is really important and English is not your first language.

Gumperz & Hymes (1972: 15) contend that communication is not governed by fixed social rules; it is a two way process in which the speaker first takes in stimuli from the outside environment, evaluating and selecting from among them in the light of his cultural background, personal history, and what he knows about his interlocutors. Rules of speaking are the ways in which the speakers associate particular modes of speaking, topics or message form, with particular settings and activities.

It is clear from these scholars' points of view that each culture has its own rules of speaking which doctors and patients should be aware of in their encounter, especially if they come from different linguistic and cultural backgrounds.

Gumperz & Hymes (1972: 53–70) suggest three units necessary in describing and analyzing communication. These units are situation, event and act.

➤ **Speech community**

A speech event is defined as a community sharing rules for the conduct and interpretation of speech, and rules for the interpretation of at least one linguistic variety. Sharing of speaking-rules is not sufficient. The difference between knowledge of a variety and knowledge of speaking does not usually become apparent within a single community, where the two are normally acquired together (Gumperz & Hymes 1972: 53-25).

Based on these scholars' views, where the encounter is between two people from different cultural backgrounds, there is a possibility of using different rules of speaking and different interpretation of linguistic varieties. This in itself can bring about miscommunication. Therefore, doctors and patients from different linguistic backgrounds should be aware of these differences to be able to communicate effectively with each other.

➤ **Speech / communicative situation**

According to Gumperz & Hymes (1972: 56) within a community one readily detects many situations associated with (or marked by the absence of) speech. Such contexts of situation will often be naturally described as ceremonies, fights, hunts, meals, lovemaking and the like. In contrast to speech community they are not in themselves governed by rules, or one set of such rules throughout.

➤ **Speech / communicative events**

Speech event will be restricted to activities, or aspects of activities, that are directly governed by rules or norms for the use of speech. A speech may consist of a single speech act, but will often comprise several. Just as an occurrence of a noun may at the same time be the whole of a noun phrase and the whole of a sentence (e.g., "fire!"), so a speech act may be the whole of a speech event, and of a speech situation. The same type of speech act may recur in different types of speech event, and the same type of speech event in different contexts or situations. Thus, a joke (speech act) may be embedded in a private conversation, a lecture, or a formal introduction (Gumperz & Hymes 1972: 56).

In a medical encounter between doctors and patients what seems to be a joke to one party may be seen as an insult to another. This is evident in my observation

in the Peddie HIV/Aids clinic (10 July, 2007) where the doctor was examining the patient. The patient had a terrible rash around the neck and his neck was swollen. The receptionist was used to bridge communication gap, since the doctor was speaking English to a Xhosa patient who did not understand English. This is how the communication unfolded verbatim:

Doctor: Take off this rope; I can't examine you with it around your neck. Don't you see that this rash is caused by your allergy to this animal's hair?

Khulula le ntambo, andinakukuxilonga unaloo ntambo entanyeni. Akuboni ukuba ayidibani negazi lakho, kwaye yiyo le ikubangela la maqhakuva?

Patient: Asiyontambo le, liyeza kum. Ayinanto yakwenza nala maqhakuva.

This is not a rope; it is my medicine. It has nothing to do with this rash.

The patient was very upset and did not take off that "rope". To the patient, the doctor was looking down upon her belief. Also, the use of the word "rope" was insulting to the patient because it is usually associated with cattle, not people.

➤ **Speech / communication act**

The level of speech acts mediates immediately between the usual levels of grammar and the rest of a speech event or situation in that it implicates both linguistic form and social norms.

To some extent the speech act may be analyzed by extensions of syntactic and semantic structure. It seems certain, that much, if not most, of the knowledge that speakers share as to the status of utterances as acts is immediate and abstract, depending upon an autonomous system of signals from both the various levels of grammar and social settings. The relation between sentence forms and their status as speech acts is of the same kind. A sentence interrogative in form may be a request, or a command, or a statement. A request may be manifested by a sentence that is interrogative, or declarative, or imperative in form (Gumperz & Hymes 1972: 56-57). There is no doubt, however, that there is a correlation between the form and content of a language and the beliefs, value, and needs present in the culture of its speaker (Gumprz & Hymes 1972: 28–29) .

Direct communication between doctors and patients is problematic especially in situations where the doctor and the patient come from different cultural and ethnic backgrounds. Miscommunication occurs even if doctors and patients come from the same cultural background and speak the same language. This statement is supported by Helman (1990: 86) because he believes that doctors and their patients, even if they come from the same cultural background, view ill–

health in a very different ways. They may not attach the same meaning to the same word. The question is: How can this problem be solved? A number of possible scenarios are outlined below.

- **The use of English language only:**

Doctors use English language when communicating with patients. The patients are indigenous language mother-tongue speakers who do not understand English well. They cannot express their problems in English to the doctors. Obviously the use of English is not a solution in this scenario.

- **The second option is the use of the patients' language:**

The doctors do not communicate well with the patients in this scenario either as their mastery of the indigenous languages is often not good enough. Therefore, the conclusion is that this is not a viable option.

The data to be analyzed in this chapter comes from the investigation of the problem of intercultural communication between the patients and doctors in HIV/Aids clinics, bearing in mind the above scenarios.

3.2. ETHNOGRAPHIC INTERVIEWS

In an effort to solicit more information on intercultural communication, I interviewed three doctors from the previously mentioned clinics and fifteen patients. The challenge I experienced is that, in the process of my research, some HIV positive patients I observed and interviewed died before the completion of my research. Their death made it impossible for me to continue with the interviews and to make follow-ups.

3.2.1. Interviewing the patients

As mentioned the interviews were conducted in Peddie - Nompumelelo clinic, Laetitia Bam clinic and the Provincial Hospital in Uitenhage. Five isiXhosa speaking patients were interviewed in each clinic. At Nompumelelo clinic, interviews were conducted in July and August 2007, with patients who did not understand English. In Laetitia Bam clinic and Uitenhage Provincial Hospital, interviews were conducted during the February and March months; patients were isiXhosa mother-tongue speakers, some with limited understanding of English and others with no understanding of it.

The purpose of the interview was to examine the issues of language and cultural gap between patients who are mainly isiXhosa speakers and the Cuban/English-speaking doctors with a Western background; to investigate the question of confidentiality especially when dealing with HIV/Aids affected and infected

patients; and to assess the patients' attitude towards the use of a foreign language in a medical encounter.

The following were some of the questions discussed:

- Do the doctors who examine you speak your language?
- How do you communicate with an English speaking doctor?
- What are the reasons for poor communication, if any?
- What can be done to resolve the problem, to ensure effective communication between doctors and patients?
- How confidential is confidentiality in HIV/Aids or life threatening disease related matters when patients do not understand the doctor's language?
- What is your attitude towards the variety of languages spoken in the clinic?
- Which language do you prefer to use when communicating with the doctor? Why?

The responses to these questions differ from clinic to clinic. Patients' responses to these questions were:

- 13 out of 15 patients said doctors speak the language which is different from theirs. Patients communicate with difficulty because of the English language used by most doctors and counselors. There are many

language barriers, for example, the medical terms. This is occasionally alleviated by the use of the health interpreters. The interpreters are not specialists in that field and they are not familiar with the medical jargon. Also the use of interpreters makes things difficult for them with regards to confidentiality.

- All the indigenous language speaking patients prefer using indigenous languages, such as isiXhosa in their encounter with doctors. They also prefer to be treated by doctors from their cultural backgrounds who understand their language and culture.

The following are extracts from some of the interviewees:

- A 35 year old Xhosa male patient admitted to a male medical ward, when asked to comment about the languages used in that clinic, said that:
 - English is used by doctors, psychologists, counselors and non–African language speakers. He added that they use abstract medical language.
 - IsiXhosa is used by nurses and cleaners.

When asked about the language preference, he opted for isiXhosa. He commented about English-speaking doctors who carry small pocket dictionaries

to refer to if they talk to a patient without the assistance of the isiXhosa speaking nurses.

He further added that when doctors use these pocket dictionaries, they do not consider the context in which the synonym is used. They just take any of the words and use them. Although they are making an effort, these doctors are not linguistically conscious or trained communicators and can inadvertently insult their patients.

For example, the English verb “die” can be translated in Xhosa as – *fa*, *-bhubha*, *sweleka*, these Xhosa synonyms are used in different contexts. The patient expressed his disgust at the English-speaking doctor who told him: *bafile abantu yingculaza ngenxa yokungayinonopheli impilo yabo. “Many people died of Aids because they did not take care of themselves”,* but the word “*file*” is usually used when referring to animals. He stressed the point of using appropriate isiXhosa words in their context; otherwise people are humiliated and insulted.

He finally recommended that it be compulsory that all the English-speaking doctors be taught an African language used in the community in which they are going to serve, such as isiXhosa in the Eastern Cape (where the majority of people are isiXhosa mother-tongue speakers), before they complete their training.

A 55 year old woman who was admitted to a surgical ward said she preferred to speak isiXhosa all the time with doctors. She claimed that she can fully express herself in that language and understands it well. To support that, she shared some of her youth experiences regarding the use of language in hospitals. The patient related that she once consulted a doctor because she had cancer of the womb. She was told by the English-speaking doctor that 'ndiza kukubulala ndikhuphe isibeleko, kuze unganweni umhlaza.' "*I will kill you (give you anesthetic) to remove the womb to prevent the spread of the cancer cells*". The use of an inappropriate Xhosa word '*bulala*' in a wrong context scared her in such a way that she left without having the womb removed.

The above scenarios confirm that limited understanding of one's language can result in miscommunication in an intercultural encounter.

3.2.2. Interviewing the doctors

Doctors were interviewed in these clinics – focus was on one doctor in each clinic. The focus was on strategies they employ in ensuring that they communicate successfully with their patients. As much as some did not cooperate, some did. Questions were not structured but open-ended.

Some of the questions asked from English-speaking doctors were:

- How do you communicate with isiXhosa-speaking patients?
- How confidential is confidentiality in the presence of the third party?
- How do you manage cultural differences in their encounter?
- What strategies do you use in ensuring that they understand each other?

The responses to these questions differ from doctor to doctor, but the common responses were the following:

- They communicate with difficulty with isiXhosa-speaking patients because they use limited isiXhosa which sometimes results in miscommunication. They make use of isiXhosa-speaking nurses at times to convey the message to and from the patient. Making use of nurses becomes a challenge at times because doctors have to keep confidential some information that is to be known by the patient alone (HIV/Aids related).
- They agree that there are times when they have to break confidentiality because of the health condition of the patients. They highlight that confidentiality is sometimes broken by the patient by bringing along a family member or a child to witness what the doctor has to say. At times a family member is brought along, as part of the culture that the sickness of one member is the family

sickness, and because the family member can speak English, thus reducing chances of nurses spreading gossip about their status.

- Doctors are aware that patients bring along their culture to the medical encounter. Some, because of the experience they have working with Xhosa patients, know that they have to accept that some illness results from evil spirits and only traditional healers can cure them.

- Some doctors have good working relations with traditional healers, in cases of HIV/Aids last stages, a traditional doctor is invited to the clinic, and in the presence of the patient to confirm that only ARVs will be necessary to better the situation.

Two doctors gave their comment regarding their communication and medical encounter with their Xhosa-speaking patients. The first doctor is Dr. Siva Naidoo, an Indian doctor in Uitenhage. Permission was given to use this doctor's name.

Dr. S. Naidoo is originally from Durban. He is an Indian doctor who is fluent in English. He graduated in 1986 from the University of KwaZulu-Natal. He speaks English and limited isiXhosa. He has nurses who act as interpreters when necessary. Communication with isiXhosa-speaking patients is not a big problem according to him.

He cited the following challenges in his practice:

- IsiXhosa-speaking patients sometimes want to explain exactly what is wrong with them and the nurses give their own interpretation, something which most of the time leads to wrong medication and misdiagnosis. The doctor may treat the patient for something which s/he is not suffering from. This becomes evident when the patient frequently visits the doctor even before the medication is finished, complaining about the same thing.
- If doctors do not have a history of that patient, that limits their assistance.
- There are situations where the patient would not understand English and refuse the assistance of the nurses, claiming she understands. In those cases, patients simply shake or nod their heads (use body language), as a sign that they understand, but they end up not doing as instructed by the doctor.
- Nursing staff shortage in hospitals creates another problem. At times they are not available to assist in doctor-patient communication. Some nurses work under pressure in as much that they do not do justice in terms of sending the message to and from the doctor. It is in fact not the work that they are employed to do i.e. interpreting.

- Dishonesty of patients; they may be given a week's medication but come back with unfinished medication after a week claiming they are taking the medication correctly. They complain that their health condition does not improve, forgetting that they are taking the medication incorrectly (e.g. antibiotics).
- HIV-positive patients do not volunteer information, nor tell doctors their problems. Confidentiality is still a huge challenge regarding medication; and the doctor has to make sure that patients take their medication at the right time.
- In cases of miscommunication, the doctor asks a nurse to interpret with the permission of the patient. When a third person is involved, the doctor often notices an element of dishonesty. The patient withholds some information fearing a situation where his/her status will be the talk of the town.
- One doctor cited an instance where he told the patient that whatever was said or done in that consulting room was between him and the patient. While the patient was talking, the doctor took some notes for medical reasons; and the patient asked what the doctor was writing and the reason why he was writing. She was upset, thinking that the doctor had betrayed

her trust because to her it was no longer confidential if it is written down. She left the room and never returned.

- From the doctor's point of view, his management of the whole situation is compromised if there is no one-to-one communication especially related to sexual problems. The big problem he mentions is trust, and a fear of spreading of news regarding someone's status to the community by nurses.

From a cultural point of view, Doctor Naidoo commented as follows:

- The majority of his patients are isiXhosa mother-tongue speakers) who have strong beliefs in *sangomas* (*amagqirha*) and traditional healers. I use the term *sangoma* as it is the more commonly used term. He usually advises his patients to take medication from him and from *sangomas*. He will, also, advise the patient to come with the medication from the *sangoma* when visiting the doctor. He tried to treat the patients psychologically, avoiding hurting them.
- Sometimes the patients come to the clinic out of routine or to please others, believing that the medication will not help since they think that they are bewitched. The doctor usually encourages them to go to the *sangoma*, because the issue may be a psychological problem. Even if the *sangoma*

can give them “chocolate” (he made a joke), they will believe that the disease is cured. It is after the psychological problem is addressed that the physical one can be cured.

The doctor cited that there are challenges of which he has no control when it comes to the beliefs of Xhosa people. He mentioned a few touching examples where he wanted to help, but he could not succeed.

