

**Communication in Health within the South
African Context: Current Practices Employed
Across Three Levels of Health Care**

**A Dissertation submitted to the Division of Communication Sciences
and Disorders, Faculty of Health Sciences, University of Cape Town
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Pathology**

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ABSTRACT

Transformation of the existing health care system to one relevant to the needs of its entire people, is the vision to which South African health providers aspire. Since citizens have a right to be addressed in the language of their choice in health services, this study set out to identify and document current practices regarding communication in health across three health care levels with the hope of informing future policy. In this study multiple methods of data collection were used in order to note complimentary findings. Both qualitative and quantitative methods of data collection were used namely, in-depth interviews, surveys and perusal of health system information. Sixty-two health professionals were interviewed and eighty health professionals formed part of the survey across three levels of health care at a Tertiary Hospital, Secondary Hospital and a Community Health Clinic in the Western Cape. Major findings included that there is currently no policy addressing effective communication at a national, provincial or institutional level. The racial and linguistic profiles of health professionals differed across three levels of health care. A greater number of first language isiXhosa speaking nursing staff were employed at a primary health care level with the majority of nursing staff at a secondary and tertiary level of health care being first language English or Afrikaans speaking, with the majority of medical officers being first language English and Afrikaans speakers. Since the majority of patients at these health care settings are first language isiXhosa speakers, a communication barrier is clearly evident between medical officers and patients, in addition, it was determined that nursing staff were used most frequently as mediators in mediated medical consultations. Two systemic challenges were identified regarding the implementation of service models for more effective communication in health. The first of the two challenges includes a serious lack of access of resources in terms of funding, posts and staff shortage for trained interpreters and nursing staff and secondly, the dire need for training of medical officers and nursing staff regarding working within mediated medical consultations. Furthermore, a service model documented at the Community Health Clinic where mediation was included as part of the job description of nursing assistants appears to be an effective service model in terms of addressing the

communication between health professionals and patients within the current financial constraints. In conclusion, considering the challenges and current practice across the three levels of health care, the researcher proposed options for future policy planning including the need to employ nursing staff (more particularly nursing assistants) as mediators. However, this option is not possible without the necessary training to work within mediated medical interview. The need for training of medical officers in mediated medical consultations was highlighted. Furthermore, a pivotal point that too arose, was the power of context in determining quality of care.

Key words: effective communication, communication barrier, policy, training, funding, trained interpreters, ad hoc mediators

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LIST OF ABBREVIATIONS

TH	Tertiary Hospital
SH	Secondary Hospital
CHC	Community Health Clinic
HCF	Health Care Facility
HCL	Health Care Level
MO	Medical Officer
N	Nursing Staff
TI	Trained Interpreter
MGA	Mediator-General Assistant

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1. INTRODUCTION

Multilingualism in South Africa

“In any society where diversity exists, cultural and language differences are indubitably the biggest barrier to receiving health care” (Davidson 2000).

Health professionals¹ and patients consistently engage in communicative acts and these communicative interactions form the foundation in any medical consultation. South Africa in particular is a country rich in terms of its multilingual diversity, more specifically in all spheres of health care between medical officers and patients. Indigenous language² speakers have long been neglected in the provision of health care, by virtue of both their race and the language they speak (Drennan, 1999a). Patient understanding in the South African health care setting is hampered by linguistic barriers, the barrier of medical discourse, cultural differences and a disparity in sophistication and education levels.

As a result of colonial rule and later apartheid there has not been equitable delivery of public services to all sectors of the South African population (Heggenhougen, 1995; Swartz, 1998; Swartz & Drennan, 2000). As a result, the delivery of public sector services has been inadequate for the majority of South Africans. This is particularly noticeable within the health care services. The language, social and cultural divide between medical officers and patients in all spheres of health care is evidence of the wide gap still existing between medical officers and the patients they treat (Crawford, 1994, 1995). It is well recognised that the South African problem is much greater and more complex than in other parts of the world as it is the majority and not the minority of the population who are relatively disadvantaged (Swartz, 1996).

¹ The term health professionals shall be used in this study to refer to any professional in the health context, i.e. nursing staff, medical officers (at all levels) and allied health professionals.

² The term indigenous language shall be used throughout this study to refer to all of the official South African languages, with the exception of English and Afrikaans. This term is interchangeable with the term Black African languages, but not with the term African languages as Afrikaans is considered to be an African language (Drennan, 1998).

The majority of patients treated at government hospitals are mother tongue indigenous language speakers (Kaschula & Anthonissen, 1995). However, the overwhelming majority of health professionals, with the exception of the nursing profession, are unable to speak any of the indigenous languages (Drennan, 1998).

Furthermore, the vast majority of patients attending government health care facilities are of lower socio-economic status. Patients of lower socio-economic status are among those groups that have been identified as being at risk of ineffective communication (Daley, 1993). Patients of different cultural, ethnic and socio-emotional backgrounds from their medical officer³ are also less likely to receive information from their medical officers (Daley, 1993).

The majority of clinical interactions in South Africa take place across cultural and linguistic boundaries. Published estimates suggest that up to 80% of medical interactions involve some form of mediation from a third person. The important role of these individuals has been recognised, and a wide variety of training expertise and functions exist ranging from persons who act as trained interpreters⁴/mediators⁵ to those such as nursing staff and trained counsellors and field workers who play a daily and critical mediating role in taking histories, imparting information and serving as cultural or linguistic brokers to the primary medical officer or researcher (Muller, 1994; Maltby, 1998; Drennan, 1999; Davidson, 2000).

The purpose of this research is to identify, examine and document current practices of communication between health professionals and patients with the hope of informing future policy. More specifically this research aims to identify, examine and document communication practices between health professionals and patients, within the specific

³ The term 'medical officer' in this study refers to medical doctors.

⁴ For the purposes of this study the term 'trained interpreter' refers to those individuals that have received formal training with regards to mediating.

⁵ For the purposes of this study the term 'mediator' will be used to refer to all individuals that do not have any formal training used to mediate medical consultations and may refer to nursing staff, other patients, family members, general assistants/cleaners, security guards etc.

economic, political and social framework of three levels of health care (i.e. a tertiary, secondary and primary level) within the Western Cape.

Communication is defined by Daley (1993) as the transmission of information, thoughts and feelings, so that they are satisfactorily received or understood. Beckman et al. (in Levinson, 1994) stated that communication problems were the major cause of malpractice depositions in health care. More specifically, these communication problems consisted of devaluing patients' views, delivering information poorly and failure to understand patients' perceptions.

Literature on patient education states that patients express fear that information is being withheld from them or that medical officers are not disclosing all the information pertaining to illness or prognosis. In particular patients have expressed a desire for information on clinical status, progress and prognosis, processes of care and education to facilitate autonomy, self-care and health promotion (Gerteis et al., 1993). Thus highlighting the importance of effective communication from the patients' point of view.

Policy and Legislation

In order to address the many issues inherent in the provision of health services in South Africa, legislation has been passed with the aim of developing a more effective health care system. Transformation of the existing health care system to one relevant to the needs of all its people is the vision to which South African health providers aspire.

Since the inception of a democratic South Africa in 1994, the Department of Health has undergone much change and restructuring in an effort to transform a previously fragmented, inefficient and inequitable health care system in South Africa. The White Paper on the Transformation of the Health System in South Africa, released via Government Gazette # 19710 Volume 382 on 16 April 1997, has provided the framework for the restructuring. In accordance with this White Paper, transformation has been based on two overarching conceptual frameworks, namely the Primary Health Care (PHC)

Approach and the District Health System (DHS). Health sector reform thus focussed on achieving universal access to integrated, comprehensive primary care services with a municipality-based district health system as the vehicle for delivery (Magwaza, Cooper & Hoffman, 2002; Hall, Haynes & McCoy, 2002; Haynes & Hall, 2002; Klugman & McIntyre, 2003).

The past ten years has thus been characterised by rapid policy changes and major restructuring within the health sector in South Africa. The decentralisation process that has taken place in moving towards a District Health System as well as the introduction of numerous new policies has had a far-reaching impact on the health care services at all levels. However, the reality of the South African situation is that the transformation process is long and tedious and the issue of effective communication has, as of yet, not been directly addressed. In newly integrated services, overt disadvantage owing to race has been replaced by covert disadvantage owing to linguistic and cultural barriers (Swartz & Drennan, 1997).

The Transformation from a Biomedical to a Biopsychosocial Approach to Medicine

This move towards transformation of the health care services in South Africa is in line with global health care trends. Inherent in this transformation is the move towards abandoning the traditional biomedical approach of health care in favour of the biopsychosocial approach. The biomedical perspective falls within the metamodel of reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle (Shaver, 1985). It embraces mind-body-dualism, the doctrine that separates the mental from the somatic (Engel, 1977). Biomedicine follows the basic principle of science, used since Descartes, that all entities can be broken down into causal chains or units (Shaver, 1985). The biopsychosocial approach falls within the constructivist, holistic metamodel. Holistic therapy can be defined as a "*conscious attempt to view all aspects of a client's problem or situation as a gestalt, and to treat all aspects accordingly*" (Hagedorn, 1982, pp. 89).

Within the biomedical approach, there is less focus on the actual patient and more on the diseased body part instead (Helman, 1996). Therefore this does not take into account the importance of the communicative interaction that forms part of seeing the patient holistically.

According to Engel (1977) the biomedical model encourages bypassing the patient's verbal account by placing greater reliance on technical procedures and measures. In contrast a biopsychosocial approach recognises the complexity of an examination, which, in the process of data collection, requires high-level interviewing skills, and a basic understanding of the psychological, social and cultural determinants of how patients communicate symptoms of disease. The biomedical defect may determine certain characteristics of the disease, but is not necessarily able to predict the patient's response to this defect.

Psychological and social factors are important and should be acknowledged as playing a role in determining patients' responses to the biochemical defect. The behaviour of the medical officer and the relationship between medical officer and patient act as powerful influences on therapeutic outcome. These constitute psychological effects, which might directly modify the illness experience or indirectly affect underlying biochemical processes. The medical officer's role of educator and psychotherapist requires psychological knowledge and skills, which are outside the biomedical framework (Engel, 1977).

It is for this reason that the proposed biopsychosocial approach that is slowly being phased into the South African health care system, takes into account the patient, the social context in which he/she lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the role of the medical officer and the health care system. Medical officers working with this model integrate biological, psychological, social and cultural domains in the process of solving clinical problems and planning treatment strategies (Bartz, 1999). The biopsychosocial approach of health is considered to be a pluralistic perspective. According to this approach, health is the result

of mutually interdependent physiological, psychological and socio-economic components that exist in a state of equilibrium (Bolaria & Dickinson, 2001).

The biopsychosocial model was originally proposed as a scientific paradigm that aimed at being as ethically neutral as any model or theory could be (Brody, 1999). This model states that if we want to understand disease in any specific context, we need to understand the social and cultural environment and the psychological impact that the environment has on the individual, as much as we need to understand the biological aspects of the disorder in that specific population (Brody, 1999). As a scientific paradigm, the biopsychosocial model speaks peripherally on the issue of medical officer-patient communication, but solely in an instrumental fashion (Brody, 1999). In other words, because science begins with accurate inquiry, scientific medical practice must begin with an accurate and thorough case history when the medical officer enters into an open, interested and facilitative relationship with the patient (Brody, 1999). Communication of this sort becomes a critical scientific tool without which medical work can proceed no further.

Bolaria and Dickinson (2001) state that for the biopsychosocial approach to succeed, it is vital for it to become a part of everyday discourse, and the core of this approach is communication. It is important to be conscious that the effort to make this approach a reality will be constrained by limited resources, the dominant biomedical model and forceful economics, social and political forces. Since language is an essential determinant of access to resources, the new Constitution's resolution that South Africa will have eleven official languages should imply that language policy must now receive urgent attention at the level of service provision (Erasmus, 1999). However, within the health sector, the issue of communication problems and the language question in relation to access of services, have yet hardly featured on the agenda of public discussion. The lack of language polices and the implementation thereof as well as the rights of individual to be treated equitably needs to be more readily addressed. Some researchers state that it would be unrealistic to expect the biopsychosocial approach to become fully integrated with health policies and actions in a short period of time. The positive impact of this

approach needs to be optimised by expanding research in this sphere (Bolaria & Dickinson, 2001).

It is not surprising that the legacy of the under-provision of facilities and the maldistribution of resources in health care as a whole, would be reproduced in the area of language service in health care (Crawford, 1994; Drennan, 1996b).

Research has indicated that medical officers have become accustomed to getting by with sub-standard communication, where frequently only rudimentary and inadequate medical histories were obtained, on which diagnosis and treatment plans were made. This has been referred to a 'veterinary care' and implies acceptance of a sub-standard level of communication with patients who speak indigenous languages (Kleinman, 1977 in Drennan, 1998). Accordingly, it has been noted that health care has become increasingly bureaucratised, where *"administrative functions are prioritised, creating notions of minimum standards of care, reductive understandings of access to services, rather than access to care"* (Swartz & Drennan, 2000, pp. 189).

If the health system is to become more accessible, legitimate and effective, the political will to address these communication barriers needs to be found. Lack of time and resources is often cited as the reason for inadequate health care. However, as Crawford (1999) suggests, this shows extreme shortsightedness on the side of health professionals.

Patient-Centredness

"The responsibility for helping falls in the medical officer-patient partnership but on neither party alone" (Wolfe, Ingelfinger & Schmitz, 1994 pp. 896).

Helman (1996) has outlined five strategies for improving medical officer-patient relationships, namely understanding illness, improving communication, increasing reflexivity, treating illness and disease, and assessing the role of context. In order to

embrace these strategies to enhance patient-medical officer interaction, the medical officer needs to adopt both a biopsychosocial and patient-centred perspective.

Pereira Gray (2001) has commented that modern medicine is moving in two directions. There is a focus on public health issues such as evidence-based medicine on the one hand, and a move towards health care that is focused on more human, interpersonal aspects on the other. *“Judging by recent inputs, it is likely that the theory of general practice will broaden and deepen. Inputs are coming from a broader range of disciplines including anthropology, literary analysis and philosophy. Two strands of thought are now visible: first, the epidemiological, public health, health economics population-based thread, with mathematical inputs from non-linear modelling, and secondly, a human, personal aspect based on interpersonal aspects of care, and on diagnosis and treatment plans produced in partnership with the patient. These two strands of thought vindicate the choice by the College of General Practitioners in 1957 of the motto Cum Scientia Caritas (Care with Science)”* (Pereira Gray, 2001 pp. 407).

The second of these two strands makes reference to a growing concern about patient-centred care. Brody (1999) advocates the need to embrace both a biopsychosocial and a patient-centred approach to health care, particularly in cross-cultural encounters. The need to embrace both the biopsychosocial and a patient-centred approach is even more crucial in practice among patients whose belief systems are more clearly at odds with the medical mindset (Brody, 1999). In the biopsychosocial approach the focus is on the inclusion of more than just medical information when obtaining information from the patient. The focus in patient-centred care is on involving the patient more actively in his care. Understanding and respecting patients' values, preferences and expressed needs are the foundation of patient-centred care (Allshouse, 1993).

Gerteis et al. (1993) outlined a number of guidelines for the provision of patient-centred care. The main principle behind such an approach is finding ways to educate and to inform the patient, to meet his emotional needs, and focusing on the patient as an individual who should be acknowledged and addressed. In addition to this, the health

care worker needs to acknowledge and to recognise that the patient's central beliefs, values and practices will influence the way he perceives illness. This will influence the patient's expectations and compliance to treatment (Allshouse, 1993). The core aspects of patient-centredness include the availability of information at all times (Fulford, 1996), the attentiveness of the medical officer (Cassell, 1985), a demonstration of empathy (Gerteis et al., 1993), the ability to make the patient feel at ease (Scamper, 1997 in Bolaria & Dickinson, 2001) and an implicit respect for the patient's values and beliefs (Daley, 1993).

Patient-centred care requires that the patient is assertive and empowered enough to take part in the decision-making process and the patient has the power to exert his/her rights as a patient, for example asking for a second opinion or questioning the medical officer. Another important aspect of patient-centred care is the appropriate training in communication skills (Fulford, Ersser & Hope, 1998). Communication skills appear to be a major factor in the provision of effective patient-centred care (Cassell, 1985a, 1985b; Fulford, 1996; Williams, 1997). Numerous studies have reported that health care professionals who display effective communication skills towards patients may benefit the patient physiologically as well as psychologically (Smith & Bass, 1982). Communication does not restrict itself only to facts (Daley, 1993). It involves the interaction between the patient and the medical officer. Both of them need to meet on equal ground as mutual partners in the communicative exchange.

Finding common ground (partnership) is one of the main domains of patient-centredness and should include establishing problems, priorities and goals of treatment by the medical officer and the patient (Little, Everitt, Williamson, Warner, Moore, Gould, Ferrier & Payne, 2001). Partners work together to achieve common goals in a relationship based on mutual respect for each other's skills and competencies, and on recognition of the advantage of combining these resources (Coulter, 1999). Successful partnerships should therefore be non-hierarchical. The defining characteristics of partnerships include mutual responsibilities, attention to and explicit discussion about the relationship, that it is dynamic and adapts to the changing circumstances of either party, that it can be initiated

at any time and that it is the key to other informed shared decision-making competencies (Towle & Godolphin, 1999). Therefore, the key to successful medical officer-patient partnership lies in the recognition that the patient is an expert too (Coulter, 1999).

There is a growing emphasis on equalising the partnership between medical officers and patients (Coulter, 1999). However, several barriers to equal partnerships need to be overcome (Coulter, 1999). These barriers are crucial to the understanding of medical officer-patient partnership in the new South African context. Little is known about the readiness of patients to take on this responsibility (Coulter, 1999). Furthermore, there will be a need for medical officers to be better trained in communication skills (Coulter, 1999). Perceived lack of time, medical officers' predisposition and skill and patients' inexperience are perceived as challenges to putting shared decision-making into practice (Towle & Godolphin, 1999).

The South African Constitution supports this move by enshrining the right of each individual to be addressed in the language of his/her choice, and through the principle that all cultures should be respected (Ntshona, 1997). Transformation has been a focus at all levels of the educational and health sectors in order to address past inequalities in service provision.

The South African Context

The development of education and training programmes aimed at recruiting and developing health professionals to meet the needs of the communities they serve, was one of the goals outlined in the 1997 White Paper on Health. Tertiary education institutions are admitting a larger number of Black students to train in those professions to which they have previously had little access, including the professions allied to medicine (Department of Education, 2001). In addition, tertiary institutions are striving towards providing training in health care that is adaptable, relevant and non-discriminatory and that values people and diversity (Klein, London & Perez, 2001). However, with time this will only partly address the existing communication barrier in that language differences

amongst medical officers will continue to exist due to the wide diversity in languages and culture across indigenous groups of South Africa. Health professionals employed in provincial health care facilities often treat patients who speak languages that may differ from their mother tongue. These health professionals therefore rely on informal approaches and systems that will support them until a fully integrated programme that addresses adequate health care including the importance of effective communication is implemented.

Within the South African health care context, numerous challenges to delivering patient-centered care are encountered. These challenges are expanded upon below and include the communication barriers that exist between health professional and patient, the effects of the apartheid era, cultural differences and differences that exist between health professional and patient even when they are of the same education and social backgrounds.

The South African health care context, with its history of segregation and limited resources for the majority of the population, has impacted on the readiness of patients in this country to take on the responsibility of mutual partnership. Indigenous-speaking patients are disadvantaged to this end by virtue of their race and culture and the language they speak. This results in evident communication barriers between health professionals and patients.

Furthermore, one of the long-term impacts of apartheid is a generation of adults whose differing culture, low levels of literacy and lack of biomedical sophistication have left them ill-equipped to cope within a 'Western' health care system.

All patients, regardless of their ethnicity or degree of socialisation, bring culturally defined beliefs and practices to the experience and meaning of illness. These meanings shape their encounters with the health care system and their response to clinical care (Allhouse, 1993). Culture is defined by Helman (1996) as "*a set of guidelines which an individual inherits as a member of a particular society, and which tells him how to view*

the world, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment" (Helman, 1996, pp. 2). Culture shapes patients' beliefs about health and illness, how they act in clinical situations, and how they expect others to act (Allhouse, 1993). Health care professionals cannot be expected to know every custom or practice that may impinge on clinical management. However, they should make a systematic effort to learn about the cultural characteristics of the populations they serve (Allhouse, 1993). In order to deal with the challenges demanded by an increasingly dehumanising system, health service providers must focus on patient-centred care informed by a realistic assessment of patient needs (Ravich & Schmolka, 1996).

Lastly, when medical officers and patients come from different social backgrounds, there is a likelihood of a greater discrepancy between patients' and medical officers' understanding of illness in that different cultures have different perceptions regarding onset and treatment, thus communication is vital at this point (Helman, 1996). However, it is documented that even medical officers from similar social and educational backgrounds to their patients often have different explanatory models (Allhouse, 1993). Unless medical officers understand how patients understand their illness and discuss their beliefs with them, the effectiveness of treatment will be compromised (Allhouse, 1993). Successful clinical relationships are considered to be those in which the patient arrives at a consensus concerning etiology, diagnostic labels, physiological processes, prognosis and optimal treatment (Helman, 1996). It is important to understand the patient's underlying explanatory model in order to reach such a consensus (Kleinman, Eisenberg & Good, 1978).

In an attempt to overcome the current communication and cultural barrier thus far, certain health care facilities introduced trained interpreters/mediators to address this issue of cultural sensitivity, where medical officers speaking indigenous languages were not available. The need for trained interpreters and ad hoc mediators within the health care context has been well documented (Evans, 2000; Fisch, 2001). However, this situation in itself is rare in the South African context as there are very few trained interpreters

working within the medical field (Erasmus, 1999; Ntshona, 1999; Evans, 2000; Fisch, 2001). Therefore, the use of ad hoc mediators is more commonly used on an informal basis, however, not as frequently as they should be. Thus, whilst the need for mediators is evident, in reality the approach currently adopted in some health care facilities is complex and unsatisfactory, implying the need for current practices to be further examined. It is necessary to work with mediators in order to provide patient-centred care to patients in cross-lingual encounters. However, problems in communication are still currently being experienced in South African health care settings.

An Overview of Past Research

Over the past decade, research in the field of interpreting and mediated medical consultations has flourished. To date, a large number of health-related professions have acknowledged the need for interpreters/mediators within health care and have conducted research relating to interpreting issues within their specific fields. These include the fields of psychiatry and clinical psychology (Crawford, 1994; Drennan, 1992, 1996a, 1996b, 1998, 1999b; Swartz, 1986, 1987, 1991a, 1991b, 1992, 1996, 1998), medicine (Wood, 1993), dietetics (Bal, 1981), social work (Devenish, 1999), pharmacy (Smit, 1999), nursing (Herselman, 1994; Elderkin-Thompson, Silver & Waitzkin, 2001), public health (Petros, 1999 in Ntshona, 1999) and speech-language therapy and audiology (Evans, 2000, 2001; Fisch, 2001).

Initially the bulk of research undertaken has focused on the accuracy of the interpreting process, particularly as it would impact upon diagnostic assessment and management (Muller, 1994). Several researchers have primarily highlighted the negative impact associated with using mediators, referring to "*alterations in meaning*" (Price, 1975, pp. 263), "*interpreter error*" (Price, 1975; Vasquez & Javier, 1991), "*mistranslations*" (Price, 1974; Ebdon, Carey, Bhatt & Harrison, 1988), "*distortions*" (Marcos, 1979, pp. 173) and "*illegitimate deviances*" (Launer, 1978, pp. 934). However, more recently, there has been an acknowledgement of examining mediators in a more positive light. This is primarily in lieu of the fact that focusing on a narrow conception of inaccuracy obscures

the remarkable accomplishments of actors in their routine production and recognition of everyday communications (Heritage, 1984 in Drennan, 1998; Penn, 2000; Evans, 2000). However, research too has demonstrated the ineffectiveness of some of the messages being transmitted in cross-cultural contexts. A large number of the utterances within a medical interview were found to contain translation errors, many of which have more negative implications in terms of accuracy and efficacy of the medical service (Evans, 2000; Fisch, 2001).

Consequently, research focus shifted from concern about the quality of interpreting to a concern for the appropriacy and accessibility of the translation (Siegrun, 1992 in Lesch, 1999). Thus, the emphasis has moved away from purely examining the problems associated with using mediators, to how mediators can meet the needs of the communities they serve.

Past research has clearly shown that while existing language legislation promotes the use of mediators in all health care sectors, common practice indicated that in most cases a trained interpreter is usually not available and at best, interpreting services are called on in an ad hoc way using nursing staff, family members or fellow patients (Drennan, 1998; Evans, 2000; Fisch, 2001). Whilst ad hoc mediating is a more common process, it was found that nursing staff were frequently utilised (Buthelezi, 1992, 1996 in Drennan, 1998). However, complex negotiations of identity in South African institutional settings were illuminated through an examination of the position of the African nurse as a cultural broker.

The important role of these individuals has been recognised, and a wide variety of training expertise and functions exist, ranging from persons who act as formal interpreters to those such as nurses and trained counsellors and field workers who play a daily and critical mediating role in taking histories, imparting information and serving as cultural or linguistic brokers to the primary medical officer or researcher (Muller, 1994; Maltby, 1998; Drennan, 1999; Davidson, 2000). Ethical concerns are of primary concern when ad hoc mediators are used in medical consultations and therefore form a fundamental part of

research and have been addressed in the field of providing more effective communication (Evans, 2000). Furthermore, studies have attempted to highlight the advantages and disadvantages of using trained versus ad hoc mediators and the need to provide skills to mediators (Fisch, 2001).

Furthermore, the training of health professionals is of concern in that they should too be addressed regarding the appreciation of roles. Since numerous parties are involved in mediated consultations, it is felt that they should all receive some form of training that will equip them with the necessary skills for more effective communication. This is currently being addressed by research that will provide tertiary institutions with guidelines necessary for training their health professionals to be more effective communicators (Penn, Ogilvy & Swartz, 2003).

With the transformation to a more biopsychosocial, patient-centred approach, health professionals have had to adopt varying approaches to obtain the necessary and relevant information that is culturally appropriate. Therefore use of more culturally appropriate methods for obtaining case histories have been assessed such as narratives that appear to be more culturally appropriate (Evans, 2001).

Health Research

“Health research...can create better understanding about the determinants of health, play a crucial role in the development and use of health technologies, and inform decision-making of various kinds which result in actions at an individual level or in health policies and programs at the population level” (Chunharas, 2000, in Guthrie, 2002 pp. 2).

Sauerborn, et al. (1999, pp. 827) stated *“in order to support adequate policy-making, the need for research has never been greater”*. Hence it is obvious that one of the main aims of health research should be to influence the development of policy and legislation (Guthrie, 2000).

Health research that aims to have an impact on policy development should be required to undergo an intensive process to be elaborated upon that could inform policy developers by providing possible options regarding planning. It is necessary for an appropriate context to be defined that includes economic, political and social constructs. Once a context has been defined and the issue/problem identified, it is necessary for research to examine and document these issues and related options. The results thereof should then be used collaboratively between researchers and policy developers to ensure relevant research issues and options are put into practice. As this research aimed to describe the context and constructs, a number of options arose which will hopefully inform policy in the future.

In addition to the development of policy, it is necessary for the individual institutions to examine themselves regarding equity and accessibility to medical services. Thus, the starting point for addressing language issues in institutions would be willingness on the part of the institution to examine its services and systems for equity, access and appropriateness to the communities who make use of them (Drennan, 1998).

Summary of the Current Research Study

In summary, past research has focused on language diversity and more specifically on the communicative dyad or triad in a medical interview with using trained interpreters and ad hoc mediators in health care facilities within the Western Cape.

