INTERPRETING SERVICES PROVIDED DURING CONSULTATIONS IN THE MEDICAL SECTOR: IDENTIFYING SHORTCOMINGS

by

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Interpreting services provided during consultations in the medical sector: Identifying short comings

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Thesis submitted in accordance with the requirements for the Master's Degree in Technology: Language Practice in the Department of Media, Language and Communication in the Faculty of Arts and Design at the Durban University of Technology.

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DECLARATION

I, Thabani Robert Khumalo , student number : 20704319 declare that 'Interpreting services provided during consultations in the medical sector: identifying shortcomings' is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature

17 August 2015

Date

ABSTRACT

The study focuses on the interpreting services provided during consultations in the medical setting. It looks broadly at the communication deficiencies created by the difference in the languages spoken by both medical practitioners and patients during consultations. Several times, the researcher's personal experience has shown that isiZulu speaking patients are frequently consulted by English speaking doctors whenever they visit medical institutions. Consequently, as a result of this situation, these isiZulu speaking patients with limited English proficiency find it difficult to fully express all their medical conditions to the English speaking doctors and vice versa due to the existing language barriers. These language barriers are most likely to give rise to inferior medical assistance to isiZulu speaking patients. Furthermore, the nurses find themselves being ad hoc interpreters in this regard based on the assumption that they are bilingual. However, their linguistic and interpreting ability are not considered. The study therefore investigates the possible shortcomings and also looks at the implications most likely to occur as a result of reluctance to provide professional medical interpreting services. The data is collected from medical practitioners (doctors and nurses) and patients. From the results obtained, the researcher suggests possible recommendations in order to address the identified shortcomings**.**

ISISONGO

Lolu cwaningo lumayelana nokutolika ezikhungweni zezempilo. Lugxile ekubhekeni izinkinga zokuxhumna ngokolimi ngenxa yokwehluka kwezilimi ezikhulunywa abasebenzi bezempilo kanye neziguli uma zize ezikhungweni zezempilo. Umcwaningi usebone izikhawu eziningi ukuthi uma iziguli ezikhuluma ulimi lwesiZulu ziya ezikhungweni zezempilo zivame ukusizwa odokotela abakhuluma isiNgisi. Ngenxa yalesi simo , iziguli ezingasazi kahle isiNgisi ziyehluleka ukuchazela odokotela ngokuphelele izinkinga zazo zezempilo, kanjanlo nodokotela bayehluleka ukuxhumana kahle nazo. Lezi zinkinga zokuxhumana, zingaba nomthelela omubi wokuthi iziguli ezikhuluma isiZulu zingatholi usizo olugculisayo lwezempilo. Ngenxa yalesi simo, abahlengikazi bagcina bezithola sebengotolika ngenxa yokuthi kucatshangelwa ukuthi bayakwazi ukukhuluma izilimi zombili. Akube kusabhekwa ukuthi bazazi kangakanani izilimi lezo kanye nokuthi bayakwazi yini ukutolika. Ucwaningo lubheka izingqinamba ezikhona kanye nezingenzeka ngenxa yokungahlinzekwa ngokutolika okusezingeni elifanele ezikhungweni zezempilo futhi kungahlinzekwa abantu abaqeqeshiwe.

Imininingwane yokwenza lolu cwaningo iqoqwe kubasebenzi bezempilo (odokotela kanye nabahlengikazi) kanye neziguli. Umcwaningi ube esenza izincomo ezingasiza ukuqeda izinkinga ezitholakele emuva kokuba esethole imiphumela.

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ACRONYMS

- HPCSA: Health Professions Council of South Africa.
- HR: Human Resources
- IMIA: International Medical Interpreters' Association
- KZN: KwaZulu-Natal
- NCIHC: National Council on Interpreting in Health Care
- NLB: National Language Board
- NLU: National Lexicography Units
- PanSALB: Pan South African Language Board
- PRO: Public Relations Officer
- SA: South Africa
- SL: Source Language
- SASL: South African Sign Language
- SATI: South African Translators' Institute
- US/ USA: United States of America
- TL: Target Language

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CHAPTER ONE: INTRODUCTION

1.1 Introduction

This chapter introduces the study and gives reasons for the researcher's choice of study. A background of the medical institutions in which the study takes place is provided. Furthermore, the research problem is outlined by the areas of difficulty in cross- cultural communication between medical practitioners (doctors & nurses) and patients who speak different languages i.e. English and isiZulu.

1.2 Background of the study

This study is concerned with the interpreting services provided during consultations in the medical sector whereby it is focusing on identifying the shortcomings existing as a result of the language difference between English speaking medical practitioners and isiZulu speaking patients. This study is conducted in two public hospitals in the eThekwini metro region. These hospitals are: King Edward VIII and R. K. Khan Hospitals. South Africa has a very long unpleasant history of the apartheid system. During apartheid, some institutions and public facilities were built to cater for certain ethnic groups and some of the needs required in these facilities differed as well. Likewise, the two aforesaid hospitals were also built to cater for certain ethnic groups as well based on their geographical locations. King Edward VIII was mainly built to cater for the white population of patients, whereas R. K. Khan hospital on the other hands was built to cater for the Indian population of patients. It is common cause that both these hospitals catered for English speaking patients only during the time of the apartheid system.

It is therefore clear that there were no facilities made available to cater for the African Black patients in any of these hospitals due to the segregation law made during the apartheid era, (Group Areas Act 1950:1). However, when South Africa eventually

got freedom in 1994, a sign of positive change and hope was brought to the citizens of the country. There was no more segregation amongst the citizens of the country due to their ethnic difference, also all the oppressing laws were all abolished. Public facilities which were previously known to belong to certain ethnic groups were then made accessible to everyone regardless of their ethnicity. Likewise, in the medical institutions the very similar process took place. Patients could then visit any medical institutions situated in their vicinity. It is also common cause that both these hospitals in which the study is conducted, consist of isiZulu and English first language speakers. However, looking at this combination from a professional interpreter's perspective, this does not give any guarantee of effective language communication and mutual understanding amongst medical practitioners only. Being that the case, one cannot help but imagine how the situation must be for patients who speak different languages from that of the medical practitioners (doctors/ nurses). Also bearing in mind the fact that none of these two hospitals were made to cater for the African black isiZulu speaking patients in the past. Therefore the situation appears to be more complex since it is assumed that a severe communication breakdown due to the language difference might occur.

The researcher therefore endeavors to ascertain the exact current situation in the medical setting. This will be done by looking at the interpreting services provided during consultations and if at all these services are provided and then identify the gaps or shortcomings related to such services.

1.3 The Research Problem

Provision of interpreting services in the medical settings in South Africa still remain the outermost informal activity occurring during consultations. According to Lesch (2007:79) the main sources of interpreting services is still provided by nurses, nursing assistants, auxiliary staff and community volunteers if not family members of the patients. According to Angelelli (2007:63) interpreting in the medical field involves a unique type of contextually bound communication in two languages, which normally takes place under pressure. Nevertheless, it has been over two decades

now ever since it was announced that indigenous languages are now recognized as official languages and acquired equal access and recognition in the new Republic of South Africa (RSA). However, it is unfortunate that the interpreting profession still suffers a lack of recognition even in critical and life threatening institutions like hospitals and clinics.

Could this suggest that South Africa as a nation is just turning a blind eye in such critical matters or are the authorities ignorant about the significance of such services being made available at a professional level? Furthermore, most health care workers can only speak one language fluently as compared to other languages. It is therefore obvious how this can lead to major problems when it comes to providing adequate health care (Schemmer and Mash 2006:1084). Where there are no proper interpreting services to facilitate communication between a health care provider and a patient, it will lead to a degree of miscommunication and disempowerment. The service rendered will only be a disadvantage for the patient because the patient's access to information and help is effectively blocked (Pienaar 2006:44 and Saulse 2010:4).

Therefore the hypothesis of this study is:

IsiZulu speakers with limited English proficiency are possibly receiving inferior medical assistance due to language barriers. The isiZulu speaking patients with extremely limited English proficiency who access the health services in public and private hospitals frequently encounter non-isiZulu speaking doctors in consultations. The resultant language barriers are likely to give rise to poor communication in these consultations.

To support this hypothesis, the researcher argues that therapy is not only influenced by the prescribed treatment, but it also relies heavily on effective language communication throughout the therapeutic process. This can only be achieved by assigning the right personnel to execute such duties, not bilingual individuals (nurses and general staff members) but professionally trained medical interpreters. This is because they would have better language skills and a broad knowledge of how to adequately and accurately carry out the interpreting assignment as compared to the assumed bilingual staff members who are currently said to be providing these

services but do not have the skills and the knowledge of what they are doing as interpreters.

It is further accompanied with the aim to answer these sub research questions:

1. What language barriers, if any, are experienced in consultations between medical practitioners and patients?
2. What possible consequences can this be seen to have for:
    a) Accurate diagnosis of the patient condition and the understanding thereof?
    b) The treatment prescribed.
3. Based on the above questions what recommendations could be made to improve patient understanding of both the medical condition and its prescribed treatment?

1.4 Aim of the study

The general aim of the study is to promote equity of healthcare information by users of South African indigenous languages in KwaZulu- Natal. It further aims to provide isiZulu speaking and other indigenous language speaking patients' medical information and access whilst using the language of their choice (mother tongue). This will include advocacy for professionally trained medical interpreters in South Africa, like is the case in other international countries e.g. Australia, Canada and United States of America. It is also well known that South Africa has eleven official languages. These are not just official languages only, but they are all recognized equally before the constitution and more over and above they are expected to be used equally in all various settings, be it general or academic.

Therefore, having mentioned such a very favorable constitution in the country, it becomes more fascinating to actually seek to know that after all these years of democracy and language rights being recognized, how much progress has been made into ensuring better medical information access for all in the medical setting using one's home language (isiZulu in this case). Lastly, it also seems relevant to seek as to whether treatment compliance is also influenced by knowledge provided

in a language well understood by patients, preferably a mother tongue. Therefore after the conclusion of this study with all the necessary findings, the researcher endeavours to contribute to new information and probably contribute in educating people about the significance of providing interpreting service in the medical sector and this is believed to add value and knowledge and also contributes positively on the society's wellbeing.

1.5 Context of the research

There are various illnesses affecting the South African population. Apart from the very well-known HIV/AIDS and cancer pandemics, there are also illnesses which do not share equal status in terms of them being well known by the community. These seemingly underestimated diseases are in fact very dangerous and some even result in mortality or other permanently life changing situations if not properly diagnosed at an early phase. On the other hand the government seems to be trying by all means possible to improve the previously extremely vulnerable healthcare system. This is seen by the increase in the number of healthcare facilities and more medically trained personnel i.e. doctors and nurses excluding other personnel who are not directly linked in to the therapeutic process. Therefore, the public is able to access these facilities free of charge, but somehow very little improvement in seen in terms of successful therapeutic process.

This indicates that even though there are people who have had a privilege to visit the medical institutions to get the necessary help, but it is not enough. There is still a lack of service in the therapeutic process. It is therefore the researcher's belief that even though such illnesses are preventable and curable however, the South African black community still lacks the right information about these illnesses due to the language differences spoken by the medical practitioners and patients. These are specifically isiZulu and English languages in this regard. This is done entirely to minimize the research scope as it would be impossible for the researcher to conduct a full research project for all the eleven South African languages. Furthermore, it is the researcher's belief that by providing interpreting services to both medical

practitioners and patients, the healthcare will improve drastically as there would be a mutual understanding between these two parties.

Previous studies have shown that common barriers to healthcare care in South Africa have been attributed to language and cultural differences. There are treatments and many of them are within the patient's control, if they learn how from their support team of health care providers (Sloane 2012:1). However, it is not clear if these patients are well informed about the seriousness of their illness and if they are able to access all the necessary medical information in relation to their illness in the language of their choice, preferably their mother tongue language (isiZulu). As it is also stated in the patients' charter that health information should be available in a language that is understood by the patient (HPCSA 2008:2).

According to the report by the National Department of Health website (2012:1) large numbers of people continue to die prematurely and suffer unnecessarily from poor health. Treatable conditions are not being treated on time and preventable diseases are not being prevented. Hence, it is for this reason this study is conducted with the hope that the relevant role players will also be encouraged to look at the situation holistically. By so doing they will pay detailed attention to other things that might appear to be minor but have a severe impact such as the language difference which prevents mutual understanding and not only to look at the technical and scientific medical factors as it appears to be the case in South Africa.

1.6 Rationale of the study

Effective communication is essential in the medical setting. According to Saulse (2010:8) in order to bridge the language gap in a specific health care situation in South Africa, untrained interpreters would typically be used. The quality of these services would thus be questionable, since these ad hoc interpreters are not equipped with the necessary skills to perform optimally within an interpreting session. Besides the limited theory knowledge these interpreters have about the interpreting process, medical interpreters should also possess certain qualities and they must fully understand both source and the target language in which they are

interpreting from and to. Therefore, if none of these ad hoc interpreters possess such skills as suggested by Saulse, this could mean that the healthcare system is in jeopardy and putting the lives of the patients in to a massive healthcare quality compromise.

The aim of this study is thus to describe the current interpreting situation experienced on a daily basis in the hospitals as well as the impact that is most likely to occur as result of the situation explained above. The participants in this study will be English speaking doctors, isiZulu speaking nurses who act as interpreters and isiZulu speaking patients who visit the hospitals in which this study is conducted.

1.7 Overview of chapters

The study consists of five (5) chapters:

- Chapter one (1) introduces the study and presents an overview of the study.
- Chapter two (2) focuses on the literature review form both global and national perspectives of literature but more particularly on interpreting in the medical sector.
- Chapter three (3) focuses on the methodology and the research design and strategies undertaken when the study was conducted. It further explains the research tools used in the data collection process.
- Chapter four (4) presents all the data collected as described in chapter three. It is in this chapter where all the findings gathered during the data collection process are carefully analyzed, presented and discussed further, linking the findings to the presented research problem. It is also in this chapter where the research questions will be answered.
- Chapter five (5) concludes the study and summarizes the main findings of the study. Also the limitations of the study will be identified, recommendations based on the findings will also be made and proposition for further research will be made.

1.8 Conclusion

This chapter introduced and provided a background of the study including the institutions where it will be conducted. It also outlined the research problem where the hypothesis of the study was stated and also the sub questions which the research hopes to find answers to at the conclusion of this study. The aim and context of research and the rationale for the study was also discussed in this chapter. In the next chapter (Chapter Two), the researcher shall present a literature review which will be obtained from both local and international sources.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents literature that has served as a background to and justification for the study. Both international and national literature relating to the study will be discussed with an aim to create an insightful argument which will later identify the shortcomings related to the interpreting services provided during consultations in the medical sector. The shortcomings that will be discussed may include looking at some of the key challenges which are currently faced by South Africa which prevent effective provision of interpreting services in the medical sector.

Furthermore, the focus on the circumstances under which these services are provided will be looked over and the accuracy and the inaccuracy of the interpreted discourse discussed. There are also considerations on the current status of the interpreting services provided during consultations in the South African context; this is further compared to other international countries which seem to have a very well established good practice. Further literature will be discussed in the following chapters such as the methodology, findings and recommendations where it will be more relevant and specific. This chapter is divided into six sections namely:

2.1 Introduction
2.2 Communication process in the medical context
2.3 Interpreting and interpreting process
2.4. Interpreting modes and types
2.5 Medical interpreting
2.6 Conclusion

2.2 Communication process in the medical context

Corner (1985:10) states that communication is an essential tool which involves, sharing of our ideas, thoughts and feelings with other people and having those ideas, thoughts and feelings understood by the people we are talking with. He further says that when we communicate we speak, listen, and observe and that the “most

prominent among all these systems of communication is, of course human speech and language" (Corner 1985:10). According to Stewart et.al (1996: 26) any communication process is regarded as an effective one if both parties that are engaged in that process clearly understand one another with no limitations and disruptions.

For these reasons, within the medical field, it is agreed that appropriate communication skills are essential in building rapport with the patient and in being able to provide the relevant information in a way that is clearly understood by the patient (Hale 2007: 40). This is also supported by Engelbrecht et.al (2008:145) when they state that "language provides an important means by which humans communicate with one another and communication plays a pivotal role in the health professions in developing trust and co-operation between a care giver and the one being cared for". According to Leonard et.al (2004:85) effective communication and teamwork in the medical setting is essential for the delivery of high quality and safe patient care. Communication failures are an extremely common cause of inadvertent patient harm. The complexity of medical care, coupled with the inherent limitations of human performance, make it critically important that medical practitioners have standardised communication tools, create an environment in which individuals can speak up and express concerns, and share common 'critical language' to alert parties to unsafe situations. All too frequently, effective communication is situation or personality dependent.

Below is an assertion cycle which briefly shows what would seem to be an ideal practical daily situation when patients visit the medical institutions and are consulted by the medical practitioners. However, it would seem to be impossible to use this proposed ideal plan if there are communication breakdowns caused by the language difference between patients and medical practitioners. Each assertion in the cycle is discussed in detail below starting from number one (1) to number five (5).

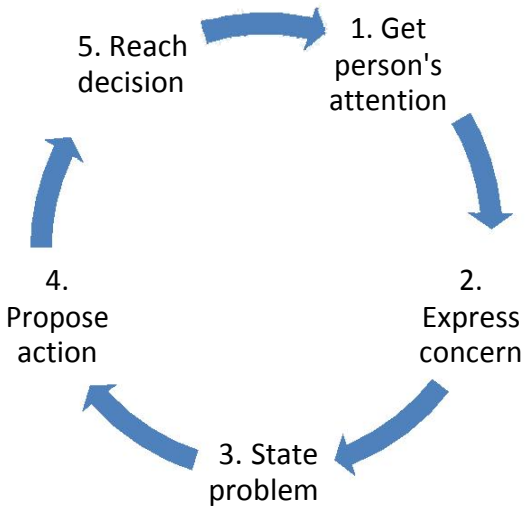


Figure: 1 Assertion cycle. This is a model to guide and improve assertion in the interest of patient safety (Leonard et al. 2004:86).

1. Get person's attention: This stage is where a care giver needs to give proper feed back to the patient based on the diagnosis identified and present the necessary precautions which need to be taken into account by the patient.

2. Express concerns: This could include the provision of all the relevant treatment information, booking the following appointments and explaining treatment dosages and expected side effects which the patient is likely to experience.

3. State the problem: This is the first vital step throughout the entire therapeutic process. This step allows the patient to state the problem in concern and the care giver to ask relevant questions in relation to the problem stated by the patient. It is therefore quite obvious that if a communication breakdown occurs at this very stage, the rest of the efforts that are going to be applied during the course of the therapeutic process are all going to be defective. This is because the problem will not be clearly identified from the beginning. Cambridge (1999:201) argues that patients may even present the wrong symptoms unrelated to the real problems and the diagnostic doctor relies heavily on skilful questioning. It is therefore significant to have a strong communication foundation process in place during this first step of consultation. It can be assumed that this would not happen or would not be effective if the doctor and patient do not share a common language.

4. Propose action: This process can be regarded as the one which allows the doctor to take the necessary action as per the problem presented before him during process three. This could include, conducting further tests and further specialised consultation if required or necessary.

5. Reach decision: This is done after a thorough consultation and proper diagnosis has been made by the care givers. It therefore determines the way forward to the situation as a whole. This may include admittance of the patient into the hospital, further operations being recommended and the prescription of the relevant and appropriate treatment.

In short, communication is a process beginning with a sender who encodes the message and passes it through some channel to the receiver who decodes the message. In the health sector the primary aim of all parties is to exchange sufficient information, to make proper diagnosis and prescribe the accurate treatment and this is only achievable if the message sent by the sender is decoded with the same meaning by the receiver (Rudvin and Tomassini 2011:51).

According to Willems et.al (2003:3) doctors' communicative style is influenced by the way patients communicate and their socio-economic status. Patients from higher social classes communicate more actively and show more affective expressiveness, eliciting more information from their doctor. Patients from lower social classes are often disadvantaged because of the doctor's misperception of their desire and need for information and their ability to take part in the care process. They further state that another prominent factor is language difference because patients from disadvantaged backgrounds often have limited English proficiency which is commonly used in the medical setting.

From what has been discussed above, it can be seen that such language difference and poor communication is counter-productive to the therapeutic process. More effective communication could be established between doctors and patients through doctors' awareness of the contextual communicative differences and empowering patients to express concerns and preferences. These preferences include access to language of the patient's choice (Hale 2007: 40; HPCSA 2008:2 and Maurice de Schryver 2003:258). Thus language communication should be viewed as a significant investment tool of time and resources in training (Jenkins 1999: 36).

In conclusion, communication in a medical context can be summarized as transference of a message from sender to a receiver in an effective and understandable manner. It has further been determined that due to the complex nature of the medical setting; a proper communication process is the tool that can be used to measure success or failure throughout the entire therapeutic process. Furthermore, it would seem that a common language between patients and medical practitioners plays a significant role in this process as stated that patients even present the wrong symptoms due to their linguistic limitation or limited English proficiency (Cambridge 1999:201). For these reasons, it would seem appropriate to have trained interpreters bridging these language differences for both patients and medical practitioners so that the limitations could be significantly reduced.

2.2.1 Communication breakdown

There are many reasons why interpersonal communications may fail. Swift (2012: 19) suggests that “on a planet where information is exchanged over thousands of kilometers in a few seconds, where tele- and video-conferencing is common-place, where flights to and from hundreds of countries happen every minute, where human movement is common and where 6909 or so languages are spoken it is to be expected that communication difficulties will occur”. In many communications, the message may not be received exactly the way the sender intended and hence it is important that the communicator seeks feedback to check that their message is clearly understood. The skills of active listening, clarification and reflection may help but the skilled communicator also needs to be aware of the barriers to effective communication (Rudvin and Tomassini 2011:52). “Active listening is a structured form of listening and responding that focuses the attention on the speaker. The listener must take care to attend to the speaker fully and then repeats in the listener’s own words what he or she thinks the speaker has said. This enables the speaker to find out whether the listener really understood. If the listener did not, the speaker can explain more” (Wiliams1994:3). She further states that active listening is a technique for clarifying communication and avoiding misunderstanding in cross-cultural communications.

Having stated that it would therefore appear that there exist many barriers to communication and these may occur at any stage in the communication

process. Barriers may lead to a message becoming distorted and therefore creates the risk of wasting both time and/or money by causing confusion and misunderstanding.

I would like to use the results of a study conducted in one of the hospitals in Cape Town by Schlemmer and Mash in 2006 as an example of the possible risks associated with communication break downs in the medical setting where they discovered following stories. One of the participants in the study who is a nurse shared her experience of a patient who responded incorrectly to his name and died after a drain was put into his normal chest. In support of this study one of the Afrikaans speaking nurses also confirmed that lots of people have already died because they cannot understand or say what the matter with them was. Likewise, there has also been a case whereby a mother brought her child to a hospital and unfortunately the child died later on that day. The doctor just literally sat in the consultation room together with the mother of the late child and waited for an interpreter to come so that he could be able to explain to the mother the cause of her child's death. Clearly the impact of the communication breakdown is unfavourable.

Effective communication involves overcoming these barriers and conveying a clear and concise message (Skills you need 2011).

If barriers are not overcome a communication breakdown could result in the most disasterous situation, particulary in the medical setting. According to Stewart et.al (1996:26) effective communication depends on a clear model of how communication takes place. They further say that communication breakdown can be the source or the result of conflict, but it is also important to know that a lack of argument can also be a sign of communication breakdown. Inadequate training, apathy, misunderstandings, channel noise (the medium through which the message is delivered to the recipients), differing backgrounds, or lack of respect can all be causes of communication breakdown. The results of communication issues include withholding information, loss of trust, reduced cooperation, reduced productivity, reduced creativity, reduced risk taking, personal attacks, sabotage, and more complaints.

In the medical setting communication breakdowns should be eliminated by all means possible. This is because this is the most critical environment which involves life changing decisions and these decisions need to be communicated effectively to both parties involved (patients and doctors). According to Jenkins (1999:35) inadequate communication may cause distress for patients and their families, who often require considerably more information than is usually provided. He further states that patients leave after a consultation unsure about the diagnosis and action needed to be taken thereafter. It can therefore be assumed that communication failure seems to be cited as a "root cause" of healthcare accidents and unsuccessful therapeutic process and this compromises patients' lives. Moorman (2007:173) argues that the safety paradigm traditionally taught in medical training is alone not sufficient enough to result in perfect patient outcomes. He further states that "breakdown in communication results in failure to achieve optimal patient outcomes", which appears to be common in the health sector.

Based on the unfavourable conditions caused by communication breakdown in the medical setting, it is therefore quite obvious that there is a great need for an efficient communication strategy to be in place and in order to provide efficient service for all parties involved in the communication process. According to Knoblauch (2001: 22) it is only a shared language which enables speakers to understand the same matter in the same manner. He further argues that language should not be considered as a means for transmitting subjective meaning but also a medium by which participants can share meaning intersubjectively.

2.2.2 Categorization of communication breakdowns

There are many different factors that can create barriers to effective communication. This section looks at the basic common factors which appear to be the most frequent factors resulting in barriers to communication. Although in the previous paragraphs, a difference in languages spoken by the participants is emphasized as one of the core factors. It should however be noted that even when people speak a common or similar language, communication breakdowns may still occur. Sometimes barriers

occur when people use inappropriate levels of language (too formal or informal) or use jargon or slang which is not understood by the people communicating.

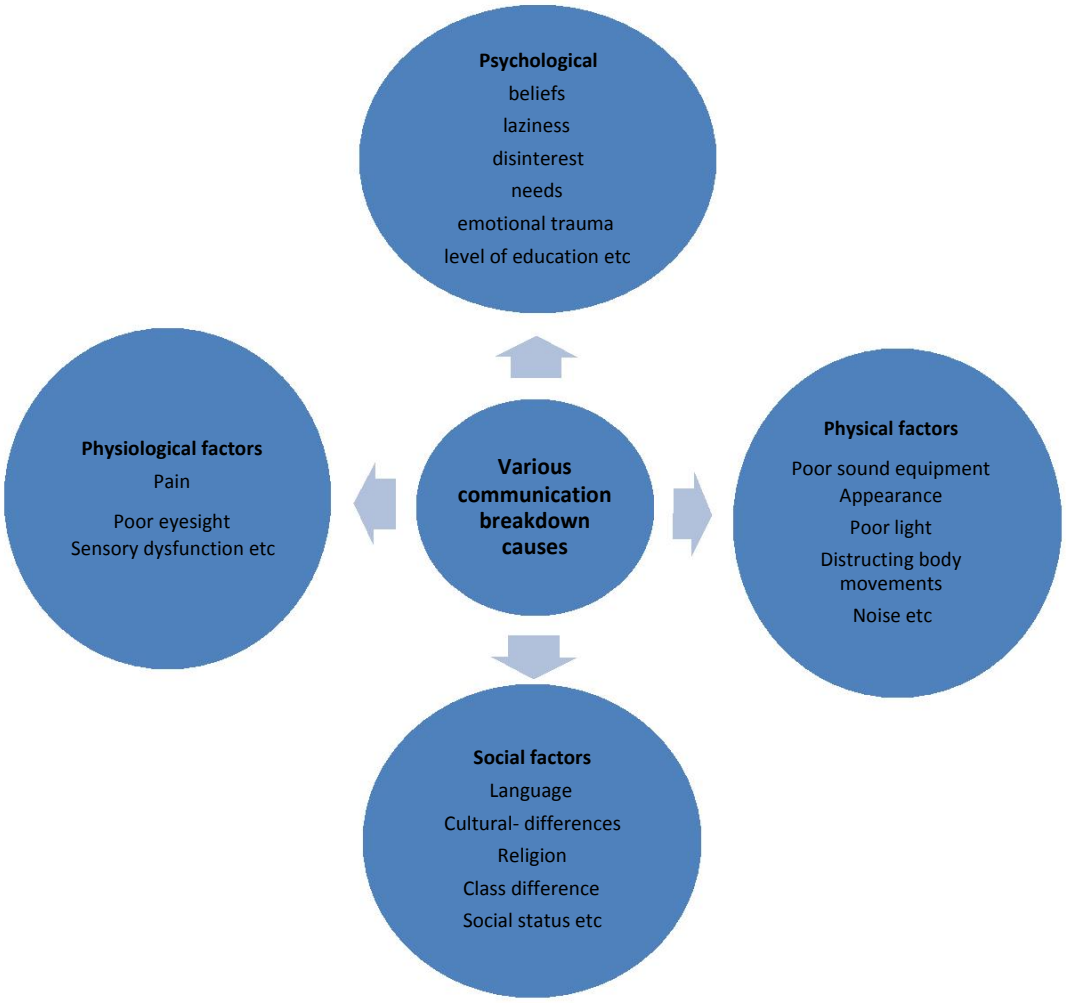


Figure: 2 indicates various factors which contribute to communication breakdown.