- A patient was diagnosed as having cancer, and the only way out was to undertake an operation. The patient refused to have an operation and went to the *sangoma*. She later died.
- A schizophrenic child was admitted to the hospital, but was taken out of hospital by the family to the *sangoma*. The doctor did not agree with the family, but he had no control. A few weeks later the child had to be re-admitted.

It is clear from these scenarios that a lot has to be done in the medical institutions to educate students on health-related issues, where consideration is given to cultural issues.

A second doctor in Peddie who did not want to be mentioned by name provided the following comments:

- Communication with isiXhosa-speaking patients is a challenge. She uses nurses as interpreters most of her time. She cited the language barrier as a major problem because isiXhosa-speaking nurses themselves are not fluent in English.
- She cited gender roles and stereotyping as another factor inhibiting effective communication. A 60 year – old Xhosa male patient visited the clinic for an HIV test, and was diagnosed positive. The doctor explained to him how he should conduct himself after that. To her surprise, the patient asked her to back off because they (White medical doctors) are the same people who invented Aids.
- When it comes to cultural issues, the doctor feels that it is the traditional healers who should come on board, because they could play a significant role in ensuring that HIV positive people adhere to medication rather than denying that this pandemic exists.
- In her practice as an HIV counsellor, she discovers that men do not make use of her services, simply because of stereotyped thinking i.e. that visiting a psychiatrist signals that they are weak and cannot handle their problems.

- Another challenge is when a patient does not understand English and does not want the involvement of a third party. She usually refers them to the Xhosa counsellor with whom she is working. That becomes a challenge as well, because some patients trust her more than her partner, and refuse to consult her partner. As a result confidentiality is broken, because the doctor will be forced to ask the assistance of a third party for the sake of the patient's health condition.

The third doctor, Doctor Siwisa is an isiXhosa mother-tongue speaker. She was born and raised in Queenstown. She was privileged to have attended the so called "multiracial schools" and is fluent in English. She graduated from Medunsa in 1986 and started her practice at the Uitenhage Provincial Hospital in 1987.

With reference to language, she does not experience any problems because most of her Xhosa patients speak isiXhosa. Patients feel comfortable in their encounters because they communicate on a one-to-one basis. What makes them more comfortable is that the doctor knows the variety of language used by different people and the various situations where such language is used, for example between Xhosa men and women.

She cited the following minor challenges:

- In cases of some diseases such as Aids, Cancer and TB, patients fail to understand that they are not related to witchcraft. When they are diagnosed with such life-threatening diseases, some patients tend to consult traditional doctors for confirmation.

- Gender stereotyping – Xhosa male patients prefer either Xhosa male doctors or doctors from other cultural backgrounds to treat them when the sickness involves their private parts. Even the female patients confirm that they prefer White or Indian doctors to examine them when private parts are involved e.g. gynecologists. In Xhosa culture, it is neither comfortable nor acceptable that another man, other than the woman's husband see the woman's private parts. Once that happens the woman's pride is taken away. Another reason is related to fear of gossip when they meet in other circles.

- She also confirms that their services are mostly used by their fellow men when they need doctor's certificates.

As Gudykunst (2003: 114) puts it, knowing people's language and culture does not guarantee that miscommunication may not occur. Helman (1990: 86) further agrees that doctors and patients, even if they come from the same cultural background, view ill-health in very different ways. Recent studies by the Care

Action-HIV/Aids Bureau have shown that Blacks are less trusting of health care providers than White people.

Culture can be thought of as an integral pattern of learned beliefs and behaviors that are shared among a group of people. Beliefs and behaviours that include styles of communication, ways of interacting, views on roles and relationships values, practices and customs. It shapes how we explain and value our world and it is the lens through which we give our world meaning. Dodd (1998: 36) agrees by stating that "...culture influences how we adapt and learn language, habits, customs, expectations and roles – it shapes thinking, acting, and communicating according to group expectation." Porter & Samovar (1994: 24) contends that culture cannot exist without communication; one cannot change without causing change in the other.

The amaXhosa culture rests on strong beliefs in natural forces, white and black magic and the community is governed according to a flexible hierarchical system. In a matter of health or medical issue, they would rely on traditional medicines. As regard to traditional healers, it is very common to consult them for health problems, or diseases, curable by herbs or medical drinks.

Culture influences how people receive health education, messages, perceptions about HIV risks, accessibility of risk reduction strategies, negotiation or safer sex practices and health seeking behaviors. Each culture provides its members with

ways of becoming ill, of shaping their suffering into a recognizable illness entity, of explaining its cause, and of getting some treatment for it. For example, in amaXhosa culture, HIV/Aids is sometimes explained as witchcraft or breaking of religious taboos because ill-health and other misfortunes are blamed on social or supernatural causes. To illustrate this, the following communication which took place at the Peddie HIV/Aids clinic (11 July, 2007) is offered:

Background

Nomsa (not the patient's real name) was diagnosed HIV-positive and had been on ARVs. She visited the doctor for a check up. The doctor speaks limited English and the patient speaks isiXhosa. The receptionist was normally used as an interpreter. In this instance the communicative event unfolded verbatim as follows:

Doctor: Have you been taking your medication regularly?

Uwasebenzisa kakuhle amayeza akho?

Patient: Hayi, ndiyekile ukuwasebenzisa.

No, I have stopped using them.

Doctor: (surprised) Why not? Are you kidding?

Kutheni ungasawasebenzisi? Kwenzeka ntoni?

Patient: Kuthe kanti andinaAids. Esi sigulo siqale ukunyuselwa kwam

kulo msebenzi wam mtsha, abantu abaninzi abayithandanga loo nto.

Nkqu nomalume kazi wam imbala, bafuna ukundidlulisa amafu.

Ixhwele lam lindinike iyeza eliyinkunzi wokundikhusela kwimimoya emdaka, lindincede kakhulu andizidingi ipilisi.

It has been discovered that I am not HIV positive. This sickness started when I got promoted in my new job, people were not happy about it, including my aunt, they are now trying to get rid of me. My traditional healer gave me a strong, powerful umuthi to protect me from the evil spirit, it helped me a lot and I do not need these capsules.

Doctor: (disappointed) I am not disputing what your traditional healer told you, but I think you should continue with the treatment, in case your health condition deteriorates. I also want to remind you that the test results were accurate and you need to follow the treatment procedures.

Andiyiphikisi into ethethwe lixhwele lakho kuwe, kodwa ndicinga ukuba kubalulekile ukuba uzisebenzise nezi pilisi ukwenzela ukuba impilo yakho ingabi mandundu. Ndifuna ukukhumbuza ukuba iziphumo zohlolo lwakho ziqinisekile kwaye kubalulekile ukuba uqhubeke ngepilisi ezi.

Patient: Ndiyabulela Gqirha, uMacebentonga uza kundinakekela (aphume).

Thank you, doctor. Macebentonga (traditional doctor's nick name) will

take care of that (she left).

It is clear from this encounter that the patient is confident that her traditional healer will save her from the Aids virus. It is important for doctors to understand the belief of the isiXhosa-speaking people as well as the role played by the traditional doctor in their culture, for effective intercultural communication to take place.

The idea is that the HIV is caused by organisms that are invisible to the naked eye, is something which is not necessarily understood and accepted in amaXhosa culture. Even the so called educated people, as much as they know the causes and effects of this pandemic, they associate this killer disease with witchcraft, evil spirits, curses, and the wrath of the ancestors.

Through interaction with some HIV-positive people, the researcher identifies certain trends that are usually followed when some amaXhosa people are ignorant of the aids pandemic – slaughtering of animals in pardoning angry ancestors, accepting a call to train as a *sangoma* and wearing traditional necklaces (made from animal hair).

It can be argued that, except for culture, the language barrier becomes a challenge in HIV/Aids clinics. Gudykunst (2003: 114) contends that:

In communication between cultural and between different racial and ethnic groups, language can pose major problems. For example, even if people from different cultures communicate in a language that all of those involved understand, not all the cultural groups will attach the same meaning to the same word. Misunderstanding can occur due to differences in interpretation.

Anthonissen (2000) in her research elaborates by stating that in a medical encounter, this may not only impair communication, but may lead to misdiagnosis or wrong medication, something which may impact negatively on a patient's health condition. Also, Herman (1990: 117 -121) argues that "...a clinician, who is unable to decode language which may be verbal or nonverbal, is in danger of making a wrong diagnosis." He further elaborates by stating that clinical consultations are usually conducted in a mixture of everyday language and medical jargon, and where medical terms are used by either party, there is a danger of mutual misunderstanding. The same terms, for example, may have entirely different meanings for the doctor and the patient. In other words, the use of the same terminology by the doctor and the patient is not a guarantee of mutual understanding; the terms and their significance may be conceptualized by both parties in entirely different ways. Language barriers, therefore, create a problem to the Aids sufferers when they cannot communicate on a one-on-one basis with the doctors in their encounters.

When it comes to intercultural communication in HIV/Aids clinics, some of the aspects mentioned above are relevant because even if doctors and patients come from the same cultural background, they view ill-health in very different ways. Also if the differences between patients and doctors are not recognized, explored and reflected in the medical encounter, the patient's health outcome may suffer because cultural differences between doctors and patients affect their relationship. They also relate to how patients feel about the quality of that relationship, which is directly linked to patient satisfaction, adherence and subsequent health outcomes.

3.2. 3. Participant Observation

I requested permission to observe doctors' and patients' interaction in the three respective clinics already mentioned.

In the Peddie HIV/Aids clinic a case study was undertaken with a Cuban doctor who does not understand isiXhosa and who speaks limited English when speaking to a patient who does not understand English. The doctor in his interaction with the patient, noticed misunderstandings, and then usually invited a receptionist to interpret the message to the patient.

In this particular instance, I noticed that the patient was freely giving the information although she was not actually answering the doctor's questions.

When the receptionist arrived, I noticed tension on the part of the patient. Apparently the patient was taken by surprise to know that the receptionist was her neighbor. This is evident from the patient's interaction with the receptionist.

Receptionist: Molo, meza, unjani?

Good morning, neighbour! How are you?

Patient: Molo, mmelwane, ndiphilile. Usebenza apha kanti?

Good morning, neighbor, I am doing fine. Are you working here?

Doctor (to both): Do you know each other?

Receptionist: Yes, doctor, we are neighbours.

When the doctor-patient communication continued in the presence of the receptionist, I noticed that the patient was reluctant to talk about her health condition. Even the information she gave prior to the arrival of the receptionist, was no longer freely given. Some information which would be of great assistance to the doctor was withheld. That is also evident from their interaction:

Doctor: Are you sure that you take the ARVs daily and at the same time?

Receptionist: *Uyabuza ugqirha ukuba uzithabatha rhoqo na iipilisi zesi sigulo unaso?*

Patient: Esiphi isigulo? Andityi zipilisi zasigulo mna. Ndizele uhlolo lwempilo apha.

What sickness? I am not taking any treatment; I am here for

a routine check up.

Doctor (puzzled): Your health condition signals that you are defaulting, hence you are not getting better. ARV's can either makes you feel better or worse, depending on how you take them.

Receptionist: *Kukhangeleka ngathi akuyilandeli imiyalelo kagqirha malunga nendlela omawuzitye ngayo iipilisi, kuloko impilo yakho ingabi ngcono. IiARVs ukuba akuzisebenzisi ngendlela zinokugulisa okanye zikwenze ngcono.*

Patient (upset): Lo gqirha uthi ndineAids? Wena, ude undixelele loo nto nje ufuna ukugqiba ilali uhambisa obu buxoki? (uphuma apho ngomsindokazi, ahambe).

Is the doctor implying that I have Aids? How dare you tell me that? Do you tell me this because you want to spread this lie all over the location?

The above scenario clearly shows that the presence of a third party in any intercultural communication can lead to miscommunication. In this instance the reason can be lack of trust. The information which was of great help to the doctor, on how medication was taken by the patient, was withheld because it had to do with the patient's status.

Thus, the presence of the third party in an HIV/Aids encounter, not only violates confidentiality between the doctor and the patient, but can jeopardize their relationship and lead to mistrust and miscommunication. It will not be surprising therefore, that the patient does not visit such a clinic again.

Most of the time a patient, to avoid the services of the third person, pretends that she/he understands English, and when a doctor communicates with him/her, she/he will smile and nod the head signaling that she/he understands all what the doctor says. The doctor will give medication based on their communication, hoping that he is understood by the patient. Misunderstanding becomes evident when the same patient revisits the doctor, complaining about the same problem. At times a doctor may ask the patient to bring medication on his/her next visit, and discover that procedures in terms of medication taking were not followed. This is what I observed in the Uitenhage clinic (05 March, 2008). An English-speaking doctor was communicating with a patient who does not understand English. The communication unfolded as follows:

Doctor: How may I help you today?

Patient: I have completed the medicine you gave me, but my condition is still the same.

Doctor: (seeing that medication was completed before time): How often do you take your medication?

Patient: After each meal.

Doctor: How many meals do you take a day?

Patient: Anytime, when I feel hungry, two to five times a day.

Doctor: Your medication is supposed to be completed next week, according to my records. Seemingly, you did not understand the instructions clearly. How about I ask the nurse to assist us in our communication?

Patient: That would be fine.

To further illustrate miscommunication between a Xhosa patient and a white doctor, the following discourse example took place in the Uitenhage clinic.

A forty-year-old Xhosa 'inkosi' (chief) from Kirkwood, a remote rural area outside Uitenhage, was drinking a type of home-made alcoholic drink from the age of eighteen, and he fell ill. His main complaint was the swelling of his whole body, but that the swelling was more pronounced around abdominal region.

In this case, the doctor was a twenty-eight-year-old European Christian man. He had been working in Uitenhage for a year and had learnt some isolated isiXhosa words. After a brief exposure to isiXhosa words, he felt very confident and thought that he knew the isiXhosa language; and that he could communicate with a Xhosa patient without the assistance of the interpreter. The communication was recorded as follows:

Doctor: Molo, tata!

Good day, father!

Patient: Molo, gqirha!

Good day, doctor!

The doctor did not ask the patient what was wrong with him, but just said the following to the patient:

Doctor: Mmmh! Tata, sukela nini ukhulelwe kangaka?

Father, since when have you been so highly pregnant?

There was no response from the patient. After a period of dead silence, the doctor said:

Doctor: Khawutsho tata, uqale nini ukukhulelwa kangaka? Ungamangaliswa izigulana zam zindibiza “Khohlelesingeni” igqirha loqobo.

Tell me, father, since when have you been so highly pregnant?