Although much has been learnt about the complexities inherent in mediated interviews within the health services, it is strongly believed that there is still much need for further research which focuses on providing information with the hope of informing policy.

Hence this research aims to examine current practices regarding communication between health professionals and patients across three levels of health care, within an economic, political and social framework incorporating aspects relating to formal policy and

legislation; the transformation of health care, that is noting the many changes that have occurred in the South African health care system, more specifically moving towards a primary health care system that focuses on achieving more universal integrated access to health care; organisational structures and processes which facilitate or hinder effective communication; available resources including funding and human resources; systemic structures and process which facilitate or hinder effective communication and to attempt to understand the social and political constructs and relations between health professional and patients within the current health care context.

The field of Speech-Language Pathology has broadened and encompasses the functional use of language and communication. Health communication is an emerging discipline and the role of the Speech-Language Pathologist is believed to be highly relevant within this discipline in that they have a comprehensive understanding of communication effectiveness. Furthermore, it is believed that Speech-Language Pathologists are good facilitators and would be effective in driving the use of good communication in all spheres of health namely research and training.

This study differs to past research in a number of ways. Unlike past research it did not focus on the communicative act per se but still reflected on the social and political issues and perceptions of medical officers and nursing staff looking at aspects of demographic information, policy and legislation, current practice, expertise, relationships and resources. It attempted to incorporate the more recent restructuring of the health system and examine practices in communication across all three levels of health care. It reflected the views of management as well as the health professionals, providing greater insight into organisational structure.

Hopefully numerous applied implications will emerge from this research. Possible options arising from the findings of this study may be used collectively with other current and past research in the field of communication and health within the South African context to inform policy in the future.

2. METHODOLOGY

The following section presents the aims, research design and informant selection criteria used in this study. In addition, the methods and procedures of data collection and methods of analysis are described.

2.1 AIMS

The aims of this study were to:

- Document current legislation and policy regarding interpreting services in health care in South Africa and more particularly in the Western Cape.
- Examine and document current practices of communication between health professionals and patients across three levels of health care.

More specifically this study aimed to:

- Document relevant demographic information relating to race and linguistic status of the health professionals and patient population served.
- Examine and document the organisational structures and processes employed in an attempt to overcome communication barriers.
- Determine the availability of resources required to promote effective communication in health.
- Understand and document the economic, political and social constructs and relations between health professionals and patients within the current health care context.

2.2 RESEARCH DESIGN

An interpretative, observational, descriptive, qualitative research design was adopted in this study. Steyn (1997) suggests that the most appropriate methodology for research on intercultural communication in Africa would be interpretive - "the study design should be such that it shows maximum respect for the meanings the participants themselves attach to communication behaviours" (pp.70).

Qualitative research is effective when used on an exploratory basis to establish hypotheses for future research and to glean an in-depth sense of what people think of a particular event, as there is space within this type of research structure to explore new information (Katzenellenbogen, Joubert and Yach, 1991). Qualitative research is deemed useful when investigating people's opinions, perceptions and experiences.

In this study the dual use of both qualitative and quantitative methods were adopted so as to work in a supportive manner. The methods used to obtain the necessary information enabled the researcher to gain access to the respondent's views and experiences, expressed in their own words (Minichiello, Aroni, Timewell & Alexander, 1990). These methods were also useful for producing new ideas in areas which are new to research (Katzenellenbogen et al., 1991).

In using differing research methods as a means of addressing similar issues, findings are further confirmed and the information obtained is expanded (Kreuger, 1994). The triangulation of data by multiple methods was considered to be essential to answer many of the most important questions in organisational research, where there is a combination of very complex processes involving a number of factors over time (Cassel & Symon, 1997). Interviews combined with a survey allowed the researcher to understand the meanings people hold for their everyday activities (Marshall & Rossman, 1995).

2.3 DESCRIPTION OF HEALTH CARE SITES

In an attempt to obtain a broad perspective across all three levels of health care, the study was conducted at three sites, that is, at a Tertiary Hospital (TH), Secondary Hospital (SH) and a Community Health Clinic (CHC) within the Western Cape. Fifty-five health professionals were interviewed and included thirty-one health professionals at the TH, twelve at the SH and twelve at the CHC. Furthermore, eighty health professionals formed part of the survey.

The Tertiary Hospital: The population supporting a tertiary level service centre is very large and will involve university teaching facilities. Furthermore, patients at the level of health care will be involved with subspecialists in, for example, oncology, cardiology, etc. (Kibel & Wagstaff, 1995). In this study, the TH is home to approximately 1100 staff members, ranging from academics, medical officers and nurses, to professions allied to medicine, clerical and non-professional staff, as well as both undergraduate and postgraduate paediatric students from South Africa and abroad that train at that Tertiary Hospital. This includes 183 000 patients that frequent the hospital on an annual basis, including inpatients, outpatients, trauma and medical emergencies and operations (www.childrenshospitaltrust.org.za). Patients that attend this TH are diverse, 40% come from outside the Western Cape, as well as from other countries such as Rwanda, Tanzania, Uganda, Namibia, Mauritius, Botswana, Kenya, Hungary, Romania, etc.

The Secondary Hospital: The SH is a referral base for patients from primary level services for more sophisticated management. The secondary level of health care consists of two classes, 'district' and 'regional' (Kibel & Wagstaff, 1995). A number of district hospitals are found in each region and run by medical officers with part-time specialist supervision that falls under a single regional hospital with full-time supervision (Kibel & Wagstaff, 1995). In this study, the SH is a drainage area for a number of local surrounding suburbs and thus accounts for a diverse patient population group. Although the majority of the patient population receiving services at the secondary hospital (SH) are first language isiXhosa speaking, the patient population also includes first language Afrikaans speakers and few first language

English speakers, 'other South African languages' or Arabic speakers (Personal Communication from Head Sister at SH).

The Community Health Clinic: This first level of health care is that which is closest to the patient (Kibel & Wagstaff, 1995). It may refer to a GP's consulting room, a well-developed group practice, a primary health care nurse in a clinic setting, or a comprehensive community development programme with health issues as its focus (Kibel & Wagstaff, 1995). Furthermore, it focuses on three main elements namely the health aspect service, the staff and the community (Kibel & Wagstaff, 1995). In this study, the CHC is a medical clinic that provides a service to a local community thus the patient population is homogenous in terms of language spoken and culture. The patient population attending this clinic are first language isiXhosa speakers.

2.4 INFORMANTS

142 informants formed part of this study. 80 informants formed part of the survey and 62 informants were interviewed by the researcher.

The informants in this study consisted of five distinct groups:

- Relevant authorities responsible for developing and implementing language policy.
- Relevant authorities responsible for developing and implementing policy within the health care sector.
- Members of the management teams at the pre-determined health care sites [i.e. Tertiary Hospital (TH), Secondary Hospital (SH) and Community Health Clinic (CHC)].
- Health professionals in these establishments who encounter first language isiXhosa patients on a daily basis.
- Both formally trained interpreters and ad hoc mediators involved in medical consultations.

2.4.1 Selection Criteria

The following criteria were applied in the process of informant selection:

2.4.1.1 Authorities Involved in Language Policy Development and Implementation

The authorities involved were required:

To be involved in Policy Planning, Development and Implementation at a Provincial or National level

2.4.1.2 Management

Management were required to be:

- Employed by the institution for a minimum of 2-3 years.
The rationale behind this selection criterion is to ensure that those professionals involved have had time to adapt to the culture of the organisation they are employed by. The ability to adapt to another culture is referred to as acculturation. Acculturation may occur in a wide range of sociocultural contexts and among a variety of groups (Fielding, 1997). The process of acculturation in an organisation refers to the ability to adapt to the institutional culture (Ruben, 1977). Since the study aims to describe the various institutional contexts wherein interpreted interviews are conducted, and it is acknowledged that interpreting is a complex process embedded within institutional and societal discourses, it is important that the participating professionals have an awareness and understanding of that culture.
- Responsible for management decisions and the implementation of guidelines and policies for more effective service provision within their specific health care facilities (HCF's).

2.4.1.3 Health Professionals

The health professionals were required to be:

- Working in that specific public health institution for a minimum of 2-3 years.
The above-mentioned rationale with regards to acculturation applies to the health professionals involved.
- Employed full time.

2.4.1.4 Trained Interpreters

a) The trained interpreters were required to:

- Be L1 isiXhosa-speakers.
- Be proficient speakers of English (to the language of the health professional involved).
- Be culturally similar to isiXhosa-speakers from the Western Cape.
- Have attended a formal interpreter training programme and to have had some exposure to field specific services/therapies.

b) The untrained ad hoc mediators were required to be:

- L1 isiXhosa-speakers.
- Proficient speakers of English.
- Culturally similar to isiXhosa-speakers from the Western Cape.
- An individual (e.g. a nurse or general assistant/cleaner) who is likely to be familiar with the site.

▪ 2.4.2 Informant Description

Figure 2.1 displays the authorities interviewed by the researcher at a national and provincial level. These authorities were involved to some extent with language policy and planning. The informants interviewed materialised in a progressive manner whereby one interview led the researcher to approach other relevant authorities.

University of Cape Town

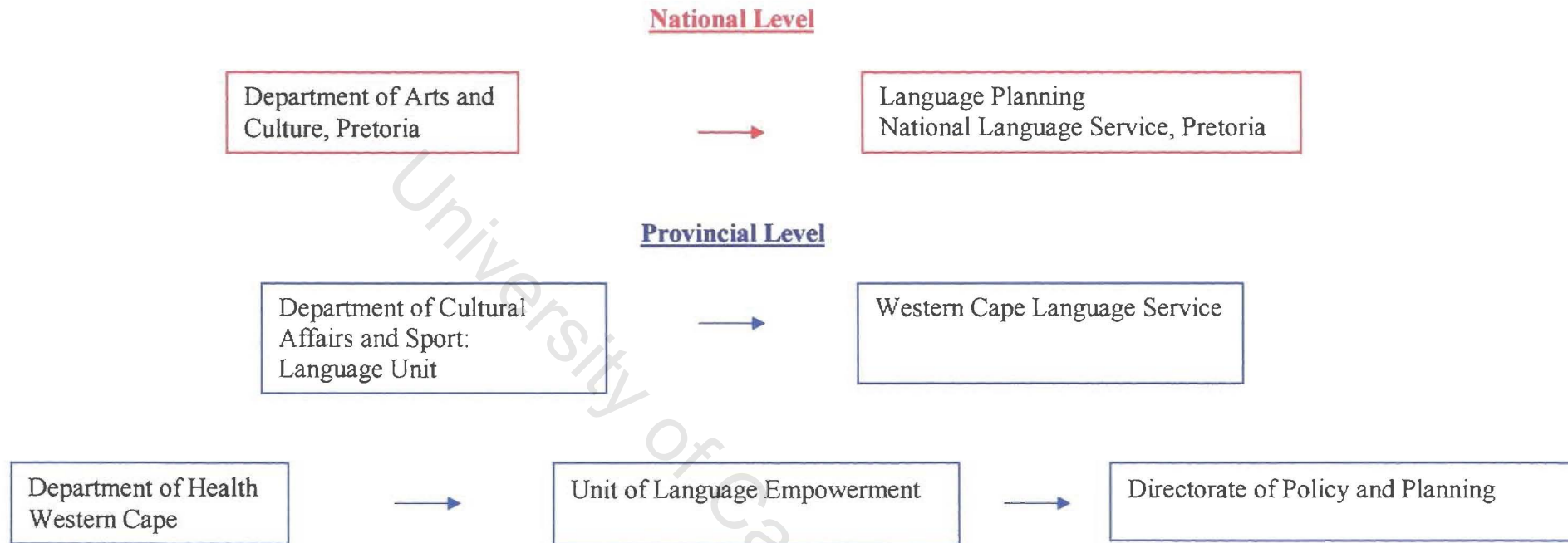


Figure 2.1: Interviews with Authorities at a Provincial and National Level

Figure 2.2 represents those informants interviewed at the TH. A number of health professionals involved in management were interviewed and included two superintendents at the TH. Furthermore, the management team included a number of heads of departments, namely outpatients, school of medicine, ICU, surgery, oncology and trauma. The heads of departments were included in that the researcher felt that different departments may utilise varying systems in addressing communication barriers that they felt may be more efficient and sustainable. Head sisters and sisters in charge of wards were interviewed as they were felt to provide important information regarding the attitudes and perceptions of the nursing staff and other members involved in mediating. A core group of interviews were represented by those health professionals both medical officers (including heads of departments who were involved on a clinical basis) and nursing staff who were clinically involved in the treatment of patients. Lastly, trained interpreters employed at the TH were interviewed so as to attain an understanding of the current system employed at the HCF.

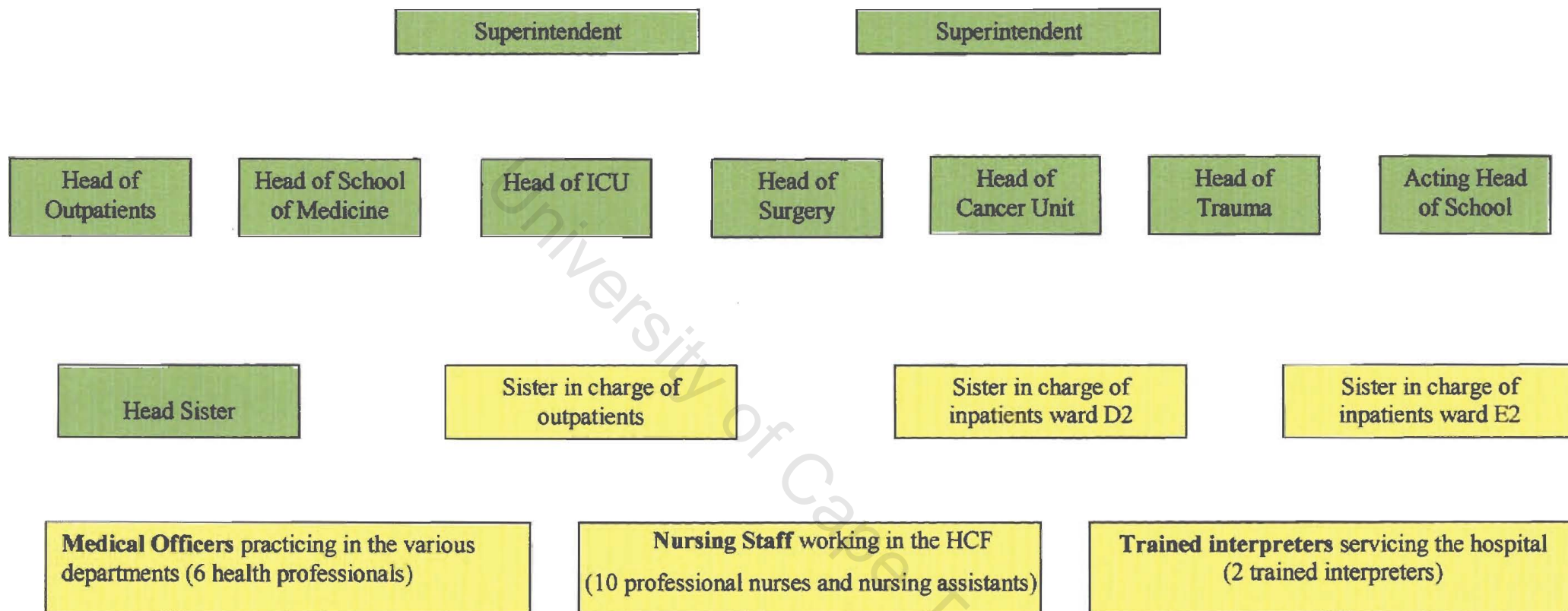


Figure 2.2: Management, Clinical Staff and Trained Interpreters Interviewed at the Tertiary Hospital

Figure 2.3 represents those informants interviewed at the SH and CHC. Nursing staff at the SH and CHC were interviewed. General assistants at the SH were interviewed as through the progression of the research it was noted that they played a role in mediating medical consultations within the SH at times.

University of Cape Town

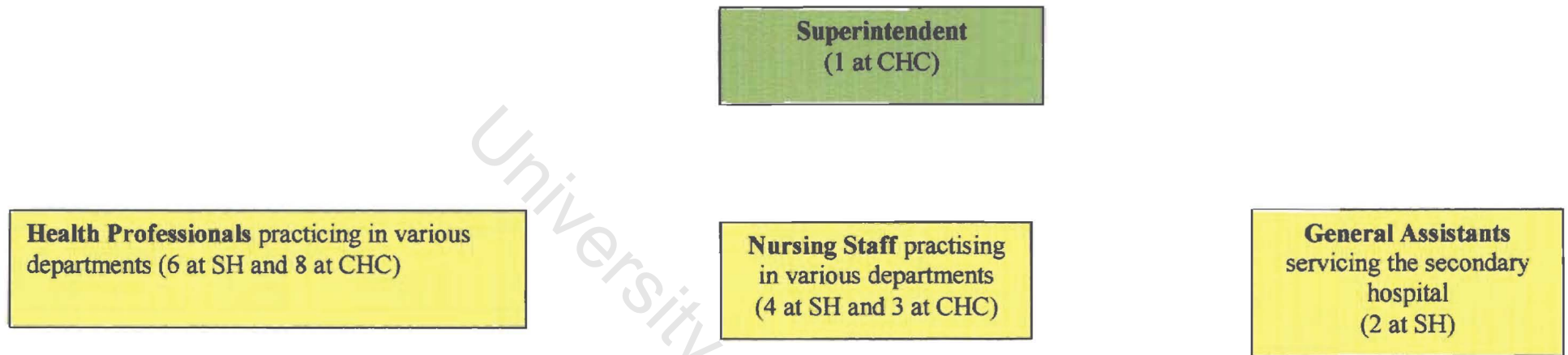


Figure 2.3: Management, Clinical Staff and General Assistants Interviewed at the Secondary Hospital and Community Health Clinic

2.4.3 Informed Consent and Confidentiality

2.4.3.1 Consent to Undertake the Study

Written permission to conduct the study was obtained from the University of Cape Town, the Department of Health and the specific health care facilities involved.

2.4.3.2 Participant Consent and Confidentiality

Verbal and written consent were obtained from the superintendents, health professionals, trained interpreters and ad hoc mediators at the various health care facilities. The purpose of the study as well as the procedures to be undertaken, were fully explained to all informants. Anonymity and confidentiality of the informants was guaranteed and maintained throughout the research project.

2.5 PROCESS OF RESEARCH

The research process consisted of four main stages. The activities within each stage are summarised in Figure 2.4.

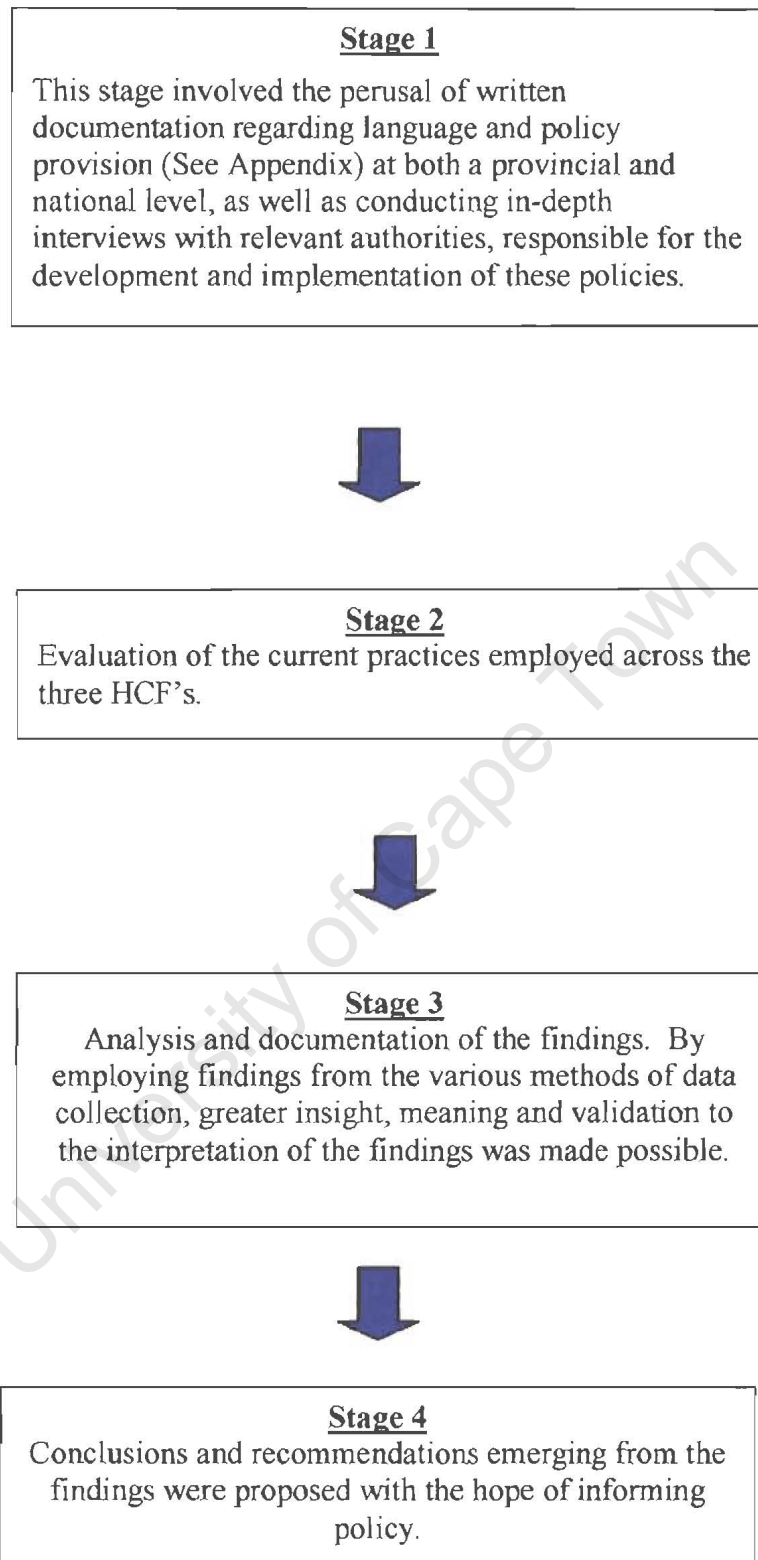


Figure 2.4: Flow Diagram Outlining the Activities Undertaken in Stages 1 – 4 of The Research Process

2.6 DATA COLLECTION

2.6.1 Methods of Data Collection Employed in Stage 2 of the Research Process

Three methods of data collection were employed at this stage of the research process. Firstly, this included perusal of health care facility (HCF) information systems regarding demographic information. Secondly, interviews were conducted with relevant authorities regarding policy planning and development and with management, as well as health professionals at the respective establishments. Lastly, a survey using a written questionnaire was distributed to health professionals employed within the selected sites (i.e. the TH, the SH and the CHC). In-depth interviews were undertaken in conjunction with a survey in that a survey provided a more general overview of the larger population whereas the in-depth interviews gave a more refined insight regarding the highlighted issues.

2.6.1.1 Perusal of Health Information Systems

Perusal of health care facility information systems was undertaken in an attempt to obtain the necessary demographic information regarding race and language status of health professionals employed at the various health care facilities and patient populations served at the specific HCF's.

2.6.1.2 In-depth Interviews

Sixty-two in-depth interviews were undertaken. This included a number of individuals at a national, provincial and institutional level, with policy planners at a national and provincial level, and health management, health professionals and trained interpreters at the various health care facilities (HCF).

The in-depth interviews undertaken with management at national and provincial (regional) levels and at the identified HCFs were semi-structured in nature. A topic – guided route was employed as a means of facilitating discussion. Broad questions were asked initially followed by more specific questions. Broad questioning allowed

the informants to raise issues, which, were important to them, as well as generate new idea and topics that may have not been previously considered. More specific questioning allowed for information to be obtained relating to particular aspects of the implementation process of the policy and management guidelines.

All questions were open-ended allowing for respondents to elaborate and respond in different directions. In addition, the principal researcher conducted all interviews, in an attempt to obtain consistency and reliability across interviews.

▪ *Principles Underlying the Construction of the Questionnaires to be Employed in the Interviews*

a) *Semi-structured vs. Unstructured Interviewing*

The purpose of the interview was to describe and understand the experience of the informants and to obtain a nuanced description (not a quantifiable one) of the informant's life and the needs thereof (Le Dorze & Brassard, 1995).

All interviews were conducted in a semi-structured manner as they follow the well-defined structure of questionnaires, but allowed for deviation from these questionnaires for clarification on certain issues and additional questioning where necessary.

A semi-structured interview was chosen above a completely unstructured interview for a number of reasons. A degree of systematicisation in questioning is sometimes necessary when many participants are interviewed (Marshal & Rossman, 1995). In addition, an unstructured interview required an interviewer to have much skill and experience in interviewing in order to avoid poor reliability as a result of increased subjectivity (Joubert & Katzenellenbogen, 1997). In addition, the employment of a semi-structured interviewing method allowed the researcher to partially control the length of the interviews, thereby limiting the length of the transcription. Considering that Skinner and van der Walt (1994 in Joubert et al., 1997) have indicated that an-hour-long interview can take up to eight hours to transcribe, limiting the length was a significant factor, considering the scope of this study.

b) *Types of Questions*

The questions (and interview questions) were developed using guidelines proposed by Katzenellenbogen, Joubert & Karim (in Joubert et al., 1997). The questions utilised in the survey were both open- and closed-ended in nature. However, the majority of the questions used in the semi-structured interviews comprised open-ended questions, which enabled the researcher to capture and understand the points of view of other people without predetermining those points of view through prior selection of questionnaire categories (Patton, 1990). Open-ended questions also enabled the researcher to obtain more opinionated and emotional responses from the informants. Closed-ended questions requiring a “yes” or “no” answer or a response limited in alternatives, were fewer in number and were used with the objective of obtaining more factual information (e.g. biographical details).

c) *Phrasing of Questions*

Questions were phrased in such a way that they were concise and unambiguous.

d) *Language of Interviews*

All informants (i.e. health professionals, trained interpreters and ad hoc mediators) responded to the interview and questionnaire in English, as they were all competent English speakers.

2.6.1.3 Survey

2.6.1.3.1 Sample Size

The survey was administered to thirty-five medical officers and forty-five nursing staff, which included both professional nurses and nursing assistants.

Development of the Questionnaire

The development of the written questionnaire for the survey required a number of processes:

- *Determining the Content of the Questionnaire*

Using a dynamic and participatory process, refinement of the specific items to be included in the survey was undertaken. This followed consultation with key personnel at national and provincial (regional) levels and at the identified HCF's. These items were primarily determined from the interviews and were grouped according to the following themes.

Table 2.1: Themes of the Questionnaire

▪ Demographic information
▪ Policy awareness
▪ Current interpreting/mediating service
▪ Health professionals' attitudes and perceptions of trained interpreters and ad hoc mediators
▪ Interpersonal communicative proficiency and competency of health professionals and interpreters/mediators within a mediated triadic medical consultation
▪ Availability of resources at the HCF's
▪ Current activities, courses, etc. offered at the various HCF's regarding more effective communication in health

The results of the in-depth interviews led to the development of the survey questions. A number of themes arose that were found to be relevant and imperative to this study, these are presented in Table 2.1 above. These will be addressed in more detail below.

Demographic information: Due to the diversity of the population group attending health care facilities in South Africa and more specifically in the Western Cape, as

well as the array of health care settings (i.e. TH, SH and CHC) employed in this study, it was deemed necessary to include the demographic details of all informants. The demographic information provided an initial prospect regarding the informants as well as an immediate, general indication of the multilingual, multicultural population attending South African health care facilities.

Policy awareness: From the in-depth interviews it was highlighted that the awareness of a policy at a national, provincial and institutional level was inconsistent. It was thus included in the survey to identify and clarify health professionals awareness of a policy regarding effective communication whether it be at a national or provincial level, or unique to that specific HCF, as well as to note where effective communication was seen as a priority.