Below, the communication breakdown factors are briefly discussed as per the Skills you need page (http://www.skillsyouneed.com/ips/barriers-communication.html.)

2.2.2.1 Language barriers

Language and linguistic ability may act as a barrier to communication. However, even when communicating in the same language, the terminology used in a message may act as a barrier if it is not fully understood by the receiver. An example of this is the use of a specialist jargon and abbreviations which most of the time is not understood by a receiver who is not familiar with the terminology used. Another distinctive example would be that of a language which is commonly used by the

youth in the South African townships (slang or isitsotsi). The way, in which this language is structured, it is almost impossible to fully understand what is being communicated by the other party unless you are part of the subculture.

2.2.2.2 Psychological barriers

The psychological state of the receiver will influence how the message is received, e.g. if a person is stressed or preoccupied by personal concerns, he or she may not be as receptive to the message as if they were not stressed.

2.2.2.3 Physiological barriers

Physiological barriers may result from the receiver's physical state e.g. a receiver with hearing difficulties or reduced hearing may not grasp the entirety of a spoken conversation especially if there is significant background noise. In the case of Deaf people if there is not sufficient light for the sign language interpreter to be clearly visible, this could also form a barrier. According to Patricelli and Blickley (2006:63) successful communication requires adequate sound through the environment between the sender and the receiver and vocalization that transmit effectively in that given environment.

2.2.2.4 Physical barriers

Geographic distance is usually seen as a core cause for communication barriers between the sender and the receiver. Communication is generally easier over shorter distances as more communication channels are available and usually less technology is required. Although modern technology often serves to reduce the impact of physical barriers, the advantages and disadvantages of each communication channel should be understood so that an appropriate channel can be used to overcome the physical barriers.

2.2.2.5 Systematic barriers

Systematic barriers to communication may exist in structures and organisations where there are inefficient or inappropriate information systems and communication channels or where there is a lack of understanding of the roles and responsibilities

for communication. This is likely to impact on employees not understanding their roles and may also result into poor work performance.

2.2.2.6 Attitude barriers

These are behaviours or perceptions that prevent people from communicating effectively. Attitudinal barriers to communication may result from personality conflicts, poor management and resistance to change or a lack of motivation.

2.3 Interpreting and the interpreting process

According to Napier et al (2006:25), the word *interpreter* is derived from Latin and refers to a person who, when others have failed to understand something, clarifies the meaning of what was said. More specifically, an interpreter is one who conveys spoken or signed messages, produced by the first interlocutor, into another language understood by the second interlocutor. In simple terms interpreting is the act of converting oral communication from one language (source language) into another language (target language) (Hale 2007:4). On the other hand, medical interpreting refers to providing interpreting services in medical settings.

Quite often people confuse interpreting with translation. They refer to both processes as translation without being fully aware that these are two different processes and require different skills. Interpreting consists of three main stages: comprehension, conversion and delivery which occur at almost the same time depending on the mode of interpreting used. Translation on the other hand involves rendering of written communication from one language into another. In both, the initial process starts with understanding the source language text in the way intended by the speaker (Hale 2004:3). She further states that with translation there is time to read a text repeatedly and fully comprehend it and subsequently make a number of drafts before the translated version, whereas with interpreting the entire process of listening, comprehending, converting take place in a few seconds and at most minutes.

2.4 Interpreting modes and types

There are two modes of interpreting namely: simultaneous and consecutive modes.

Each of these modes is used in different settings depending on the setting's specific requirements. According to the Health interpretation Network (HiN) (2007:14) simultaneous interpreting refers to the nearly instantaneous delivery of the speaker's massage from the source language into the target language. Whereas, consecutive interpreting refers to the interpreter listening to the whole message uttered by the speaker and conveying it to the target language afterwards. This is also known as a turn-taking mode of interpreting. It should be noted that interpreting modes are different to types of interpreting. Types of interpreting refer to the different setting or environments where interpreting services are rendered, for example these include:

- Medical (hospitals, clinics and doctors' surgeries)
- Legal (court proceedings, conciliations, arbitrations, mediations and facilitations)
- Scientific (scientific conferences)
- Educational (university lectures, schools, colleges and in other academic related areas)
- Financial (accounting or economic related matters)

Below the simultaneous and consecutive modes are defined as per Hale's definition of each mode (Hale 2007:10).

2.4.1 Simultaneous mode with equipment

The interpreter listens to the speaker through headphones and begins interpreting a few seconds after the commencement of each utterance. This is said to be the most technical practice, as it requires a broad knowledge of equipment use and mind focus. Furthermore, it is recommended that interpreters of a similar language combination work at least in pairs as this exercise is extremely cognitively demanding. The prescribed session for each interpreter using this mode is a maximum of 15 to 20 minutes. This mode is commonly used in conferences, international meetings and was introduced at the Durban University of Technology for the first time during spring graduation in September 2012. The service was

provided again in the 2013 April graduation ceremonies at both campuses in Pietermaritzburg and Durban, South Africa. Several higher education institutions in South Africa use this mode of interpreting to provide services during academic lectures (*viz*. North West University, Free State University)

In this mode of interpreting, the interpreters do no not interact with the speaker or the audience. The booth where the interpreters are seated during the proceedings is usually placed at the back or on the far side of the venue. It is therefore the audiences' responsibility to alert either the speaker or the provided technicians of any technical difficulties experienced such as that of inaudibility. The very same principle applies for the assigned interpreters. This is strongly emphasized during interpreter training as failure to do so might result in poor delivery of the message and this might tarnish or compromise the trust relationship between the audience and the interpreter.


Figure: 3 indicates interpreters performing simultaneous interpreting in the interpreting booths.

The picture on the left hand side was taken at the Durban University of Technology 2014 graduation ceremony and the other one was downloaded online http://www.fxtrans.com/primer-difference-between-consecutive-and-simultaneous-interpreting/

2.4.2 Simultaneous mode without equipment

This mode is commonly known as *whispered interpreting* mode. Although the practice of speaking almost at the same time as the source speaker is similar to that one mentioned above, this mode does not require the use of equipment. This mode

is commonly used in settings where more than one person requires interpreting services e.g. break away sessions at a conference. The interpreter sits next to the target audience and interprets what is being spoken by the source language speaker almost at the same time. Another example where this kind of interpreting is commonly used is at the North West University. The interpreters sit right in the front of the class in the first row facing the lecturer and whisper into the microphone.

2.4.3 Consecutive mode (long consecutive)

This is known as a turn taking mode. In this process the speaker delivers a speech in segments from a minute up to twenty minutes while the interpreter takes notes. The interpreter then renders each segment in turn in the target language. Note taking skills are an essential requirement for this mode to be executed successfully. This mode is commonly practiced in small conferences and information sessions (Gilleis 2005:3).

2.4.4 Dialogue (short consecutive)

In this mode the interpreter interprets a dialogue between two different people who speak different languages. Each turn is relatively short and the duration of deliverance of the message to the target language is determined by the length of the previous turn from the source speaker. This form of interpreting is commonly used in churches and during interview sessions.

Figure: 4 indicates interpreters performing consecutive mode of interpreting.

The pictures were downloaded online http://www.fxtrans.com/primer-difference-between- consecutive-and-simultaneous-interpreting

2.5 Medical interpreting

In a presentation by Bancroft on 20 January 2013, medical interpreting is defined as interpreting in settings where healthcare services are provided. She further distinguishes it from community interpreting by defining community interpreting as that form of interpreting that supports access to public or community services. On the other hand, Saulse (2010: 13) argues that there is a difference between medical interpreting and healthcare interpreting as defined by Bancroft. She defines medical interpreting as a type of interpreting that includes the setting in which health care interpreting usually takes place, as well as any other setting related to the medical profession. These settings may include events such as conferences held by the United Nations and other events which include discussions on medical matters. She further states that "medical interpreting is thus the overall term encompassing any interpreting that takes place in a medical setting, which may or may not include a patient". She then states that health care interpreting, on the other hand, usually takes place with a patient present. However, this seems to be a matter of how each of these authors chooses to define and distinguish medical and healthcare interpreting according to their understanding of the matter. In the end though, the results of it all involve better or worse service delivery to patients. Thus, whether patients were involved or not, they are directly or indirectly linked to the impact of either of the presence or absence of either of the two types of interpreting. These forms of interpreting therefore do not seem to be distinct from one another.

Likewise, as defined in Bancroft's presentation on 20 January 2013, community interpreting is a form of interpreting that supports access to public or community services. According to Corsellis (2008:4) "public service refers mainly to those services that are provided for the public either by the local or central government". These include legal, health, and a range of other social services such as housing, education, welfare and environmental health. Saulse (2010:14) states that the purpose of community interpreting is to provide access to any public service to a person who does not speak the majority language spoken in that service. She further illustrates a mechanism which this form of interpreting results in. She says both of these types of interpreting (medical and community interpreting) are bi-directional,

meaning that interpreting takes place between two languages where each language functions as both the source language (SL) and target language (TL). For example:

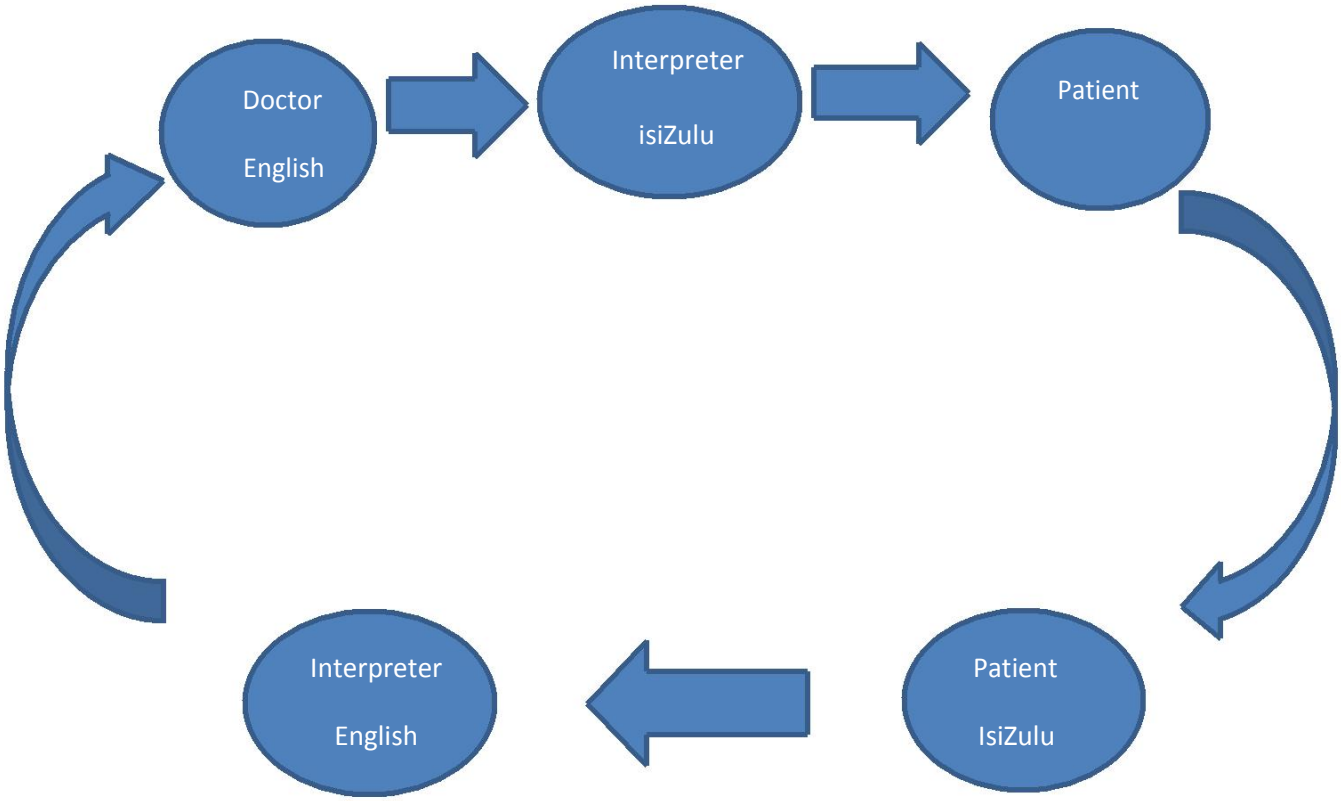


Figure: 5 indicates the process of interpreting in the medical setting.

Doctor → English (SL) → interpreter → isiZulu (TL) → patient → isiZulu (SL) → interpreter → English (TL) → doctor, where English and isiZulu both function as SL and TL. In such a setting isiZulu would usually be Language A of the interpreter and English would be Language B. Language A represents the language in which the interpreter has native proficiency in speaking and listening (usually the interpreter's mother tongue) and Language B is the language in which the interpreter has full functional proficiency in speaking and listening.

2.5.1. Medical interpreting code of good practice

Like any other professions, there are rules and regulations which provide the guidelines for all the personnel practicing in those different fields. Similarly, there are

rules that apply in the field of interpreting, be it ad hoc (community interpreting with no special jargon or complex or technical terminology used e.g. in churches) or specialized interpreting (where complex or technical or specific terminology is used e.g. business seminars, courts and hospitals). There are thirty two (32) standards of practice grouped under nine (9) headings (National Council on Interpreting in Health Care (NCIHC) 2005: 2). Although not all of these will be stated in this research, a basic summary of the guidelines will be provided. According to NCIHC (2005:2) these guidelines are necessary for improved intensive training for medical interpreters in order to raise the quality and consistency of interpreters and ensure that they know what is expected of them as indicated in the code of good practice.

The code of good practice for interpreters in the medical setting includes the following as stipulated by Northern Ireland Health and Social Service Interpreting Services (2004:5-8), NCIHC (2005:5-8), National Register of Public Service Interpreters (20115) and Rudvin and Tomassini (2011:37- 43):

- *Accuracy* – interpreters strive to render the message accurately, conveying the content and spirit of the original message and also taking into account the cultural differences in each context. This includes rendering the message accurately and completely without adding, omitting or substituting.
- *Confidentiality* – interpreters treat all information confidentially. This applies to all information learned in the performance of their professional duties. This means that information should not be disclosed outside the treating team, except with the patient's consent or if required by law.
- *Impartiality* – interpreters must by all means possible remain neutral. This means that they must not allow any personal judgments or cultural values to influence objectivity. In a case where an interpreter feels it will not be easy to carry out the interpreting assignment, it is recommended that he or she must simply withdraw. For example, in a case where a family member or a close friend is involved.
- *Respect* – interpreters must treat all parties with respect and they must use professional and culturally appropriate ways of showing respect.
- *Cultural awareness* – the main objective of interpreting is to facilitate language communication across cultural differences. It is therefore of great significance

for the interpreter to strive to understand the cultures associated with the languages he or she interprets, including the biomedical culture. Hence generally interpreters are said to be bilingual and bicultural.

- *Role boundaries* – the interpreter maintains the boundaries of professional role by refraining from personal involvement.
- *Professionalism* – interpreters must at all times act in a professional and ethical manner. This includes being honest and ethical in all business practices and carrying out the interpreting assignment in the very best way possible.

2.5.2 The current medical interpreting situation in South Africa

This section focuses more on the aspects which seem to be the most contributing factors concerning the provision of inadequate interpreting services in the health care. It is assumed this is the core first step towards ascertaining the real problems in this field if there are any at all. Furthermore, it could also give direction towards the formulation of a proper mechanism in which these shortcomings, if identified, could be overcome as far as the *'language communication'* is concerned.

Interpreting in the medical setting has increasingly become a focus of attention as a significant area of speciality practice (Pöchhacker and Kadric 1999:161). However, often times in South Africa, interpreting services are not provided at a professional level in medical institutions. If one happens to be fortunate enough to be provided with such services, they are either provided by the nurses or general working staff members such as hospital cleaners or even by family members of the patients. However, none of these people are professionally trained medical interpreters. This is also supported by Pöchhacker and Kadric (1999:161), Drennan (1996:343) and Lesch (2007:75) when they state that the main sources for interpreting services are still nurses, nursing assistants, auxiliary staff and community volunteers if not family members. Therefore this makes the entire interpreting session very informal. The nursing staff who interpret also complain that their role is not recognised, it keeps them away from their work and they are not paid for it. This practice is merely based on the assumption that since they can speak both the languages of the doctors and patients that they can interpret.

The aforementioned complaints of the nurses show that health care interpreters require more than just a linguistic knowledge; they also need to have knowledge of the medical terms and most importantly, they need to have empathy and sensitivity for the doctor – patient relationship. Similar to any other professions, “healthcare interpreting is a distinctive and specialized area of practice. Interpreters working in healthcare facilitate communication between providers and patients or families who do not share a language” (NCIHC 2005:2). This shows clearly that there is indeed a demand for suitably qualified interpreters to execute these prescribed specialized duties. This would make a positive impact towards improved healthcare service delivery, as qualified interpreters have the ability to understand patient’s socio-cultural perspectives of health problems (Pöchhacker and Schlesinger 2007: 12).

Saulse (2010:7) argues that besides the fact that ad hoc interpreters do not have the theoretical knowledge of interpreting; health care interpreters should also possess certain qualities. In the case of liaison interpreters, interpreters should have a good knowledge and grasp of the target language (they interpret into) as well as the source language (the language they interpret from). They should also have sufficient knowledge on the subjects that they interpret. Lastly, interpreters should know how to interpret. These basic traits set the norm for all interpreters: anything above the norm suggests an interpreter who is qualified; anything below the norm suggests the opposite, an interpreter who is unqualified.

According to Levin (2006:1076), where language barriers exist, there is patient dissatisfaction. These barriers have been identified in various countries including South Africa as the core sources of unsuccessful therapy. Language difficulties result in reduced patient understanding of diagnoses, medication and follow –up as well as non –adherence to medical advice. This appears to be a direct contravention of a very favourable constitution, especially in a country like South Africa where eleven official languages are equally recognised by the constitution and by right should “enjoy parity of esteem and must be treated equitably” (Constitution of the Republic of South Africa 1996:4). Erasmus (1999: 145) further states that in the case of a medical setting, it is very important to know that the communication problem experienced by the two parties is not simply a matter of language, but of power as well. The difference in power is directly related to class, race, culture and/or gender as well as to knowledge differences between the medical professional and his lay

patient. Furthermore, community or medical interpreters are accountable to the community rather than the institution at which they work. This is because they do not only convey the message between both parties involved but also represent the interest of public service clients, assess their needs and help them obtain the care to which they are entitled (http://www.bls.gov/oco/ocos175.htm).

2.5.3 The impact of the lack of the provision of professional interpreting services

As discussed previously in (2.5.2) the lack of professional medical interpreting services is more likely to result in unpleasant situations. In this section and others to follow, the researcher shall be looking at the impact caused by the lack of these services at a professional level. According to Rivadeneyra et.al (2000:470) when patients are treated as partners in the medical dialogue, rather than reporters of symptoms, they become more willing to ask questions or express concerns. They are also more likely to receive the kind of information about their treatment that they find more useful. Williams et.al (1998:486) support this suggestion by saying that doctors should not use a book as the main form of reference when making a diagnosis but should rather be more patient centred. This means that they must make use of what they define as a 'patient-led' approach. This approach allows patients to express their reasons for attending, including their symptoms, ideas, feelings and expectations. This has been proven as one of the most effective means for a successful road to recovery for the patients (Williams *et.al* 1998:486).

With all that being said, it seems substantively fair to say that it is quite impossible to achieve such satisfactory results when the doctor and patient do not share a common language through which to communicate. Therefore there is a huge demand for the inclusion of suitably qualified medical interpreters to ensure this becomes achievable. The reason for emphasis on the use of the suitably qualified interpreters is clear; interpreting is a very complex practice, it requires specialist skills and in depth knowledge in the field (Angelelli 2007: 63 and Hale 2004:3). The Health Care Interpreting in the News (2011:1) also supports these statements by saying "patients may even present symptoms unrelated to the real problems and the diagnostic doctor relies heavily on skillful questioning which is more likely achievable with the use of medical interpreter".

It has been proven in the United States of America that language barriers complicate many aspects of patient care, including receipt of medical services and patient satisfaction (Schenker et.al 2007:294). “Medical interpreting for limited English speaking patients significantly increases the quality of health care delivery, patient compliance and overall patient satisfaction with the medical encounter” (Ginde, et.al 2008:527). They further say that “lack of attention to language barriers can lead to poor communication, a poor therapeutic alliance, suboptimal quality care and poor health outcomes” (Ginde et.al 2008:527). Pöchhaker and Schlesinger (2007:11) add that there is a great risk in the health care if language barriers are not overcome. This strongly indicates that indeed action needs to be taken in order to improve efficient service delivery in health care.

Language barriers have deleterious effects and patients who face such barriers are less likely than others to have efficient medical care and have an increased risk of noncompliance to the prescribed treatment (Flores 2006: 230). There are treatments and many of them are within the patient’s control, if they learn how to use them optimally from their support team of health care providers (Sloane 2012:1). However, it is not clear if the patients with limited English proficiency are well informed about the seriousness of their illness and if they are able to access all the necessary medical information in relation to their illness in the language of their choice, preferably their mother tongue language (isiZulu). It is also stated in the South African Patients’ Charter (HPCSA 2008:2) that health information should be available in a language that is understood by the patient.

It is because of these undesirable implications that the responsible bodies in the Department of Health in collaboration with the HPCSA should take ownership and act accordingly to prevent such mistakes form occurring. This could be done by means of making amendments which will comply with the constitution of South Africa, the raising of more language awareness (indigenous languages) and accessibility of medical care in the language of the patients’ choice preferably the mother tongue language. Surely with effective use of these aforementioned suggestions improvement would be observed in public health services. Likewise, the reality in this situation is noted that it will not be an exercise achieved overnight; Rome was also not built in one day. However, it would be a starting point for the country as opposed to not having these crucial services at all.

2.5.4 Bilingual personnel versus qualified interpreters in the medical setting

Quite often people assume that if an individual can speak more than one language, that person can therefore interpret. As a result of this assumption, in most hospitals, nurses, general personnel, family members and cleaners are used as interpreters for doctors and patients (Lesch 2007:75 and Pöchhacker and Kadric 1999:161). This is astonishing, as one cannot help but wonder if the information rendered is anywhere close to being accurate. “Interpreting is a profession where - like medicine, teaching and law - the client’s welfare is affected directly because interpreting has its own particular kinds of knowledge, skills and practices which require particular ethical considerations” (Kainz et.al 1996:57).

However, according to Meyer et.al (2010: 298) having interpreting services provided by healthcare providers including the family members and general working staff members is an advantage because it reduces the need for interpreters and the patient can form a better relationship with the doctor. Furthermore, in a study which was conducted in one of the hospitals in the Western Cape by Drennan (1996), results suggest that individual units would not be able to support full-time interpreters. Hence, it appears that the majority of patients with limited English proficiency are being assisted through the use of family members, cleaners and other inappropriate or untrained people (Drennan 1996:344).

Now the greatest concern is, how can a doctor-patient relationship be formulated and nourished if there is not sufficient communication or similar level of understanding due to the language barrier and socio economic status? Besides that, the high expectations of interpreting add to the complexity of determining meaning in situations where there are multiple levels at which the meaning can be constructed. Furthermore, omissions or inaccuracy could have great detrimental effects in the medical setting (Drennan and Swartz 1996:170). Hale (2007:35) argues that untrained interpreters may not understand all procedures and various forms of questioning or different modes of delivery in various settings. Likewise, professionals working with interpreters rarely understand the complexity of the task and the interpreters’ needs in producing an accurate rendition. She further states

that professional interpreters have a responsibility to acquire the necessary language and interpreting skills to gain an understanding of the settings in which they work in and the specific requirements, or the purposes for which language is used in each and every setting and to abide by a code of ethics.

In a study conducted by Athorp and Downing in 1996, where a professional interpreter and a nurse were used to interpret in different consultation rooms it was clear that the interview with the professional interpreter compared favourably to the other event, with the interpreter's utterances on the whole being a more accurate rendition of the doctor's and patient's turns.

They also discovered that the nurse often assumed a caregiver role and reduced the number of direct interactions between the doctor and the patient. This is in line with the role of a nurse as an information provider and care giver. The study was concluded by stating that there is great benefit for the medical profession in using the services of professional, trained interpreters, as opposed to untrained bilinguals (Hale 2007:58).

Another example to substantiate this argument would be again of Dimitrova (in Hale 2000:56) where he also conducted a study on the analysis of the work of a professionally trained medical interpreter and discovered that every turn was interpreted accurately and the interpreter always used the first person (Hale 2000:56). That study also found that untrained, ad hoc interpreters always interpret what comes naturally at the time simply because they want to offer a summary of what they feel is relevant. This again compromises the accuracy of the target message which is the most significant component in the patient and doctor communication process (Scott 2009: 1). That is why Lesch (2007:76) suggests that healthcare interpreters must undergo a more specific medical interpreting training which might be of assistance to them with the relevant terminology and this will enhance the communication flow. According to Candlin and Candlin (2003:137) the severe lack of qualified medical interpreters is almost endemic in healthcare worldwide in such a way that pragmatic, ethical, clinical and ideological issues inevitably arise. This has also been proven to be the case here in South Africa. Often times when one visits the medical institutions, such services are either provided by

people who are considered bilingual or not provided at all. Both the medical practitioners and patients have to struggle for better communication.

2.5.5 Shortage of isiZulu speaking doctors in KwaZulu- Natal

“In South Africa where there are eleven official languages, discrepancy between the language spoken by patients and doctors is extremely common. The overwhelming majority of health professionals, with the exception of nurses, cannot speak any of the indigenous African languages.” (Levin 2006:1076). According to the 2011 census it is estimated that 22.7 % of the South African population speak isiZulu while only 9.6% of the population speak English as their home language (South Africa. Info: 2012). In KwaZulu – Natal, isiZulu is the home language of 77.8% of the population and English as a home language is sitting at 13.2 %. However in 2008 a report that was published which showed that in 2007 only 35.1% of the doctors in public healthcare were African (Department of Labour 2008:28). Similar data for the current situation is not publically available but the healthcare system confirms this low percentage of African doctors has not changed much. Of these 35.1% African doctors, it is not stated how many are isiZulu speakers but we may assume that it is not all of them.

The reality of the public health system in KwaZulu - Natal therefore is that in the region of 70% of doctors and specialists are unable to speak isiZulu while well over 70% of the population of the province are isiZulu mother tongue users. Furthermore, “among the many acts and regulations emanating from the Department of Health since 1994, there are a number designed specifically to correct the imbalance between rural/ urban/ private provision” (Department of Labour 2008:47).Therefore with that being stated as one of the aims of the healthcare service’s aim, surely means for effective communication should also form part of these aforementioned aims. Especially in the case of the rural settlements, efficient interpreting services are in great demand. This is because there is also a high percentage of illiteracy as well, which is another contributing factor to poor language communication in the medical sector. There are places where people cannot even utter one meaningful sentence in English. Therefore these people depend highly on the interpreters for better healthcare delivery. As further discussed above that there is a very limited

number of doctors who are isiZulu speakers so this means that both parties require these services to be readily available at all times.

"Medical health system is a crucial service. While some countries invest little in it, others are committed to making it available to every citizen. Canada, through its Medicare system, provides one of the best medical services in the world. Meanwhile, South Africa is struggling to maintain adequate healthcare" (Hathout 2003:141). As a result of this, South Africa has made a cordial relationship with Canada in order to share ideas which could improve the South African healthcare system. Suitably qualifying interested students are sent to Canada from time to time for enrolment in medicine and all this is done with the aim of improving the healthcare system. However, there seems to be a gap for other very crucial skills which are required for an effective therapeutic process.

This is because it does not seem like there are any efforts put into place with regards to addressing patient – doctor language communication. Yet South Africa is a multicultural and multilingual country like Australia (Cioffi 2002:299). On top of that it has one of the most favourable constitutions in the world as compared to other countries when it comes to language rights. There are eleven official languages in the country and all languages should "enjoy parity of esteem and must be treated equitably" (Republic of South Africa 1996:4). Furthermore, the national patients' right charter recognizes the right of access to health care information. Health information which includes information on the availability of health services and how best to use such services and such information shall be in the language understood by the patient (HPCSA 2008:2). The biggest question is, with such a favorable constitution and charter in place how much progress has South Africa made in ensuring this does not exist only on paper but becomes a daily practical experience? Perhaps there is a need to first establish as to whether interpreting services are provided in the medical setting, if yes, by whom are these services provided and do the personnel providing such service meet the requirements in terms of having suitable credentials?