Don't be surprised, my patients call me 'Khohlelesingeni' a real 'sangoma' doctor.

The doctor proudly and confidently said that pointing to himself. There was no response from 'inkosi'. After a further period of silence, the chief responded with a trembling loud forceful tone saying:

Patient: Hayi bo! Andikhulelwanga gqirha, indoda ayizange ikhulelwe, sisithuko eso.

No, I am not pregnant, a man never gets pregnant. That is an insult.

Doctor: Ukhulelwe, nasi isisu sakho sisikhulu kangaka.

You are pregnant; your abdomen is much enlarged.

Patient: Gqirha uyandithuka, ngabafazi kuphela abakhulelwayo.

Doctor, you are insulting me, it is only women who fall pregnant.

The above scenario shows how an impoverished, monolingual, Black man could be traumatized by a Eurocentric and largely monolingual English dominant South African health system. This also clearly illustrates the importance of the role of the socio-cultural factor, when related to discourse in a multilingual and multicultural hospital situation and any other communicative encounter for that matter.

The White doctor in the above scenario did not intend to insult the Xhosa chief by saying he was pregnant. He intended to explain to the Xhosa chief that he had an enlarged abdomen. It was his lack of linguistic competence in isiXhosa that made him use the word '*khulelwe*' instead of swelling. Due to minimal social and language background knowledge, he further made the situation worse by claiming to equate himself with the respected Xhosa traditional doctor

'*Khohlelesingeni*' who diagnoses his patients without getting the relevant history from them.

Culturally, amaXhosa value their traditional healers and associate them with their supernatural ancestors. For a young doctor to equate himself with a *sangoma*, was insulting to the Xhosa chief. Arguably a violation of the amaXhosa values as well as cultural norms and rules took place in this instance. The norms of the white doctor completely clashed with those of the Xhosa chief, and their communication was derailed, resulting in an unwanted and strained situation. The intended aim of communication became null and void. It is not surprising that an American sociolinguist, Dell Hymes, (quoted in Webb & Kembo-Sure: 2000: 247) stresses the need for effective communicative competence and appropriateness. Saville-Troike (1982) is of the opinion that communicative competence plays a major role in effective communication. It teaches us what to say, to whom, and how to say it, when to talk, when to listen and when to be silent. Therefore in HIV/Aids clinics, doctors need to be sensitive to this, failing which communication breakdown may occur.

Another aspect contributing to language barriers is the fact that people whom doctors use as interpreters may not be fluent in that language, and communication breakdown may occur due to misunderstanding of a word. At times interpreters use their personal frame of reference; and they add their own experiences and comments in the message to the patient. Bonvillain (2003: 40)

argues that "...cultural diversity in interpreting nonverbal behavior can lead to misunderstanding between people of different ethnic backgrounds. When someone is confronted with an unfamiliar act, and the person knows that he or she cannot properly decode the message intended, the meaning is different." Shneller (1988: 155-156) further contends that "...misled by the familiarity of the gesture, the decoder will most likely be unaware of this discrepancy, and consequently act according to her or his erroneous interpretation...while a strange gesture will cause miscommunication, the false decoding of familiar gestures will produce miscommunication and misunderstanding."

In one instance at the Peddie clinic (29 August, 2007), as I was observing an interaction between a Cuban doctor and an isiXhosa-speaking patient, the patient narrated a very long story and the nurse gave a brief interpretation to the doctor. The patient was then silent and looked upset. The doctor suspected that something went wrong in their communication. After a moment of silence the patient turned to the nurse and said:

Patient: Umxelele yonke le nto bendiyithetha ugqirha?

Did you tell the doctor all what I've just said?

Nurse: Ewe, kutheni undibuza loo nto nje? Ukuba akundithembi zithethele.

Yes, I did, why do you ask? If you don't trust me, then speak for yourself.

Patient: Ndibona indlela le okhawuleze ngayo ukumxelela. Mna ndithathe

ixesha elide ukuchaza isiqalo sale ngulo, wena uthethe nje imizuzwana. Nokuba andisazi isiLungu akuthethanga le nto bendiyithetha, nasoloko ningxamile ukuthetha, kodwa nithatha ithuba ukusibhalisa.

Your speech was too short. I took a long time trying to explain how this sickness started, and you only took seconds to report. Even if I don't understand English, what you said is not what I told you. You are always in hurry when telling doctors our sickness, but you take your time registering us.

The patient was not happy with the way the nurse interpreted his story, and thought that he was misrepresented and decided not to say anything further, and then communication was derailed.

Another problem that both patients and doctors bring to their interaction is that of biases, many of which are rooted in culture, for example, some patients may be uncomfortable dealing with doctors of the opposite sex because of gender roles prescribed by their culture. This is supported by Ting–Toomey (1999: 6–7) in chapter two of this thesis when she says “...among people with dissimilar habits and communication rules, we experience interaction unpredictability. In an unfamiliar environment, we experience emotional vulnerability and threat.”

This became evident in my observation (30 August, 2007) in a remote rural area Peddie HIV/Aids clinic in a case where a middle-aged male patient was consulting a doctor. Unfortunately for him the doctor was a female and young. He was examined and diagnosed HIV-positive. He was asked if he had multiple partners and whether he was using condoms when having sex. In an African culture, particularly amaXhosa culture, it is disrespectful of a female, be it a doctor or not, to ask such questions to an older person. It became worse when the doctor raised her voice seeking more clarity. The patient was silent and very upset for being ridiculed and embarrassed by the doctor. He left the room without saying anything further. The problem according to my observation did not relate to the questions necessarily, but rather the lack of communicative competence, particularly cultural competence when it came to the manner in which the questions were asked. According to the patient's culture, it was disrespectful of the female doctor to ask such questions to a man who might be as old as her father.

Steyn & Moshabi (1996: 113) believe that the age hierarchy becomes an important factor within the consulting room. The consultation will also be influenced by other factors, such as the race or the color of the doctor. The patient may relate differently to a white doctor than to a black doctor. Thus they will accept certain behavior or attitudes which they think the white doctor is entitled to, but will not accept them from a different person.

From what Steyn & Motshabi say (supra), young doctors should use language of respect (*hlonipha*) when speaking to older people; be aware that having multiple partners is socially acceptable in amaXhosa culture; and that sex related matters are not divulged to anyone, let alone strangers. Also in communication with an elderly person, it is important for young doctors not to dominate in the interaction, but to wait for the elderly person to talk first and respond thereafter.

In my observation in the Uitenhage-HIV/Aids clinic (12 June, 2008), two female patients from different cultural backgrounds came for test results. The doctor was an English mother-tongue speaker. The first patient was a white middle-aged woman and the second was a middle-aged Xhosa woman. The isiXhosa-speaking woman had a limited understanding of English. The communication proceeded in the following manner:

Doctor: Good morning, how are you today?

Patient 1: I am very well, thank you, doctor. I came for my test results.

Doctor: Would you like a cup of tea?

Patient 1: Yes, I will appreciate that, it will calm my nerves.

Doctor (to the receptionist): Bring us two cups of tea, please!

The patient was so relieved, citing that her late mother used to give her a cup of tea whenever she was to tell her something. That she did this to calm her nerves. The doctor and the patient discussed the results while drinking their tea.

The patient left the room in a relaxed mood. It was the Xhosa woman's turn and the communication unfolded somewhat differently:

Doctor: Good morning, how are you?

Patient 2: Good morning, doctor, I am fine, thank you!

Doctor: How may I help you today?

Patient 2: I am here for my test results.

Doctor: Would you like a cup of tea before we discuss your results?

Patient 2 (nervous): Can you tell me if I am positive or negative? I am not here for a cup of tea, I want my test results, so please stop buying time.

Gudykunst in Wiseman and Koester (1993: 36) is of the opinion that "...interaction with people from other cultures is a novel situation characterized by high levels of anxiety and uncertainty." It becomes more stressful in HIV/Aids clinics. It is advisable that doctors should be mindful of their communication when interacting with HIV-positive patients from different cultural backgrounds. Whilst "tea" was seen as relaxing a stressful situation with the first patient, the very same invitation was seen as adding to the second patient's stress levels.

To be diagnosed HIV-positive causes anxiety and uncertainty, because a patient has to deal with the stigma attached to the virus, the disease itself, and attitudes of family, religious affiliates and friends. If the anxiety and uncertainty are not

properly managed, a patient's health may deteriorate; hence more people die prematurely.

In the Uitenhage clinic (Letitia Bam), the doctor I observed speaks the same language as the patients and they are from the same amaXhosa cultural background. The doctor-patient encounter is appropriately managed, because there is no need for a third person to interpret. There is one-on-one interaction which promotes confidentiality. The doctor understands the patients' language and culture; they are aware of language varieties used when interacting with their isiXhosa-speaking patients, i.e. the language of respect (*hlonipha*) when interacting with elders.

Recent studies by the HIV/Aids Bureau have indicated that trust is greater when the doctor is of the same race as the patient. Trust is associated with listening, information provided, time spent and participation in decision-making. The doctor has knowledge of the amaXhosa people that he serves; he knows their beliefs, acknowledges the role of traditional healers and diviners and understands the lifestyle of his patients.

For example, at the Uitenhage clinic (25 June, 2008), an HIV-positive patient was sick and visited the doctor. Seemingly, the patient had visited the doctor the previous week. The encounter was recorded as follows:

Doctor: (erhanela ukuba isigulana asiwasebenzisanga amayeza): Usenawo amayeza aseleyo?

(suspecting that the patient was not using the medication he gave her):

Do you have any medication left?

Patient: Andiwasebenzisanga lawaa ubundinike wona. Ndisuke ndabona izinto ezingaqhelekanga ndingalali ebusuku, ndaya kwixhwele lam landinika iyeza lesixhosa, ndisasela lona ngoku, kwaye liyandinceda kuba andisaziboni ngoku ezo zinto zimdaka ebusuku.

I did not use them. I saw strange things at night and I went to see my traditional healer who gave me a strong medical drink. After drinking his medication I never saw such things again, the medical drink helped me a lot, I am still drinking it and I no longer see those strange things again.

Doctor: Usebenzise ingqondo kwaye yingcaphephe ixhwele lakho ndiyavuma, Kuyabonakala ukuba ubuneshwangusha elikulandelayo; Ndingca ukuba abaluleke kakhulu la mayeza exhwele lakho, kwaye akufuneki siwaxube nala wam. Kunganjani xa unokusebenzisa la wam uwagqibe , wandule ke ukusebenzisa la kamhlelekezi?

You are brilliant! I take my cap off to your traditional healer. It is true that there had been a misfortune. I think your traditional healer's

medication are important for your health, you must not drink them simultaneously with mine. How about you start with mine, finish them and continue with the sangoma's medical drinks?

An isiXhosa mother-tongue speaking doctor is aware that unless the psychological part of the patient is stable, then western medication cannot do the job. Some doctors would have scolded the patient for not taking medication, thus looking down on the patient's beliefs. Steyn & Motshabi (1996: 16) in chapter two of this thesis support this statement when they say "...if someone believes that the voice in the wind can guide their behavior along the proper path, we cannot throw up our hands and declare the belief is wrong; we must be able to recognize and deal with that belief if we wish to obtain satisfactory and successful communication."

In this clinic, traditional healers do have their special days to examine the patients, in order to cater for the psychological part and belief that Aids is caused by witchcraft. This involvement of traditional healers in matters of health makes patients comfortable and increases trust in the western medication and it also increases levels of adherence.

It is important for doctors and patients to be tolerant of each other and to understand and respect each other's culture in a medical encounter. I argue that

both parties have to suspend their prejudice and stereotyping and learn each other's language to be successful in their intercultural encounter.

In my observation in the Peddie and Uitenhage clinics, doctors are Indian, Cuban and White English-speakers with limited understanding of isiXhosa and the majority of patients observed are isiXhosa mother-tongue speakers with limited understanding of the English language. A middle-aged man visited a doctor, the doctor in greeting the patient, inappropriately used the word '*mfana*', as discussed previously. This incident clearly shows that doctors need to be fluent in a patient's language, or at least they need to be "mindful", because using limited understanding of language can create tensions, anxiety and uncertainty.

One problem that both patients and doctors bring to their interaction is that of biases, many of which are rooted in culture. Some patients become uncomfortable dealing with doctors of the opposite sex because of the gender roles prescribed in their culture. For example, a mature Xhosa woman from the Uitenhage Provincial Hospital was being assessed for abdomen pain. The Black male gynecologist asked her to take off her underwear. The patient refused to do that, as she preferred to be examined by a stranger (any doctor other than a Black male) if a female doctor is not available. According to Xhosa culture, it is unacceptable for a man, particularly from one's culture, who is not one's husband or partner, to see a woman's private parts. The common reasoning being that if someone sees your private parts, you are left with nothing to be proud of as a

woman. Another reason is that you may come across this man again in a social encounter, and he may tell others about you. With a stranger, no ill feelings are attached.

What I observed during the medical interviews is that, doctors hold the master narrative. The discourse holds questions of who can speak and who must be silent. The patient's story is not central. The doctor generally asked closed-ended questions in relation to the body of knowledge that is not accessible to the patient in order to make a diagnosis.

My view is that the doctor's narrative is the one that is validated and takes precedence in the exchange between doctors and patients, while the patient's version is not solicited, not engaged and may be actively discouraged as an inappropriate and illegitimate claiming of discursive space.

3.3. CONCLUSION

The following were the common reasons given by both doctors and patients regarding poor communication between them:

- **Language Barrier**

IsiXhosa-speaking patients not understanding English and White/Indian/Cuban doctors not understanding isiXhosa properly. This results in the communication between doctors and patients being hampered. Anthonissen (2000) puts it clearly that such miscommunication may lead to misdiagnosis and wrong medication, which will eventually lead to the deterioration of the patient's health conditions.

- **Contextual factors**

Contextual factors co-determine the context of communication that takes place between the White/Cuban/Indian doctor and the black patient. The following are the contextual factors:

- **Situation**

The hospital environment and the ward may be a strange place to a Black patient from the rural areas, thus causing a degree of uneasiness. This relative degree of uneasiness on the part of the patient may result to poor communication between him/her and the doctor.

A White/Cuban doctor walking into a hospital ward and trying to initiate a formal dialogue with the black rural patient may be an unusual encounter for the patient. The relation of power may also affect their communication process.

The communication between the two may further be difficult or strained due to having to discuss a topic that is taboo in the amaXhosa culture, for example, sex (indirectly impacting on HIV/Aids issues). The effect of the situation on text construction, for example, in a serious high pitched tone of the White/Indian/Cuban doctor using the medical register may be interpreted as arrogant or scolding by a non-English speaking Black rural patient. This negative interpretation may lead to misunderstandings between the two parties.