Current interpreting/mediating services: Variability was noted between HCF's as well as between health professionals within the individual HCF's. Thus, the researcher found it necessary to acquire further information regarding the more common practices employed across and within the HCF's. It was necessary to note whether it was a system developed by the institution, or whether it was one adopted by the individual health professional.

Health Professionals' attitudes and perceptions of trained interpreters and ad hoc mediators: The health professionals' attitudes and perceptions regarding the use of trained interpreters versus ad hoc mediators led to the above theme. Through discussions from the in-depth interviews, it was evident that the health professionals' attitudes and perceptions varied depending on who was used to mediate these consultations. It was further highlighted that the institutional culture adopted by different health professionals depending on their previous job, language status, race, etc played a role in their attitudes and perceptions. Attitudes and perceptions were felt to be important in that they bring with them the reality of communication at various levels of health care.

Interpersonal communicative proficiency and competency of health professionals and interpreters/mediators within a mediated triadic medical consultation: Due to the multilingual diversity that exists between health professionals and patients in

the South African health care context, the majority of health professionals were found to make use of an interpreter/mediator at some time during their career. The effectiveness of a triadic team was found to be crucial in that both parties, that is the medical officer and interpreter/mediator should be proficient and competent and be able to work as a unit for the best possible results. Thus by incorporating this theme into the survey, one was able to obtain information regarding individual abilities and preferences.

Availability of resources at the HCF's: From the in-depth interviews, it was found that resources across the three levels of health care differed. Therefore, each HCF developed and uses systems best suited to their individual needs and is often driven by the availability of resources. It was thus deemed necessary to identify what resources were available and how the HCF's made use of them as well as what they do when there are insufficient or a lack of resources.

Current activities, courses, etc. offered at the various HCF's regarding more effective communication in health: The transformation of health care in South Africa was evident from the interviews. However, although a transformation is occurring, where health care was now becoming more available to everyone, there is still large gap between the old and new systems. It was thus important to note how and if HCF's and health professionals from the old system together with newly qualified health professionals were adapting to the change, that is being able to provide and effective and efficient communication to the multilingual population attending the various HCF's.

▪ *Structure and Design of the Questionnaire*

A structured, self-administered, questionnaire, comprising 48 items, was developed.

▪ *Format of the Questionnaire*

The format of the questionnaire was designed in such a manner so as to:

- facilitate limited time required for the respondent to complete the

questionnaire

- facilitate understanding by including items which were unambiguous, specific, only including one idea and devoid of emotive words

- *Variety of Types of Items*

The questionnaire included the use of a variety of types of items:

- Scale items, such as, semantic differential and cumulative scales
- Fixed alternative questions, with a yes/no response
- Open-ended questions requiring specific factual information

The specific items included in the questionnaire appeared to be relevant and important as was determined by the high response to the majority of items in the questionnaire.

2.6.2 Procedure

This section examines the procedure in terms of setting, timing and equipment used.

2.6.2.1 Setting

The in-depth interviews and survey were conducted at the respective health care facilities. This is in accordance with Katzenellenbogen et al. (1991), who suggest that qualitative research needs to be carried out in as natural environment as possible as this shows acknowledgement of the influence that the situation has on behaviour and that behaviour has on situations (Cassel & Symon, 1997). Attention was also paid to Lutz et al.'s (1992) recommendations that interviews should preferably be conducted with the respondent alone, in a place of reasonable comfort and away from disturbance.

2.6.2.2 Time

The length of the semi-structured interviews ranged from 20 – 30 minutes. In total 35 hours of interview material were recorded. The length of time required to complete the questionnaire ranged from 5 – 10 minutes.

2.7 TREATMENT OF DATA

2.7.1 Transcription of Data

Each session and interview was transcribed verbatim from the tape recordings. Verbatim transcriptions are deemed necessary in order to allow a detailed analysis to be carried out (Patton, 1990). This was considered to be a major advantage because it allowed the researcher to become familiar with much of the data and at the same time allowed for the process of data analysis to begin (Minichiello et al., 1990).

2.7.2 Coding of Data

All data from the questionnaires were coded using a formal coding system necessary for analysis using a statistical programme SPSS, which allowed for descriptive statistical procedures to be applied to the data.

2.8 DATA ANALYSIS

The data from the in-depth interviews was analysed using a thematic analysis.

The data from the questionnaires was analysed using various statistical procedures.

2.8.1 Thematic Analysis

The data obtained from the interviews was not simply analysed according to the questions asked. A thematic analysis, involving various stages of analysis and organisation of information was undertaken.

Data interpretation and analysis in qualitative research involves making sense of what people have said, looking for commonalties and integrating themes. It is an inductive analysis, meaning that patterns, themes and categories emerge from the data (Patton, 1990). Data analysis essentially involves reading through one's data repeatedly and engaging in activities of breaking the data down (thematizing and categorising) and then building it up again via elaboration (exploring of themes more closely) interpretation and integration (Terre Blanche & Durrheim, 1999). The transcribed interviews were analysed according to the principles of thematic analysis. Certain key procedures were used in thematic analysis and included the immersion in the data and generating categories. An examination of the qualitative analysis procedures by a number of sources (Corbin & Strauss, 1990; Patton, 1990; Marshall & Rossman, 1995) allowed for the development of a five-stage procedure of data analysis, depicted in Figure 2.5.

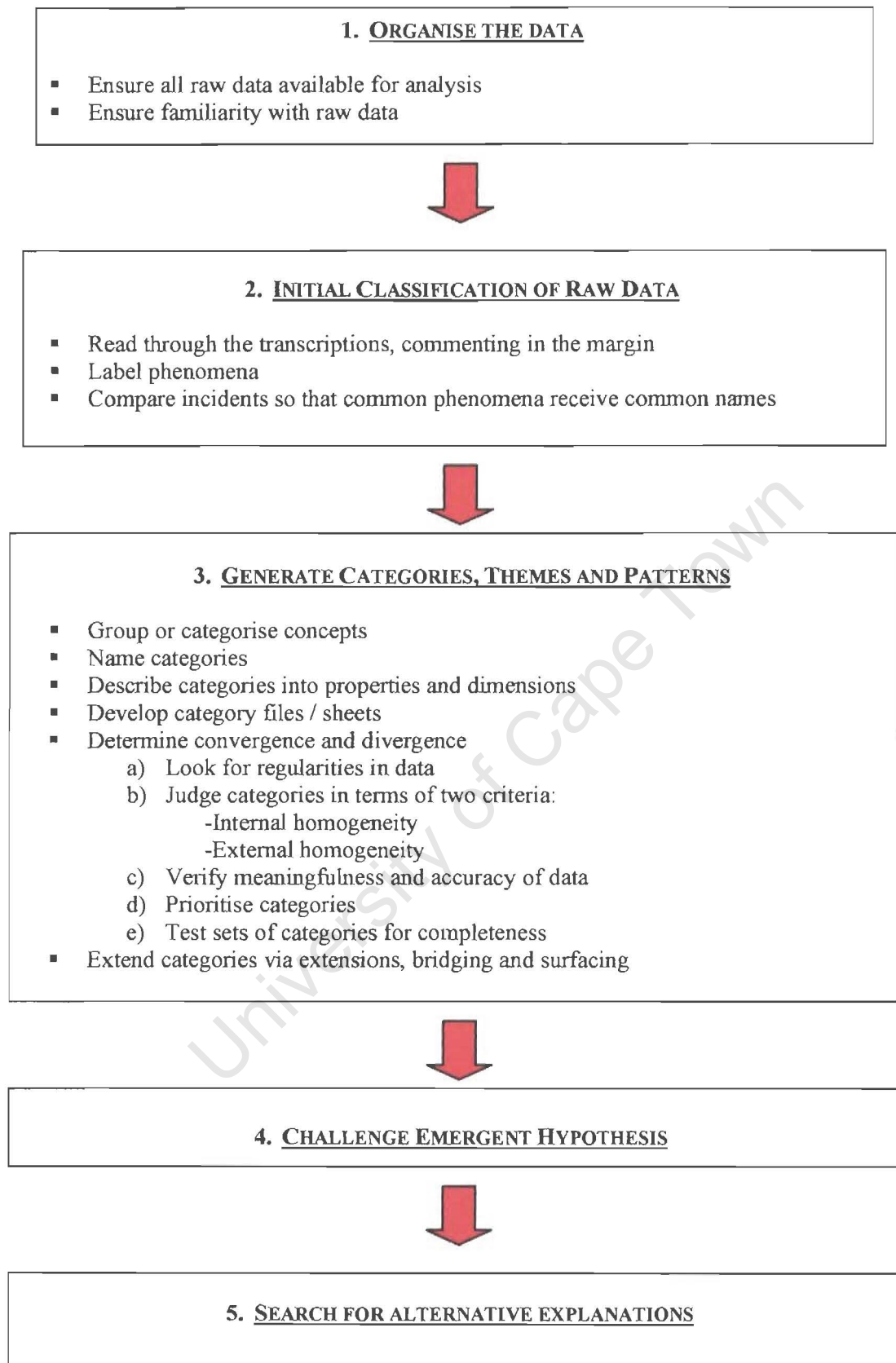


Figure 2.5: Flow Diagram Depicting the Stages Involved in the Data Analysis

These stages will now be discussed in more detail:

Stage One: Organisation of the Data

The first step of the analysis procedure was to ensure that all raw data had been gathered and was available for analysis. The transcription of the interviews, as well as numerous additional read-throughs of the raw data allowed the researcher to become familiar with the information, thereby facilitating further analysis (Patton, 1990; Marshall & Rossman, 1995).

Stage Two: Initial Classification of the Data

This stage marked the beginning of the coding process which takes place in content analysis. The researcher was required to read through each of the transcripts from the semi-structured interviews and make comments in the margin (Patton, 1990). These comments included ideas and perceptions of particular observations, sentences and paragraphs. Each of these incidents, ideas or events, in turn were given a label that was felt to represent that phenomenon. Incidents were then compared so that common phenomena would receive common names (Corbin & Strauss, 1990). The data was conceptualised in this way to facilitate the large amount of raw data in the transcriptions.

Stage Three: Generate Categories, Themes and Patterns

Once the phenomena had been identified, they were grouped together into categories. Categories were given names that were more abstract than the concept names, but were still felt to be transparent enough to remind the researcher of the raw data. Categories were further developed in terms of their properties and dimensions (Corbin & Strauss, 1990). These characteristics formed the basis for differentiating categories and subcategories.

Patton (1990) suggests that data should be organised into topics and files. Each category was therefore allocated a separate category sheet. After completing a

detailed coding procedure, the information pertaining to the topic was then cut out from a copy of the original raw data and placed onto the category sheet.

At this stage of the analysis, categories were examined for divergence, convergence and completeness as proposed by Guba (1985 in Patton, 1990). This entails “fleshing out” patterns and categories in order to determine what could be appropriately fitted together in particular categories. This was achieved by:

- a) Looking at regularities in the data.
- b) Judging categories in terms of internal homogeneity (the extent to which data in a category holds together) and external homogeneity (the extent to which differences in a category are bold and clear).
- c) Working back and forth between data and classification systems to verify meaningfulness and accuracy of placement of data within certain categories.
- d) Prioritising categories, by determining which categories were more important according to features of saliency, uniqueness and credibility.
- e) Sets of categories being tested for completeness by:
 - o Extension – building on items of information already known.
 - o Bridging – making connections between different items.
 - o Surfacing – proposing new information that should fit and verifying its existence.

At this stage certain categories were joined together to form themes, while other categories were reduced to variables in the study. Themes are defined by Ely (1991) as statements of meaning that run through all or most of the important data. Their impact is thought to be primarily emotive and actual (Ely, 1991). Categories were also laid out in terms of priority so that they could be reported on in this order in the Results & Discussion section of this study.

Stage Four: Challenge Emergent Hypotheses

At this point, the data was searched in order to challenge the established hypotheses and to find information that may not be in agreement with the hypotheses (Corbin & Strauss, 1990).

Stage Five: Search for Alternative Explanations

When challenging the patterns that seemed to be apparent, alternative explanations were sought out, identified and described. It was deemed necessary to demonstrate why a particular explanation was the most plausible (Corbin & Strauss, 1990).

2.8.2 Statistical Analysis

Data collected in the survey, was entered into a database using Excel. Data was analysed quantitatively using the statistical package of SPSS. Data analysis was explorative. This provided quantitative information and allowed for any general patterns regarding the structures, mechanisms and processes employed in the implementation of the “use of interpreters in HCFs” across and within the respective regions to emerge. Categorical Principal Component Analysis and HOMALS (cluster analysis) were used as a preliminary investigation into the inter-relationships between variables. Furthermore specific information relating to individual HCFs was determined.

2.9 RELIABILITY

Research is said to be trustworthy if the research process is carried out fairly and the product is closely representative of the informants involved. Thus, a number of methods will be employed in this study in order to enhance and determine the rigour of the data analysis procedure. This will have to be undertaken at a number of different levels in the research to ensure that the data is accurate throughout.

2.9.1 Confirming the Accuracy of the Transcription of the Data

The data was checked and consisted of only one possible level of breakdown – in the transcription phase.

To ensure intra-rater reliability, the researcher validated all the data.

In addition to this, twenty percent of the data, from the interviews, was reviewed by an L1 English speaker, to ensure inter-rater reliability. Twenty percent of the data was chosen from a cross-section of recorded sessions. The data was randomly selected in that any part of these sessions was selected for the purpose of reviewing.

Based on suggestions by Cucchiarini (1995), a word-by-word percentage agreement procedure was used to determine inter-rater reliability of transcribed English data in an objective manner. The following formula was employed (Cucchiarini, 1995):

$$\frac{\text{Number of Agreements}}{\text{Number of Agreements} + \text{Number of Disagreements}} \times 100$$

Figure 2.6: Formula for Inter-rater Reliability

Inter-rater word-by-word agreements for transcriber 1 vs. transcriber 2 across 62 transcribed interviews are presented below.

Table 2.2: Inter-rater Transcription Reliability

	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5	Interview 6
Rater 1 & 2	96%	98%	100%	98%	99%	99%
	Interview 7	Interview 8	Interview 9	Interview 10	Interview 11	Interview 12
Rater 1 & 2	97%	98%	98%	99%	97%	99%
	Interview 13	Interview 14	Interview 15	Interview 16	Interview 17	Interview 18
Rater 1 & 2	99%	97%	99%	99%	98%	96%
	Interview 19	Interview 20	Interview 21	Interview 22	Interview 23	Interview 24
Rater 1 & 2	99%	98%	98%	98%	100%	99%
	Interview 25	Interview 26	Interview 27	Interview 28	Interview 29	Interview 30
Rater 1 & 2	96%	96%	99%	100%	100%	98%
	Interview 31	Interview 32	Interview 33	Interview 34	Interview 35	Interview 36
Rater 1 & 2	99%	95%	99%	97%	98%	98%
	Interview 37	Interview 38	Interview 39	Interview 40	Interview 41	Interview 42
Rater 1 & 2	99%	96%	99%	96%	100%	96%
	Interview 43	Interview 44	Interview 45	Interview 46	Interview 47	Interview 48
Rater 1 & 2	96%	97%	99%	100%	97%	98%
	Interview 49	Interview 50	Interview 51	Interview 52	Interview 53	Interview 54
Rater 1 & 2	100%	100%	99%	97%	98%	98%
	Interview 55	Interview 56	Interview 57	Interview 58	Interview 59	Interview 60
Rater 1 & 2	98%	96%	99%	97%	97%	98%
	Interview 61	Interview 62				
Rater 1 & 2	98%	100%				

The mean percentage word-by-word agreement across 62 interviews for transcriber 1 and transcriber 2 was 98%. This result indicates high inter-rater transcription reliability. Subjectively, it was found that there were no errors of content, in that there were no propositions missing. However some ritual utterances and prompts were missing. Where notable discrepancies arose in the interview transcriptions, changes were made to the transcripts prior to further analysis.

2.9.2 Validating the Data at the Level of Thematic Analysis

Validation of the data at this level was based on suggestions by Patton (1990), Polgar and Thomas (1991), DePoy and Gitlin (1994), and Joubert et al. (1997). These suggestions are outlined below.

2.9.2.1 Data on Characteristics of Informants

Joubert et al. (1997) state that it is important to report on the characteristics of the respondents in order to give an indication of the reliability of the responses. It was suggested that characteristics such as training, experience and the agendas of the informants be made known so that the results could be correctly interpreted within context.

According to Polgar and Thomas (1991), research demonstrated that in ones everyday communications and social interactions, people take an enormous amount of cultural context for granted and they tend to bracket this as obvious or common sense. When the cultural backgrounds of individuals diverge, the understanding of personal meaning becomes less obvious. Consequently, people need to establish what cultural background the informants in the study come from and what their previous training and experience are, in order for their perceptions to be analysed in context. For these reasons, the biographical details of all informants are included as well as, in the case of the trained interpreters, details of training and experience and descriptions of the programmes to which the informants are affiliated.

2.9.2.2 Audit Trial

It has been reported that in qualitative research such as this, the researcher is more a part of the phenomenon being investigated than in quantitative research (Polgar & Thomas, 1991). However the advantages of using a human measuring instrument, is that we are more adaptable and multi-purpose than even the most sophisticated machinery and we can observe subtle behavioural changes as well as verbal and non-verbal cues in subjects.

One way of indicating the train of thought of the researcher, is through an audit trial. An audit trial refers to the thinking and action processes involved in obtaining results and involves the researcher reporting on his or her train of thought (DePoy & Gitlin, 1994). This was felt to be achieved via the following: notes on procedures in methodology, notes on the construction of materials in the methodology and notes on the utilisation of the constructed materials in the methodology.

2.9.2.3 Triangulation

Triangulation is a process whereby one source of information is checked against one or more other sources of information (DePoy & Gitlin, 1994). According to Patton (1990), the combination of methodologies in the study of the same phenomena strengthens the study design. It can involve using several kinds of methods or data, including using both quantitative and qualitative approaches. Any given study can include several mixes of the approaches by including several measurement approaches, varying design approaches and varying different analytical approaches to achieve triangulation (Patton, 1990). Using triangulation is recognition that the researcher needs to be open to more than one way of looking at things.

Denzin (1978 in Patton, 1990) stated that no single method ever adequately solves the problem of rival causal factors. Furthermore, each method reveals different aspects of empirical reality, and consequently multiple methods should be employed in every investigation (Denzin, 1978 in Patton, 1990).

2.9.2.4 Subjective Assessment of the Interviews Immediately after the Recording

Directly after each interview, the researcher wrote down brief field notes on the positive and negative aspects of each session, as well as the researcher's feelings about the responsiveness of the informants. In order to make this as easy and as quick as possible to administer, the researcher constructed a short checklist to be used after each interview. The checklist was based on suggestions from several researchers (Patton, 1990; Marshall & Rossman, 1995; Evans, 2000; Fisch, 2001) and included comments on the following:

- Others present during the interview
- Distractions during the interview
- Interviews affected by others present and distractions
- Informant characteristics
- General
- Equipment check
- Ideas from the interview which needed to be followed up.

2.9.2.5 Missing Data

The incidence of data that could not be transcribed was minimal (Joubert & Katzenellenbogen in Joubert et al., 1997). The little data that could not be transcribed could be attributed to one of the following:

- Speaker variables: Some of the informants had very soft voices which contributed to poor sound quality.
- Environmental/situational variables: At times, background noise at the various HCFs interfered with the sound quality.

2.10 Pilot Study

A pilot study was carried out with three health professionals at a tertiary-based health care facility. The aims of the pilot study were as follows:

- To estimate the time required for each interview.
- To measure the effectiveness and appropriateness of the open and closed-ended questions that were developed for the interviews.
- To identify any technical difficulties that may arise from the tape-recording and the quality of sound.

Based on the pilot study, the following was determined:

- Twenty to thirty minutes should be allowed for the interview process.

- The analysis would need to be data driven in order for all relevant data to be included in the analysis.

Data from this pilot study was not included in the research project.

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3. RESULTS

In this section, the qualitative findings from the interviews with the informants and the quantitative and qualitative data obtained from the survey are discussed. The results are considered under each of the themes that emerged from the thematic analysis of the in-depth interviews. These themes are listed in Table 3.1 below.

Table 3.1: List of Themes

DEMOGRAPHIC INFORMATION REGARDING RACE AND LANGUAGE STATUS OF HEALTH PROFESSIONALS AND PATIENTS
POLICY AND LEGISLATION
CURRENT PRACTICE
EXPERTISE
RELATIONSHIPS
RESOURCES

3.1 DEMOGRAPHIC INFORMATION REGARDING RACE AND LANGUAGE STATUS OF HEALTH PROFESSIONALS AND PATIENTS

To date, no formal health information statistics are available regarding the language status of the health professionals providing medical services at the tertiary hospital, secondary hospital or community health clinic, nor of the patient populations served at the various health care facilities.

3.1.1 Tertiary Hospital

i). *The Languages of the Population Served*

From the findings of the interviews conducted at the TH, it was evident that a large majority of the patients attending the TH do not present the so-called 'dominant' languages of English and Afrikaans as their first languages.

MO: I would think 80% of the patients are isiXhosa and 20 % are Afrikaans or English and we see more and more children from abroad, from Central Africa, French speaking, or what's that Swahili.

MO: But certainly 40% – 50% of outpatients, you know, something like that, are isiXhosa and the parent, well, it's mainly the parents that are isiXhosa of whom probably half speak English to some degree. The other half, they don't, particularly the ones who recently arrived from the Eastern Cape, they cannot speak English, or very, very poorly. So it's not really possible to communicate on difficult issues.

The TH provides a service to number of people of different cultures and language groups. However, results from the survey by medical officers and nursing staff, reported that isiXhosa is the first language of the majority of the patients. Furthermore the health professionals reported that it appears that at least 10% of the patients served at the TH

speak other indigenous languages as well as languages spoken in the rest of Africa such as French and Swahili. French-speaking patients attending the TH were reported to have markedly increased as a result of a greater amount of referrals from other countries in Africa as well as increasing numbers of French-speaking African immigrants in South Africa.

MO: I think it's not just for South Africa languages. I think even other African languages, because we're getting lots of refugees coming in to live in Cape Town who speak French, who speak Somalian.

MO: I mean, we've had a Somalian patient.

MO: So it's not, definitely not only isiXhosa. We have to get, you know, the guys who do the parking, one of them, they speak French.

ii). The Health Professionals' Language Status and Diversity

As illustrated in Figure 3.1, the nursing population at the TH comprises, 74.8% Coloured, 15.0% Black, 9.7% White and 0.5% Indian ⁶(Provincial Administration of the Western Cape {PAWC} statistics, 14 November 2003).

⁶ The use of terms to denote 'race' are controversial and the researcher's intention is not to offend but to use terms which still have social meaning in South Africa.

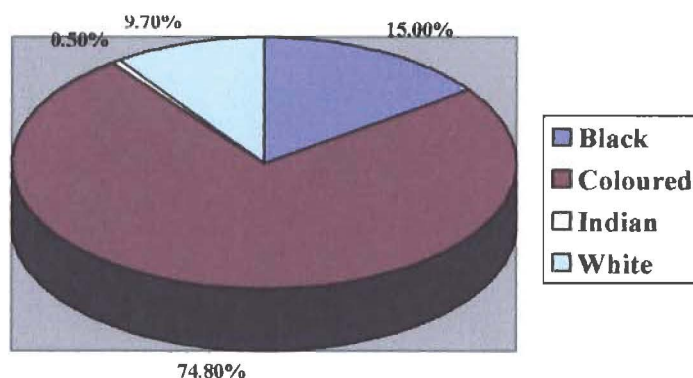


Figure 3.1: Racial Percentages of the Nursing Staff Employed at the Tertiary Hospital (PAWC, 14 November 2003)

Considering the socio-linguistic history of South Africa, the majority of White, Coloured and Indian nurses are unable to speak isiXhosa, and even if one assumes that all of the 15.0% Black nursing staff are first language isiXhosa, it is strikingly low when one considers that the majority of the patient population is isiXhosa-speaking. As reported by informants in the interviews, the nursing staff at the TH are predominantly Coloured, either English or Afrikaans first language speakers, and are unable to speak isiXhosa.

MO: Almost all of our nurses are English or Afrikaans speaking but we have a recent acquisition to the staff, who is the junior sister, who's fluent in isiXhosa, and that's very nice.

As illustrated in Figure 3.2, 74.5% of medical officers at the TH are White, 11.8% Coloured, 8.1% Indian, 5.5% Black (Provincial Administration of the Western Cape statistics, 14 November, 2003).

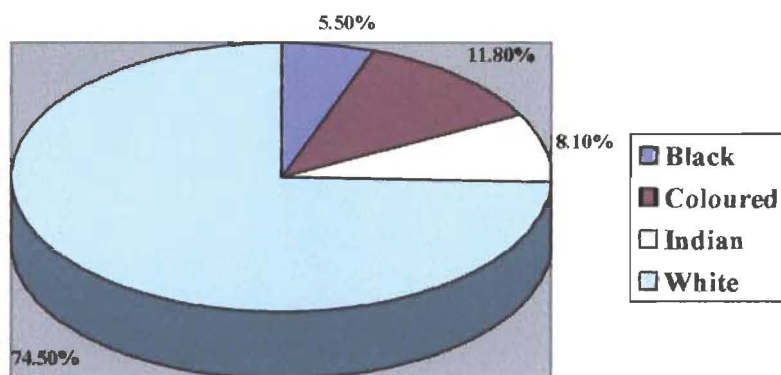


Figure 3.2: Racial Percentages of Medical Officers Employed at the Tertiary Hospital (PAWC, 14 November, 2003)

From the survey employed in this study it was found that of the 5.5% Black medical officers, few are unable to speak isiXhosa, as they are from other indigenous African groups and thus speak other languages such as Sesotho, Zulu, etc. As reported in the interviews, the majority of the White, Coloured and Indian medical officers are first language English/Afrikaans speakers and are unable to speak isiXhosa. In addition, informants reported that amongst the White medical officers, a small percentage are foreign.

It is thus evident from Figures 3.1 and 3.2 that the highest percentage of medical officers together with nursing staff are first language English or Afrikaans speaking, with little knowledge of isiXhosa. Considering that the majority of the patients attending the TH are isiXhosa and the majority of health professionals are first language English or Afrikaans speaking, there is clearly an existing communication and cultural barrier between health professionals and patients.

The extent of language diversity was expressed by the health professionals as an extensive problem that needs to be dealt with.

MO: Ja, I mean, the diversity of languages here is huge. It's massive!

3.1.2 Secondary Hospital

i). *The Languages of the Population Served*

As noted from the interviews, the majority of the patient population receiving services at the secondary hospital (SH) are also first language isiXhosa speakers. First language Afrikaans speakers with few first language English speakers and 'other South African languages' or Arabic speakers also receive medical services at this HCF (Personal Communication from Head Sister at SH).

MO: "Um", here most patients speak isiXhosa but some tend to be able to speak like at least smatterings of English or Afrikaans if they're isiXhosa. You know, like they'll be at least sort of, you know, you'll have your own language and then like little bits and I mean, the patients mostly, the medical officers are appalling, they'll speak English and Afrikaans only.

ii). *The Health Professionals' Language Status and Diversity*

As represented in Figure 3.3, 61.5% of nursing staff were reported to be Coloured and 38.5% Black (Provincial Administration of the Western Cape, 14 November 2003). Again highlighting the more dominant languages amongst nursing staff, being Afrikaans and/or English.

However, as illustrated in Figure 3.3 (compared to Figure 3.1), currently there is a larger proportion of Black nursing staff employed at the SH as compared to the TH, with the majority of Black nursing staff being first language isiXhosa speakers.