2.5.6 The lack of formal training for interpreters in South Africa

“The political and social transformations taking place in South Africa have given rise to a mood of optimism regarding the speed and extent of the changes that are possible in a short space of time. In the context of limited language resources for the delivery of health care, the role of the interpreter has particular currency.” (Drennan and Swarts 1999:169).

Several people in the province of KwaZulu –Natal who visit the public hospitals have limited English proficiency. Nevertheless, it would seem as if very little is known about the effect and the significance of providing medical interpreting services on health care quality. According to Flores (2005: 255) numerous studies have shown that quality of care is compromised when limited English proficiency (LEP) patients require interpreting services but are not afforded such services. LEP patients' quality of care is therefore inferior, and more interpreter errors occur with untrained, ad hoc interpreters. As mentioned before, inadequate interpreter services can have serious consequences for patients. Trained professional interpreters and bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers.

According to Davidson (2001:171) and Gibbons (1994:30) interpreting is always a contextual act. However, interpreting in institutional settings like courts and hospitals, discourse is defined at least by the social and behavioral norms of the institution. This clearly indicates that the one providing the interpreting services in these institutions must have in depth cultural and linguistic knowledge in order to facilitate accurate interpretation. Angelelli (2007: 63) states that interpreting in the medical field involves a unique type of contextually bound communication in two languages, which normally takes place under pressure. It would therefore seem reasonable and fair enough to disagree with what Flores says about the use of “bilinguals” as medical interpreters in order to provide adequate communication for patients. This is because the chances that these “bilinguals” will grasp sufficient and all the necessary interpreting skills, are extremely limited.

At least in the court setting the situation is slightly different because, in as much as most South African court interpreters do not have a formal training, they do go through a language proficiency test after they have been short listed for the job interviews. This from a professional interpreter's perspective does not reflect quality service and efficient way of securing employment in the language field or profession. However, at least these candidates are afforded an opportunity to prove their language proficiency and interpreting skills as they go through induction training for court interpreting after being appointed as court interpreters. This way, they get to understand the court setting and the relevant jargon which they require in their daily working lives as court interpreters.

Whereas in hospitals the main sources for interpreting services is still provided by nurses, nursing assistants, auxiliary staff, cleaning staff and community volunteers if not family members (Cioffi 2002:299), (Lesch 2007:75) and (Pöchhacker and Kadric 1999:161). At times these services are not available at all (Levin 206:1076). Clearly, with all these complications involved, one cannot expect to receive adequate healthcare due to not being afforded an opportunity to be clearly understood. Therefore this puts the lives of the patients with limited English proficiency at severe risk. Also this is another contributing factor in the decreasing healthcare system in South Africa. As is stated by various authors, patients who have been provided with the interpreting services are less likely not to comply with the prescribed treatment (Hale 2007: 40), (Pèrez-Stable et.al 1997:1212 and Rivadeneyra 2000: 470). Levin (2006:1077) states that in a survey by Saohatse in 1998, nurses and ad hoc interpreters were most often used for interpreting and poor quality care resulted. Examples of poor care include inappropriate discharge leading to patient distress, medical consequences and non- compliance with medication as well as anger from doctors and resentment from nurses.

In spite of the mere fact that this study focuses on medical interpreting in two hospitals the eThekwini district, , this problem still does not seem to have been overcome in South Africa as a whole. This is because there are still no qualified medical interpreters providing these services in the health institutions anywhere in the country. Could this mean that South Africa is turning a blind eye to such critical cases? Surprisingly enough, it has been observed several times that when a nurse or other personnel are attending a disciplinary hearing in relation to an error that they

have been involved in, they are afforded interpreting services. However, when it comes to providing these services to people who urgently require them (patients), they are not given. Also bearing in mind that the majority of them did not attend school and others cannot even utter one meaningful sentence in English. How much difficult could this situation be for these patients, if people who serve as their interpreters cannot speak English to save their careers. Indeed this appears as a huge gap that needs to be addressed to the relevant role players in this field.

2.5.7 Marginalization of indigenous languages.

According to Pretorius and Bosch (2003:268), Africa has an extreme high degree of illiteracy and indigenous languages are at constant threat of marginalization. Perhaps this, as well as other social factors, could be one of the implications of colonization. Nevertheless, in South Africa only nine percent (9 %) of the population are English language first speakers. Surprisingly enough, English still dominates almost all the other indigenous languages as it remains the most frequently used language for both spoken and written communication. Although this may be the common situation, but it is also very interesting to know that previous research has shown that most people do not fully understand communication written or spoken in English and prefer the use of their mother tongue languages (Pretorius and Bosch 2003:58). This is in full support of the PanSALB's vision to ensure that the majority of South Africans are addressed in their mother tongue languages (PanSALB: 2012: 6).

Therefore the ball is in our court now to implement a strategy which would be a practical solution in addressing these issues. The most important step which will determine a possible solution to this problem would be to ascertain the ethnicity of these problems pertaining to marginalization of the indigenous languages. There are many misconceptions about indigenous languages. One of the most astonishing is that found in the education sector. According to the report (PanSALB's 2012-2013 annual report), there is a public conception that African learners do not like to be taught in their home language and to learn their home language as a subject. Moreover, they prefer to be taught in English simply because it is taught in a more interesting and fun way. This is a debatable report, as the reasons provided do not provide any further details to substantiate the reasons why this is said to be the case.

For argument purposes, one may argue that the entire reason for learners to prefer English more than their home languages is basically the fact that they have a better relationship with the English teacher or perhaps the teacher is brilliant in teaching the subject. It could also be the fact that an indigenous language teacher is not in possession of a professional qualification with a specialization in indigenous languages. Hence that teacher is not fully equipped to teach the indigenous language in an effective and competent manner as compared to the English teacher. A similar case applies in mathematics. Most learners have extreme difficulty grasping and mastering mathematics and as a result the matric pass rate for this subject still remains at an inadequate unsatisfactory level. As a result mathematics literacy was implemented as a substitute for 'core mathematics' in order to accommodate learners who seem to have had some learning difficulties regarding the subject.

It is for these two reasons that I would rather say the problem with indigenous language learning is more of an inferior attitude towards these languages. Gwele in her speech on 5 March 2014 made an example of the inferior attitude towards indigenous languages, particularly isiZulu in this regard. She spoke of a little girl who was at Musgrave Shopping Mall in Durban with her father. This young girl requested her father to buy her ice cream. *"Baba ngicela ungithengele u- ice cream" (Father please buy me ice cream).* The father just literally ignored the child and never responded. The young girl repeatedly requested for the ice cream in isiZulu up until the father got irritated and responded to the child viciously, *"Are you talking to me?"* Automatically the child could see that she was not supposed to speak isiZulu with her father, she then responded in English *"Father please buy me ice cream"* and the father responded *"You are now talking"* and bought the ice cream for the child with a smile on his face.

Now the concern is, if indigenous languages are not promoted at home and such an inferior attitude is displayed publicly towards them, how are the children going to acquire an interest in learning the languages that put them at such a great disadvantage? It would therefore seem appropriate to start a proper promotion of the use of mother tongue languages at homes and then escalating it to the educational institutions. Although this may not guarantee a brilliant outcome, but it can be regarded as a practical, efficient move because a foundation for the proper use of a

home language would be installed. Also there is a need to ascertain as to whether African Black learners are sent for enrolment into the multiracial schools for English or better academic purposes.

2.5.8 The delay in the implementation of language units in the public sector

According to Ostarhild (2002:110) communication across language and culture is required in a wide range of languages. She further states that public interpreting has developed over the past decade to meet some of these demands. This seems to be an exclusive case at least for London where these services are fully functional. The reason for this is because in South Africa this practice is not functional as yet and there is no clear indication as to when, if ever, these services are going to be made available. Often times we have heard that the government is in a process of implementing language units in all the public service organizations in order to bridge the language gap which appears to be the depriving people with limited English command from equitable access to services. Hence there are various organizations or bodies tasked to ensure that this plan comes to practice effectively. However, the frequently asked question is that of 'how much progress has been made?' especially given the number of years these bodies have been into action regarding the address of these language issues. Perhaps this could also mean that the South African constitution and language acts only exist on paper but are not fully followed and utilized appropriately.

"The deliberate use of language policies for the purpose of creating a national identity and fostering sentimental attachment is usually not desirable. Rather, language policies ought to be designed to meet the needs and interests of all segments of the population effectively and equitably, thus fostering instrumental attachments out of which sentimental ones can emerge" (Alexander 1989:53).

According to Phillipson (1996:161) "The Organization for African Unit (OAU) Language Plan of Action for Africa sets out priorities and a languages programme of action at various levels, with the following aims:

a. To encourage each and every Member State to have a clearly defined language policy;

b. To ensure that all languages within the boundaries of Member States are recognized and accepted as a source of mutual enrichment;

c. To liberate the African peoples from undue reliance on the utilization of non-indigenous languages as the dominant, official languages of the state in favour of the gradual takeover of appropriate and carefully selected indigenous African languages in this domain;

d. To ensure that African languages, by appropriate provision and practical promotions, assume their rightful role as the means of official communication in the public affairs of each Member State in replacement of European languages which have hitherto played this role;

e. To encourage the increased use of African languages as vehicles of instruction at all educational levels."

This was indeed an optimistic initiative that was implemented especially in South Africa. However, the regrettable truth is that, this initiative still seems to exist on paper only and not much is done to ensure implementation.

2.5.9 Lack of formal training for both translators and interpreters

"Career patterns are becoming increasingly fluid and a job for life is being replaced by lifelong learning. Increasingly, job seekers will require flexibility and mobility to be able to pursue career opportunities where and when they arise. Career changes frequently require training and qualifications. As a result, a flexible job market stimulates education and training, both for the individual seeking a career change and for trainers and teachers in colleges that provide training courses" (Ostarhild 2002: 2). Nevertheless, previous research has shown that in South Africa most people serving as interpreters do not have formal training. Usually, these people have been in the language field for a number of years and have gained a portion of the necessary experience. For these reasons mentioned above they therefore automatically become translators and interpreters without any appropriate credentials. This is one of the most common practices in the country which is accompanied by extreme emotional sensitivity that needs a proper mechanism and high levels of diplomacy when addressing it. This is because when one suggests to

these experienced translators and interpreters without a formal training to at least obtain a qualification so that they become qualified practitioners, the response received is not of a very positive nature, but rather seen as a point of undermining people. Nolan (2005: 5) states that there is no single, uniform accreditation process to become a translator or interpreter but it all depends on the employer's employment requirements. This situation therefore makes these professions to appear more informal and obviously tarnishes the dignity of the profession. If we say there are no specific qualifications required in this field, then people could argue there should be no significance in existence of the language profession. Furthermore, if this is seen as an unnecessary profession, we must therefore apply the same strategies in other field of professionalism by utilising lay people and expect them to perform wonders in those respective professions.

When one looks at the provision of interpreting services in the medical sector in the South African context, the sad reality is that we seem to be lacking way too behind from other countries. This is because almost all the people serving as interpreters are not in any possession of a suitable qualification which recognizes them as interpreters. However, these individuals are just bilingual (Saulse 201:28). Another concern is that the medical jargon is very selective and being bilingual alone without proper additional knowledge does not appear to be sufficient for one to fulfil these duties. This was also discovered by Lesch (2007:75) that the main source of interpreting in the medical setting is obtained from hospital cleaning staff, nurses and administration staff if not family members of the patient. This further increases risks as these people who are considered bilingual could possibly omit or alter the message completely which could lead to improper diagnosis and prescription of the wrong treatment.

Another important question that one may ask is how is one considered or classified as bilingual. According to Nolan (2005:6), in order for one to be considered bilingual they must be thoroughly conversant with both languages, sensitive to the differences between them and able to use both equally well as a medium of expression. He further states that very few people are truly bilingual as being truly bilingual requires early exposure to languages. This trains the ear to recognize the sounds of both languages, to grasp difficult accents and to recognize nuances and idiomatic expressions. But most importantly he emphasizes that the aforementioned

requirements are not sufficient without additional information and formal training. This is further supported by Chen (2006:812) when he states that using bilingual staff members as interpreters is not a good alternative plan. This is because staff members without formal training may not be fluent in the critical medical terminology and their interpreting skills may be questionable which will thus compromise adequate healthcare service delivery to the patient.

Therefore the discussion made in this section clearly indicates that formal training is indeed needed in this profession, not only for the recognition of the profession alone but also for much improved healthcare service delivery. Although the main focus of this research is based on medical interpreting, the training is also significant to other professions as well such as in the justice systems i.e. (Criminal courts) and labour dispute related institutions (Commission for Conciliation, Mediation and arbitration CCMA and various bargaining councils). These are the organizations where drastic decisions which have a lifetime impact on peoples' lives, jobs and organizations' reputation are taken. Therefore the evidence given by each of the parties is dependent entirely on the accuracy of the message rendered by the interpreter. Under no normal circumstances should it be accepted that any unfavorable decision taken in a case was influenced by the inaccuracy of the messaged rendered by the interpreter during the interpreting process. The very similar case applies in the medical setting; patients should not find themselves in a situation where they are improperly diagnosed and end up having to do severe and unnecessary operations due to the communication breakdown caused by the language barriers.

2.5.10 The misunderstanding of the interpreter's role in the medical setting

According to Angelelli (2004: 8) interpreters have always been significant not only for bridging communication between individuals from multilingual and highly advanced civilization, but also in breaking the differences between them. She further states that in ancient history, interpreters were not only regarded as linguistic mediators for regular business transactions, but also considered as semi-divine and capable of performing multiple tasks. Bolden (200:388) states that despite the growing need for medical interpreting and the recognition of its significance, very little is known about the role interpreters play in the communication process between medical practitioners and patients. Again the recognition of the significance of medical

interpreting is slightly distinct in the South African context, as it would seem this profession is poorly recognised, if at all.

Interpreting in general has been clearly defined previously as the transference of an oral text from one language into another and also as interpreting in a setting where healthcare services are provided in a case of medical setting (Hale 2007:3)\; Napier et al. 2006:25 and Makhubu 2011:38). Other studies have defined the interpreter in these various settings as passive members who are regarded as absent in the entire process. However, the role of an interpreter goes much further than simply converting one language into another. The role of an interpreter is to bridge the gap between cultures, to create a mutual understanding of facts and what is being communicated between two parties (Roy 2000:4). Therefore it is disputable that an individual with such a significant role can be regarded as a ghost or as just a conduit.

The following figures illustrate some brief ideas of the interpreting process in the medical context; or rather what would be ideal in countries where such practices are neither well established nor recognised efficiently.

2.5.10.1 Bilingual setting

The diagrams below indicate how the communication process is taking place in the medical setting. The arrows further illustrate how the conversation between the doctor and the patient is conveyed with the services of an interpreter in a bilingual situation.

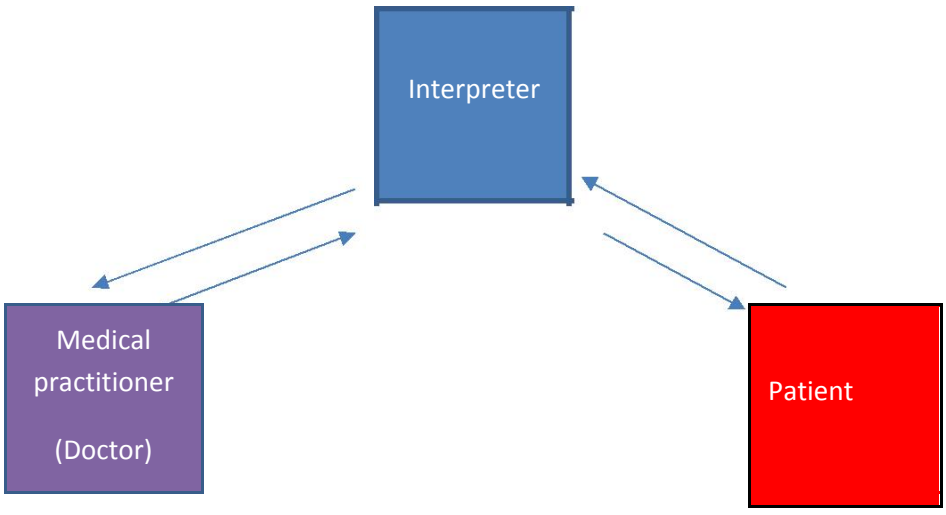


Figure: 6 indicates the interpreting process in a bilingual medical setting.

2.5.10.2 Monolingual setting

In a monolingual situation, usually parties or participants share a common language and culture. Therefore interpreting services are usually not required as the participants communicate directly to one another as opposed to a bilingual situation where a message is conveyed to either of the parties by an interpreter.

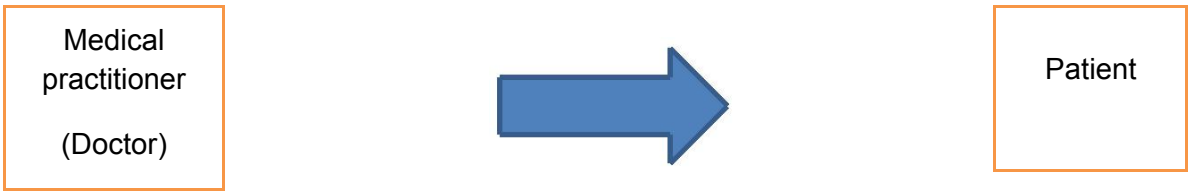
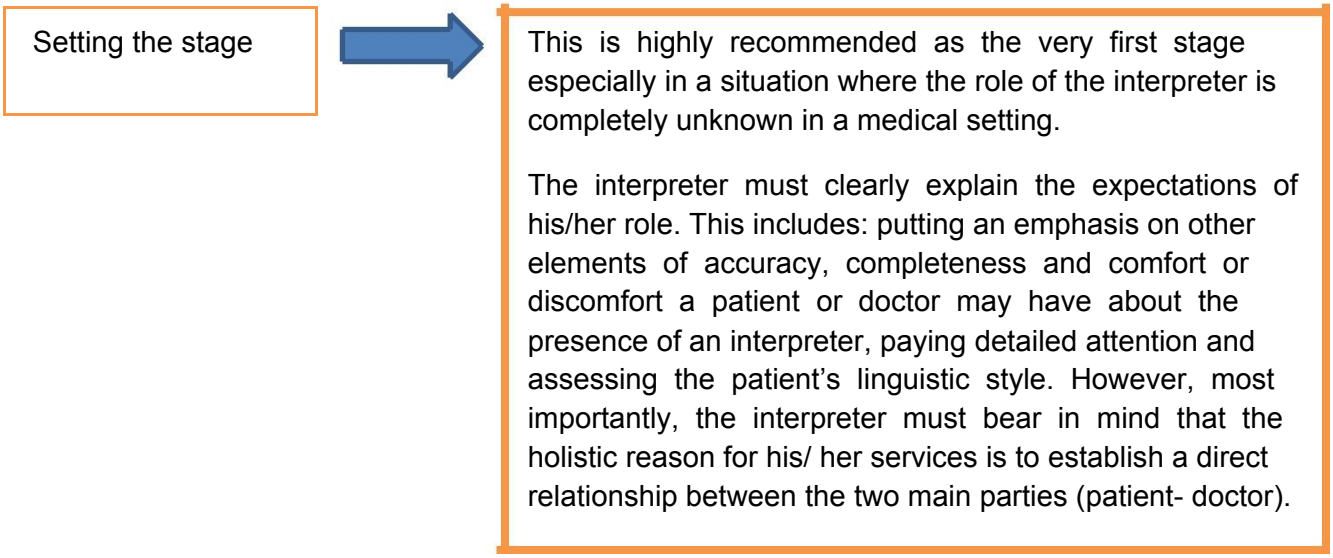


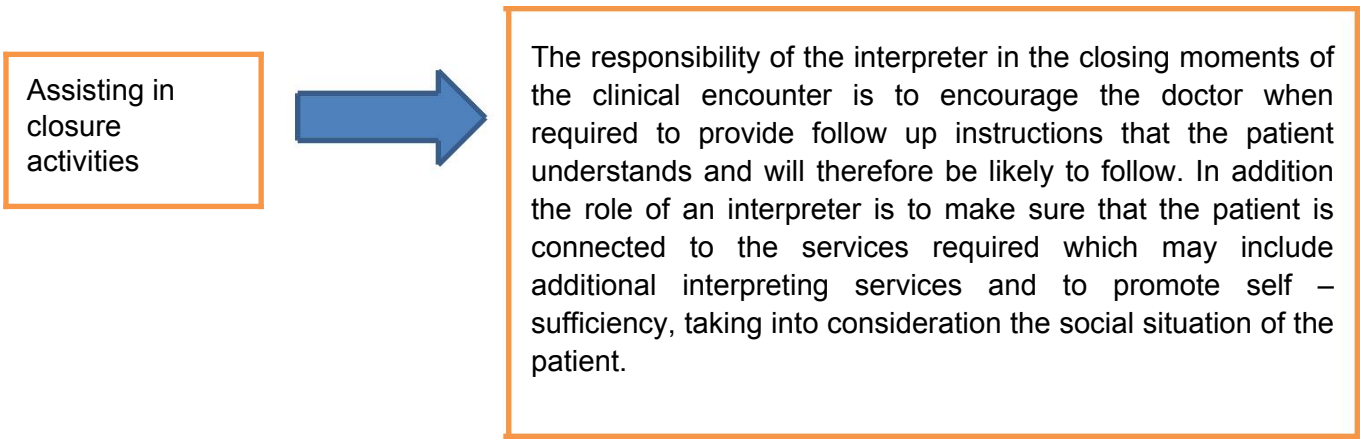
Figure: 7 shows how the doctor and patient consultation process in a monolingual situation with the absentia of the interpreter.

2.5.10.3 Defining the roles of a professionally trained interpreter in the medical setting.

According to the International Medical Interpreters Association (IMIA) (1995:13) although the role of medical interpreter is to interpret and ensure that the message is conveyed accurately. Nevertheless, there are other skills that are regarded as complimentary skills which also strongly assist the interpreter and the parties during consultations. These skills are classified into five groups and are listed below in accordance to the IMIA standards for professional medical interpreters.



Interpreting	This is the stage whereby an interpreter must convey the message accurately. All the essential elements of the communication in both languages must be retained. Interpreters with high linguistic proficiency are most likely to have an easy flow in the conversation flow. Those with limited linguistic ability can apply the necessary strategies to ensure that they get clarity before attempting to convey the message.
Managing the flow of communicatio	In the interest of accuracy and completeness, interpreters must be able to manage the flow of communication so that important information is not lost or miscommunicated. It is recommended that interpreters attend to the interpersonal interaction between provider and patient, e.g. when tension or conflict arises. The role of the interpreter is not to take responsibility for the actions of the two parties but rather to assist in establishing a common communication process that flows the parties to work things out for themselves.
Managing the triadic relationship	Medical interpreters are professionals, they therefore have a significant role to play in terms of rendering a quality and an accurate message to all the parties involved in the communication process. Their services must not compromise the therapeutic relationship and its goals for quality healthcare. Their sole responsibilities is to fully support both parties in their respective domains of expertise i.e. the doctor being the technical expert with all the knowledge and skills in medicine and healthcare and the patient being the expert in his or her symptoms, beliefs and needs. The doctor offers informed opinions and options, while the patient remains the ultimate decision maker in terms of treatment. Therefore the role of the interpreter is not to take control of substance of the message but rather to manage the process of communication.



Corselllis (2008:125) further recommends that in order for medical interpreters to be more efficient in their practice they must acquire the following skills:

- Communicate within a shared language and culture.
- Communicate through a shared language but without a shared culture.
- Work closely with translators for self-development in the profession.
- Deliver appropriate and effective service working across cultures.

In conclusion, in this section the role of interpreters in the medical setting has been explained by providing a clear description of the role which they play and that is recommended to be of a better standard for service delivery by the IMIA. Furthermore, having explained the specific role of medical interpreters and their significant role in the consultation process, this has also assisted in substantiating the dispute against seeing medical interpreters as invisible or passive participants. This is because it would seem improbable to state that interpreters are passive participants throughout the entire process whereas they play such a significant role. In this view a proper induction about the role of the interpreters in the medical setting in South Africa would seem appropriate in order to avoid such statements being made which seem to be uttered due to lack of proper knowledge about the role of the interpreter.

2.5.11 Language practitioners' social responsibilities

This is again one of the most concerning factors here in South Africa in the language profession field. Except for the extreme lack of recognition of the language related professions, language practitioners still experience extremely low salary scales. According to Ostarhild (2002:53) it no longer makes good business practice to expect all transactions and social contacts to be conducted in English. She further states that there is a need for almost all languages to be used in all industries and commerce. Likewise, the need for language skills is also in great demand for effective communication in different levels. This is because it has been increasingly identified that spoken skills and the ability to conduct a conversation are the most significant tools. In cases where people in the various fields do not have adequate language skills it would seem ideal to utilize the services of a trained interpreter for spoken language and translators for textual communication. Again it is unfortunate that people with such a significant role to play in various sectors are poorly paid.

According to the South African Translators' Institute (2007:1) "It is important to bear in mind that language practitioners offer a specialized service and should be remunerated accordingly. Consider what you are prepared to pay a plumber, a computer technician or your GP. Just because you are able to speak a language but know nothing about plumbing, the insides of your PC or medicine does not mean that language services are worth less than other services". This is indeed a very valid point made by SATI, as it seems to be a common assumption that if people have basic knowledge of any language they therefore can interpret or translate into it. For these obvious assumptions and false thoughts, the dignity of the language related profession is compromised and the practitioners are poorly paid.

Furthermore, we cannot neglect the current situation where most personnel acting as language practitioners are not qualified nor in possession of suitable qualifications to provide such services. Some of these aforementioned personnel were recruited ages ago before the issue of formal training was suggested. It is therefore a challenge to teach or implement the training to these experienced yet not properly qualified language practitioners. It would further seem as if they have no intensions of gaining

further and modern information which would assist in equipping them with more knowledge and the necessary skills required.

Likewise, when it comes to charging for language services provided, it is not easy as yet to come up with a counter proposal figure due to the complexities involved in the profession. Language practitioners work in almost every field that exists in the world e.g. law, science, commercials, medical etc. and for this variety, obviously the language (jargon) in use is different. This therefore means that language practitioners must apply their minds in all these various fields in order to be able to produce work that is of high standard. Professionals in this field even go the extra mile of conducting their own research in the subject matter. Although a translation and interpreting brief is supposed to be given by the clients, this is not always possible especially in an interpreting context. If interpreters are not the last ones to be given documentation, they are often not given anything at all but they are still expected to perform miracles. It is for these reasons mentioned above that language work is said to involve concentrated effort and requires commensurate remuneration and the remuneration received must enable the language practitioners to make a decent living as is the case for lawyers, doctors, accountants etc. (SATI 2007:1). At the 2013 International Medical Interpreter's Association conference Bancroft also stated that if language practitioners cannot make a decent living of their professions then language professions should not be considered as careers.

Although nothing has been officially documented in South Africa with regards to poor payment for language practitioners, but it has been observed that people from this profession are seeking employment in other fields where they can make a better decent living. A typical example of this situation would be that of the court interpreters. The majority of these personnel are currently registered in universities for law degrees which would lead to greener pastures. However, it seems quite impossible to achieve if they are still employed as interpreters. This is further influenced by the treatment they receive, as they are seen as voice overs or passive personnel who do not add much significance in the proceedings. In the case of the freelance interpreters, experience has also proven that these personnel are using this profession as a stepping stone whilst waiting for better career opportunities to emanate.

If this situation escalates, clearly the country will be left with less qualified personnel in this field. This again will result in more untrained and unaccredited candidates being appointed to fill in the gaps for those who have abandoned the profession due to being poorly remunerated. Moreover, this will later on result in more compromised service delivery, which will not only result in communication breakdowns but in disastrous situations as well where lives might even be lost, especially in the medical setting, due to interpreting services being rendered by unqualified personnel.

2.6 Conclusion

This chapter focused on the existing literature where both global and local research cases were viewed. Based on the linguistic situation discussed in this chapter, it is evidently clear that English still remains the language mostly used during consultations between English speaking doctors and isiZulu speaking patients. This, despite the fact that isiZulu is the predominant language of the province of KwaZulu-Natal. However, no efforts seem to have been made to assist with the provision of medical interpreting services at a professional level in the hospitals. Therefore, it seems as if isiZulu patients are increasingly exposed to high medical risks, some of which they are not even aware of as there is no proper system yet in place to facilitate professional medical interpreting services. It appears that the current services are rendered on an ad hoc basis and by unsuitably qualified personnel.