➤ The psycho-context factors

○ **Cognitive processes**

An example of this is when a patient is anxious because s/he lacks knowledge about his/her sickness. The anxiety usually manifests in cases of HIV/Aids, where patients have insufficient information about their disease and perceive

his/her illness only as fatal/ irreversible. A marked degree of anxiety may result in impaired /poor communication.

➤ **Socio-cultural Context**

According to Webb (2000: 317) the term culture refer to "...ways in which people do things, patterns of behavior, norms, values, beliefs, and assumptions, attitudes. Ting-Toomey (1999: 15) goes on to say, "Culture affects communication, and communication affects culture. It is through communication that culture is passed down, created, and modified from one generation to the next".

- **Culture:** Each doctor and patient has his/her own socio-cultural identities. In order for them to communicate effectively, there has to be common cultural grounds. Thus both should have a relative degree of understanding of each other's culture and language.
- **Class:** The social class of the White/Indian/Cuban doctors differs from that of the isiXhosa-speaking patients, who do not understand English. The majority of White doctors belong to the upper middle-class, whereas the non-White patients belong to the working and peasant classes. Their operational worlds are far apart.

- **Language:** The linguistic behavior also differs. Doctors use mainly medical language and the Xhosa patients use everyday language. The intervention of the professional health interpreters may also succeed in improving communication in this regard.

HIV/Aids itself presents a challenge to the patients. Thus patients do not need to deal with additional barriers from doctors once they get access to health-care. Patients also, must view themselves as stakeholders and be responsible. If they want to see results, they must also improve their level of intercultural communication and expect that people see the world differently, including their doctors.

It is important to say that culture is not static or fixed, but changes over time. This implies that as time goes by, the White or Cuban doctors may acquire some of the Xhosa culture, for example, have a good understanding of the isiXhosa language and the rules that govern their use. The reverse may also happen to the Xhosa patients.

This chapter has concentrated mainly on ethnography and observation. Mills (1997: 119) argues that discourse analysis can be seen as a reaction to traditional linguistics which is focused on the constituent units and structure of the sentence and which does not concern itself with an analysis of language in use.

The primary aim of this research is ethnographic in nature. However, the researcher felt it necessary to analyze the actual conversation of her participants in the next chapter. This will further enhance the ethnographic material and participant observation insights as presented in chapter three.

CHAPTER FOUR

CONVERSATIONAL ANALYSIS OF SELECTED TEXTS

4.1. INTRODUCTION

This chapter will outline the theory associated with conversational analysis. It will also look at how this theory relates to intercultural communication. Conversational analysis will be undertaken in order to assess the effect of shared background or lack thereof between doctors and patients. Comments on doctor–patient miscommunication will also be made.

In any doctor–patient conversation, it is extremely important that a patient be given the opportunity and even be encouraged to ask questions. Doctors should routinely check for understanding to ensure that there is neither miscommunication nor a mismatch between what the patient wants and what the doctor assumes the patient wants.

Doctors are members of a medical culture with its own language, style of communication, and accepted behavior; and patients are part of a different culture. If these differences were not obvious to the two, they would realize they have to find ways to understand each other. The problem is that doctors and patients usually do not know there are differences, which can result in miscommunication, frustration, and a less than ideal relationship.

Clinical realities are formulated in a setting heavily influenced by a doctor–dominant relationship with recipients of health care. S/He organizes the discussion, directs it in a fashion that will be optimally relevant to the patient’s complaints and situation, and they make decisions unilaterally and independent of the patient’s view, and then describes both the diagnostic and therapeutic action to be taken. The doctor’s view may be biased by his/her personal background, values, and social class. These circumstances can lead to a situation in which a patient’s views are overlooked or excluded as invalid concerns. In chapter two, Gudykunst in Wiseman & Koester (1993: 40) highlighted that we cannot communicate effectively if our uncertainty and anxiety are too high, nor can we interpret the stranger’s messages or make accurate predictions about the stranger’s behavior.

Faced with uncertainty about what to expect in a diagnostic encounter, as pointed out in chapter three, the patient may withhold personal views of what is wrong or histories of non biomedical diagnostic action already undertaken. Patients may be reluctant to discuss beliefs, herbal therapies; home remedies, and practices; fearing the doctor’s disdain for these activities. Information may be withheld or altered to avoid labeling, to cope with anxiety about illness, and at times to comply with the doctor’s wishes. Hence Dodd (1998: 6-10) in chapter two speaks about the adaptive model of communication, which calls for participants to suspend judgment and bias while they engage in the third culture created by the intercultural participants to explore goals and common concerns.

4.2. DEFINING CONVERSATIONAL ANALYSIS

It is against the above background that Stubbs (1983: 7) argues that:

Sociolinguistics will ultimately have to be based, at least partly, on analysis of how people actually talk to each other in everyday settings, such as streets, pubs, shops, restaurants, buses, trains, schools, doctor's surgeries, factories and homes. He further says that they have to incorporate analysis on how conversation works: that is; how talk between people is organized; what makes it coherent and understandable; how people introduce and change topics; how they interrupt, ask questions, and give or evade answers; and in general, how the conversational flow is maintained and disrupted.

Kaschula & Anthonissen (1995: 19) are of the opinion that "...societies throughout the world have rules concerning the way language should be used; and that these rules may differ from culture to culture". Stubbs (1983: 7) stresses that "...culture is what everyone knows; and part of this knowledge is conversational competence."

One starting point is the following quotation from Stubbs (1983: 1), in which discourse analysis is defined as, (a) concerned with language use beyond the

boundaries of a sentence or utterance, (b) concerned with the interrelationship between language and society, and (c) as concerned with the interactive or dialogic properties of everyday communication.

Mills (1997: 119) also describes discourse analysis as "...a reaction to traditional linguistics which is focused on the constituent units and structure of the sentence; and which does not concern itself with an analysis of language in use".

It has been discussed in chapter two of this thesis that when two people from different cultural and linguistic background interact, the possibility of miscommunication is inevitable. The doctor–patient cultural and linguistic differences tend to influence the way they talk to each other and led to miscommunication. This is evident from the following recorded snippet, where the English-speaking young doctor communicates with a middle-aged patient who speaks limited English, in a medical encounter. The patient came for HIV testing and the doctor, after explaining the test results advised the patient on how to live healthily thereafter. This conversation was recorded at the Uitenhage clinic and follows verbatim:

Doc: You are fortunate that your test results are negative...

Pat: What do you mean by fortunate? Did you think that I was positive when I entered this room?

Doc: No, *tata*, I mean, these days you can count yourself lucky for....

Pat: I am not your father, I am as young as you are, call me Sandile.

Doc: Sandlie, I am sorry, I did not mean to imply that you are old, I was using a language of respect. Can we continue with our conversation?

Pat: (silent)

Doc: From now on, I suggest that you have one partner, use condoms when having sex, eat a balanced diet. You must come after three months for another test which will confirm today's results.

Pat: I hear, you, doctor, but I am not married yet, why should I stick to one partner? The condom thing is irrelevant, I am an African man.

Doc: Having one partner and being faithful to her, can limit chances of contracting this virus. Using condoms does not only protect you from contracting the Aids virus, but it protects you from other sexually transmitted diseases.

Pat: I have to go now, good bye, doctor!

Doc: Good bye, Sandile!

In the above interaction, cultural differences increase the chances of divergent understanding. Before the doctor finishes his speech, the patient steps in attributing indirect meaning to the doctor's speech, thus causing discourse miscommunication. Bonvillain (2003: 362) is also of the opinion that "...problems can arise when participants attribute direct or indirect meaning to each others's speech". In the above scenario, the doctor is trying to calm the patient for testing negative, knowing very well that testing itself leads to anxiety and stress,

because a person is not sure of what the results will be. The fact that the patient did not wait for the doctor to finish his speech resulted in the patient misinterpreting what the doctor was saying.

Again, the doctor lacks what Saville–Troike (1982: 23) in chapter two called communicative competence: "...knowledge and expectations of who may or may not speak in certain settings; ...who may speak to, how one may talk to persons of different statuses and roles...how to ask and how to give information...." It was disrespectful of the young doctor to ask and advise the patient on sex-related matters. The doctor further ignored the patient's silence; by being silent the patient was sending a certain message. Ting–Toomey (1999: 110-111) is of the opinion that silence can oftentimes say as much as words. She further argues that silence can serve various functions, depending on the type of relationship, the interactive situation, and the particular cultural beliefs held.

Another noticeable point in the above discourse also is the use of the word *tata*; or "father". To the doctor it was meant to show respect; and to the patient it was understood as ridicule. The patient was young to be called *tata*. It is evident from this encounter that education is much needed on HIV/Aids, culture and language-related matters.

Hoey (1983: 1) states that:

Conversation involves an interaction between two or more people in which each contributor may produce more than one utterance and each contribution is built upon the previous contributions either directly or indirectly.

Conversational analysis is an approach to the study of natural conversation, especially with a view to determine the participant's method of turn-taking, construction sequences of utterances, identifying and repairing problems, and employing gaze and movement. It attempts to describe the orderliness, structure, and sequential pattern of interaction, whether this is institutional or casual conversation. Turn-taking is one of the fundamental organizations of conversation. Repair is another aspect that describes how parties in conversation deal with problems in speaking, hearing, or understanding.

It is believed that when we act as a speaker or a listener in a conversation, we bring to bear large complex systems of norms for the exchange of conversational turns. Part of what we acquire as we are learning our language and culture is a sense of when it is right to speak, when should we be quiet, how much should we say, how we know if there is a problem in the conversation, and so forth.

Kaschula (1987: 57) in his study also believes that conversational analysis involves the study of the organization of language in terms of larger linguistic

units such as conversational exchanges or written texts and not merely the analysis of sentences or clauses.

This thesis is concerned with communication between people from different cultural and linguistic backgrounds. Conversational analysis forms an integral part of this topic. Communication will have to be based on how doctors and patients talk to one another in a clinical encounter.

Conversations are one of the central activities of social life, and that through them much social life is organized. Conversational analysis sets out to record patterns of conversation in order to detect underlying rules that enable communication to proceed in a largely orderly fashion.

In some cultures a person will begin to speak just before the other has finished, in others people speak in order of their rank, but in amaXhosa culture it is not strange for people to speak simultaneously. Most conversation consists of two or more participants taking turns, and only one participant speaking at a time. Smooth transitions from one speaker to the next seem to be valued. Transitions with a long silence between turns or with substantial overlap (i.e. both speakers trying to speak at the same time) are felt to be awkward.

When two people attempt to have a conversation and discover that there is no “flow”, or smooth rhythm to their transitions, much more is being communicated

than said. Within an extended turn, however, speakers still expect their conversational partners to indicate that they are listening. There are many different ways of doing this, including head nods, smiles, and other facial expressions and gestures, but the most common vocal indicators are called backchannel signals (uh – uh, yes, mmm,), in-between sentences, to show that you are listening and giving feedback that the message is being received (Yule 1996: 72–75).

4.3. ANALYSIS OF DOCTOR-PATIENT CONVERSATION

Turn-taking is another interesting concept of conversation. It guards the smooth flow of conversation between speakers. According to Stubbs (1983: 52) “...one of the basic facts of conversation is that the role of speaker and listener change, and this occurs with remarkably little overlapping speech and remarkably few silences.” The distribution of talking between participants is governed by turn-taking norms and conventions which determine who talks, for how long and when. A basic rule is that one person speaks at a time.

Sack, Schegloff and Jefferson (1974) in Bowe & Martin (2007: 61) observe three key features in the organization of turn-taking in conversation:

- one party talks at a time
- transitions are finely coordinated for speaker change
- utterances are constructed in such a way as to show coordination of turn transfer and speakership.

They identified adjacency pairs as a key feature of conversation and they also pointed out that most conversation is composed of pairs of utterances, with the prototypical example of being a question and answer sequence. There is a sense in which the question “requires” the answer as the second part of the adjacency pair.

Clark (1993: 196–197) further provides an excellent summary of some of the key principles of conversational analysis. He gives the following five properties of adjacency pairs identified by Sacks, Schegloff and Jefferson (1974):

- Adjacency pairs consist of two ordered utterances - the first pair part and the second pair part.
- The two parts are uttered by different speakers
- The two parts come in types that specify which part is to come first and which second.
- The form and content of the first part depends on the type of the first part.
- Given the first pair part is conditionally relevant - that is, relevant and expectable – as the next utterance.

This is illustrated in the following recorded conversation between a Cuban doctor and an isiXhosa-speaking patient in the Peddie HIV/Aids clinic. The purpose of the encounter was VCT (voluntary counseling and testing). In this conversation,

the doctor is a female and young and the patient is a middle-aged Xhosa male. The nurse is used to bridge the language gap.

1. **Doc:** Good morning, *mfana!*

Molo, mfana

2. **Pat:** Molo, gqirha!

Good morning, doctor!

The above snippet, confirms that a conversation does not simply begin and end, but it is structured into openings and endings. In this instance, the conversation is opened through the use of adjacency pairs such as a greeting-greeting. The first person to greet being the doctor, allowing the patient to feel at ease and talk further. The conversation continues with a question and answer pattern.

1. **Doc:** You look upset, what happened?

Ukhangeleka ucaphukile, kwenzeke ntoni?

2. **Pat:** Akukho nto ingalunganga.

There is nothing wrong.

The response of the other party usually indicates which direction the conversation will go. Here, the patient seems not interested in further talk, that is, discussing his personal problem with the doctor, hence his answer is straight, short and to the point. This normally occurs when there is uncertainty and lack of

trust between the speakers. Noticing that the patient is not in the best mood, the doctor continues with her business.

1. **Doc:** What can I do for you, today?

Ndingakwenzela notni namhlanje?

2. **Pat:** *Ndize kutesta le ntsholongwane.*

I have come for an HIV/Aids test.

It is clear from the patient's response that the reason why he does not want to engage in further talks with the doctor, is because of the uncertainty and anxiety of not knowing what to expect from his encounter with the doctor. The epidemic of HIV/AIDS presents unique challenges to the health professional in South Africa. The majority of health care encounters involve the presence of a third party who serve in the multiple roles of counselors, interpreters, and cultural brokers. These unique communication challenges have been largely unexplored; and little is known about this process, nor about how to identify and measure the important variables and minimize the barriers to effective health care. Evian (1993: 303) agrees that "Aids has created new challenges and problems for health care workers."