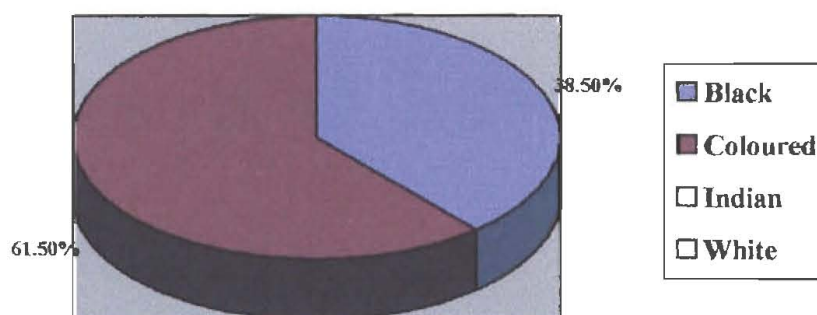


Figure 3.3: Racial Percentages of Nursing Staff Employed at the Secondary Hospital (PAWC, 14 November 2003)

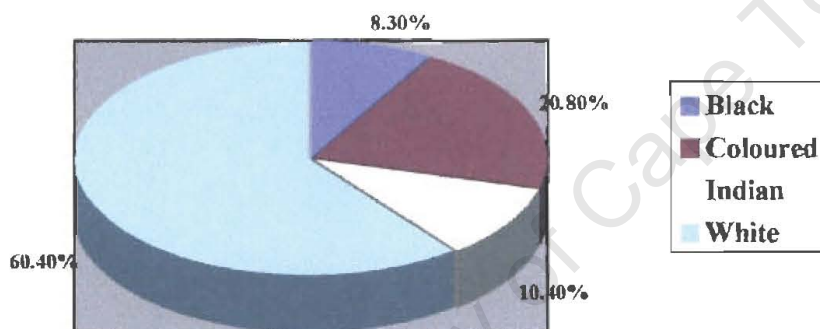


Figure 3.4: Racial Percentages of Medical Officers Employed at the Secondary Hospital (PAWC, 14 November 2003)

Statistics illustrated in Figure 3.4 regarding race once again found that the medical officers in the SH comprise 60.4% White, 20.8% Coloured, 10.4% Indian and 8.3% Black (Provincial Administration of the Western Cape, 14 November 2003). Hence, the majority of the medical officers at the SH are White English/Afrikaans first language speakers, although there is a higher percentage of Black and Coloured medical officers at the SH than the TH, it is still however, markedly less than Whites. With the large isiXhosa-speaking patient population and the limited number of isiXhosa-speaking medical officers, coupled with the majority of the nursing staff being first language English and Afrikaans speakers at the SH, again a communication barrier between health professional and patient is evident.

3.1.3 Community Health Clinic

i). The Languages of the Population Served

As noted from the interviews and in response to the survey, it was clearly determined that the patient population attending the Community Health Clinic (CHC) are first language isiXhosa speakers.

ii). The Health Professionals' Language Status and Diversity

According to Senior Management interviewed, the majority of medical officers at the CHC are first language English and Afrikaans speakers, with few who are able to communicate in isiXhosa. Unfortunately no statistics were available from the Provincial Administration of the Western Cape as well as from personal communication with the Head Sister at the CHC pertaining to the race and language status of the health professionals employed at the CHC. However, it was strongly agreed by all informants interviewed and those forming part of the survey that isiXhosa is the most dominant first language amid the majority of the nursing staff.

3.1.4 Summary of the Language Diversity across the Three Health Care Sites amongst Health Professionals and Patients

As can be seen from these findings, there is a vast language divide between medical officers and patients across all three health care facilities. This is a result of the overwhelming majority of medical officers, being unable to speak isiXhosa. Furthermore, medical officers were required to rate their own proficiency in communicating in isiXhosa. As is illustrated in Figure 3.5, 90.40% of the medical officers participating in the survey rated their proficiency in isiXhosa as 'very poor' or 'poor', thus supporting the finding of the evident communication barrier existent between medical officers and patients.

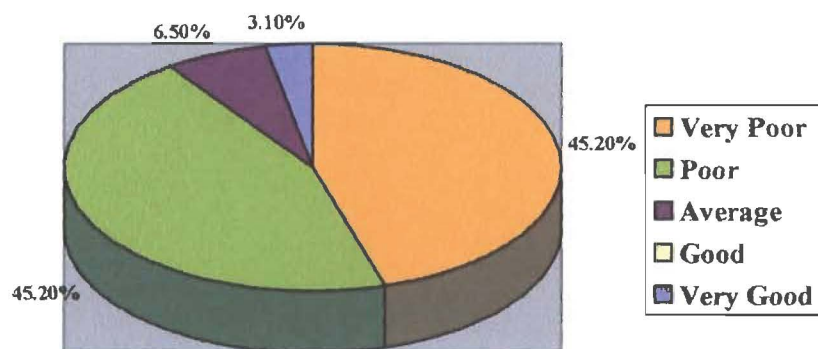


Figure 3.5: Medical Officers' Self-Rated Proficiency in isiXhosa

Nursing staff were required to rate their own proficiency in communicating in isiXhosa. As can be seen from the results of the survey illustrated in Figures 3.6 and 3.7, 72.8% and 60.0% respectively of the nursing staff at the TH and SH were reported to be 'very poor' or 'poor' with regards to isiXhosa proficiency. However, this is not the case regarding the nursing staff at the CHC. As can be seen in Figure 3.8 100% of the informants participating in this study rated their proficiency in isiXhosa as 'very good'.

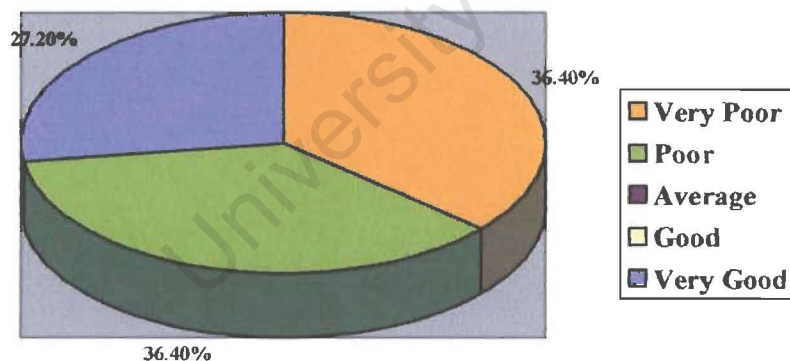


Figure 3.6: Nursing Staffs' Self-Rated Proficiency in isiXhosa at the TH

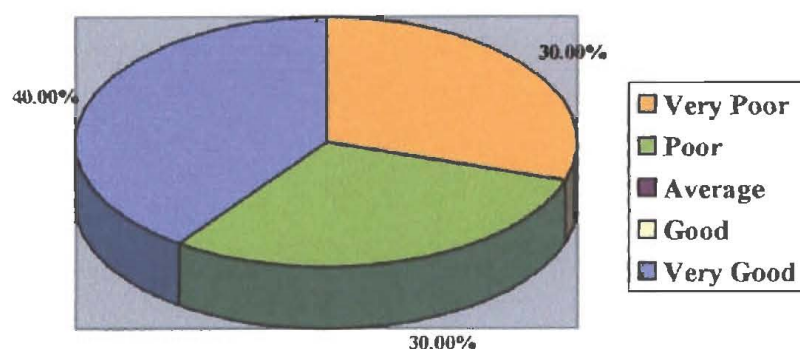


Figure 3.7: Nursing Staffs' Self-Rated Proficiency in isiXhosa at the SH

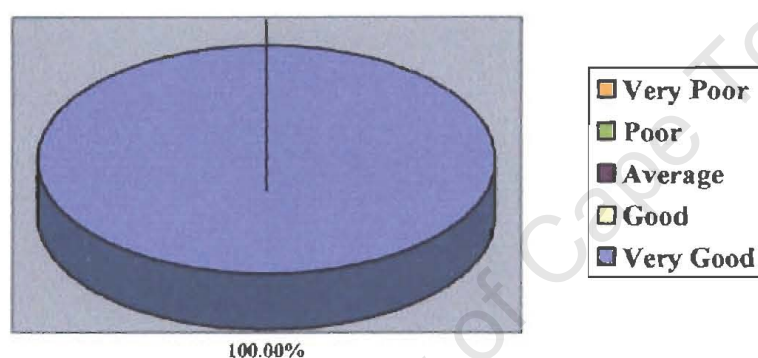


Figure 3.8: Nursing Staffs' Self-Rated Proficiency in isiXhosa at the CHC

The TH appeared to experience wider language diversity among patients and health professionals than the other two HCF's. This diversity in the patient population may partly be explained by the TH being an academic institution providing a service to a wider diverse population extending beyond the borders of the Western Cape, even including countries such as Angola, Zimbabwe, Somalia and Botswana. It is a referral hospital that offers specialised services that are not available at a primary or secondary health care level (Lachman & Stander, 1990). In addition, health professionals reported that over time the amount of isiXhosa patients has increased. They too reported that of the percentage of Black patients, the majority are isiXhosa speakers and a smaller percentage is comprised of other indigenous languages beyond the borders of the Western Cape.

MO: I think it is complicated by the fact that 20 odd years ago when I first came here, there were relatively few isiXhosa-speaking patients, probably less than 10% of patients and now it's certainly you know, it's certainly well over 50%, and going up, so I mean there has been a graphic change and particularly when the patients come in here, a 'helluva' lot of those patients that previously sort of people who have been in Cape Town for some time, did speak English and Afrikaans, a large number of those patients now have come down from the Transkei and the Eastern parts, Ciskei and they just don't speak English at all.

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3.2 POLICY AND LEGISLATION

As was determined from the interviews conducted with relevant authorities on language policy and planning, to date, no formal language policy has been developed or formulated within the health sector. However, the Department of Arts and Culture is currently developing and implementing a language policy.

3.2.1 Provincial Progress on Policy

“Taking into account that the challenge for us, as Government, is to ensure the delivery of an efficient service responsive to the needs of our citizens, and the language is the means through which we communicate them, it is imperative that the Language Policy be implemented with urgency”

(Director-General of Arts and Culture, Implementation Plan: National Language Policy Framework, Draft March 2002).

Following interviews at the Department of Culture Affairs and Sport: Language Unit, it was determined that the Western Cape is the only province with its own Languages Act and Language Policy. The Western Cape Language Policy was approved by the Western Cape Cabinet on 21 November 2001, with the provision that it be resubmitted for consideration. Within the Policy it states, *“that every organ or institution of the provincial or local government must, in its oral, written and electronic communication with and rendering of service to the public, ensure that these are carried out in the most appropriate manner, with the assistance of interpreters and translators and other technical means such as simulcast and subtitling, in any of the three official languages of the Western Cape, depending on the language usage and the needs of the residents”* (Western Cape Language Policy, November, 2001). Secondly, it states *“that of the language policy, which was not included in the version of the Language Policy that was accepted in principle by the Western Cape Cabinet, makes specific provision for translation and interpreting in providing that trilingualism and translation and/or interpreting experiences should, wherever possible, be prioritised in filling vacant posts*

within the Provincial Administration by the end of 2004” (Western Cape Language Policy, November, 2001). The above two points highlight the province’s advancement and awareness of the importance of linguistic accessibility in the public services.

Municipalities are becoming increasingly aware of their legal obligations regarding multilingualism and thus the onus is upon them to administer both constitutional and legal language provisions of the Western Cape Language Policy (Cilliers, 2001). Since the last language survey, there has been marked increase in the awareness for the need and scope for a language policy (Cilliers, 2001).

Furthermore, the Department of Arts and Culture has drafted an implementation plan regarding the national language policy framework. This policy was discussed in an interview with employees at the Department of Arts and Culture and will be elaborated below.

From the interviews it was noted that the aim of this policy is to promote equitable use of all eleven official languages to facilitating equitable access to government services, knowledge and information, as well a respect for language rights (Implementation Plan, 2003). It is to be noted that all government structures are obligated by the requirements of the policy, including institutions exercising public power or performing a public function in terms of legislation (Implementation Plan, 2003).

It is stated in the policy that for communication with members of the public, that the language of the citizen’s choice must be used and where necessary, facilities such as interpreting should be used so as to meet this criteria (Implementation Plan, 2003). One of the key focus areas of this implementation plan is to encourage language learning, specifically modified to the needs of the public service, so as to improve the public servant’s efficiency and output in the multilingual workplace (Implementation Plan, 2003). A national sociolinguistic survey in 2000 showed that more than 40% of the people in South Africa often do not understand what is being communicated in English and are unhappy with the way their languages are being used in the public sector (Implementation Plan, 2003).

It was further reported that provincial language committees will play a role in advising and working on issues in relation to a variety of issues. *“A language code of conduct for all public servants will stipulate how public servants have to communicate and interact with the public in order to render effective service. The code of conduct will embrace the Batho Pele principles (of impartial service delivery by promoting equal access to public services and programmes by removing communication or language barriers, Draft Language Policy for the Western Cape, August 2000) in as far as the public service has an obligation to provide complete, accurate information to customers in the language they understand best. The code will emphasise the fact that no customer or public servant may be marginalised or disadvantaged through the use of languages”* (Implementation Plan, 2003, pp. 20). Thus laying a foundation to improve health care services.

3.2.2 Health Care Facility Management and Health Professionals’ Awareness of Language Policies

Awareness of language policies at a national, provincial or institutional level highlighting the importance and necessity in linguistic accessibility between health professionals and patients formed a primary question posed to the informants in the survey.

As illustrated in Figure 3.9, the results from the survey show that all medical officers at the SH and CHC, and 40% of the medical officers at the TH reported that there was no official policy as a national, provincial or institutional level that pertains to the implementation of equal and effective communication in the health care setting. Interestingly, 60.0% of medical officers from the TH believed that there was a policy at either a national, provincial or institutional level.

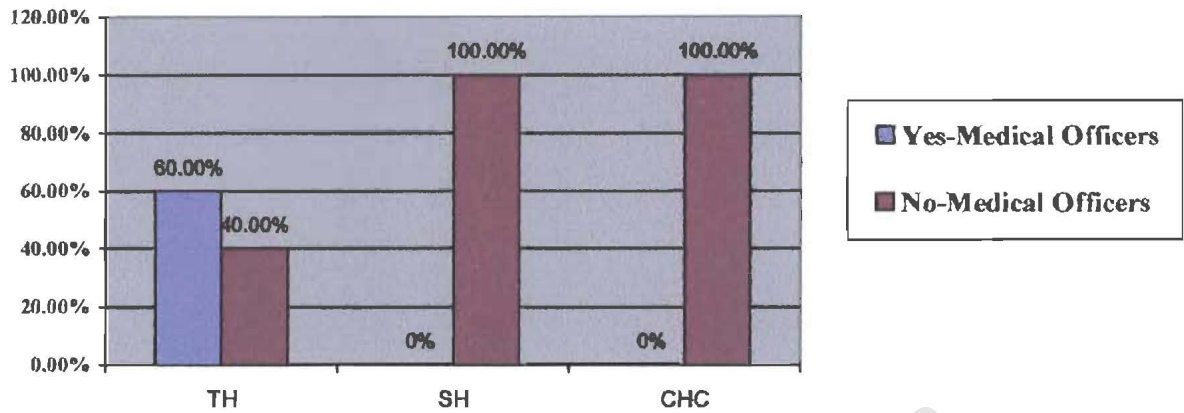


Figure 3.9: Medical Officers' Perceptions Regarding the Existence of a Provincial or National Policy for Equal and Effective Communication in Health

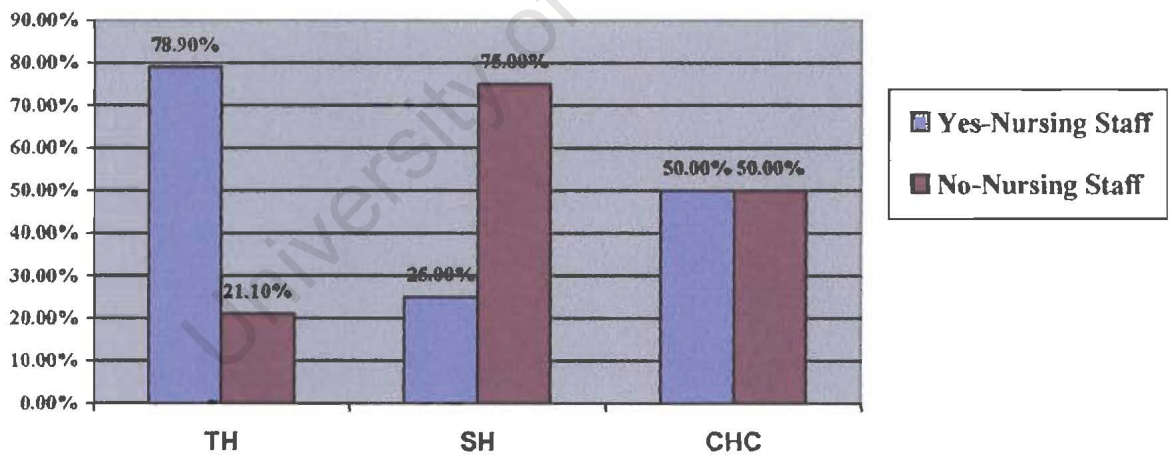


Figure 3.10: Nursing Staffs' Perceptions Regarding the Existence of a Provincial or National Policy for Equal and Effective Communication in Health

The results from the survey illustrated in Figure 3.10 indicate, 75.0% and 50.0% of the nursing staff at the SH and CHC respectively and 21.10% of the nursing staff at the TH reported that there was no official provincial or national policy pertaining to the implementation of equal and effective communication in the health setting. Much variation in the perceptions of nursing staff across the three HCF's was noted. From the interviews and survey, the perception that there is a formal provincial or national policy by both medical officers and nursing staff at the TH may be due to the fact that they have more recently implemented a more formal approach in an attempt to provide more effective communication, the employment of trained interpreters.

Whilst some of the managerial staff interviewed across the three HCF's were confident in their response that they were unaware of any official policies at provincial or institutional level pertaining to effective communication, few were hesitant and admitted to be completely ignorant and unsure of any policies, which in turn suggests the limited importance bestowed on communication in health by health management.

MO: No, no, there's nothing, no interpreting policy. We get uh...everything's unofficial, we have Xhosa classes and that sort of thing, but there's no policy that I'm aware of.

MO: I'm not aware of any official policy. All I know is that everybody pays lip service to having interpreters but, we've taken a huge battle to get any interpreters established at X. It's been about eight years I would say to get our interpreters, the few that we've got, properly.

MO: They don't have a policy as such, no, we, we have basically two, two paid interpreters.

Although some HCF's have taken initiative in becoming more effective communicators, they appear to be functioning in an informal manner. Thus highlighting to the researcher

that communication was not a topic in the forefront of these HCF's, although the evidence of communication difficulties is endless.

3.3 CURRENT PRACTICES REGARDING INTERPRETING/MEDIATING ACROSS LANGUAGE BARRIERS BETWEEN HEALTH PROFESSIONALS AND PATIENTS

From an interview administered at the Department of Health Western Cape, it was reported that currently there are no formal/official posts for interpreters within the health care system.

The interviews and survey indicated that none of the three health care facilities have specific posts allocated for interpreters. According to Drennan and Swartz (2002), there have never been any official interpreting posts in the public service outside of the judiciary. Twenty interpreters were originally employed by the International Language Project that introduced official interpreting into South African Health Care. However, funding was exhausted, and only a few HCF's were able to make arrangements for their interpreters to remain employed.

The TH is the only HCF in the study to employ trained interpreters. At present two trained interpreters are employed at the TH. Interpreters currently employed at the TH occupy nursing posts, which in turn, does not abet the problem already being faced, that being the shortage of nursing staff in the health care system.

Each HCF in this study has developed its own approach in an attempt to overcome communication barriers, which is relevant and specific to their particular setting.

As can be determined from the survey, illustrated in Figure 3.11, the TH offers an interpreting service, whereas the SH and CHC make use of ad hoc mediators. However, although trained interpreters are available at the TH, not all medical officers make use of them, the systems used will now be elaborated on.

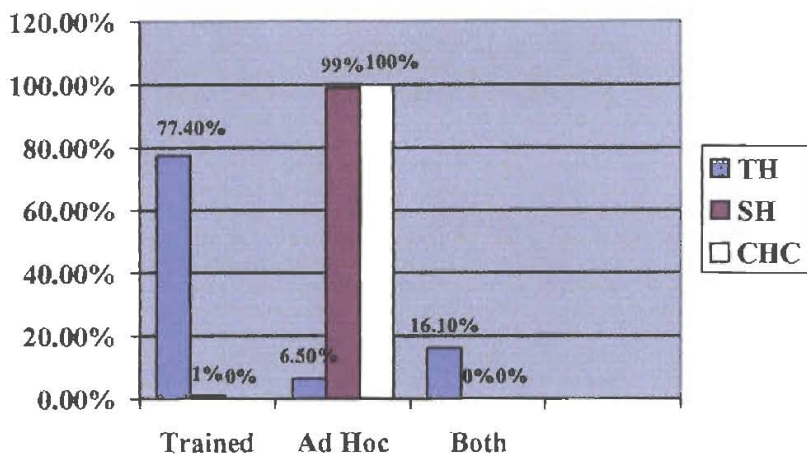


Figure 3.11: Types of Mediators Used Across the Three HCF's

3.3.1 Tertiary Hospital

The interviews revealed that the TH in this study was able to maintain these interpreters by employing them in 'nursing posts'.

For the last seven years the TH employed three trained interpreters. Of the initial three employed, currently only two remain employed by the institution. Considering that the hospital services annually approximately 183 000 patients and has an estimated 1100 staff members, the low ratio of trained interpreters to health professionals and patients in need of their services, clearly indicates the shortage of interpreters necessary to overcome communication barriers in this system.

The formal interpreters are, however, recognised in their capacity and are easily distinguished from other staff members by their distinctive uniforms. Each interpreter has been assigned to certain departments within the HCF by providing an interpreting service to outpatients and the other inpatients.

MO: Well when they are available they are helpful, but I can't always wait around for her.

Furthermore, the trained interpreters are contactable by bleeps at all times during working hours. Since they are employed in nursing posts, they report to the head matron. The bleep system requires the medical officers at the TH to contact the interpreters, should their services be required. The interpreters respond to the call and inform the medical officer as to the approximate time they will attend to them. However, medical officers often have to use ad hoc mediators, as there are only two interpreters who are available from 9:00AM to 5:00PM and medical officers attend to large caseloads on a daily basis.

From the interviews it was reported that the system/process regarding the assessment of trained interpreters was not formally addressed to the staff at the TH. Hence, not all health professionals are aware of the system. In addition, some medical officers at the TH are unaware of the trained interpreters.

MO: I'm not aware of a process, I think that you know, it's quite an established institution now, unlike the myriad of other arrangements that one picks up as one learns the ropes. I think it happens like that.

MO: It's efficient in working hours, here it works. If they're not here, then we fall back on the old system whereby we do it ourselves. We go through the systems that have been developed.

The ease of accessing a trained interpreter at the TH was reported to vary across departments as well as across individual health professionals. Certain departments conveyed that they often used the trained interpreters in that they were readily available. This was not true for all departments. Other departments expressed their preference for using ad hoc mediators who were, generally nursing staff in their departments, who had field specific knowledge and who were immediately available. Although trained interpreters were found to be efficient, some medical officers preferred using ad hoc mediators, in that these mediators were more easily accessible and the medical officers need not wait to receive assistance.

A common thread that arose amongst the informants was one of hierarchy. It appears that numerous medical officers interviewed, commented that they perceived accessibility to be easy and highlighted that this could possibly be due to their more senior position in the HCF and they were unsure as to whether or not other health professionals received the same service.

MO: Yes, when the interpreters are available they are easy to access, I'm not sure how general that is because I'm older and more senior as a result, I may go to the top of the queue. I don't know.

Although the TH supports two trained interpreters, it is clearly not adequate to service the large TH, hence health professionals are still required to rely on ad hoc mediating services. This appears to be primarily due to insufficient numbers of interpreters only available during working hours. Furthermore, some medical officers expressed their preference for ad hoc mediators over trained interpreters in that it was more practical for them as ad hoc mediators were more easily attainable.

MO: I don't often use them, because there are only two trained interpreters for the hospital.

Certain departments within the TH rely on nursing staff members within their units who are readily able to assist in mediating. They are frequently used and help with the mediating of conversations in that department. This is undertaken in such a way that it is not in any manner condescending. The importance of their primary job (i.e. nursing) as well as their ability to converse in more than one language is highlighted and commended. For these departments, this has been reported as a move in the right direction.

MO: I tend to use who's in the ward, so quite a few of our staff nurses.

MO: Yes, that's right. Ja, in trauma similarly there, although they aren't with you, 100% of the time as they are here in the consulting rooms, if you need an interpreter there's a nurse around in the department who you can call on for that.

3.3.2 Secondary Hospital

From the findings of the interviews and the responses to the survey, it is clear that numerous difficulties are currently experienced at the SH with regard to overcoming linguistic barriers between health professionals and patients.

The SH appears to not have any formal structure, processes or mechanisms with regards to obtaining assistance in overcoming communication barriers. The SH has no formal trained interpreter and thus rely on ad hoc mediators on a daily basis. As mentioned previously, when the International Language Project was launched, the SH was one of the institutions to obtain a trained interpreter, however, the interpreters employment was not sustained. The SH provides health care services to a large multi-lingual population and relies heavily on nursing staff, general assistants and family members to help them overcome communication barriers. Due to the shortage of first language isiXhosa nursing staff, medical officers often receive assistance from general assistants.

MO: Well, I can't speak isiXhosa, so and I don't understand it as well. If there's a problem, I usually ask one of the isiXhosa speaking members of the staff, usually a nurse or a porter, or anyone, it's not a problem, but if there's no one available that can speak isiXhosa, then obviously there's a gap and then it's difficult to do.

MO: Sometimes there may be miscommunication, but I don't know, because I'm not sure what the patient is saying in the first place.

Furthermore, the interviews showed that nursing staff at the SH indicated some resistance to providing interpreting services. However, the general assistants expressed their

understanding of the importance of their communication skills to support the patients. Health professionals from the SH tend to use other patients and family members more frequently, but not if confidentiality is an issue.

MGA: They ask us (general assistant) to interpret and we don't ask them why. We just go and interpret. You know why you must, because you see that we've got a lot of isiXhosa ladies who are coming, a lot of isiXhosa patients, who are coming here and they don't understand the language.

MO: Well, I think it will be a very big help if we get, because at this moment we're using the nurses as interpreters and I mean, they're overworked as well, so if we call them from doing their work, then the whole system falls apart.

3.3.3 Community Health Clinic

As mentioned previously, within the CHC, patients are predominantly isiXhosa speaking and the majority of medical officers are unable to speak isiXhosa. However, unlike the TH and the SH, the majority of nursing staff employed at the CHC, are first language isiXhosa speakers. The interviews and survey highlighted that there are no trained/formal interpreters employed at the CHC. Although not documented, an informal planned system in overcoming communication barriers is reported to have been adopted at the CHC.

The informants expressed that each individual medical officer within the CHC has a member of the nursing team assisting him/her when consulting patients. The majority of the nursing staff's task is to act as a mediator between the patient and the medical officer. The nursing staff vary in their qualifications. However, the majority are generally nursing assistants. On employment they are made aware that their role in the HCF is to act as mediators for the medical officer on a regular basis. Whilst mediating is their primary responsibility, they also assist the medical officer in other medical procedures during the consultations. The nursing staff forms an integral part of the medical team and are relied

upon by the health professionals to provide effective communication during medical consultations.