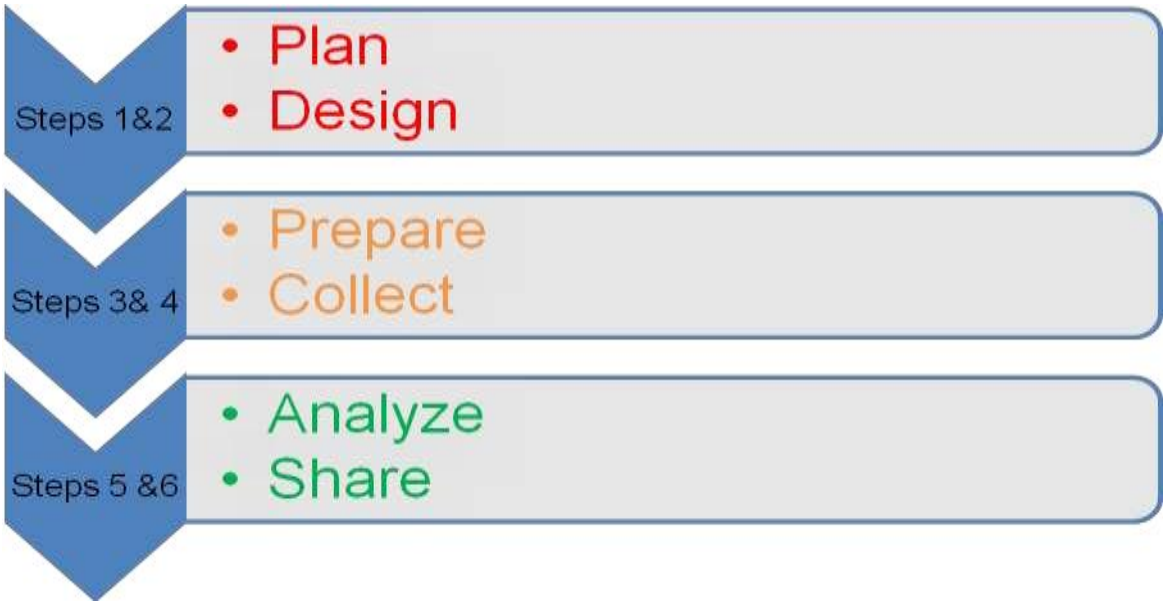
It was further ascertained that the situation in South Africa is still very much below the adequate expected standard compared to other countries, especially in a country with such a desirable constitution regarding language rights. Likewise, the issue of formal training appears in almost all the discussed areas as the key and core solution to this dilemma. Other critical social shortcomings in the language and medical profession were also discussed and key starting solutions were recommended by the researcher.

Therefore the reviewed literature supports the significance of this research. The following chapter (Chapter 3) will discuss the methodological approach adopted in this study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter aims to provide an overview of the research procedures, approaches or the designs employed in this study. Creswell and Plano Clark (2011:53) describe research designs as procedures for collecting, analysing, interpreting and reporting data in the research studies. They further state that these represent different models for conducting research and provide unique types and names and procedures associated with them. It is therefore in this chapter that the researcher endeavours to explore the current interpreting situation during consultations in the medical setting. The data collected that is described in this chapter will possibly assist the researcher in terms of confirming the hypothesis and answering the sub research questions as well. Furthermore, this will confirm if the initial shortcomings stated in the previous chapter (chapter two) are somehow linked to these which are to be gathered during the data analysis process. However, the hypothesis and all the research questions will be discussed in detail in the next chapter. Lee (n.d.) defines the methodology in the following steps:



Therefore, this chapter will cover the following six (6) aspects:

3.1 Introduction
3.2 Research approach
3.3 Research design
3.4 Target population
3.5 Data collecting tools
3.6 Conclusion

3.2 Research Approach

Because of the nature of the study which is mostly focused on human interactions, certain behaviours and common norms, a qualitative method is considered appropriate for this study. According to Kothari (2004:5) this approach is concerned with subjective assessment of attitudes, opinions and behaviours. Research in such a situation is a function of the researcher's insights and impressions. Such an approach generates results either in non- quantitative form or in the form which is not subjected to rigorous quantitative techniques and in-depth interviews are used. This is also supported by Patton (2001:10) whereby she also states that "Qualitative research analyses data from direct fieldwork observations, in-depth, open-ended interviews, and written documents. Qualitative researchers engage in naturalistic inquiry, studying real-world settings inductively to generate rich narrative descriptions and construct case studies. Inductive analysis across cases yields patterns and themes, the fruit of qualitative research".

Nevertheless, the reason for distinctively selecting this kind of approach is also purely based on the characteristics of this type of approach which appear to be more inline, applicable and relevant to the research study. To mention a few relevant features in this approach, Leedy (1993:141) states the following about the qualitative research:

- It is field focus; the researchers go out to various fields to collect data e.g. educational institutions and medical institutions etc.

- The researcher is an active tool, because he/she engages in the situation and makes sense of it.

- It consists of interpretive character. This means that inquirers try to account for what they have given an account of. Furthermore, qualitative inquirers aim beneath manifest behavior to the meaning events have for those who experience them.

- Qualitative studies display the use of expressive language and the presence of voice in the text.

- Qualitative research pays attention to particulars.

- Qualitative research pertains to the criteria for judging their success, meaning that it becomes believable because of its coherence, insight and instrumental utility.

It is therefore for the aforementioned characteristics that the qualitative approach was selected.

3.3 Research Design

As stated previously in 3.2, this is a qualitative study whereby in-depth factual interviews and questionnaires will be used as means for data collection and will be analysed as is by the researcher. Kvale (2007:71) states that qualitative interviews do not only focus on the interviewees' perspectives and meanings. He makes an example of a medical interview, whereby a doctor needs to acquire the correct information about the exact bottle of medical pills the child had eaten from. Such information is of great significance in life threatening situations like these. Therefore, interview questions for such purpose should under no circumstances be restricted, and then follow up questions are considered necessary in such instances.

Also this suggests that even the interviewer must have certain interviewing skills in order to obtain effective responses. Furthermore, he urges the interviewers to be extremely mindful in wording their interview questions when interviewing for factual information. Similarly, with regards to the use of questionnaires as data collecting tools, Leedy (1993:188) states that questionnaires should be well structured in order

to answer specific research questions and objectives. Moreover, he recommends with emphasis that questionnaires should be quality tested in order to retain and reflect quality results. Therefore this design is selected to answer the following:

3.3.1 Hypothesis of the study:

IsiZulu speakers with limited English proficiency are possibly receiving inferior medical assistance due to language barriers. The isiZulu speaking patients with extremely limited English proficiency who access the health services in public and private hospitals frequently encounter non-isiZulu speaking doctors in consultations. The resultant language barriers are likely to give rise to poor communication in these consultations.

3.3.2 Research aim:

To demonstrate whether the provision of interpreting services in South African indigenous languages results in equity of healthcare information in the health care systems of KwaZulu- Natal.

3.3.3 Research objectives:

1. To identify any language barriers experienced in consultations between non-isiZulu speaking medical practitioners and isiZulu patients in consultations where a mutually understood language is not available.
2. To explore the actual and potential consequences of misunderstanding in medical consultations.
3. To make recommendations as to how any problems identified in 1 and 2 could be solved.

3.3.4 Research questions:

1. What language barriers, if any, are experienced in consultations between medical practitioners and patients?
2. What possible consequences can this be seen to have for:

a) Accurate diagnosis of the patient's condition and the understanding thereof?
b) The treatment prescribed.

3. Based on the above questions, what recommendations could be made improve understanding of both the medical condition and its prescribed treatment?

3.4 Target population

As mentioned in the previous chapter, there are many personnel involved in the medical settings in terms of delivering various services to ensure quality healthcare delivery to the public. However, the main active participants in the therapeutic process consist of the following people: doctors, nurses and patients. Thus, these are the main participants targeted in this study and are grouped as follows in no specific order in terms of their selection: six (6) doctors from each hospital who are non-isiZulu speakers, six (6) hospital staff members from each hospital who are used by doctors as ad-hoc interpreters e.g. nurses and cleaners and at least ten (10) isiZulu speaking patients form each hospital where the study is conducted.

3.5 Data collection tools

The initial plan for the data collection was to utilise interviews for all the participants in both the selected medical institutions (King Edward VIII and R. K. Khan Hospitals). This was chosen with an aim to explore the study and possibly obtain more detailed responses from the all the participants. However, given the hectic nature of the medical setting, it seemed improper or rather inconvenient to conduct interviews with medical practitioners. Therefore, the researcher opted to use questionnaires as data collection tools for the medical staff members. It should be noted that both medical groups of the participants had unique types of interview questions in order to suit their role in the medical setting. This means that the doctors had their own questions which covered their specific roles in the research as compared to the ad-hoc interpreters (nurses). As a result, the only group of the participants that ended up having the interviews was the patients, but there were also some challenges

encountered as the participants refused to have the interviews recorded. The researcher then ended up jotting the responses of each participant as the interview went along.

3.5.1 Questionnaires

According to Rubin and Rubin (2012:26) this method is regarded in the research field as documentary analysis. This is because it involves detailed analysis and examination of various documents. These could include newspapers, speeches, transcripts of meetings, personal and public letters and so on but as long as those things appear in a written form and or visual recordings. For this study, this method was applied mostly to the medical staff members (doctors and nurses).

This was done in order to save time due to the sever time constraints experienced by the medical professionals. The environment they work under is quiet critical and requires too much focus to the people they serve. However, a space for additional information regarding language and communication issues in the hospitals they work at was included in the questionnaire and will be included in the findings or recommendations. These questionnaires will be available in the form of appendices.

3.5.2 Interviews

Kvale (2007:52) cited Spradley (1979:34) about the aim of conducting interviews which he describes as follow: “I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand?” Indeed this explains the exact feelings or aims of social researchers. This is because, we see things happening and become fascinated about how and why such things do happen and then embark on the research journey in order to bring a detailed meaning to the actual situation, rather than basing it on the commonly known assumptions.

He further provides guidelines which should be used when conducting interviews in order to get the maximum responses. The very same guidelines will be employed in the study and are listed as follow:

- Interview briefing – The interview is introduced by a briefing in which the interviewer defines the situation for the subject, briefly tells them about the purpose of the interview, the use of a tape recorder if applicable and other technical or non-technical tools if applicable and so on and asks if the interviewee has any questions before the commencement of the interview.

- Debriefing after the interview- Due to the emotions involved in most social research interviews Kvale (2007) suggests that a debriefing after the interview should be done. He says the reason for this is because it might happen that after the interview there may be tensions or anxiety because the subject has been talking about often personal and emotional experiences and maybe wondering about the purpose and later use of the interview. However, he recommends that this must be done off record as some participants might actually become more comfortable and at ease to raise subjects which they were not comfortable with during the live recorded interview. The researcher must also take a minimum break reflecting on the responses given before engaging in another interview.

The interview questions used in this study are semi-structured as it will depend on the interviewer's judgement and tact as to how much follow up questions should be used, based on the responses provided by the interviewees (Kvale 2007:57). The interview questions will be also attached in a form of appendices.

3.6 Sample size

The sample size of this study comprises two (2) public hospitals in the province of KwaZulu- Natal. These are King Edward VIII and R. K. Khan Hospitals which are both situated at the eThekwini metropolitan region. It should be noted that the initial plan of this study was for it to be conducted in a private and a public hospital. However, with some extreme and unforeseen challenges encountered with gaining access to the private hospital, the researcher then opted to use both public hospitals. The number of the participants from each of these hospitals is the same and is as follows:

- Questionnaires were distributed to 12 Doctors who are not isiZulu speakers (six (6) from each hospital).
- Questionnaires were distributed to 12 nurses who act as ad-hoc interpreters for patients and doctors during consultations.
- Interviews were conducted with 20 isiZulu speaking patients (10) from each of the hospitals where the study was conducted.

3.6.1 Doctors

The fundamental reason for selecting non-isiZulu speaking doctors is because they are the first medical professionals encountered by isiZulu speaking patients. They are therefore in a better position to share their personal day to day experiences regarding serving non English speaking patients. They will further be able to explain the communication barriers caused by the lack of professional interpreting services in the participating hospitals.

3.6.2 Nurses as ad-hoc interpreters

Unlike in other case studies where it has been confirmed that in some of the hospitals, any general working person can serve as an interpreter e.g. cleaners Lesch (2007:75), in this case only the nursing staff members were confirmed as the main providers of interpreting services for both doctors and patients. This was further personally confirmed by the participants in the study. They were therefore found to be in a better position to share the exact experiences that they came across on a daily basis regarding the interpreting situation in the medical setting. It is also hoped that, based on the responses they will provide, they could further make more specific recommendations than the more general ones.

3.6.3 IsiZulu-speaking patients

This is the targeted population of this study. The whole rationale of this study is to ensure that these participants get the best medical services which are not limited nor compromised in any way possible especially with regards to the language difference. Therefore, the participants are going to explain their difficulties, if any, which are

experienced during consultations with the non-isiZulu speaking doctors. This will be done through interviews with the researcher. Makwerere (2009:47) cited (Ribson 1993) where he stated that the interviews are the preferred methods because they are quite straightforward and non-problematic means of finding things out. Nevertheless, face-to-face interviews offer the opportunity of modifying one's line of enquiry, following up interesting responses and investigating underlying motives. This will therefore actually assist in ascertaining the real challenges in the medical setting, if any are discovered, and would also lead the researcher to recommend the proper possible solutions.

3.7 Ethical considerations

Medical institutions such as hospitals are very crucial and critical; therefore one must follow the prescribed protocol at all times when conducting any kind of research in such institutions so as to not tarnish the image or the reputations of the participating institutions. For such stated reasons, ethical considerations for this study were therefore carefully contemplated. The researcher made applications to both the participating hospitals and the applications were graciously approved by the hospitals' Chief Executive Officers (CEOs). One of the participating hospitals further required an additional approval from the Department of Health's head office which is based in Pietermaritzburg. Likewise, the application was granted.

In terms of protecting the identities of the participants, the researcher followed the Durban University of Technology's (DUT) ethics clearance guidelines. The participants were assured that their participation in the study would remain anonymous and were also given a choice to use a pseudonym in case they feared to participate with their true identity in the study. Furthermore, the aim of the study was clearly outlined to all the participants in the form of an information letter and consent forms. Both these documents were available in English and translated into isiZulu in order to accommodate the isiZulu monolingual speakers and readers. The aforesaid documents are available as appendices at the back of the thesis.

It should be noted that the initial aim was to electronically record the interviews with all the participating patients using an audio recording device. These recordings were going to be transcribed by a professional transcriber and made available in a hard

copy. However, when the researcher introduced this subject to the participants, signs of fear and reluctance to participate in the study were then observed which created a rather uncomfortable environment. Given all the reluctances in a form of verbal and nonverbal communication by the participants, the researcher then chose not to record the interviews with the participating patients, but rather write all the responses given by the participants as they were. This was done to with the intention to ease the tension. The decision turned out well eventually as there were no further challenges encountered with this particular group and they were more willing to participate in the study.

3.8 Conclusion

In this chapter, the research methods used in this research study is captured. Furthermore, the instruments used to collect data and the strategies used are highlighted as well as the ethical considerations. It should further be noted that there were also some challenges faced by the researcher as some of the participating doctors did not duly complete the questionnaires and submit timeously as proposed. The researcher then had to re-visit the hospitals more than once in order to obtain the answered versions of the questionnaires. This is because it was assumed that their responses would contain more insightful information relating to language communication barriers caused by the difference in languages spoken by medical practitioners and the patients during consultations. In the next chapter the captured data will be presented, discussed and will be used to answer some of the research questions.

CHAPTER FOUR: DATA PRESENTATION, DISCUSSION AND ANALYISIS

4.1 Introduction

In the previous chapter, the methodology of the data collection was presented and discussed in detail. This chapter therefore presents the actual data collected in the field, the responses received are further discussed and analysed in this chapter. The questionnaires relating to the responses are provided in the form of various appendices. The responses received from all the medical personnel (doctors and nurses) are presented in the form of pie charts and also in the form of paragraph discussions where applicable. As for the patient participant's response, the responses are discussed in lengthy discussions as these were collected in a form of the face to face interviews. Further, in this chapter whereby the hypothesis and all research questions are to be answered.

Therefore this chapter will address the following aspects:

4.1 Introduction
4.2 Data presentation and analysis
4.3 Summary of the findings
4.4 Conclusion

4.2 Data presentation and analysis

Odewumi (2014: 47) cited Neuman (1997:7) where he states that data is obtained using specific tools which could either accept or reject certain theories. Whereas Fink (2005:17) states that data collection relevant to literature reviews relies heavily on the following categories:

- Online public bibliography databases;
- Online private bibliography databases;
- Manual searches of references in articles; and

- Manual searches of references in expect guidance.

The researcher relied heavily on the prescribed participants to duly complete the questionnaires and the willingness to participate for those with whom the interviews were to be conducted. At the King Edward VIII hospital the questionnaires for the doctors were furnished to the ward manger timeously (four (4) days) prior to the commencement of full data collection with the rest of the participants. This was done as a courtesy to allow doctors to have more time to complete the questionnaires and submit it back to the ward manager timeously. However, it was discovered that only one doctor had completed the questionnaire timeously as the rest were still in possession of the other participating doctors. As a result, the researcher had to leave the questionnaires behind for another week in order to allow the doctors more time to complete it.

As for the nurses (ad-hoc interpreters), the sister in charge of the orthopaedic ward t allocated two groups of participants whereby the researcher gave each group a brief about the study and their significance in participating in the study. After the briefing the questionnaires were handed out to the participants and collected immediately after being duly completed.

The interviews were also conducted with ten (10) patients. The researcher was advised to go to the pharmacy where there would be plenty of patients waiting to collect their medications which is usually the last stage of their visit to the hospital, as opposed to use those who were still waiting to be seen by the medical practitioners. Therefore, the patients were selected randomly. Once a group of ten was gathered, the participants were then given a brief about the study and their significant role in the study was properly outlined and consent forms were accordingly signed. The interviews were then conducted with one participant at the time; the interviewer jotting the participants' responses as they were uttered by each of the participants on the questionnaires.

As for the R.K. Khan hospital, a similar principle for the doctors was used. The questionnaires together with the information letter and the consent forms were sent electronically to the personal assistant of the CEO a week before the commencement of the full data collection process as per the agreement. Again this was done to accommodate the doctors in terms of the busy nature of their job.

Likewise, when the researcher arrived and requested the answered questionnaires, it was discovered that the questionnaires were in fact never given to the doctors. As a way forward, the public relations officer had to accompany the researcher into various wards in order to secure English speaking doctors. The questionnaires were then left with the participating doctors with an understanding that they would be collected by the public relations officer upon completion. The researcher was then going to collect it from the officer after a week in order to ensure that these were duly completed. Again some extreme challenges were experienced with obtaining the answered versions of the questionnaires; as a result it took the doctors more than two full months to answer the questionnaires.

As for the ad-hoc interpreters (nurses), the researcher had to get the participants from three different wards as they were extremely busy as well. They however, managed to answer all the questionnaires and handed it back to the researcher immediately after completion. The challenge was therefore that of getting the patient participants, but the researcher opted to use the similar strategy used at the King Edward VIII hospital which was more efficient and convenient to both the researcher and the participants.

4.2.1 Data analysis of doctors' responses

Makwerere (2009:52) cited Glensne and Peeshkin, (1992) where they state that data analysis involves organizing what you have seen, heard and read. This is done in order to make sense of what you have learned. They further state that working with the data you create explanations, pose hypothesis, develop theories and link your stories. To do so one must categorise, synthesize, search for patterns and interpret the collected data. The data obtained from the questionnaires and the one on one interviews as discussed above were evaluated qualitatively in order to elicit information relevant to the study. The pie charts using the Microsoft Excel 2010 programme was used to indicate various percentages for some of the responses given by the doctors and nurses. However, their comments and recommendations are discussed in paragraph format.

4.2.1.1 Comments on the home language

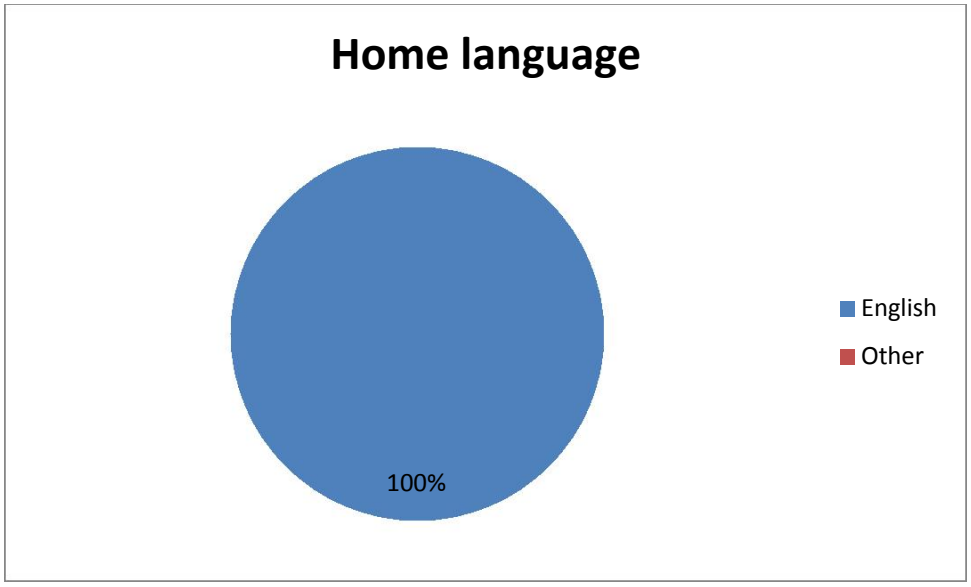


Figure: 8 indicates the doctors' home language

This study targeted English speaking doctors. However, the reality is that there are other doctors who come from other countries or provinces where isiZulu is not the language of the majority as it is the case in KwaZulu- Natal. Therefore, if such doctors were found in the participating hospitals, particularly in this study, they would be more likely to use English as a medium of communication. Therefore al the doctors confirmed that they were English first language speakers.

4.2.1.2 Responses in respect of experience in the medical profession

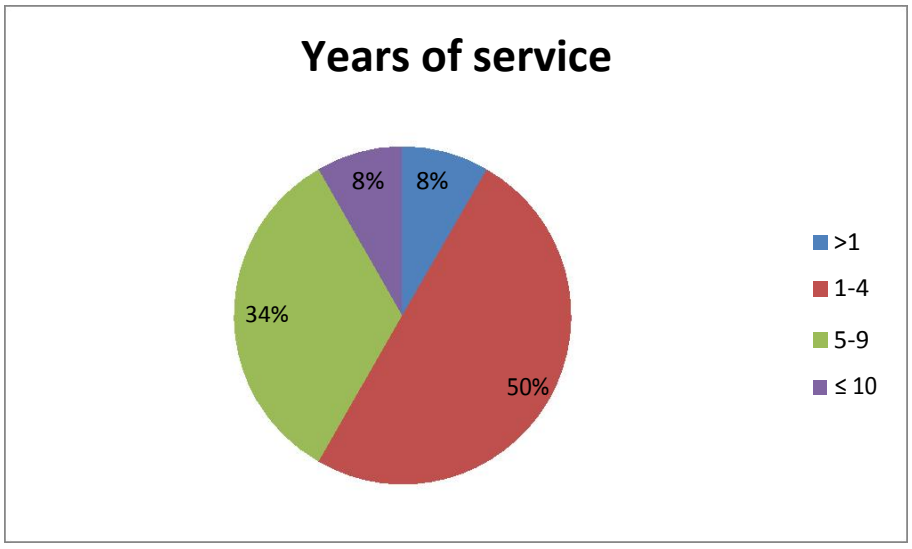


Figure: 9 indicates the doctors' years of service in the profession.

The pie chart above indicates the doctors' medical experience in their respective field. The results indicate that 8% of the doctors had a year less of practice in the medical field. The other 50% had 1-4 years' experience. Whereas another 34 % consists of doctors who have served in the medical field for a period of 5 to 9 years, also another 8 % have 10 years and more of experience in the medical field. By looking at the results reflecting the experience of the doctors, we can therefore conclude that the study consisted of the well experienced medical practitioners. And therefore, the responses given are most likely to reflect the actual situation especially with regards to the interpreting services.

4.2.1.3 Responses regarding the used languages during consultations

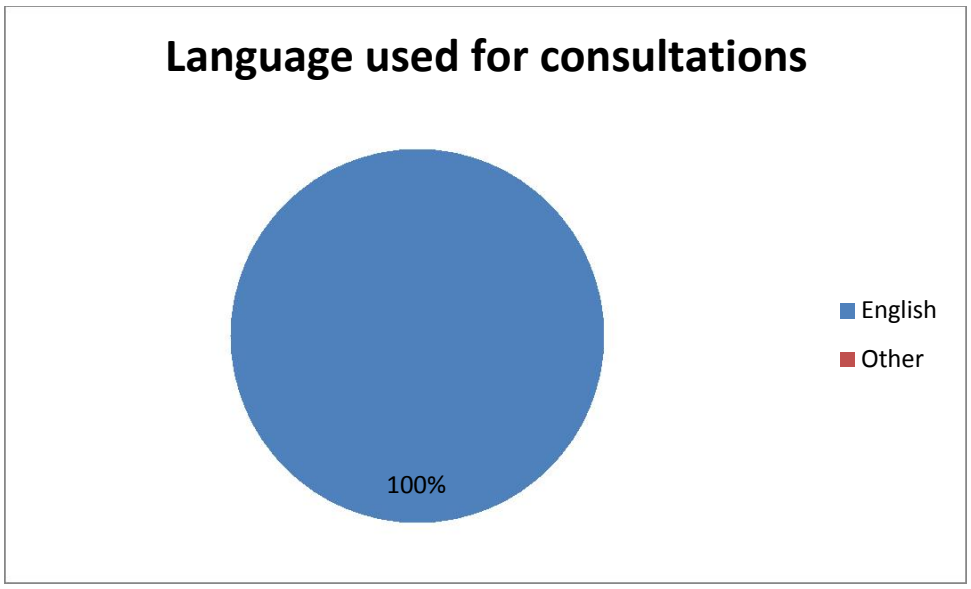


Figure: 10 indicates the results of the language used for consultations.

This was the first significant question, as it was hoped that the question would confirm the initial hypothesis which is the fact that isiZulu speaking patients mostly encounter English speaking doctors and as a result they are unable to fully describe their medical conditions to these doctors due to English limited command. Indeed the results obtained confirmed this to be the case, as English was seen as the medium of communication during patients and doctor consultations. Having said that, the situation described above would seem to be the main factor leading to the language communication breakdowns. These language communication breakdowns are also most likely to result in unsuccessful therapy. This is because, the parties involved in

this process, might not share the equal understanding of the language in use and inaccurate diagnosis and limited cooperation might begin at this stage.

4.2.1.4 Response regarding the understanding of isiZulu (Yes or No question)

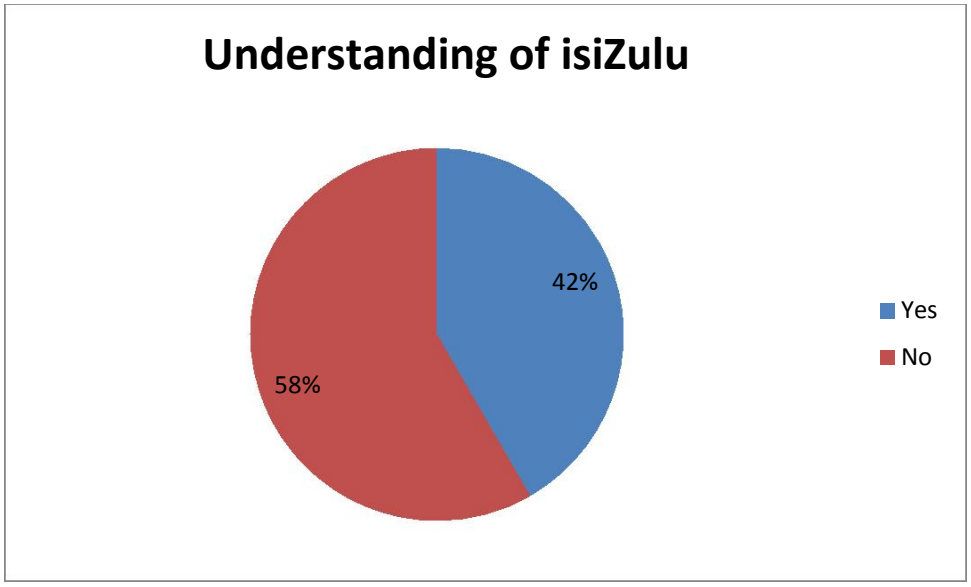


Figure: 11 indicates the doctors' results of understanding of isiZulu.