1. **Doc:** I will have to counsel you first, this is a procedure.

*Ndiza kukhe ndikunike ingcebiso kuqala ngale meko uze ngayo,
akukho nto imbi, yindlela esiqhuba ngayo.*

2. **Pat:** *Andinaxesha lininzi ke gqirha, ungabe unditesta kuqala ndakube ndize ukuza kukhanselwa.*

I don't have time, can you test me, then do counseling at a later stage.

The above conversation took the form of adjacency pairs of utterances with the prototypical example being, greetings, question and answers, and participants' turn-taking. Communication flowed smoothly except for the fact that the patient was not concerned with medical procedures – or with counseling before and after testing. The researcher interviewed the patient after that encounter to find out what made him not to do pre-counseling. The patient alluded to the fact that doctors are insensitive to the patients feelings, are not aware of how stressful and frustrating it is to listen to the lengthy speech of doctors; advising, counseling, saying all sorts of things before someone is told whether s/he is positive or negative. He further said that, pre-counseling is the most frightening experience to a patient; and he preferred that he be counseled after being given his test results. He also did not want to be counseled by a female doctor.

Van Dyk (1999: 248) is of the opinion that "...it is difficult for the health professionals to share positive HIV test results with their clients." Counselors have to work through their own feelings about the results before they counsel. The counselor should be sensitive to the individual needs and the cultural needs of each client.

It has been noted in the doctor–patient interaction that when the two do not speak the same language, there is less opportunity to develop a rapport or use ‘small talk’ to obtain a comprehensive patient history, learn relevant clinical information or increase emotional engagement in treatment. Rather than solving these problems, the introduction of an interpreter may raise another set of questions. When the third person is involved, the important information may be withheld by the patient, something which may result in doctors giving wrong medication thus leading to deterioration of the patient’s health.

The researcher found that patients who had difficulty speaking English are less likely than others to ask the nursing staff for things they need, unless it is truly urgent. When a male patient was asked about the reasons for that, after the encounter, it was discovered that the presence of the third person makes things more difficult than they usually are. The patient also pointed out that it is embarrassing to ask a person to interpret what the doctor says and what you are telling the doctor. It also becomes more difficult to ask further questions concerning yourself, through an interpreter. He cited that he sometimes feels responsible for being illiterate and unable to directly speak to the doctor; and that he is putting an unnecessary burden on the nurse, who has to do her job, which does not essentially involve interpreting for him.

People interact primarily through talk, most often in informal conversation. Conversation is structured, framed by openings and closings, and internally characterized by rules of turn-taking and turn allocation. Although these properties can be defined abstractly, analysis of ongoing talk demonstrates situational and interactional complexities that influence how the structure of conversation is actualized. Co-participants are expected to adhere to cultural norms or postulates of conversational behavior. Specifications and strength of these postulates vary across culture. They vary across speech events as well, depending on the relationships, rights, and purposes of interlocutors. Speakers need to take care in their selection of forms in order to make clear their intent and to avoid an affront to the addressee (Bonvillain 2003: 116 – 117).

Although speakers in intercultural communication typically choose a single language in which to communicate, individuals typically bring their own sociocultural expectations of language to the encounter. Speakers' expectations shape the intercultural interaction. This effectively means that speakers need to be aware of the inherent norms of their own speech practices, the ways in which norms may vary depending on situational factors and the ways in which speakers from other language backgrounds may have different expectations of language usage and behavior (Bowe & Martin 2007: 1-2). This is clearly illustrated in an interview between a white doctor with limited understanding of isiXhosa, and an isiXhosa-speaking patient. This discourse was also referred to in chapter three of

this thesis, but begs further analysis. The patient was visiting the doctor as his body was swollen. The following discourse was recorded:

Doc: Molo, tata!

Hello, father/old man!

Pat: Molo, qqirha!

Hello, doctor!

Doc: Mmmh! Tata sukela nini ukhulelwe kangaka?

Father, when did you get so pregnant?

Pat: (cwaka)

(Quiet)

Doc: Khawutsho tata, uqale nini kukhulelwa kangaka?

Ungamangaliswa izigulana zam zindibiza “Khohlelesingeni”
igqirha loqobo.

*Tell me, father, when did you get so pregnant? My patient's call me
Khohlelesingeni because of my extraordinary powers.*

Pat: Hayi bo! Andikhulelwanga gqirha, indoda ayizange ikhulelwe,
sisithuko eso.

*I am not pregnant doctor. A man can't be pregnant. You are swearing at
me.*

Doc: Ukhulelwe nasi isisu sakho sisikhulu kangaka.

You are pregnant. Look at your big stomach.

Pat: Gqirha uyandithuka, ngabafazi kuphela abakhulelwayo.

Doctor, you are swearing at me (offending me), only women can get pregnant.

In the above scenario, the doctor tried to impress the patient by speaking his language i.e. isiXhosa. To the doctor's surprise the patient felt humiliated and embarrassed by being made a woman. At the beginning of the conversation, an adjacency pair of utterances was followed, where the doctor and the patient greeted each other. As Gudykunst (1991: 38) puts it in chapter two of this thesis that "...the ritual of greeting others reduces the vast amount of uncertainty and anxiety present in initial interaction to manageable portions and allows us to interact with others in a coordinated fashion. The doctor, after greeting the patient, did not ask what was wrong with the patient, but simply jumped to the conclusion that he was "pregnant". In this instance he would have wanted to mean "bloated" but instead made use of the wrong word which was interpreted as offensive by the patient.

In regard to leave-taking, Kramsch (1981: 4) had observed that:

...people from different cultures have different ways of breaking contact with each other. In small close-knit societies in which continuing relations among individuals are taken for granted, people may not need an elaborate form of leave-taking.

The researcher has observed miscommunication in a doctor–patient encounter which resulted in the patient leaving the consulting room in anger. In the above encounter, the doctor did not for example necessarily mean that the patient was pregnant. Also what the researcher gathered from the doctor was that, by not asking the patient what was wrong with him; and by associating himself with the well–respected Xhosa traditional healer, the doctor wanted to gain the trust of the patient. The intentions were good, and in line with Dodd’s (1998: 6–10) opinion in chapter two of this thesis that there must be a positive feeling toward the other person or group (affective level), such as trust, comfort, safety, affirmation or lowered anxiety. He further argues that without this feeling, a person is less likely to communicate well with another who is different. In this instance what was expected to create comfort, trust and affirmation actually had the opposite effect.

It is of great importance, according to Bonvillain (2003: 274) that speakers must learn to be sensitive to the feelings of addressees, to be aware of how their statements may affect others and so on. Listeners also, have a responsibility in negotiating harmony. They must learn to interpret speaker’s underlying intentions and opinions from inexplicit surface statements.

In a health-care environment, cultural differences take on greater significance. Proficiency in English may not always be enough to remove any cultural barriers between doctors and patients. Bonvillain (2003: 386) states that analyses of transcripts of medical interviews reveal several important recurrent themes.

Firstly, doctors direct the encounter through use of questioning, establishing relevant topics and their development. Secondly, their reactions to patient contributions validate responses and thereby reassert control. Thirdly, they dismiss, by ignoring or redirecting, patients' talk if it is not consistent with the scientific medical model upheld by the doctor. Finally, by controlling and interpreting information dispensed to patients, doctors influence decisions that patients ostensibly have a right to make for themselves.

In the following interview from the beginning the doctor directs and limits patients' responses. He uses chaining to maintain control and interrupts the patients' responses. For example, when the patient discusses fever, the doctor interrupts to ask about the assumptions. He uses back channeling which limits the patients' contribution. The language used was English and the patient had limited understanding of it.

Doc: Good morning!

Pat: Good morning, doctor!

Doc: What's the problem today?

Pat: Since last week, I have sore throat.

Doc: Hm, hm!

Pat: Whenever I drink something cold...uuh and then a cough.

Doc: A cold, you mean what? Stuffy nose?

Pat: Uh, stuffy nose, yes not a chest cold...

Doc: Hm, hm!

Pat: Uhm!

Doc: And a cough.

Pat: And a cough...which is the most interesting aspect.

Doc: Ok. U – Any fever?

Pat: Not that I know of. I look it a couple of times.

Doc: Hm, how about your ear?

Pat: Uhm...

Doc: Do you have any pressure around your eyes?

Pat: No!

Doc: Ok. How do you feel?

Pat: Uh...tired. I couldn't sleep last night. Uhm...

Doc: Because of the cough?

The above interaction is more of a question and answer form of communication. The patient is not given time to express herself, the doctor predicts what the patient will be saying and uses back channeling thus limiting chances for the patient to express her feelings. The researcher has noticed that the doctor is dominating in this conversation; the patient is led to what the doctor wants her to say regarding her sickness. The patient is not given enough time to narrate her story, thus leaving her with no choice but to sometimes agree on what the doctor is saying. In instances like these, doctors may end up giving wrong medication based on what they think the patient is suffering from.

Davidson (2000: 163) agrees by characterizing medical interviews as a "...type of verbal and physical investigation." He further contends that:

A matching of unorganized experiences against familiar patterns and processes of human vulnerability to disease. The overt elaborated goals of the medical interview are: (1) from the data provided, determine what, if anything, is wrong with the patient; (2) Elaborate a plan of treatment for the ailment; and (3) Convince the patient of the validity of diagnosis so that treatment can be followed...Since the diagnosis and subsequent decision – making regarding treatment rely so heavily on input from the patient, any difficulties in information gathering may undermine the process significantly.

Take also the following example of a forty-year-old isiXhosa-speaking patient complaining of nausea, vomiting, abdominal pain and an inability to sleep, who came to the extended emergency room at the Peddie clinic. As I was listening to his conversation with the doctor, I believed that he patient was associating his illness with witchcraft. He believed that he was bewitched. According to his long narration, his illness had begun after a dispute with an older neighbour, a woman felt to be a witch by the community. Some members of his family concurred with his beliefs. The negotiation regarding therapy involved a number of issues. Firstly, the patient was offered a referral to a healer. He accepted, acting on the

advice of family members and being aware that the *sangoma* had successfully treated one of his relatives for a similar illness. Secondly, it was essential to separate his active biomedical problems from the psychological issues.

It was agreed that the therapy was aiming at the witchcraft problems and that he would continue to use his ARVs and other medication on a regular basis. The patient was treated with a combination of hypnosis and suggestions. Dodd (1998: 51) is also of the opinion that a person who believes in witchcraft and spirits needs to be evaluated in light of the entire culture's beliefs. He further contends that "...by western psychological standards, a person having a vision may seem mentally unstable, but by certain traditional African standards, the person would be normal". It has also been mentioned in chapter two of this thesis that to be able to heal the physical aspect of a patient believing in witchcraft, it is important to heal his/her psychological aspect first.

Lack of cultural understanding and sensitivity by doctors also contribute to problems of communication, establishment of trust and satisfaction. Trust is associated with listening, information provided, time spent and participation in decision-making. Doctors, who show comforting and caring behavior, encourage questions and provide answers are associated with trust. This is particularly evident in the Laettitia Bam clinic, where patients share the same linguistic and cultural background. Trust resulted as part of this communicative process and patients generally communicated well and cooperated with the doctor.

The researcher has also noticed, in her observation and interaction with doctors and patients in Peddie, that many infected people remain fully unaware that they are HIV-positive, since testing systems are far from being available everywhere.

But when detected through HIV testing, the societal and cultural short and long term effects of the infection are generally disastrous for the infected person. The effects can be felt in relation to his/her human environment, for example, family or peer-group. It is frequently a motive for rejection of the infected and even a motive for moving the sick person from their work, pushing them at the same time into the disease as a result of socio-economic collapse, as well as moral and cultural distress. They may be pushed away from their family or village. This is especially true for women. Once patients are deprived of emotional support, healing is delayed and conditions are created for the disease to thrive as the patient's state of mind is affected and depression can set in.

From the researcher's point of view, this might be the reason why the infected person, in many occasions feels so depressed and ashamed of their situation that she/he will not dare to inform his or her sexual partner, even if they are spouses. In other cases, s/he will not pay any attention to being infected because of his/her generally disastrous situation or due to a lack of concern regarding an occasional sexual partner.

In an encounter with a patient who speaks limited English, miscommunication was again observed at the Peddie clinic. The patient's reluctance to get an interpreter led to the wrong medication being given and to the deterioration of the health condition. In this instance the HIV-positive patient who was suffering from diarrhea and vomiting was given medication and instructions on how to take it. When she visited the doctor sooner than expected, the doctor asked: 'How often do you take your medication?' The patient responded: 'After each meal.' When the patient was asked how many meals she took in a day, she replied: 'Anytime, when I feel hungry.' From this conversation, it becomes clear that medication is not taken according to the doctor's orders; hence the patient's condition did not improve. The doctor is then forced to request for a third party intervention in the form of the interpreter, to assist where there is a language gap.

Also in one recorded instance, an isiXhosa-speaking patient at the Peddie clinic was complaining of vomiting and running tummy. The doctor did not understand isiXhosa and an assistant nurse was brought to assist in decoding the message to and from the doctor. As I was listening to the conversation, I discovered that the nurse was not decoding exactly what the patient was saying. For example, the doctor asked, "How long have you been suffering from gastro?" The patient cited a long period saying 'kudala ndigula yile nto ndiqonde ukuba mandize namhlanje', the nurse told the doctor '*it's a long sickness, but it starts today*'. The doctor gave the patient medication which she was to take immediately and after each 'stool'. In the process of decoding the message to the patient, the nurse did

not understand the meaning of stool; instead of seeking clarity from the doctor, she misinterpreted the message saying, 'usela ngoku iyeza, uphinde emva kokuhlala esitulweni usele. Uyakwenza njalo ke rhoqo' *Take the medicine now and again after sitting down. You will do this all the time.*

The researcher was concerned about the doctor–patient communication when they do not understand each other's language. I have noticed with disappointment, how communication seems to flow, but in the wrong direction. The doctor depends on what the nurse is saying to be able to assist the patient. He also gives medication in terms of what he believes the patient is complaining about, not knowing that there may be miscommunication. On the other side, the patient relies on the nurse; trusts that the nurse is representing her. What she is told by the nurse is what she thinks the doctor is saying. The researcher was tempted on many occasions of her research to step in and help, but that was not possible.

What follows is another illustration of a recorded conversation where the patient was complaining about stomach and back pains. In this conversation the doctor and the patient are of the same age. The patient had a limited understanding of English, which was the language used in that encounter. The doctor wanted to bring the nurse in as an interpreter but the patient refused.

Doc: What can I do for you?