The informal process adopted at the CHC involves patients first being attended to by a team of nursing staff who peruse folders, obtain a detailed case history and any other necessary information. This allows the patients to relay their information in their mother tongue. The nurse using the same first language and being of the same culture as the patient not only allows for more effective communication but also enables cultural aspects relating to the patient's illness to be more fully understood. The nursing staff are therefore reported to play a critical role in imparting this information to the medical officers. Furthermore, they are instrumental in assisting in communicating the treatment and management processes to the patient. As could be determined from the interview and the responses to the questionnaires, this system enables more effective communication and medical management, which is delivered in a shorter space of time.

The staff used as mediators reported that they are fully aware of their role and thoroughly enjoy what they do. They feel it is a necessary and important task to help 'their people' in understanding health, as they are as entitled as anyone else to receive medical assistance in their mother tongue. They are very willing to help their colleagues, even though they are severely under-staffed and the entire team supports each other where possible.

MO: The system at the moment is probably most effective; having an isiXhosa-speaking nurse and you who are probably not isiXhosa speaking and the patient is isiXhosa-speaking. That's probably the best way to do it.

MO: We've got what we've called enrolled nursing assistants. They do basic training in nursing and they function as interpreters for us in consulting rooms, so most, all the medical officers who cannot speak isiXhosa, or are not isiXhosa speaking or of a isiXhosa background, will be having a nurse with him or her every day throughout the day, basically just for interpreting.

N: Yes, we have been told before we do this, that we are going to help our people, because they can't understand what the medical officers say.

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3.4 EXPERTISE

It was evident from the interviews that some medical officers are unsure of the different interactions trained interpreters are qualified to interpret. One would assume that they are qualified to mediate all medical interactions. However, this is in fact untrue, as one area to which they are not obliged to mediate for is that of counselling since counselling is a skill that requires much more than simply interpreting/mediating skills. Although interpreters are not expected to mediate in circumstances such as counselling, they often do assist.

MO: I don't see it written down. Their job description is pretty circumscribed, which is merely to provide a service in interpreting that's um, what they're doing, to whoever needs it. But when we explored the idea of them doing some HIV/AIDS counselling, which through their experience they certainly don't know anything, is absolutely above their job description. If they wanted to do it, they could be part of it, but it is certainly not something we expect from them or they shouldn't spend any of their time doing the actual counselling rather than interpreting the session.

Informants in this research expressed their awareness that the trained interpreters had completed a formal interpreting training programme. They acknowledged that the trained interpreters in the TH did receive training and skills in counselling and communication that were to some degree related to the medical setting.

MO: Now I think that must be because these girls have very good interpreting skills, they are trained before they come here.

MO: It doesn't, that's part of our problems. They were funded in X, so these interpreters were employed by them and then they actually worked, they were trained by them. They actually had quite a lot of training, a bit of background in

medical things and so they had some medical background, but also they were trained, I think in communication skills and counselling skills.

In addition to the interpreters' formal training, they are reported to have developed field specific knowledge through increased exposure over time. Education/training is an ongoing process and is apparent in the case of the trained interpreters who were reported to have enhanced their medical knowledge during their time at the HCF.

MO: But then they also have a medical knowledge which has been taught and acquired in their time here and they've got, you know quite a lot of experience and training with counselling, you know how to do things and how to tell bad news and all those kind of things.

MO: Y is very competent. I mean, she's one of those people who actually takes a lot of initiative so even though, you know, if you're asking, for example, about epilepsy, she already knows all the questions she needs to ask, so without you having to tell her.

The trained interpreters themselves expressed that they felt they had received sound training through the International Language Project, which prepared them for working in the health sector. However, they reported that attaining more field specific knowledge would allow them to be more efficient in the medical consultation.

TI: They taught us some of the things and then we came for another month for the practical here at different hospitals and then after that we started working.

The advantage of using trained interpreters and more specifically interpreters who work in the same field for a set period of time, is the acquisition and building-up of medical field specific knowledge.

Some health professionals stressed that a mediator and one with medical knowledge should not be separate entities but skills that are acquired by a single person. This raises what was suggested by Swartz et al. (1997) that training of interpreters should possibly come from the personnel already employed at that establishment i.e. the *add-on approach*.

MO: I think that if you are, I think more so for the person who's going to be the interpreter, they need to be trained on, ja, about you know, the kind of, especially in the medical field, kind of information that you want.

MO: I mean, even though like for example, some of the nurses have medical knowledge, it doesn't necessarily make them good interpreters.

Some medical officers in this study reported that the use of mediators has assisted them in speeding up seeing their caseloads. However, this was only true when they had confidence in their ability and where the process proceeded smoothly. On the other hand others believed it slowed down the consultation.

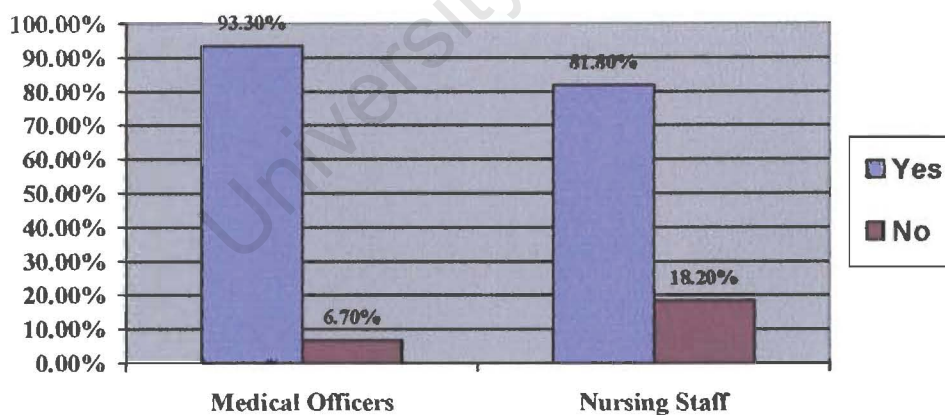
MO: Ja, ja, no once I've got an interpreter, it definitely speeds the process up.

A lot of responsibility was reported in to be laid on an interpreter or mediator and he/she is responsible for imparting extremely important information. Once interpreters/mediators form part of a team they develop and adopt tactics and strategies that aid their communicative intent so that the message being conveyed is being understood by both parties. These may include skills learned in training programmes or skills such as expansion, etc. that fill gaps or elaborate issues such as culture, making the message meaningful. Being effective also includes the ability of the interpreter/mediator to interpret more than just the words; they are to incorporate emotions as well as other influential components.

MO: And they obviously have that, so they tell you exactly what the patient says. And if there's an argument going on and the patient's unhappy, they will turn back and say, 'I'm sorry to tell you this Prof, but the mother is angry', this is what she said, which is actually very nice.

MO: You, you can't get to the subtleties that the same language could get in terms of communication.

As illustrated in Figure 3.12, the survey showed 93.3% of medical officers have worked with interpreters/mediators and 81.8% of nursing staff have either experienced working with an interpreter/mediator, or themselves have been used to mediate in a consultation. Although the majority of health professionals are reported to have worked with a mediator, the mediator was not necessarily a trained interpreter. Although having engaged with interpreters/mediators, these health professionals reported to not have received any formal training for a triadic interaction. Therefore it can be seen that the majority of informants have experienced working with mediators. However, as can be seen in Figure 3.13 few have received formal training.



**Figure 3.12: Health Professionals' Previous Experience with Interpreters/
Mediators**

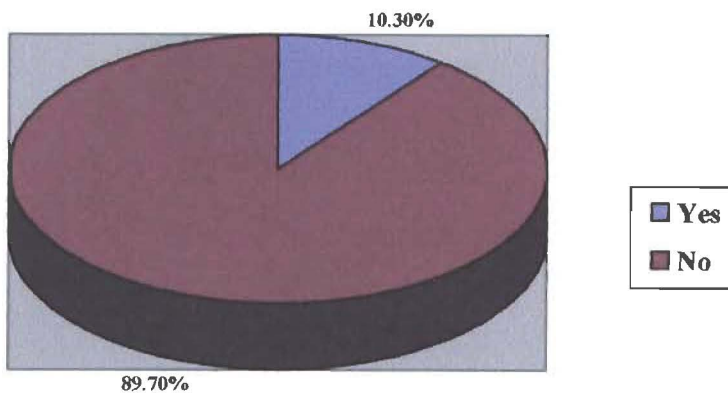


Figure 3.13: Health Professionals' Currently Engaged in Courses For Improved Communication Skills

Although some health professionals were trained to work with mediators at a university level others were only exposed when placed in a community where the first language of the patients was different to that of the health professional and where an interpreter was a necessity in order for a communicative interaction to take place. Furthermore, there are those health professionals that have never had any previous exposure to working with trained interpreters or ad hoc mediators.

MO: No, not really. Um, we, we weren't taught to work with interpreters at University.

MO: I have, yes. I've worked in my final years of studies, we had an interpreter, because we worked in a community, near Pretoria, so for a month about, we worked there.

Since there is a large population of medical officers and other health professionals who have been qualified for a reasonable time period and are currently engaged in HCF's where their language is of the minority group, they have expressed the need for knowledge enhancement in the field of communication, language and culture.

MO: And at my advanced age then, I was in my mid-thirties it was talking to more junior medical officers who just qualified and my, there was only one person that I can remember who spoke functional isiXhosa.

MO: We've done some basic isiXhosa training students in our third year, but it was sort of applied to medical, to the medical profession, so anything other than outside of the medical profession, you know, any terms outside of that, you'd sometimes struggle with and also the more complicated the problem gets, the more difficult it is for the nurse to interpret, because sometimes like I said, there are certain phrases in isiXhosa. Other health professionals provided ideas as to how these 'isiXhosa classes' offered at University could be more beneficial and that was firstly by offering it throughout the medical degree and secondly, by applying the language in practical situations.

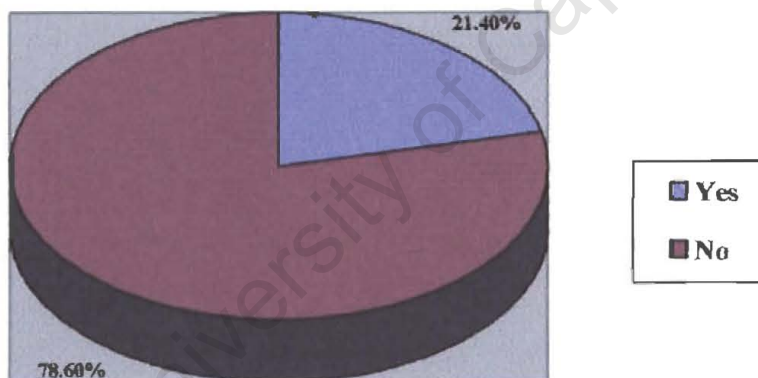


Figure 3.14: Opportunity to Further Improve Training Opportunities of Communication and Culture Skills

As illustrated in Figure 3.13, 89.7% of the informants reported that they have not engaged in courses for improved communication skills. This is concurrent with the results illustrated in Figure 3.14 that is that 78.6% of the informants reported that their HCF does not provide opportunities to improve training opportunities for communication and cultural skills of the health professional. This in turn reiterates that effective

communication and the need to improve inter-cultural communication is not seen as a priority by the HCF's.

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3.5 RELATIONSHIPS

The ability of the medical officer to relinquish power is introduced in mediated medical consultations. However, the medical officer's willingness varies depending on who is used to mediate. A key issue in handing over power in a medical consultation is trust. In order for a medical team to be more 'team-like', there needs to be a basis of trust between health professional, mediator and patient, with the health professional being ready to relinquish power to the mediator.

Medical officers are placing large responsibility and trust in interpreters/mediators and although there may be times that information is lost, it is hoped that this is not critical to the assessment or intervention.

MO: You know I don't really know what it is they are saying to each other, but I hope that the correct message is being passed on. Sometimes I hear them speaking for a long time, but then I just get a one word answer, but I hope they are not leaving out anything too important, and are just making sure they understand each other.

As emerged from the findings of the interviews and the survey, the development of trust between the medical officer and the mediator appears to be related to factors such as training and field specific knowledge of the mediator. In addition, the relationships that develop between medical officer and the mediator are important in that it may allow for trust to develop between medical officer and mediator and hence the relinquishment of power. The more frequently individuals work together, the more likely they are to form a good working relationship.

MO: You've got to generate trust and so what happens is that to get the most out of someone, they've actually got to spend some time around you to trust them.

3.5.1 Medical Officers' Perceptions and Views Regarding the Use of Ad Hoc Mediators

As can be seen in Figure 3.15, in the use of ad hoc mediators, although nursing staff appears to be most prevalent in mediating across the three HCF's, variation across the three HCF's was noted.

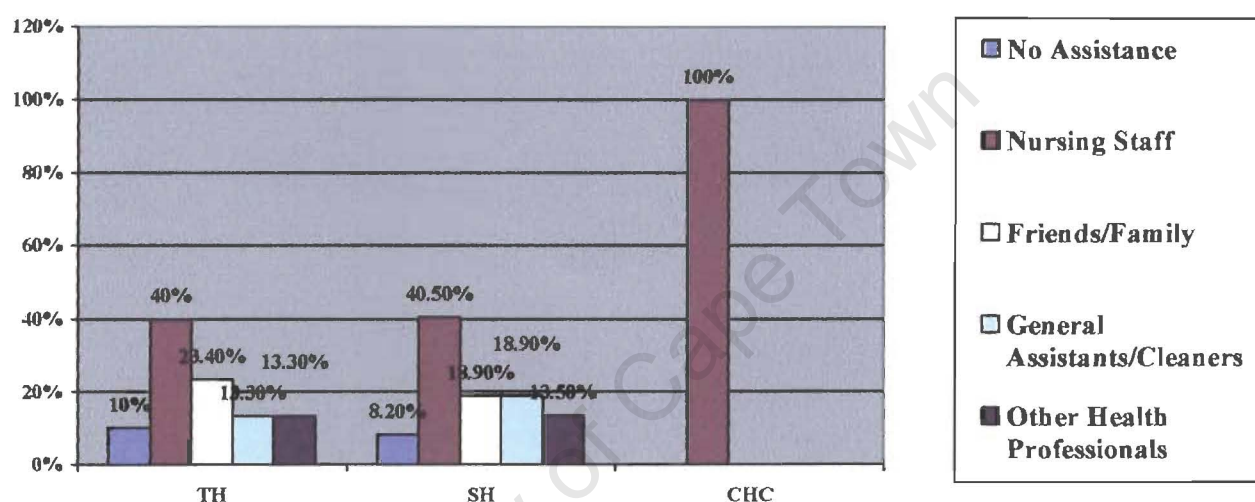


Figure 3.15: Most Frequently Used Ad Hoc Mediators According to Medical Officers

Medical officers at the CHC expressed using nursing staff 100% of the time to mediate their medical consultations. This is inherent in that they have implemented an approach that utilises nursing staff as mediators, thus allowing relationships between health professionals and mediators to evolve and develop. Furthermore, should a mediator be required, nursing staff are made readily available to assist. Thus, the medical officers at the CHC reported them to form an integral part of the medical team. Since their roles were clearly defined good, trusting relationships have developed. At the TH and the SH, 40.0% and 40.50%, respectively reported to use nursing staff most frequently as

mediators. However, in addition, family/friends, general assistants and other health professionals were employed at times when no assistance was obtained.

As can be seen in Figure 3.16 there is a direct relationship between those most frequently used i.e. nursing staff and those viewed as part of the medical team. At the CHC nursing staff used to mediate were seen to be part of the medical team 100% of the time. At the TH 54.40% of medical officers and 35.30% of medical officers at the SH viewed nursing staff used to mediate as part of the medical team. General assistants, family members, other patients, etc, were not viewed as part of the medical team. The reason for nursing staff being viewed as part of the team is believed to be primarily due to this medical knowledge and patient care and awareness of the nursing staff, as well as their ability to communicate in the language of the patient.

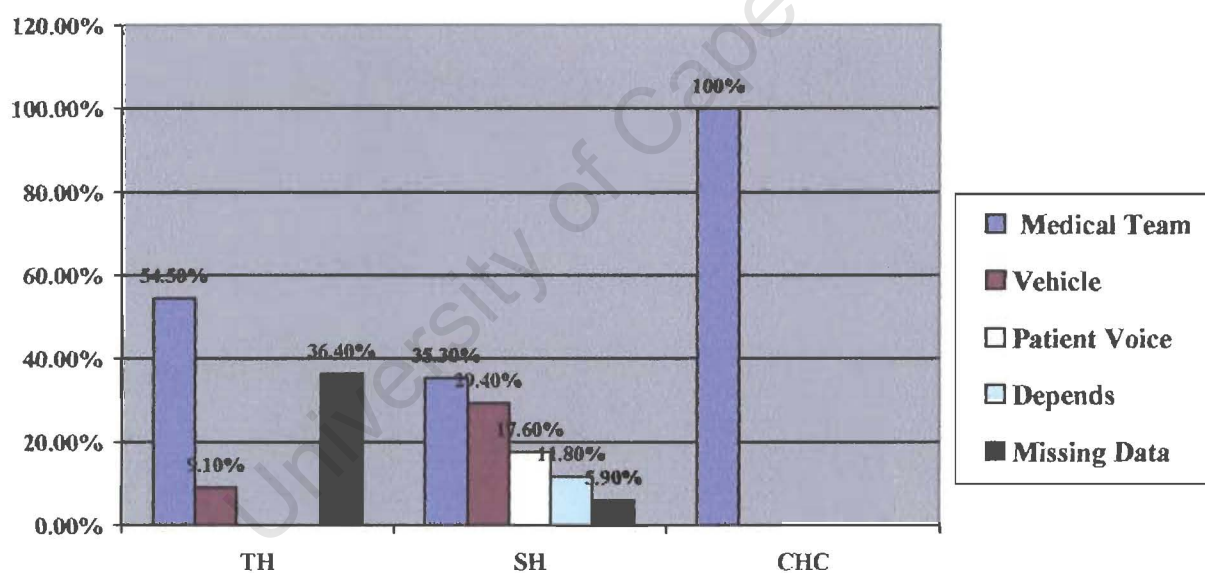


Figure 3.16: Perceived Status of the Mediator by Medical Officers

The use of nursing staff is a common occurrence in South African health care facilities. Where they are used to mediate, they are still viewed by the medical officers to be part of the medical team. Although they are not trained as interpreters, their medical skills and

knowledge along with their ability to communicate in isiXhosa are much acknowledged by the medical officer in the CHC, and this was also clearly expressed by the medical officers at the TH and SH.

MO: We use nursing staff to interpret. Then she's definitely part of the medical team, because she will immediately ask questions about you having to ask, you know, something...

Medical officers interviewed in this study from the TH regarded trained interpreters as valued members of the health care team.

MO: When we use trained interpreters, well then they definitely form an important part of our team. I mean without their skills we wouldn't get very far.

However, although the majority viewed mediators as part of the medical team, there were a few exceptions. That is, a number of health professionals viewed even trained interpreters or nursing staff as a 'vehicle', someone who is simply a translator, and is used merely to transfer a message. These medical officers displayed no interest in the extent to which the use of mediators has improved working conditions for medical officers and effective communication for patients. Family members, other patients and security guards were also reported to be a 'vehicle' or a translator.

MO: She's a vehicle.

MO: She takes my question and my answer to the person and the person gives it back.

In the triadic mediated consultations questions regarding confidentiality were raised. Although some medical officers reported that they would prefer having someone there who could help them communicate, the use of ad hoc mediators other than nursing staff is

not the preference for most medical officers as they reported confidentiality becomes a problem and information is often not relayed appropriately.

MO: If you've got a relative or another mother in the room that you can use, that's okay, however there are issues of privacy and confidentiality.

Although patients were not directly interviewed as part of this study, the health professionals expressed their opinions of how they perceive patients to view trained interpreters and ad hoc mediators.

The informants tended to agree on most accounts that the patients are generally not concerned about the interpreter/mediator present in the consultation. They are often grateful to be able communicate with the health professional. They reported that patients welcome interpreters/mediators to their consultation.

MO: I think they don't worry, because especially if it's a Sister speaking to them, so confidentiality is not really an issue. She is also part of the medical team, so I don't think that's a problem.

N: No, no, you know, when I'm with the medical officer and the patient, then the patient normally says, "Oh, I'm so glad, you know, because I'm so nervous, I can't speak this English and I can't understand this English, you know" and then she say, "Oh, I'm glad you're one of, one of me now like".

N: And the patients they also feel happy and free to explain, to express their feelings to us if they, if they don't understand. I mean, they are scared of the operation. They express their feelings to us, so most of the medical officers use medical terms, the patients they don't understand medical terms sometimes, ja, so we help to interpret to them so they can speak freely.

There are times when patients are aware that interpreters/mediators are available at the various institutions and they make a concerted effort to request their assistance in a medical consultation, as they feel it makes their interactions with health professionals more meaningful.

TI: The patients feel very happy because they, more especially those girls who can't even express themselves. They feel very, very happy, even, sometimes if I'm not around, they will just look around for me, it's fine if the Medical officer will see you. Then the medical officer knows how to contact you, so you just be free, otherwise they feel very...

MO: So the interpreter is very useful to them. Of children, patients, parents on a higher level, often prefer a one-on-one interview, and if you see they are battling with the language, then you ask 'Would you like an interpreter?' They almost always say yes.

The higher percentages relating to the mediator being viewed as part of the medical team for the TH and CHC could be as a result of the already established systems evident in the TH and CHC. Therefore the medical officers appear to have built up relationships with a consistent group of people who assist them in overcoming communication barriers.

3.5.2 Nursing Staffs' Perceptions Regarding Their Own Status When Acting as Mediators

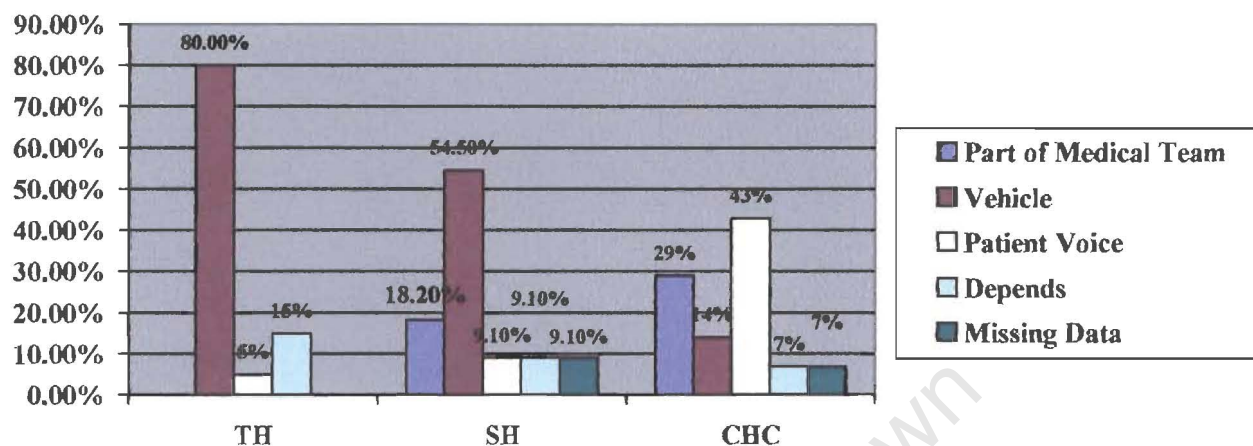


Figure 3.17: Nursing Staffs' Perception Regarding Their Own Status When Acting as Mediators

As seen in Figure 3.17, the majority of nursing staff at the TH and SH viewed the mediator (often themselves or other nursing colleagues) as merely a vehicle. The researcher poses that a reason for this could be due to the fact that they generally reported in their interviews to not enjoy mediating in that it was not their job/duty. Within the CHC, 43% of nursing staff viewed the mediator (reflecting on how they view their own roles) as representing the patient voice. It is within the CHC that the nursing staff act as mediators 100% of the time and are seen as part of the medical team by medical officers. Furthermore, they developed an informal system that has been beneficial and where nursing staff reported to enjoy this task. It appears quite clear that the nursing staff at the CHC perform a dual role. They feel part of the medical team as a result of their medical knowledge, but also view themselves a voice for the patient. This duality is proposed by the researcher to be an ideal situation in that they feel they are a representative of both the patient and medical officer.

From the interviews and survey, a variation as to how nursing staff perceive their own status when acting as mediators was noted. Whilst they appear to feel part of the medical team regarding their nursing duties, their perception of their status alters to being that more of a vehicle when they are mediating in that they have no training or skills for mediating and thus feel less competent and confident. This highlights the need to train those nursing staff able to mediate medical consultations.

N: I don't feel comfortable interpreting cos I am not qualified for it, so when I do it I don't feel as comfortable with the rest of the doctors and nurses as when I am doing my nursing work.

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3.6 RESOURCES

Management at the TH reported that they were unaware of any current post being opened to a trained interpreter and expressed the opinion that should posts become vacant, they would most likely be filled by nursing staff.

MO: Um, we're very constrained uh, well with what I can say with the budget process with who we can appoint at the moment, we are actually stuck with a really strict amount of people between now and the new financial year, we prioritize special posts, and most of them are clinical or majority are nursing, critical nursing posts, um and in my life there are certainly no interpreters. No one has come forward to motivate for interpreters again, it's because I don't think we have posts. You cannot actually motivate for a post that is not in your establishment. See, even if there is a vacant post, I am just saying, if there is, there still...it's a huge process to actually motivate to have that post filled. It's not automatic, and depends on funding. If there isn't an official post, then you're really in trouble, because, then you have to create a post and that is a, I think in the beaurocracy of state, is not so simple and straight forward, so, I mean, at the moment the answer is no, I'm not aware of any plan. I don't know if there's something happening form the outside, if they're coming from a different section, I don't know, I really don't know.

Such constraints have lead to a competitive environment, where health care institutions at community, secondary and tertiary health care levels have had to resort lobbying for posts in the various establishments, motivating that posts benefit the HCF as a whole. Nursing staff forms an integral part of any health care facility and assume a number of responsibilities.

Currently, interpreters have received no official accreditation or status. Although trained interpreters form part of the judicial system, they do not have official posts in the realm of health care service delivery.

Owing to the interpreter-patient and interpreter-medical officer ratios at the TH as well as the existent communication barriers, the trained interpreters experience a heavy workload. Many medical officers and other health care professionals expressed their concern regarding the need to increase the number of interpreters, as it appears to be providing a positive service in the respect of aiding understanding, but unfortunately their work and expertise are limited in that they are only reaching a few patients and medical officers in need.

MO: You can't, we've only got two, they're so snowed under and as I say, I am not even sure if they officially funded, I think they are but that we'd have to check. If we had a whole group of interpreters, if we had a department of interpreters, sure then you could say when you hit certain really difficult issues where a nurse or where someone is not comfortable, or able to translate, we need to get an official interpreter. We don't have that depth of availability to think up a policy.

MO: They have made a major difference to the hospital. Um, and then we don't have at times good staff nurses who are isiXhosa speaking, but that's not very often, most of our nurses are not isiXhosa speaking in this ward. Almost all of our nurses are English or Afrikaans speaking but we have a recent acquisition to the staff, who is the junior sister, who's fluent in isiXhosa, and that's very nice.

MO: It's, I mean, when you able to get hold of her and she comes, she's brilliant. It's a very nice way of just speaking to patients and it works quite well. Then we can get on, I just think she's overloaded.

The issue of working hours as being a matter that influences accessibility to interpreters/mediators was discussed. Current employment of the two trained interpreters is restricted to working hours. A number of patients attend the HCF after hours due to the inability to take off work. This results in a situation whereby there is no official interpreter available should the need arise. Although the trained interpreters are

accessible when they are available during working hours, it is necessary for medical officers to use an ad hoc mediator to assist them when the trained interpreters are not available.