According to the responses given as reflected in the pie chart above, 58% of doctors indicated that they do not understand isiZulu. Whereas, another 42% shows that although the doctors are first language English speakers, they do understand isiZulu. The next question will assess the level of understanding isiZulu of the participating doctors who answered "yes" to the understanding of isiZulu question. "In South Africa, where we have11 official languages, discrepancy between the language spoken between patients and doctors is extremely common. The overwhelming majority of health professionals, with the exception of nurses, cannot speak any of the indigenous African languages" (Levin 2006:1076). Therefore, if the results to be obtained in the following question prove that indeed the English speaking doctors understand isiZulu, then this will prove Levin's findings to have changed over a very short period of time with regard to the doctors being unable to speak indigenous languages, particularly isiZulu.

4.2.1.5 Responses regarding the level of understanding isiZulu

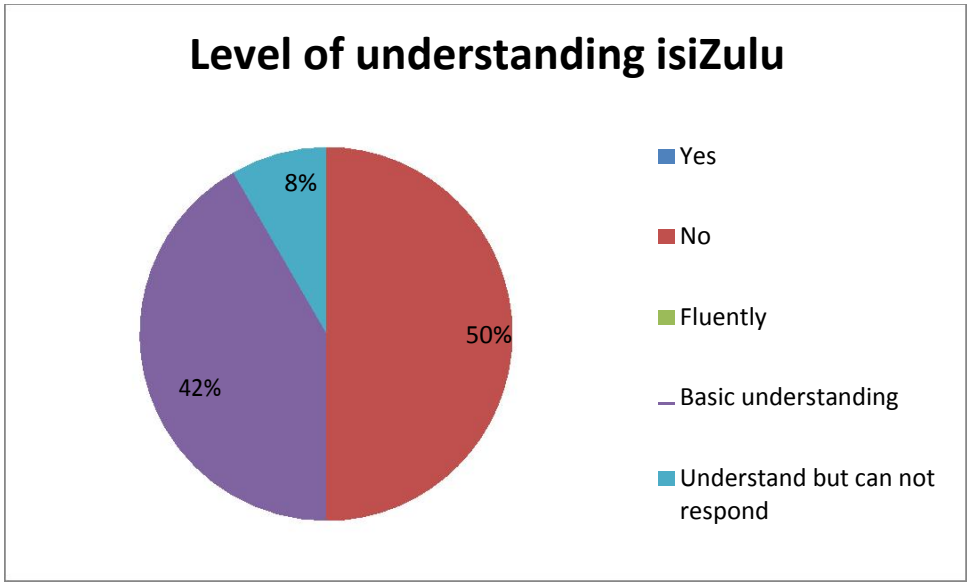


Figure: 12 indicates the doctors' level of isiZulu understanding.

As stated previously, this question is meant to assess the level of isiZulu understanding of the doctors who answered "yes" in the previous question. Apart from the 50% of respondents who maintained that they do not understand isiZulu, the results obtained in respect of this question indicate that 8 % of some of the English speaking doctors can understand what is being uttered in isiZulu, but cannot reply in the same language. We can conclude that this 8% means that these participants do not understand isiZulu and therefore falls back to the initial 58% as obtained in 4.2.1.4. Although this is a common issue with most people including isiZulu or other language speakers whereby they state that they can understand what is being said in another language but cannot respond within the same language except their own. The truth of the matter is that there is an existing communication breakdown which defeats effective communication between these two parties. This is because in a case of a medical setting the doctor will still have a difficulty asking all the relevant and significant questions to either a limited English proficiency patient or a monolingual isiZulu speaking patient.

The other 42% who maintained to have an understanding of isiZulu, again the results obtained indicate that they only understand the basics of isiZulu as none of them selected the fluent option in the questionnaire as would have been expected from the people who claim to understand the language. Again the argument in this regard is

the fact that basic understanding of isiZulu alone is not sufficient for the diagnostic process nor for the whole therapeutic process. This is because the basic understanding could suggest that a doctor may only understand certain simple utterances such as the basic greetings e.g. hello, how are you? / *sawubona, unjani?* Alternatively in the medical setting it could suggest being able to give basic instructions to the patients in order to make a diagnosis e.g. open your mouth, breath in and out or cough / *vula umlomo, phefumula noma khwehlela.*

Based on these responses given above, it is clear that the doctors do not understand isiZulu. Furthermore, although the efforts of those with the basic understanding of isiZulu are appreciated, the reality is that in critical institutions such as hospitals, this level of understanding alone is not sufficient. Therefore, this situation is an indication that better communication strategies are required and these could possibly enhance effective language communication and reduce the risks associated with language communication breakdowns. Therefore, since this study is mainly focusing on the provision of professional medical interpreting services, it would seem that the only possible way to achieve this is by ensuring these services are provided at a professional level and by suitably qualified personnel.

4.2.1.6 Response regarding the description of the patient/ doctor communication process during consultations

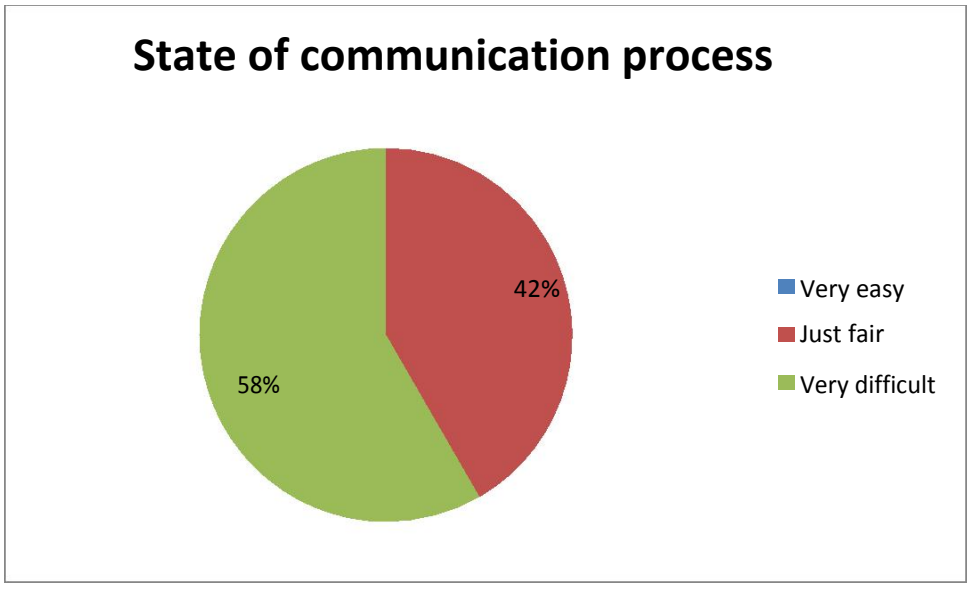


Figure: 13 indicates the state of the communication process.

This question was meant to evaluate the state of the communication process between English speaking doctors and isiZulu speaking patients with limited English command. It was designed to afford the doctors an opportunity to describe or rate their communication process when consulting patients with English limited proficiency patients. There were three options to select from ranging from “very easy, just fair and very difficult”. Again the results obtained in respect to this evaluation indicate that the majority of the doctors experienced extreme communication challenges when consulting patients with English limited proficiency. On the other hand, some of the doctors opted for a fair communication process which could again be linked to those doctors who had a basic understanding of isiZulu. Therefore, they found the communication process with such patients neither extremely easy nor extremely difficult but rather fair.

4.2.1.7 Availability of interpreting services

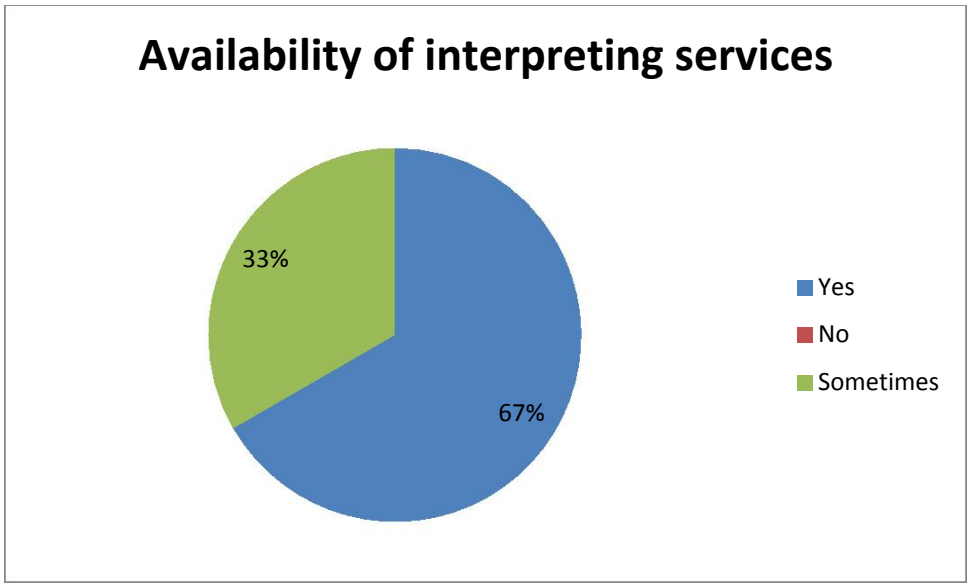


Figure: 14 indicate availability of interpreting services.

This question was meant to determine if the interpreting services are provided in the hospitals at all, regardless of whom these services are provided by. Therefore the participants were meant to respond on the provisional aspect of the questionnaire. The majority of the participants stated that yes indeed the interpreting services are provided in the hospitals. However, some of participants (the minority), as reflected on the pie chart above, stated that even though such services are provided they are not always available at all times as required and they opted for the “sometimes”

option. Even though the interpreting services may not always be available, but it is common cause that such services are being provided in this medical institution. This therefore covers the provision aspect of the interpreting services in the hospital as stipulated in the questionnaire. The following question determines who renders or provides these aforesaid interpreting services in the hospitals and look at their professional scope in the medical setting.

4.2.1.8 Responses regarding the personnel facilitating or executing the interpreting services

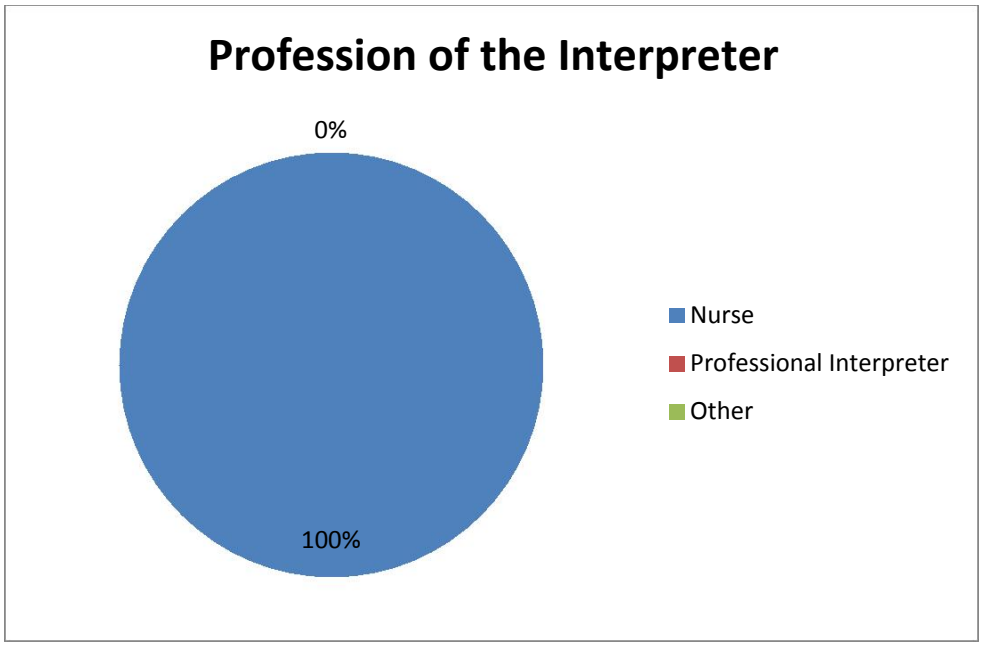


Figure: 15 indicate the original scope of the interpreter.

"The main sources for interpreting services is still provided by nurses, nursing assistants, auxiliary staff and community volunteers if not family members" (Lesch 2007:75). Based on the responses given above, it substantively fair to agree with Lesch's findings as this was found to be the case in these medical institutions where the study was conducted as well.

4.2.1.9 Responses regarding the availability of the interpreters when required

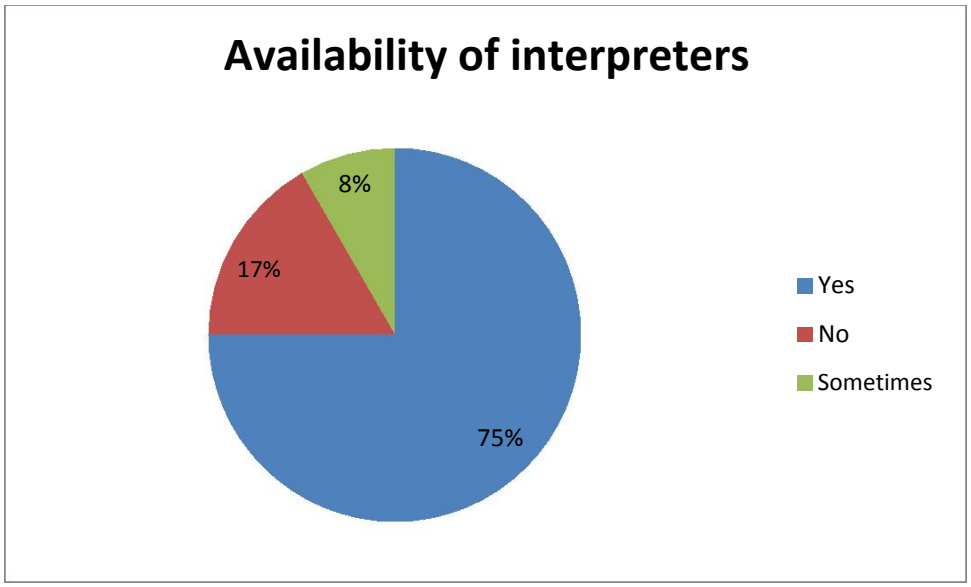


Figure: 16: indicate the readily availability of interpreters.

The results obtained from this question indicate that the nurse interpreters are always available to assist with the interpreting services as it would be required when doctors consult with the English limited proficiency patient. This is confirmed by the major percentage obtained from this question as also reflected in the pie chart above. However, peoples' views are most likely to differ in every situation they come across in life due to their personal experiences as well. Likewise, in this case 17% of the doctors disputed that the interpreters were at all times readily available to assist with the interpreting services when required. Whereas, the other 8% stated that these interpreters are only available sometimes as opposed to being readily available at all times when required by both the doctors and patients.. However, the gap shown by those who selected the "no and sometimes" options is still seen as a gap which could again compromise quality healthcare of the patient as language communication breakdown could possibly occur and increase medical risks.

4.2.1.10 Interpreters' efficiency

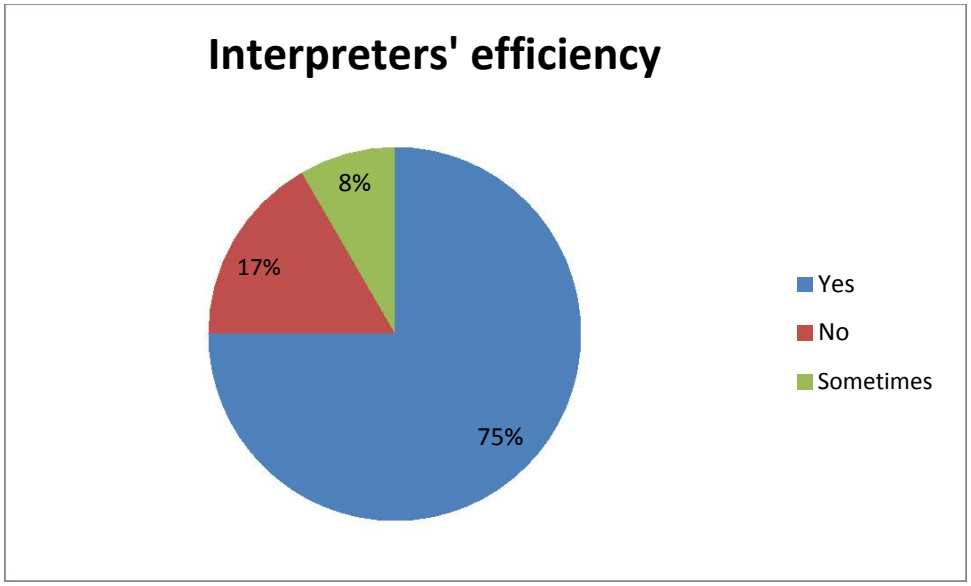


Figure: 17 indicates the interpreters' efficiency.

The responses received in response to this question were similar to the ones previously received in 4.2.1.9 regarding the readily availability of interpreters. Whilst 75% of the responses indicated that the nurses were efficient interpreters and that there was a smooth flow of the communication process, the other responses appeared to suggest the opposite of what the majority had stated regarding the efficiency of nurses as interpreters. 17% firmly suggested that nurses were not competent medical interpreters. Also the other 8% suggested that sometimes the nurses do not effectively interpret the massage accurately. One of the reasons given by the doctors was that "nurses understanding was occasionally limited leading to inaccuracies and omissions". According to Corsellis (2008:45) nothing should be omitted when interpreting. She further states that interpreters are responsible for the communication process and there are risks involved if they add, omit or take on additional roles where for instance they give their personal opinions and the chances are extremely high for things to go wrong. For such reasons it then becomes difficult to sort out who had said what to whom and on what basis. This is in fact likely to also be the case here in South Africa where nurses are executing the duties of the interpreters and being nurses at the same time. They could assume diagnosis based on their experience without fully realizing that the conditions might be slightly

different to the normal and general common cases that they usually come across. Furthermore, they might not realise that the case requires specialist attention and obviously treating a serious case as a normal one. Likewise, things could possibly go very wrong and leading to morality in a worst case scenario.

4.2.1.11 Responses regarding the worst case scenarios ever experienced due to language communication breakdown

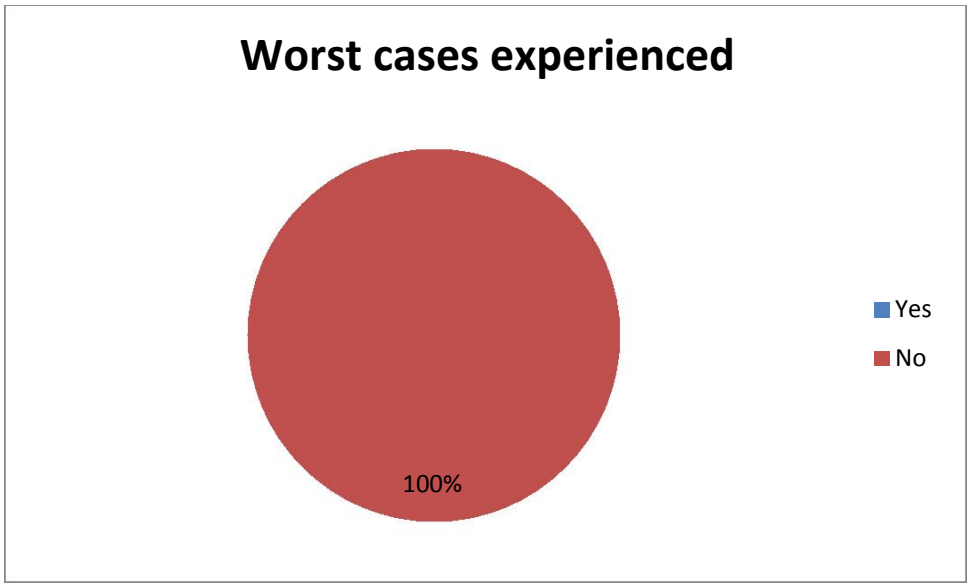


Figure: 18 indicates the results of worst cases experienced.

This question was meant to evaluate if any of the participating doctors had ever experienced any severe bad impacts as a result of language communication breakdown. The worst cases in question could include wrong surgical procedures being performed on the wrong people, wrong diagnosis or wrong parts being amputated etc. However, the responses given to this question were unanimously given a 100% i.e. none of the health practitioners having ever experienced such a bad experience as a result of language communication breakdown. This suggests that even though there might be difficulties experienced during consultations between doctors and patients, the situation is somehow under control as there has never been any worst case experienced at least by the doctors who participated in the study.

4.2.1.12 Responses regarding the recognition of a need for professionally trained interpreters in the medical settings

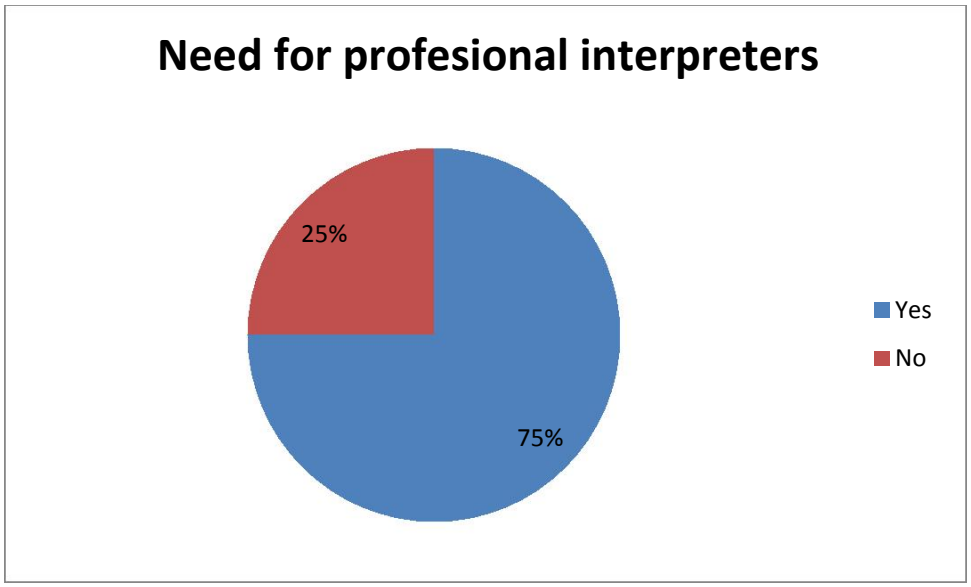


Figure: 19 indicates the results for the recognition of professional interpreting services.

The response given above regarding the recognition for professionally trained interpreters in the medical setting show that indeed there is a significant need for such services to be rendered at a professional level. The 75% of participants who agreed collectively about the importance of having such services stated valid reasons for their responses which shall be listed below. However, not all of the doctors who participated in the study stated reasons, as some of them only answered “yes” and did not substantiate their answers.

Below are some of the reasons stated by the doctors who recognised the need for professionally trained medical interpreters:

- Yes, there is a need for trained interpreters in order to allow accurate history taking and portrayal of important symptomatology for accurate diagnosis.
- Yes, there is a need for professionally trained interpreters because other patients do not know how to speak English; they rely on the nurses to help them with interpreting.
- Yes there is a need as it would be helpful to understand the patients’ needs.
- Yes, it will save the patients’ lives.

- Yes there is a need for professional medical interpreters as it is sometimes inconvenient for people in other roles to interpret as they have other duties to fulfill.
- Yes there is a need for professionally trained medical interpreters since they have the key expertise of certain languages and can interpret more efficiently.
- Yes there is a need for professional medical interpreters as it would afford clear communication with the patients and ensuring that the nurses are not taken away from their nursing duties.
- Yes there is a need for professionally trained medical interpreters as not all departments in the hospital or health facilities have access to trained and experienced nursing staff to assist with interpreting.

These reasons provided above are very significant and some of them confirm that when the nurses are called to assist with interpreting, they have to leave their original duties as well.

Likewise, the other 25% did not recognise the need for professionally trained medical interpreters. Out of this 25% responses received which did not recognise the need for these services to be rendered at a professional level; it was unfortunate to see that only one participant stated a reason for not recognising this need. The reason provided by this respondent is as follow:

- No, there is no need for professional interpreters as most nurses speak isiZulu and are medically trained. Therefore, interpreting is not a problem.

Now the argument here is, yes indeed the nurses are medically trained for rendering the health care services to the patients but they are not experts in medical interpreting as stated by this participating doctor. Interpreting is a very complex practice, it requires specialist skills and in depth knowledge in the field (Angelelli 2007: 63 and Hale 2004:3). Therefore, having explained the complexities involved in the interpreting process here and in chapter two, it is inappropriate for the doctors to heavily rely on isiZulu speaking nurses to render accurate interpreting services for correct diagnosis and other therapeutic processes involved thereafter.

4.2.1.13 Responses regarding personal rating of patients' treatment compliance

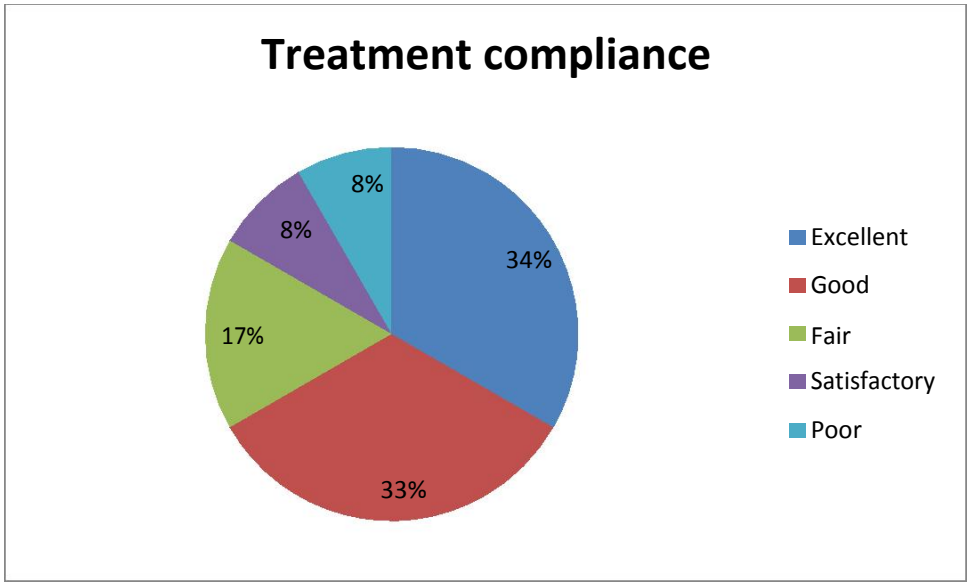


Figure: 20 indicates the rate of patient compliance to treatment.

With regards to treatment compliance, various responses were given by the participating doctors based on their personal observations and knowing the history of the patients. 4% indicated that indeed patients comply 100% with the prescribed treatment, 33% stated that the level of treatment compliance was in a good state, another 17% stated that the patients complied fairly to the prescribed treatment, 8% stated that the results were satisfactory and another 8% indicated that patients did not comply with the prescribed treatment. Based on the responses given, it is clear that the overall treatment compliance is not in such a critical state. This is because it was found that there is not a huge alarming number of noncompliance to the prescribed treatment by the patients. The percentage of noncompliance to treatment was found to be much less as opposed to that of those who complied.