Pat: I feel pain all over my body.

Doc: Take off your clothes and lie on your back for examination.

Pat: (taking off the clothes).

Doc: Where does it hurt most? Here? (Pointing below the chest)

Pat: (nods the head).

Doc: Are you smoking or drinking?

Pat: I don't feel pain when I am smoking; I have been drinking since childhood and I never felt any pain. What has my drinking to do with these pains?

Doc: (avoiding further discussion) I think you have an ulcer; I have to refer you for camera swallowing.

Pat: What? Are you joking? No, I am not going there.

Doc: Why not? It is going to give us indications on the nature of your sickness.

Pat: (shaking the head).

Doc: (laughing) It is not a literal swallowing of the camera. It is a procedure done to check inside one's stomach using some scopes. In the meantime, you will be using these capsules for three days, if the pain does not disappear, then we will consider camera swallowing.

Pat: Thank you, doctor.

Doc: Bye!

Pat: Bye!

In this encounter the patient did not understand the medical jargon used by the doctor and that resulted in misunderstanding and confusion. Also, the fact that

the doctor mentioned his smoking and drinking as the possible cause of his sickness did not make sense to the patient. The researcher noticed that the patient nodded her head but did not understand exactly what was said. The response should be by pointing the direction of the pain if one does not want to speak.

It is understandable that doctors, due to long queues and shortage of personnel, work under a lot of pressure. At times they become so exhausted that they do not do justice to their patients, who have waited in long queues for many hours. They sometimes show this attitude when examining patients. Some doctors ask what is wrong with the patient, examine and tell the patient what to do. It has to be noted that isiXhosa-speaking patients come from a culture where, the doctor (igqirha) does not ask but tell the patient what is wrong. The tendency of examining a patient based on what he or she is saying, contributes to mistrust of the non-Xhosa doctor.

Another interesting scenario in my observation was one when a group of four isiXhosa-speaking men visited a doctor. When they were asked who was sick, they responded by saying she was at home, they brought the patient's vest and a bottle of urine. That was very strange to the European doctor, to leave the sick person behind and ask for medication on her behalf. The urine was tested and the group was told to bring the patient for an injection because the urine test revealed that the patient had an infection.

According to the researcher, when analysing the situation, the group consultation stems from an *inyanga* consultation and the fact that one's sickness may be a family sickness. They come to listen to the *indaba* for and with the patient. What the doctor says is a concern of the group. It has been noticed that the group consultation is one of the aspects of amaXhosa culture that doctors have to use where confidentiality is not of utmost importance. People feel more comfortable to speak out in a group, whereas in a doctor–patient situation they are inclined to be intimidated. This type of consultation is important for chronic diseases such as Diabetes, TB, Cancer, etc., where family support is needed for survival.

4.4 CONCLUSION

In conclusion, the above testimonies or incidences and conversational analysis confirm that when problems surface because a doctor and a patient are out of step, the result is costly for everyone involved. The following reflects some of the negative fallout when mutual communication is not a priority:

- Patient non–compliance

- Repeat visits due to non-compliance, thus frustrating for the doctor and the patient.
- Loss of confidence in the doctor - frustration on the part of the doctor, patient, the patient's family, the employer, etc.
- Additional medical complications.
- Patient complaints of inadequate care.

Medical errors are problems that can exist at any stage in today's complex health-care system.

- Prescribing the wrong medication due to not having complete patient information. For example, not knowing about the patient's history, their allergies or medicines they are taking.
- Patients receiving the wrong medication due to miscommunication between a doctor and a pharmacist most often as a result of a poor handwriting, confusion between drugs with similar names, dosing mistakes and inappropriate abbreviation.
- Errors in diagnosis, such as, misinterpretation of test results, not using the right diagnostic tool.
- Infections, due to inefficient hand writing.
- Mistakes in following medical orders.

It may therefore be concluded that there is an urgent need for English and other non-Xhosa speaking doctors to be trained in the local indigenous language and culture of the communities they are going to serve as well as interpreters to do the job rather than leaving it to the untrained receptionist or nurses. Also, there is a need to train interpreters specifically for the health fraternity to do the job rather than leaving it to the untrained receptionists or nurses.

The following chapter will be focusing on the summary of findings regarding this research. Certain recommendations will also be made.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. INTRODUCTION

We have seen that linguistics and cultural barriers between doctors and patients pose problems, especially in South Africa which has eleven official languages. Due to the lack of trained health interpreters to bridge the language gaps in these situations, English and non-Xhosa speaking doctors, therefore, have no choice but to use nurses or receptionists to rephrase what they say, in a way that is understandable to the patients' mother-tongue language.

It has also been noted that using the third person's services does not guarantee that the message will reach its destination undistorted. This intervention strategy has its own challenges in any kind of communication, especially in HIV/AIDS related clinical encounters, where confidentiality is highly sought after. The involvement of the third person in a clinical encounter, not only violates confidentiality, but it jeopardizes the relationship between the doctor and the patient.

Different scholars' views were explored in chapter two of this thesis regarding intercultural communication and how it affects the doctor – patient relationship, when the two come from different cultural and linguistic backgrounds. Scholars agree that when people come from different cultural and linguistic backgrounds, possibilities of miscommunication are inevitable. Some scholars such as Helman (1990: 86) contend that doctors and their patients, even if they come from the same cultural background, view ill – health in very different ways.

This has been proven to be true in instances where the isiXhosa-speaking doctor is unable to convince the patient that HIV/AIDS has nothing to do with being

bewitched. In a matter of health and medical issues, isiXhosa-speaking patients would rely on traditional medicine and traditional healers which some of the authorities see as possible intermediaries for shaping and conveying health messages to rural populations and underprivileged urban areas.

Gudykunst (1991: 2) in chapter two contends that language and culture are inseparable. It has also been noted that knowing one's language is not a guarantee that we know their culture. We have learnt that communicating with people who are different from us, is more like communicating with strangers. Strangers in this case refer to doctors and patients from different linguistic and cultural backgrounds. In HIV/Aids clinics, where the patients are anxious of what to expect, for example, if they come for an HIV/Aids test, the fact that they have to deal with language barriers adds to the stress they already experience.

It was discussed in this thesis that such encounters with people who are different from us causes uncertainty and anxiety. If therefore, patients experienced anxiety and uncertainty, little is achieved in such an encounter. Thus they have to deal with these challenges, and feel comfortable for communication to be effective. It has also been noted that both patients and doctors bring their attitudes and stereotypes to their encounter, something which makes communication difficult at best. Yet, the function of communication is to understand each other and to be understood.

In a scenario where doctors and patients come from different cultures and speak different languages, Dodd (1998) in chapter two introduced the adaptive model of communication which calls for participants to suspend their judgment and bias while they engage in the third culture created by the intercultural participants to explore mutual goals and common concerns. For example, instead of saying, 'this is the way things are done in my culture', one has to start learning and accepting the way things are done in another culture.

In other interviews conducted during the process of research, some patients displayed negative attitudes to the doctors who do not understand their language and culture. For example, in the scenario where the doctor was trying to show some understanding of the isiXhosa language in order to be respected, trusted and appreciated by the patient, to his surprise the communication process was derailed due to the use of a word that the doctor and the patient interpreted differently, resulting in miscommunication. "Good morning, *mfana*". It is understood that the doctor is trying to win the trust of his isiXhosa-speaking patient by using the Xhosa word '*mfana*' which, according to his limited knowledge of isiXhosa, refers to males. It was unfortunate for him that the word was used at a wrong time to refer to a wrong person. The doctor was trying to practice what Dodd calls the adaptive model of communication.

The patient may be seen as behaving inappropriately by being angry with the doctor who is trying to accommodate him, and who is trying to familiarize himself with the language spoken by his patients. It has also been highlighted in this thesis that lack of communicative competence results in misunderstanding. As much as the doctor might have been trying to win trust or make his patient feel at ease by speaking the patient's language, the fact that he was not a competent speaker of that language put him in a disadvantageous situation.

On the one hand, if the doctor was competent in the isiXhosa language, he would know what to say, to whom and how to say it. On the other hand, the patient might have been behaving like that because of what Gudykunst (1991: 12 -14) believes is uncertainty and anxiety resulting from inability to predict and explain the degree to which one can predict a stranger's attitudes, beliefs, values and behaviors. Dodd (1998: 6 -10) further states "...without accurate understanding, a person is less likely to communicate well with another who is different".

Another interesting point mentioned by Steyn & Motshabi (1996: 13) is that knowledge of a person's language, traditions, customs, values, and beliefs may

help a lot, but if an individual is not sensitive and perceptive to the needs, motivation and intent of his or her communication partner, the total communication effort may be in vain. We have seen that when the doctor told the patient to take off the “rope” from their neck. The doctor showed insensitivity to the patient’s belief. He further made things worse by saying “...don’t you see that this rash is caused by an allergy to this animal’s hair?” The doctor did not even notice the body language of the patient and the message contained therein, nor did he understand the meaning of the patient’s silence. I have noticed that patients come to these clinics uneasy and tense; anything that may be done or said by the doctor is reason enough for them to leave the clinic.

It has been discussed in chapter two of this thesis that communication patterns are related to the function categories of talk, and attitudes and conceptions about language and speakers. Saville–Troike (1982: 14) also mentions that communication patterns itself according to particular roles and groups within the society, such as, sex, age, social status, and occupation. She further says that ways of speaking also pattern according to educational level, rural or urban residence, geographical region and other features of social organization.

The isiXhosa-speaking patients have that understanding, hence one patient demanded that the doctor show some respect when talking to an elderly person like him. For a young doctor to ask middle-aged patient about the number of his sexual partners, was showing lack of understanding of patterns of communication with regards to age. Also the fact that the doctor was a female spoke volumes to the isiXhosa-speaking patient because Xhosa women know how to address men in their culture.

Doctors sometimes joke with things that their patients regard as important and valuable culturally. To ask a male patient the question: “sukela nini ukhulelwe, tata?” *‘Father, how long have you been pregnant?’* is not only insensitive but insulting to the patients, even if the doctor uses this term intending a totally

different meaning. This is further illustrated by the way the patient reacted after being asked how long he was pregnant. It is against this background that the behavior of the patient is understandable.

5.2. FINDINGS

Cultural understanding between doctors and patients will improve adherence, patient care, and clinical outcomes. Cultural competency refers to possessing knowledge, awareness, and respect for other cultures. Doctors must respectfully elicit needed information from patients from various cultures to make accurate diagnoses and negotiate acceptable treatment goals. The conviction that one's culture is superior, has been discovered as hindering effective intercultural communication.

It is also important to distinguish between stereotyping (the mistaken assumption that everyone in a given culture is alike) and generalizations (awareness of cultural norms). Generalizations can serve as a starting point and do not rule out factoring in individual characteristics such as education, nationality, faith, and acculturation. Every patient is unique, and must be treated in that fashion.

Regarding patient's views of disease causation, it has been learned that a person's worldview, that is, basic assumption about reality, is closely linked with his or her cultural and religious background and has profound health-care implications. For example, persons with chronic diseases who believe in predetermined fate often do not adhere to treatment, because they believe that medical intervention cannot affect their outcomes. Some see illness as having not only physical but also spiritual causes, for example, being HIV positive is seen as a curse for premarital sex which is against God's commandment. Doctors should respectfully explore a patient's beliefs within the context of the patient's religion and culture.

A worldview is internally consistent and serves as a source of comfort to most patients. Many patients have confessed that they use home remedies or visit traditional healers before seeking conventional medical treatment or use both treatments at the same time. Patients often lose confidence in their doctors because they did not receive prompt, culturally comprehensible diagnosis. I therefore, believe that clinical success depends on communicating with these healers and prioritizing tests and ailments.

It has been discovered that intercultural interviews requires time and patience. The researcher spent more time than she planned. Interviews also require patience because doctors are sometimes working under pressure due to shortage of doctors, and they become overworked and do not avail themselves even though an appointment was made. Patients take their time in responding to the questions asked. They do not normally want to be interviewed, fearing that something may come up after disclosing some information; and they are made responsible. The researcher has spent time trying to befriend patients before she was able to access the required information.

First, 'small talk' has to be used to established trust between doctors and patients. Doctors should try by all means to use a patient's formal name if they are unsure of the appropriate way to address the patient. This is of great importance judging from the case where the doctor used the word '*mfana*' to greet the mature man. If the doctor was aware of the end results, he would have used the name written in the patient's file.

We have learnt in this thesis that patients sometimes avoid eye contact with doctors out of respect, especially if they are of a different gender or social status. In Xhosa culture, it is not allowed to be touched by someone of the opposite sex. In these instances the researcher finds that it would be best to have the same – sex doctor to examine the patient. If this is impossible, it would be wise for the

doctor to explain what s/he will be doing, and why it will be necessary to touch the patient in the process of examination.

Language barriers were found to create misunderstandings in a doctor – patient encounter where the parties do not share the same language and cultural background. Doctors, in cases where the patient has a limited understanding of the language in use (e.g. English) should use body language and speak slowly and directly to the patient, rather than using the expertise of the interpreter; use short sentences and a normal tone of voice. Idioms, a loud tone of voice, and medical jargon should be avoided. Patients may say they understand something or nod in agreement even if they do not understand. Embarrassment or respect sometimes prevents patients from asking necessary questions.

It was learned that effective communication is necessary for the provision of good quality health-care as it enables a helpful process in being able to meet the service user's need. However, due to language and cultural differences, many service users do not receive health services on a par with their English-speaking compatriots.

Language differences can be excluding in terms of service users not being able to communicate needs, not being understood, and not being made to feel empowered in determining the types of services that are provided.

Non – English speaking doctors using patients' friends and family as interpreters should also be avoided. Wrong information dissemination can be witnessed because of poor interpretation skills by family members and there would be potential for embarrassing the patient by revealing his or her personal information (HIV/Aids status) in front of the family members and friends. Interpreters not only bridge the language gap but they also assist in explaining the cultural differences. Although family members or friends are the most convenient interpreters, this practice breaches confidentiality and makes it impossible to assess sensitive

issues such as sexuality and domestic violence. Experienced and qualified interpreters are needed whenever possible to facilitate and process communication that is mutually beneficial to the service user and the service provider. Each person is likely to experience a sense of having been understood when the process of interpreting has taken place in a constructive manner. Sometimes communication may suffer an apparently minor breakdown because of an unknown word.