MO: Ja, I mean, they get used a lot, so you know, certainly during office hours we will contact them. The difficulty for us is that you know, probably at least half of our admissions are after office hours. It works 24 hours a day, about 60 odd hours a week and the working week is 40 hours which means $\frac{3}{4}$ of the week, so for a lot of parents, particularly those who are employed, they can't afford to lose their jobs, so they come after hours and they come in the evenings and they come over weekends, so often in most instances, the interpreters are not there.

MO: Ja, they're not always available. They're busy somewhere else, they may be not available after 4 o'clock. They're not here over weekends and I would say about 40 % of our work occurs at night. It's very difficult to get them.

MO: No, I was aware of them, but the ones, the times I usually get one of the Nurses, whenever I tried to get hold of them, they're not available.

TI: Yes, because like here at night, we don't work night duties as well. So at night there's Black nursing staff inside and outside.

Therefore as can be seen in the above much medical consultation occurs after hours when trained interpreters are not on duty. Although difficulty is experienced at these times the majority of medical officers found that during working hours the trained interpreters were indeed accessible in their capacity. Furthermore, the medical officers found the system of accessing the interpreters to be working in that the interpreters are responsive and attend to the call as soon as they can. However, it must be noted that when one says they are accessible, they are referring to being able to contact them although the interpreters themselves may not be available for an extended time period.

MO: No, she is easy to access in the sense that she has the bleep, so you could bleep her. But in terms of fitting her in with what you want to do and all the other things you want to do, because we can't just sit and wait for her to come.

Nursing staff are reported to be most frequently used in terms of ad hoc mediators and this, in no uncertain terms, puts a strain on their workload. The fact that the majority of HCF's in South Africa are under-staffed is a subject that will come up time and time again. This study shows that it is nursing staff who were used as mediators in the three HCF's.

Within the TH, the general consensus amongst health professionals is that there is a demand for interpreters/mediators within the HCF in that their nursing staff often exceed their abilities both physically and practically and this results in the building of a stressful situation in that other responsibilities are expected to take precedence. This often results in nursing staff having to return to complete duties and this stress often has an affect on the patient-nurse relationship.

N: Yes, that they still have to go back to, once they have interpreted, say they interpret, that task takes them half-an-hour, sometimes it could go up to an hour. Even if they have to interpret and our staffing situation is such that often there isn't another person to fill in, a child may have to be fed maybe, so she still has to go back and feed the child, so her work gets behind.

Due to the increased workload experienced by nursing staff, their attitudes and perceptions with regards to acting as mediators may vary. Again individual personalities play key features in attitudes and willingness to assist medical officers. Medical officers reported that one gets acquainted with whom one can approach. Certain nursing staff expressed that they are prepared to assist mediating within their department, but not in other departments, as doing so often tends to lead to resentment.

N: Okay, it depends on, on the type of person because I know of some people that, that's not really keen to do that, they will say point blank that that's not their job and they'll refuse. But I must admit on the ward that I'm working, the people that are isiXhosa speaking are not that difficult, they are prepared to do it, if time allows.

N: You know, it depends also on, on the day, if it's like busy or if we like, very short-staffed and I think they do tend to become a bit frustrated because they are actually wasting, they feel they are wasting time by interpreting, where they could have done other duties.

N: No, we refuse to do that. We will only um, our isiXhosa speaking; my isiXhosa speaking colleagues will only do it in the ward where we are working.

MO: Well because uh, it's taken for granted perhaps right, that they'll do it. Because it's not that they were trained to do uh, because, um, ya, I think um, I think it's not in their job description. People are much more aware of their job descriptions.

MO: I think that if the nurses are prepared to do it um, then it's very reasonable to ask them to do so.

Although the TH is generally short staffed and has a large workload, head nurses reported that they do not mind if their nursing staff help in situations where an interpreter is needed. However, nursing staff often reported feeling frustrated when called to mediate. This is as a result of still having to return to complete duties they were previously occupied with.

N: Well, yes, well that definitely is a problem for us - the fact that Nurses are being used, because, you know, it takes them away from patient care and it often takes a lot of time, a long time for a medical officer to talk to a mother through a

nurse, I mean the explanation takes a long time so the major thing is that that then takes the nurse away from what she really has to do and that is patients care. So that's a problem for us, but I don't know if you are aware, we do have interpreters in the hospital?

N: Yes, so it's not that they mind doing it, but then their job, their work is still waiting for them to be done.

The medical officers at the SH reported mixed feelings depending on who is used to interpret. Medical officers reported nursing staff willing to offer their services. However, due to the demand and need for mediators within the SH, medical officers found the majority of nursing resentful as it is interfering with their specific nursing duties.

MO: Yes, I must say, some of them are very helpful, so I mean, most of the time I mean, they, they also know and knowledge of the fact that there is a problem, so no, they're very helpful.

MO: There's some, no actually, I lied. There's one who is always willing.

On the contrary there were those nursing staff that were not prepared to assist in that it did not form part of their job description.

Interestingly, in the CHC all mediators were nursing staff and they were quite willing to assist medical officers, and expressed the view that they were interested in helping the patients, who needed them. Although a similar workload is experienced at the CHC, the attitudes of the nursing staff appeared more positive in that their roles and duties are explained prior to their appointment.

MO: You know, we've got nursing assistants who can do that, or carrying bedpans and that type of thing which Enrolled Nurses are doing. You know, that is part of their Job Description, so more often than not, you find on a daily basis,

uh, uh, Interpreting probably is, is sort of the bulk of the time that they spend, the most of the time that they spend interpreting and like I said, in the rule, we utilise them, so we'll say, "Okay, this patient just need a, a sugar check".

MO: I think they're perfectly happy to do it, personally. I mean they're trained Nurses, but they don't take blood pressures or do anything. They sit with us and interpret. I mean, they actually switched roles now. They are just...

The system developed and implemented within the CHC highlights the primary role of certain members of their nursing staff that act as a mediator for the medical officers. However, in their case the workload remains the same but this time their priorities are reversed. That is, they firstly assist in mediating after which they are involved in other nursing activities, whether it be blood taking, dressing wounds etc.

N: Because you have to work here. If you have finished your place, you must go to another place to help there again, because of short staff.

N: So we should be in the dressing room helping there and helping in trauma, so we're sometimes always short, but most of the time we are working with the medical officers to help with interpreters, because this is the main thing that we do in the room.

3.7 SUMMARY OF FINDINGS

In summary, the language divide identified and documented in previous research between health care professionals, more specifically medical officers and patients, still exists across all three levels of health care investigated in this study.

To date, no formal policies exist at a national, provincial or institutional level regarding communication in the health sector.

Information obtained from the semi-structured interviews and survey provided much insight into the nature of the current systems implemented at the various health care facilities in an attempt to address this communication barrier. This is summarised below and illustrated in Figure 3.18.

The TH is the only institution within this study that has employed trained interpreters. However, due to the insufficient number of trained interpreters, ad hoc mediators are still required to bridge the communication gap between health professionals and patients. Whilst ad hoc mediators are utilised across all three HCF's, it is only the community health clinic that makes use solely of nursing staff, whereas the tertiary and secondary hospitals in addition to using nursing staff are still relying on other health professionals, patients, friends and family as mediators.

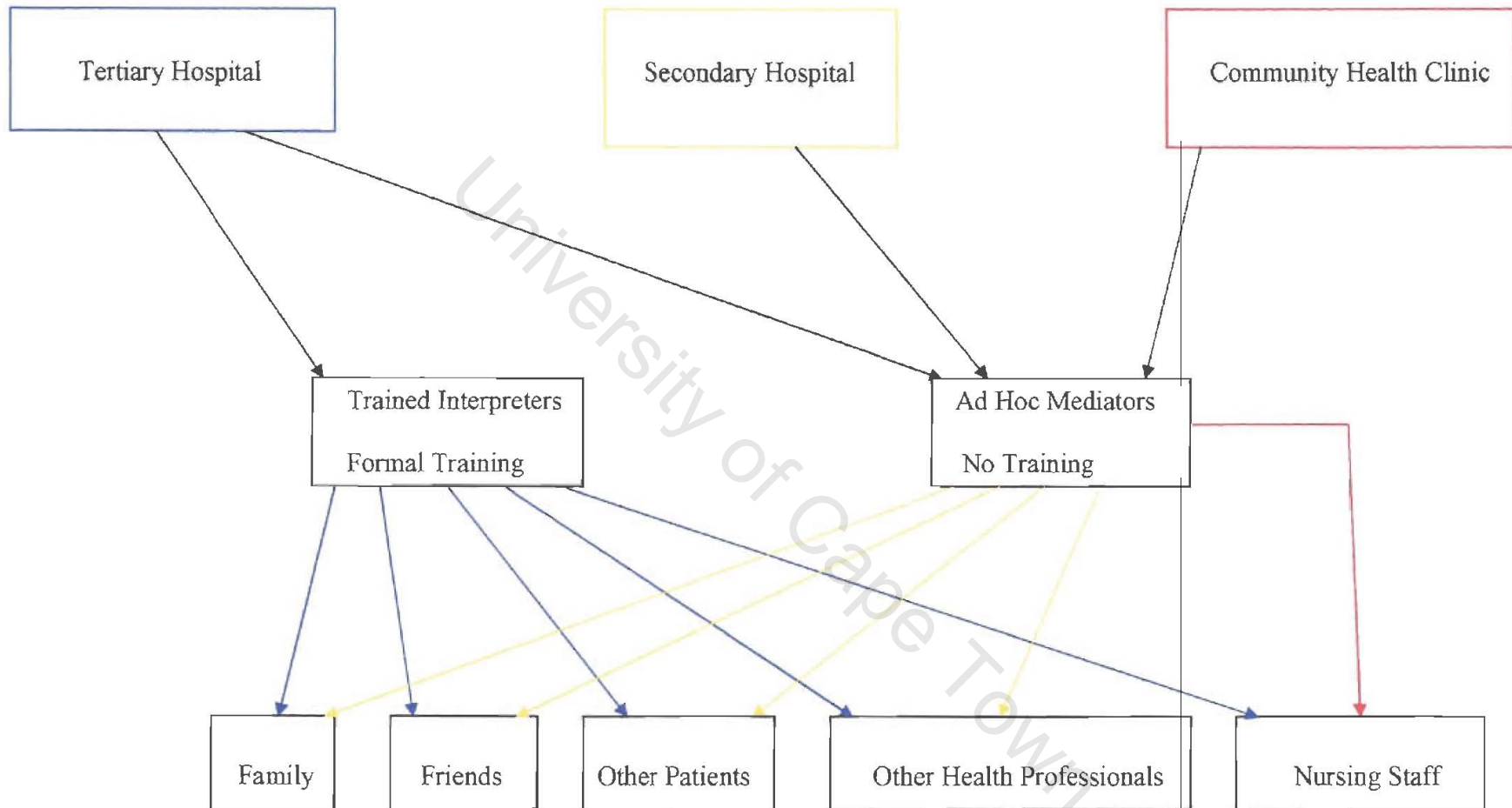


Figure 3.18: Schematic Representation of Current Systems Adopted for Mediated Medical Consultations

Although the racial and linguistic profiles of the nursing staff differed across the three health care facilities, it was still evident that the most common persons used as ad hoc mediators are nursing staff as they are already part of the medical team, thus having the necessary medical knowledge, and they appear to be more readily accepted by medical officers. The larger percentage of nursing staff being isiXhosa first language speakers and acting as mediators at the CHC appear to have resulted in the communication barrier between health professionals and patients being mainly addressed. On the other hand, the fact that the majority of nursing staff are first language English or Afrikaans speakers at the SH and TH, does not allow the nursing staff to play a significant mediating role as at the CHC.

Additional complexities were raised regarding the use of nursing staff as mediators. Although views varied in the secondary and tertiary hospitals, the nursing staff generally expressed that they were not comfortable in mediating in that it was not their job and more importantly they were not trained to do so. Nursing staff reported that they were aware of their lack of skills necessary to guide them when mediating.

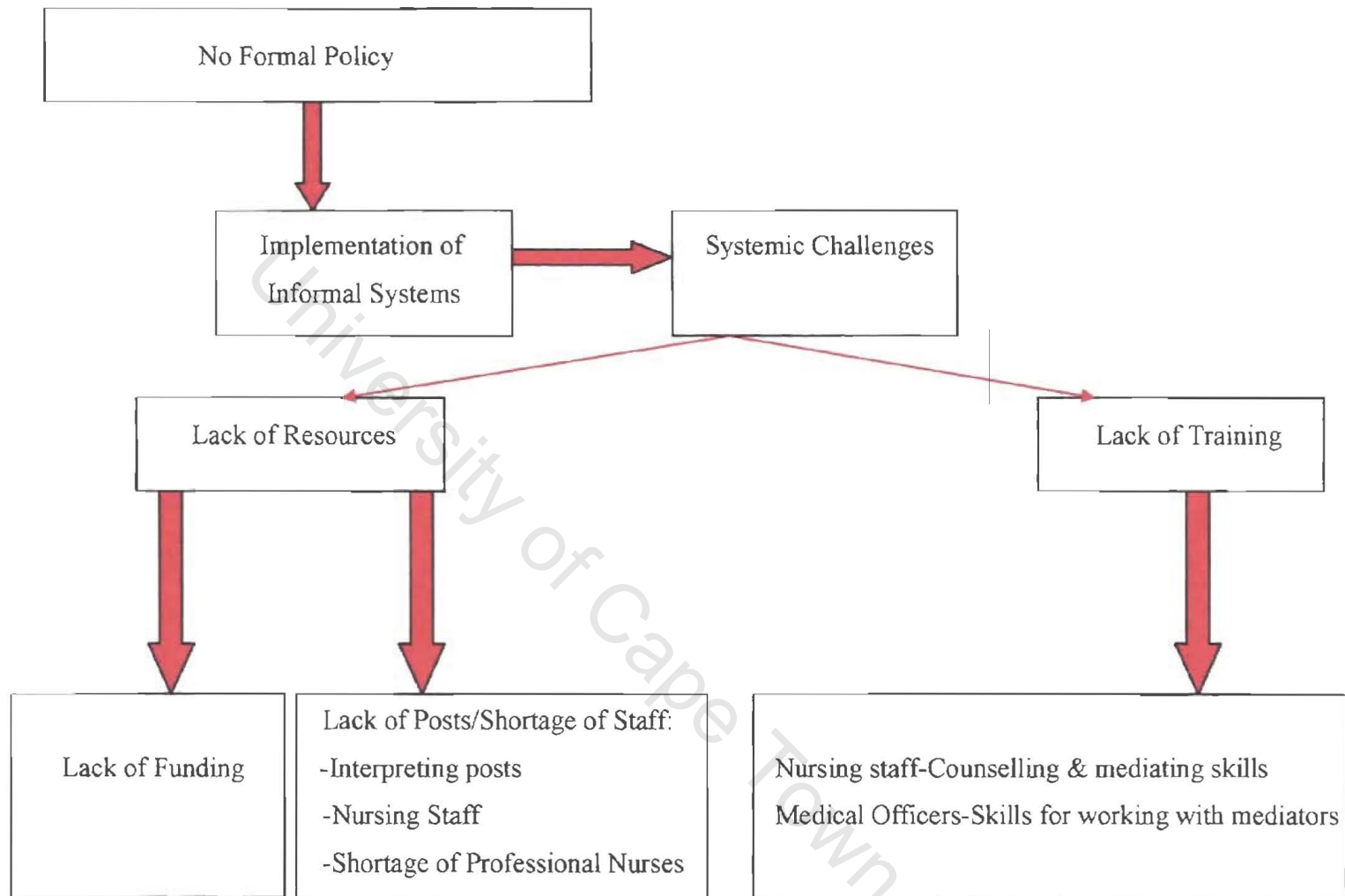


Figure 3.19: Schematic Representation of Current Practice and Challenges

The current formal and informal approaches, processes and mechanisms adopted in the three HCF's are faced with a number of systemic challenges. As is graphically illustrated in Figure 3.19, two primary challenges identified are lack of resources and lack of training.

Currently there is no available funding for the employment of trained interpreters within health care. In addition, as a result of a lack of funding numerous health care facilities are under-staffed. Current nursing staff are reported to be over worked due to the staff shortage and nearing burnout as they are performing tasks beyond their training and capability.

The second systemic challenge is that of lack of training. Although it was evident that nursing staff were used more often as ad hoc mediators, they have to date received no training in mediating skills. Furthermore, medical officers were reported to have received little or no training in working with mediators. Opportunities for health professionals to enhance their knowledge and skills regarding communication and working with mediators are currently not offered by the respective institutions in this study.

4. DISCUSSION

As determined from the results of the interviews and survey presented in Section 3, there is an evident communication barrier between health professionals and patients across all three HCF's. Furthermore, each individual HCF has adopted their own system and approach, which is currently being implemented. Six major themes were identified and were noted to be pivotal issues in the provision of more effective communication in South African health care.

4.1 POLICY AND LEGISLATION

According to the findings of this study, health professionals are unaware of any formal policy or legislation addressing communication in the health sector at a national, provincial or institutional level. This lack of policy undoubtedly results in inadequate delivery of equitable services at the three levels of health care.

Furthermore, within this study the awareness of patients' rights was demonstrated. The implementation of new concepts and policies are important attributes to any institution and bring with it a new dimension and that is 'the rights of patients'. These rights are threefold and include the right of the patient to know what the diagnosis, prognosis and treatment/management is with regards to them or their children, the right to receive medical treatment no matter where their place of residence may be, dealing with real life issues and lastly they have a right to know the medical team who is seeing to their problems. However, illiteracy and communication barriers often hamper such rights and it is thus up to the health professional to intervene and make sure this is being explained by whatever means necessary. Furthermore, the rights of patients were discussed and clearly acknowledged by medical officers, nursing staff and interpreters through interviews and the survey.

As there is no policy, there is a need for policy development that would allow for more access to equitable linguistic services in the context of health care. Clearly, even when there is a well-described need, many facilities fail to deal with language and cultural problems in a formal operational sense (Putsch, 1985). In agreement with

Johnson et al. (1999) the difficulties in matching the language skill available with the patient's need, confirms the need for service models, management processes and policies that would facilitate more effective use of language skills and cultural knowledge in the clinical setting. In addition, they state that there is paucity in the knowledge base required to provide guidelines for effective service provision.

As noted previously, there is no formal policy that addresses language. This supports Swartz (1998), who reminds us that an aggressive language policy can radically change the accessibility of language services. An enormous challenge faces policy-makers with the diversity of the eleven official languages across South Africa; however this reality demonstrates that the inequality across language groups is currently evident.

Complication in language policy formation is the fact that language policy in health is not service driven in terms of what users require to access services. In addition, there are ideological and political struggles expressed through language (Swartz et al., 1997). In a system previously riddled with racism, making language services available in an 'ad hoc' fashion is not sufficient. Although it might grant a certain amount of improved access, it would by no means alter the dominant language structures and discourses in health care that exclude and marginalize both patient and health care professionals (Swartz et al., 1997).

Upon examination of existing language policies in South Africa, it is clear that there is lack of clarity regarding policy issues relating to language. The application of a new language policy without the development of a clear implementation strategy by the government does not reflect an adequate understanding of the importance of the multilingual society, where people are not marginalized by the dominance of any particular language (Heugh, 1995). Reagan (1995) claims that the extent to which current language policy in South Africa aims for equal status across all languages, is not clear. Heugh (1995) indicates that there has been a discernable shift in statement of policy from linguistic integration, a system of drawing together disparate groups to co-exist interdependently to multiculturalism, a system that recognises diversity and issues of power relationships across all languages. Despite this Beukes (1996) has noted that there is a considerable trend towards unilingual practice in public services

in that the government has failed to acknowledge the role of language in access to services and was not taking any steps to remove language barriers to such access. Furthermore, she argues this is due to a variety of factors, including the fact that the role of language in development has not yet been properly deliberated, as well as the assumption that multilingualism leads to increased government expenditure. She concludes that a language policy strategy for public service must be adopted in order to achieve functional multilingualism (Beukes, 1996).

Erasmus (1999) suggests that a comprehensive plan of action be implemented to cultivate a greater awareness of the need for interpreters within health care and in the communities. Empowerment through effective communication is indispensable to the rendering of a good service (Corsellis, 1999a).

4.2 EXPERTISE

From this study it was highlighted that only the TH had trained interpreters employed to mediate multilingual medical consultations. The CHC use nursing staff, and have involved them appropriately in all necessary facets of a mediated medical consultation. Furthermore, the TH and SH use ad hoc mediators on all other occasions. From this study it was found that interpreters, medical officers and nursing staff most commonly used in mediated medical consultations were more efficient if they were exposed to some form of formal training prior to forming part of the mediated interaction, thus allowing for a more natural situation to be experienced.

Expertise in intercultural mediation requires an individual to become confident, competent, and skilled in that endeavour. These findings therefore support Van Dessel (1999), who found that gaining expertise in various fields includes gaining field specific knowledge, being able to put learned skills into practice and acquiring a particular professional attitude through education and training. One's expertise may be enhanced with practice in time and new skills may be gained and improved upon over time. Both the health professional and interpreter/mediator have to be thoroughly familiar with their individual roles (Van Dessel, 1999).

Concurrent with the shift towards greater recognition for the need of mediators in health care, is the need for a better understood and more well defined role and function of the mediator. Several studies have highlighted the frequent expression of dissatisfaction of mediators at their lack of credential and resultant unacknowledged status (Crawford, 1994; Muller, 1994; Drennan, 1998).

As Drennan (1998) suggests, medical interpreting/mediating has been slow to crystallise a clear set of professional expectations, as opposed to other more distinct forms of language practice such as legal interpreting.

Professionalisation of interpreters/mediators refers to appropriate selection, training according to professional standards, accreditation and professional registration of interpreters/mediators (De Ridder, 1999). International trends in countries such as Canada, Australia, Sweden, England and Europe, regarding “community-based” interpreting (CBI) show a tendency towards professionalisation, as well as the formal organisation of CBI services. These services are largely still lacking in South Africa (Erasmus, 2001). Although conference and court interpreting/mediating services have been established in South Africa, there is no coherent or joint organisation of CBI. As noted by De Ridder (1999), professionalisation of interpreters/mediators would guarantee high-quality interpreting/mediating to clients and services, and at the same time ensure status and recognition for interpreters, as well as establishing uniform tariffs.

An important consideration in being educated is that a professional qualification for interpreters/mediators cannot be attained without training (Baker, Hussain & Saunders, 1991). Developing a qualification for interpreters/mediators would allow for the establishment of professional standards and ethics, as well as a means of validating the skills of interpreters/mediators, so they would receive their due recognition (Baker et al., 1991). In addition to training and professionalisation of interpreters/mediators, there is also a pressing need for recognition of the skills that interpreters/mediators have and thus the provision of appropriate remuneration for these skills.

Without systematic training or credentialing, interpreters'/mediators' power and legitimacy is primarily limited to situations in which a medical professional requires cultural brokerage. The development of a clear path for mediators within health care, with opportunities for systematic training and credentialing may resolve some of the problems associated with the role dissonance (Kaufert & Koolage, 1984). Diaz-Duque (1982) strongly urges health care professionals to work with trained interpreters who are familiar with interpreting techniques, patients' rights and the way the health care system functions. However, in the South African health care system working with a trained interpreter is more of a novelty. Medical officers are currently making more frequent use of ad hoc mediators, more specifically nursing staff and to a lesser degree other lay persons.

As mentioned previously, only the TH within this study employs trained interpreters. These interpreters were reported to have completed theoretical modules in their training comprising interpreting, counselling and cultural issues, skills development, health information including health promotion, ethical issues, administration and constitutional affairs (Ntshona, 1999).

It is one thing to be trained as an interpreter, but being employed in the medical world brings with it a whole new dimension and requires the interpreter/mediator to educate themselves regarding the context in which they are to work. The need for interpreters/mediators with field-specific knowledge in medicine, as well as other disciplines has been verified by the observations and comments of several researchers (Marcos, 1979; Kline, Acosta, Austin & Johnson, 1980; Wood, 1993; Drennan, 1996a, 1998).

Due to the formality of interpreting services being unrecognised, the results of this study further support Drennan (1998), who found the role of ad hoc mediating often to be left to nursing staff. Interpreting is thus often viewed by Black nursing staff as an incidental, although daily aspect of their work (Buthelezi, 1992 in Drennan, 1998). To date, nursing staff although expected to fulfil the mediating position, have received no form of training necessary to equip them with the relevant skills necessary for mediating. Therefore it is felt that training should be introduced so as to equip individuals for the various roles they may offer in a mediated medical consultation.

Furthermore, although nursing staff is consistently being used, some medical officers identified problems when nursing staff were used as interpreters and there were conflicting interests of their role, should they be cultural brokers, patient advocates, interviewer, etc (Drennan, 1998). Therefore, there appears to be a need to train those persons who are to mediate medical consultations as well as those involved in the communicative triad so as to develop clear roles of the participants.

Furthermore, it was found that within a medical setting the majority of patients regardless of language, race, creed or colour have difficulty in comprehending the medical terminology often thrust upon them during their medical consultations with a health professional. Often this results in complete confusion that may lead to anxiety.

Jargon is something many health professionals include in their daily consultations that pose a problem for patients and mediators. It is a difficulty that is apparent in any situation where people are unfamiliar with the context and thus require people to be able to either explain it to them in lay man's terms, either directly or by means of a mediator.

Although medical terms may not be understood initially, medical officers are able to explain them in simpler terms. However, when a foreign language is introduced, the explanatory procedure is not so clear in that certain languages and cultures do not have terminology for more current or Western issues or concepts. This is clearly illustrated in isiXhosa where there is not necessarily an isiXhosa equivalent word for certain words used in English and there is a lack of terminology for these concepts (Kaschula & Anthonissen, 1995). Therefore a number of words have been adopted from the English language to isiXhosa. However, the ability to understand and explain that word is a more difficult process. Furthermore, medical officers often do not understand a patient's response or questions as a result of cultural aspects and thus need mediators to explain and elaborate on what the patient's communicative intent is.

As expressed in the interviews, trained interpreters have received some form of formal training that equip them however, further skills were reported to be acquired

through exposure to the medical environment as well as certain unique characteristics such as culture that they bring with themselves, thus providing a more efficient mediating service. However, the training for health professionals in working in a triadic consultation was not evident. This supports Swartz et al. (1997) who have indicated, and seen from the interviews and survey, although there have been various attempts to train interpreters for health services in South Africa, there has been no parallel formal training for health professionals in how to work with mediators. The expertise of health professionals in making use of mediators has been questioned, particularly because health professionals often do not consider the complexity of the mediator's role (Muller, 1994). The traditionally dyadic relationship between health professional and patient becomes triadic and decidedly more complicated, with the presence of a mediator. Swartz et al. (1997) point out that most health professionals do not have training in sociolinguistics and similar disciplines. This lack of training, in combination with the low status of the mediator in South Africa in the context of racial politics, may result in health professionals being unlikely to theorise about the implications of different models of interpreting for the provision of democratic health care (Swartz et al., 1997).

Adequate education should be a prerequisite for all parties involved in communicative interactions irrelevant of any previous education. It is necessary for health professionals to work effectively with mediators, they need not know the kinds of problems mediators have, as well as what to expect from them (Diaz-Duque, 1982; Crawford, 1994; Drennan, 1998). Furthermore, the mediating situation can be further complicated by medical officers who are not cognisant of the inherent complexities of the mediated consultation. Just as mediators need training in specific linguistic skills and counselling techniques, health professionals also need training in the effective use of mediators (Swartz, 1998; Crawford, 1999).

A number of solutions for dealing with language diversity in health care settings have been proposed. Two suggested solutions that were continuously reiterated was that health professionals should learn the indigenous language of their service users (in the case of this research isiXhosa) and the training of more first language isiXhosa-speakers as health professionals to enable direct interaction with their patients.