4.2.1.14 Responses regarding the influence of language in the patient treatment compliance

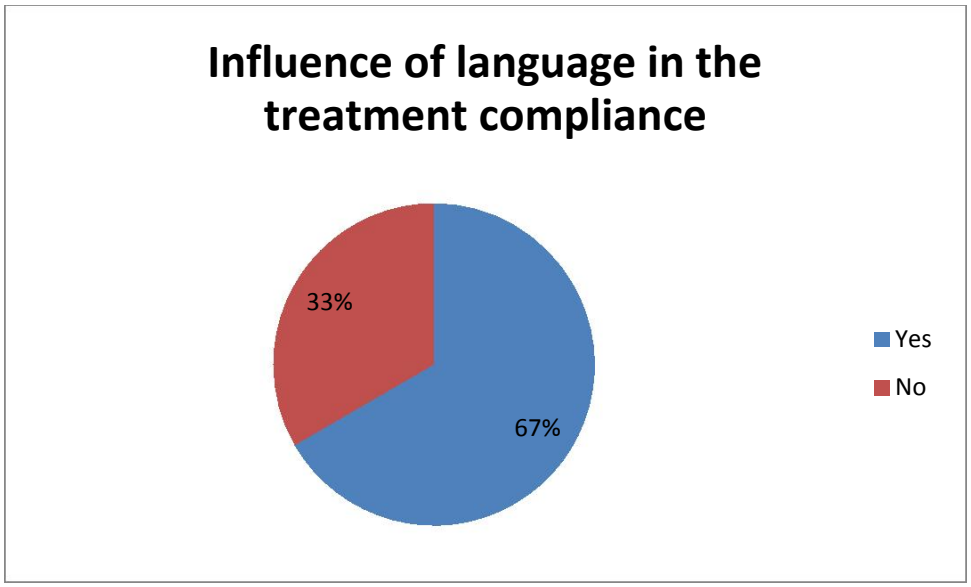


Figure: 21 indicates the influence of language on treatment.

This question asked the participants as to whether they thought language had an influence on the patient treatment compliance. The expected answers were either yes or no, but in any of the given responses, the participants were expected to substantiate their answers. Again, some of the participants substantiated their given responses and some did not. 67% indicated that indeed the language difference might also play a role into treatment non-compliance by the patients. Various reasons were again given by some of the participants and are as follow:

- Yes, some of the patients default treatment due to the language barrier.
- Yes, it has an impact the absence of interpreters, which results in high rate of defaults.
- Yes definitely, taking two tablets once a day as opposed to taking one tablet twice a day can be easily confused.
- Yes, patients that do not understand English in most cases are less likely to comply with the treatment.

As stated above, even though some of the doctors stated that language has an impact on the treatment compliance, but some of them did not state their reasons for this. In the case of those who disagreed to this question, the similar

challenges of no reasons being provided was also experienced. Only one participant stated a reason for his/ her response and it is as follows:

- No, treatment compliance is not influenced by language because we experience the same problems regarding compliance even with English speaking patients.

Therefore, although both reasons provided in respect to this question are reasonably fair, it would seem fair to agree with the majority in this regard as their reasons are more convincing and suggest that the fact that if ever patients are fully advised about the treatment in their home language, the results would improve. Therefore, it is agreed that indeed the manner in which patients are given instruction about the prescribed treatment is also highly dependent on effective language understanding. As for the English speaking patients who do not comply with the prescribed treatment, it is suggested that the health practitioners evaluate the actual cause of this problem as it could be due to various factors such as a lack of sufficient information given to the patient and other social factors which are not related to language communication.

4.2.1.14 Personal recommendation on language communication in the medical setting

This was an optional question in order to allow the participants to suggest or recommend possible solutions to the identified problems. However, due to the busy nature of their work, the majority did not suggest or make any recommendations regarding the situation discussed above. Therefore, out of twelve (12) participating doctors, only three (3) doctors made recommendations and are as follow:

- Having interpreters will improve medical settings as doctors will be able to consult patients efficiently with the interpreters.
- More interpreters would effectively help in the consultation process.
- Interpreters must be hired.

As stated, the aforesaid recommendations were the only three recommendations made by the doctors. The next section shall discuss the nurses responses since they were 100% confirmed to be the ones fulfilling the role of medical interpreters based

on the fact that they can speak isiZulu and are medically trained and therefore found to be in a better position to render such services effectively.

4.2.2 Data analysis of nurses' responses

This section presents and analyses data gathered from the nursing staff participants. It was previously confirmed by all the doctors who participated in the study that indeed the nurses were the main source of isiZulu and English interpreting services during medical consultations in both the hospitals where this study was conducted. The responses shall also evaluate their main challenges and well as their personal thoughts about having to fulfil the interpreting role as required by the doctors and patients.

4.2.2.1 Nurses responses regarding the years of experience

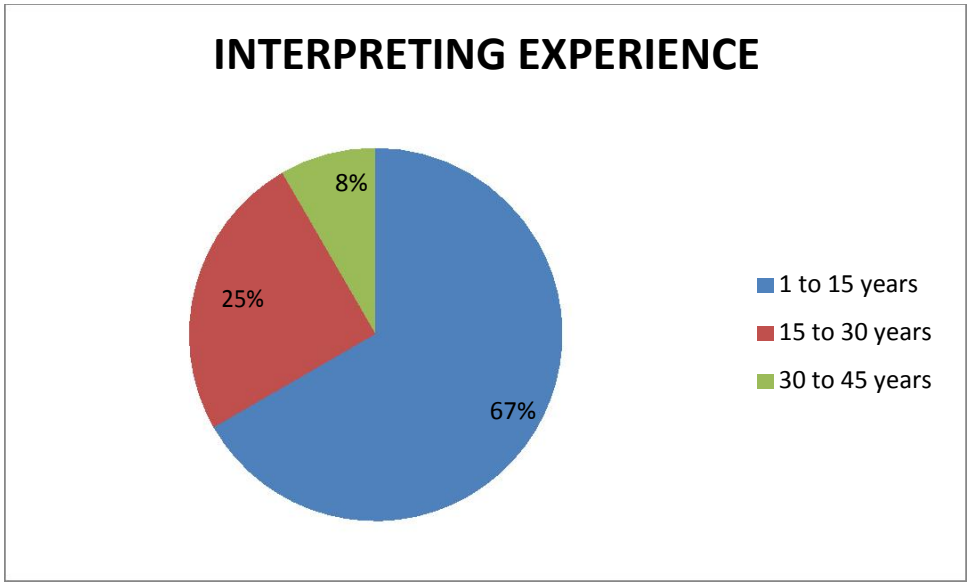


Figure: 22 indicate the nurses' working experiences as patients and doctors interpreters.

The nurses who participated in the study were not selected in any specific order. They were however, very well experienced in the nursing profession. Furthermore it has been confirmed that they have been rendering the interpreting services to both patients and doctors throughout their working experience in the medical field. The above pie chart indicates their years of experience as nurses which also incorporates interpreting.

4.2.2.2 Comments on the level of education

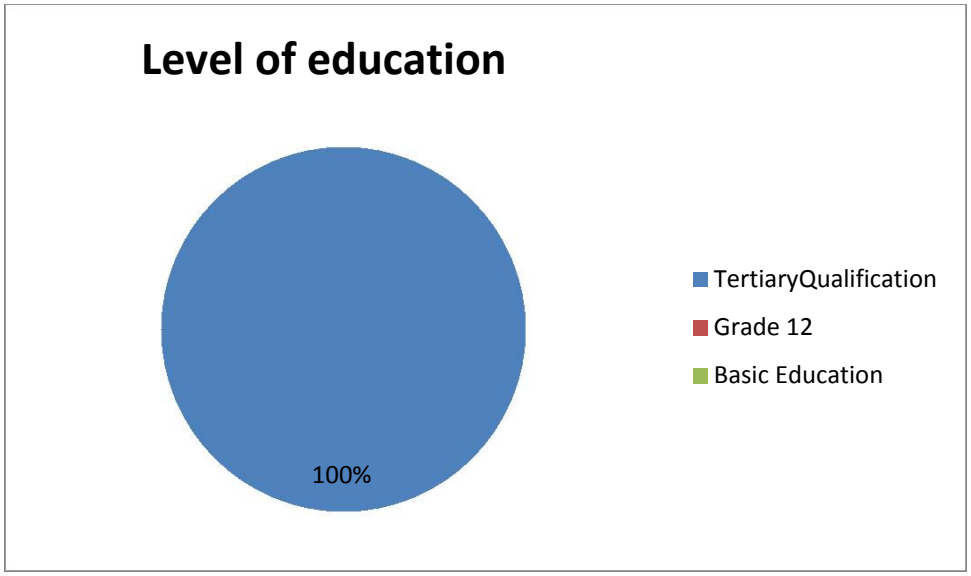


Figure: 23 indicates the participants' level of education.

The above figure indicates the level of education of the participants. The participants were given three options to select from as indicated in the pie chart so that they could select the applicable option to themselves. This question was designed also with the intention to accommodate those who serve as interpreters but do not possess any educational qualification or perhaps never completed basic education e.g. general workers, volunteers or cleaners as it is the case in other hospitals across the globe. In this case, it had been initially confirmed by the doctors that their main source of interpreting services were the nurses who had obviously undergone further educational training. Hence, the results were 100% of tertiary education for all the participants.

4.2.2.3 Personal rating of the English proficiency

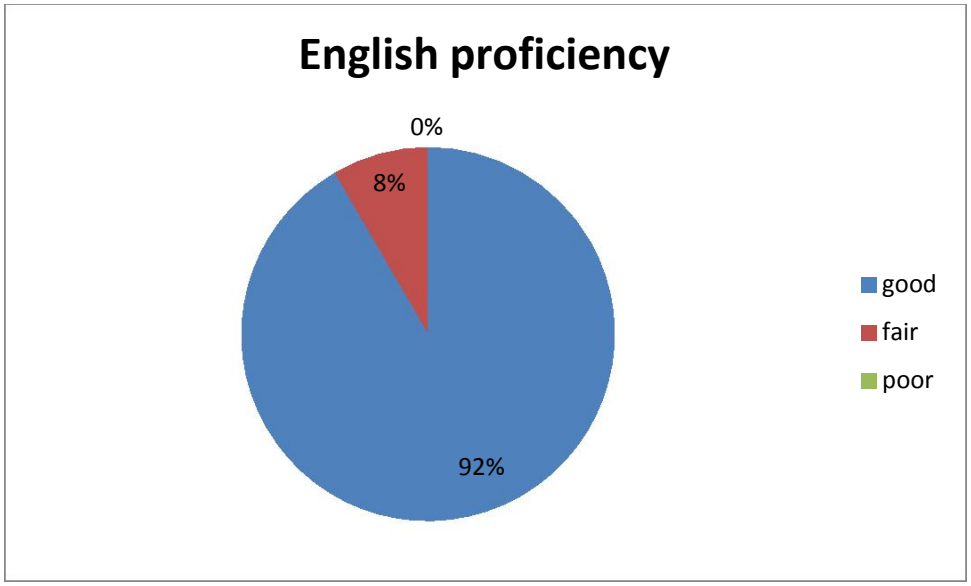


Figure: 24 indicates the nurses' English proficiency

The results shown above indicate that about 92% of the participants (which was obviously the majority) selected the "good" option regarding the level of the English command. Whereas, the other 8% selected the "fair" option. From the results obtained and indicated above, we are therefore led to believe that the majority of the participants can speak English fluently without any difficulties. Likewise, with the remaining 8% we can expect the opposite of the other aforesaid side. However, having the ability to speak English fluently, does not necessarily confirm that an individual can interpret, especially in the case of the medical setting. But it is purely an indication that one is most likely to communicate in English effectively without any difficulties. Also in the case of those who can speak the language fairly, it could suggest that they can speak fairly especially in cases where there is no technical jargon involved in the conversation.

4.2.2.4 Responses with regards to personal feelings about interpreting for doctors and patients

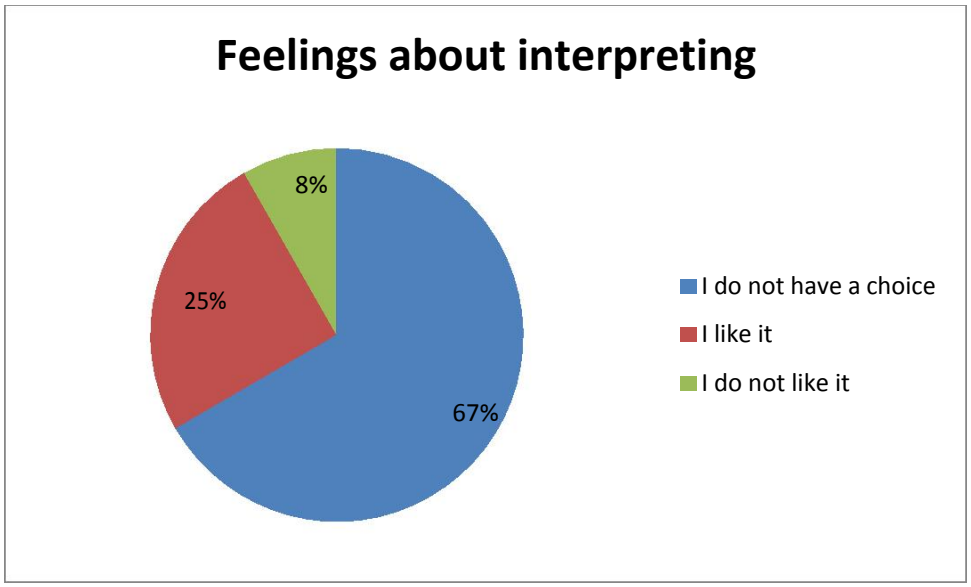


Figure: 25 indicate the nurse's feelings regarding executing the duties of the medical interpreters.

Based on the results reflected above on the pie chart, it is crystal clear that the nurses had different feelings about executing the duties of the interpreters. It is further evidently clear, that most of them are not given much of a choice about being used as medical interpreters, but somehow interpreting is a form of an indirect obligation in which they are compelled to do on a daily work basis. On the other hand, another 25% of the participants stated that they liked interpreting and the other 8% selected the "I do not like it" option. Having stated different percentages above in the form of a pie chart, the participants were then expected to state various reasons to substantiate their answers and are discussed in the following paragraph.

The responses given, indicated that interpreting alone is a different profession as compared to the nursing profession. This is because although some of the nurses do not seem to have any linguistic limitations in terms of rendering the interpreting services for the doctors and patients, but somehow interpreting distracts them from their own scope of practice as nurses. They further stated that interpreting is time consuming. Others also chose to clearly outline their scope of practice as being that of taking care of the patients' medical needs, not interpreting for them. Another interesting response which was highly noted was that of a huge linguistic limitation

as some of the nurses mentioned that there is a lack of direct equivalence of isiZulu and English terms. Therefore only professionally trained interpreters would understand the culturally specific terms and have the skills to utilize when one comes across such terms but also ensuring that the message is clearly conveyed and does not suffer any alterations or omissions. Also with regards to the long history that patients tend to tell during consultations, professionally trained interpreters would use the art of note taking so that the message is fully conveyed. That way a proper diagnosis would be made. This shows that health care interpreters require more than just linguistic knowledge; they need to have knowledge of the medical terms but most importantly, they need to have empathy and sensitivity for the doctor –patient relationship. Also this would make a positive impact as qualified interpreters have the ability to understand patient's socio-cultural perspectives of health problems (Pöchhacker and Schlesinger 2007: 12).

4.2.2.5 Regarding interpreting as a scope of practice for the nurses

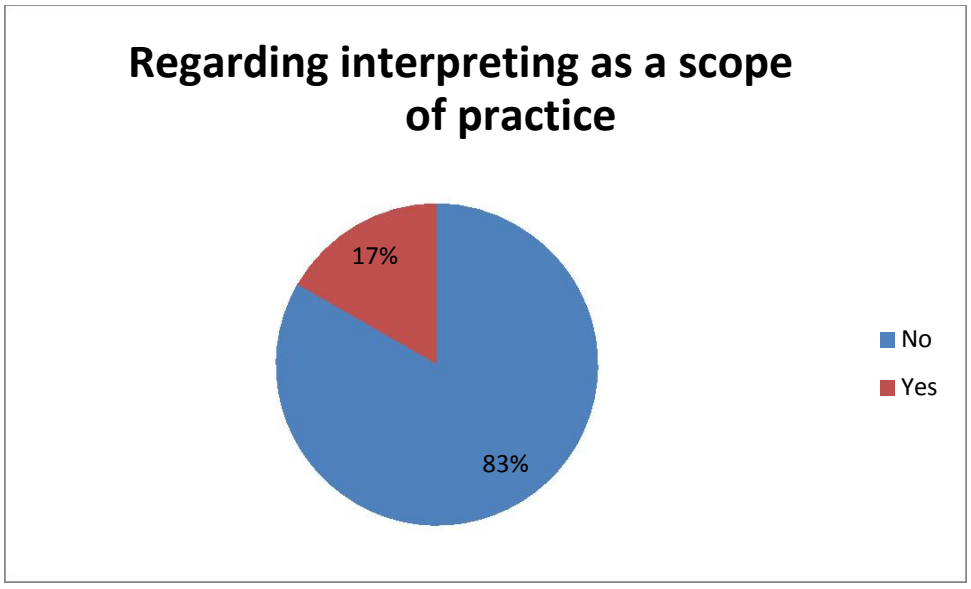


Figure: 26 indicates the responses regarding the nurses seeing interpreting as their scope of practice

About 83% of the participants stated that interpreting for doctors and patients does not form part of their job description as prescribed by the department of health. Whereas the other 17% of the participants agreed that interpreting for doctors and patients is part of their job description. It was interesting to see that some of the

nurses regarded interpreting for the doctors and patients as their scope of practice as well. This is interesting especially after having discussed the interpreting process and the requirements that professional interpreters must possess, in order to be recognised as fully competent medical interpreters in chapter two. This could also be an indication of the lack of knowledge about the interpreting profession by the public in general.

4.2.2.6 Comments about the disturbances caused by interpreting

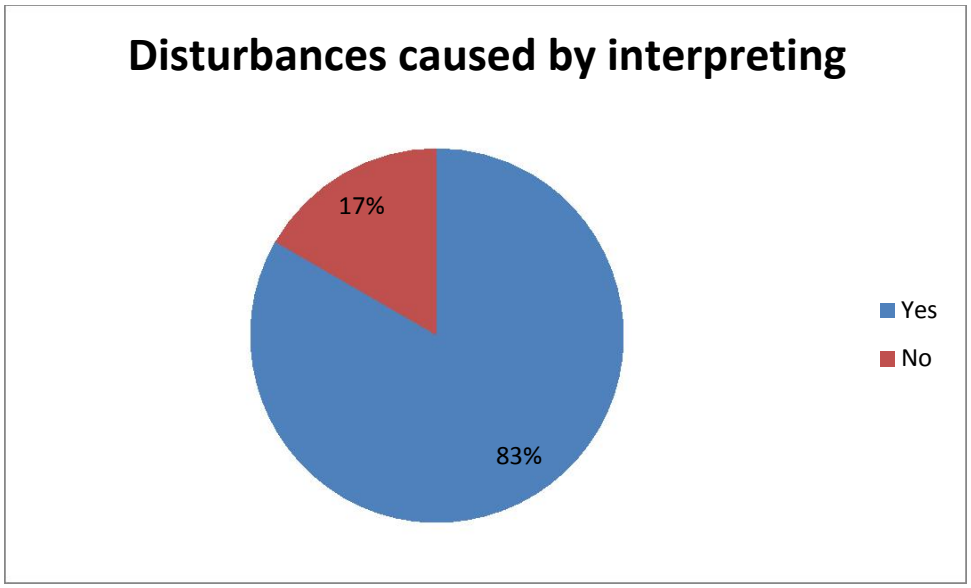


Figure: 27 indicates the nurses' response regarding the disturbances caused by interpreting in their work.

The responses given above show that the nurses are unhappy about being called upon to come and interpret for doctors and nurses during consultations. This is further supported by Lesch (2007:75) where he states that the nursing staff who interpret also complain that their role is not recognised and it keeps them away from their work and they are not even paid for it. Besides the nurses not being remunerated for the additional interpreting responsibilities, especially for those who stated it clearly that interpreting is not within their scope of practice. It would seem that their original nursing scopes are literally placed on hold up until such time they have finished interpreting for doctors and patients and only then they could continue with their professional nursing duties. Furthermore, one of the nurses shared that the

nursing scope involves the distribution of drugs (treatment) to patients at specific times especially in the case of the hospitalized patients. So when they are called upon to interpret, they are distracted from this significant process, compromising their efficiency as nurses as well. Therefore, the frustrations expressed above in reference to this question are understandable and found substantively fair for the nursing staff to complain about.

4.2.2.7 Responses regarding realising the need for professionally trained interpreters

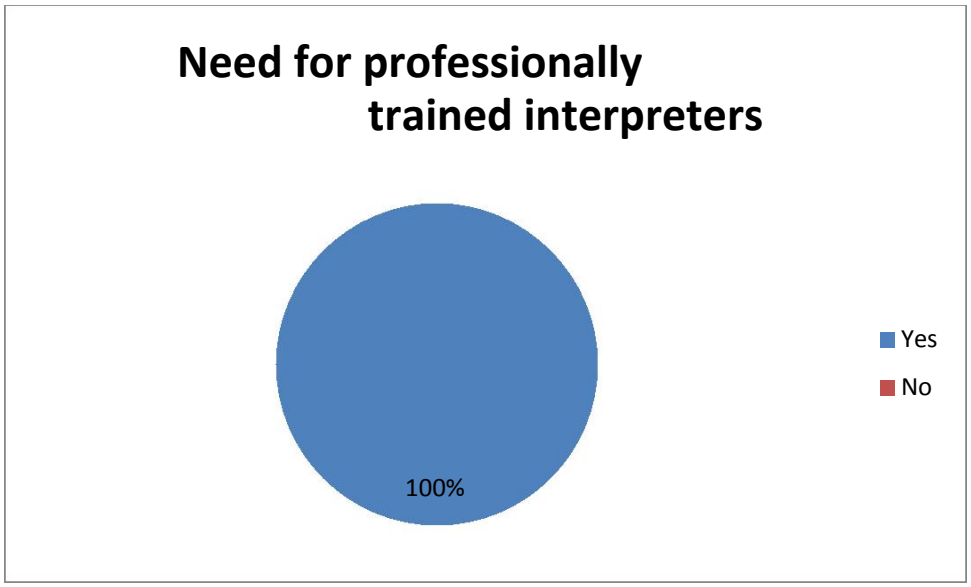


Figure: 28 indicate the responses received in reference to recognising the need for professionally trained interpreters

It was unanimously agreed by all the participants that indeed there is a need for professionally trained interpreters in the medical setting. Also the participants were required to substantiate their responses for any of their preferred given responses to this question. Again, the most significant supporting response to their option was unanimously proven to be that of time consumption and disturbances caused whenever they were required to leave their original scopes of practice in order to execute the interpreting duties. This again confirms that interpreting is a profession on its own and should be allocated to suitably qualified personnel and be given recognition as well. Furthermore, the fact that the nursing staff find themselves having to spend so much time executing these duties instead of their original

professional duties is another service compromising factor in the healthcare system. Therefore, the employment of professional medical interpreters would be an ultimate solution in eliminating the problem discussed above.

4.2.2.8 Comments about the impact caused by language barriers in the therapeutic process

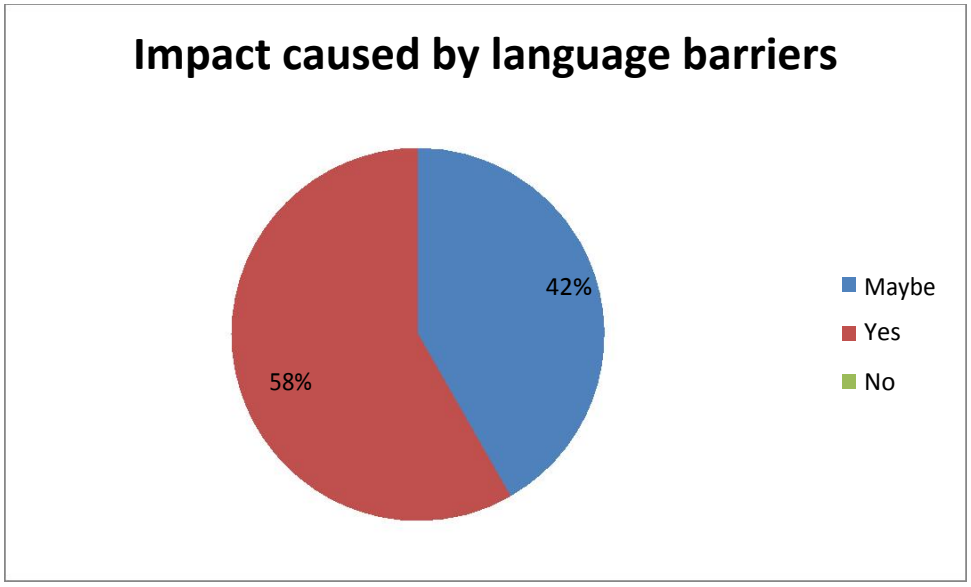


Figure: 29 indicates the responses given by the nursing staff regarding the impact of language barriers.

Given the responses above as displayed in the pie chart, it is clear that the therapeutic process is also highly influenced by language communication. Although, some of the participants selected the "maybe" option, it is however noticed that none of the participants disputed that indeed successful therapy is also influenced by effective language communication and preferably the patient's' mother tongue language in this regard.

Again various reasons were provided to support the above seen responses and are as follow:

- There are instances where nurses cannot fully explain to the doctor what is being exactly said by the patient. Sometimes nurses even try to use examples which cause the doctors to be more confused. This is also supported by Corsellis (2008:44) where she states that interpreters cannot always know what is relevant; as a result the impact could be of great damage if anything is

omitted. In a case of medical setting, patients would state everything they wish and if there is any ambiguity, the interpreter should clarify exactly what is meant. This would only seem to be achievable through the use of professionally trained interpreters.

- Message during the communication is being distorted and obliviously causing the parties not to fully understand one another.
- There are also patients who are from foreign countries and they can speak none of the languages spoken in South Africa. When these patients visit the hospitals they end up not being fully assisted medically due to the language barrier because the doctors are unable to make a proper diagnosis and the nurses are unable to interpret for them because they also do not understand their home languages.
- Language communication breakdown also causes wrong treatment prescription because the patients are unable to full address their problems in other language from the beginning.

This also confirms that patients may present symptoms unrelated to the real problem The Health Care Interpreting in the News (2011:1).

The reasons given by all confirm that the patient health care system is being compromised due to the language barriers caused by the different languages spoken during consultations and the lack of efficient trained medical interpreters. Corsellis (2008:33) argues that patients are bound to forget what was being said by the doctor during consultation even with the intervention of medical interpreters. He states that the prescribed treatment should contain information the patients can read and refer to at home by means of having the instructions translated in the patient's home language. However, in a case of KwaZulu – Natal, particularly in the rural areas where the majority of patients are illiterate or perhaps short sighted, this idea does not appear to be ideal. Therefore, putting emphasis on how to use the prescribed treatment in a language understood by the patient seems more feasible, and then the translation of the instruction should serve as a backup for those who are fortunate to have the ability to read and write.

4.2.2.9 Nurses' recommendations

Again, the recommendations made by the nursing staff participants all boil down to the necessity of having professionally trained medical interpreters. This was seen as one of the mechanisms which would improve the patient care. The Department of Health was seen as the responsible body for implementing and assuring the availability of such services within the medical sector. Also the doctors were recommended to learn the language of the area which they serve. However, the argument regarding doctors learning the language of the area they serve, is why they should be forced to learn the language of the area whereas there are interpreting graduates who can interpret for them. It is my opinion that let us rather develop a proper interpreting system first just like in other countries and then let the doctors learn the local language at their own accord.

4.2.3 Data analysis of patients' responses

This section presents data received from the patient participants who are isiZulu speaking. The responses received from these participants was collected using face to face interviews with the participants as discussed in the research methodology in chapter three. However, the responses are discussed in paragraphs forms, not in the form of pie charts as previously seen in the doctors' and nurses' responses.

4.2.3.1 Home language

As stated in the previous chapter, all patient participants were all isiZulu language first speakers and were all selected randomly at no specific order. It should be remembered that the idea behind the selection of isiZulu first speakers was to ensure that the outcome is in line with the hypothesis of this study.

4.2.3.2 English proficiency

The results obtained from the participants indicated that the majority did not understand English at all. There were also some responses whereby some participants stated that they could understand what was being said in English but do not have the ability to reply in English. This is similar to the case of some of the doctors who stated that they understand basic isiZulu or they can understand what is

being said in isiZulu but cannot respond in isiZulu. There were also some responses received from this group of participants who stated that they can speak English fluently.

Cha angisazi nhlobo nje / *I do not understand English at all.*
Ngiyasizwa kodwa angisizwa ngokuphelele futhi kunezinto engingakwazi ukzisho ngesiNgisi / *I do understand English however; there are things that I cannot convey in English.*
Ngiyasizwa kancane, kodwa angikwazi ukuphendula ngaso */ I understand it a little bit, but I cannot respond in English*
Ngisazi kahle nje impela isiNgisi/ I can speak fluent English

Figure: 30 indicates various responses given by patients in terms of their level of the English proficiency.