Data from the interviews reveals that knowing about HIV/AIDS is not a problem, but in the Xhosa culture, gender roles play a vital role. Women have no power when it comes to sexual decision matters. And men do not believe in using condoms. They say they develop a rash around the male organs when they use condoms. One elderly woman in the Peddie clinic when asked if her husband uses a condom, emphasized this point: "In our culture, in marriage two people become one in sickness and in health, this means that if the other person is sick, you are also sick". She further said, "I listened to people, in particular western doctors who do not understand our culture, and ask my marriage partner to use a condom. I must be sick in the head to do that".

It is not only the elderly rural people who shared this idea, a highly educated friend of the researcher, whom I cannot mention for confidentiality reasons, shared the following shocking information, when we were casually discussing the spread of this virus irrespective of the exposure to the information on HIV/AIDS.

"I love my man too much, AIDS and all. We do not use condoms when practicing sex. Even if I am infected that will make no difference. Research done thus far has shown that with a healthy lifestyle, it is possible to lead a long and productive life. ARVs are accessible and have proven to have been delaying the death process. I am eventually going to die, anyway. The only favor you (me) can do is to make sure that you give me the support I will need when I am on my death bed".

If a highly educated person, who is well-informed about the risks of having sex without a condom, can be that careless; it really shows that it is not about lack of knowledge at times, but people being careless risk-takers. I was made to believe that the spread of HIV/AIDS is not only about not having information or taking precautions, but about the hope-giving messages during counseling, the accessibility of ARVs and other boosters, may contribute to this rapid spread of the virus among professionals. This should be the subject of further research and it does not form part of the approach to this thesis.

Gudykunst (1983: 2) argues that language and culture are not the only factors that can contribute to misunderstandings in an intercultural encounter, our attitudes and stereotypes create expectations that often lead us to misinterpret messages we receive from people who are different and they misinterpret the messages they receive from us. Culture influences how we adapt and learn language, habits, customs, expectations and roles. Thus culture and language are inseparable.

When the patient and the doctor do not speak the same language, there is less opportunities to develop rapport or use “small talk” to obtain a comprehensive patient history, learn relevant clinical information or increase emotional engagement in treatment. Rather than solving these problems, the introduction of an interpreter further raises another set of questions. Unfortunately, most interpreters learn their trade through on – the – job training.

Reasons for poor health associated with culture relates to:

- Lack of financial recourses causes people to wait too long before calling a health practitioner.
- Traditional remedies may be used because modern medicines are too expensive or because it is seen as ineffective.

- Little trust in health subsystem or health doctors.

HIV/AIDS does not carry with it any positive connotation, it runs from mistrust to criticism; from ostracism to discrimination; from rejection to desertion; and from stigmatization to spoliation. Hostile attitudes towards AIDS sufferers, reinforced by the negative associations of the disease, seem to be a cultural invariant.

Discrimination is also regarded as a public health issue in that, it is an obstacle to the provision of information on the risks of transmission, which should be as broadly based as possible to boost prevention; it inhibits personalization of the risk of HIV for fear of generating mistrust or criticism, which reduces chances of negotiating and preventing measures.

Discrimination makes infected individuals deny that they have the disease and makes them less likely to seek treatment; it causes the specific needs of the infected person to be neglected and encourages inaction by public health institutions and a lack of commitment on the part of the doctors. Discrimination increases vulnerability of individuals and their families and indirectly increases vulnerability to the risk of HIV.

During the course of my interviews, a shocking scene was observed at Laetticia Bam clinic in Uitenhage, and it needs urgent attention if we really want to decrease the rapid spread of this pandemic.

In the above –mentioned clinic, HIV positive people are treated separately, they have their own consulting room outside the clinic. It is a prefab structure far from the clinic itself. I observed a form of discrimination between HIV positive and other patients. That kind of discrimination has a potential of increasing the number of infected people.

People may be reluctant to come for testing, and treatment if diagnosed HIV positive, and to disclose their status; because the mere sight of a person in that room means s/he is positive. Stigmatization is enforced by having separate rooms for positive people. Also confidentiality is violated because the minute a person gets into that room everybody knows that his/her sickness is HIV/AIDS related. I was, therefore, forced to ask the sister in charge the reasons behind that situation. I was told that the clinic does not discriminate between its patients; the only reason that they are put in separate consulting rooms, was because they did not have enough space inside; and that some patients are too weak to stand in the long queues for long hours.

Based on the above scenario, stigmatization, discrimination and confidentiality are matters which command urgent attention in some HIV Clinics. Even in other clinics where they are treated in the same clinic building, confidentiality is still a problem. Everybody knows that a certain consultation room in a clinic is for HIV positive people, though they are waiting in the same room, sitting in the same chair, that person knows that he is not supposed to go to a particular room.

The explanation I received was the same; they need not wait for a long time due to their lack of stamina. I was also told that they have different rooms for patients suffering from hypertension as well, it was not about Aids. I feel that something has to be done to protect the Aids patient from such situations.

Another important feature I discover in Xhosa culture, is that it rests in strong beliefs in natural forces, in a matter of health and medical issues, Xhosa people rely on traditional healers which some of the authorities see as possible intermediaries for shaping and conveying the health message to rural populations and underprivileged urban areas. Moreover, the influence of the chief and the elders can be used to advise the younger generation against sexual carelessness.

5.3. RECOMMENDATIONS

The growing awareness of cultural issues and their relation to both individual outcome and population - based health disparities, however, is likely to motivate providers to acquire new tools to enhance the quality of care, such as different approaches to communicating with parents or greater appreciation of the role of traditional medicine.

Individuals, both patients and family members and their view on HIV/AIDS may be powerfully affected by the culture, ethnicity, upbringing, religion and spirituality. Health-care providers need to openly acknowledge and address cultural issues with their patients. Learning about differences between groups can be a helpful guide, but knowing also about a particular preference in a community does not mean that every member of the community will feel that way. Cultural competency takes time and requires effort to ask the right questions and then listen and learn from what patients tell us.

Based on the findings, there is a need for:

- Bridging the cultural gap or differences in HIV/Aids clinics at all costs.
- Assessment of patients' attitudes about discussing their care.
- Preparation, for example, building trust with patient and family, make clear that you care about them as individuals and that you want what is best for them; Involve traditional healers if that would be helpful; communicate in a caring way. That is referring to the third party when talking about risks, rather than saying:

“If you fail to take medication on time and as prescribed, your health condition will deteriorate” or “if you live like this...you will die or there is a 20% chance that you will die”.

Instead doctors should be portraying the following: “It is very important that people take their medication correctly and regularly to improve their health conditions” or “Among people who have HIV/Aids, and who take care of their lifestyle, 80% of them live longer”.

Following through and fostering hope is an important part of communication. To build trust, doctors should talk about issues of trust directly with the patients and families, for example, some people find it hard to trust a doctor who is not from their culture.

The researcher, therefore, saw it fit to recommend the following strategies:

- Shifting control strategy to support patients to take greater control over their health-care, thus increasing opportunities for patients and families to participate in service planning and management;
- increasing patient control over interaction , for example, the topic, the participants, the time and place;
- identify and respond to the priorities of patients and their families; provide access to meaningful information in the patient’s preferred language utilizing effective communication strategies;
- Create opportunities for staff and indigenous patients/ interpreters/ health workers to work together to develop a shared understanding about their perspectives and practices.
- Provide appropriate and confidential health-care facilities which do not discriminate against HIV sufferers, for example as is the case in the Uitenhage clinic.

5.4. CONCLUDING REMARKS

The researcher has managed to identify some of the intervention strategies used by doctors who are non–Xhosa speakers when communicating with isiXhosa

mother–tongue speaking patients. Some use pocket dictionaries to interpret some English words into isiXhosa. This strategy has been found inadequate, because isiXhosa words have multiple meanings, depending on the situation in which they are used. Instead of solving language barriers, the words may create misunderstanding.

Another strategy is using interpreters (nurses, receptionists, family members) to decode the message from the patient to the doctor and vice versa. As much as this strategy may assist in the doctor–patient encounter, it has been noted that this strategy is not 100% perfect. The following were identified as flaws:

- Nurses or receptionists are not trained as professional interpreters, communication may suffer minor breakdown because of the unknown word. This may lead to wrong diagnosis, incorrect medication and deterioration in the patient’s health condition.
- Interpreters may interpret using their own cultural background thus derailing the information.
- Patient may withhold information which may be of great importance to the doctor, such as history of the illness, medication the patient is currently taking, etc, because of the third party.
- Confidentiality may be violated due to the presence of the third person and embarrassment of the patient when s/he has to talk about sex related issues in front of the third person.

It has been discovered that cultural differences affect the doctor–patient relationship to such an extent that if it is not explored, miscommunication does occur. Culture plays an important role in advising on ill–health. It tells us what to say, to whom and how to say it. It was highlighted in this thesis that both doctors and patients should be accommodative of each other’s culture and be sensitive thereof to be able to communicate effectively.

The isiXhosa-speaking doctor was used as an example of effective communication, and someone who can assist non-Xhosa speaking doctors in dealing with isiXhosa speaking patients. It was discovered that doctors, even if they come from different cultural and linguistic backgrounds, view ill-health differently. They may not attach the same meaning to the same word. The isiXhosa-speaking doctor understands and respects the patient's culture; she even acknowledges them seeing traditional healers and drinking traditional medicine, something which makes the patients to trust her.

It is against this background that the researcher proposes or recommends the integration of indigenous languages and culture learning as a key component in the training of health practitioners such as doctors, pharmacists, psychologist, etc. She also recommends the training of Indigenous language speakers as interpreters, or perhaps what one could term "language facilitators", specifically on health related matters, to bridge the language and cultural gaps between Western doctors and indigenous language speaking patients. The researcher believes that with doctors who are familiar with indigenous languages and cultures of their patients; and with trained health interpreters/language facilitators fully employed by the Department of Health, communication effectiveness will be the end result. The researcher also believes that wrong diagnosis, incorrect medication, and information withholding would be less, and people's health conditions will improve.

APPENDIX 1

SURVEY USED FOR PATIENTS

Adapted from the model produced by J.D. Brown

Survey: Patient Intercultural Communication

We are inviting you to be a respondent and assist in the study: “Intercultural Health Communication between non–Xhosa speaking doctors and isiXhosa-mother–tongue speaking patients”.

Professor Russell Kaschula from the School of Languages (African Language Studies) at Rhodes University is in charge of this study. You can contact him at this number 0466038952 / 0466038222 or you can contact Veliswa Mandla at 041 9771745.

Your participation in this study is voluntary. You can stop at any point if you become uncomfortable answering any of the questions. I want to emphasize that we will maintain your confidentiality, but if you want your name to be mentioned, we will also appreciate that.

Demographic Information:

Please select one answer for the following questions:

Sex: Male Female

Ethnicity:

Yearly Income: R_____

Number of visits to this clinic: _____

Number of children: _____

Marital Status: Single Married Separated Divorced Widowed

Does your culture affect the way you communicate with the doctor?

Not at all 1 2 3 4 5 6 7 Definitely

If yes, how strong does your culture affect the way you communicate with the doctor?

Somewhat strongly 1 2 3 4 5 6 7 Very strongly

If no, which other identity characteristics affect the way you speak with the doctor (language, religion, beliefs, etc)?

How would you rate your health status?

Very ill 1 2 3 4 5 6 7 Very Healthy

Education level: Less than high school some high school high school graduate

Please answer the following questions according to the scale listed below.

1=Strongly Agree; 2=Agree; 3=Neutral/Not sure; 4=Disagree; 5=Strongly Disagree

Section 1: Cultural Sensitivity

___1: I tend to know a lot more about the doctor's culture.

___2: I tend to adapt my level of satisfaction with treatment according to a doctor's culture.

___3: I normally consider the doctor's culture when listening to his recommendations.

Section 2: Effective Intercultural Communication

___4: I usually understand the feelings of the doctor who comes from a culture that is different from mine.

___5: I tend to communicate well with doctors from other cultures.

___6: I tend to easily resolve misunderstanding with doctors from other cultures.

___7: I normally understand the point of view of doctors from other cultures.

___8: I tend to empathize with doctor from other cultures.

___9 I can usually interpret the nonverbal language of doctors from other cultures.

Section 3: Anxiety

___10: I tend to seek opportunities to interact with doctors from other cultures.

___11: I normally feel relaxed when interacting with doctors from other cultures.

___12: I usually feel nervous when interacting with doctors fro other cultures.

___13: I intend to feel self confident when interacting with doctors from other

cultures.

___14: I usually feel anxious when interacting with doctors from other cultures.

___15: I tend to seek to enjoy interacting with doctors from other cultures.

___16: I normally feel relaxed when interacting with doctors from other cultures.

___17: I usually feel nervous or uncomfortable when interacting with doctors from other cultures.

___18: I tend to have an uneasy feeling when interacting with doctors from other cultures.

___19: I usually get a fluttering feeling in my stomach when interacting with doctors from other cultures.

Survey Instrument– Patient Satisfaction

Instructions: The purpose of this questionnaire is to investigate your reactions to the conversation you just had with your doctor. Please indicate the degree to which you agree that each statement describes this conversation by putting the number that corresponds to your degree of agreement in the blank space to the left of each statement. The '4' or middle position on the scale represents "undecided" or "neutral", then moving out from the centre, "slight" agreement or disagreement, then "moderate", the "strong" agreement or disagreement. For example, if you strongly agree with the following statement you will circle '1'.

The doctor moved around a lot.

Agree : 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

- ___1: The doctor told me that I was communicating effectively.
- ___2: Nothing was accomplished.
- ___3: I would like to have another conversation like this one with a doctor.
- ___4: The doctor genuinely wanted to get to know me.
- ___5: I was very dissatisfied with the conversation that I had with the doctor.
- ___6: I had something else to do.
- ___7: I felt that during the conversation with the doctor, I was able to present how I wanted the doctor to view me.
- ___8: The doctor showed that he/she understood what I said.
- ___9 I was very satisfied with the conversation with the doctor.
- ___10: The doctor expressed a lot of interest in what I had to say.
- ___11: I did not enjoy the conversation with the doctor.
- ___12: The doctor did not provide support for what he/she was saying.
- ___13: I felt I could talk about anything with the doctor.
- ___14: We each got to say what we wanted.
- ___15: I felt that we could laugh easily together.

___16: The conversation flowed smoothly.

___17: The doctor changed the topic when his/her feelings were brought into the conversation.

___18: The doctor frequently said things which added little to the conversation.

___19: We talked about something I was not interested in.

The above questions were formulated into isiXhosa when conducting interviews with Xhosa speaking patients.