This supports a number of researchers who have highlighted that health care providers, in an effort to provide an effective service should be encouraged to learn the language spoken by their patients (Baker, Hussain & Saunders, 1991; Ntshona, 1997; Swartz, Drennan & Crawford, 1997; Drennan, 1998; Swartz, 1998). In fact, it has been suggested that all health care providers, and indeed all human service personnel, should have training in one or other indigenous language (Swartz, 1998). In line with these suggestions, health care professionals acknowledge that they need to learn the indigenous language of their region in order to serve their patients adequately, but few have been able to make any progress in this direction (Crawford, 1999).

Since language acquisition as an adult is not easy, sustained high levels of motivation are required, often for years, to reach adequate proficiency and even then insufficient levels of language and cultural knowledge might have been acquired by the health care professional, preventing the interaction with the patient from being satisfactory (Wood, 1993). Swartz & Drennan (2000) state that medical officers' complaints that learning isiXhosa is difficult for English-speakers are justified. However, it should also be noted that although English-speakers have a reputation worldwide for resisting multilingualism, English-speakers are capable of learning other 'difficult' languages if they have to do so (Swartz & Drennan, 2000). Nonetheless, they make an interesting point in querying whether it is worth risking learning a language only to verify what South African socialism has made us feel -- that irrespective of what White health professionals do, they might never understand Black people (Swartz & Drennan, 2000).

As discovered through this study very few medical officers are able to converse in isiXhosa. The health professionals themselves expressed the need to improve their expertise in the field of communication and become more accustomed to the ethnic language and culture of their area. However, although isiXhosa was offered at university to some extent it was extremely informal, sporadic, for a short time period and very specific, not allowing the students to acquire an adequate vocabulary or use of the language.

Evidence regarding the difficulty in training students in African languages has recently been highlighted by Penn (2003). In the training of health professionals in the field of Speech-Language Pathology, a profession concerned specifically with communication aspects, it has in the past been insisted that White students are required to learn an African language for a year of study. Feedback from graduates, their clinical supervisors and a survey from recent graduates from a South African university currently completing their year of community service, indicated that the language they learned was not guaranteed to be the language of the area in which they are working, and the course failed to provide them with relevant linguistic and cultural skills and even the top student was unable to develop the necessary fluency in a year's tuition. It takes more than a language to train them for the skills they need (Penn, 2003).

4.3 RELATIONSHIPS

From the perceptions elicited by the medical officers in this study, it was found that the greater the trust between medical officer and mediator, the greater the willingness of the medical officer to relinquish power. This was evident in that medical officers expressed that they were more willing to relinquish power to nursing staff in that they were already part of the medical team, thus already having sufficient medical knowledge as well as relevant cultural and language competencies to act as mediators.

These findings are in accordance with sociolinguists, who are particularly concerned with the use of language to establish and maintain relationships, as opposed to the use of language purely for the transmission of factual information (Brown & Yule, 1983). This statement clearly distinguishes between interactional and transactional use of language. According to Collier (1989 in Ulrey & Amason, 2001), intercultural communication has become increasingly more important as a result of today's culturally diverse world, as an array of workers have to learn to communicate more effectively with people from other cultures (Schneider, 1993 in Ulrey & Amason, 2001). Clark (1996) describes conversation as an "*'opportunistic' endeavour, in which two or more participants in a discourse work together to towards achieving common goals by constructing, as best they can, a reciprocally held common store of information, the conversational 'common ground'*" (Davidson, 2000, pp. 1273).

Previously, few studies have documented how culture and language impact on the interpersonal interaction of the participants of the interpreted interview. Recently, more studies have examined the complex relationships and group dynamics that exist between the medical officer, patient and interpreter within an interpreted interview, particularly considering South Africa's unique political history (Crawford, 1994; Muller, 1994; Evans, 2000; Fisch, 2001).

From the semi-structured interviews and the survey, the views and perceptions of the health professionals regarding the interpersonal relations in the complex triadic medical consultation involving the medical officer, patient and interpreter/mediator were obtained. Issues relating to trust, power and teamwork were highlighted.

It is proposed that the monolingual, ethnocentric nature of the health care system cannot be examined in isolation but needs to be contextualised within the apartheid-constructed society, where Black voices have been historically suppressed and English and Afrikaans are the languages of power (Fisch, 2001). In addition, it is not possible to isolate the patient, disempowered in terms of the language barrier, from the whole bio-medical discourse in which patients occupy a disempowered position.

The system of power relations operating within the health system as a whole is indeed complex. Within the medical profession, we are confronted with the enormous disparity of power between medical officer and patient, even when the patient comes from the same social class and speaks the same language (Lazarus, 1988). The medical officers are located at the top of the hierarchy, while the patient is positioned at the bottom (Crawford, 1999). When additional language barriers with an isiXhosa-speaking patient and an English-speaking medical officer, as well as differences in culture and social class exist, the power imbalance between medical officer and patients is even further aggravated. This is generally the case in the South African health system.

At this point a third party is introduced to mediate communication, a trained interpreter or an ad hoc mediator, who is often a nurse, a general assistant (cleaner), other patients or family member, and thus further complexities are introduced. The ad

hoc mediator generally receives no recognition, remuneration or training for this complex and demanding task, which involves far more skills than bilingualism. The mediator is having to mediate between two different linguistic and conceptual systems within the rigidly hierarchical structure of medical officer being at the apex of the hierarchy and patients at the bottom, while he or she is located somewhere in the middle, subject to conflicting demands, roles and pressures (Crawford, 1995). The conflicted and ambivalent position of the mediator who is not recognised or rewarded, in the context of medical systems, where race, class and gender intersect to assign the interpreter a lowly position, means that the patient's story is even less likely to be heard than in the case of direct medical officer-patient interaction (Crawford, 1995; Drennan, 1998; Swartz, 1991b).

Miscellaneous opinions are generated when it comes to trust and the relationship that evolves between interpreter/mediator and medical officer. However, this is something that needs to be addressed, since trust forms an integral part of effective communication, as without trust, neither the sender nor the receiver will risk the transmission of an honest message (Lancaster, 1995).

As determined from the interviews and survey, medical officers often present issues regarding the relinquishment of power in a mediated medical consultation. This is more apparent when ad hoc mediators are used. Medical officers felt interpreters/mediators would often launch into lengthy discussions often not involving them and making them feel like an 'outsider'. These interludes in which the health professional was not directly involved, that is the interaction between the mediator and patient appeared to be a means for the mediator to exert authority over the health professional and to take control of the interview. Furthermore, it appeared as a means to even the power balance between mediator and health professional who is historically the more powerful in the interpreted triad (Muller, 1994).

Again depending on who is used to mediate, the status of the mediator as viewed by medical officers may vary. This in turn appears to result in more or less power and to be relinquished by the medical officer. Conflicting ideas develop amongst members of staff as to whether these interpreters/mediators are professional members of the

multi-disciplinary team, and whether they qualified enough in the field of interpreting/mediating to be termed 'professionals' (Drennan, 1999).

As noted by De Ridder (1999), in this view, the unequal quality of service provision is not seen as resulting from incidental communication problems due to differences in language and culture, but from power inequities, relating to gender, class, ethnicity and religion. Communication can be an important tool for consolidating power through subtle mechanisms, such as withholding information, oversimplifying, decontextualising, disqualifying information and adopting prejudicial, patronising attitudes (De Ridder, 1999).

Therefore, trained interpreters and nursing staff that are used as ad hoc mediators are seen to form an integral part of the medical team without which medical officers may not have been able to provide efficient and effective duties to their patients. Wood (1993) proposes that this model of partnership is ideal, since both the clinician and the interpreter have specialised knowledge to offer the patient and thus functioning as a team will allow the patient to receive optimal care.

Trained interpreters that are employed by the TH were reported to generally form part of the medical team and medical officers were reported to feel comfortable in engaging with them in their medical consultations. They implied that the trained interpreters understand the confidential and ethical code that is expected of them and hence they are viewed as part of the professional team. It appears that medical officers are more willing to hand over power to nursing staff as they form part of the medical team and are thus acquainted with the necessary terminology and knowledge as well as being inducted to the health care systems code of ethics.

Drennan (1998) acknowledges that interpreters are invariably subject to the stresses on fulfilling a function from which there is a lack of definition. These roles include, the interpreter as a 'linguist', a 'cultural broker', 'a patient advocate', 'an interviewer', 'a member of the team', 'an assistant', 'a supporter' or an 'interpreter within an institution'. The kind of interpreter one likes working with is quite a personal taste. While some people prefer the interpreter to interpret their message verbatim, others prefer it when the interpreter acts as a cultural broker. However, this

should be in a set domain. This is viewed to support the patient in understanding the message more clearly.

4.4 RESOURCES

As was clearly determined from the findings of this study, all three health care facilities are severely under-resourced in terms of funding, posts/shortage of staff and the necessary training of health professionals and mediators when forming part of a mediated medical consultation. The lack of such resources inhibits the potential services these HCF's have to offer the community.

As mentioned previously, two systemic challenges were identified and were found to act as barriers to establishing more equitable linguistic access within health care. These are limited resources, that is, lack of funding and shortage of nursing staff, and the current lack of training of health professionals regarding communication issues and cultural sensitivity.

These findings advocate Lehmann & Sanders (2002, pp. 1), who stated that "*it is almost true that human resources determine the success or failure of health sector transformation*". In South Africa the National Assembly Portfolio Committee on Health expressed concern regarding the "*lack of synergy between National Department of Health's policies and the implementation thereof in the respective provinces*" as well as the fact that successful health sector reform hinges on its human resources (Lehmann & Sanders, 2002, pp. 1).

Staff salaries form the largest part of the recurrent budget and thus is a major object of restructuring related to funding of health services and resource allocation (Saltman & von Otter, 1995 in Martinez & Martineau, 1998). With this being the largest item on the repeated budget, it is a palpable target for government-aimed reforms aimed at reducing costs (Martinez & Martineau, 1998).

Government resources are severely constrained (Thomas, Muirhead, Doherty & Muheki, 2001). Thomas & Muirhead et al. (2001) stated that the current financial arrangements restrict resource to the health sector at a time of need, and limit the

focus of resource allocation. It is proposed by the researcher that there is insufficient funding to support the amount of trained interpreters required to address the needs of indigenous language speakers within the health sector.

As determined in this research and previously by Drennan & Swartz (2002), there are no official posts for interpreters in South African health care. This is primarily as a result of two issues namely due to financial constraints and the lack of recognition for the importance of addressing equitable linguistic access within health care.

Although it is appreciated that the health sector is experiencing severe financial constraints, this issue can no longer be the means of sidelining the importance of linguistically equitable service provision in health care.

Furthermore, although a number of health professionals report that communication is a vital process in the world of health, this may not be true in its entirety in that when lobbying and filling of posts arises, it is more likely that a nursing staff member will fill that post due to the current shortage of nursing and medical staff and not by that of an interpreter/mediator.

Results from the interviews showed that there is a lack of posts in health care and therefore, interpreting posts are less likely to be considered. Furthermore, where trained interpreters are employed, issues such as workload, working hours, etc hinder adequate services. Thus, lack of time and resources is often cited as the reason for inadequate health care. However, as Crawford (1999) suggests, this shows extreme shortsightedness on the side of health professionals. Therefore, health care facilities are required to opt for a more feasible and sustainable system that provides a service to their clients when the need arises.

If the health system is to become more accessible, legitimate and effective, the political will to address these communication barriers will have to be found. Lack of time and resources is often cited as the reason for inadequate health care. However, as Crawford (1999) suggests, this shows extreme shortsightedness on the side of health professionals. It is clearly a multi-faceted problem that has to be conceptualised in a

more global way than merely the provision of interpreters, although this is clearly indicated.

Considering the serious financial constraints within the South African health care system, one of the most feasible, sustainable and cost-saving options may be the utilisation of different staff mixes to provide services (Martinez & Martineau, 1998). More specifically using nursing staff for example, since employing a trained interpreter may be more costly than providing a bilingual nurse with the necessary skills for mediating.

However, there is currently much debate over who are suitable candidates to train. Thus, although it is obvious that interpreters/mediators are needed, it is not as clear who should be doing the interpreting within a mediated interview, should they be individuals brought into the institution specifically for interpreting/mediating, or should it be those individuals who already form part of the medical team. What sort of training is then appropriate for that interpreter/mediator.

The *add-on approach* refers to the use of existing personnel as mediators. Swartz et al. (1997) believe that this practice would be favourable to policy makers, since it would require no additional funding, and because it would institutionalise what has been proven to be an existing practice. However, it is proposed that this approach might not be optimal, unless the existing personnel are trained in interpreting skills. The training of existing staff might prove to be less financially draining than training and employing new interpreters/mediators.

Although nursing staff are most frequently used to mediate, by training them to mediate alongside their nursing duties is further affected since, there is no available nursing staff to fill the vacant posts of the crippled health system. South Africa is currently experiencing a nursing shortage and a shortage of other health care workers as well as supplies necessary for caring for patients (Thompson Jackson, 2003). In addition, South Africa is experiencing a 'brain drain' due to the number of professionals leaving because of working conditions and low pay (Thompson Jackson, 2003). These working conditions could possibly be linked not only to

community setting, but to jobs that lead to burnout due to being short-staffed as well as the performing of services such as mediating that one is not trained to do.

There is currently a shortage of skilled nursing staff in South Africa, with more than 30 000 vacancies. However there is not nearly enough nursing staff being trained to fill these posts (Cape Argus, 2003). The findings from this study further support Swartz & Drennan (2002) who found the use of ad hoc mediators in South African health care settings to be a common occurrence.

Whilst using nursing staff to act as mediators is an extremely powerful tool, it puts increasing demand on them. Furthermore, using a service model similar to that adopted in the CHC of this study, perhaps the increased employment of nursing assistants, who may provide nursing support in addition to acting as a mediator is a model that needs to be seriously considered across the secondary and tertiary levels of health care in the future.

However, it is still proposed that funding should be made available for the employment of central interpreting service for languages that are not official in South Africa, so as to provide the necessary and appropriate communication for patients attending the HCF's for outside of South African borders.

Whilst the nursing staff are equipped with excellent nursing skills, they have not received the necessary formal training to act as mediators in medical consultations although used on a regular basis.

On the contrary, Erasmus (2001) recommends training lay mediators who are already involved in interpreting/mediating within health care, so that they are familiar with the health care setting, and have realistic expectations of what their duties will be. Thereafter, she suggests entering into negotiation with authorities, offering training courses, career path and job recognition for these interpreters/mediators, thereby allowing them to establish themselves as interpreters/mediators (Erasmus, 2001).

Swartz et al. (1997) propose a *cultural change model*. Due to the complexity of issues involved, an eclectic approach is required. They state "*what we need is an*

analytic approach to understanding both the factors which will enable developments in changes in language practices and those which are unlikely to inhibit such changes" (Swartz et al., 1997, pp. 175). This implies that any investment in changing organisational practices with respect to language necessitates investment in dealing with the issues involved with such change. They highlight the importance of providing support for health professionals to think through language issues and for re-framing some of the challenges that language diversity poses into manageable portions, and support national context for local changes within an enabling framework, rather than a set of inflexible prescriptions.

It is proposed that public institutions should realise that it is a basic human right to afford patients services in the language of their choice, and infringement of this right is paramount when service providers cannot speak the languages of their patients. Swartz et al. (1997) propose that the transformation process can be facilitated by changes such as the following: it should be regarded as unethical not to offer interpreting services if a patient cannot communicate without one, the circumstances under which an interpreter is present should be defined, and multilingualism should form part of the training of all health care professionals. Finally, it is suggested that people need to work together as a united front (Erasmus, 1999).

South African health care facilities are confronted with a wide variety of critical issues. The solutions and strategies that address these issues are addressed around the skills of numerous people, therefore it is the health professionals and other health care facility staff members that ultimately determine the success of these responses (Elbert & Smith, 1990).

Workloads continue to be a controversial issue, particularly in community health care settings (Lehmann & Sanders, 2002). This includes workloads experienced by the entire spectrum of health professionals as well as other hospital staff.

However, within the three HCF's, nursing staff were reported to experience an extremely busy workload mainly as a result of being short-staffed. Workload is not merely a question of individual nursing staff's efficiency and productivity, although they are contributing factors that need to be considered, but is determined by

fundamental contributing factors that include location, size, staffing levels, infrastructure and resourcing (Lehmann & Sanders, 2002). Depending on the HCF one is employed at, the workload and working itinerary may vary, as to what is expected from them. With nursing staff, irrelevant of ranking, being used more frequently as mediators in their respective HCF's, their workload capacity is constantly being heightened. Research is presently under way at clinics in the Cape Town vicinity that aim to explore qualitative aspects of workload of which includes the impact of infrastructure and skills (Lehmann & Sanders, 2002). However, many conflicting views arose regarding using nursing staff used as mediators.

Interestingly the feelings amongst nursing staff varied across the three HCF's, depending on where their HCF was situated as well as the population they serve. As is evident from the attitudes and perceptions of nursing staff from the three HCF's, nursing staff from the CHC who have a primary duty of mediating are more willing to assist in mediating than that of nursing staff from the TH and SH. This supports Lehmann and Sanders (2002), who noted that it can be seen that depending on health care settings the focus of tasks among nursing staff may vary. For example, in one setting health care workers may be able to concentrate on their core responsibilities drawing on other support, whereas in another setting nursing staff have to take on other roles (Lehmann & Sanders, 2002).

This reluctance is often as a result of senior nursing staff perceiving their colleagues not to be trained in interpreting and if being used to mediate, it affects their duties. It can thus be seen that nursing staff are currently experiencing what can be termed as 'transformation fatigue' and confronting these challenges is dependent on human resources, and it is felt that action must be taken (Lehmann & Sanders, 2002).

"Coherent and comprehensive human resource strategy for the health sector is urgently needed" (Lehmann & Sanders, 2002 pp. 7). New emphasis on primary health care in the 1980's meant that new skills for better planning and management of health care are required (Martinez & Martineau, 1998). The researcher proposes that empowering a target group of health professional, changing their behaviour, improving current skills, or acquiring new ones are necessary support reforms, as they are often resistant of change (Martinez & Martineau, 1998).

Research has demonstrated that the communication behaviours of health personnel can be modified effectively and demonstrably after appropriate context-specific training (Penn, 2000; Rollnick et al., 2002).

To date, the acquisition of communication skills has been largely neglected in both the training and functioning of public service professionals (De Ridder, 1999). Even within the academic fields underpinning these professions, little or no attention has been paid to communication skills in general, let alone to the skills pertaining to the complex field of intercultural communication. Considering the existing 'ad hoc' status of interpreting services countrywide, there is a growing awareness that medical officers need to accept some responsibility for their interaction with interpreters and learn to work with them efficiently.

In line with the Minister of Education, Kader Asmal's call for educational institutions to show commitment to and implement transformation agendas, a response has been noted nation wide and training students representative of the population demographics is indeed being attempted. As Ncayiyana (1999) has indicated, one of the greatest challenges faced by all medical schools today is to find academically qualified Black students for admission to the medical curriculum. Thus, although these aspects are changing as the country continues its political and albeit lagging economic transformation, it is anticipated that the training and employment of health professionals who are first language isiXhosa-speakers, or even the teaching of indigenous languages with any level of proficiency, will not be a speedy process and thus the impact will not be immediate.

Furthermore, the issue of power in medical consultation relationships between the more highly educated and more qualified individual. Therefore, these constructs highlight this need for more effective communication to be supported by the implementation of a policy that addresses these issues along with training programmes to support the individuals involved. Even if transformation is successful in training health professionals representative of the linguistic and cultural communities in South Africa, it is quite likely that interpreting services will permanently be needed in this multilingual, multicultural nation.

The investment in the appropriate training of health professionals should provide good outcomes for effective communication and can be measured in tangible benefits for the patients, medical officers and the institution.

Especially considering the burden of disease currently being faced in South Africa including the rising epidemic of numerous diseases. This poses a formidable challenge to researchers and medical officers. Communication effectiveness is pivotal to each aspect of prevention and management including issues around education, explanations of testing distributing biomedical information, informed consent in clinical trials, participation in vaccine trials, patients' understanding of treatment protocols and compliance with voluntary counselling and testing and providing support and guidance in problem solving and decision making for the patient prior and post testing (Stein, Steinberg, Allwood, Kartaedt & Brouard, 1994).

The need for an emphasis to be placed on communication within the health setting is long overdue and is a prerequisite for the effective delivery of equitable access to service.

Effective communication has vital benefits for the patient, which includes increased accuracy of diagnosis, understanding of treatment, adherence to treatment/research protocols, greater satisfaction and greater likelihood of returning for follow-up treatment. Furthermore, patients demonstrating valid informed consent show decision satisfaction (as opposed to regret), and decreased stress and anxiety (Baker et al., 1996; Baker et al., 1998; Thom et al., 2001; Browner et al., 2003; Flores et al., 2003).

Potential benefits for the medical officer include increased speed and efficiency, more accurate diagnosis, less stress and burnout and in turn greater job satisfaction, less dependence on costly diagnostic tests (Maguire & Pitceathly, 2002; O'Leary et al., 2003). Institutions benefit from effective communication, as they are likely to experience less turnover of staff, financial savings and arguable most importantly, they comply with the legal and ethical obligations of providing equitable services to patients (Tang, 1999; Davidson; 2000; McIntyre & Gilson, 2002).

Concurrent with this need for trained interpreters or mediators (e.g. nursing staff) is the institutions' commitment to a general strategy of changing to a more culturally sensitive patient-centred model of care. This will result in medical officers relinquishing degrees of power in certain instances. However, the renouncing of power is associated with trust that is more likely to occur with other members of staff. This supports Crawford (1999) who suggests, that changing to a more patient-centred model of care will involve medical officers having to relinquish some degree of power and control within medical interviews. In addition, a consideration of the provision of linguistically equitable services should be embedded in an overall strategy to create and deliver culturally appropriate and equitable services to all patients.

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5. CONCLUSION & IMPLICATIONS

In conclusion, this study set out to examine and document current practices of communication between health professional and patient across the three levels of health care. This study is believed to be necessary and timeous in that firstly, it was conducted at a time in which major restructuring and policy changes have occurred over the past decade within South African health care. Secondly, although there is no policy available that addresses communication in health, the issue of language accessibility is currently being addressed by the Department of Arts and Culture. Lastly, it is hoped that the findings of this study can be used in conjunction with the findings from large-scale collaborative research project currently being undertaken in South Africa which is addressing communication issues pertaining to health with a focus on the health professional and training. Hopefully, the findings of this research together with the findings from the above-mentioned project, as well as other current research, will collectively inform policy regarding linguistic accessibility in the health sector.

This study was conducted within an economic, political and social framework incorporating aspects relating to:

- formal policy and legislation
- the transformation of health care, that is noting the many changes that have occurred in the South African health care system, more specifically moving towards a primary health care system that focuses on achieving more universal integrated access to health care
- organisational structures and processes which facilitate or hinder effective communication
- available resources including funding and human resources
- systemic structures and processes which facilitate or hinder effective communication
- an attempt to understand the social and political constructs and relations between health professionals and patients within the current health care context.

The main findings from this study are presented below.

Clearly there is still a wide communication barrier between medical officers and patients across all three levels of health care. A major finding of this study was that there is currently no formal policy or legislation within the health sector regarding the provision of linguistic and cultural accessible services between health professional and patient. It is believed that research of this nature may be used to inform policy, which will be in line with the current health care reform in South Africa and the constitutional rights of its citizens. Furthermore, appropriate linguistic and cultural services should be a priority owing to the current burden of illness being facing South Africa.

Furthermore, there appears to be no formal policy at an institutional level regarding the delivery of equitable services. It is at the different levels of health care that a large disparity is evident between health professional and patient. As can be seen from the results, the majority of patients that attend these HCF's are first language isiXhosa speakers. However, a marked discrepancy is noted amongst health professionals. The majority of medical officers across the three HCF's are not first language isiXhosa speakers. Furthermore, nursing staff are also often not the same mother tongue as their patients however, this difference decreases at a CHC level.

Marked differences across the three levels of health care were noted. Medical officers appeared to be the same with regard to language status across all three levels of health care. The majority were first language English or Afrikaans speakers. However, as noted above, the racial and linguistic differences across the nursing population varied considerably across the three health care settings. Hence patient accessibility to linguistic services in health care differed depending on the HCF they attended.

One hundred percent of nursing staff employed at the CHC are first language isiXhosa speaking and are able and willing to act as mediators. Furthermore, effective communication at this HCF is seen as a priority. Although this is an informal approach, the CHC has adopted a system that is efficient and attends to their homogenous patient and nursing staff population. At the SH one third of the nursing staff are isiXhosa first language speakers. Due to the evident communication barrier

within the SH, and since no system has been developed, medical officers rely heavily on ad hoc mediators for medical consultation. Within the TH only 15% of nursing staff are first language isiXhosa speakers. The TH attempted to address the issue of a communication barrier with the employment of two trained interpreters. This was found to be clearly insufficient. As a result of the language diversity and the low interpreter-medical officer ratio ad hoc mediators were reported to be used. Furthermore, as can be seen from the results, the percentage of first language isiXhosa speakers becomes more widespread as one moves to more primary levels of health care. Therefore as can be noted, the CHC, unlike the SH and TH, has addressed this communication gap well by involving nursing staff, more particularly nursing assistants as playing a critical role in mediated medical consultations.

Furthermore, two systemic challenges were found to be barriers to the implementation of effective communication systems at the HCF's. These included the lack of resources regarding effective communication in health, more specifically, the lack of financial constraints or lack of funding and the lack of training across health professionals were evident in South African health care.

The serious lack of resources highlighted by the informants of this study in terms of funding and human resources leads the researcher to support the *add-on approach* originally proposed by Swartz et al. (1997). Since health care systems in South Africa are under financial constraint, it is proposed that existing resources within the establishment be used so as to utilise resources appropriately. Furthermore, since there are no posts allocated to trained interpreters, it is proposed by the researcher that based on the sustainable service model at the CHC, the use of nursing staff (nursing assistants) as mediators is a viable and sustainable option in that they are able to communicate effectively in isiXhosa. Thus by providing them with skills necessary for mediating, they may provide a beneficial service.

The use of nursing staff brings with it numerous complexities namely, current racial/linguistic profiles of the nursing population across the three levels of health care, nursing staff are currently experiencing work overload, the need for clearly defined job descriptions, lack of training within field of mediating and communication

and whether it should indeed be nursing assistants or nursing professionals that should be trained as mediators.

However, should such options be utilised towards developing policy within the health sector or within each institution, clearly the need for training is highlighted; not only the training of nursing staff, but the training of medical officers. It is proposed that without such training the sustainability and the implementation of the policy cannot be supported. Furthermore, this training should include a continued drive towards patient-centred care. In turn this would allow for a team approach to develop.

A number of patients attend these HCF's are from outside the borders of South Africa, and thus experience a communication barrier with the health professional. However, in such cases nursing staff are generally unable to act as mediators. The researcher therefore proposes a central system whereby a group of mediators representative of a wide array of languages is established and contactable from a central base.

It was further evident from this study that systems work differently depending on context. It was found that certain contexts have supra-variables that translate down into significant, meaningful indices of satisfaction. Therefore, the development of a system in one context that works effectively may be less successful in another context. Thus the need for context specific training is crucial in the implementation of such systems.

This study differs to past research in a number of ways. It attempted to incorporate the more recent restructuring of the health system and examine practices in communication across all three levels of health care. It reflected the views of management as well as the health professionals, providing greater insight into organisational structure. Unlike past research it did not focus on the communicative act per se but still reflected on the social and political issues and perceptions of medical officers and nursing staff looking at aspects of demographic information, policy and legislation, current practice, expertise, relationships and resources.

Speech-Language Pathology has extended beyond syntax and semantics over the past few years, and has led to the inclusion of functional communication and language in use, which is evident in all realms of life. Due to their knowledge and understanding of effective communication, Speech-Language Pathologists are believed to be good facilitators and play a vital role in driving the training and research of more effective communication in health.