4.2.3.3 Patients' level of Education

It appeared that the majority of the participants did not complete grade 12 as some of them dropped out of school due to various personal reasons and others never even attended school. Even though the majority of the participants did not have adequate basic education, there were others but in a very limited number who had completed grade 12 and others also had tertiary qualifications. Considering the institutions visited, one would expect an obvious language miscommunication based on the majority's level of education of these patient participants. It is also highly possible that the people who had completed grade 12 together with those who had tertiary qualifications could express themselves better in English as opposed to those who did not have such a privilege of completing school. Again, this suggests that educational level also has an impact in the therapeutic process. Although it was not part of the research questions or aims to find out the reasons why the participants did not complete school, but some of them chose to share with the researcher their reasons and are as follow:

- In my family, my father regarded educating a girl child as a waste because it was known that she would get married to another family

- I never went to school, I was looking after my father's livestock, whom after his passing I had to go find employment so that I could support my family

The reasons given by the two participants indicate that indeed the participants might have some extreme challenges when it comes to communicating in a different language other than that of their home language. Furthermore, it would seem that even if translation services were made available in terms of written documents, they would still have some difficulties in reading the translated versions because there are illiterate. Therefore, adequate interpreting services are highly required for such needy patients so that they fully understand all the medical procedures, are also fully informed about the diagnosis and the prescribed treatment for successful therapy.

4.2.3.4 Level of visits to the hospital

Again the majority of the participants confirmed that they visit the hospital more often. The results indicated that some of them come to the hospital every month for routine check-ups and to get their medications as it would seem they suffer from various chronic diseases such as diabetes, arthritis and other non-specified illnesses.

4.2.3.5 Language used during consultations

This question was given a unanimous confirmation that yes indeed English was the language in use during consultations when patients visit the hospital. This again is one of the most concerning factors, this is because in KwaZulu – Natal isiZulu is the home language of 77% of the population and English as home language is sitting at 13.2% (South Africa.infor:2012). However, in 2008 a report was published which showed that in 2007 only 35.1% of the doctors in the public healthcare were African (Department of Labour 2008:28).

Similar data for the current situation is not publically available but the healthcare system confirms that this low percentage of African doctors has not changed much. Of these 35.1% African doctors, it is not stated how many are isiZulu speakers but

one may assume that it is not all of them. The reality of the public healthcare system in KwaZulu- Natal therefore is that in the region of 70% of doctors and specialists are not able to speak isiZulu as confirmed by the patient participants, while well over 70% of the population of the province are isiZulu mother-tongue users.

Likewise, based on this reality in a language perspective, it has been previously confirmed by the doctors themselves that communicating with isiZulu speaking or English limited proficiency patients is extremely difficult during consultations. Furthermore, the nurses struggle to effectively render the interpreting services in terms of ensuring 100% accuracy. According to Inghilleri (2012:27) interpreters are deemed to maintain neutrality and faithful reproduction of original utterances. She further makes reference to the code of ethics whereby she states that interpreters should adhere to it, as it is there to provide guidance and assist the interpreters to avoid certain practices such as omitting potentially incriminating information. Therefore the obligation of interpreters is to aspire to objective or impartial positions and it is assumed it encourages them to interpret utterances not based on their own or another party's self-interest, but rational, objective criteria established by and in language itself. However, the challenge is again that the nurses are not professionally trained medical interpreters and as a result they lack the aforesaid basic and significant information which they require for guidance when rendering interpreting services. This again would seem a fruitless exercise as the nurses themselves stated previously that interpreting for doctors and patients is not part of their scope of practice, but they somehow do it because they are not given much of a choice by the doctors.

4.2.3.6 Patients' ability to describe medical conditions to English speaking doctors

This was one of the most significant questions which the participants had to respond to. This is because it formed part of the research questions and it was hoped that it would explain the actual situation which isiZulu speaking patients come across every day when visiting medical institutions. Indeed the responses given in respect of this question were not very positive. This is due to the fact that the majority of the participants stated that they were all unable to fully explain or describe their medical conditions to English speaking doctors. Whereas, on the other hand, those who

could speak English fluently also expressed that there were some challenges experienced, especially in terms of the medical terminology which obviously consists of specific jargon. Even though that was the case, they insisted that the English speaking doctors still managed to make sense of what these patients were trying to convey to them.

Although we may accept that the doctors understood what these patients were trying to communicate to them, but that is still not considered as an effective means of communication because clearly the message is not fully conveyed. Furthermore, for obvious reasons, it is highly possible that the patients in this regard might have possibly ended up agreeing to the leading questions which might have been asked by the doctors but may be irrelevant to their conditions. However, somehow they agreed to it due to the fear of being seen as persons with limited English proficiency. According to Levin (2006:1079) when patients do not have access to the same language spoken by the medical practitioners they tend to express dissatisfaction by means of blaming themselves for their linguistic limitations rather than that of the medical practitioners. When this occurs, wrong symptoms are then presented before the doctors and leads to improper or wrong diagnosis of the illness. Flores (2010:229) shares a true story of a Spanish –speaking woman who told a resident that her two year old had “hit herself” when she fell off her tricycle; it is said that the resident misinterpreted two words, understood the fracture to have resulted from abuse and contacted the Department of Social Services who then sent a social worker who without an interpreter present, had the mother signing over custody of her two children without even being aware what she was signing up for. This case is a true reflection of how disastrous and detrimental language communication breakdown could be, especially in a case of medical settings.

These are some of the responses given by patient participants in respect of the aforesaid question:

- I am unable to fully describe everything, but the doctors understand what I am trying to say
- Yes, I have managed to speak to English speaking doctors before
- No, I cannot speak English
- No, I struggle with other words

- No, I do not understand English and I cannot speak it

According to Simpson et.al (1991:1385) most complaints by the public about medical practitioners deal not with the clinical competency problems, but rather with communication problems. Likewise, the majority of malpractice allegations arise from communication breakdown errors. The responses illustrated above are an indication of the inferior medical services rendered to patients as a result of the lack of professional medical interpreting services in the hospitals which result in miscommunication.

4.2.3.7 Patients' need for interpreting service and the availability of interpreters during consultations

"The quality of clinical communication is related to positive health outcomes. Explaining and understanding patient concerns, even when they cannot be resolved, results in a significant fall in anxiety. Greater participation by the patient in the encounter improves satisfaction, compliance and outcome of treatment. The level of psychological distress in patients with serious illness is less when they perceive themselves to have received adequate information" (Simpson et al. 1991:1385). In response to patients' need for interpreting services, the majority of the participants stated that they do require such services to be available when they come for medical consultations. The reasons are derived from the previous discussion which relate to the inability to communicate effectively with English speaking doctors.

Some of the responses given in respect to this question were as follow:

- Yes I do require interpreting services because I do not understand English, I also did not go to school and I come from the rural areas
- Yes I do require interpreting services because I am not well educated and I struggle to communicate in English
- Yes I do require interpreting services because I do not understand the commonly used language (English) and therefore I need someone who speaks my language, so that I can understand
- Yes I do because sometimes we do not fully understand each other with the doctors when we speak **isifanakalo**

- Yes I do require interpreting services because the majority of the doctors speak English. I then struggle to communicate with them, again “isifanakalo” which the doctors tend to speak is also confusing

The aforesaid reasons are some of the responses provided by the participants. Although these are not all the responses given by the participants, but all given responses are similar to these. Furthermore, the use of “isifanakalo” is seen as an effort made by the doctors to try and meet the patients half way in terms of communication. However, it is also noticed that “isifanakalo” itself is confusing the patients further as they have stated in the aforesaid responses. According to Soanes and Branford (2002:320) isifanakalo also known as fanagalo is a pidgin developed by mining companies with elements taken from English, Afrikaans and the Nguni languages. It originates from the Nguni languages which is fana + ka + lo = like this or in this manner. This formulated isifanakalo language is not an official South African language. Therefore, its use in the medical institutions does not guarantee adequate and effective doctor- patient communication. Especially with the mere fact that some patients find it even more confusing instead of it being a better means for communication.

There was also a minority of the participants who stated that they do not require such services as they can speak English fluently. However, this contradicts their previous responses whereby they stated that even though they can speak fluently English, but there are some limitations encountered due to the unique medical jargon used by the medical practitioners. They themselves as laymen in the medical field do not understand and it requires specialized knowledge. In the absence of professional interpreting services in the medical setting in the province or in the participating hospitals, it would seem as if it is only the nurses who can assist with such services. This was also confirmed by the participants who use the interpreting services rendered by the nursing staff during consultations. Therefore, the only available sources of isiZulu and English interpreting services are again the nurses, as also confirmed by doctor participants. However, the nurses themselves are not always readily available to render such services.

Furthermore, the results obtained from their responses clearly indicated that there are forcing powers behind them rendering these services and they do not do it out of

their own will. Also they expressed that interpreting services distract them from their scope of practice. As a result they have to leave whatever they are doing when a doctor requires them to interpret for them and also complained that their jobs are left unattended until they return to it, which again in my view I regard it as a quality service delivery compromising factor.

4.2.3.8 Worse medical cases experienced by patients in the hospitals

According to Schlemmer and Mash (2006:1084) errors frequently occur in interpretations provided by untrained nurse- interpreters and yet in South Africa it is most often an ad hoc duty provided by the nurses, ancillary staff or even patients and relatives. They further documented one of the responses given by a hospital clerk where she stated that *"We all have our tasks to complete for the day. Because, if someone calls me to go and translate, it is not the matter. But the fact that I have something to do – I will not always be there. That is why many people go away without knowing the reasons why they came to hospital".* Now, the issue of one visiting the hospital with an intention and hope to get medical assistance, but only to discover that they will leave the hospital without being properly diagnosed is very problematic and concerning. This is because even if there were precautions that a patient might have possibly managed to take provided with proper knowledge to try and avoid the illness from escalating, but due to the poor and inadequate communication services they are unable to do so. This could result in fatal disasters as well.

Well in this particular study, it was fortunate to discover that none of the participants has ever experienced severe bad impact as a result of language miscommunication. Unlike in the case of other hospitals in the country and across the world; whereby severe bad impact has occurred, creating permanent changes in patients' lives.

Flores (2006:230) states that inadequate communication can have tragic consequences. He further shares a story in a medical setting where one word was misinterpreted and resulted to an extreme delayed healthcare and preventable quadriplegia. This is similar to the case of one of the studies conducted by Levin in one of the hospitals in the country, whereby incorrect pronunciations of isiXhosa names in the waiting area resulted in delays and patient anxiety. It is further said that the nurses were unwilling to assist with interpreting and lay interpreters were used

mostly with subsequent errors in the interpreted discourses (Levin 2006:1076). As stated in chapter two, interpreting is a profession on its own and it requires specialist skills and in depth knowledge in the field (Angelelli 2007: 63 and Hale 2004:3). Therefore, subsequent interpreting errors are bound to occur when lay interpreters such as hospital cleaners are used. It is also said that when such interpreters are called upon to assist with the interpreting services, they express their linguistic limitations due to the difficult or rather challenging medical jargon. However, doctors give them what is seen as unfair emotional blackmail by saying to them “they are not doing it for them, but they are doing it for the patients” (Schlemmer and Mash 2006:1085). As a result, this situation of not having professional medical interpreters ends up creating an unpleasant working environment for many in the hospitals as it fairly obvious that there are now emotions involved.

4.2.3.9 The provision of adequate medical information to patients

Experience has shown that when one visits the medical institutions such as local clinics, where doctors are not always available or perhaps come for specially booked emergency cases only, a consulting nurse who shares a common language with that of the patient in most cases would make a diagnosis and further advice on the use of the prescribed treatment and follow ups. However, the situation tends to differ when patients are hospitalised where in most cases they are consulted by various medical specialists who do not share a common language with them. Usually, when patients are hospitalised, it is due to severe illnesses which requires intensive care. Hence, in most cases these patients are not in a correct or stable psychological state. In such cases the doctors must make proper decisions in order to save lives. However, the concern is, in instances whereby they need to do specialised surgical procedures such as operations, how well do they communicate such information to the patients or to the family members in order to ensure that they understand fully the significance of such procedures to be undertaken.

Various responses were given in respect of this question. Some participants stated that indeed the doctors fully informed them about the procedures which were to be undertaken. Whereas on the other hand, some stated that indeed the doctors try to explain to them. The use of the term “try” alone suggests various ideas. However, based on the context and the manner in which it was used, it suggested an extra

effort made by the doctors to give adequate information to the patients regarding the medical procedures. This is indeed in compliance with what is stated in the Health Professions Council of South Africa (HPCSA: 2008:3) where it states that “everyone has a right to be given full and accurate information about the nature of one’s illnesses, diagnosis, procedures, the proposed treatment and risks associated therewith and the costs involved”. Therefore given the above responses, it seems fair to commend these doctors for efficient services rendered in this regard.

Below is a list of some of the responses given by the patients, the questionnaire is available as appendix (F)

- Yes they do
- The nurses do tell us what is going to happen after they have been informed by the doctors
- Yes they do try and explain everything
- Yes they do and I ask questions where I do not understand and they explain further

However, there were other patient participants who expressed a lack of being given sufficient information when it comes to the aforesaid procedures to be undertaken. This is because some of them stated that they were not being fully informed about such procedures. On the other hand others stated that they were only informed by the nurses, but still not adequately. It would seem as if even though these patients might have wished to ask questions to get detailed information, not many opportunities are afforded to them in order to do such. This is purely based on some of the responses they gave which are as follow:

- They do not explain, but instead they tell us what needs to be done
- No they do not explain, instead they are the ones who make decisions over my life. I therefore keep quite because I want to live
- No, they make decisions and inform you
- No, instead they just tell you that you are going to be admitted in hospital and after that they do many things which one does not understand. However, we are grateful to be alive.

The responses given are now in contradiction with what is stated in the (HPCSA). This is because based on the aforesaid responses, it is clear that the patient participants who showed dissatisfaction in this regard are not given much of a choice over certain procedures nor given an opportunity to seek alternative advice as enshrined on the patients' charter. The charter states that "a person may refuse treatment and such refusal shall be verbal or in writing, provided that such refusal does not endanger the health of others" It further states that "everyone has the right on request to be referred for a second opinion to a health provider of one's choice" (HPCSA : 2008:2-3). Therefore, these responses suggest room for a more improved language information communication between patients, doctors and nurses. In doing so it may effectively, also eliminate other possible complex cases e.g. whereby a medical procedure might be unsuccessful in various ways and due to various reasons. However, if information was not adequately communicated to the patient or the patient's family, it is highly possible that the patient or the family might shift the responsibility or blame to the hospitals on the grounds that not adequate information was being provided and they never consented to the procedure to be undertaken.

4.2.3.10 Patients' recommendations

The recommendations made were all purely based on the recognition for the provision of professional medical interpreting services. It was also fascinating to see that even the participants who stated that they do not require such services initially, but they recommended that these services must be provided for those who require it. Likewise, the need for doctors to learn isiZulu was also recommended as one of the means that could possibly improve effective language communication and lead to an efficient healthcare provision.

4.3 Summary of the findings and answers to the research questions

The study has discovered that there are indeed some language barriers existing in the medical sector as a result of the difference in languages spoken by both medical practitioners and patients (isiZulu and English). It is also evident that all three parties (patients, nurses and doctors) involved in the consultation process are not satisfied with the language communication. This is because it was firstly stated by the doctors

that indeed they found the communication process with limited English speaking patients very difficult. Also in the events where nurses were used as ad hoc interpreters for both parties as they are considered to be bilingual, but still some nurses had some interpreting difficulties due to their linguistic inability to speak English fluently as well, and as a result the message suffered from a lot of omissions and inaccuracies. This has answered research question number one (1) which is

'what language barriers if any are experienced in consultations between medical practitioners and patients?'

According to Karliner et al. (2008:1559) the use of bilingual individuals to act as interpreters in the medical setting negatively affects health quality services. Nolan (2005:6) also argues that the aforesaid interpreters may not always be bilingual, as being bilingual requires an early exposure to both languages, which appears not to be the case for the nurses whom are regarded as bilinguals and expected to interpret. This has also been supported by Ngo- Metzger et al. (2007:324) where they state that even with the use of ad hoc interpreting services, the quality of health services given to the patient and the degree of health education received is found to be below the expected standard. Also some of the doctor participants stated that

"nurses understanding is occasionally limited leading to inaccuracies and omissions" which is also a confirmation that the nurses are not truly bilingual. Furthermore, patients seem to give lengthy information to the nurse in the presence of the consulting doctor, but a nurse will only convey a very short summary of what was being said by the patients, which obviously shows that there has been a severe omissions taking place in the dialogue. Having mentioned the reasons above, it would therefore seem unfair to hold the nurses accountable for any inaccuracies or omissions in the message during the course of interpreting. This is because in some of the responses given, it was discovered that interpreting is a profession on its own, therefore nurses cannot be expected to perform such duties because they do not have all the relevant and required skills to do so. It is therefore evidently clear that with all the language communication barriers experienced, the diagnosis and treatment prescription ends up being inaccurate and causing inferior medical assistance. The aforesaid reasons, responses received from the participants and the analysis of the data confirms the hypothesis of this study **'isiZulu speakers with**

limited English proficiency are possibly receiving inferior medical assistance due to language barriers*'.*

Again the responses given by the doctors and patient participants in this study confirmed another part of the hypothesis which stated that "isiZulu speaking patients frequently encounter non-isiZulu speaking doctors in consultations". This is because almost one hundred percent of the responses given confirmed this to have been the case which still exists. Although there were also doctor participants who stated that they understood isiZulu, it was discovered that their level of understanding was below average. This is because it also appeared that they only understood the basics of isiZulu, which are not of great assistance during medical consultations with patients for effective diagnostic process. Furthermore, according to some of the responses given by the patients whereby they stated that the doctors use isifanakalo which again is found to be more confusing to some of the patients is also an indication of inferior medical services given to limited English proficient patients. This was also confirmed by the responses given by the majority of the patients, whom it was also ascertained that their level of the English command was quite poor due to various reasons. One of the most prominent reasons given for poor English command was that of illiteracy as some of the patients were never afforded an opportunity to attend school. As for those who were given such opportunities, it was however also not adequate to acquire sufficient linguistic knowledge which would have enabled them to speak English fluently.

It was further noticeable that none of the participants from all three categories of the targeted populations has ever witnessed a worst case as a result of language communication breakdown. Unlike in some of the cases globally and in some parts of the country where this has been witnessed more than once and where some of the bad experiences resulted in a lifetime changes especially for the patients. Such cases include, errors in surgical procedures e.g. amputations of the wrong body parts or names being mispronounced and resulting in patients not being attended to at all. Therefore, these are some of the actual and potential consequences which could also be suffered in the hospitals in the province, if not already by other patients who utilize these public health facilities but never participated in the study, as a result of language communication breakdowns.

Another area of concern was that of the nurses being instructed to interpret for doctors and patients. The results obtained show that indeed they are not happy about being forced to render these services due to the fact that it keeps them away from their original nursing scope of practice, especially in instances where they are giving treatment to the admitted patients. It is said that, they have to leave everything and attend to the doctor and the patient involved in order to render the interpreting services this is also confirmed by Schlemer and Mash (2006:185) and Lesch (2007:75). It was also discovered that interpreting does not form part of the nurses' scope of practices. The nurses emphasised the fact that their main scope of practice was strictly for patient care rather than interpreting, which was found to be a challenge to the majority of the nurses due to the specialised medical jargon in use. As a result, some patients expressed dissatisfaction with the medical services given to them as some of them noticed that their explanations were summarized when conveyed to the English speaking doctors.

According to the National Patients' Right Charter, "every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision – making on matters affecting one's own health" it also states that "everyone has a right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and risks associated therewith and the costs involved" (HPCSA: 1 and 3). These are indeed the most favourable and significant rights for both parties involved in the therapeutic process. However, the unfortunate reality is the fact that these seem to exist on paper only, as the actual situation encountered in the public health facilities on a daily basis proves to be the opposite of what is written on the charter. This is because from the responses given by the participants, it is clear that such significant information is not fully communicated to them. Also it shows that the patients are not given sufficient information or being given an opportunity to make their own decisions based on what they have been told or diagnosed with by the doctors. Not to mention the fact that accurate diagnosis is achieved after several language communication difficulties. These difficulties are also compromising the accuracy of diagnosis as it was said that the nurses omit so much information which is considered critical in this stage. According to the Health Care Interpreting in the News (2011:1) patients may even present symptoms unrelated to the real problems

and the diagnostic doctor relies heavily on skilful questioning. However, with all the aforesaid challenges in the diagnostic process it seems almost impossible to achieve accurate diagnosis. It was further noted that this was not the case for all the patients, as some of the responses given indicated that some of the doctors do go an extra mile in explaining the situation to the patients, some with the help from the nurses and some without. However, again the responses given by the majority of the patients indicated that critical decisions e.g. surgical procedures are made on their behalf, rather than allowing the patients themselves to decide on the issues affecting their health or allowing for a second opinion as enshrined in the charter. This again is an impact of the language communication breakdown caused by the difference in languages spoken by doctors, nurses and patients in the hospitals. Also the lack of professional medical interpreting services is the main cause of this unpleasant situation. If ever such services were provided by suitably qualified personnel, some of the errors would be prevented from occurring. Also patients would have more detailed information regarding their illnesses. The discussion above has answered part one of the second research question which was focusing on the possible consequences regarding accurate diagnosis of the patient condition and the understanding thereof.

The medical staff participants also felt that indeed language difference has an impact on the treatment compliance. Although their personal ratings on treatment compliance were above average and it seems to be an acceptable situation, but there was still a gap as patients still do not fully comply with the prescribed treatment. Some of the doctors stated that proper understanding of treatment and its importance needs to be explained in a manner that is easily understood by the patient. This is because the lack of the treatment understanding could also result in high risk difficulties such as defaulting the treatment or consuming an over dosage of the prescribed treatment. Therefore, the only possible way to ensure that such risks are prevented is by no other means except effective language communication achieved by speaking the mother tongue language of the patient. This allows both speakers to have a mutual understanding of the situation at hand and enables the patient to ask all the necessary follow up questions for better understanding and a caregiver is also able to provide all the necessary medical information. This

paragraph has also answered the other part of the second research question which was regarding the prescription of treatment and compliance.

4.4. Conclusion

In conclusion, this chapter presented data which was collected from all three groups of the target population i.e. medical doctors, nurses and patients. The responses given were grouped in various categories presented and analysed. Furthermore, the hypothesis has been proven and the two main research questions have been answered in accordance to the responses received and aligning it with the previous medical research nationwide and worldwide. The next chapter concludes the study by first looking at all the previous chapters and making possible recommendations based on the findings received.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter gives a summary of the research as a whole, its key findings and the emerging recommendations. It first looks at all the content covered in all the previous chapters and then concludes by drawing recommendations from the findings of the study. It is therefore structured as follows:

5.1 Introduction
5.2 Summary of the study
5.3 Summary based on the findings
5.4 Limitations of the study
5.5 Recommendations
5.6 Conclusion

5.2 Summary of the study

The aim of the study was to identify the shortcomings in the medical settings caused by the language difference between English speaking medical practitioners and isiZulu speaking patients. The study was conducted in two public hospitals i.e. King Edward VIII and R. K. Khan Hospitals. The main focus of the study was to look at the communication breakdowns and difficulties experienced by all the three parties involved in the therapeutic process. These difficulties were initially assumed to compromise the efficient medical assistance to isiZulu speaking patients with extremely limited English proficiency.

This study began by defining the informal state in which interpreting services are being provided during consultations in the medical sector. This was based on the daily observed and practical situations encountered by both medical staff members and the patients when patients visit the hospitals. The interpreting role which is proven to be fulfilled by the nurses based on the assumption that they are bilingual and medically trained and they could therefore effectively act in the role of medical interpreters was also discussed. Furthermore, the unique and specialised interpreting skills were also discussed in detail in order to outline the significance of

professionally trained medical interpreters. Based on the aforesaid points, the study managed to prove that interpreting services rendered by the nursing staff members are not adequate and they are also the main compromising factor to successful therapy. This is because it was proven that most of the nursing staff members had some extreme linguistic challenges particularly when it comes to interpreting a lengthy conversation form isiZulu to English and vice versa.

The study targeted three population groups of participants i.e. English speaking doctors, isiZulu speaking nurses who act as interpreters and isiZulu speaking patients. The data was collected by randomly selecting the aforesaid participants randomly but based on their availability. For the medical staff members who participated in the study, questionnaires were used and for the patient participants one on one or face to face interviews were used. Although, the initial aim was to have the interviews electronically recorded with a tape recorder and transcribing the responses into a hard copy, the reluctance expressed by the patient participants in having their responses recorded led the researcher to deviate from this idea and opted to rather write the responses on a questionnaire for each participant. This was done to avoid a limited turnout of the patient participants, also complying with the research ethics especially regarding the issue of information and consent from the participants. However, the amount of data collected from the patient participants was not affected as opposed to an event whereby the interviews were to be electronically recorded.

Chapter two also focused on the general communication process, where this process was defined and also the key characteristics were discussed. It also looked at the process of effective communication in the medical context where certain key requirements for such a process to be considered effective were discussed in details as well. Also the key role played by language in the communication process between the medical practitioners and the patients was discussed. It was discovered that indeed language communication played a pivotal role in the medical setting by means of creating trust and cooperation between the medical practitioners and the patients. Furthermore, effective language communication in the medical setting was said to improve high quality health care to the public and eliminate risks such as

inaccurate diagnosis and other dangers which could occur as a result of poor communication.

Additionally, the process of communication breakdown was discussed. In this section, various causes of communication breakdowns were discussed. An example of a deadly situation in the medical context as result of poor communication process in the medical setting was used to highlight the possible and severe dangers caused by communication breakdowns. Various factors influencing or enhancing the process of communication breakdowns were then presented and discussed according to their unique characteristics. These factors included language barriers, where a difference in languages was seen as a key factor. However, it was fascinating to discover that even if people share a common language the use of specific jargon could still result into a communication breakdown as well. Other factors discussed included the psychological barriers, physiological barriers, physical barriers, systematic barriers and attitude barriers. All these were discussed to highlight their role in affecting effective communication.

This chapter further discussed interpreting and the interpreting process. This was done to clarify the difference between translation and interpreting, as it was established that the public in general lacked knowledge regarding the distinction of these two processes. As a result, the term “translation” is commonly used to define interpreting. Also various modes of interpreting including settings where such services are found were discussed into details. Furthermore, while the study investigated language barriers in the medical setting, it was discovered that there is a huge lack of interpreting services in the medical institutions in KwaZulu–Natal. However, the significance of having these services was emphasised approximately in all chapters. This is because the possible unpleasant implications due to the lack of medical interpreting services were clearly outlined. It is was further confirmed that if these services were readily available at all times, it would have opened channels for patients and medical practitioners to act interactively as partners and allow both parties to participate in the therapeutic process more effectively without any linguistic challenges due to limited English proficiency. The availability of professional medical interpreting services would assist with effective questioning and getting proper responses from each party. Likewise, the medical practitioners would also be able to make proper diagnosis and further advice or recommend proper

medical treatment. However, as a result of the lack of these services at a professionally and recognised level, people are not properly diagnosed and do not fully understand their medical conditions as they are supposed to. This also confirms that indeed the prescribed treatment is also highly influenced by effective language communication which in this regard would have been provided by suitably qualified medical interpreters if the South African hospitals had such services readily available in all hospitals across the country.

Chapter two also looked at the current linguistic situation in South Africa where some of the main factors relating to the lack of professional interpreting services being provided at a professional level in the medical institutions were discussed. It was found that there were several factors influencing the problem presented in the hypothesis of the study. These include: the shortage of isiZulu speaking doctors, yet these doctors are serving the majority of the first language speakers of the province, the challenges within the health sector, the lack of formal training for interpreters in South Africa, marginalization of the indigenous languages, implementation of language units in the public sector, lack of formal training for both translators and interpreters, the misunderstanding of the interpreters' role in the medical setting and remuneration. All the aforesaid factors were individually discussed briefly and found to have a haphazard impact in the medical setting, but mostly to the patient population as opposed to the other parties involved in the medical setting.

Chapter three presented the methodology used to conduct the whole study. It looked at the theories employed and all the strategies used to collect data from all the participants in both the medical institutions where the study was conducted.

5.3 A summary based on findings

In chapter four, the data collected from the previous chapter was presented and analysed in various categories and in accordance to the groups of the participants. Data for the medical staff members was presented in the form of pie charts. The pie charts indicated the percentages based on the responses provided for each question posed to the participants and findings were then determined thereafter and analysed in relation to the study.