APPENDIX 2

SURVEY USED FOR DOCTORS

Adapted from the model produced by J.D. Brown

Survey: Doctor Intercultural Communication

We are inviting you to be a respondent for the study: “Intercultural Health Communication between non–Xhosa speaking doctors and isiXhosa mother–tongue-speaking patients.

Professor Russell Kaschula from the School of Languages (African Language Studies) at Rhodes University is in charge of this study. You can contact him at this number 0466038952 / 0466038222 or you can contact Veliswa Mandla at 041 9771745.

Your participation in this study is voluntary. You can stop at any point if you become uncomfortable answering any of the questions. I want to emphasize that we will maintain your confidentiality, but if you want your name to be mentioned, we will also appreciate that.

Demographic Information:

Please select one answer for the following questions:

Sex: Male Female

Ethnicity:

Yearly Income: R _____

Number of visit to this clinic: _____

Number of children: _____

Marital Status: Single Married Separated Divorced Widowed

Does your culture affect the way you communicate with the patient?

Not at all 1 2 3 4 5 6 7 Definitely

If yes, how strong does your culture affect the way you communicate with the patient?

Somewhat strongly 1 2 3 4 5 6 7 Very strongly

If no, which other identity characteristics affect the way you speak with the patient (language, religion, beliefs, etc)?

How would you rate your health status?

Very ill 1 2 3 4 5 6 7 Very Healthy

Education level: Less than high school some high school high school graduate
Some college Vocational/Technical school 2-year degree
4-year degree Master's degree PhD Professional degree

Please answer the following questions according to the scale listed below.

1=Strongly Agree; 2=Agree; 3=Neutral/Not sure; 4=Disagree; 5=Strongly Disagree

Section 1: Cultural Sensitivity

___1: I tend to know a lot more about the patient's culture.

___2: I tend to adapt my level of satisfaction with treatment according to a patient's culture.

___3: I normally consider the patient's culture when listening to his recommendations.

Section 2: Effective Intercultural Communication

___4: I usually understand the feelings of the patient who comes from a culture that is different from mine.

___5: I intend to communicate well with patients from other cultures

___6: I tend to easily resolve misunderstanding with patients from other cultures.

___7: I normally understand the point of view of patients from other cultures.

___8: I tend to empathize with patient from other cultures.

___9 I can usually interpret the nonverbal language of patients from other cultures.

Section 3: Anxiety

___10: I tend to seek opportunities to interact with patients from other culture.

___11: I normally feel relaxed when interacting with patients from other cultures.

___12: I usually feel nervous when interacting with patients fro other cultures.

___13: I intend to feel self confident when interacting with patients from other cultures.

___14: I usually feel anxious when interacting with patients from other cultures.

___15: I tend to seek to enjoy interacting with patients from other cultures.

___16: I normally feel relaxed tense when interacting with patients from other cultures.

___17: I usually feel nervous comfortable when interacting with patients from other cultures.

___18: I tend to have an uneasy feeling when interacting with patients from other cultures.

___19: I usually get a fluttering feeling in my stomach when interacting with patients from other cultures.

Survey Instrument– Doctor Satisfaction

Instructions: The purpose of this questionnaire is to investigate your reactions to the conversation you just had with your patient. Please indicate the degree to which you agree that each statement describes this conversation by putting the number that corresponds to your degree of agreement in the blank space to the left of each statement. The '4' or middle position on the scale represents "undecided" or "neutral", then moving out from the centre, "slight" agreement or disagreement, then "moderate", the "strong" agreement or disagreement. For example, if you strongly agree with the following statement you will circle '1'.

The patient moved around a lot.

Agree :1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

- ___1: The patient told me that I was communicating effectively.
- ___2: Nothing was accomplished.
- ___3: I would like to have another conversation like this one with a patient.
- ___4: The patient genuinely wanted to get to know me.
- ___5: I was very dissatisfied with the conversation that I had with the patient.
- ___6: I had something else to do.
- ___7: I felt that during the conversation with the patient, I was able to present how I wanted the patient to view me.
- ___8: The patient showed that he/she understood what I said.
- ___9 I was very satisfied with conversation with the patient.
- ___10: The patient expressed a lot of interest in what I had to say.
- ___11: I did not enjoy the conversation with the patient.
- ___12: The patient did not provide support for what he/she was saying.
- ___13: I felt I could talk about anything with the patient.

___14: We each got to say what we wanted.

___15: I felt that we could laugh easily together.

___16: The conversation flowed smoothly.

___17: The patient changed the topic when his/her feelings were brought into the conversation.

___18: The patient frequently said things which added little to the conversation.

___19: We talked about something I was not interested in.

DOCTORS OPEN ENDED QUESTIONNAIRE

1: Do you believe that your language and culture affect the way you communicate with your patient? Explain

2: Have you experienced any challenges communicating with patients, from various cultural and linguistic backgrounds that are not similar to your own? Describe these encounters:

3: Do you have any comments concerning ways that patients from different cultural and linguistic backgrounds would communicate their concerns to you? If so, list them below.

The above questions were formulated into isiXhosa when conducting interviews.

APPENDIX 3

SAMPLE CONVERSATION

What follows is a sample of a recorded conversation

SETTING: The participants are in the doctor's consulting room.

Patient (IsiXhosa mother-tongue speaker, old man)

Doctor (Indian, English speaker, young man)

Communication break-down occurs between the participants as a result of the incorrect use of a word normally associated with youth rather than an older person. Use of this term is interpreted by the patient as lack of respect on the part of the doctor. The doctor's effort to connect and create a sense of trust are disregarded in this instance.

Doctor: Good morning, "*mfana*"

Molo mfana

Patient: (cwaka)
(*silent*)

Doctor: I greet you, "*mfana*"
Ndiyabulisa mfana

Patient: Unomfana ongangam kakade? Ndakugqiba ukuba yintanga kayihlo, akunantloni ukundenza umfana? Khona, lungathini usapho lwam xa lunokuva le ndelelo uyenzayo? Jonga apha mfana wam, imfundo yakho mayingakuphazamisi ungababoni abantu abadala.

Do you have a young man of my age? Can't you see that I am your father, where are your manners? What would my family say if they heard you belittling me like this? Look here, my son, your education must not confuse you, so much that you don't recognize your seniors.

Doctor: I am sorry; it was not my intention to belittle you. I thought the word was referring to men of all ages.

Ndiyaxolisa, bendingazimiselanga kukudelela. Bendinga ukuba eli gama libhekiselele kuye wonke umntu oyindoda.

BIBLIOGRAPHY

- Abelson, R. 1976. Script processing in attitude formation and decision – making. In J. Carroll & T. Payne (Eds.). *Cognition and social behavior*. pp 33-45. Hillsdale, NJ: Lawrence Erlbaum.
- Allwood, J. 1993. Feedback in second language acquisition. C. Perdue (Ed.), *The cross linguistic study of second language*. pp 186–235. Volume ii. Cambridge: Cambridge University Press.
- Anthonissen, C. 2000. Using English as *Lingua Franca* in Health Worker –patient discourse in a Western Cape Day – clinic that attends to HIV/ AIDS testing and treatment. Unpublished paper. Cape Town. University of the Western Cape.
- Bonvillain, N. 2003. *Language, culture and communication*. New Jersey: Prentice Hall.
- Bowe, H. & Martin, K. 2007. *Communication across cultures*. Cambridge: Cambridge University Press.
- Bristin, R. 1993. *Understanding culture's influence on behavior*. Fort Worth, TX: Harcourt Brace Jovanovich, Inc.
- Brown. J.D. 2006. Communication Studies. MA thesis. Texas: University of Texas.
- Callport, G. 1954. *The nature of prejudice*. Wesley: Cambridge.

- Candlin, C. N. & Gotti, M. (eds.). 2004. *Intercultural aspects of specialized communication*. Germany: Peter King.
- Clark, D. 1993. *Cultural issues in terminal care*. Philadelphia, PA: Oxford University Press.
- Christie, P. 1990. *Open schools – Racially mixed Catholic schools in South Africa*. Johannesburg: Raven Press.
- Davidson, B. 2000. The interpreter as institutional gatekeeper – The socio – linguistic role of interpreters in Spanish – English medical discourse. *Journal of socio – linguistics*, vol. 4 no.3 pp379 - 408
- Deen, J. 1997. *Dealing with problems in intercultural communication*. LE Tilburg: Tilburg University Press.
- Dixon, L. O. 2004. A case study of an intercultural health care visit. An African American woman and her white male physician. *Women and Language*. 27(1) 45–52.
- Dodd, C. H. 1998. *Intercultural communication*. New York: MC Graw Hill.
- Downes, W. 1984. *Language and society*. London: Fontana Publications.
- Durandt, A. 2001. *Linguistic anthropology*. Germany: Blackwell Publishers.
- Evian, C. 1993. *Primary Aids Care*. Houghton: Jacana education
- Galant, G. 1997. *Caring for patients from different cultures. A case study from American hospitals*. Philadelphia, PA: Oxford Press.

- Gudykunst, W. B. 2003. *Cross – cultural and Intercultural communication*. London: SAGE Publishers.
- Gudykunst, W. B. 1991. *Effective intergroup communication*. London: SAGE Publishers.
- Gudykunst, W. B. 1983. *Intercultural communication theory*. London: SAGE Publishers.
- Gudykunst, W. B. & Hammer, M. R. 1987. The influence of ethnicity, gender and dyadic composition on uncertainty reduction in initial interaction. *Journal of Black Studies*. 18 (2) 191 – 214.
- Gropper, R. 1996. *Culture and the clinical encounter – an intercultural sensitizer for the health professions*. Yarmouth, NM: Intercultural Press.
- Gumperz, J. J. & Hymes D. 1972. *Directions in socio linguistics – The ethnography of communication*. New York: Basil Blackwell Ltd.
- Hammersley, M. & Arkinson, P. 1983. *Ethnography. Principles in practice*. London: Tavistock Publishers.
- Helman, C. G. 1990. *Culture, health and illness*. London: Butterworth & Co. Ltd.
- Heugh, K. Siegruhn, A. & Philadelphia, P. 1995. *Multilingual education for South Africa*. Isando: Heinemann.

- Higgs, P., Vakalisa. N. C. G., Mda, T. V., & Assie – Lumumba, N. T. 2000.
African voices in education. Lansdowne: Juta & Co. Ltd.
- Hoey, M. 1983. *On the surface discourse*. London: Allen & Unwin.
- Hostede, G. & Bond, M. Hofstede's culture dimensions. *Journal of Cross – cultural Psychology*. 15. 417– 433.
- Hughes, P. C. & Baldwin, J. R. 2002. Black, white and shades of gray;
Communication predictors of stereotyping impressions.
Southern Communication Journal. 68 (1). 40 – 56.
- Hymes, D. 1996. *Ethnography, Linguistics, Narrative Inequality*. London: Talyer & Francis.
- Jackson, J. 1964. The normative regulation of authoritative behavior. In W. Grove & Dyson (Eds.). *The making of decisions*. New York: Free Press.
- Kaschula, R.H. 1987. Communicating across cultures in a North-Eastern Cape Farming Community. Honours mini-thesis. Grahamstown: Rhodes University.
- Kaschula, R.H. & Anthonissen, C. 1995. *Communicating across cultures in cultures in South Africa. Toward a critical language awareness*. Johannesburg: Witwatersrand University Press.
- Kim, Y. & Gudykunst, W. B. 1987. *Cultural adaptation*. London: SAGE Publishers.
- Kramsch, C. 1998. *Language and culture*. Cambridge:

Cambridge University Press.

Lago, C. & Thompson, J. 1996. *Race, culture and counseling*.

Philadelphia: Open University Press.

Langacker, R. W. 1967. *Language and its structure*. USA: Harcourt Brace

Jovanovich, Inc.

Mills, S. 1997. *Discourse*. London: Routledge Press.

Parry, I. 1994. Cultural barrier to intercultural / interracial communication among

black and white South African women. *Communication*. 12 (2)

620.

Porter, R. E. & Samovar, L. A. 1994. *Intercultural communication*.

California: ITP Press.

Risager, K. 2006. *Language and culture*. London: Multilingual Matters

Pty. Ltd.

Sacks, H., Schegloff, E. A. & Jefferson, G. 1974. A simplest systematic for the

organisation of turn – taking in conversation. *Language*.

Vol.59. pp. 941 – 942.

Saville–Troike, M. 1982. *The ethnography of communication*. *Language*

in society. London: Basil Blackwell.

Shneller, R. 1988. The Israel experience of cross cultural

misunderstanding: Insights and lessons. In *Cross –
cultural perspectives in nonverbal communication*.

(ed.). Pougitos, Lewiston. NY: C.J. Hogrefer. pp 153 –

171.

- Styen, M. E. & Motshabi, K. B. 1996. *Cultural synergy in South Africa*. Pretoria: Sigma Press.
- Stubbs, M. 1983. *Discourse analysis. The socio linguistic analysis of natural language*. London: Basil Blackwell.
- Ting-Toomey, S. 1981. Ethnic identity and close friendships among Chinese-American students. *International Journal of Intercultural Relations*. 5. 383 – 406.
- Ting-Toomey, S. 1999. *Communication across cultures*. London: The Gilford Press.
- Tjale, A. & de Villiers L. 2004. *Cultural issues in health and health care*. Cape Town: Juda Academy.
- Urley, K. I. & Amason, P. 2001. Intercultural communication between patients and health care providers. An exploration of Intercultural communication effectiveness, cultural sensitivity, stress and anxiety. *Health Communication*. 13 (4). 449 – 469.
- Van Dyk, A. 1999. *HIV/AIDS care & counseling*. Cape Town: Pearson Education.
- Wardhaugh, R. 1986. *An introduction to socio linguistics*. New York: Basil Blackwell.
- Watson, B., & Gallois, S. 2002. Patients' interaction with health providers. A linguistic category model approach. *Journal of Language and Social Psychology*. 2 (1). 32 – 52.

Watts, R. J. 2003. *Politeness*. Cape Town: Cambridge University Press.

Webb, V.N.2003. *Unpublished Study Guide – LIN857 Discourse Analysis*.
Department of Afrikaans. University of Pretoria.

Webb, V.N. & Sure, K. 2000. *African Voices. An introduction to the Language and Linguistics of Africa*. Published by the University Press Southern Africa. C.T, SA

Wiseman, R. L. & Koester, J. 1993. *Intercultural communication competence*. London: Sage Publications.

Widdowson, H.G. 1998. *Communication*. Oxford: Oxford University Press.

Yael, T. 1995. *Democratic education in a multicultural state*. USA:
Blackwell publishers.

Yule, G. 1996. *Pragmatics*. New York: Oxford University Press.