The use of both qualitative and quantitative methods of data collection was found to be complementary. Qualitative data was found to be particularly effective when used simultaneously with other methods of research such as quantitative data collection to get additional perspectives on the problem. Furthermore, in using differing research methods as a means of addressing similar issues, findings were often supported and confirmed and the information obtained is expanded. The survey provided a broader perspective of the findings whereas the qualitative methods provided more in-depth, rich information. Hence the researcher proposed that the findings of this study may be adopted with confidence and reflects current practice across various levels of health care.

The lack of formal statistics available at each health care institution as well as at a provincial level was limiting.

Numerous theoretical and applied implications arose from this study. By capturing language issues at source, which includes emphasizing dominant language patient versus health professional groups. This is critical in addressing effective communication. This would in turn affect the relevant development of language policies. From this various HCF's would develop systems appropriate to their individual needs and train all parties involved in mediated medical consultations. Hopefully the findings from this research may be used in collaboration with other current research on informing the development of policy, more specifically policy addressing linguistic accessibility in health care.

Furthermore, there is a need for training in which health professionals, both medical officers and nursing staff, are provided with the necessary skills to facilitate more effective communication.

Numerous future research options emerged from this study.

Firstly, should a policy be developed and implemented, it will be necessary for it to be evaluated. Secondly, the attitudes and perceptions of patients would provide interesting and critical results in that they are ultimately being affected. Thirdly, further research is needed in the area of training. That includes research aimed at developing training programmes and guidelines necessary for informing health professionals, both those mediating as well as the third party involvement. Thereafter, it will be necessary to evaluate any training programmes introduced. Fourthly, for relevant research to be undertaken, it will be necessary to record the language status of health professionals and the populations they serve at the various levels of health care. Lastly, in a society as diverse as South Africa, the provision of culturally and linguistically appropriate services should be a top priority and warrants ongoing future research.

“What is important is relevant research and research that targets policy makers and managers as consumers. South Africa also needs to invest time in face-to-face communication of research findings, and not rely on passive paper-based dissemination” (Connolly, 2002 pp. 4).

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8. APPENDICES

8.1 Appendix 1 – Written Documentation

WRITTEN DOCUMENTATIONS

Department of Arts and Culture: National Language Policy Framework, Final Draft, 13 November 2002

Departments of Arts and Culture: Implementation Plan: National Language Policy Framework, Draft, 13 March 2003

Relevant Sections on Language Provision within the 1993 Constitution of the Republic of South Africa

Relevant Sections on Language Provision within the 1996 Constitution of the Republic of South Africa

8.2 Appendix 2 – Questionnaire Administered to Medical Officers Across the Three Health Care Facilities

University of Cape Town



Division of Communication Science and Disorders

School of Health and Rehabilitation Sciences

Faculty of Health Sciences

F46 Old Main Building, Groote Schuur Hospital

Observatory 7925

Telephone: 406-6313

Fax: 406 6323

My name is Taryn Schwartz, I am a Speech-Language Pathology student currently completing my Masters degree.

This research project forms part of a larger study that focuses on communication in health funded by SANDPAD. This larger project involves collaboration with University's of Cape Town, Witwatersrand and Stellenbosch.

Thank you so much for participating in my study, this questionnaire should not take more than 5 minutes to complete.

This research project has been approved by the superintendent of your Health Care Facility and ethics approval has been obtained at both a university and hospital level.

It is important to note that all questionnaires are anonymous and will remain confidential.

Questionnaire for Doctors

Communication in Health

Thank you very much for participating in this research project and completing this questionnaire. Your opinions will assist us in understanding the challenges that health professionals may face in terms of cultural in linguistic barriers when providing medical care to persons of another culture and language than their own.

Please mark appropriate boxes with an X.

SECTION A TO BE COMPLETED BY EVERYONE

1. Name of Health Care Facility

Red Cross Hospital	G F Jooste Hospital	Khayelitsha Day Hospital
--------------------	---------------------	--------------------------

2. Position at Institution

Superintendent	Head of a Clinic	Medical Consultant	Medical Officer	Registrar	Community Service
----------------	------------------	--------------------	-----------------	-----------	-------------------

3. Years of service at current Health Care Facility

<2 years	2-5 years	5-10 years	>10 years
----------	-----------	------------	-----------

4. Sex

Male	Female
------	--------

5. Rate your competence/proficiency in conversing in the Xhosa language

Very Poor	Poor	Average	Good	Very Good
-----------	------	---------	------	-----------

6. Mother tongue / first language

English	Afrikaans	Xhosa	Other African Language	Other Foreign Language
---------	-----------	-------	------------------------	------------------------

SECTION B
TO BE COMPLETED BY EVERYONE

1. Are you aware of either a national, provincial or hospital policy that focuses on the use of interpreters in health care?

Yes	No
-----	----

2. If yes, which policy are you aware of?

National Policy	Provincial Policy	Hospital Policy
-----------------	-------------------	-----------------

3. Is there a copy of a policy or management guidelines for use of interpreters (trained or ad hoc) for health professionals at your health care facility?

Yes	No
-----	----

4. If yes, is the copy of the policy or management guidelines easily accessible to all personnel involved with patient-health professional interaction at your facility?

Not at all	Fairly accessible	Accessible	Very accessible	Extremely accessible
------------	-------------------	------------	-----------------	----------------------

SECTION C

1. Is an interpreting service offered at your Health Care Facility?

Yes	No
-----	----

2. Do you make use of the...

Trained Interpreters	Ad Hoc Interpreters	Both
----------------------	---------------------	------

If you make use of trained interpreters ONLY complete SECTION C, if you make use of ONLY ad hoc interpreters complete SECTION D. If you use BOTH trained and ad hoc interpreters, complete SECTIONS C AND D.

3. The interpreting service provided, is accessible...

During working hours only	24 hours daily	After hours	No service provided
---------------------------	----------------	-------------	---------------------

4. If working hours only, who is used to assist both patients and health professionals after hours?

5. Have your interpreters received any formal training?

Yes	No
-----	----

6. If yes, specify where possible what training?

7. Is there a formal process in obtaining the services of an interpreter?

Yes	No
-----	----

8. If yes, is it a formal system prescribed by management?

Yes	No
-----	----

9. If no, do you simply use whoever is most readily/easily available to you at any given time?

Yes	No
-----	----

10. Do certain departments obtain precedence with regards to receiving an interpreter?

Yes	No
-----	----

11. How often do you make use of an interpreter

Never	Infrequently	Sometimes	Frequently	All the time
-------	--------------	-----------	------------	--------------

12. How do you view the interpreter you use with regards to status, do you see them as...

Part of the medical team	A middle man	Part of the patient unit
--------------------------	--------------	--------------------------

13. How accessible are interpreters in your health care facility?

Not at all	Fairly accessible	Accessible	Very accessible	Extremely accessible
------------	-------------------	------------	-----------------	----------------------

14. Please list the main areas your patients come from and the languages they generally speak.

Area	Language patients speak

15. Please list the areas and the languages the health professionals (your colleagues) in your Health Care Facility – i.e. what you are aware of.

Area	Language health professionals speak

SECTION D

1. Since no service is provided, who is used to assist you in communication between the patient and yourself? In addition, please indicate the approximate percentage of how often you use the various persons.

No-one	Nurses	Family/friends of patient	Cleaning staff	Other health professionals
None	None	None	None	None
1-20%	1-20%	1-20%	1-20%	1-20%
21-40%	21-40%	21-40%	21-40%	21-40%
41-60%	41-60%	41-60%	41-60%	41-60%
61-80%	61-80%	61-80%	61-80%	61-80%
81-100%	81-100%	81-100%	81-100%	81-100%

2. How do you view the interpreter you use with regards to status, do you see them as...

Part of the medical team	A middle man	Part of the patient unit
--------------------------	--------------	--------------------------

3. Please list the main language your patients speaks and approximate the percentage (i.e. what you are aware of)

Language patients speak	Approximate Percentage of those speakers

4. Please list the main languages the nursing staff in your Health Care Facility speaks as well as the approximate percentage (i.e. what you are aware of).

Language Nursing Staff speak	Approximate Percentage of those speakers

5. Please list the main languages the medical doctors in your Health Care Facility speak as well as the approximate percentage (i.e. what you are aware of).

Language Medical Doctors speak	Approximate Percentage of those speakers

SECTION E
TO BE COMPLETED BY EVERYONE

1. Have you as a health professional conducting the consultations worked with interpreters (trained/ad hoc) before?

Yes	No
-----	----

2. How competent do you feel working with an interpreter?

Very Incompetent	Fairly competent	Competent	Very competent	Extremely competent
------------------	------------------	-----------	----------------	---------------------

3. Do you personally experience a communication barrier between yourself and the patient (Xhosa/African or foreign speaking)?

Yes	No
-----	----

4. Do you personally experience a cultural barrier between yourself and the patient (Xhosa/African or foreign speaking)?

Yes	No
-----	----

5. Do you think that every patient has a right to receive treatment in his/her language of preference/mother tongue?

Yes	No
-----	----

6. If yes, are patients who speak a different language to the health professional examining them always offered an 'interpreter' at your health facility?

Never	Infrequently	Sometimes	Frequently	All the time
-------	--------------	-----------	------------	--------------

7. Do you think patients feel at ease/happy when a third party is introduced into their consultation?

Never	Infrequently	Sometimes	Frequently	All the time
-------	--------------	-----------	------------	--------------

8. If you use nursing staff, how do you think they feel working as an interpreter, being called away from their line of work?

Annoyed	Fairly annoyed	Helpful	Very helpful	Extremely helpful
---------	----------------	---------	--------------	-------------------

9. Does using a nurse affect the running of the health care facility in any way e.g. back log in patients being seen etc.

Never	Infrequently	Sometimes	Frequently	All the time
-------	--------------	-----------	------------	--------------

10. Do you think it is ethical to use ad hoc interpreters?

Yes	No
-----	----

11. I feel the interpreters role as part of the team is ...

Not important	Fairly Important	Important	Very Important	Extremely Important
---------------	------------------	-----------	----------------	---------------------

12. How proficient is the field specific knowledge of the interpreter(s) that you use?

Not very proficient	Fairly proficient	Proficient	Very proficient	Extremely proficient
---------------------	-------------------	------------	-----------------	----------------------

13. How do you feel the interpreter gathers and imparts information to the patient?

Very Poorly	Poorly	Average	Well	Very Well
-------------	--------	---------	------	-----------

SECTION F
TO BE COMPLETED BY EVERYONE

1. Are you currently engaging in any workshops, activities, courses, etc to assist you in overcoming the communication barrier you may experience with your patients?

Yes	No
-----	----

2. If YES, please list

3. Does your Health Care Facility provide any opportunity in which to enhance your knowledge and strategies with regards to communication and culture?

Yes	No
-----	----

4. If yes, what do they offer?

5. What 3 things can you suggest that can assist health professionals and your respective Health Care Facilities in bridging this 'communication gap'?

**8.3 Appendix 3 – Questionnaire Administered to Nursing Staff Across the
Three Health Care Facilities**

University of Cape Town



Division of Communication Science and Disorders

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My name is Taryn Schwartz, I am a Speech-Language Pathology student currently completing my Masters degree.

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Thank you so much for participating in my study, this questionnaire should not take more than 5 minutes to complete.

This research project has been approved by the superintendent of your Health Care Facility and ethics approval has been obtained at both a university and hospital level.

It is important to note that all questionnaires are anonymous and will remain confidential.

Questionnaire for Nurses

Communication in Health

Thank you very much for participating in this research project and completing this questionnaire. Your opinions will assist us in understanding the challenges that health professionals may face in terms of cultural in linguistic barriers when providing medical care to persons of another culture and language than their own.

Please mark appropriate boxes with an X.

SECTION A TO BE COMPLETED BY EVERYONE

1. Name of Health Care Facility

Red Cross Hospital	G F Jooste Hospital	Khayelitsha Day Hospital
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2. Position at Institution

Nursing Auxiliaries/Assistant Nurse	Enrolled Nurses/Staff Nurse	Professional Nurse/Sisters or Charge Nurses
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3. Years of service at current Health Care Facility

<2 years	2-5 years	5-10 years	>10 years
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4. Sex

Male	Female
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5. Rate your competence/proficiency in conversing in the Xhosa language

Very Poor	Poor	Average	Good	Very Good
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6. Mother tongue / first language

English	Afrikaans	Xhosa	Other African Language	Other Foreign Language
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SECTION B
TO BE COMPLETED BY EVERYONE

1. Are you aware of either a national, provincial or hospital policy that focuses on the use of interpreters in health care?

Yes	No
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2. If yes, which policy are you aware of?

National Policy	Provincial Policy	Hospital Policy
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3. Is there a copy of a policy or management guidelines for use of interpreters (trained or ad hoc) for health professionals at your health care facility?

Yes	No
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4. If yes, is the copy of the policy or management guidelines easily accessible to all personnel involved with patient-health professional interaction at your facility?

Not at all	Fairly accessible	Accessible	Very accessible	Extremely accessible
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SECTION C

1. Is an interpreting service offered at your Health Care Facility?

Yes	No
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If YES answer question 2 onwards, if NO answer from question 6 onwards.

2. The interpreting service provided, is accessible...

During working hours only	24 hours daily	After hours	No service provided
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3. If working hours only, who is used to assist both patients and health professionals after hours?

4. Have your interpreters received any formal training?

Yes	No
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5. How accessible are interpreters in your health care facility?

Not at all	Fairly accessible	Accessible	Very accessible	Extremely accessible
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6. How do you view the interpreter used with regards to status, do you see them as...

Part of the medical team	A middle man	Part of the patient unit
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7. Please list the main language your **patients** speaks and approximate the percentage (i.e. what you are aware of)

Language patients speak	Approximate Percentage of those speakers

8. Please list the main languages the **nursing staff** in your Health Care Facility speaks as well as the approximate percentage (i.e. what you are aware of).

Language Nursing Staff speak	Approximate Percentage of those speakers

9. Please list the main languages the **medical doctors** in your Health Care Facility speak as well as the approximate percentage (i.e. what you are aware of).

Language Medical Doctors speak	Approximate Percentage of those speakers

SECTION D
TO BE COMPELTED BY EVERYONE

1. Who is used to assist in communication between the patient and health professional? In addition, please indicate the approximate percentage of how often the various persons are used.

No-one	Nurses	Family/friends of patient	Cleaning staff	Other health professionals
None	None	None	None	None
1-20%	1-20%	1-20%	1-20%	1-20%
21-40%	21-40%	21-40%	21-40%	21-40%
41-60%	41-60%	41-60%	41-60%	41-60%
61-80%	61-80%	61-80%	61-80%	61-80%
81-100%	81-100%	81-100%	81-100%	81-100%

2. Have you as a Nurse ever been called out to interpret?

Yes	No
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3. How often does this happen?

Never	Infrequently	Sometimes	Frequently	All the time
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4. How do you feel being called out to interpret?

Dislike it completely	Don't mind	Enjoy it	Enjoy it a little	Enjoy it a lot
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5. Do you see it as part of your job?

Yes	No
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6. Does it interfere with your workload?

Yes	No
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7. What percentage of your day is spent interpreting?

0%	1-25%	26-50%	51-75%	76-100%
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8. Has the fact that you may be used as an interpreter ever been explained to you?

Yes	No
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9. How difficult do you find this task of interpreting?

Not difficult at all	Fairly difficult	Easy	Very easy	Extremely easy
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SECTION E
TO BE COMPLETED BY EVERYONE

1. Do you think that there is an evident cultural and communication barrier that occurs between patient and health professional?

Yes	No
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2. Do you think that every patient has a right to receive treatment in his/her language of preference/mother tongue?

Yes	No
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3. If yes, are patients who speak a different language to the health professional examining them always offered an 'interpreter' at your health facility?

Never	Infrequently	Sometimes	Frequently	All the time
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4. Do you think patients feel at ease/happy when a third party (an interpreter) is introduced into their consultation?

Never	Infrequently	Sometimes	Frequently	All the time
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5. How beneficial to the team do you feel the use of an interpreter is?

Not at all	Fairly beneficial	Beneficial	Very beneficial	Extremely beneficial
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SECTION F
TO BE COMPLETED BY EVERYONE

1. Are you currently engaging in any workshops, activities, courses, etc to assist you in overcoming the communication barrier you may experience with your patients?

Yes	No
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2. If YES, please list

3. Does your Health Care Facility provide any opportunity in which to enhance your knowledge and strategies with regards to communication and culture?

Yes	No
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4. If yes, what do they offer?

5. What 3 things can you suggest that can assist health professionals and your respective Health Care Facilities in bridging this 'communication gap'?

University of Capetown

8.4 Appendix 4 – Framework of Questions Employed During Interviews With Health Professionals Across the Three Health Care Facilities

University of Cape Town

Interviewing Framework for Heads of Clinics

Theme 1: Clinic Specific

- **Cancer:** Requiring a lot of explanations, information giving and counseling, how do you attempt to bridge this gap, as often it involves quite complex information giving processes?
- **ICU:** Critical / life threatening circumstances often at your doorstep, where family members are often in distress, this is further aggravated by the problem of language accessibility. Is the addressed seriously? Would you say your staff generally uses interpreters?
- **Trauma:** Things in trauma happen obviously on the spur of the moment and accessing staff or interpreters is thus often not an easy task. What are the general on goings as such, how are such fast pace situations handled?
- **Surgery:** Consent prior to surgery is critical in any setting and more importantly, understanding the procedure to be undertaken and possible outcomes. How do you conform to these ethical 'musts'?

Theme 2: Need for Interpreters

- Do you feel that within ' ', you experience a great deal of language diversity between health professionals and patients?
- How do you accommodate for this problem of language accessibility?
- Do you make use of the interpreters?
- Are you aware of them and their role?
- What, or is there anything different in your department as opposed to any other, that may call for more or less use of interpreters?
- How do you view the role of the interpreter as part of the team?

Theme 3: The Interpreting System

- ' ' requires quite a lot of interaction with the patient, ranging from gaining consent in some cases, to case history and counseling, thus incorporating a lot of information giving and one on one interactions.
- Does your department have accessibility to the interpreters?
- How efficient is the system? I.e. how often do you actually make use of them and if unable to access them in time of need, what are your recommendations to your staff?
- Who do they utilize as an interpreter / middle man in instances when an interpreter is unavailable?
- Is there a formality explained to health professionals for use of interpreters?

Theme 4: Ethical Considerations

- Do you think the patient feels that they are receiving fair treatment / service when an interpreter is used and the consultation is not 'one on one' as such or alternatively do you think it is fair that a patient does not have linguistic accessibility, resulting in a breach of confidentiality, which is a problem on the

with the use of both trained and ad hoc interpreters, and more specifically at the clinician / health professional during this consultation. That is, it looks to training health professionals in working with trained and untrained interpreters. How do you see this as being beneficial for the future?

University of Cape Town

Interviewing Framework for Management

Language Accessibility and Culture

Theme 1: Policy and Guidelines

- Can you tell me a little about whether there is a formal policy at either or both the provincial and/or national levels of health? (Re: interpreting??)
- Tell me about the policy or policy that addresses communication accessibility of patients
 - where health professionals are English and patients are either Xhosa for example, or the culture and language across this type of consulting dyad differs.
- What are the implications of the above? (Possibly may reply: 'Use of interpreters'), then,
- Does RXH have any formal policy?
- What does it entail? (If different from DOH, ask to get a copy of it).
- What are the specific guidelines (if any) for health professional with regard to communication / language accessibility and the resultant service they provide?
- As part of the management team of RXH, how do you feel about this issue that is currently being posed as a problem in the general context of things (i.e. not specific to RXH, and addressing the topic of language accessibility)?
- What is your view regarding how health professionals prioritise this 'gap' (language and culture), considering their constant stress and strain? I.e. are they keen to address this communication breakdown? If so, how do they manage this, what do they do?
- Regarding any cultural issues that may arise in a consultation, what are / if any, the guidelines, policy or committees that address such issues and relationships between the health professionals and patients?

Theme 2: Implementation and Use

- What is the planned structures Vs the actual processes of the hospital (RXH)?
- What structures have been put into RXH to support this policy? (If reply is two full-time interpreters have been employed, then go into the role of the interpreter)
 - What is their job description?
 - What is their salary / where does it come from?
 - Who do they serve?
 - Why two and not more or less?
 - Is this as a result of financial constraints, no more posts, what is the cause? (Look at other systems)
 - What is the demand for interpreters?
 - If unable to get an interpreter, how do the health professionals compensate?
 - Who gets precedence regarding the use of interpreters?
 - How do health professionals access the interpreters, what system / framework, is used?
 - How does the system work?

(Two interpreters cannot realistically serve the entire hospital)

- What is your view on the use of ad hoc interpreters?
- What are your feelings with regard to the use of nursing staff as sit in interpreters?
- What pressure do you think this is adding to the nurse's workload?
- How do you think, they feel about it?
- What are your perceptions regarding their views on being used from an alternate service?
- If there were a nurse shortage where would their priorities regarding service lie?

(If use ad hoc interpreters)

- Who generally acts as ad hoc interpreters?
- Is there a policy regarding the use of ad hoc interpreters?
- What actually happens?

Theme 3: Interpreter Specific

- Where do you find / look for / advertise for your interpreters?
 - What qualifications do require of them? (What qualifications meet the employment criteria?)
 - Are you aware of the courses offered for interpreters?
 - Have they completed any formal courses regarding interpreting?
 - What structure of employment do they receive? (I.e. contract, temporary, permanent, etc)
 - What is the interpreters role in the hospital? (Job description / outline)
 - Who do they report to?
 - How are they monitored?
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- How had RXH manage with this problem of language accessibility and culture in the past and what do you foresee to better this gap in the future?

Theme 4: Ethical Considerations

- Do you think the patient feels that they are receiving fair treatment / service when an interpreter is used and the consultation is not 'one on one' as such or alternatively do you think it is fair that a patient does not have linguistic accessibility, resulting in a breach of confidentiality, which is a problem on the other hand. How do we get around this? What pro's and con's can you derive from the two scenarios?
- I'm not sure whether you are aware or not, of the new medical curriculum happening in the sixth semester. Well, it looks at the triad of a consultation with the use of both trained and ad hoc interpreters, and mores specifically at the clinician / health professional during this consultation. That is, it looks to training health professionals in working with trained and untrained interpreters. How do you see this as being beneficial for the future?

other hand. How do we get around this? What pro's and con's can you derive from the two scenarios?

- I'm fully aware of the problem with interpreters, not having access to patients medical information etc, and I'm not sure whether you are aware or not, of the new medical curriculum happening in the sixth semester. Well, it looks at the triad of a consultation with the use of both trained and ad hoc interpreters, and more specifically at the clinician / health professional during this consultation. That is, it looks to training health professionals in working with trained and untrained interpreters. From a departmental point of view, on language, what do you see as something formal that can be done about it?

University of Cape Town

Interviewing Framework for Health Professionals

Theme 1: Interpreting Practices within the Busy Health Context

- Red Cross is an extremely busy institution, with large amounts of caseloads to get through on a daily basis:
- Due to the diversity of people in South Africa, health professionals and patients are often of different language and cultural groups. How is this posed as a problem for you as a health professional in today's society, having to service people with whom it may be difficult to communicate with and relate to due to cultural variations?
- What is your view with regards to the need for interpreters in the health system?
- What suggestions could you give to narrow this communication gap that occurs between the health professional and patient?
- Is there practicality in using an interpreting system?

Theme 2: The Interpreting System

- Do you find the interpreters easy to access?
- What if you can't access an interpreter, what do you do then?
- Are they willing, and how do they feel using them?
- How often do you use them?
- Has the process of accessing an interpreter ever been explained to you?

Theme 3: Health Professional and Interpreter Inter personal Dynamics

- How do you feel working with interpreters?
- How competent do you feel they are (do you trust them fully in relaying information)?
- How do you think they feel with regards to acting as interpreters? (if ad hoc, bring in questions around that)
- How proficient are you in working with an interpreter?
- Have you had any experience or practice in working with an interpreter or do you think that it is an obvious process?
- How do you see an interpreter with regards to status? (i.e. do you see them as part of the team, or how do you perceive them?)

Theme 4: Ethical Considerations

- Do you think the patient feels that they are receiving fair treatment / service when an interpreter is used and the consultation is not 'one on one' as such or alternatively do you think it is fair that a patient does not have linguistic accessibility, resulting in a breach of confidentiality, which is a problem on the other hand. How do we get around this? What pro's and con's can you derive from the two scenarios?
- I'm not sure whether you are aware or not, of the new medical curriculum happening in the sixth semester. Well, it looks at the triad of a consultation

Interviewing Framework for Nursing

Theme 1: Biographical Information

- What is your job description?
- What type of workload do you actually experience here, and what does it entail?

Theme 2: Interpreting Activities

- Have you or any of your colleagues ever been called in to interpret?
- How often does this happen?
- Where do they call you from?
- Does it interfere with your work? What do you do in such a case?
- Is it clinic / ward specific when you or colleagues are called or is it extended into other wards?
- Does it, and if so, how does this affect your workday?

Theme 3: Feelings and Perceptions

- Has the fact that you may be used as an interpreter ever been addressed to you by anyone?
- How do you feel when you are called?
- Do you feel obliged to go when you are called? Or do you / colleagues enjoy doing it?
- What do you think your role is as an interpreter, acting as a middleman or a health professional, seeing that you have medical knowledge?
- How if indeed, is this a difficult task for you?

Theme 4: Ethical Considerations

- Do you think the patient feels that they are receiving fair treatment / service when an interpreter is used and the consultation is not 'one on one' as such or alternatively do you think it is fair that a patient does not have linguistic accessibility, resulting in a breach of confidentiality, which is a problem on the other hand. How do we get around this? What pro's and con's can you derive from the two scenarios?
- I'm not sure whether you are aware or not, of the new medical curriculum happening in the sixth semester. Well, it looks at the triad of a consultation with the use of both trained and ad hoc interpreters, and mores specifically at the clinician / health professional during this consultation. That is, it looks to training health professionals in working with trained and untrained interpreters. How do you see this as being beneficial for the future?

Interviewing Framework for Interpreters

Theme 1: Background Training and Formal Interpreter Training

- Where did you undertake your training to become an interpreter?
- What did the course entail? (include duration and practical issues)

Theme 2: Interpreting in Health

- How long have you been practicing as an interpreter and more so in the realm of health care? (more specifically at Red Cross Hospital)
- How do you think that your training has equipped you for this job? (Do you think...)
- How did you adapt to interpreting in a health system as opposed...?
- How do you enjoy working in the health system?

Theme 3: Job Structure

- On what basis are you employed? (temporary vs permanent)
- How did you feel about the uncertainty of your position, not knowing the stability of your position?
- How many interpreters are there that service Red Cross?
- Do you feel that that's an adequate number?
- What is your job description?
- Do you feel that you adhere to that, and are paid accordingly?
- Where is your base?
- Could you explain your workload and hours?
- How do you view your role, firstly as an interpreter and secondly, as the member of a bigger team?
- How important do you view your role?
- How do you think other health professionals perceive you?
- What do you advise health professionals when you are unable to assist?

Theme 4: Ad Hoc Interpreters

- What are your views on the use of ad hoc interpreters?
- If they were to be used, whom would you recommend do this job?

Theme 5: Interpreting System within the Establishment

- Tell me a bit about how the interpreting system works:
 - What are the formal channels that you 'should' follow in acquiring an interpreter? (i.e. what is the procedure that should be undertaken when health professionals require your service)
 - Who monitors you? How often are you monitored and whom do you report to?
 - What clinics do you service?
 - Why those ones in particular and not others?
 - Which clinics do you prefer working in? Why?
 - Do you feel more competent in certain clinics? Why?