5.3.1 Existing language communication breakdowns

Although the study did not holistically describe communication breakdowns in the medical setting due to the difference in languages spoken by the medical practitioners and the patients, this is due to the fact that the findings were given by the minority of the participants in the study as the study was not designed to cater for all medical staff members together with the patients who visit the hospitals where the study was conducted. However, the study has found that there are indeed communication breakdowns caused by language differences in the hospitals. Based on the responses given by doctors and patients, it is evidently clear that English remains the most frequently used language during medical consultations between isiZulu speaking patients and English speaking doctors. Although some of the doctors tried to code switch by using the basic isiZulu, it was discovered that such exercise is not sufficient for efficient medical services to the patients. This is also because the doctors could not fully engage in a conversation with isiZulu speaking patients vice versa. Furthermore, the majority of the responses received form the doctors confirmed that most of the doctors do not understand isiZulu; as a result they depend heavily on the provision of interpreting services which are rendered by isiZulu speaking nurses, again on the assumption that they are bilingual, medically trained and they could therefore interpret.

Furthermore, the responses received form all groups of the respondents implicitly revealed that the communication process between English speaking doctors and isiZulu speaking patients was in fact extremely difficult. However, it would seem that there was no other proper mechanism to be used in order to address such difficulties except depending on the nursing staff to assist with the facilitation of interpreting services.

5.3.2 Inaccuracy and omissions of significant information

Although interpreting services were said to have been rendered by the nursing staff, the nurses were not always available to render such services. Also the issue of inaccuracy in the conveyed message was also noticed. This was also confirmed by the nurses in their responses where they emphasized the issue of lengthy

discussions which patients tend to state and the nurses only convey some parts of it but not the whole message as stated by the patient. This way, significant information for proper diagnosis suffers omissions and inaccuracy. Likewise, the technicality of the medical jargon was seen as the most challenging factor to the nurses when they were required to interpret. But that was not the only challenge raised with regards to the issue in the technicality of medical jargon, the lack of direct equivalence in both English and isiZulu was another key challenge expressed by the nurses. The respondents, particularly the nurses in this regard, revealed that, they were terms which they could interpret into both the languages whenever these terms were mentioned. As a result of this some nurses tried to make examples to the doctors, with the hope that they would understand, but somehow the doctors seem even more confused by the given examples. This was also supported by some of the responses given by the doctors where they confirmed that indeed the nursing staff do not fully understand both languages and as a result the message is not properly conveyed and obviously compromising the efficiency in the healthcare system. Furthermore, if such difficulties as discussed are experienced at the primary stage, it is most likely that even the follow up procedures taken thereafter might be in error and this includes the incorrect diagnosis.

5.3.3 The rate of treatment compliance and the influence of language on the prescribed treatment

With regards to treatment compliance by the patients, the results obtained indicated a satisfactory state, even though the desired percentage is one hundred percent (100%) compliance, but the results obtained were above average and satisfactory. However, the responses received when the participants were asked to comment if whether they felt that treatment compliance was also influenced by language were thought provoking. The medical practitioners raised the issue of high default rate and intake of incorrect dosages. They further felt that if such important information was communicated in the language spoken by the patient, this would not be the case. Although, some of the medical practitioners did not see the language barrier as a factor to the treatment in compliance due to the fact that similar challenges were also experienced with English speaking patients. However, the high percentages of information given by the doctors and nurses in this regard proved this to be the case.

Furthermore, the respondents all confirmed not to have ever experienced any severe bad experience as a result of language communication breakdowns. About bad experiences, the researcher was referring to the wrong medical procedures being undertaken, over dosages of medication and other wrongful activities in the medical setting which could have occurred as a result of having not fully understood the language and the medication instructions and precautions. Again, if any of the medical staff members had experienced such bad experiences before, the chances would be extremely low for such information to be disclosed to the public. Thus, in all of the responses received from the medical staff show that, if the prescribed treatment was fully communicated in the language well understood by the patients, preferably their mother tongue language, the result would differ into a more optimistic level.

5.3.4 Lack of patient medical information and informed consent to the medical procedures

The study also revealed that the lack of proper interpreting services has resulted in compromising some of the patients' rights in respect of having full medical information regarding their medical conditions as enshrined in the charter. This is because some of the patients stated that in an event where they were required to have surgical procedures, they were not fully made to understand their medical conditions which include explaining other available alternatives and further risks associated with their illnesses. Instead drastic decisions which they had no choices of overturning were taken on their behalf. Also when it comes to the issue of signing the consent form, the results obtained indicate that patients with limited English command just sign without knowing what they are signing up for which is another huge technicality which in the researcher's view could be used by the patient or family members to sue the hospitals in the event that an operation becomes unsuccessful. This in the researcher's view is very critical and requires urgent and serious attention as it is also contrary to what is enshrined in the charter.

5.3.5 The challenges caused by interpreting to the nursing staff

The study also evaluated and revealed the unrecognized significant role of the nursing staff as interpreters. This interpreting role of the nurses seems to be

assumed to fall within the scope of practice of the nurses; as a result some of the staff members who participated in the study were not too clear about it. Hence, some of the nurses carried out this practice as a matter of providing better patient healthcare as required. Whereas, on the other hand the majority made it clear that interpreting during consultation does not fall within their scope of practices and seem aggrieved when they were required to render these services. Of course, knowing the technicalities involved in the interpreting process in a professional interpreter's perspective, it was understandable why the nurses expressed unpleasant emotions about this. This is because it was merely assumed they would be better interpreters because of their medical knowledge and medical procedures. However, their interpreting skills and their level of linguistic ability in terms of fluency in both English and isiZulu remained elusive. Apart from the linguistic difficulties experienced by the nurses, the disturbances caused to the nurses' work as a result of being called to assist with the interpreting services was alarming and seemed to frustrate the staff further. As a result all respondents unanimously recognized and suggested a need for professionally trained interpreters so that all parties involved in the therapeutic process could perform their scopes efficiently and effectively as expected.

5.3.6 The influence of patient illiteracy

The results also showed that illiterate patients are most likely to suffer in the medical settings as a result of language communication breakdowns as opposed to those who are literate. This is because a severe difference and a gap in their level of understanding the English language were noticed. There were respondents who stated that they did not understand English language at all and feared that if they tried to speak it they would be a joke, as a result they preferred to stick to their home language especially those who come from the rural settlements. This is because as discussed in chapter four, some did not attend school at all or dropped out at a very early stage due to various social circumstances back then. Whereas, on the other hand there were also participants who claimed to have understood what was being conveyed by the English speaking doctors, but could not revert into English. Likewise, the linguistic challenges mentioned in this regard are also an indication of the mere fact that patients struggle to express themselves fully in English. Therefore, they are also unable to fully describe their medical conditions to the health

practitioners. This is a confirmation of the hypothesis of the study. Again this situation is an indication that these patients require efficient interpreting services when visiting the hospitals for medical consultations as failure to provide such services could open a door for disastrous situations.

5.4. Limitations of the study

The researcher encountered the following deficiencies in conducting the study:

- The study was initially designed to be conducted at Northdale (public) and St Anne's (private) hospitals. These hospitals are both based in the researcher's home town in Pietermaritzburg. However, severe administrative challenges were experienced in terms of getting access into both these medical institutions. As a result the researcher had to deviate from the initial plan and select other two hospitals in the eThekwini metropolitan region which were also not too far from the university in order to have quick access and follow ups whenever required. This was also done in order to at least meet the deadline of the sponsors (Durban University of Technology Scholarship).
- Extreme delay in obtaining the research ethics clearance approval from the university.
- Obtaining the dully completed questionnaires from the doctors and also the extreme delay taken to get the questionnaires answered.
- Patient participants' reluctance in having the interviews electronically recorded.

5.5 Recommendations

On the basis of the findings of this particular study, it is clear that in as much as our South African government has given massive attention to the healthcare services in terms of ensuring the availability of various treatments, the healthcare services are still massively compromised by language communication breakdowns due to the use of the English language as the main language for consultation in the hospitals. Therefore, the researcher managed to draw the following recommendations:

- Implementation of proper language units in the hospitals and other public entities should come into effect. These language units will cater for both translation and interpreting services to the public. This way the public will have full access to information and this significant information will be accessed through the use of a language of choice (mother tongue) without any linguistic limitations.
- Appointment of professionally trained interpreters to render medical interpreting services in the medical institutions. Having these personnel will improve the healthcare system by ensuring quality healthcare, especially with regards to accurate diagnosis which is the fundamental stage of the therapeutic process. Furthermore, having professionally trained interpreters will allow the nurses to practice their scope of practice more efficiently without any disturbances caused to them as it is the case.
- Training of medical staff members is also required in order to clarify the roles of the medical interpreters particularly where there are one on one consultations between the doctors and patients taking place.
- As a short term solution, a medical bilingual dictionary should be made available in order to assist the nursing staff members with interpreting of the terms, especially the ones they regard as difficult and do not have direct equivalence in either of the two languages in question.
- Indigenous languages must not only be recognized on paper (constitution), but the equal use of these languages must come into effect as enshrined in the South African constitution.

5.6 Recommendations for further research

- The implementation of an effective language unit in the medical settings.
- The quality measurement of the interpreted discourse in the medical settings
- A comparison study in public and private hospitals in terms of the provision of both translation and interpreting services.

5.7 Conclusion

In conclusion, the study has successfully managed to prove the hypothesis which was that isiZulu speakers with limited English proficiency are possibly receiving inferior medical assistance due to language barriers. The isiZulu speaking patients with extremely limited English proficiency who access the health services in public and private hospitals frequently encounter non-isiZulu speaking doctors in consultations. The resultant language barriers are likely to give rise to poor communication in these consultations. Indeed this hypothesis was proven by the responses obtained from all three groups of the participants i.e. English speaking doctors, isiZulu speaking nurses who act as medical interpreters and isiZulu speaking patients. The results were presented and discussed in chapter four. It further managed to identify the language gaps and explored the actual potential consequences as a result of language miscommunication. Nevertheless, the findings of the study all boiled down to the fact that there was a massive lack of provision of professional interpreting services which as a result led to the patients not being able to describe their medical conditions to the English speaking doctors. The results obtained from the study also proved that language barriers have a bad impact on treatment compliance. Also as a result of the lack of these services the doctors were limited to make proper diagnosis and further give significant information to the patients due to the language barrier experienced. Recommendations were then drawn in order to fill the identified shortcomings in order to improve the healthcare system in the hospitals.

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APPENDIX A

Letter to the authority

O-25 Lembede Drive

Ashdown Township

Pietermaritzburg

3201.

22 April 2013.

Dear Sir/Madam

My name is Thabani Robert Khumalo student number 20704319; I am currently registered for MTech: Language Practice at the Durban University of Technology (DUT) in the department of Media, Language and Communication. In order for me to complete this degree, I am required to conduct a research project.

Tittle of research:

Interpreting services provided during consultations in the medical sector: identifying shortcomings (Supervisor: Dr. R. L. Makhubu).

The following methodology will be used to collect data for the study:

- Interviews will be conducted with six (6) Doctors who are not isiZulu speakers.
- Interviews will be conducted with six (6) hospital staff members who are used by doctors as ad-hoc interpreters e.g. nurse and cleaners.
- Interviews will also be conducted with at least ten (10) isiZulu speaking patients.

I therefore request permission to conduct my research at your hospital so that my research can be a valid and a very successful one.

Should you wish to look at my thesis after completion, my hands are open without any hesitations.

I thank you in advance and I am looking forward into a positive response in this regard.

Yours sincerely

Mr. T.R Khumalo.

APPENDIX B

LETTER OF INFORMATION

Title of the Research Study: Interpreting services provided during consultations in the medical sector: identifying shortcomings

Isihloko socwaningo: *Interpreting services provided during consultations in the medical sector: identifying shortcomings*

Principal Investigator/s/researcher: Thabani Robert Khumalo, MTech; Language Practice

Umcwaningi noma abacaningi abakhulu: *Thabani Robert Khumalo, MTech; Language Practice*

Co-Investigator/s/supervisor/s: Dkt. R. L. Makhubu: DTech: Language Practice

Abambisene nabo noma abeluleki: *Dkt. R. L. Makhubu: DTech: Language Practice*

Brief Introduction and Purpose of the Study: The study aims to investigate the communication breakdowns caused by the difference in languages spoken by medical practitioners and patients during medical consultations.

Isifingqo mayelana nenhloso yocwaningo: *Lolucwaningo luhlose ukuphenya kabanzi ukungaxhumani kahle kubasebanzi bezempilo kanye neziguli ngenxa yokwehluka kwezilimi abazikhulumayo uma iziguli zize ezikhungweni zempilo .*

Outline of the Procedures:

- Interviews will be conducted with six (6) Doctors who are not isiZulu speakers. (Questionnaires)
- Interviews will be conducted with six (6) hospital staff members who are used by doctors as ad-hoc interpreters e.g. nurses and cleaners.
- Interviews will be conducted with at least ten (10) isiZulu speaking patients.

Uhlelo locwaningo:

- *Uhla lemibuzo luzonikezwa odokotla abayiithupha (6) abangasikhulumi isiZulu.*
- *Eminjye imibuzo izonikezwa abasebenzi baseibhedlela abayisithupha (6) abasetshenziswa ngo dokotela ukuba babe ngo tolika isibo.abahlengikazi Kanye naabo abahlanza isibhedlela.*
- *Eminye imibuzo izobhekiswa ezigulini eziyishumi (10) ezikhuluma isiZulu.*

Risks or Discomforts to the Participant: N/A

Ubungozi noma okungabanga ukuthi obambe iqhaza angakhululeki kahle: Akukho

Benefits: The thesis will be published in accordance to the Durban University of Technology's procedures.

Imihlomulo: *Ucwaningo luzoshicilelwa ngokwemithetho yese Durban University of Technology.*

Reason/s why the Participant May Be Withdrawn from the Study: There will be no adverse consequences for the participant should they choose to withdraw.

Izizathu ezingabangela ukuthi umuntu ahoxixe ukubamba iqhaza ocwaningweni: *Ayikho imiphumela emibi ezokwehlela lobo obabambe iqhaza ocwaningweni uma sebefisa ukuhoxa.*

Remuneration: N/A

Iholo: *Alikho*

Costs of the Study: N/A

Imali ekhokhwayo ukubamba iqhaza ocwaningweni: *Ayikho*

Confidentiality: The participants will not be identified and all the information gathered will be treated as anonymous.

Ukuvikela ababambe iqhaza: *Angeke badalulwe labo ababambe iqhaza futhi yonke imininingwane ezotholakala izogcinwa njengemfihlo.*

Research-related Injury: This study is not risky and therefore there will be no compensation given to the participants.

Ukulimala okudalwa ucwaningo: *lolucwaningo alinabo ubungozi nagkho asikho isinxephezelo esizonikwa labo ababambe iqhaza.*

Persons to Contact in the Event of Any Problems or Queries:

Dr. R.L. Makhubu (Supervisor) Tel no. 031 373 6718 or Please contact the researcher Thabani Khumalo (Tel no. 073 551 8 248), or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Abantu oxhumana nabo uma kunezinkinga noma imibuzo:

Dkt. R.L. Makhubu (Umeluleki) Inombolo yocingo- 031 373 6718 noma umcwaningi uThabani Robert Khumalo inombolo yocingo 073 551 8 248 noma umphathi wesikhungo semithetho yokwenziwa yocwaningo kwinombolo ethi-031 373 2900. Izikhalazo zingabikwa kwi- DVC: TIP, Solwazi F. Otieno ku- 031 373 2382 noma ngokuthumela imeyili ku dvctip@dut.ac.za.

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population e.g. isiZulu.

APPENDIX C

CONSENT/ *IFOMU LOKUNIKA IMVUME*

Statement of Agreement to Participate in the Research Study: *Isivumelwano sokubamba iqhaza ocwaningweni*

- I hereby confirm that I have been informed by the researcher, Thabani Robert Khumalo (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 037/14 / *Ngiyaqiniseka ukuthi Thabani Robert Khumalo ungichazele mayelana nesimo socwaningo lonke kanye nobungozi balo – Ngaphansi kwe nombolo yemigomo elawula ukwenziwa ko cwaningo engu: 037/14.*
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study. *Ngiphinde ngayithola incwadi, ngayifunda futhi ngayiqondisisa yonke imininingwane ebhaliwe (Incwadi yababambe iqhaza) mayelana nocwaningo.*
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report. *Ngiyazi futhi ukuthi imiphumela yocwaningo ebandakanya imininingwane yami yobulili, iminyaka, usuku lokuzalwa, izinhlavu zokuqala zamagama nesibongo sami kanye nesifo esingiphethe kuzoba yimfihlo emiphumeleni yocwaningo.*
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher. *Ngokwezidingo zocwaningo, ngiyavuma ukuthi imininingwane eqoqiwe kulolucwaningo ingasetshenziswa ngokusebenzisa ubuchwepheshe be khompuyutha.*
- I may, at any stage, without prejudice, withdraw my consent and participation in the study. *Ngingahoxa noma inini ngaphandle kokuphoqwa, ekubambeni iqhaza ocwaningweni.*
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study. *Ngibe nethuba elanele lokubuza imibuzo (ngokuthanda kwami) ngaze ngazizwa ukuthi sengikulungele ukubamba iqhaza ocwaningweni.*
- I understand that significant new findings developed during the course of this

research which may relate to my participation will be made available to me.

Ngiyaqonda ukuthi imiphumela emisha ebalulekile ezotholakala ngenxa yokubamba kwami iqhaza ngizokwaziswa ngayo.

_____ _____ _____ _____

Full Name of Participant Date Time Signature / Right Thumbprint

I, Thabani Robert Khumalo herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Mina, Thabani Robert Khumalo ngiyaqiniseka ukuthi lona obambe iqhaza uchazeliwe ngokuphelele mayelana nesimo kanye nangobungozi balolucwaningo.

_____ _____ _____

Full Name of Researcher Date Signature

_____ _____ _____

Full Name of Witness (If applicable) Date Signature

_____ _____ _____

Full Nme of Legal Guardian (If applicable) Date Signature*Please note the following:*

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level - use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. wrong date or spelling mistake a new document has to be completed. The incomplete original document has to be kept in the participant file and not thrown away and copies thereof must be issued to the participant.

References:

Department of Health: 2004. *Ethics in Health Research: Principles, Structures and Processes* http://www.doh.gov.za/docs/factsheets/guidelines/ethnics/

Department of Health. 2006. *South African Good Clinical Practice Guidelines*. 2nd Ed. Available at: http://www.nhrec.org.za/?page_id=14

APPENDIX D

Interpreting services provided during consultations in the medical sector: identifying short comings

Questionnaire for the medical practitioners (Doctors)

1. What is your home language?

   .....
   .....

2. How long have you been working in this hospital?

   ……
   ……..

3. What language do you use during consultations with your patients?

   .....
   .....

4. Do you understand isiZulu? (Yes or No)

   …….....
   .....

5. If your above answer was yes, to what extent do you understand isiZulu?

I can speak it fluently.	I understand it but I cannot respond in isiZulu.	I only understand the basics of isiZulu.

6. How would you describe your communication process with limited English command patients?

Very easy	Very difficult	Just fair

7. Do you have someone who interprets for you during consultations with your patients?

Yes	No	Sometimes

8. What is his or her profession if he is employed by the hospital?

   ……

   ……..

9. Is that interpreter readily available at all time when required?

Yes	No	Sometimes

10. Would you say you are able to communicate effectively with your patients with the help of this interpreter without having any omissions and inaccuracies in the conversation?

    ……

    ……

    ……

    ……

11. Have you ever had the worse communication breakdown due to language difference in the hospital which resulted haphazardly on you patient? If yes please

    share……

    ……

    ……

    .....

12. Do you see a need for professionally trained medical interpreters? Please support your answer?

    .....

    .....

    .....

    .....

13. In general, how would you rate the patients' treatment compliance?

    .....

.....

.....

14. Do you think language has an impact in the way patients react towards treatment compliance? please kindly support your answer

.....

.....

.....

.....

15. Would you like to make any recommendation in relation to different language spoken in the medical setting?

.....

.....

.....

.....

Thank you very much for all your responses and participation.

APPENDIX E

Interpreting services provided during consultations in the medical sector: identifying short comings

Questionnaires for the ad-hoc interpreters in the hospitals/ *Imibuzo yalabo abaolika ezibhedlela*

1. How long have you been interpreting for doctors and patients*?/ Kungabe usubatolikele isikhathi esingakanani odokotela neziguli?*

2. What is your level of education? / *Kungabe ufunde kangakanani*?

Tertiary qualification/ *Iziqu zemfundo ephakeme*	Grade 12/ *Ibanga le-12*	High school not completed or primary/ *Angisiqedanga isikole*

3. How would you rate your English command?/*Usazi kangakananai isiNgisi?*

Good/ *Kahle*	Fair/ *Kanconywana*	Poor/ *Angisazi*

4. How do you feel about interpreting? / *Kungabe uzizwa kanjani ngokutolika?*

I LIKE IT/ *NGIYAKUTHANDA*	I DO NOT LIKE IT/ *ANGIKUTHANDI*	I DO IT BECAUSE I HAVE NO CHOICE/ *NGIYAKWENZA NGOBA NGIPHOQELEKILE*

5. Do you encounter any problems or challenges during the interpreting process? *Kungabe zikhona izinkinga noma izingqinamba ohlangabezana nazo uma utolika?*

YES/ *YEBO*	NO/ *CHA*

Please state a reason for your answer/ *Ngicela useke impendulo yakho*
……
……
……

6. Does interpreting for patients and doctors form part of your professional scope of practice given by the Department of Health? (Applicable to hospital personnel only)

Kungabe ukutolikela odokotela neziguli kuyingxenye yomsebenzi wakho owunikezwe uMnyanmgo Wezepilo na?(Umbuzo uqondiswe kubasebenzi basesibhedlela qha)

YES/ *YEBO*	NO/ *CHA*

7. Doesn't interpreting keeps you away from your original scope of practice and causes delays in your job? Please state a reason for your answer */Kungabe ukutolika akukubambezeli yini ekwenzeni umsebenzi wakho owuqashelwe na? Ngecela useke impedulo yakho*

……
……..……
……..

8. Do you see a need for professionally trained interpreters in the hospitals? *Kungabe uyasibona isidingo sotolika abaqeqeshiwe ezibhedlela na?*

YES/ *YEBO*	NO/ *CHA*

Please give a reason for your answer/ *Ngicela useke impendulo yakho*
……
……
……

9. From your personal experience as an ad-hoc interpreter, would you say language differences have a bad impact in the therapeutic process?

Ngokwezigigaba oseke wazibona njengotolika, ungasho ukuthi ukuhluka kolimi olukhulunywayo kunomthelela omubi ekwelashweni kweziguli?

YES/ *YEBO*	NO/ *CHA*	MAYBE/ *KUNGENZEKA*

Please give a reason for your answer/ *Ngicela useke impendulo yakho* ……
……
…….

10. Would you like to make any recommendations with regards to language and communication in the hospitals*?/ kungabe zikhona izincomo ofisa ukuzenza mayelana nokuxhumana ngolimi ezibhedlela?*

……
……
…….
……
…….

Thank you very much for your time and answers/

Ngiyabonga kakhulu ngesikhathi sakho kanye nezimpendulo zakho

APPENDIX F

Interpreting services provided during consultations in the medical sector: identifying short comings

Questionnaires for the patients*/ Imibuzo yeziguli*

1. What is your home language?/ *Iuphi ulimi lwebele lakho?*

2. Do you understand English? If you answered yes, to what extent do you understand it? *Kungabe uyasazi isiNgisi na? uma uphendule ngo yebo, kungabe usazi kangakanani na?*

3. What is your educational level? /*Kungabe ufunde kangakanani?*

4. How often do you visit the hospital? /*Kungabe uza kangaki esibhedlela?*

5. What language is mostly spoken by the doctors during your visits to the hospital*?/ Kungabe odokotela bakhuluma luphi ulimi uma uze esibhedlela na?*

6. Are you able to fully describe all your medical conditions to the English speaking doctors*?/ Kungabe uyakwazi ukumchazela ngokuphlele udokotela okhuluma isiNgisi inkinga yakho yezempilo na?*

7. Is there someone who interprets for you during consultations? If yes please state who that person is./ *Kungabe ukhona okutolikelayo uma uze kudokotela na? Uma kunjalo ngicela usho ukuthi ubani lowo.*

8. Do you require interpreting services during your visit to the hospital? Please state a reason for your answer*./ Kungabe uyadinga ukutolikelwa uma uze isibhedlela na? Ngicela weseke impendulo yakho.*

9. Has there ever been a case whereby you could not understand an English speaking medical practitioner or anything that was going to be done to you due to the language barrier? *Kungabe siseke saba khona isigameko lapho ungakwazanga ukumuzwa udokotela okhuluma isiNgisi noma into eyayizokwenziwa kuwe ngenxa yokungafani kolim enilukhulumayo?*

10. Do the medical practitioners explain everything that they are going to do to you e.g. an operation*?/ Kungabe odokotela bayakuchazela ngako konke abasuke bezokwenza kuwe na isb. ukuhinzwa?*

11. Would you like to add anything with regards to language barriers in the medical setting*?/ Kungabe kukhona ofisa ukukungeza mayelana nezinkinga eziphathelene ngokuxhumana ngokolimi ezikhungweni zezempilo?*

Thank you very much for your time and answers

Ngiyabonga kakhulu ngisikhathi sakho kanye nezimpendulo

APPENDIX G

Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334 Durban South Africa 4000

Tel: 031 373 2900
Fax: 031 373 2407
Email: [illegible]
[illegible]

www.dut.ac.za

11 June 2014

IREC Reference Number: **REC 18/14**

Mr T R Khumalo
0-25 Lembede Drive
Ashdown Township
Pietermaritzburg
3201

Dear Mr Khumalo

Interpreting services provided during consultations in the medical sector: identifying shortcomings

I am pleased to inform you that Full Approval has been granted to your proposal REC 18/14.

The Proposal has been allocated the following Ethical Clearance number **IREC 037/14**. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Please note that should the researcher pilot the data collection tools, the IREC is to be notified of any changes to the questionnaires.

Yours Sincerely

[redacted]

Prof J K Adam
Chairperson: IREC

APPENDIX H

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

OFFICE OF THE HOSPITAL CEO

KING EDWARD VIII REGIONAL HOSPITAL
Private Bag X02, CONGELLA, 4013
Corner of Rick Turner & Sydney Road
Tel.031-3603853/3315; Fax.031-2361457;
Email:rejoice.khuzwayo@kznhealth.gov.za;
www.kznhealth.gov.za

Ref.: KE 2/7/1/ (32/2014)
Enq.: Mrs. R. Sibiya
Research Programming

07 August 2014

Mr. T. Khumalo
0 25 Lembede Drive
Ashdown Township
PIETERMARITZBURG
3201

Dear Mr. Khumalo

Protocol: Interpreting services provided during consultations in the medical sector: identifying shortcomings REF. REC 18/14

Permission to conduct research at King Edward VIII Hospital is provisionally granted, pending approval by the Provincial Health Research Committee, KZN Department of Health.

Kindly note the following:-

- The research will only commence once confirmation from the Provincial Health Research Committee in the KZN Department of Health has been received.
- Signing of an indemnity form at Room 8, CEO Complex before commencement with your study.
- King Edward VIII Hospital received full acknowledgment in the study or all Publications and reports and also kindly present a copy of the publication or report on completion.

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours faithfully

SUPPORTED/~~NOT SUPPORTED~~

[redacted]

DR. OSB BALOYI
ACTING CHIEF EXECUTIVE OFFICER

[redacted]

DATE

APPENDIX I

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

R.K.KHAN HOSPITAL/ETHEKWINI
DISTRICT
OFFICE OF THE CEO
PRIVATE BAG X004
CHATSWORTH
4030

Tel.. 031-4596C01
Fax. No. 031-401 1247
E-mail: reena.ramcharan@kznhealth.gov.za
www.kznhealth.gov.za

ENQUIRIES: DR P.S. SUBBAN

4 SEPTEMBER 2014

Mr T.R. Khumalo
C-25 Lembede Drive
Ashdown Township
PIETERMARITZBURG

Dear Sir

RE: PERMISSION TO CONDUCT RESEARCH : "INTERPRETING SERVICESPROVIDED DURING CONSULTATIONS IN THE MEDICAL SECTOR : IDENTIFYING SHORTCOMINGS

Permission is granted to conduct your research at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Institution with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. You will be expected to provide feedback on your findings to this institution.

Yours faithfully

[redacted]

HOSPITAL CEO